

MISSISSIPPI DIVISION OF MEDICAID UNIVERSAL PREFERRED DRUG LIST

EFFECTIVE 10/1/2026
VERSION 2026_14
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General Preferred Drug List Information

- Gainwell Technologies DUR+ process is a proprietary electronic prior authorization system used for Medicaid pharmacy claims.
- Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an all-inclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.
- **PREFERRED BRANDS** will not count toward the two-brand monthly Rx Limit.
- Drugs highlighted in **yellow** denote change in PDL status.
- To search the PDL, **press CTRL + F**.

Medication Coverage Status Search Tool - [Pharmacy Drug Coverage Inquiry](#)

ACNE AGENTS

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTI-INFECTIVES		Maximum Age Limit • 21 years: all acne agents except isotretinoin products Topical Clindamycin 1% lotion • 21 years and older AND • Documented diagnosis of hidradenitis suppurativa Note: Isotretinoin products available for all ages Clindamycin 1% lotion only available for ages 21 years and older with approvable diagnosis Preferred clindamycin 1% lotion for ages < 21 years does not require PA
clindamycin gel (generic CLEOCIN-T)	azelaic acid	
clindamycin lotion, medicated swab, solution	CLEOCIN T (clindamycin)	
erythromycin gel, solution	CLINDACIN (clindamycin)	
	clindamycin foam	
	clindamycin gel (generic CLINDAGEL)	
	dapsone	
	ERY (erythromycin)	
	MORGIDOX (doxycycline)	
	sulfacetamide sodium suspension	
	WINLEVI (clascoterone) cream	
ISOTRETINOIN PRODUCTS		
AMNESTEEM (isotretinoin)	ABSORBICA (isotretinoin)	
CLARAVIS (isotretinoin)	isotretinoin	
ZENATANE (isotretinoin)		
KERATOLYTICS (BENZOYL PEROXIDES)		
ACNE MEDICATION (benzoyl peroxide)	BPO towelette (benzoyl peroxide)	
benzoyl peroxide		
RETINOIDS		
adapalene gel, gel with pump	adapalene cream	
tretinoin cream	AKLIEF (trifarotene)	
	ATRALIN (tretinoin)	
	DIFFERIN (adapalene)	
	FABIOR (tazarotene)	
	tretinoin gel	
	tretinoin microsphere	
OTHERS/COMBINATION PRODUCTS		
adapalene/benzoyl peroxide gel	CLEANSING WASH (sulfacetamide sodium/sulfur/urea) cleanser	
clindamycin/benzoyl peroxide 1%-5% gel	clindamycin phosphate/benzoyl peroxide 1.2%-2.5% gel	
clindamycin phosphate/benzoyl peroxide 1.2%-5% gel	clindamycin/benzoyl peroxide 1.2%-3.75% gel w/pump (generic ONEXTON)	
sodium sulfacetamide w/sulfur 8%-4%, 9%-4.25%, 10-5% suspension	clindamycin phosphate/tretinoin 1.2%-0.025% gel	

	EPIDUO FORTE (adapalene/benzoyl peroxide) gel	
	erythromycin/benzoyl peroxide gel	
	NEUAC (benzoyl peroxide/clindamycin) cream, gel	
	sodium sulfacetamide w/sulfur 9.8%-4.8%	
	sodium sulfacetamide w/sulfur 10%-2% cream	
	sodium sulfacetamide w/sulfur 10%-5% cream, lotion	
	SSS (sodium sulfacetamide/sulfur)10-5 cream, foam	
	TWYNEO (benzoyl peroxide/tretinoin) cream	
ALPHA-1 PROTEINASE INHIBITORS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ARALAST NP		
GLASSIA		
PROLASTIN C		
ZEMAIRA		
ALZHEIMER’S AGENTS ^{DUR+}		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
CHOLINESTERASE INHIBITORS		Preferred Criteria - Documented approvable diagnosis Non-Preferred Criteria - Documented approvable diagnosis AND - Have tried 2 different preferred agents in the past 6 months NAMZARIC - Requires clinical review ZUNVEYL - Requires clinical review
donepezil 5 mg, 10 mg ODT, tablets	ARICEPT (donepezil)	
galantamine	donepezil 23 mg tablet	
galantamine ER	EXELON (rivastigmine)	
rivastigmine	ZUNVEYL (benzgalantamine gluconate)	
NMDA RECEPTOR ANTAGONISTS		
memantine	memantine ER	
	NAMENDA XR (memantine ER)	
COMBINATION AGENTS		
	memantine/donepezil ER	
	NAMZARIC (memantine/donepezil)	
ANALGESICS, OPIOID-SHORT ACTING ^{DUR+}		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
acetaminophen/caffeine/dihydrocodeine	ASCOMP WITH CODEINE (aspirin/butalbital/caffeine/codeine)	MS DOM Opioid Initiative Criteria details found here Morphine Equivalent Daily Dose

acetaminophen/codeine	aspirin/butalbital/caffeine/codeine	- Concomitant use of Opioids and Benzodiazepines Minimum Age Limit 6 years: tapentadol solution 18 years: codeine-containing products and tramadol-containing products Quantity Limit (per 31 rolling days) 62 tablets: butalbital/codeine combinations, codeine combinations, dihydrocodeine combinations, fentanyl, hydrocodone, hydromorphone, levorphanol, meperidine, morphine, oxycodone, oxymorphone, pentazocine, tapentadol, tramadol 186 tablets: butalbital/acetaminophen, butalbital/aspirin 5 mL: butorphanol nasal 180 mL: oxycodone liquid 280 mL: QDOLO Non-Preferred Criteria - Requires clinical review
codeine	butalbital/acetaminophen/caffeine/codeine	
ENDOCET (oxycodone/acetaminophen)	butorphanol	
hydrocodone/acetaminophen	carisoprodol/aspirin/codeine	
hydromorphone	DILAUDID (hydromorphone)	
morphine sulfate	FIORICET WITH CODEINE (butalbital/acetaminophen/codeine)	
oxycodone	hydrocodone/ibuprofen	
oxycodone/acetaminophen (325 mg acetaminophen formulations)	levorphanol	
tramadol 50 mg tablet	meperidine	
tramadol/acetaminophen	NALOCET (oxycodone/acetaminophen)	
	oxymorphone	
	pentazocine/naloxone	
	PERCOCET (oxycodone/acetaminophen)	
	PROLATE (oxycodone/acetaminophen)	
	ROXICODONE (oxycodone)	
	ROXYBOND (oxycodone)	
	tapentadol	
	tramadol 25 mg, 75 mg, 100 mg tablet	
	tramadol solution	
	XYVONA (levorphanol)	
ANALGESICS, OPIOID-LONG ACTING ^{DUR+}		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
BUTRANS (buprenorphine)	BELBUCA (buprenorphine)	Quantity Limit (per 31 rolling days) 31 tablets: AVINZA, hydromorphone ER, HYSINGLA ER, tramadol ER 62 tablets: methadone, morphine ER, OXYCONTIN, oxymorphone ER, ZOHYDRO ER 62 films: BELBUCA 10 patches: fentanyl 4 patches: BUTRANS Non-Preferred Criteria - Have tried 2 preferred agents in the past 6 months Minimum Age Limit 18 years: BUTRANS
fentanyl patch	buprenorphine patch	
morphine sulfate ER tablet	CONZIP (tramadol)	
	DISKETTS (methadone)	
	hydrocodone ER	
	hydromorphone ER	
	HYSINGLA ER (hydrocodone)	
	methadone	
	methadone intensol	
	METHADOSE (methadone)	
	morphine sulfate ER capsule	
	MS CONTIN (morphine)	
	oxycodone ER	
	OXYCONTIN (oxycodone)	
	oxymorphone ER	
	tapentadol ER	

	tramadol ER	
ANALGESICS/ANESTHETICS (TOPICAL)		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
diclofenac 3% gel	DERMACINRX LIDOCAINE (lidocaine)	Quantity Limit (per 31 days) • 1 bottle (112 mL): diclofenac 2% solution pump Non-Preferred Criteria • Have tried 2 preferred agents in the past 6 months Lidocaine 5% Patch • Documented diagnosis of Herpetic Neuralgia OR • Documented diagnosis of Diabetic Neuropathy ZTLIDO • Documented diagnosis of postherpetic neuralgia OR • History of 3 claims with preferred lidocaine 5% patch in the past 6 months
lidocaine 2% viscous solution	DERMACINRX LIDOCAN (lidocaine)	
lidocaine 4% cream, solution	DERMACINRX LIDOGEL (lidocaine)	
lidocaine 5% ointment, patch	DERMACINRX LIDOREX (lidocaine)	
lidocaine/prilocaine cream	diclofenac epolamine	
TRIDACAINE (lidocaine) patch	diclofenac sodium 2% solution pump	
TRIDACAINE XL (lidocaine) patch	DICLOGEN (diclofenac/menthol/camphor) kit	
	DOLOGESIC PAIN RELIEF (lidocaine)	
	LIDAFLEX (lidocaine)	
	lidocaine 3% cream	
	lidocaine 4% kit, liquid	
	lidocaine/hydrocortisone	
	lidocaine/prilocaine kit	
	LIDOCAN II, III, IV, V (lidocaine)	
	LIDOCORT (lidocaine/hydrocortisone)	
	LIDODERM (lidocaine)	
	LIDOTRAL (lidocaine)	
	LIXOFEN (diclofenac)	
	PLIAGLIS (lidocaine/tetracaine)	
	TRIDACAINE II, III (lidocaine) patch	
	ZTLIDO (lidocaine)	
ANDROGENIC AGENTS ^{DUR+}		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
testosterone	ANDROGEL (testosterone)	All Agents • Limited to male gender Non-Preferred Criteria • Have tried 2 different preferred agents in the past 6 months TLANDO • Requires clinical review
	JATENZO (testosterone undecanoate)	
	NATESTO (testosterone)	
	TESTIM (testosterone)	
	TLANDO (testosterone undecanoate)	
	VOGELXO (testosterone)	
ANGIOTENSIN MODULATORS ^{DUR+}		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA

ANGIOTENSIN CONVERTING ENZYME (ACE) INHIBITORS	
benazepril	ACCUPRIL (quinapril)
captopril	ALTACE (ramipril)
enalapril	EPANED (enalapril)
fosinopril	LOTENSIN (benazepril)
lisinopril	moexipril
quinapril	perindopril
ramipril	QBRELIS (lisinopril)
trandolapril	ZESTRIL (lisinopril)
ACE INHIBITOR (ACEI) COMBINATIONS	
benazepril/amlodipine	ACCURETIC (quinapril/hydrochlorothiazide)
benazepril/hydrochlorothiazide	LOTENSIN HCT (benazepril/hydrochlorothiazide)
captopril/hydrochlorothiazide	LOTREL (benazepril/amlodipine)
enalapril/hydrochlorothiazide	ZESTORETIC (lisinopril/hydrochlorothiazide)
fosinopril/hydrochlorothiazide	
lisinopril/hydrochlorothiazide	
quinapril/hydrochlorothiazide	
trandolapril/verapamil ER	
ANGIOTENSIN II RECEPTOR BLOCKERS (ARBs)	
irbesartan	ARB LI (losartan)
losartan	ATACAND (candesartan)
olmesartan	AVAPRO (irbesartan)
telmisartan	azilsartan
valsartan tablet	BENICAR (olmesartan)
	candesartan
	COZAAR (losartan)
	DIOVAN (valsartan)
	EDARBI (azilsartan)
	MICARDIS (telmisartan)
	valsartan solution
ARB COMBINATIONS	
irbesartan/hydrochlorothiazide	ATACAND HCT (candesartan/hydrochlorothiazide)
losartan/hydrochlorothiazide	AVALIDE (irbesartan/hydrochlorothiazide)
olmesartan/amlodipine	AZOR (olmesartan/hydrochlorothiazide)

EPANED

- Automatic approval issued for 0-6 years of age

valsartan/sacubitril

- Age ≥1 year **and** documented diagnosis of Heart Failure with Systemic Ventricular Systolic Dysfunction **OR**
- Age ≥ 18 years **and** documented diagnosis of Heart Failure

Non-Preferred Criteria

- ACEIs:**
 - Have tried 2 different preferred single entity agents in the past 6 months **OR**
 - 90 days of therapy with the requested agent in the past 105 days
- ACEI Combinations:**
 - Have tried 2 different preferred ACEI combination agents in the past 6 months **OR**
 - 90 days of therapy with the requested agent in the past 105 days
- ACEI/Diuretic Combinations:**
 - Have tried 2 different preferred ACEI/Diuretic agents in the past 6 months **OR**
 - 90 days of therapy with the requested agent in the past 105 days
- ARBs:**
 - Have tried 2 different preferred single entity agents in the past 6 months **OR**
 - 90 days of therapy with the requested agent in the past 105 days
- ARB Combinations:**
 - Have tried 1 preferred ARB combination agent in the past 6 months **OR**
 - 90 days of therapy with the requested agent in the past 105 days
- ARB/Diuretic Combinations:**
 - Have tried 2 different preferred ARB/Diuretic agents in the past 6 months **OR**
 - 90 days of therapy with the requested agent in the past 105 days
- Direct Renin Inhibitors:**
 - Documented diagnosis of Hypertension **AND**
 - Have tried 2 different preferred ACEI or ARB single-entity agents in the past 6 months **OR**
 - 90 days of therapy with the requested agent in the past 105 days
- Direct Renin Inhibitor Combinations:**
 - Documented diagnosis of Hypertension **AND**
 - Have tried 2 different preferred ACEI or ARB diuretic agents in the past 6 months **OR**
 - 90 days of therapy with the requested agent in the past 105 days
 - Have tried 2 different preferred ACEI/Diuretic agents in the past 6 months **OR**
 - 90 days of therapy with the requested agent in the past 105 days

olmesartan/amlodipine/hydr ochlorothiazide	BENICAR HCT (olmesartan/hydrochlorothia zide)		
olmesartan/hydrochlorothia zide	candesartan/hydrochlorothia zide		
telmisartan/hydrochlorothia zide	DIOVAN-HCT (valsartan/hydrochlorothiazi de)		
valsartan/amlodipine	EDARBYCLOR (azilsartan/chlorthalidone)		
valsartan/hydrochlorothiazi de	ENTRESTO (valsartan/sacubitril)		
valsartan/sacubitrij ^{DUR+}	EXFORGE (valsartan/amlodipine)		
	EXFORGE HCT (valsartan/amlodipine/hydro chlorothiazide)		
	HYZAAR (losartan/hydrochlorothiazid e)		
	MICARDIS HCT (telmisartan/hydrochlorothia zide)		
	telmisartan/amlodipine		
	TRIBENZOR (olmesartan/amlodipine/hydr ochlorothiazide)		
	valsartan/amlodipine/hydroc hlorothiazide		
	WIDAPLIK (telmisartan/amlodipine/inda pamide)		
DIRECT RENIN INHIBITORS			
	aliskiren		
	TEKTURNA (aliskiren)		
ANTIBIOTICS (GI) & RELATED AGENTS			
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA	
metronidazole tablet	AEMCOLO (rifamycin)		
neomycin	DIFICID (fidaxomicin)		
tinidazole	FIRVANQ (vancomycin)		
vancomycin capsule, oral solution	FLAGYL (metronidazole)		
	LIKMEZ (metronidazole)		
	metronidazole 125 mg tablet, 375 mg capsule		
	nitazoxanide		
	paromomycin		
	REBYOTA (fecal microbiota, live-jslm)		
	VANCOCIN (vancomycin)		
	VOWST (fecal microbiota spore, live-brpk)		
ANTIBIOTICS (MISCELLANEOUS)			

PREFERRED AGENTS		NON-PREFERRED AGENTS		PA CRITERIA	
LINCOSAMIDE ANTIBIOTICS				Quantity Limit • 6 tablets/month: SIVEXTRO SIVEXTRO MANUAL PA	
clindamycin		CLEOCIN (clindamycin)			
		CELOCIN PEDIATRIC (clindamycin)			
MACROLIDES					
azithromycin		E.E.S. (erythromycin ethylsuccinate) suspension			
clarithromycin		ERYPED (erythromycin ethylsuccinate) suspension			
clarithromycin ER		ERYTHROCIN (erythromycin stearate)			
E.E.S. (erythromycin ethylsuccinate) 400mg tablet		ZITHROMAX (azithromycin)			
ERY-TAB (erythromycin)					
erythromycin					
erythromycin ethylsuccinate					
NITROFURANTOIN DERIVATIVES					
nitrofurantoin capsule		FURADANTIN (nitrofurantoin) suspension			
nitrofurantoin monohydrate macrocrystals		MACROBID (nitrofurantoin monohydrate macrocrystals)			
		nitrofurantoin suspension			
OXAZOLIDINONES					
linezolid tablet		linezolid suspension			
		SIVEXTRO (tedizolid)			
		ZYVOX (linezolid)			
ANTIBIOTICS (TOPICAL)					
PREFERRED AGENTS		NON-PREFERRED AGENTS		PA CRITERIA	
bacitracin ^{OTC}		CENTANY (mupirocin)			
bacitracin/polymyxin ^{OTC}		CENTANY AT (mupirocin)			
gentamicin sulfate		mupirocin cream			
mupirocin ointment		XEPI (ozenoxacin)			
neomycin/bacitracin/polymyxin ^{OTC}					
ANTIBIOTICS (VAGINAL)					
PREFERRED AGENTS		NON-PREFERRED AGENTS		PA CRITERIA	
CLEOCIN (clindamycin)		clindamycin phosphate			
NUVESSA (metronidazole)		CLINDESSE (clindamycin)			
		SOLOSEC (secnidazole)			
		XACIATO (clindamycin)			
ANTICOAGULANTS					
PREFERRED AGENTS		NON-PREFERRED AGENTS		PA CRITERIA	

LOW MOLECULAR WEIGHT HEPARIN (LMWH)		Non-Preferred Criteria • LMWH: ○ Have tried 1 preferred agent in the past 6 months OR ○ 90 days of therapy with the requested agent in the past 105 days • Oral: ○ Have tried 2 different preferred oral agents in the past 6 months OR ○ 90 days of therapy with the requested agent in the past 105 days XARELTO Dose Pack • Requires clinical review
enoxaparin	ARIXTRA (fondaparinux)	
	fondaparinux	
	FRAGMIN (dalteparin)	
	LOVENOX (enoxaparin)	
ORAL		
dabigatran	PRADAXA (dabigatran)	
ELIQUIS (apixaban)	rivaroxaban	
ELIQUIS SPRINKLE (apixaban)	SAVAYSA (edoxaban)	
JANTOVEN (warfarin)	XARELTO (rivaroxaban) dose pack	
warfarin		
XARELTO (rivaroxaban) tablet, suspension		
ANTICONVULSANTS ^{DUR+}		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ADJUVANTS		Minimum Age Limit • 6 months: DIACOMIT • 1 year: BANZEL, EPIDIOLEX • 2 years: ONFI, SYMPAZAN, SUBVENITE, VALTOCO • 12 years: NAYZILAM • 18 years: XCOPRI Maximum Age Limit • 2 years: VIGAFYDE Quantity Limit (per 31 days) • 2 twin packs: DIASTAT • 2 packages: NAYZILAM • 5 blister packs: VALTOCO Non-Preferred Criteria • Have tried 2 different preferred agents in the past 6 months OR • Documented diagnosis of Seizure AND • 90 days of therapy with the requested agent in the past 105 days BANZEL, ONFI, and SYMPAZAN • Documented diagnosis of Lennox-Gastaut Syndrome and have tried 1 preferred agent for Lennox-Gastaut Syndrome in the past 6 months OR • Documented diagnosis of Seizure AND 90 days of therapy with the requested agent in the past 105 days DIACOMIT • Documented diagnosis of Dravet Syndrome AND • 1 claim for clobazam in the past 30 days EPIDIOLEX • Documented diagnosis of Dravet Syndrome, Lennox-Gastaut Syndrome, or Seizures associated with Tuberous Sclerosis Complex OR • 1 claim for EPIDIOLEX in the past 30 days
carbamazepine	APTIOM (eslicarbazepine acetate)	
carbamazepine ER 12-hour capsule	BANZEL (rufinamide)	
DEPAKOTE ER (divalproex)	brivaracetam	
DEPAKOTE SPRINKLE (divalproex)	BRIVIACT (brivaracetam)	
divalproex	carbamazepine ER 12-hour tablet	
divalproex ER	CARBATROL (carbamazepine)	
divalproex sprinkle	DEPAKOTE (divalproex)	
EPIDIOLEX (cannabidiol)	DIACOMIT (stiripentol)	
lacosamide	ELEPSIA XR (levetiracetam)	
lamotrigine	EPRONTIA (topiramate)	
lamotrigine blue, green, orange dose pack	EQUETRO (carbamazepine)	
levetiracetam	eslicarbazepine	
levetiracetam ER	felbamate	
oxcarbazepine tablet	FELBATOL (felbamate)	
tiagabine	FINTEPLA (fenfluramine)	
topiramate	FYCOMPA (perampanel)	
topiramate sprinkle 15, 25 mg (generic Topamax)	KEPPRA (levetiracetam)	
TRILEPTAL (oxcarbazepine) suspension	KEPPRA XR (levetiracetam)	
valproic acid	LAMICTAL (lamotrigine)	
zonisamide	LAMICTAL XR (lamotrigine)	
	lamotrigine ER	
	lamotrigine ODT	

	lamotrigine ODT blue, green, orange dose pack	FINTEPLA Requires clinical review
	MOTPOLY XR (lacosamide)	
	oxcarbazepine suspension	SABRIL Powder for Oral Solution - Documented diagnosis of Infantile Spasms OR - Have tried 2 different preferred agents in the past 6 months OR - Documented diagnosis of Seizure AND 90 days of therapy with the requested agent in the past 105 days
	oxcarbazepine ER	
	OXTELLAR XR (oxcarbazepine)	TOPIRAMATE ER - Documented diagnosis of Seizure AND 90 days of therapy with the requested agent in the past 105 days OR 30 days of therapy with topiramate IR in the past 6 months
	perampanel	
	QUDEXY XR (topiramate)	VIGAFYDE - Age $\leq$ 2 years AND - Documented diagnosis of infantile spasms
	ROWEEPRA (levetiracetam)	
	rufinamide	
	SABRIL (vigabatrin)	
	SPRITAM (levetiracetam)	
	SUBVENITE (lamotrigine)	
	SUBVENITE (lamotrigine) blue, green, orange dose pack	
	TEGRETOL (carbamazepine)	
	TEGRETOL XR (carbamazepine)	
	TOPAMAX TABLET (topiramate)	
	TOPAMAX SPRINKLE (topiramate)	
	topiramate ER capsule (generic Trokendi XR)	
	topiramate ER sprinkle capsule (generic Qudexy XR)	
	topiramate sprinkle 50 mg	
	TRILEPTAL (oxcarbazepine) tablet	
	TROKENDI XR (topiramate)	
	vigabatrin	
	VIGADRON (vigabatrin)	
	VIGAFYDE (vigabatrin)	
	VIGPODER (vigabatrin)	
	VIMPAT (lacosamide)	
	XCOPRI (cenobamate)	
	ZONISADE (zonisamide) suspension	
	ZTALMY (ganaxolone)	
HYDANTOINS		
	DILANTIN (phenytoin)	
	DILANTIN-125 (phenytoin)	
	PHENYTEK (phenytoin)	
	phenytoin	
	phenytoin ER	
SELECTED BENZODIAZEPINES		
	clobazam	
	DIASTAT (diazepam) rectal gel	
	diazepam rectal gel	
	LIBERVANT (diazepam)	
	NAYZILAM (midazolam)	
	ONFI (clobazam)	

VALTOCO (diazepam)	SYMPAZAN (clobazam)	
SUCCINIMIDES		
ethosuximide	CELONTIN (methsuximide)	
	methsuximide	
	ZARONTIN (ethosuximide)	
ANTIDEPRESSANTS, OTHER ^{DUR+}		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
bupropion	AUVELITY (bupropion/dextromethorphan)	Minimum Age Limit • 18 years: all agents Non-Preferred Criteria • Have tried 2 different preferred agents in the past 6 months OR • Have tried 1 preferred agent and 1 SSRI in the past 6 months OR • 90 days of therapy with the requested agent in the past 105 days AUVELITY • Documented diagnosis of major depressive disorder AND • 90 days of therapy with the requested agent in the past 105 days OR • Have tried preferred bupropion for 60 days in the past 6 months AND • Have tried another preferred agent that is not bupropion for 60 days in the past 6 months • Indication of agitation associated with dementia due to Alzheimer's disease requires clinical review DRIZALMA SPRINKLE • Automatic approval issued with a diagnosis of Generalized Anxiety Disorder for 7-11 years of age duloxetine 20 mg, 30 mg, 60 mg DR capsule • Automatic approval issued with a diagnosis of Generalized Anxiety Disorder for 7-17 years of age OR • 90 days of therapy with the requested agent in the past 105 days EXXUA • Documented diagnosis of unipolar major depressive disorder AND • Have tried 2 different preferred agents in the past 6 months OR • Have tried 1 preferred agent and 1 SSRI in the past 6 months OR • 90 days of therapy with the requested agent in the past 105 days RALDESY • Requires clinical review ZURZUVAE MANUAL PA
bupropion SR	CYMBALTA (duloxetine)	
bupropion XL	desvenlafaxine ER	
duloxetine 20 mg, 30 mg, 60 mg DR capsule	DESYREL (trazodone)	
mirtazapine	DRIZALMA SPRINKLE (duloxetine DR)	
trazodone	duloxetine 40 mg, 80 mg, 90 mg, 120 mg DR capsule	
TRINTELLIX (vortioxetine)	EFFEXOR XR (venlafaxine)	
venlafaxine	EMSAM (selegiline)	
venlafaxine HCl ER	EXXUA (gepirone hcl)	
vilazodone	FETZIMA (levomilnacipran)	
	FORFIVO XL (bupropion)	
	MARPLAN (isocarboxazid)	
	NARDIL (phenelzine)	
	nefazodone	
	phenelzine	
	PRISTIQ (desvenlafaxine)	
	REMERON (mirtazapine)	
	tranylcypromine	
	Trazodone solution	
	venlafaxine besylate ER	
	VIIBRYD (vilazodone)	
	WELLBUTRIN SR (bupropion)	
	ZURZUVAE (zuranolone)	
ANTIDEPRESSANTS, SSRIs ^{DUR+}		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
citalopram solution, tablet	CELEXA (citalopram)	Minimum Age Limit • 6 years: ZOLOFT • 7 years: LEXAPRO, PROZAC • 8 years: fluvoxamine • 18 years: CELEXA, LUVOX CR, PAXIL, PROZAC 90 mg
escitalopram solution, tablet	citalopram capsule	
fluoxetine capsule, solution	escitalopram capsule	
fluvoxamine	fluoxetine tablet	
paroxetine tablet	fluoxetine DR capsule	
paroxetine CR	fluvoxamine ER capsule	

paroxetine ER	LEXAPRO (escitalopram)	Maximum Age Limit 60 years CELEXA Non-Preferred Criteria - Have tried 2 different preferred agents in the past 6 months OR 90 days of therapy with the requested agent in the past 105 days
sertraline tablet, solution	paroxetine suspension, capsule	
	PAXIL (paroxetine)	
	PAXIL CR (paroxetine)	
	PROZAC (fluoxetine)	
	sertraline capsule	
	ZOLOFT (sertraline)	
ANTIEMETICS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
5HT3 RECEPTOR BLOCKERS		Quantity Limit (per 31 days) 6 tablets: AKYNZEO 100 mL: ZOFRAN solution Non-Preferred Agents - Requires clinical review AKYNZEO MANUAL PA Note: Injectables in this class are closed to point of sale. PA required if not administered in clinic/hospital.
ondansetron solution, tablet	ANZIMET (dolasetron)	
ondansetron ODT 4 mg, 8 mg	granisetron	
	GRANISOL (granisetron)	
	ondansetron ODT 16 mg tablet	
	SANCUSO (granisetron)	
ANTIEMETIC COMBINATIONS		
DICLEGIS (doxylamine/pyridoxine)	AKYNZEO (netupitant/palonosetron)	
	BONJESTA (doxylamine/pyridoxine)	
	doxylamine/pyridoxine	
CANNABINOIDS		
	dronabinol	
	MARINOL (dronabinol)	
NMDA RECEPTOR ANTAGONISTS		
aprepitant	EMEND (aprepitant)	
	NEREUS (tradipitant)	
ANTIFUNGALS (ORAL)		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
clotrimazole	CRESEMBA (isavuconazonium sulfate)	Minimum Age Limit 18 years: CRESEMBA Non-Preferred Criteria - Requires clinical review CRESEMBA MANUAL PA griseofulvin suspension - Automatic approval issued for 0-11 years of age griseofulvin tablets (all except ultramicrodose 165 mg) - Automatic approval issued for 12-17 years of age
fluconazole	DIFLUCAN (fluconazole)	
nystatin	flucytosine	
terbinafine	FULVICIN P-G (griseofulvin ultramicrosize)	
	griseofulvin ^{DUR+}	
	griseofulvin ultramicrosize ^{DUR+}	
	itraconazole	
	ketoconazole	
	NOXAFIL (posaconazole)	
	ORAVIG (miconazole)	
	posaconazole	
	SPORANOX (itraconazole)	
	TOLSURA (itraconazole)	
	VFEND (voriconazole)	
	VIVJOA (oteseconazole)	

	voriconazole	
ANTIFUNGALS (TOPICAL) ^{DUR+}		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTIFUNGALS		Non-Preferred Criteria - Have tried 2 different preferred agents in the past 6 months LASOLEX, clotrimazole 30 mL solution - Require clinical review
ciclopirox cream, gel, solution, suspension	BENSAL HP (salicylic acid)	
clotrimazole cream, solution ^{Rx & OTC}	CILODAN (ciclopirox)	
econazole	ciclopirox shampoo	
ketoconazole cream, shampoo	clotrimazole solution (NDCs 50228-0502-61, 82568-0036-06)	
MICOCLEAR (clotrimazole)	EXTINA (ketoconazole)	
miconazole cream, powder, solution ^{OTC}	ketoconazole foam	
nystatin cream, ointment, powder	KETODAN (ketoconazole)	
terbinafine ^{OTC}	LASOLEX (clotrimazole) ^{OTC}	
tolnaftate cream, powder ^{OTC}	LOPROX (ciclopirox)	
tavaborole	luliconazole	
	miconazole/zinc oxide/petrolatum ointment	
	MICOTRIN AC (clotrimazole)	
	MICOTRIN AP (miconazole nitrate powder)	
	MYCOZYL AC (clotrimazole)	
	MYCOZYL AP (miconazole)	
	naftifine	
	NAFTIN (naftifine)	
	oxiconazole	
	OXISTAT (oxiconazole)	
	VOTRIZA-AL (clotrimazole)	
	VUSION (miconazole/zinc oxide/petrolatum)	
ANTIFUNGAL/STEROID COMBINATIONS		
clotrimazole/betamethasone cream	clotrimazole/betamethasone lotion	
nystatin/triamcinolone		
ANTIFUNGALS (VAGINAL)		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
3-DAY VAGINAL CREAM (clotrimazole) ^{OTC}	GYNAZOLE 1 (butoconazole)	
clotrimazole cream ^{OTC}	miconazole 3 kit ^{OTC}	
clotrimazole-3 cream	terconazole suppository	
miconazole 1 ^{OTC}		
miconazole 3 combo pack ^{OTC} , cream ^{OTC} , suppository		
miconazole 7 ^{OTC}		

terconazole cream		
ANTIHISTAMINES, MINIMALLY SEDATING AND COMBINATIONS ^{DUR+}		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
MINIMALLY SEDATING ANTIHISTAMINES		Non-Preferred Criteria - Documented diagnosis of Allergy or Urticaria AND - Have tried 2 different preferred agents in the past 12 months Quantity Limit 118 mL: desloratadine solution DES Loratadine Solution - Requires clinical review
cetirizine solution, tablet ^{OTC}	cetirizine chewable tablet ^{OTC}	
loratadine chewable tablet, ODT, solution, tablet ^{OTC}	CLARINEX (desloratadine)	
	desloratadine	
	levocetirizine	
MINIMALLY SEDATING ANTIHISTAMINE/DECONGESTANT COMBINATIONS		
cetirizine/pseudoephedrine	CLARINEX-D 12 HOUR (desloratadine/pseudoephedrine)	
loratadine/pseudoephedrine ^{OTC}		
ANTIMIGRAINE AGENTS, ACUTE TREATMENT		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
CGRP ORAL AND NASAL ^{DUR+}		Minimum Age Limit 6 years: MAXALT 12 years: almotriptan, sumatriptan/naproxen, ZOMIG nasal spray 18 years: FROVA, IMITREX, naratriptan, NURTEC ODT, RELPAX, REYVOW, SYMBRAVO, TOSYMRA, UBRELVI, ZAVZPRET, ZEMBRACE, ZOMIG tablets Quantity Limit (per 31 days) ORAL 4 tablets: REYVOW 50 mg 6 tablets: almotriptan, RELPAX, ZOMIG 8 tablets: NURTEC ODT, REYVOW 100 mg 9 tablets: naratriptan, FROVA, IMITREX, sumatriptan/naproxen, SYMBRAVO 12 tablets: MAXALT 16 tablets: UBRELVI NASAL 1 box: all agents CUMULATIVE Quantity Limit (per 31 days) INJECTABLES 4 injections: all agents Non-Preferred Criteria ORAL - Have tried 2 preferred oral agents in the past 90 days NASAL - Requires clinical review INJECTABLES - Requires clinical review Almotriptan and sumatriptan/naproxen - Automatic approval for 12-17 years of age
NURTEC ODT (rimegepant)	ZAVZPRET (zavegepant)	
UBRELVI (ubrogepant)		
INJECTABLES		
sumatriptan pen injector, vial	IMITREX (sumatriptan)	
	sumatriptan cartridge	
	ZEMBRACE SYMTOUCH (sumatriptan)	
NASAL		
sumatriptan spray	IMITREX (sumatriptan)	
zolmitriptan spray	TOSYMRA (sumatriptan)	
	ZOMIG (zolmitriptan)	
TRIPTANS AND RELATED AGENTS (ORAL) ^{DUR+}		
naratriptan	almotriptan	
rizatriptan	eletriptan	
sumatriptan	FROVA (frovatriptan)	
zolmitriptan	frovatriptan	
zolmitriptan ODT	IMITREX (sumatriptan)	
	MAXALT (rizatriptan)	
	MAXALT MLT (rizatriptan)	
	RELPAX (eletriptan)	
	REYVOW (lasmiditan)	
	sumatriptan/naproxen	
	SYMBRAVO (rizatriptan benzoate/meloxicam)	
	ZOMIG (zolmitriptan)	

		NURTEC ODT and UBRELVY MANUAL PA • Documented diagnosis of Migraine AND • Have tried 2 different triptans in the past 6 months AND • No concurrent therapy with another CGRP agent or strong CYP3A4 inhibitor REYVOW • Documented diagnosis of Migraine AND • Have tried 2 different triptans in the past 90 days AND • Have tried preferred NURTEC ODT in the past 90 days SYMBRAVO MANUAL PA ZAVZPRET MANUAL PA • Documented diagnosis of Migraine AND • Have tried 2 different triptans in the past 6 months AND • Have tried both NURTEC ODT and UBRELVY in the past 6 months AND • No concurrent therapy with another CGRP AGENT
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ANTIMIGRAINE AGENTS, PROPHYLAXIS

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
INJECTABLES		Preferred Injectables • History of 3 claims with the requested agent in the past 105 days OR • New starts require manual PA (see criteria below) • AJOVY Autoinjector 3 Pack requires clinical review Non-preferred Injectables • Requires clinical review Quantity Limit • 4.5 mL (per 90 days): AJOVY Autoinjector 3 Pack AIMOVIG, AJOVY (except Autoinjector 3 Pack), EMGALITY, NURTEC ODT, and QULIPTA MANUAL PA VYEPTI MANUAL PA
AIMOVIG Autoinjector (erenumab-aooe) ^{DUR+}	EMGALITY Syringe (galcanezumab-gnlm) 300 mg/mL	
AJOVY Autoinjector (fremanezumab-vfrm) ^{DUR+}	VYEPTI (eptinezumab-jjmr)	
AJOVY Syringe (fremanezumab-vfrm) ^{DUR+}		
EMGALITY Pen (galcanezumab-gnlm) ^{DUR+}		
EMGALITY Syringe (galcanezumab-gnlm) 120 mg/mL ^{DUR+}		
ORAL		
	QULIPTA (atogepant)	
	NURTEC ODT (rimegepant)	

ANTINEOPLASTICS SELECTED SYSTEMIC ENZYME INHIBITORS

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
BOSULIF (bosutinib) tablet	AFINITOR (everolimus)	LYNPARZA Tablets MANUAL PA Non-Preferred Criteria • Requires clinical review
CAPRESLA (vandetanib)	AFINITOR DISPERZ (everolimus)	
COMETRIQ (cabozantinib)	AKEEGA (niraparib/abiraterone)	
COTELLIC (cobimetinib)	ALECENSA (alectinib)	
ENSACOVE (ensartinib hydrochloride)	ALUNBRIG (brigatinib)	
everolimus	AUGTYRO (repotrectinib)	
GILOTRIF (afatinib)	AYVAKIT (avapritinib)	

IBTROZI (taletrectinib)	BALVERSA (erdafitinib)
ICLUSIG (ponatinib)	BOSULIF (bosutinib) capsule
imatinib	BRAFTOVI (encorafenib)
IMBRUVICA (ibrutinib)	BRUKINSA (zanubrutinib)
INLYTA (axitinib)	CABOMETYX (cabozantinib)
IRESSA (gefitinib)	CALQUENCE (acalabrutinib)
JAKAFI (ruxolitinib)	CAVHANZA (nilotinib)
JAKAFI XR (ruxolitinib)	COPIKTRA (duvelisib)
MEKINIST (trametinib)	DANZITEN (nilotinib)
NEXAVAR (sorafenib)	dasatinib
ROZLYTREK (entrectinib)	DAURISMO (glasdegib)
SPRYCEL (dasatinib)	ERIVEDGE (vismodegib)
STIVARGA (regorafenib)	ERLEADA (apalutamide)
SUTENT (sunitinib)	erlotinib
TAFINLAR (dabrafenib)	FOTIVDA (tivozanib)
TARCEVA (erlotinib)	FRUZAQIA (fruquintinib)
TASIGNA (nilotinib)	GAVRETO (pralsetinib)
TURALIO (pexidartinib)	gefitinib
TYKERB (lapatinib)	GLEEVEC (imatinib)
VOTRIENT (pazopanib)	HERNEXEOS (zongertinib)
XALKORI (crizotinib)	HYRNUO (sevabertinib)
YULITHIRA (everolimus)	IBRANCE (palbociclib)
XTANDI (enzalutamide)	IDHIFA (enasidenib)
ZELBORAF (vemurafenib)	IMKELDI (imatinib)
ZYDELIG (idelalisib)	INLURIYO (imlunestrant tosylate)
ZYKADIA (ceritinib)	INQOVI (decitabine/cedazuridine)
	INREBIC (fedratinib)
	ITOVEBI (inavolisib)
	IWILFIN (eflornithine)
	JAYPIRCA (pirtobrutinib)
	KISQALI (ribociclib)
	KISQALI-FEMARA CO- PACK (ribociclib/letrozole)
	KOMZIFTI (ziftomenib)
	KOSELUGO (selumetinib sulfate)
	KRAZATI (adagrasib)
	lapatinib
	LAZCLUZE (lazertinib)
	LENVIMA (lenvatinib)
	LIFYORLI (relacorilant)
	LOBRENA (lorlatinib)
	LUMAKRAS (sotorasib)
	LYNPARZA (olaparib)
	LYTGOBI (futibatinib)
	MEKTOVI (binimetinib)
	MODEYSO (dordaviprone)
	NERLYNX (neratinib)
	nilotinib
	NUBEQA (darolutamide)

	ODOMZO (sonidegib)	
	OGSIVEO (nirogacestat)	
	OJEMDA (tovorafenib)	
	OJJAARA (momelotinib)	
	ONUREG (azacitidine)	
	ORGOVYX (relugolix)	
	ORSERDU (elacestrant)	
	pazopanib	
	PEMAZYRE (pemigatinib)	
	PIQRAY (alpelisib)	
	QINLOCK (ripretinib)	
	RETEVMO (selpercatinib)	
	REVUFORJ (revumenib)	
	REZLIDHIA (olutasidenib)	
	RUBRACA (rucaparib)	
	RYDAPT (midostaurin)	
	SCEMBLIX (asciminib)	
	sorafenib	
	sunitinib	
	TABRECTA (capmatinib)	
	TAGRISSO (osimertinib)	
	TALZENNA (talazoparib)	
	TAZVERIK (tazemetostat)	
	TEPMETKO (tepotinib)	
	TIBSOVO (ivosidenib)	
	TORPENZ (everolimus)	
	TRUQAP (capivasertib)	
	TUKYSA (tucatinib)	
	VANFLYTA (quizartinib)	
	VEPPANU (vepdagestrant)	
	VERZENIO (abemaciclib)	
	VITRAKVI (larotrectinib)	
	VIZIMPRO (dacomitinib)	
	VONJO (pacritinib)	
	VORANIGO (vorasidenib)	
	WELIREG (belzutifan)	
	XOSPATA (gilteritinib)	
	XPOVIO (selinexor)	
	ZEJULA (niraparib)	
ANTIOBESITY SELECT AGENTS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
FOUNDAYO (orforglipron) DUR+	liraglutide	Provider Education on Prescribing Select Anti-Obesity Agents can be found here
SAXENDA (liraglutide)	orlistat	All agents MANUAL PA required
WEGOVY (semaglutide) ^{DUR+}	XENICAL (orlistat)	
ZEPBOUND (tirzepatide) DUR+		
		Quantity Limit 30 tablets per 30 days: FOUNDAYO, WEGOVY 2 mL per 28 days: WEGOVY 0.25 mg, 0.5 mg, 1 mg pens/vials 3 mL per 28 days: WEGOVY 1.7 mg, 2.4 mg, 7.2 mg pens/vials, ZEPBOUND pens/vials Concurrent use of a GLP-1 and an Anti-Obesity Agent - Requires clinical review

		FOUNDAYO, WEGOVY, ZEPBOUND • Submission of a manual PA and clinical review may be required when DUR+ electronic PA criteria are not met. • Reauthorization after 12 months requires submission of a manual PA to confirm continued appropriateness of therapy.
ANTIPARASITICS (TOPICAL) DUR+		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
PEDICULICIDES		Minimum Age Limit • 2 months: permethrin 1% (OTC), permethrin 5% • 6 months: NATROBA, SKLICE • 2 years: piperonyl/pyrethrins (OTC) • 4 years: NATROBA • 6 years: OVIDE • 18 years: EURAX Non-Preferred Criteria • Pediculicides ○ Have tried 2 preferred topical lice agents in the past 90 days • Scabicides ○ Have tried permethrin 5% in the past 90 days
permethrin 1% cream ^{OTC}	lindane	
spinosad	NATROBA (spinosad)	
VANALICE (piperonyl butoxide/pyrethrins)	malathion	
	OVIDE (malathion)	
	SKLICE (ivermectin)	
SCABICIDES		
ivermectin	CROTAN (crotamiton)	
permethrin 5% cream	ELIMITE (permethrin)	
	EURAX (crotamiton)	
	STROMECTOL (ivermectin)	
ANTIPARKINSON'S AGENTS (INJECTABLE)		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	VYALEV (foscarbidopa/foslevodopa)	VYALEV • Requires clinical review
ANTIPARKINSON'S AGENTS (ORAL) DUR+		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTICHOLINERGICS		Non-Preferred Criteria • Documented diagnosis of Parkinson's disease AND • Have tried 2 different preferred agents in the past 6 months OR • 90 days of therapy with a selegiline agent in the past 105 days GOCOVRI • Documented diagnosis of Parkinson's disease AND • 30 days of therapy with amantadine IR in the past 105 days AND • 30 days of therapy with a carbidopa/levodopa combination agent in the past 45 days INBRIJA • Documented diagnosis of Parkinson's disease AND • 30 days of therapy with a carbidopa/levodopa combination agent in the past 45 days NOURIANZ • Documented diagnosis of Parkinson's Disease AND • Have tried 1 preferred carbidopa/levodopa combination agent in the past 30 days AND • 30 days of therapy with a preferred adjunctive therapy in the past 45 days XADAGO • Documented diagnosis of Parkinson' s Disease AND • History of 30 days of therapy with a carbidopa/levodopa combination agent in the past 45 days AND • History of 30 days of therapy with a selegiline agent the in past 45 days
benztropine		
trihexyphenidyl		
COMT INHIBITORS		
entacapone	OAGENTYS (opicapone)	
DOPAMINE AGONISTS		
pramipexole	NEUPRO (rotigotine)	
ropinirole	pramipexole ER	
	ropinirole ER	
MAO-B INHIBITORS		
selegiline	AZILECT (rasagiline)	
	rasagiline	
	XADAGO (safinamide)	
OTHERS		
amantadine	bromocriptine capsule	
bromocriptine tablet	carbidopa	
carbidopa/levodopa ER tablet	carbidopa/levodopa ER capsule	
carbidopa/levodopa tablet	carbidopa/levodopa ODT	
	carbidopa/levodopa/entacap one	
	CREXONT (carbidopa/levodopa)	

	DHIVY (carbidopa/levodopa)	
	DUOPA (carbidopa/levodopa)	
	GOCOVRI (amantadine)	
	INBRIJA (levodopa)	
	NOURIANZ (istradefylline)	
	OSMOLEX ER (amantadine)	
	RYTARY (carbidopa/levodopa)	
	SINEMET (carbidopa/levodopa)	
	STALEVO (carbidopa/levodopa/entacapone)	
ANTIPSORIATICS (TOPICAL)		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
calcipotriene cream	calcipotriene foam, ointment, solution	
ENSTILAR (calcipotriene/betamethasone)	calcipotriene/betamethasone	
TACLONEX (calcipotriene/betamethasone)	calcitriol ointment	
	SORILUX (calcipotriene)	
	tazarotene	
	VECTICAL (calcitriol)	
	VTAMA (tapinarof)	
	ZORYVE (roflumilast)	
ANTIPSYCHOTICS ^{DUR+}		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
INJECTABLE, ATYPICALS ^{DUR+}		Concurrent Therapy Limit for Age < 18 years • 90 days with ≥ 2 agents in the last 120 days will require a MANUAL PA Minimum Age Limit • 3 years: HALDOL • 5 years: RISPERDAL, thioridazine • 6 years: ABILIFY, trifluoperazine • 10 years: LATUDA, SAPHRIS, SEROQUEL, SYMBYAX, VRAYLAR (0.5, 0.75, 1.5, 3, 4.5 mg) • 12 years: INVEGA, molindone, perphenazine, pimozide, thiothixene • 13 years: REXULTI, ZYPREXA • 18 years: ABILIFY MYCITE, BYSANTI, CAPLYTA, CLOZARIL, COBENFY, FANAPT, fluphenazine, GEODON, loxapine, LYBALVI, NUPLAZID, perphenazine/amitriptyline, SECUADO, VRAYLAR 6 mg, and all injectable agents Quantity Limit • 3 syringes/year: ARISTADA INITIO Non-Preferred Criteria Oral Atypical Agents (unless specified below) • Have tried 2 preferred agents in the past 12 months OR • 30 days of therapy with the requested agent in the past 180 days
ABILIFY ASIMTUFII (aripiprazole)	ERZOFRI (paliperidone palmitate)	
ABILIFY MAINTENA (aripiprazole)	GEODON (ziprasidone)	
ARISTADA, ARISTADA INITIO (aripiprazole lauroxil)	olanzapine	
INVEGA HAFYERA (paliperidone)	risperidone ER	
INVEGA SUSTENNA (paliperidone palmitate)	RYKINDO (risperidone)	
INVEGA TRINZA (paliperidone)	ziprasidone	
PERSERIS (risperidone)	ZYPREXA (olanzapine)	
RISPERIDAL CONSTA (risperidone)	ZYPREXA RELPREVV (olanzapine)	
UZEDY (risperidone)		
ORAL ^{DUR+}		

aripiprazole tablet	ABILIFY (aripiprazole)	ARISTADA INTIO, ARISTADA ER, INVEGA SUSTENNA, INVEGA TRINZA and PERSERIS • Documented diagnosis of schizophrenia or schizoaffective disorder
asenapine	ABILIFY MYCITE (aripiprazole)	
clozapine tablet	ADASUVE (loxapine)	ABILIFY MAINTENA, ABILIFY ASIMTUFII, RISPERDAL CONSTA, or UZEDY • Documented diagnosis of schizophrenia, schizoaffective disorder or bipolar disorder
fluphenazine	aripiprazole ODT, solution	
haloperidol	BYSANTI (milsaperidone)	CAPLYTA • 30 days of therapy with the requested agent in the past 105 days OR • Documented diagnosis of Bipolar II Depression OR • Documented diagnosis of Bipolar I Depression AND • 30 days of therapy with a preferred oral atypical antipsychotic indicated for requested diagnosis in the past 105 days OR • Documented diagnosis of Major Depressive Disorder AND • 120 days of therapy with two antidepressants that are not atypical antipsychotics in the past 180 days AND • 30 days of therapy with a preferred oral atypical antipsychotic indicated for requested diagnosis in the past 105 days OR • Documented diagnosis of schizophrenia AND • 30 days of therapy with a preferred oral atypical antipsychotic indicated for requested diagnosis in the past 105 days
haloperidol lactate	CAPLYTA (lumateperone)	
lurasidone	chlorpromazine	INVEGA HAFYERA • Documented diagnosis of schizophrenia or schizoaffective disorder AND ○ 4 claims for INVEGA SUSTENNA in the past year OR ○ 1 claim for INVEGA TRINZA in the past year OR ○ 1 claim for INVEGA HAFYERA in the past year
olanzapine	clozapine ODT	
perphenazine	CLOZARIL (clozapine)	NUPLAZID • Documented diagnosis of Parkinson's Disease
perphenazine/amitriptyline	COBENFY (xanomeline/trospium)	
quetiapine	FANAPT (iloperidone)	VRAYLAR • 30 days of therapy with the requested agent in the past 105 days OR • Age 10-17 years or older AND • Documented diagnosis of bipolar 1 disorder AND • 30 days of therapy with a preferred oral atypical antipsychotic indicated for requested diagnosis in the past 105 days OR • Age 13-17 years or older AND • Documented diagnosis of schizophrenia or schizoaffective disorder AND • 30 days of therapy with a preferred oral atypical antipsychotic indicated for requested diagnosis in the past 105 days OR • Age 18 years or older AND • Documented diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder AND • 30 days of therapy with a preferred oral atypical antipsychotic indicated for requested diagnosis in the past 105 days OR • Age 18 years or older AND • Documented diagnosis of major depressive disorder AND • 120 days of therapy with two antidepressants that are not atypical antipsychotics in the past 180 days AND • 30 days of therapy with a preferred oral atypical antipsychotic indicated for requested diagnosis in the past 105 days
quetiapine ER	GEODON (ziprasidone)	
risperidone	IGALMI (dexmedetomidine)	ARIPRAZOLE ODT, BYSANTI, CLOZAPINE ODT, ERZOFRI, OPIPZA, generic risperidone ER, RYKINDO ER, and ZYPREXA RELPREVV • Require clinical review
thioridazine	INVEGA (paliperidone)	
trifluoperazine	LATUDA (lurasidone)	
ziprasidone	LYBALVI (olanzapine/samidorphan)	
	molindone	
	NUPLAZID (pimavanserin)	
	olanzapine/fluoxetine	
	OPIPZA (aripiprazole)	
	paliperidone ER	
	REXULTI (brexpiprazole)	
	RISPERDAL (risperidone)	
	SAPHRIS (asenapine)	
	SEROQUEL (quetiapine)	
	SEROQUEL XR (quetiapine ER)	
	SYMBYAX (olanzapine/fluoxetine)	
	VERSACLOZ (clozapine)	
	VRAYLAR (cariprazine)	
	ZYPREXA, ZYPREXA ZYDIS (olanzapine)	
TRANSDERMAL, ATYPICALS		
	SECUADO (asenapine)	

ANTIRETROVIRALS ^{DUR+}

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
CAPSID INHIBITORS		Minimum Age Limit • 10 years: YEZTUGO Non-Preferred Criteria • 1 claim with the requested agent in the past 105 days STRIBILD MANUAL PA SUNLENCA • Requires clinical review TROGARZO • Requires clinical review TYBOST MANUAL PA NOTE: Agents with ** are indicated for Pre-Exposure Prophylaxis (PrEP).
YEZTUGO** (lenacapavir) tablet and injection	SUNLENCA (lenacapavir)	
CD4 DIRECTED ATTACHMENT INHIBITORS		
	RUKOBIA (fostemsavir)	
CD4 DIRECTED HIV-1 INHIBITORS		
	TROGARZO (ibalizumab-uiyk)	
COMBINATION PRODUCTS NRTIs		
abacavir/lamivudine	COMBIVIR (lamivudine/zidovudine)	
CABENUVA (cabotegravir/rilpivirine)	EPZICOM (abacavir/lamivudine)	
DOVATO (dolutegravir/lamivudine)		
lamivudine/zidovudine		
COMBINATION PRODUCTS NUCLEOSIDE AND NUCLEOTIDE ANALOG RTIs		
DESCOVY** (emtricitabine/tenofovir alafenamide)	TRUVADA** (emtricitabine/tenofovir)	
emtricitabine/tenofovir**		
COMBINATION PRODUCTS NUCLEOSIDE AND NUCLEOTIDE ANALOG AND NON-NUCLEOSIDE RTIs		
DELSTRIGO (doravirine/lamivudine/tenofovir)	ATRIPLA (efavirenz/emtricitabine/tenofovir)	
efavirenz/emtricitabine/tenofovir	CIMDUO (lamivudine/tenofovir)	
ODEFSEY (emtricitabine/rilpivirine/tenofovir)	COMPLERA (emtricitabine/rilpivirine/tenofovir)	
	IDVYNZO (doravirine/islatravir)	
COMBINATION PRODUCTS PROTEASE INHIBITORS		
lopinavir/ritonavir	KALETRA (lopinavir/ritonavir)	
ENTRY INHIBITORS CCR5 CO-RECEPTOR ANTAGONISTS		
	maraviroc	
	SELZENTRY (maraviroc)	
ENTRY INHIBITORS FUSION INHIBITORS		
	FUZEON (enfuvirtide)	
INTEGRASE STRAND TRANSFER INHIBITORS		

APREUDE** (cabotegravir)	cabotegravir ER
ISENTRESS (raltegravir)	ISENTRESS HD (raltegravir)
TIVICAY, TIVICAY PD (dolutegravir)	VOCABRIA (cabotegravir)
NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NNRTI)	
EDURANT (rilpivirine)	etravirine
efavirenz	INTELENCE (etravirine)
	nevirapine, nevirapine ER
	PIFELTRO (doravirine)
	rilpivirine
NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTI)	
abacavir	didanosine
EMTRIVA (emtricitabine)	emtricitabine
lamivudine	EPIVIR (lamivudine)
ZIAGEN (abacavir)	RETROVIR (zidovudine)
zidovudine	stavudine
	VIREAD (tenofovir disoproxil fumarate)
PHARMACOENHANCER CYTOCHROME P450 INHIBITORS	
	TYBOST (cobicistat)
PROTEASE INHIBITORS (NON-PEPTIDIC)	
darunavir	APTIVUS (tipranavir)
PREZISTA (darunavir) 75mg tablet, 150mg tablet, 100mg/mL suspension	PREZCOBIX (darunavir/cobicistat)
	PREZISTA (darunavir) 600mg tablet, 800mg tablet
PROTEASE INHIBITORS (PEPTIDIC)	
atazanavir	fosamprenavir
EVOTAZ (atazanavir/cobicistat)	LEXIVA (fosamprenavir)
ritonavir	NORIVIR (ritonavir)
	REYATAZ (atazanavir)
	VIRACEPT (nelfinavir)
SINGLE PRODUCT REGIMENS	
BIKTARVY (bictegravir/emtricitabine/te nofovir)	efavirenz/lamivudine/tenofovir
GENVOYA (elvitegravir/cobicistat/emtri citabine/ tenofovir alafenamide)	JULUCA (dolutegravir/rilpivirine)
SYMFI (efavirenz/lamivudine/tenofovir)	rilpivirine ER
SYMFI LO (efavirenz/lamivudine/tenofovir)	STRIBILD (elvitegravir/cobicistat/emtricitabine)

	itabine/tenofovir disoproxil fumarate)	
TRIUMEQ (abacavir/dolutegravir/lamivudine)	SYMTUZA (darunavir/cobicistat/emtricitabine/tenofovir alafenamide)	
TRIUMEQ PD (abacavir/dolutegravir/lamivudine)		
ANTIVIRALS, ORAL		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTI-CYTOMEGALOVIRUS AGENTS		PREVYMIS - Requires clinical review Valganciclovir solution - Automatic approval issued for 0-12 years of age
valganciclovir tablet	LIVTENCITY (maribavir)	
	PREVYMIS (letermovir)	
	VALCYTE (valganciclovir)	
	valganciclovir solution	
ANTI-HERPETIC AGENTS		
acyclovir	SITAVIG (acyclovir)	
famciclovir	VALTREX (valacyclovir)	
valacyclovir		
ANTI-INFLUENZA AGENTS		
oseltamivir	FLUMADINE (rimantadine)	
	RAPIVAB (peramivir)	
	RELENZA (zanamivir)	
	rimantadine	
	TAMIFLU (oseltamivir)	
	XOFLUZA (baloxavir)	
COVID-19		
PAXLOVID (nirmatrelvir/ritonavir)	XOCOVA (ensitrelvir) ^{DUR+}	
ANTIVIRALS, TOPICAL		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
acyclovir cream, ointment	DENAVIR (penciclovir)	ZELSUVMI MANUAL PA
	penciclovir	
	ZELSUVMI (berdazimer)	
AROMATASE INHIBITORS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
anastrozole	ARIMIDEX (anastrozole)	
exemestane	AROMASIN (exemestane)	
letrozole	FEMARA (letrozole)	
ATOPIC DERMATITIS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
SYSTEMIC		Minimum Age Limit 3 months: EUCRISA 2 years: OPZELURA, pimecrolimus, tacrolimus 0.03% 16 years: tacrolimus 0.1%
ADBRY (tralokinumab-ldrm)	CIBINQO (abrocitinib)	
ADBRY Autoinjector (tralokinumab-ldrm)	NEMLUVIO (nemolizumab-ilto)	

DUPIXENT (dupilumab) DUR+		ADBRY MANUAL PA DUPIXENT 1 claim with DUPIXENT in the past 60 days OR - New starts require clinical review (see manual PA links below) Allergic Fungal Rhinosinusitis MANUAL PA Asthma MANUAL PA Atopic Dermatitis MANUAL PA Bullous Pemphigoid MANUAL PA COPD MANUAL PA Chronic Spontaneous Urticaria MANUAL PA Eosinophilic Esophagitis MANUAL PA Nasal Polyposis MANUAL PA Prurigo Nodularis MANUAL PA EBGLYSS MANUAL PA EUCRISA 30 days of therapy with a calcineurin inhibitor or topical steroid in the past 6 months NEMLUVIO - Atopic Dermatitis MANUAL PA - Prurigo Nodularis MANUAL PA OPZELURA 30 days of therapy with pimecrolimus, EUCRISA or tacrolimus in the past 6 months ANZUPGO, CIBINQO, ZORYVE 0.15% - Requires clinical review
EBGLYSS pen and syringe (lebrikizumab-lbkz)		
TOPICAL		
EUCRISA (crisaborole) ^{DUR+}	ANZUPGO (delgocitinib)	
pimecrolimus	OPZELURA (ruxolitinib)	
tacrolimus	ZORYVE (roflumilast) 0.15% cream	
BETA BLOCKERS, ANTIANGINALS & SINUS NODE AGENTS ^{DUR+}		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTIANGINALS		Non-Preferred Criteria - Have tried 2 different preferred agents in the past 6 months OR 90 days of therapy with the requested agent in the past 105 days ASPRUZYO SPRINKLE, LOPRESSOR SOLUTION, and metoprolol tartrate 12.5 mg tablet - Requires clinical review COREG CR - Documented diagnosis of hypertension AND - Have tried generic carvedilol AND 1 preferred agent in the past 6 months OR 90 days of therapy with the requested agent in the past 105 days CORLANOR MANUAL PA HEMANGEOL - Documented diagnosis of infantile hemangioma
ranolazine ER	ASPRUZYO SPRINKLE (ranolazine)	
	RANEXA (ranolazine ER)	
BETA- AND ALPHA-BLOCKERS		
carvedilol	carvedilol ER	
labetalol	COREG (carvedilol)	
	COREG CR (carvedilol)	
BETA-BLOCKER/DIURETIC COMBINATIONS		
atenolol/chlorthalidone	TENORETIC (atenolol/chlorthalidone)	
bisoprolol/hydrochlorothiazide	ZIAC (bisoprolol/hydrochlorothiazide)	
metoprolol/hydrochlorothiazide		
propranolol/hydrochlorothiazide		
BETA-BLOCKERS		

acebutolol	BETAPACE (sotalol)	
atenolol	BETAPACE AF (sotalol)	
bisoprolol	betaxolol	
HEMANGEOL (propranolol)	BYSTOLIC (nebivolol)	
metoprolol succinate	INDERAL LA (propranolol)	
metoprolol tartrate (except 12.5 mg tablet)	INDERAL XL (propranolol)	
nadolol	INNOPRAN XL (propranolol)	
nebivolol	KAPSPARGO SPRINKLE (metoprolol succinate)	
pindolol	LOPRESSOR (metoprolol tartrate)	
propranolol	metoprolol tartrate 12.5 mg tablet	
propranolol ER	SOTYLIZE (sotalol)	
SORINE (sotalol)	TENORMIN (atenolol)	
sotalol	TOPROL XL (metoprolol succinate)	
sotalol AF		
timolol		
SINUS NODE AGENTS		
	CORLANOR (ivabradine)	
	ivabradine	
BILE SALTS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ursodiol	BYLVAY (odevixibat)	
	CHENODAL (chenodiol)	
	IQIRVO (ela fibranor)	
	LIVDELZI (seladelpar)	
	LIVMARLI (maralixibat)	
	LYNAVOY (linerixibat)	
	OCALIVA (obeticholic acid)	
	RELTONE (ursodiol)	
	URSO FORTE (ursodiol)	
	URSOLIGN (ursodiol)	
BLADDER RELAXANT PREPARATIONS ^{DUR+}		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
MYRBETRIQ ER tablet (mirabegron)	darifenacin ER	Non-Preferred Criteria - Have tried 2 different preferred agents in the past 6 months mirabegron ER suspension, MYRBETRIQ ER SUSPENSION - Requires clinical review
oxybutynin	DETROL (tolterodine)	
oxybutynin ER	DETROL LA (tolterodine)	
solifenacin	fesoterodine	
	GEMTESA (vibegron)	
	mirabegron ER	
	MYRBETRIQ ER suspension (mirabegron)	
	tolterodine	
	tolterodine ER	
	TOVIAZ (fesoterodine)	
	trospium	

	trospium ER	
	VESICARE (solifenacin)	
	VESICARE LS (solifenacin)	
BONE RESORPTION SUPPRESSION AND RELATED AGENTS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
BISPHOSPHONATES ^{DUR+}		Non-Preferred Bisphosphonate Criteria - Documented diagnosis of osteoporosis or osteopenia AND - Have tried 2 different preferred agents in the past 6 months Non-Preferred Others MANUAL PA
alendronate tablet	ACTONEL (risedronate)	
ibandronate tablet	alendronate solution	
risedronate	ATELVIA (risedronate)	
	BINOSTO (alendronate)	
	FOSAMAX (alendronate)	
	FOSAMAX PLUS D (alendronate/vitamin D3)	
	ibandronate syringe/vial	
	risedronate DR	
OTHERS		
BILDYOS (denosumab-nxxp)	AUKELSO (denosumab-kyqq)	
BILPREVDA (denosumab-nxxp)	BOMYNTRA (denosumab-bnht)	
ENOBY (denosumab-qbde)	BONSITY (teriparatide)	
FORTEO (teriparatide)	BOSAYA (denosumab-kyqq)	
raloxifene	calcitonin salmon	
XTRENBO (denosumab-qbde)	CONEXXENCE (denosumab-bnht)	
	EVENITY (romosozumab-aqqg)	
	EVISTA (raloxifene)	
	JUBBONTI (denosumab-bbdz)	
	JUBEREQ (denosumab-desu)	
	MIACALCIN (calcitonin salmon)	
	OSENVELT (denosumab-bmwo)	
	OSVYRTI (denosumab-desu)	
	PROLIA (denosumab)	
	STOBOCLO (denosumab-bmwo)	
	teriparatide	
	TYMLOS (abaloparatide)	
	WYOST (denosumab-bbdz)	
	XGEVA (denosumab)	
BPH AGENTS ^{DUR+}		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
5-ALPHA-REDUCTASE INHIBITORS		CARDURA, FLOMAX, PROSCAR, terazosin, or UROXATRAL Female Documented State-accepted diagnosis
dutasteride	AVODART (dutasteride)	

finasteride	ENTADFI (finasteride/tadalafil)	Non-Preferred Criteria Male - Have tried 2 different preferred agents in the past 6 months OR 90 days of therapy with the requested agent in the past 105 days ENTADFI - Requires clinical review
	PROSCAR (finasteride)	
ALPHA BLOCKERS		
alfuzosin ER	CARDURA (doxazosin)	
doxazosin	CARDURA XL (doxazosin)	
tamsulosin	dutasteride/tamsulosin	
terazosin	FLOMAX (tamsulosin)	
	RAPAFLO (silodosin)	
	silodosin	
PHOSPHODIESTERASE TYPE 5 (PDE5) INHIBITORS		
	CIALIS (tadalafil)	
	tadalafil	
BRONCHODILATORS & COPD AGENTS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTICHOLINERGIC-BETA AGONIST COMBINATIONS		Minimum Age Limit 4 years: SEREVENT, XOPENEX HFA 6 years: SPIRIVA RESPIMAT, XOPENEX Solution 12 years: BREZTRI AEROSPHERE 160-18-4.8 mcg 18 years: BROVANA, BREZTRI AEROSPHERE 160-9-4.8 mcg, PERFOROMIST, STRIVERDI RESPIMAT, TRELEGY ELLIPTA Non-Preferred Criteria 1 claim for a preferred agent in the past 6 months OR 3 claims with the requested agent in the past 105 days Quantity Limit (per 31 days) 10.7 units BREZTRI AEROSPHERE BREZTRI AEROSPHERE 160-9-4.8 mcg - Age 18 years and older AND - Documented diagnosis of COPD AND 1 claim with the BREZTRI AEROSPHERE or TRELEGY ELLIPTA in the past 105 days OR - Documented diagnosis of COPD AND 60 days of therapy with a preferred anticholinergic product in the past 90 days AND 60 days of therapy with a preferred ICS-LABA product in the past 90 days BREZTRI AEROSPHERE 160-18-4.8 mcg - Age 12 years and older AND - Documented diagnosis of asthma AND 1 claim with the BREZTRI AEROSPHERE or TRELEGY ELLIPTA in the past 105 days OR - Documented diagnosis of asthma AND 60 days of therapy with a preferred anticholinergic product in the past 90 days AND 60 days of therapy with a preferred ICS-LABA product in the past 90 days TRELEGY ELLIPTA - Documented diagnosis of asthma or COPD AND 1 claim with the BREZTRI AEROSPHERE or TRELEGY ELLIPTA in the past 105 days OR
ANORO ELLIPTA (umeclidinium/vilanterol)	BEVESPI AEROSPHERE (glycopyrrolate/formoterol)	
COMBIVENT RESPIMAT (ipratropium/albuterol)	DUAKLIR PRESSAIR (aclidinium/formoterol)	
ipratropium/albuterol		
STIOLTO RESPIMAT (tiotropium/olodaterol)		
ANTICHOLINERGIC-BETA AGONIST-GLUCOCORTICOID COMBINATIONS ^{DUR+}		
BREZTRI AEROSPHERE (budesonide/glycopyrrolate/formoterol)		
TRELEGY ELLIPTA (fluticasone/umeclidinium/vilanterol)		
ANTICHOLINERGICS AND COPD AGENTS		
ATROVENT HFA (ipratropium)	DALIRESP (roflumilast)	
ipratropium solution	INCRUSE ELLIPTA (umeclidinium)	
SPIRIVA HANDIHALER (tiotropium)	ipratropium HFA	
SPIRIVA RESPIMAT (tiotropium)	OHTUVAYRE (ensifentrine)	
	roflumilast	
	tiotropium	
	TUDORZA PRESSAIR (aclidinium)	
	umeclidinium ellipta	
	YUPELRI (revfenacin)	
INHALATION SOLUTION ^{DUR+}		
albuterol	arformoterol	
	BROVANA (arformoterol)	

	formoterol, formoterol fumarate	- Documented diagnosis of asthma or COPD AND 60 days of therapy with a preferred anticholinergic product in the past 90 days AND 60 days of therapy with a preferred ICS-LABA product in the past 90 days XOPENEX HFA and Solution 1 claim for a preferred albuterol (inhaler or vials) in the past 30 days
	levalbuterol	
	PERFORMIST (formoterol)	
INHALERS, LONG ACTING DUR+		
SEREVENT DISKUS (salmeterol)		
STRIVERDI RESPIMAT (olodaterol)		
INHALERS, SHORT ACTING		
albuterol HFA	levalbuterol HFA	
VENTOLIN HFA (albuterol)	PROAIR DIGIHALER (albuterol)	
	XOPENEX HFA (levalbuterol)	
ORAL		
albuterol IR	albuterol ER	
terbutaline		
CALCIUM CHANNEL BLOCKERS DUR+		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
LONG-ACTING		Quantity Limit (per 21 days) 252 capsules: nimodipine 2520 mL: nimodipine Non-Preferred Criteria Long Acting - Have tried 2 different preferred Long Acting CCB agents in the past 6 months OR 90 days of therapy with the requested agent in the past 105 days Non-Preferred Criteria Short Acting - Have tried 2 different preferred Short Acting CCB agents in the past 6 months OR 90 days of therapy with the requested agent in the past 105 days CARDAMYST - Requires clinical review KATERZIA MANUAL PA
amlodipine	diltiazem ER 12 HR	
CARTIA XT (diltiazem)	diltiazem LA 24 HR	
diltiazem ER 24 HR	KATERZIA (amlodipine)	
diltiazem CD 24 HR	levamlodipine	
diltiazem XR 24 HR	MATZIM LA (diltiazem)	
DILT-XR 24 HR (diltiazem)	nisoldipine	
felodipine	NORLIQVA (amlodipine)	
nifedipine ER	NORVASC (amlodipine)	
TAZTIA XT (diltiazem)	PROCARDIA XL (nifedipine)	
TIADYLT ER (diltiazem)	SDAMLO (amlodipine)	nimodipine - Documented diagnosis of subarachnoid hemorrhage in the past 45 days AND - Duration of therapy limited to 21 days SDAMLO MANUAL PA
verapamil ER	SULAR (nisoldipine)	
verapamil SR	TIAZAC (diltiazem)	
	verapamil PM	
	VERELAN PM (verapamil)	
SHORT-ACTING		
diltiazem	CARDAMYST (etripamil)	
nicardipine	isradipine	
nifedipine	nimodipine	
verapamil	NYMALIZE (nimodipine)	
CALORIC AGENTS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
BOOST	All non-preferred caloric/nutritional agents (which are all other products except those specifically listed as preferred) require a manual prior authorization.	Non-Preferred Agents MANUAL PA
BREAKFAST ESSENTIALS		
BRIGHT BEGINNINGS		
DUOCAL		
ENSURE		

NUTREN		
OSMOLITE		
PEDIASURE		
PROMOD		
RESOURCE		
TWOCAL HN		
CEPHALOSPORINS AND RELATED ANTIBIOTICS (ORAL)		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
BETA LACTAM/BETA-LACTAMASE INHIBITOR COMBINATIONS		Non-Preferred Criteria All Cephalosporin Generations - Have tried 2 different preferred agents in the past 6 months Maximum Age Limit 18 years: cefdinir suspension
amoxicillin/clavulanate	amoxicillin/clavulanate ER	
	AUGMENTIN (amoxicillin/clavulanate)	
CEPHALOSPORINS FIRST GENERATION		
cefadroxil capsule, suspension	cefadroxil tablet	
cephalexin capsule, suspension	cephalexin tablet	
CEPHALOSPORINS SECOND GENERATION		
cefaclor capsule	cefaclor ER	
cefprozil	cefaclor suspension	
cefuroxime		
CEPHALOSPORINS THIRD GENERATION		
cefdinir	cefixime suspension, tablet	
cefixime capsule	SUPRAX (cefixime)	
cefpodoxime		
COLONY STIMULATING FACTORS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
LONG-ACTING		
FULPHILA (pegfilgrastim-jmdb)	FYLNETRA (pegfilgrastim-pbbk)	
	NEULASTA, NEULASTA ONPRO (pegfilgrastim)	
	NYVEPRIA (pegfilgrastim-apgf)	
	RYZNEUTA (efbemalenograstim alfa-vuxw)	
	ROLVEDON (eflapeggrastim-xnst)	
	STIMUFEND (pegfilgrastim-fpgk)	
	UDENYCA, UDENYCA ONBODY (pegfilgrastim-cbqv)	
	ZIEXTENZO (pegfilgrastim-bmez)	
SHORT-ACTING		
NEUPOGEN (filgrastim)	FILKRI (filgrastim-laha)	

RELEUKO (filgrastim-ayow)	GRANIX (tbo-filgrastim)	
	LEUKINE (sargramostim)	
	NIVESTYM (filgrastim-aafi)	
	NYPOZI (filgrastim-txid)	
	ZARXIO (filgrastim-sndz)	
CYSTIC FIBROSIS AGENTS ^{DUR+}		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
PULMOZYME (dornase alfa)	ALYFTREK (vanzacaftor/tezacaftor/deuti vacaftor)	Minimum Age Limit • 1 month: KALYDECO granules • 3 months: PULMOZYME • 1 year: ORKAMBI • 2 years: COLY-MYCIN M, TRIKAFTA granules • 6 years: ALYFTREK, BETHKIS, KALYDECO tablet, KITABIS, SYMDEKO, TOBI, TOBI PODHALER, TRIKAFTA tablet • 7 years: CAYSTON • 18 years: BRONCHITOL Maximum Age Limit • 2 years: ORKAMBI 75-94 mg granules • 5 years: KALYDECO, ORKAMBI 100-125 mg granules, ORKAMBI 200-125 mg granules, TRIKAFTA granules • 11 years: TRIKAFTA 50-25-37.5 mg tablets Preferred Agents • Documented diagnosis of Cystic Fibrosis OR • Require clinical review ALYFTREK MANUAL PA KALYDECO MANUAL PA ORKAMBI MANUAL PA SYMDEKO MANUAL PA TOBI PODHALER Require clinical review TRIKAFTA MANUAL PA
tobramycin (generic TOBI)	BETHKIS (tobramycin)	
	BRONCHITOL (mannitol)	
	CAYSTON (aztreonam)	
	colistimethate	
	COLY-MYCIN M (colistin)	
	KALYDECO (ivacaftor)	
	KITABIS (tobramycin)	
	ORKAMBI (lumacaftor/ivacaftor)	
	SYMDEKO (tezacaftor/ivacaftor)	
	TOBI (tobramycin)	
	TOBI PODHALER (tobramycin)	
	tobramycin (generic BETHKIS & KITABIS)	
	TRIKAFTA (elexacaftor/tezacaftor/ivacaftor)	
CYTOKINE & CAM ANTAGONISTS ^{DUR+}		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
adalimumab-aaty autoinject	ABRILADA (adalimumab-afzb)	Non-Preferred Agents • Require clinical review IV Administered Agents • Require clinical review adalimumab-aaty autoinject, HADLIMA (adalimumab-bwwd), and YUFLYMA (adalimumab-aaty) – Age specific indications: • Age 2 years and older AND • Diagnosis of juvenile idiopathic arthritis (JIA) OR • Diagnosis of uveitis
AVSOLA (infliximab-axxq)	ACTEMRA (tocilizumab)	
CYLTEZO (adalimumab-adbm)	adalimumab-aaty syringe	
ENBREL (etanercept)	adalimumab-adaz	
HADLIMA (adalimumab-bwwd)	adalimumab-adbm	
HUMIRA (adalimumab)	adalimumab-fkjp	
IMULDOSA (ustekinumab-srlf)	adalimumab-ryvk	

KINERET (anakinra)	AMJEVITA (adalimumab-atto)	• Age 6 years and older AND • Diagnosis of Crohn's disease (CD)
methotrexate	ARCALYST (rilonacept)	
OLUMIANT (baricitinib)	AVTOZMA (tocilizumab-anoh)	• Age 12 years and older AND • Diagnosis of hidradenitis suppurativa (HS)
ORENCIA CLICKJECT (abatacept)	AVTOZMA AUTOINJECTOR (tocilizumab-anoh)	• Age 18 years and older AND • Diagnosis of rheumatoid arthritis (RA) OR • Diagnosis of plaque psoriasis (PsO) OR • Diagnosis of psoriatic arthritis (PsA) OR • Diagnosis of ulcerative colitis (UC) OR • Diagnosis of ankylosing spondylitis (AS)
ORENCIA VIAL (abatacept)	BIMZELX (bimekizumab-bkzx)	
OTEZLA (apremilast)	CIMZIA (certolizumab)	
PYZCHIVA (ustekinumab-ttwe)	COSENTYX (secukinumab)	
RINVOQ (upadacitinib)	ENTYVIO (vedolizumab)	
RINVOQ LQ (upadacitinib)	HULIO (adalimumab-fkip)	
SELARSDI (ustekinumab-aekn)	HYRIMOZ (adalimumab-adaz)	
SIMPONI (golimumab)	ICOTYDE (icotrokinra)	
STARJEMZA (ustekinumab-hmny)	IDACIO (adalimumab-aacf)	
TALTZ (ixekizumab)	ILARIS (canakinumab)	• Age 18 years and older AND • Diagnosis of rheumatoid arthritis (RA) OR • Diagnosis of plaque psoriasis (PsO) OR • Diagnosis of psoriatic arthritis (PsA) OR • Diagnosis of ankylosing spondylitis (AS)
TYENNE (tocilizumab-aazg)	ILUMYA (tildrakizumab-asmn)	
ustekinumab-aaaz	INFLECTRA (infliximab-dyyb)	
XELJANZ (tofacitinib) tablet	infliximab	
YUFLYMA (adalimumab-aaty)	JYLAMVO (methotrexate)	
	KEVZARA (sarilumab)	
	LEQSELVI (deuruxolitinib)	
	LITFULO (ritlecitinib)	• Age 6 years and older AND • Diagnosis of Crohn's disease (CD)
	OMVOH (mirikizumab-mrkz)	
	ORENCIA SYRINGE (abatacept)	• Age 12 years and older AND • Diagnosis of hidradenitis suppurativa (HS)
	OTEZLA XR (apremilast)	
	OTREXUP (methotrexate)	
	OTULFI (ustekinumab-aaaz)	• Age 18 years and older AND • Diagnosis of rheumatoid arthritis (RA) OR • Diagnosis of plaque psoriasis (PsO) OR • Diagnosis of psoriatic arthritis (PsA) OR • Diagnosis of ulcerative colitis (UC) OR • Diagnosis of ankylosing spondylitis (AS)
	RASUVO (methotrexate)	
	REMICADE (infliximab)	
	RENFLEXIS (infliximab-abda)	
	SIMLANDI (adalimumab-ryvk)	
	SIMPONI ARIA (golimumab)	
	SKYRIZI (risankizumab-rzaa)	• Age 2 years and older AND • Diagnosis of juvenile arthritis (JIA) OR • Diagnosis of juvenile psoriatic arthritis (PsA)
	SOTYKTU (deucravacitinib)	
	SPEVIGO (spesolimab-sbzo)	• Age 4 years and older AND • Diagnosis of plaque psoriasis (PsO)
	STELARA (ustekinumab)	
	STEQEYMA (ustekinumab-stba)	• Age 18 years and older AND • Diagnosis of rheumatoid arthritis (RA) OR • Diagnosis of psoriatic arthritis (PsA) OR • Diagnosis of ankylosing spondylitis (AS)
	TOFIDENCE (tocilizumab-bavi)	
	tofacitinib	

AVSOLA (infliximab-axxq) – Age specific indications:

- Age 6 years and older **AND**
- Diagnosis of Crohn's disease **OR**
- Diagnosis of ulcerative colitis

CYLTEZO (adalimumab-adbm) – Age specific indications:

- Age 2 years and older **AND**
- Diagnosis of juvenile idiopathic arthritis (JIA) **OR**
- Diagnosis of uveitis (UV)

ENBREL (etanercept) – Age specific indications:

- Age 2 years and older **AND**
- Diagnosis of juvenile arthritis (JIA) **OR**
- Diagnosis of juvenile psoriatic arthritis (PsA)

	TREMFYA (guselkumab)	
	TREXALL (methotrexate)	HUMIRA (adalimumab) – Age specific indications:
	ustekinumab	• Age 2 years and older AND • Diagnosis of juvenile idiopathic arthritis (JIA) OR • Diagnosis of uveitis (UV)
	ustekinumab-aekn	
	ustekinumab-ttwe	
	XATMEP (methotrexate)	
	XELJANZ (tofacitinib) solution	• Age 5 years and older AND • Diagnosis of ulcerative colitis (UC)
	XELJANZ XR (tofacitinib)	• Age 6 years and older AND • Diagnosis of Crohn's disease (CD)
	YESINTEK (ustekinumab-kfce)	
	YUSIMRY (adalimumab-aqvh)	• Age 12 years and older AND • Diagnosis of hidradenitis suppurativa (HS)
	ZYMFENTRA (infliximab-dyyb)	• Age 18 years and older AND • Diagnosis of rheumatoid arthritis (RA) OR • Diagnosis of plaque psoriasis (PsO) OR • Diagnosis of psoriatic arthritis (PsA) OR • Diagnosis of ankylosing spondylitis (AS) IMULDOSA (ustekinumab-srlf), PYZCHIVA (ustekinumab-ttwe), SELARSDI (ustekinumab-aekn), STARJEMZA (ustekinumab-hmny), and ustekinumab-aaaz – Age specific indications: • Age 6 years and older AND • Diagnosis of plaque psoriasis (PsO) OR • Diagnosis of psoriatic arthritis (PsA) • Age 18 years and older AND • Diagnosis of ulcerative colitis (UC) OR • Diagnosis of Crohn's disease (CD) KINERET (anakinra) – Age specific indications: • Age 18 years and older AND • Diagnosis of rheumatoid arthritis (RA) • Other indications require clinical review OLUMIANT (baricitinib) – Age specific indications: • Age 18 years and older AND • Diagnosis of alopecia areata (AA) • Other indications require clinical review ORENCIA (abatacept) – Age specific indications: • Age 2 years and older AND • Diagnosis of juvenile arthritis (JIA) OR • Diagnosis of psoriatic arthritis (PsA) • Other indication requires clinical review • Age 18 years and older AND • Diagnosis of rheumatoid arthritis (RA) • Non-preferred Oencia syringe requires clinical review OTEZLA (apremilast) – Age specific indications: • Age 6 years and older AND • Diagnosis of plaque psoriasis (PsO) OR • Diagnosis of psoriatic arthritis (PsA)

		• Age 18 years and older AND • Diagnosis of Bechet's disease • Non-preferred Otezla XR requires clinical review RINVOQ (upadacitinib): • Age 2 years and older AND • Diagnosis of juvenile idiopathic arthritis (JIA) OR • Diagnosis of psoriatic arthritis AND • History of 3 claims with preferred TNF Inhibitor Avsola, Enbrel, Humira or Simponi OR • History of 1 claim with Rinvoq in the past AND • NO history of concomitant therapy in the past 30 days with any of the following: ◦ A different JAK Inhibitor ◦ A different biologic ◦ Immunosuppressant azathioprine or cyclosporine • Age 18 years and older AND • Diagnosis of ankylosing spondylitis OR • Diagnosis of Crohn's disease OR • Diagnosis of giant cell arteritis OR • Diagnosis of active non-radiographic axial spondyloarthritis (nr-axSpA) OR • Diagnosis of rheumatoid arthritis (RA) OR • Diagnosis of ulcerative colitis AND • History of 3 claims with preferred TNF Inhibitor Avsola, Enbrel, Humira or Simponi OR • History of 1 claim with Rinvoq in the past AND • NO history of concomitant therapy in the past 30 days with any of the following: ◦ A different JAK Inhibitor ◦ A different biologic ◦ Immunosuppressant azathioprine or cyclosporine • Atopic Dermatitis MANUAL PA SIMPONI (golimumab) – Age specific indications: • Age 18 years and older AND • Diagnosis of rheumatoid arthritis (RA) OR • Diagnosis of psoriatic arthritis (PsA) OR • Diagnosis of ankylosing spondylitis (AS) OR • Diagnosis of ulcerative colitis • Ages less than 18 years require clinical review • Non-preferred Simponi Aria requires clinical review STELARA MANUAL PA TALTZ (ixekizumab) – Age specific indications: Taltz 20 mg, 40 mg and 80 mg • Age 6 AND • Diagnosis of plaque psoriasis (PsO) Taltz 80 mg • Age 18 years and older AND
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		• Diagnosis of psoriatic arthritis (PsA) OR • Diagnosis of ankylosing spondylitis (AS) OR • Diagnosis of active non-radiographic axial spondyloarthritis (nr-axSpA) TYENNE (tocilizumab-aazg) – Age specific indications: • Age 2 years and older AND • Diagnosis of juvenile arthritis (JIA) • Age 18 years and older AND • Diagnosis of rheumatoid arthritis (RA) OR • Diagnosis of giant cell arteritis XELJANZ IR (tofacitinib) – Any of the following: • Age 2 year and older AND • Diagnosis of juvenile arthritis (JIA) OR • Diagnosis of psoriatic arthritis (PsA) • Age 18 years and older AND • Diagnosis of rheumatoid arthritis (RA) OR • Diagnosis of ulcerative colitis (UC) OR • Diagnosis of ankylosing spondylitis (AS) • Non-preferred Xeljanz oral solution and Xeljanz XR require clinical review Preferred methotrexate does not require prior authorization
ERYTHROPOIESIS STIMULATING PROTEINS ^{DUR+}		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
MIRCERA (methoxy polyethylene glycol-epoetin-beta)	ARANESP (darbepoetin alfa)	Non-Preferred Criteria • Requires clinical review MIRCERA • Documented diagnosis of chronic renal failure in the past 2 years
RETACRIT (epoetin alfa-epbx)	EPOGEN (epoetin alfa)	
	JESDUVROQ (daprodustat)	
	PROCRIT (epoetin alfa)	
	VAFSEO (vadadustat)	
FACTOR DEFICIENCY PRODUCTS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
FACTOR VIII		Non-Preferred Agents • Require clinical review HEMLIBRA • 3 claims with HEMLIBRA in the past 105 days OR • New starts require clinical review MANUAL PA
ADVATE	ADYNOVATE	
AFSTYLA	ELOCTATE	
ALPHANATE	ESPEROCT	
ALTUVIIIIO	JIVI	
FEIBA	KCENTRA	
HEMOFIL M	OBIZUR	
HUMATE-P	VONVENDI	
KOATE		
KOGENATE FS		
KOVALTRY		
NOVOEIGHT		
NUWIQ		
RECOMBINATE		

WILATE		
XYNTHA, XYNTHA SOLOFUSE		
FACTOR IX		
ALPHANINE SD	BEQVEZ	
ALPROLIX		
BENEFIX		
IDELVION		
IXINITY		
PROFILNINE		
REBINYN		
RIXUBIS		
OTHER HEMOPHILIA PRODUCTS		
COAGADEX (factor X)	ALHEMO (concizumab-mtci)	
FESILTY (fibrinogen)	CORIFACT (factor XIII)	
FIBRYGA (fibrinogen)	HYMPAVZI (marstacimab-hncg)	
HEMLIBRA (emicizumab-kxwh) ^{DUR+}	NOVOSEVEN RT (factor VII)	
RIASTAP (fibrinogen)	QFITLIA (fitusiran)	
	SEVENFACT (factor VII)	
	TRETEN (factor XIII)	
FIBROMYALGIA/NEUROPATHIC PAIN AGENTS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
duloxetine 20 mg, 30 mg, 60 mg DR capsule	CYMBALTA (duloxetine)	Minimum Age Limit • 18 years: CYMBALTA, DRIZALMA SPRINKLE, duloxetine DR capsule TONMYA MANUAL PA RELGAABI • Requires clinical review
gabapentin	DRIZALMA SPRINKLE (duloxetine)	
pregabalin	duloxetine 40 mg, 80 mg, 90 mg, 120 mg DR capsule	
SAVELLA (milnacipran)	gabapentin ER	
	GABARONE (gabapentin)	
	GRALISE (gabapentin)	
	HORIZANT (gabapentin enacarbil)	
	LYRICA, LYRICA CR (pregabalin)	
	milnacipran	
	NEURONTIN (gabapentin)	
	pregabalin ER	
	RELGAABI (gabapentin)	
	TONMYA (cyclobenzaprine)	
FLUOROQUINOLONES ^{DUR+}		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ciprofloxacin tablet	BAXDELA (delafloxacin)	Non-Preferred Criteria • 1 claim for a preferred agent in the past 30 days CIPRO Suspension for Age < 12 Years • Documented diagnosis of Cystic Fibrosis or Anthrax infection or exposure OR • Documented diagnosis of Pneumonic plague or tularemia AND
levofloxacin tablet	CIPRO (ciprofloxacin)	
	ciprofloxacin suspension	
	levofloxacin solution	
	moxifloxacin	
	ofloxacin	

		- History of doxycycline in the past 3 months OR 7 days of therapy with a preferred agent from 2 of the classes below in the past 3 months: - Penicillin, 2nd or 3rd generation cephalosporin or macrolide LEVAQUIN Suspension for Age < 12 Years - Documented diagnosis of Anthrax infection or exposure OR - History of 7 days of therapy with a preferred from 2 of the following classes in the past 3 months - Penicillin, 2nd or 3rd generation cephalosporins, or macrolide AND - History of ciprofloxacin suspension in the past 3 months
GAUCHER'S DISEASE		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ELELYSO (taliglucerase alfa)	CERDELGA (eliglustat)	
ZAVESCA (miglustat)	CEREZYME (imiglucerase)	
	miglustat	
	VPRIV (velaglucerase alfa)	
	YARGESA (miglustat)	
GENITAL WARTS & ACTINIC KERATOSIS AGENTS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
CONDYLOX (podofilox)	VEREGEN (sinecatechins)	Minimum Age Limit 12 years: ALDARA 18 years: CONDYLOX, PICATO, VEREGEN
fluorouracil		
imiquimod		
podofilox		
GI ULCER THERAPIES		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
H2 RECEPTOR ANTAGONISTS		PRILOSEC 2.5 mg suspension - Automatic approval issued for 0-2 years of age PRILOSEC 10 mg suspension - Requires clinical review
famotidine	cimetidine	
	nizatidine	
	ranitidine	
OTHERS		
CARAFATE (sucralfate) suspension	CARAFATE (sucralfate) tablet	
misoprostol	CYTOTEC (misoprostol)	
sucralfate	DARTISLA (glycopyrrolate)	
	EOHILIA (budesonide)	
	VOQUEZNA (vonoprazan)	
PROTON PUMP INHIBITORS		
esomeprazole capsule	DEXILANT (dexlansoprazole)	
NEXIUM (esomeprazole) packet	dexlansoprazole	
omeprazole	esomeprazole packet	
pantoprazole tablet	KONVOMEF (omeprazole/sodium bicarbonate)	
	lansoprazole Rx	

	NEXIUM (esomeprazole) capsule	
	omeprazole/sodium bicarbonate	
	pantoprazole packet	
	PREVACID (lansoprazole)	
	PRILOSEC (omeprazole) packet	
	PROTONIX (pantoprazole)	
	rabeprazole	
	ZEGERID (omeprazole/sodium bicarbonate)	
GLUCOCORTICOIDS (INHALED)		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
GLUCOCORTICOIDS		Non-Preferred Criteria • Glucocorticoids ○ 2 preferred single-entity agents in the past 6 months OR ○ 90 days of therapy with the requested agent in the past 105 days • Glucocorticoid/Bronchodilator Combinations ○ 2 preferred combination agents in the past 6 months OR ○ 90 days of therapy with the requested agent in the past 105 days • Note: ○ Institutional-sized products are non-preferred AIRDUO DIGIHALER • Requires clinical review ARMONAIR DIGIHALER • Requires clinical review Minimum Age Limit • 18 years: AIRSUPRA Quantity Limit (per 31 days) • 2 inhalers: AIRSUPRA MANUAL PA
ASMANEX (mometasone)	ALVESCO (ciclesonide)	
budesonide 0.25 mg and 0.5 mg	ARMONAIR DIGIHALER (fluticasone)	
fluticasone	ARNUITY ELLIPTA (fluticasone)	
fluticasone diskus	ASMANEX HFA (mometasone)	
fluticasone HFA	beclo methasone	
QVAR REDIHALER (beclo methasone)	budesonide 1 mg	
	FLOVENT HFA (fluticasone)	
	FLOVENT DISKUS (fluticasone)	
	PULMICORT (budesonide) nebulizer solution	
GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS		
ADVAIR DISKUS (fluticasone/salmeterol)	AIRDUO DIGIHALER (fluticasone/salmeterol)	
ADVAIR HFA (fluticasone/salmeterol)	AIRSUPRA (albuterol/budesonide)	
DULERA (mometasone/formoterol)	BREO ELLIPTA (fluticasone/vilanterol)	
fluticasone/salmeterol diskus	BREYNA (budesonide/formoterol)	
SYMBICORT (budesonide/formoterol)	budesonide/formoterol	
	fluticasone/salmeterol HFA	
	fluticasone/vilanterol	
	WIXELA INHUB (fluticasone/salmeterol)	
GROWTH HORMONES ^{DUR+}		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
GENOTROPIN (somatropin)	HUMATROPE (somatropin)	Preferred Criteria

NORDITROPIN FLEXPRO (somatropin)	NGENLA (somatrogen-ghla)	• Age ≥ 18 years • Documented diagnosis of craniopharyngioma, HIV associated cachexia, iatrogenic growth deficiency due to drug-induced or post-procedural hypopituitarism, Noonan Syndrome, panhypopituitarism, Prader-Willi Syndrome, renal function impairment growth disorders, short stature shox deficiency, Turner Syndrome or history of cranial irradiation • Age < 18 years • Diagnosis of approvable pediatric diagnosis or history of cranial irradiation Minimum Age Limit • 3 years: NGENLA Maximum Age Limit • 18 years: NGENLA Non-Preferred Criteria Age ≥ 18 years • Documented approvable diagnosis for age as above diagnosis of craniopharyngioma, HIV associated cachexia, iatrogenic growth deficiency due to drug-induced or post-procedural hypopituitarism, Noonan Syndrome, panhypopituitarism, Prader-Willi Syndrome, renal function impairment growth disorders, short stature shox deficiency, Turner Syndrome or history of cranial irradiation AND • History of 28 days of therapy with a preferred Growth Hormone in the past 6 months OR • 84 days of therapy with the requested agent in the past 105 days Age < 18 years • Diagnosis of congenital malformation syndrome, HIV associated cachexia, hypopituitarism, iatrogenic growth deficiency due to drug-induced or post-procedural hypopituitarism, mosaicism 45, Prader-Willi Syndrome, renal function impairment growth disorders, short stature due to endocrine disorder, small for gestational age or Turner Syndrome AND • History of 28 days of therapy with a preferred Growth Hormone in the past 6 months OR • 84 days of therapy with the requested agent in the past 105 days SKYTROFA Age ≥ 18 years • Documented diagnosis of craniopharyngioma, HIV associated cachexia, iatrogenic growth deficiency growth deficiency due to drug-induced or post-procedural hypopituitarism, Noonan Syndrome, panhypopituitarism, renal function impairment growth disorders, short stature shox deficiency, Turner Syndrome or history of cranial irradiation AND • No history of diagnosis of Prader Willi Syndrome AND • History of 28 days of therapy with a preferred Short-Acting Growth Hormone in the past 6 months OR • 84 days of therapy with Skytrofa in the past 105 days Age < 18 years • No history of diagnosis of Prader Willi Syndrome AND • History of 28 days of therapy with a preferred Short-Acting Growth Hormone in the past 6 months OR • 84 days of therapy with Skytrofa in the past 105 days
SKYTROFA (lonapegsomatropin-tcgd)	OMNITROPE (somatropin)	
	SEROSTIM (somatropin)	
	SOGROYA (somapacitan-beco)	
	ZOMACTON (somatropin)	

H. PYLORI COMBINATION TREATMENTS

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
PYLERA (bismuth subcitrate potassium/metronidazole/tetracycline)	bismuth subcitrate potassium/metronidazole/tetracycline	Quantity Limit • 1 treatment course/year: all agents
	lansoprazole/amoxicillin/clarithromycin	
	OMECLAMOX (omeprazole/clarithromycin/amoxicillin)	

	TALICIA (omeprazole/amoxicillin/rifabutin)	
	VOQUEZNA DUAL PAK (vonoprazan/amoxicillin)	
	VOQUEZNA TRIPLE PAK (vonoprazan/amoxicillin/clarithromycin)	
HEPATITIS B TREATMENTS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
entecavir	adefovir dipivoxil	
lamivudine HBV	BARACLUDE (entecavir)	
tenofovir disoproxil fumarate	VEMLIDY (tenofovir alafenamide)	
	VIREAD (tenofovir disoproxil fumarate)	
HEPATITIS C TREATMENTS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
MAVYRET (glecaprevir/pibrentasvir)	EPCLUSA (sofosbuvir/velpatasvir)	EPCLUSA, HARVONI, MAVYRET, SOVALDI, VOSEVI, ZEPATIER MANUAL PA Note: • EPCLUSA, HARVONI, MAVYRET and SOVALDI have FDA-approved pediatric indications
PEGASYS (peginterferon alfa-2a)	HARVONI (ledipasvir/sofosbuvir)	
ribavirin tablet	ledipasvir/sofosbuvir	
sofosbuvir/velpatasvir	ribavirin capsule	
	SOVALDI (sofosbuvir)	
	VIEKIRA PAK (ombitasvir/paritaprevir/ritonavir)	
	VOSEVI (sofosbuvir/velpatasvir/voxilaprevir)	
	ZEPATIER (elbasvir/grazoprevir)	
HEREDITARY ANGIOEDEMA TREATMENTS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
PROPHYLAXIS		Non-Preferred Criteria • Requires clinical review
HAEGARDA (C1 esterase inhibitor)	ANDEMBRY (garadacimab-gxii)	
	CINRYZE (C1 esterase inhibitor)	
	DAWNZERA (donidalorsen)	
	ORLADEYO (berotralstat)	
	TAKHZYRO (lanadelumab-flyo)	
ACUTE TREATMENT		
BERINERT (C1 esterase inhibitor)	EKTERLY (sebetralstat)	

icatibant	FIRAZYR (icatibant)	
	KALBITOR (ecallantide)	
	RUCONEST (C1 esterase inhibitor)	
	SAJAZIR (icatibant)	
HYPERURICEMIA & GOUT ^{DUR+}		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
allopurinol	ALOPRIM (allopurinol)	Non-Preferred Criteria Have tried 2 different preferred agents in the past 6 months
colchicine tablet	colchicine capsule	
probenecid	COLCRYS (colchicine)	
probenecid/colchicine	febuxostat	
	GLOPERBA (colchicine)	
	MITIGARE (colchicine)	
	ULORIC (febuxostat)	
	ZYLOPRIM (allopurinol)	
HYPOGLYCEMIA TREATMENT		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
BAQSIMI (glucagon)	GVOKE (glucagon) ^{Step Edit}	Minimum Age Limit 1 year: BAQSIMI 2 years: GVOKE Quantity Limit (per 31 days) 2 packs (or kits): BAQSIMI, glucagon, GVOKE, ZEGALOGUE Non-Preferred Criteria GVOKE 1 claim with preferred BAQSIMI or ZEGALOGUE in the past 30 days
GLUCAGEN (glucagon)		
glucagon emergency kit		
glucagon vial		
ZEGALOGUE (dasiglucagon)		
HYPOGLYCEMICS, BIGUANIDES		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
metformin 500 mg, 850 mg, 1,000 mg tablets	GLUMETZA (metformin)	
metformin ER (generic GLUCOPHAGE XR)	metformin 625 mg, 750 mg tablets	
	metformin ER (generic FORTAMET)	
	metformin ER (generic GLUMETZA)	
	metformin solution	
	RIOMET (metformin)	
HYPOGLYCEMICS, DPP4s AND COMBINATIONS ^{DUR+}		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
JANUMET (sitagliptin/metformin)	alogliptin	Non-Preferred Criteria - Have tried 2 different preferred DPP4 agents in the past 6 months OR 90 days of therapy with the requested agent in the past 105 days Note: Concomitant use of a GLP-1 agent and a DPP-4 agent requires clinical review
JANUMET XR (sitagliptin/metformin)	alogliptin/metformin	
JANUVIA (sitagliptin)	BRYNOVIN solution (sitagliptin)	

JENTADUETO (linagliptin/metformin)	JENTADUETO XR (linagliptin/metformin)	Minimum Age Limit • 18 years: BRYNOVIN solution
TRADJENTA (linagliptin)	KAZANO (alogliptin/metformin)	
	KOMBIGLYZE XR (saxagliptin/metformin)	
	linagliptin/metformin	
	NESINA (alogliptin)	
	ONGLYZA (saxagliptin)	
	OSENI (alogliptin/pioglitazone)	
	saxagliptin	
	saxagliptin/metformin ER	
	sitagliptin	
	sitagliptin/metformin	
	sitagliptin/metformin ER	
	ZITUVIMET (sitagliptin/metformin)	
	ZITUVIMET XR (sitagliptin/metformin)	
	ZITUVIO (sitagliptin)	
HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS		
PREFERRED AGENTS^{DUR+}	NON-PREFERRED AGENTS	PA CRITERIA
BYETTA (exenatide)	BYDUREON (exenatide)	Minimum Age Limit • 10 years: BYDUREON BCISE, MOUNJARO, TRULICITY, VICTOZA • 18 years: BYETTA, OZEMPIC, RYBELSUS Preferred Criteria • Documented diagnosis of Type 2 Diabetes AND • No history of GLP-1 agonist therapy for obesity in the past 30 days OR • No documented diagnosis for Type 2 Diabetes AND • No history of GLP-1 agonist therapy for obesity in the past 30 days AND • 84 days of therapy with the requested agent in the past 105 days Non-Preferred Criteria • Requires clinical review
MOUNJARO (tirzepatide)	exenatide	
OZEMPIC (semaglutide)	liraglutide	
TRULICITY (dulaglutide)	RYBELSUS (semaglutide)	
VICTOZA (liraglutide)	SOLIQUA (insulin glargine/lixisenatide)	
	SYMLINPEN (pramlintide)	
	XULTOPHY (insulin degludec/liraglutide)	
HYPOGLYCEMICS, INSULINS & RELATED AGENTS^{DUR+}		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
RAPID-ACTING		Non-Preferred Criteria • Documented diagnosis of Diabetes Mellitus AND • Have tried 1 preferred agent in the past 6 months OR • 1 claim with the requested agent in the past 105 days Quantity Limit • Insulin quantity limits can be found here Note: • Insulin pen formulations are not covered for Long Term Care (LTC) beneficiaries.
insulin aspart, insulin aspart flexpen	ADMELOG, ADMELOG SOLOSTAR (insulin lispro)	
insulin lispro, insulin lispro junior kwikpen, insulin lispro kwikpen	AFREZZA (insulin regular)	
	APIDRA, APIDRA SOLOSTAR (insulin glulisine)	
	FIASP, FIASP FLEXTOUCH (insulin aspart/niacinamide)	

	HUMALOG; HUMALOG JUNIOR KWIKPEN, HUMALOG KWIKPEN, HUMALOG TEMPO PEN (insulin lispro)	BASAGLAR, AWIQLI FLEXTOUCH Requires clinical review
	KIRSTY, KIRSTY PEN (insulin aspart-xjhz)	
	LYUMJEV, LYUMJEV KWIKPEN U-100, U-200, LYUMJEV TEMPO PEN (insulin lispro-aabc)	
	MERIOLOG, MERIOLOG SOLOSTAR (insulin aspart-szji)	
	NOVOLOG, NOVOLOG FLEXPEN (insulin aspart)	
SHORT-ACTING		
HUMULIN R vial (insulin regular)	NOVOLIN R, NOVOLIN R FLEXPEN (insulin regular)	
HUMULIN R U-500 KWIKPEN (insulin regular)		
INTERMEDIATE-ACTING		
HUMULIN N vial (insulin NPH)	HUMULIN N KWIKPEN (insulin N)	
	NOVOLIN N, NOVOLIN N FLEXPEN (insulin NPH)	
LONG-ACTING		
LANTUS, LANTUS SOLOSTAR (insulin glargine)	AWIQLI FLEXTOUCH (insulin icodec-abae) ^{NR}	
TOUJEO MAX SOLOSTAR (insulin glargine)	BASAGLAR KWIKPEN, BASAGLAR TEMPO PEN (insulin glargine)	
TOUJEO SOLOSTAR (insulin glargine)	insulin degludec, insulin degludec pen U-100, U-200	
	insulin glargine Max SoloStar, insulin glargine SoloStar	
	insulin glargine-yfgn	
	REZVOGLAR KWIKPEN (insulin glargine-aglr)	
	TRESIBA, TRESIBA FLEXTOUCH U-100, U-200 (insulin degludec)	
PREMIXED		
HUMALOG MIX 75/25 vial (insulin lispro/lispro protamine)	HUMALOG MIX KWIKPEN 50/50, 75/25 (insulin lispro/lispro protamine)	
HUMULIN 70/30 vial (insulin NPH/regular)	HUMULIN 70/30 KWIKPEN (insulin N/regular)	
insulin aspart protamine mix 70/30	NOVOLIN 70/30, NOVOLIN 70/30 FLEXPEN (insulin NPH/regular)	
insulin lispro protamine mix 75/25	NOVOLOG MIX 70/30, NOVOLOG MIX 70/30	

	FLEXPEN (insulin aspart protamine/aspart)	
HYPOGLYCEMICS, MEGLITINIDES		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
nateglinide		
repaglinide		
HYPOGLYCEMICS, SODIUM GLUCOSE COTRANSPORTER-2 (SGLT-2) INHIBITORS ^{DUR+}		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
SGLT-2 INHIBITORS		Non-Preferred Criteria - Have tried 2 different preferred SGLT-2 inhibitors in the past 6 months OR 90 days of therapy with the requested agent in the past 105 days
dapagliflozin	FARXIGA (dapagliflozin)	
JARDIANCE (empagliflozin)	INPEFA (sotagliflozin)	
	INVOKANA (canagliflozin)	
	STEGLATRO (ertugliflozin)	
SGLT-2 INHIBITOR COMBINATIONS		
GLYXAMBI (empagliflozin/linagliptin)	dapagliflozin/metformin ER	
SYNJARDY (empagliflozin/metformin)	dapagliflozin/saxagliptin	
SYNJARDY XR (empagliflozin/metformin)	INVOKAMET (canagliflozin/metformin)	
TRIJARDY XR (empagliflozin/linagliptin/metformin)	INVOKAMET XR (canagliflozin/metformin)	
	SEGLUROMET (ertugliflozin/metformin)	
	STEGLUJAN (ertugliflozin/sitagliptin)	
	XIGDUO XR (dapagliflozin/metformin)	
HYPOGLYCEMICS, THIAZOLIDINEDIONES (TZDs) and TZD Combinations		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
pioglitazone	ACTOPLUS MET (pioglitazone/metformin)	
pioglitazone/metformin	ACTOS (pioglitazone)	
pioglitazone/glimepiride	DUETACT (pioglitazone/glimepiride)	
IDIOPATHIC PULMONARY FIBROSIS ^{DUR+}		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
nintedanib (except Dexcel Pharma brand)	ESBRIET (pirfenidone)	All Agents Documented diagnosis of Idiopathic Pulmonary Fibrosis
pirfenidone	JASCAYD (nerandomilast)	
	nintedanib (Dexcel Pharma brand)	OFEV - Documented diagnosis of Idiopathic Pulmonary Fibrosis, Progressive Pulmonary Fibrosis, or Systemic Sclerosis-associated Interstitial Lung Disease OR 90 days of therapy with Ofev in the past 105 days
	OFEV (nintedanib)	

		pirfenidone - Documented diagnosis of Idiopathic Pulmonary Fibrosis OR 90 days of therapy with pirfenidone or Esbriet in the past 105 days ESBRIET, nintedanib - Requires clinical review JASCAYD MANUAL PA
IMMUNE GLOBULINS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
BIVIGAM	ALYGLO	
FLEBOGAMMA	ASCENIV	
GAMASTAN	CABLIVI	
GAMMAGARD	CUTAQUIG	
GAMMAGARD S-D	CUVITRU	
GAMUNEX-C	GAMMAGARD ERC	
HIZENTRA	GAMMAKED	
HYQVIA	GAMMAPLEX	
PANZYGA	OCTAGAM	
PRIVIGEN	QIVIGY	
XEMBIFY		
IMMUNOLOGIC THERAPIES FOR ASTHMA		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
DUPIXENT (dupilumab) DUR+	NUCALA (mepolizumab)	DUPIXENT 1 claim with DUPIXENT in the past 60 days OR - New starts require clinical review (see manual PA links below) Allergic Fungal Rhinosinusitis MANUAL PA Asthma MANUAL PA Atopic Dermatitis MANUAL PA Bullous Pemphigoid MANUAL PA COPD MANUAL PA Chronic Spontaneous Urticaria MANUAL PA Eosinophilic Esophagitis MANUAL PA Nasal Polyposis MANUAL PA Prurigo Nodularis MANUAL PA FASENRA - Requires clinical review Asthma MANUAL PA NUCALA - Requires clinical review TEZSPIRE - Requires clinical review XOLAIR 1 claim with XOLAIR in the past 45 days OR - New starts require clinical review Asthma MANUAL PA
FASENRA (benralizumab)	OMLYCLO (omalizumab-igec)	
XOLAIR (omalizumab)	TEZSPIRE (tezepelumab-ekko)	

		○ Chronic Spontaneous Urticaria MANUAL PA ○ Nasal Polyposis MANUAL PA
IMMUNOSUPPRESSIVE AGENTS, ORAL		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
AZASAN (azathioprine)	ASTAGRAF XL (tacrolimus)	Minimum Age Limit
azathioprine	ENVARUS XR (tacrolimus)	• 13 years: RAPAMUNE • 18 years: ZORTRESS
CELLCEPT (mycophenolate)	LUPKYNIS (voclosporin)	
cyclosporine	MYFORTIC (mycophenolate)	Maximum Age Limit
everolimus	MYHIBBIN (mycophenolate)	• 12 years: PROGRAF Granules
mycophenolate	PROGRAF (tacrolimus)	Preferred Criteria
mycophenolic acid	REZUROCK (belumosudil)	• AZASAN ○ Documented diagnosis of kidney transplant, RA, or a State-accepted diagnosis
NEORAL (cyclosporine)	tacrolimus XL	• CELLCEPT ○ Documented diagnosis of heart, kidney, or liver transplant or a State-accepted diagnosis
RAPAMUNE (sirolimus)	ZORTRESS (everolimus)	• GENGRAF, NEORAL, SANDIMMUNE ○ Documented diagnosis of heart transplant, kidney transplant, liver transplant, psoriasis, RA, or a State-accepted diagnosis
SANDIMMUNE (cyclosporine)		• everolimus ○ Documented diagnosis of kidney or liver transplant
sirolimus		• RAPAMUNE ○ Documented diagnosis of kidney transplant
tacrolimus		• tacrolimus ○ Documented diagnosis of heart, kidney, liver, or lung transplant or a State-accepted diagnosis
		Non-Preferred Criteria • ASTAGRAF XL or ENVARUS XR ○ Documented diagnosis of heart, kidney, liver, or lung transplant or a State-accepted diagnosis AND ○ 30 days of therapy with tacrolimus XL in the past 105 days OR ○ 90 days of therapy with the requested agent in the past 105 days • PROGRAF Granules ○ Age ≤ 11 years AND ○ Documented diagnosis of heart, kidney, liver, or lung transplant or a State-accepted diagnosis • MYFORTIC ○ Documented diagnosis of kidney transplant or psoriasis • MYHIBBIN ○ Documented diagnosis of heart, kidney, or liver transplant or a State-accepted diagnosis AND ○ 30 days of therapy with mycophenolate suspension in the past 105 days OR ○ 90 days of therapy with MYHIBBIN Suspension in the past 105 days • tacrolimus XL ○ Documented diagnosis of heart, kidney, liver, or lung transplant or a State-accepted diagnosis AND ○ 30 days of therapy with tacrolimus IR in the past 105 days OR ○ 90 days of therapy with the requested agent in the past 105 days • ZORTRESS ○ Documented diagnosis of kidney or liver transplant LUPKYNIS and REZUROCK • Requires clinical review
INTRANASAL RHINITIS AGENTS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA

ANTICHOLINERGICS		Non-Preferred Criteria Corticosteroids - Documented diagnosis of allergic rhinitis AND - Have tried 1 different preferred agent in the past 6 months
ipratropium		
ANTIHIISTAMINE/CORTICOSTEROID COMBINATIONS		
	azelastine/fluticasone	
	DYMISTA (azelastine/fluticasone)	
	RYALTRIS (olopatadine/mometasone)	
ANTIHIISTAMINES		
azelastine	olopatadine	
	PATANASE (olopatadine)	
CORTICOSTEROIDS ^{DUR+}		
fluticasone	BECONASE AQ (beclomethasone)	
NASONEX 24 HOUR ALLERGY SPRAY (mometasone) ^{OTC}	flunisolide	
	mometasone	
	NASONEX (mometasone)	
	OMNARIS (ciclesonide)	
	QNASL (beclomethasone)	
	XHANCE (fluticasone)	
IRON CHELATING AGENTS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
deferasirox (all manufacturers except those listed as non-preferred)	deferasirox (manufacturers starting with 62332)	JADENU and JADENU SPRINKLE MANUAL PA
deferiprone 500 mg tablet	deferiprone 1,000 mg tablet	
FERRIPROX (deferiprone)	EXJADE (deferasirox)	
	JADENU (deferasirox)	
	JADENU SPRINKLE (deferasirox)	
IRRITABLE BOWEL SYNDROME/SHORT BOWEL SYNDROME AGENTS/SELECTED AGENTS ^{DUR+}		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
IRRITABLE BOWEL SYNDROME CONSTIPATION ^{DUR+}		Minimum Age Limit 1 year: GATTEX 2 years: LINZESS 72 mcg 7 years: LINZESS 145 mcg 18 years: AMITIZA, IBSRELA, LINZESS 290 mcg, MOTTEGRITY, MOVANTIK, MYTESI, SYMPROIC, VIBERZI Gender Limit Female AMITIZA 8 mcg
LINZESS (linaclotide)	AMITIZA (lubiprostone)	
lubiprostone	IBSRELA (tenapanor)	
	MOTTEGRITY (prucalopride)	
	MOVANTIK (naloxegol)	
	prucalopride	
	SYMPROIC (naldemedine)	
IRRITABLE BOWEL SYNDROME DIARRHEA		
dicyclomine	alosetron	
hyoscyamine, hyoscyamine ER	DIGENYX (hyoscyamine)	
HYOSYNE (hvoscvamine)	VIBERZI (eluxadoline) ^{DUR+}	
		LINZESS 72 mcg - Age 2-17 years AND - Documented diagnosis of pediatric functional constipation AND - No history of bowel or GI obstruction

LEVSIN, LEVSIN-SL (hyoscyamine)		
NULEV (hyoscyamine)		
OSCIMIN, OSCIMIN SL (hyoscyamine)		
SHORT BOWEL SYNDROME AND SELECTED GI AGENTS ^{DUR+}		
	GATTEX (teduglutide)	
	MYTESI (crofelemer)	
IRRITABLE BOWEL SYNDROME CONSTIPATION ^{DUR+}		
Chronic Idiopathic Constipation (CIC): Amitiza 24 mcg, LINZESS, MOTEGRITY • LINZESS 72 mcg ○ Age 6-17 years AND ○ Documented diagnosis pediatric functional constipation in the past year AND ○ No history of GI or bowel obstruction OR ○ Age 18 years or older AND ○ Documented diagnosis of CIC in the past year AND ○ No history of GI or bowel obstruction • LINZESS 145 mcg and lubiprostone 24 mcg ○ Age 18 years or older AND ○ Documented diagnosis of CIC in the past year AND ○ No history of GI or bowel obstruction • LINZESS 290 mcg ○ Age 18 years or older AND ○ Documented diagnosis of CIC in the past year AND ○ No history of GI or bowel obstruction AND ○ 1 claim with LINZESS 145 mcg in the past 45 days • Non-Preferred CIC Agents	Irritable Bowel Syndrome Constipation Dominant (IBS-C): AMITIZA 8 mcg, IBSRELA, LINZESS 290 mcg • Preferred IBS-C Agents ○ Documented diagnosis of IBS-C in the past year AND ○ No history of GI or bowel obstruction • Non-Preferred IBS-C Agents ○ Documented diagnosis of IBS-C in the past year AND ○ No history of GI or bowel obstruction AND ○ Have tried 2 preferred IBS-C agents in the past 6 months OR ○ 1 claim with the requested agent in the past 105 days	Opioid Induced Constipation (OIC): AMITIZA 24 mcg, MOVANTIK, SYMPROIC • Preferred OIC Agents ○ Documented diagnosis of OIC and chronic pain in the past year AND ○ No history of GI or bowel obstruction AND ○ 1 claim for an opioid in the past 30 days • Non-Preferred OIC Agents ○ All preferred criteria met AND ○ Have tried 1 preferred OIC agents in the past 6 months OR ○ 1 claim with the requested agent in the past 105 days

○ Documented diagnosis of CIC AND ○ No history of GI or bowel obstruction AND ○ Have tried 2 preferred CIC agents in the past 6 months OR ○ 1 claim with the requested agent in the past 105 days		
IRRITABLE BOWEL SYNDROME DIARRHEA		
VIBERZI [New starts require clinical review] • Documented diagnosis of IBS D in the past year and 1 claim for Viberzi in the past 105 days LOTRONEX • 1 claim for LOTRONEX in the past 105 days OR • New starts require MANUAL PA		
SHORT BOWEL SYNDROME AND SELECTED GI AGENTS ^{DUR+}		
HIV/AIDS Non-infectious Diarrhea • MYTESI ○ Documented diagnosis of HIV/AIDS and non-infectious diarrhea in the past year AND ○ 1 claim for an antiretroviral in the past 30 days	Short Bowel Syndrome (SBS) • GATTEX ○ 1 claim for GATTEX in the past 105 days OR ○ New starts require clinical review	
LEUKOTRIENE MODIFIERS ^{DUR+}		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
montelukast	ACCOLATE (zafirlukast)	Minimum Age Limit • 12 years: ZYFLO & ZYFLO CR Non-Preferred Criteria • Have tried 2 different preferred agents in the past 6 months
zafirlukast	SINGULAIR (montelukast)	
	zileuton	
	ZYFLO (zileuton)	
LIPOTROPICS, OTHER (NON-STATINS)		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ACL INHIBITORS AND COMBINATIONS		JUXTAPID MANUAL PA
	NEXLETOL (bempedoic acid)	KYNAMRO • Requires clinical review
	NEXLIZET (bempedoic acid/ezetimibe)	LEQVIO • Requires clinical review
ANGIOPOIETIN-LIKE 3 INHIBITORS		NEXLETOL and NEXLIZET • Require clinical review
	EVKEEZA (evinacumab-dgnb)	
BILE ACID SEQUESTRANTS		
cholestyramine	colesevelam	PRALUENT MANUAL PA
cholestyramine light	COLESTID (colestipol)	
colestipol tablet	colestipol packet	REPATHA MANUAL PA
	PREVALITE (cholestyramine)	

	QUESTRAN (cholestyramine)	WELCHOL • Documented diagnosis of Type 2 Diabetes AND • 30 days of therapy with an antidiabetic agent in the past 6 months OR • 90 days of therapy with WELCHOL in the past 105 days
	QUESTRAN LIGHT (cholestyramine)	
	WELCHOL (colesevelam) DUR+	
CHOLESTEROL ABSORPTION INHIBITORS		
ezetimibe	ZETIA (ezetimibe)	
FIBRIC ACID DERIVATIVES		
fenofibrate	fenofibric acid	
gemfibrozil	FENOGLIDE (fenofibrate)	
	FIBRICOR (fenofibric acid)	
	LIPOFEN (fenofibrate)	
	LOPID (gemfibrozil)	
	TRICOR (fenofibrate)	
	TRILIPIX (fenofibric acid)	
MTP INHIBITOR		
	JUXTAPID (lomitapide)	
NIACIN		
niacin ER	niacin	
OMEGA-3 FATTY ACIDS		
omega-3 acid ethyl esters	icosapent ethyl	
	LOVAZA (omega-3 acid ethyl esters)	
PCSK-9 INHIBITORS		
REPATHA (evolocumab)	LEQVIO (inclisiran)	
	LIPFENDRA (enlicitide) ^{NR}	
	PRALUENT (alirocumab)	
LIPOTROPICS, STATINS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
STATINS DUR+		Minimum Age Limit • 10 years: ATORVALIQ Suspension Non-Preferred Criteria Statins • Have tried 2 different preferred statin or statin combination agents in the past 6 months OR • 90 days of therapy with the requested agent in the past 105 days Simvastatin • Daily doses ≥ 80 mg require clinical review
atorvastatin	ALTOPREV (lovastatin)	
lovastatin	ATORVALIQ (atorvastatin)	
pravastatin	CRESTOR (rosuvastatin)	
rosuvastatin	EZALLOR SPRINKLE (rosuvastatin)	
simvastatin	FLOLIPID (simvastatin)	
	fluvastatin	
	fluvastatin ER	
	LESCOL XL (fluvastatin)	
	LIPITOR (atorvastatin)	
	LIVALO (pitavastatin)	
	pitavastatin	
	ZOCOR (simvastatin)	
	ZYPITAMAG (pitavastatin)	
STATIN COMBINATIONS		
ezetimibe/simvastatin	amlodipine/atorvastatin	
	CADUET (amlodipine/atorvastatin)	
	VYTORIN (ezetimibe/simvastatin)	

MISCELLANEOUS BRAND/GENERIC		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ALLERGEN EXTRACT IMMUNOTHERAPY		CUMULATIVE Quantity Limit (per 31 days) • 31 tablets: alprazolam ER Quantity Limit (per 31 days) • 2 kits: epinephrine EVRYSDI MANUAL PA PALSONIFY MANUAL PA RHAPSIDO MANUAL PA *The Miscellaneous subclass contains drugs that do not belong to any PDL drug classes. A non-preferred drug in this subclass may not require a documented history of preferred agents within the Miscellaneous subclass except for a brand name product with a generic equivalent.
	GRASTEK	
	ORALAIR	
	RAGWITEK	
ANXIOLYTICS		
alprazolam	alprazolam ER	
hydroxyzine HCL	VISTARIL (hydroxyzine pamoate)	
hydroxyzine pamoate	XANAX, XANAX XR (alprazolam)	
EPINEPHRINE		
epinephrine (Mylan)	AUVI-Q (epinephrine)	
	epinephrine (all other manufacturers)	
	EPIPEN (epinephrine)	
	EPIPEN JR (epinephrine)	
	NEFFY (epinephrine)	
FAMILIAL CHYLOMICRONEMIA SYNDROME		
	REDEMPLO (plozasiran sodium)	
	TRYNGOLZA (olezarsen)	
MISCELLANEOUS*		
megestrol	BLUJEPA (gepotidacin)	
REVLIMID (lenalidomide)	BRINSUPRI (brensocatib)	
	CAMZYOS (mavacamten)	
	CRENESSITY (crinecerfont)	
	ERGOMAR (ergotamine)	
	EVRYSDI (risdiplam)	
	HARLIKU (nitisinone)	
	KORLYM (mifepristone)	
	lenalidomide	
	MYQORZO (aficamten)	
	PALSONIFY (paltusotine)	
	pomalidomide	
	POMALYST (pomalidomide)	
	RHAPSIDO (remibrutinib)	
	TARPEYO (budesonide)	
	VERQUVO (vericiguat)	
SUBLINGUAL NITROGLYCERIN		
nitroglycerin		
NITROLINGUAL (nitroglycerin)		
NITROSTAT (nitroglycerin)		
MOVEMENT DISORDER AGENTS ^{DUR+}		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
AUSTEDO (deutetrabenazine)	INGREZZA INITIATION PACK (valbenazine)	AUSTEDO and AUSTEDO XR

AUSTEDO XR (deutetrabenazine)	XENAZINE (tetrabenazine)	• Documented diagnosis of Huntington's chorea AND • 30 days of therapy with tetrabenazine in the past 180 days OR • 90 days of therapy with either agent in the past 105 days • Documented diagnosis of tardive dyskinesia AND • 90 days of therapy with either agent in the past 105 days OR • New starts require clinical review MANUAL PA INGREZZA and INGREZZA SPRINKLE • Documented diagnosis of Huntington's chorea AND • 30 days of therapy with tetrabenazine in the past 180 days OR • 90 days of therapy with the requested agent in the past 105 days • Documented diagnosis of tardive dyskinesia AND • 90 days of therapy with the requested agent in the past 105 days OR • New starts require clinical review MANUAL PA
INGREZZA (valbenazine)		
INGREZZA SPRINKLE (valbenazine)		
tetrabenazine		
MULTIPLE SCLEROSIS AGENTS ^{DUR+}		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
HIGHLY ACTIVE		Preferred Agents • Documented diagnosis of multiple sclerosis Preferred Agents • Documented diagnosis of multiple sclerosis Non-Preferred Criteria (Highly Active) • Requires clinical review Non-Preferred Criteria (Mildly Active) • Documented diagnosis of multiple sclerosis AND • Have tried 2 different preferred agents in the past 6 months OR • 3 claims with the requested agent in the last 105 days GILENYA, KESIMPTA, PONVORY, TASCENSO ODT, and ZEPOSIA • Requires clinical review cladribine and MAVENCLAD MANUAL PA MAYZENT MANUAL PA OCREVUS and OCREVUS ZUNOVO MANUAL PA
TYSABRI (natalizumab)	BRIUMVI (ublituximab-xiiv)	
	cladribine	
	KESIMPTA PEN (ofatumumab)	
	MAVENCLAD (cladribine)	
	OCREVUS (ocrelizumab)	
	OCREVUS ZUNOVO (ocrelizumab/hyaluronidase-ocsg)	
	TYRUKO (natalizumab-sztn)	
MODERATELY ACTIVE		
fingolimod	GILENYA (fingolimod)	
	MAYZENT (siponimod)	
	PONVORY (ponesimod)	
	TASCENSO ODT (fingolimod)	
	ZEPOSIA (ozanimod)	
MILDLY ACTIVE		
BETASERON (interferon beta-1b)	AMPYRA (dalfampridine)	
COPAXONE (glatiramer) 20 mg	AUBAGIO (teriflunomide)	
dalfampridine ER	AVONEX (interferon beta-1a)	
dimethyl fumarate	BAFIERTAM (monomethyl fumarate)	
REBIF (interferon beta-1a)	COPAXONE (glatiramer) 40 mg	
REBIF REBIDOSE (interferon beta-1a)	glatiramer	
teriflunomide	GLATOPA (glatiramer)	
	PLEGRIDY (peginterferon beta-1a)	

	TECFIDERA (dimethyl fumarate)	
	VUMERITY (diroximel fumarate)	
MUSCULAR DYSTROPHY AGENTS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
EMFLAZA (deflazacort)	AGAMREE (vamorolone)	AGAMREE MANUAL PA
	AMONDYS-45 (casimersen)	AMONDYS-45 MANUAL PA*
	deflazacort	
	DUVYZAT (givinostat)	DUVYZAT MANUAL PA
	ELEVIDYS (delandistrogene moxeparvovec-rokl)	ELEVIDYS MANUAL PA*
	EXONDYS-51 (eteplirsen)	EXONDYS-51 MANUAL PA*
	JAYTHARI (deflazacort)	JAYTHARI MANUAL PA
	KYMBEE (deflazacort)	KYMBEE MANUAL PA
	VILTEPSO (viltolarsen)	VILTEPSO MANUAL PA*
	VYONDYS-53 (golodirsen)	VYONDYS-53 MANUAL PA*

indomethacin capsule	FELDENE (piroxicam)	
indomethacin ER	fenoprofen	
ketorolac	ibuprofen 300 mg	
nabumetone	indomethacin suspension, suppository	
naproxen 250 mg, 500 mg	ketoprofen	
piroxicam	LOFENA (diclofenac potassium)	
sulindac	meclofenamate	
	mefenamic acid	
	NALFON (fenoprofen)	
	NAPRELAN (naproxen)	
	NAPROSYN 375 mg (naproxen)	
	naproxen 375 mg, naproxen CR 375 mg, naproxen ER 500 mg	
	ORUDIS (ketoprofen)	
	oxaprozin	
	RELAFEN DS (nabumetone)	
	TOLECTIN (tolmetin)	
	tolmetin	
NSAID/GI PROTECTANT COMBINATIONS		
	ARTHROTEC 50 mg, 75 mg (diclofenac/misoprostol)	
	diclofenac/misoprostol	
	ibuprofen/famotidine	
	naproxen/esomeprazole	
	VIMOVO (naproxen/esomeprazole)	
OPHTHALMIC AGENTS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTIBIOTICS		Minimum Age Limit • 16 years: RESTASIS • 17 years: XIIDRA • 18 years: CEQUA, EYSUVIS, MIEBO, TRYPTYR, VEVYE Quantity Limit (per 31 days) • 2 mL: VEVYE • 3 mL: MIEBO • 5.5 mL: RESTASIS Multidose • 8.3 mL: EYSUVIS • 60 units: CEQUA, RESTASIS Droperette, TRYPTYR, XIIDRA • 1 bottle (150 mL): diclofenac 1.5% solution Non-Preferred Criteria • Anti-Inflammatory Agents ○ Have tried 2 different preferred agents in the past 6 months
bacitracin/polymyxin	AZASITE (azithromycin)	
ciprofloxacin	bacitracin	
erythromycin	besifloxacin	
gentamicin	BESIVANCE (besifloxacin)	
moxifloxacin	CILOXAN (ciprofloxacin)	
ofloxacin	gatifloxacin	
polymyxin B/trimethoprim	NATACYN (natamycin)	
tobramycin	neomycin/bacitracin/polymyxin	
	OCUFLOX (ofloxacin)	
	sulfacetamide	
	TOBREX (tobramycin)	
	VIGAMOX (moxifloxacin)	
ANTIBIOTIC-STEROID COMBINATIONS		
BLEPHAMIDE S.O.P. (sulfacetamide/prednisolone)	MAXITROL (neomycin/polymyxin/dexamethasone)	Dry Eye Agents

neomycin/bacitracin/polymyxin/hydrocortisone	neomycin/polymyxin/gramicidin	○ History of 1 claim for both RESTASIS Droperette and XIIDRA in the past 6 months BYQLOVI, MIEBO, RESTASIS Multidose, TRYPTYR, TYRVAYA, VEVYE • Requires clinical review
neomycin/polymyxin/dexamethasone	TOBRADEX ST (tobramycin/dexamethasone)	
PRED-G (gentamicin/prednisolone)	tobramycin/loteprednol	
sulfacetamide/prednisolone		
TOBRADEX (tobramycin/dexamethasone)		
tobramycin/dexamethasone		
ZYLET (tobramycin/loteprednol)		
ANTI-INFLAMMATORY AGENTS^{DUR+}		
dexamethasone	ACULAR, ACULAR LS (ketorolac)	
diclofenac sodium	ACUVAIL (ketorolac)	
difluprednate	bromfenac	
FLAREX (fluorometholone)	BROMSITE (bromfenac)	
fluorometholone	BYQLOVI (clobetasol)	
flurbiprofen	DUREZOL (difluprednate)	
FML FORTE (fluorometholone)	FML (fluorometholone)	
ketorolac	ILEVRO (nepafenac)	
MAXIDEX (dexamethasone)	INVELTYS (loteprednol)	
PRED MILD (prednisolone)	LOTEMAX, LOTEMAX SM (loteprednol)	
prednisolone acetate	loteprednol	
prednisolone sodium phosphate	NEVANAC (nepafenac)	
	PRED FORTE (prednisolone)	
	PROLENSA (bromfenac)	
DRY EYE AGENTS		
EYSUVIS (loteprednol)	CEQUA (cyclosporine)	
RESTASIS Droperette (cyclosporine)	cyclosporine	
XIIDRA (lifitegrast)	MIEBO (perfluorohexyloactane)	
	RESTASIS Multidose (cyclosporine)	
	TYRVAYA (varenicline)	
	VEVYE (cyclosporine)	
OPHTHALMIC, GLAUCOMA AGENTS^{DUR+}		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
BETA BLOCKERS		Minimum Age Limit • 18 years: IYUZEH
BETIMOL (timolol)	betaxolol	Non-Preferred Criteria • Have tried 2 different preferred agents in the past 6 months OR
carteolol	BETOPTIC S (betaxolol)	
ISTALOL (timolol)	timolol droperette, daily drop, ael	

levobunolol	TIMOPTIC; TIMOPTIC OCUDOSE, XE (timolol)	90 days of therapy with the requested agent in the past 105 days
timolol drops 0.25%, 0.5%		
CARBONIC ANHYDRASE INHIBITORS		
dorzolamide	AZOPT (brinzolamide)	
	brinzolamide	
COMBINATION AGENTS		
COMBIGAN (brimonidine/timolol)	brimonidine/timolol	
dorzolamide/timolol	COSOPT (dorzolamide/timolol)	
SIMBRINZA (brinzolamide/brimonidine)	dorzolamide/timolol PF	
PARASYMPATHOMIMETICS		
pilocarpine 1%, 2%, 4%		
PROSTAGLANDIN ANALOGS		
latanoprost	bimatoprost	
	IYUZEH (latanoprost)	
	LUMIGAN (bimatoprost)	
	tafluprost	
	TRAVATAN Z (travoprost)	
	travoprost	
	VYZULTA (latanoprostene bunod)	
	XALATAN (latanoprost)	
	XELPROS (latanoprost)	
	ZIOPTAN (tafluprost)	
	ZOLYMBUS (bimatoprost)	
RHO KINASE INHIBITORS/COMBINATIONS		
RHOPRESSA (netarsudil)		
ROCKLATAN (netarsudil/latanoprost)		
SYMPATHOMIMETICS		
ALPHAGAN P (brimonidine)	brimonidine 0.1%, 0.15%	
brimonidine 0.2%		
OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ALREX (loteprednol)	ALOCRIL (nedocromil)	Non-Preferred Criteria - Have tried 2 different preferred agents in the past 6 months VERKAZIA - Requires clinical review
azelastine	ALOMIDE (lodoxamide)	
cromolyn	bepotastine	
ketotifen ^{OTC}	BEPREVE (bepotastine)	
olopatadine	epinastine	
ZADITOR (ketotifen)	LASTACRAFT (alcaftadine)	
	VERKAZIA (cyclosporine)	
	ZERVIAE (cetirizine)	
OPIATE DEPENDENCE TREATMENTS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
DEPENDENCE		Buprenorphine/naloxone provider summary found here

buprenorphine/naloxone SL tablet ^{DUR+}	BRIXADI (buprenorphine)	Minimum Age Limit • 18 years: VIVITROL SUBLOCADE MANUAL PA VIVITROL • Documented diagnosis of opioid related disorder
naltrexone	buprenorphine ^{DUR+}	
SUBOXONE (buprenorphine/naloxone) ^{DUR+}	buprenorphine/naloxone film ^{DUR+}	
	lofexidine	
	LUCEMYRA (lofexidine)	
	SUBLOCADE (buprenorphine)	
	VIVITROL (naltrexone) ^{DUR+}	
	ZUBSOLV (buprenorphine/naloxone)	
TREATMENT		
KLOXXADO (naloxone)	LIFEMS NALOXONE (naloxone convenience kit)	
naloxone		
NARCAN (naloxone)		
OPVEE (nalmefene)		
REXTOVY (naloxone)		
ZIMHI (naloxone)		

OTIC ANTIBIOTICS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
CIPRO HC (ciprofloxacin/hydrocortison e)	ciprofloxacin	Maximum Age Limit • 9 years: CIPRO HC and ciprofloxacin/hydrocortisone Ciprofloxacin/Dexamethasone Suspension Criteria • Age ≥ 6 months AND • Experiencing otorrhea secondary to recent, post-tympanostomy tube placement AND • Continued otorrhea after 10 days of otic treatment with ciprofloxacin ophthalmic solution and dexamethasone ophthalmic suspension
CORTISPORIN-TC (neomycin/colistin/hydrocortison e)	ciprofloxacin/dexamethason e	
fluocinolone	ciprofloxacin/fluocinolone	
neomycin/polymyxin/hydrocortison e	ciprofloxacin/hydrocortisone	
	DERMOTIC (fluocinolone)	
	FLAC OTIC OIL (fluocinolone)	
	hydrocortisone/acetic acid	
	OTOVEL (ciprofloxacin/fluocinolone)	

PANCREATIC ENZYMES		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
CREON (lipase/protease/amylase)	VIOKACE (lipase/protease/amylase)	Non-Preferred Criteria • Have tried 2 different preferred agents in the past 6 months
PERTZYE (lipase/protease/amylase)		
ZENPEP (lipase/protease/amylase)		

PARATHYROID AGENTS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
calcitriol	doxercalciferol	

cinacalcet	RAYALDEE (calcifediol)	
ergocalciferol	ROCALTROL (calcitriol)	
paricalcitol	SENSIPAR (cinacalcet)	
ZEMPLAR (paricalcitol)	YORVIPATH (palopegteriparatide)	
PHOSPHATE BINDERS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
calcium acetate	AURYXIA (ferric citrate)	
CALPHRON (calcium acetate)	FOSRENOL (lanthanum)	
sevelamer carbonate tablet	lanthanum	
	MAGNEBIND (calcium carbonate/magnesium)	
	REVELA (sevelamer)	
	sevelamer carbonate packet, sevelamer HCl	
	VELPHORO (sucroferric oxyhydroxide)	
	XPHOZAH (tenapanor)	
PLATELET AGGREGATION INHIBITORS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
aspirin/dipyridamole	BRILINTA (ticagrelor)	Non-Preferred Criteria • Documented diagnosis AND • Have tried 2 different preferred agents in the past 6 months OR • 90 days of therapy with the requested agent in the past 105 days ZONTIVITY MANUAL PA
cilostazol	EFFIENT (prasugrel)	
clopidogrel	PLAVIX (clopidogrel)	
dipyridamole		
pentoxifylline		
prasugrel		
ticagrelor		
PLATELET STIMULATING AGENTS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
NPLATE (romiplostim)	ALVAIZ (eltrombopag)	
PROMACTA (eltrombopag) tablet	DOPTELET (avatrombopag)	
	DOPTELET SPRINKLE (avatrombopag maleate)	
	MULPLETA (lusutrombopag)	
	PROMACTA (eltrombopag) packet	
	TAVALISSE (fostamatinib)	
POTASSIUM REMOVING AGENTS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
LOKELMA (sodium zirconium cyclosilicate)	KIONEX (sodium polystyrene sulfonate)	
SPS (sodium polystyrene sulfonate) suspension	sodium polystyrene sulfonate	

	SPS (sodium polystyrene sulfonate) enema	
	VELTASSA (patiomer calcium sorbitex)	
PRENATAL VITAMINS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
CLASSIC PRENATAL COMPLETE NATAL DHA COMPLETENATE CONCEPT DHA CONCEPT OB M-NATAL PLUS PRENATAL PRENATAL PLUS VITAMIN-MINERAL PRENATAL VITAMIN PRENATAL VITAMIN PLUS LOW IRON PRENATAL VITAMINS PROVIDA OB SELECT-OB + DHA SE-NATAL-19 STUART ONE THRIVITE RX TRICARE TRINATAL RX 1 VITAFOL FE PLUS VITAFOL ULTRA VITAFOL-OB VITAFOL-ONE WESNATAL DHA COMPLETE WESTAB PLUS	All prenatal vitamins are non-preferred except for those specifically indicated as preferred.	List of Preferred NDC's for Prenatal Vitamins can be found here
PSEUDOBULBAR AFFECT AGENTS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	NUEDEXTA (dextromethorphan/quinidine)) dextromethorphan/quinidine	Non-Preferred Criteria - Documented diagnosis of pseudobulbar affect disorder OR 90 days of therapy with NUEDEXTA in the past 105 days
PULMONARY ANTIHYPERTENSIVE AGENTS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ACTIVIN SIGNALING INHIBITORS		Minimum Age Limit 18 years: ADEMPAS, OPSYNVI, TADLIQ
	WINREVAIR (sotatercept-csrk)	
COMBINATION AGENTS		Maximum Age Limit 12 years: REVATIO suspension
	OPSYNVI (macitentan/tadalafil)	
ENDOTHELIN RECEPTOR ANTAGONISTS		Preferred Criteria

ambrisentan	macitentan (Apotex brand)	• PAH Agents ○ Documented diagnosis of pulmonary hypertension • Sildenafil tablets ○ ≤ 1 year of age and documented diagnosis of pulmonary hypertension, patent ductus arteriosus, or persistent fetal circulation OR ○ ≥ 1 year of age and documented diagnosis of pulmonary hypertension OR ○ 90 days of therapy with the requested agent in the past 105 days • Sildenafil suspension • < 12 years of age AND • Documented diagnosis of pulmonary hypertension, patent ductus arteriosus, or persistent fetal circulation, or a history of a heart transplant OR • 90 days stable therapy with sildenafil suspension in the past 105 days Non-Preferred Criteria • Documented diagnosis of pulmonary hypertension AND • Have tried 1 preferred PAH agent in the past 6 months OR • 90 days of therapy with the requested agent in the past 105 days OPSUMIT, OPSYNVI, ORENITRAM ER, TYVASO, and VENTAVIS • Require clinical review
bosentan	OPSUMIT (macitentan)	
LETAIRIS (ambrisentan)	TRACLEER (bosentan)	
macitentan (except Apotex brand)	TRYVIO (aprocitentan)	
PDE5 INHIBITORS ^{DUR+}		
sildenafil (generic REVATIO) tablet, suspension	ADCIRCA (tadalafil)	
tadalafil	ALYQ (tadalafil)	
	REVATIO (sildenafil)	
	TADLIQ (tadalafil)	
PROSTACYCLINS		
	ORENITRAM ER (treprostinil)	
	ORENITRAM TITRATION PAK (treprostinil)	
	TYVASO (treprostinil)	
	VENTAVIS (iloprost)	
	YUTREPIA (treprostinil)	
SELECTIVE PROSTACYCLINE RECEPTOR AGONISTS		
	UPTRAVI (selexipag) ^{DUR+}	
SOLUABLE GUANYLATE CYCLASE STIMULATORS		
	ADEMPAS (riociguat) ^{DUR+}	
ADEMPAS • Documented diagnosis of persistent/recurrent chronic thromboembolic pulmonary hypertension (WHO Group 4) or pulmonary arterial hypertension (WHO Group 1) AND • Have tried 1 preferred PAH agent in the past 6 months OR • 90 days of therapy with ADEMPAS in the past 105 days		
TADLIQ • Documented diagnosis of pulmonary hypertension AND • Have tried preferred sildenafil suspension in the past 6 months OR • 90 days of therapy with TADLIQ in the past 105 days		
UPTRAVI • Documented diagnosis of pulmonary hypertension AND • Have tried 1 preferred endothelin receptor antagonist in the past 6 months AND • Have tried 1 preferred PDE5 inhibitor in the past 6 months OR • 90 days of therapy with UPTRAVI in the past 105 days		

ROSACEA TREATMENTS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
metronidazole	AVAR (sulfacetamide sodium/sulfur)	Note: • Topical Sulfonamides used for Rosacea will require a manual PA for age > 21 years. • Other labeled indications are limited to < 21 years.
	AVAR LS (sulfacetamide sodium/sulfur)	
	AVAR-E (sulfacetamide sodium/sulfur)	
	BP 10-1 (sulfacetamide sodium/sulfur)	
	brimonidine	
	EPSOLAY (benzoyl peroxide)	
	FINACEA (azelaic acid)	

	METROCREAM (metronidazole)	
	METROGEL (metronidazole)	
	MIRVASO (brimonidine)	
	OVACE (sulfacetamide sodium)	
	OVACE PLUS (sulfacetamide sodium)	
	oxymetazoline cream	
	RHOFADE (oxymetazoline)	
	ROSADAN (metronidazole)	
	ROSULA (sulfacetamide sodium/sulfur)	
	sodium sulfacetamide	
	sodium sulfacetamide/sulfur	
	SOOLANTRA (ivermectin)	
	SUMADAN (sulfacetamide sodium/sulfur)	
	SUMADAN XLT (sulfacetamide sodium/sulfur/avob)	
	SUMAXIN (sulfacetamide sodium/sulfur)	
	SUMAXIN CP (sulfacetamide sodium/sulfur)	
	SUMAXIN TS (sulfacetamide sodium/sulfur)	
SEDATIVE HYPNOTIC AGENTS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
BENZODIAZEPINES ^{DUR+}		MS DOM Opioid Initiative Criteria details found here Concomitant use of Opioids and Benzodiazepines
estazolam	flurazepam	
temazepam 15 mg, 30 mg capsule	HALCION (triazolam)	Maximum Age Limit 64 years: zolpidem 7.5 mg, 10 mg, and 12.5 mg
	quazepam	
	RESTORIL (temazepam)	
	temazepam 7.5 mg, 22.5 mg capsule	Gender and Dose Limit Female: AMBIEN 5 mg, AMBIEN CR 6.25 mg, INTERMEZZO 1.75 mg Male: all strengths of zolpidem
	triazolam	
OTHERS ^{DUR+}		Non-Preferred Criteria Have tried 2 different preferred agents in the past 6 months
eszopiclone	AMBIEN (zolpidem)	
ramelteon	AMBIEN CR (zolpidem)	
zaleplon	BELSOMRA (suvorexant)	
zolpidem tablet	DAYVIGO (lemborexant)	HETLIOZ capsules - Age 18 years or older AND - Documented diagnosis of circadian rhythm sleep disorder - OR - Age 16 years and older AND - Documented diagnosis of Smith-Magenis syndrome
	doxepin	
	EDULAR (zolpidem)	
	HETLIOZ LQ (tasimelteon)	
	LUNESTA (eszopiclone)	
	QUVIVIQ (daridorexant)	
	ROZEREM (ramelteon)	
	tasimelteon	HETLIOZ liquid

	zolpidem capsule	• Age 3-15 years AND • Documented diagnosis of Smith-Magenis syndrome
	zolpidem sublingual tablet	
	zolpidem ER	
		Note: • Single-source benzodiazepines and barbiturates are NOT covered. ◦ PA s will NOT be issued for these drugs.
		See below for additional PA Criteria/DUR+ Rules

CUMULATIVE Quantity Limit Benzodiazepines

- **31 units/31 days:** Quantity limit per rolling days for all strengths. DUR+ will allow an early refill override for one dose or therapy change per year.

CUMULATIVE Quantity Limit Triazolam

- **10 units/31 days:** Quantity limit per rolling days for all strengths.
- **60 units/365 days:** Quantity limit per rolling days for all strengths.

CUMULATIVE Quantity Limit Non-Benzodiazepines

- **31 units/31 days:** Quantity limit per rolling days for all strengths. DUR+ will allow an early refill override for one dose or therapy change per year.

CUMULATIVE Quantity Limit HETLIOZ LQ

- **1 bottle (48 mL or 158 mL):** Quantity limit per rolling days for all strengths. DUR+ will allow an early refill override for one dose or therapy change per year.

CUMULATIVE Quantity Limit ZOLPIMIST

- **1 canister/31 days:** male; Quantity limit per rolling days for all strengths. DUR+ will allow an early refill override for one dose or therapy change per year.
- **1 canister/62 days:** female; Quantity limit per rolling days for all strengths. DUR+ will allow an early refill override for one dose or therapy change per year.

SELECT CONTRACEPTIVE PRODUCTS

PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
INJECTABLE CONTRACEPTIVES		Non-Preferred Criteria • 1 claim with the requested agent in the past 105 days
medroxyprogesterone	DEPO-PROVERA (medroxyprogesterone)	
INTRAVAGINAL CONTRACEPTIVES		
ENILLORING (etonogestrel/ethinyl estradiol)	ANNOVERA (segesterone/ethinyl estradiol)	
NUVARING (etonogestrel/ethinyl estradiol)	PHEXXI (lactic acid/citric acid/potassium bitartrate)	
ORAL CONTRACEPTIVES ^{DUR+}		
All oral contraceptives are preferred except for those specifically indicated as non-preferred.	AMETHIA (levonorgestrel/ethinyl estradiol)	
	AMETHYST (levonorgestrel/ethinyl estradiol)	
	BALCOLTRA (levonorgestrel/ethinyl estradiol)	
	BEYAZ (drospirenone/ethinyl estradiol/levomefolate)	
	CAMRESE (levonorgestrel/ethinyl estradiol)	

	CAMRESE LO (levonorgestrel/ethinyl estradiol)	
	JOLESSA (levonorgestrel/ethinyl estradiol)	
	LO LOESTRIN FE (norethindrone/ethinyl estradiol/iron)	
	LOESTRIN (norethindrone/ethinyl estradiol)	
	LOESTRIN FE (norethindrone/ethinyl estradiol/iron)	
	MINZOYA (levonorgestrel/ethinyl estradiol/iron)	
	NATAZIA (estradiol valerate/dienogest)	
	NEXTSTELLIS (drospirenone/estetrol)	
	OCELLA (ethinyl estradiol/drospirenone)	
	SAFYRAL (drospirenone/ethinyl estradiol/levomefolate)	
	SIMPESSE (levonorgestrel/ethinyl estradiol)	
	TAYTULLA (norethindrone/ethinyl estradiol/iron)	
	TYDEMY (drospirenone/ethinyl estradiol/levomefolate)	
	YASMIN (ethinyl estradiol/drospirenone)	
	YAZ (ethinyl estradiol/drospirenone)	
TRANSDERMAL CONTRACEPTIVES		
TWIRLA (levonorgestrel/ethinyl estradiol)	norelgestromin/ethinyl estradiol	
XULANE (norelgestromin/ethinyl estradiol)		
ZAFEMY (norelgestromin/ethinyl estradiol)		
SICKLE CELL AGENTS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA

CASGEVY (exagamglogene autotemcel)	ADAKVEO (crizanlizumab- tmca)	ENDARI MANUAL PA CASGEVY MANUAL PA LYFGENIA MANUAL PA
DROXIA (hydroxyurea)	ENDARI (glutamine)	
hydroxyurea	HYDREA (hydroxyurea)	
LYFGENIA (lovotibeglogene autotemcel)	l-glutamine	
	SIKLOS (hydroxyurea)	
SKELETAL MUSCLE RELAXANTS ^{DUR+}		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
baclofen 5 mg, 10 mg, 20 mg tablet	AMRIX (cyclobenzaprine)	Quantity Limit • 84 tablets/180 days: carisoprodol Non-Preferred Criteria • Documented diagnosis of an approvable indication AND • Have tried 2 different preferred agents in the past 6 months Baclofen granules, solution, and suspension • Require clinical review. Carisoprodol • Documented diagnosis of acute musculoskeletal condition AND • No history with meprobamate in the past 105 days AND • History of 1 claim for cyclobenzaprine in the past 21 days AMRIX, ATMEKSI, cyclobenzaprine ER, metaxalone 640 mg, ONTRALFY, TANLOR, and tizanidine capsules • Requires clinical review
chlorzoxazone	ATMEKSI (methocarbamol suspension)	
cyclobenzaprine 5 mg, 10 mg tablet	baclofen 15 mg tablet	
methocarbamol	baclofen suspension	
tizanidine tablet	carisoprodol	
	carisoprodol/aspirin	
	cyclobenzaprine 7.5 mg tablet	
	cyclobenzaprine ER	
	DANTRIUM (dantrolene)	
	dantrolene	
	FEXMID (cyclobenzaprine)	
	FLEQSUVY (baclofen)	
	LORZONE (chlorzoxazone)	
	LYVISPAH (baclofen)	
	metaxalone	
	NORGESIC (orphenadrine/aspirin/caffeine)	
	NORGESIC FORTE (orphenadrine/aspirin/caffeine)	
	ONTRALFY (tizanidine)	
	orphenadrine	
	orphenadrine/aspirin/caffeine	
	ORPHENGESIC FORTE (orphenadrine/aspirin/caffeine)	
	SOMA (carisoprodol)	
	TANLOR (methocarbamol)	
	tizanidine capsule	
	ZANAFLEX (tizanidine)	
SMOKING DETERRENTS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
NICOTINE TYPE		Minimum Age Limit

nicotine gum ^{OTC}	NICOTROL INHALER CARTRIDGE	• 18 years: CHANTIX Quantity Limit • 336 tablets/year: CHANTIX 0.5 mg tabs, 1 mg tabs, and continuing pack • 2 treatment courses/year: CHANTIX Starter Pack
nicotine lozenge ^{OTC}	NICOTROL NASAL SPRAY	
nicotine patch ^{OTC}		
NON-NICOTINE TYPE		
bupropion SR		
CHANTIX (varenicline)		
varenicline		
STERIODS (TOPICAL) ^{DUR+}		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
LOW POTENCY		Non-Preferred Criteria • Low Potency ○ Have tried 2 different preferred low potency agents in the past 6 months • Medium Potency ○ Have tried 2 different preferred medium potency agents in the past 6 months • High Potency ○ Have tried 2 different preferred high potency agents in the past 6 months • Very High Potency ○ Have tried 2 different preferred very high potency agents in the past 6 months amcinonide, clobetasol 0.025%, hydrocortisone 2% gel, HYDRAVEX, HYDROXYM, MICORT-HC, PROCTOCORT • Requires clinical review.
alclometasone	fluocinolone	
DERMA-SMOOTH-ES (fluocinolone)	hydrocortisone gel, lotion	
desonide	HYDRAVEX (hydrocortisone)	
hydrocortisone cream, ointment, solution	HYDROXYM (hydrocortisone)	
	MICORT-HC (hydrocortisone)	
	PROCTOCORT (hydrocortisone)	
MEDIUM POTENCY		
fluticasone	BESER (fluticasone)	
mometasone	CAPEX (fluocinolone)	
PANDEL (hydrocortisone probutate)	clocortolone	
prednicarbate cream	CLODERM (clocortolone)	
	flurandrenolide	
	fluticasone lotion	
	LOCOID (hydrocortisone butyrate)	
	prednicarbate ointment	
	SYNALAR (fluocinolone)	
HIGH POTENCY		
betamethasone dipropionate cream, lotion	amcinonide	
betamethasone dipropionate augmented	betamethasone dipropionate ointment	
betamethasone valerate	desoximetasone	
fluocinolone	diflorasone	
fluocinonide	Halcinonide	
fluocinonide-E	HALOG (halcinonide)	
triamcinolone cream, ointment, lotion	KENALOG (triamcinolone)	
	TOPICORT (desoximetasone)	
	triamcinolone spray	
VERY HIGH POTENCY		
clobetasol cream, foam, gel, ointment, shampoo, solution	APEXICON E (diflorasone)	

clobetasol-E	clobetasol emulsion	
halobetasol cream and ointment	clobetasol 0.025% cream	
	CLOBEX (clobetasol)	
	CLODAN (clobetasol)	
	DIPROLENE (betamethasone)	
	halobetasol foam and lotion	
	IMPEKLO (clobetasol)	
	IMPOYZ (clobetasol) 0.025% cream	
	LEXETTE (halobetasol)	
	OLUX (clobetasol)	
	TEMOVATE (clobetasol)	
	TOVET (clobetasol)	
	ULTRAVATE (halobetasol)	
STIMULANTS AND RELATED AGENTS ^{DUR+}		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
SHORT-ACTING		Minimum Age Limit • 3 years: ADDERALL, EVEKEO, PROCENTRA, ZENZEDI • 6 years: ADDERALL XR, ADHANSIA XR, ADZENYS ER SUSPENSION, ADZENYS XR ODT, APTENSIO XR, ARYNTA, atomoxetine, ATONCY, AZSTARYS, clonidine ER, CONCERTA ER, COTEMPLA XR ODT, DAYTRANA, DESOXYN, DEXEDRINE, DYANAVEL XR, EVEKEO ODT, FOCALIN, FOCALIN XR, JORNAY PM, METADATE CD, METHYLIN, ONYDA XR, QELBREE, QUILLICHEW, QUILLIVANT XR, RELEXXII ER, RITALIN LA, VYVANSE, WAKIX, XELSTRYM • 7 years: XYREM • 13 years: MYDAYIS • 16 years: modafinil • 18 years: armodafinil, SUNOSI Maximum Age Limit • 18 years: clonidine ER, COTEMPLA XR ODT, DAYTRANA, EVEKEO ODT, guanfacine ER Quantity Limit Stimulants (per 31 days) • 31 tablets: ADDERALL XR, ADHANSIA XR, ADZENYS XR ODT, APTENSIO XR, AZSTARYS, CONCERTA ER 18, 27, & 54 mg, COTEMPLA XR-ODT 8.6 mg, DAYTRANA, DEXEDRINE Spansule, DYANAVEL XR Tablet, FOCALIN XR, JORNAY PM, METADATE CD, METHYLIN ER, MYDAYIS 37.5 mg & 50 mg, QUILLICHEW, RELEXXII ER, RITALIN LA & SR, VYVANSE, XELSTRYM • 62 tablets: ADDERALL, CONCERTA ER 36 mg, COTEMPLA XR-ODT 17.3 & 25.9 mg, DESOXYN, EVEKEO, FOCALIN, METHYLIN, RITALIN, ZENZEDI • 248 mL: DYANAVEL XR Suspension • 310 mL: METHYLIN • 372 mL: QUILLIVANT XR • 465 mL: PROCENTRA Quantity Limit Narcolepsy (per 31 days) • 31 tablets: armodafinil 150, 200 & 250 mg, modafinil 200 mg, SUNOSI • 46.5 tablets: modafinil 100 mg • 62 tablets: armodafinil 50 mg, WAKIX Quantity Limit Non-Stimulants (per 31 days) • 31 tablets: atomoxetine, guanfacine ER • 93 tablets: QELBREE 200 mg • 124 tablets: clonidine ER • 1 bottle (30 mL or 60 mL): ONYDA XR Suspension
dexmethylphenidate	ADDERALL (dextroamphetamine/amphe tamine)	
dextroamphetamine	amphetamine	
dextroamphetamine/amphe tamine	EVEKEO (amphetamine)	
methylphenidate tablet, solution	dextroamphetamine solution	
PROCENTRA (dextroamphetamine)	EVEKEO ODT (amphetamine)	
	FOCALIN (dexmethylphenidate)	
	methamphetamine	
	METHYLN (methylphenidate)	
	methylphenidate chewable tablet	
	RITALIN (methylphenidate)	
	ZENZEDI (dextroamphetamine)	
LONG-ACTING		
ADDERALL XR (dextroamphetamine/amphe tamine)	ADZENYS XR ODT (amphetamine)	
CONCERTA (methylphenidate)	amphetamine ER ODT (generic ADZENYS XR ODT)	
dexmethylphenidate ER	APTENSIO XR (methylphenidate)	
dextroamphetamine ER	ARYNTA (lisdexamfetamine) solution	
dextroamphetamine/amphe tamine ER (generic ADDERALL XR)	AZSTARYS (serdexmethylphenidate/dex methylphenidate)	

DYANAVEL XR (amphetamine) suspension	COTEMPLA XR ODT (methylphenidate)	ARYNTA Requires clinical review
lisdexamfetamine	DAYTRANA (methylphenidate)	
methylphenidate CD	DEXEDRINE (dextroamphetamine)	
methylphenidate ER tablet	dextroamphetamine/amphet amine ER (generic MYDAYIS ER)	
methylphenidate LA	DYANAVEL XR (amphetamine) tablets	
QUILLICHEW ER (methylphenidate)	FOCALIN XR (dexmethylphenidate)	
QUILLIVANT XR (methylphenidate)	JORNAY PM (methylphenidate)	
VYVANSE (lisdexamfetamine) capsules	methylphenidate patch	
	methylphenidate ER capsule, ODT	
	MYDAYIS (dextroamphetamine/amphe tamine)	
	RELEXXII (methylphenidate)	
	RITALIN LA (methylphenidate)	
	VYVANSE (lisdexamfetamine) chewable tablets	
	XELSTRYM (dextroamphetamine)	
NARCOLEPSY		
armodafinil	NUVIGIL (armodafinil)	
modafinil	PROVIGIL (modafinil)	
SUNOSI (solriamfetol)	sodium oxybate	
XYREM (sodium oxybate)	WAKIX (pitolisant)	
	XYWAV (calcium/magnesium/potassi um/sodium oxybate)	
NON-STIMULANTS		
atomoxetine	ATONCY (atomoxetine)	
clonidine ER (generic Kapvay only)	INTUNIV (guanfacine)	
guanfacine ER	ONYDA XR (clonidine)	
QELBREE (viloxazine)	STRATTERA (atomoxetine)	
Non-Preferred Short Acting Criteria ADD/ADHD - Documented diagnosis of ADD/ADHD AND - Have tried 2 different preferred Short Acting agents in the past 6 months OR 1 claim for a 30-day supply with the requested agent in the past 105 days		Non-Preferred Long Acting Criteria ADD/ADHD - Documented diagnosis of ADD/ADHD AND - Have tried 2 different preferred Long-Acting agents in the past 6 months OR 1 claim for a 30-day supply with the requested agent in the past 105 days Narcolepsy: ADDERALL XR, APTENSIO XR, CONCERTA ER, DEXEDRINE, METADATE CD, METHYLIN ER, MYDAYIS, NUVIGIL, PROVIGIL, QUILLICHEW, QUILLIVANT XR, RITALIN LA

Narcolepsy: ADDERALL, EVEKEO, METHYLIN, PROCENTRA, RITALIN, ZENZEDI • Documented diagnosis of narcolepsy AND • 30 days of therapy with preferred modafinil or armodafinil in the past 6 months AND • 1 preferred agent indicated for narcolepsy in the past 6 months OR • Have tried 1 claim for a 30-day supply with the requested agent in the past 105 days	• Documented diagnosis of narcolepsy AND • 30 days of therapy with preferred modafinil or armodafinil in the past 6 months AND • 1 different preferred agent indicated for narcolepsy in the past 6 months OR • 1 claim for a 30-day supply with the requested agent in the past 105 days
Armodafinil • Documented diagnosis of narcolepsy, obstructive sleep apnea, shift work sleep disorder, or bipolar depression Atomoxetine • Age ≥ 21 years AND • Documented diagnosis of ADD/ADHD Clonidine ER • Documented diagnosis of ADD/ADHD Guanfacine ER • Documented diagnosis of ADD/ADHD JORNAY PM • Diagnosis of ADD/ADHD AND • History of 84 days of therapy with 2 different preferred LA methylphenidate products in the past 12 months AND • History of 84 days of therapy with 1 preferred non-methylphenidate LA stimulant in the past 12 months OR • History of 84 days of therapy with JORNAY PM in the past 105 days Modafinil • Documented diagnosis of narcolepsy, obstructive sleep apnea, shift work sleep disorder, depression, sleep deprivation or Steinert Myotonic Dystrophy Syndrome ONYDA XR MANUAL PA	QELBREE 100 mg • Quantity of 1 per day AND • Documented diagnosis of ADD/ADHD AND • No history of a different strength of QELBREE in the past 26 days AND • 30 days of therapy with a preferred ADHD agent in the past 105 days OR • 30 days of therapy with QELBREE in the past 105 days QELBREE 150 mg • Quantity of ≤ 2 per day AND • Documented diagnosis of ADD/ADHD AND • No history of a different strength of QELBREE in the past 26 days AND • 30 days of therapy with a preferred ADHD agent in the past 105 days OR • 30 days of therapy with QELBREE in the past 105 days QELBREE 200 mg • Age 18 years and older AND • Quantity of ≤ 3 per day AND • Documented diagnosis of ADD/ADHD AND • No history of a different strength of QELBREE in the past 26 days AND • 30 days of therapy with a preferred ADHD agent in the past 105 days OR • Age 6-17 years AND • Quantity of ≤ 2 tablets per day AND • Documented diagnosis of ADD/ADHD AND • No history of a different strength of Qelbree in the past 26 days AND • 30 days of therapy with a preferred ADHD agent in the past 105 days OR • 30 days of therapy with QELBREE in the past 105 days SUNOSI • Documented diagnosis of narcolepsy or obstructive sleep apnea AND • 30 days of therapy with preferred modafinil or armodafinil in the past 6 months VYVANSE • Documented diagnosis of binge eating disorder or ADD/ADHD OR • 90 days of therapy with Vyvanse in the past 105 days ATONCY, WAKIX, XYWAV • Requires clinical review XYREM • Diagnosis of narcolepsy or excessive daytime sleepiness OR • 30 days of therapy with this agent in the past 105 days
TETRACYCLINES	

PA CRITERIA		PREFERRED AGENTS	NON-PREFERRED AGENTS
Non-Preferred Agents Requires clinical review		doxycycline hyclate (except 75 mg capsule)	demeclocycline
		doxycycline monohydrate capsule	DORYX (doxycycline hyclate)
		minocycline capsule	DORYX MPC (doxycycline hyclate)
		tetracycline capsule	doxycycline hyclate 75 mg capsule
			doxycycline hyclate DR
			doxycycline IR/DR
			doxycycline monohydrate suspension, tablet
			LYMEPAK (doxycycline hyclate)
			MINOCIN (minocycline)
			minocycline tablet
			minocycline ER
			MINOLIRA ER (minocycline)
			MORGIDOX (doxycycline hyclate)
			NUZYRA (omadacycline)
			ORACEA (doxycycline monohydrate)
			SOLODYN (minocycline)
			tetracycline tablet
ULCERATIVE COLITIS & CROHN'S AGENTS ^{DUR+} *See Cytokine & CAM Antagonists Class for Additional Agents*			
PA CRITERIA		PREFERRED AGENTS	NON-PREFERRED AGENTS
Non-Preferred Criteria - Documented diagnosis of Ulcerative Colitis AND - Have tried 2 different preferred agents in the past 6 months OR 90 days of therapy with the requested agent in the past 105 days VELSIPITY - Requires clinical review		ORAL	
		balsalazide	AZULFIDINE (sulfasalazine)
		budesonide	DELZICOL (mesalamine)
		PENTASA (mesalamine)	DIPENTUM (olsalazine)
		sulfasalazine	LIALDA (mesalamine)
		sulfasalazine DR	mesalamine
			mesalamine DR, mesalamine ER
			VELSIPITY (etrasimod)
		RECTAL	
		mesalamine suppository	budesonide
			CANASA (mesalamine)
			mesalamine enema
			ROWASA (mesalamine)
			SFROWASA (mesalamine)
UREA CYCLE DISORDER AGENTS			
PA CRITERIA		PREFERRED AGENTS	NON-PREFERRED AGENTS
		CARBAGLU (carglumic acid)	BUPHENYL (sodium phenylbutyrate)
			carglumic acid
			glycerol phenylbutyrate

	OLPRUVA (sodium phenylbutyrate)	
	PHEBURANE (sodium phenylbutyrate)	
	RAVICTI (glycerol phenylbutyrate)	