Virginia Medicaid's Preferred Drug List (PDL)
Common Core Formulary
7/1/2018

Magellan Medicaid Administration
Virginia Medicaid's Pharmacy Benefits Management System
Phone: 800-932-6648 Fax: 800-932-6651

General Information:

- **Virginia Medicaid's Preferred Drug List (PDL) only includes select drug classes**
- PDL preferred drugs do not require Service Authorizations (SA) unless subject to additional clinical criteria (e.g., long acting opioids, hepatitis C therapies, growth hormone)
- Non-preferred drugs require a SA
- Drugs not on the PDL are subject to Virginia's mandatory generic substitution requirements.
- SAs may be submitted by fax, phone or WebPA. For urgent requests, please call **800-932-6648.** Fax requests receive a response within 24 hours.

PDL drug coverage information can be found at http://www.VirginiaMedicaidPharmacyServices.com. **The following "routine" PDL criteria guidelines will be applied to all non-preferred drugs.**

1. Is there any reason the member cannot be changed to a preferred drug within the same class? Acceptable reasons include:

- Allergy to preferred drug.
- Contraindication to or drug-to-drug interaction with preferred drug.
- History of unacceptable/toxic side effects to preferred drug.
- Member's condition is clinically stable; changing to a preferred drug might cause deterioration of the member's condition.

2. The requested drug may be approved if both of the following are true:

- There has been a therapeutic failure of at least **two** preferred drugs **within the same class as appropriate for diagnosis unless otherwise noted in the clinical criteria**. A therapeutic failure of only one preferred drug is required when there is only one preferred drug within a therapeutic class.
- The requested drug's corresponding generic (if a generic is available **and** covered by the State) has been attempted and failed or is contraindicated.

All changes from last posting will be highlighted in yellow.

LEGEND

ST = step edit
QL = quantity limit
AG = age edit
cap = capsule
cr = cream
ER = extended release
inj = injection
IR = immediate release
ODT = oral disintegrating tablet
oint = ointment
soln = solution
supp = suppository
susp = suspension
tab = tablet

	Preferred Agents	Non-Preferred Agents	SA Criteria
Analgesics			
	*** Opioids – Long Acting (LAO)**		
	Preferred (Sch III-VI)	***Non-Preferred***	***All Long Acting Opioids (preferred and non-preferred) require submission of a Clinical SA. Refer to combined short/long-acting opioid SA form (Short & Long Acting Opioid SA Form)** **LENGTH OF AUTHORIZATIONS** • Up to 6 months for chronic pain, (includes chronic non-malignant pain, cancer pain, palliative care, end-of-life care) • Up to 1 month for severe post op pain Daily dose limits have been established for all LAO. Quantity limits can be found at : **Daily Dose Limits for Short & Long Acting Opioids**
	Butrans® (buprenorphine) Transdermal Patch	*Belbuca (buprenorphine buccal film)* *buprenorphine (generic Butrans®)* *ConZip® (tramadol ER)* *Ryzolt™ (tramadol ER)* *tramadol ER* *Ultram ER® (tramadol ER)*	
	Preferred (Sch II)	***Non-Preferred***	
	fentanyl 12, 25, 50, 75 & 100 mcg patches **morphine sulfate ER tab**	*Arymo™ER* *Duragesic®* *Embeda* *Exalgo®* *fentanyl 37.5 mcg, 62.5 mcg, and 87.5 mcg patches* *Hysingla ER™* *Kadian® ER* *Morphabond™ ER* *morphine ER cap (generic Avinza®)* *morphine ER cap (generic Kadian®)* *MS Contin®* *Nucynta® ER* *Oramorph ® SR®* *oxycodone-long acting* *OxyContin®* *oxymorphone ER* *Xartemis™ XR* *Xtampza ER®* *Zohydro ER™*	

Preferred Agents	Non-Preferred Agents	SA Criteria
***Methadone Drugs**		
	Dolophine® *Methadose® oral soln & tab* *methadone oral soln & tab*	*Methadone requires the completion of the Clinical SA form **(Methadone SA Form)** unless prescribed for neonatal abstinence syndrome for an infant under the age of one.
***Opioids – Short Acting**		
***Transmucosal Immediate Release Fentanyl**		**LENGTH OF AUTHORIZATIONS:** • 1 month for severe post-surgical pain, OR • Up to 6 months for chronic pain (includes chronic non-malignant pain, active cancer pain, palliative care, end-of-life care).
	Actiq® *Fentora®* *fentanyl citrate* *Lazanda®* *Subsys®*	
Short-Acting Opioids		***All Short-Acting Opioids (preferred and non-preferred) require the submission of a Clinical SA if prescribed for > 7 days or if more than two 7 day supply prescriptions within 60 days. Refer to combined short/long-acting opioid SA form (Short & Long Acting Opioid SA Form)**
codeine/APAP **codeine/APAP/caff/butal** **hydrocodone/APAP** **hydrocodone/ibuprofen** **hydromorphone** **morphine IR** **oxycodone IR** **oxycodone/APAP** **tramadol HCL**	*Abstral®* *codeine tab/soln* *butalbital comp with codeine* *butalbital/caffeine/APAP w/codeine* *butorphanol tartrate nasal* *dihydrocodeine/APAP/caffeine* *dihydrocodeine/ASA/caffeine* *hydromorphone liq/supp* *meperidine tab* *morphine supp* *Nucynta®* *Oxaydo®* *oxycodone/APAP (generic PrimLev™)* *Oxycodone conc* *oxycodone/ASA* *oxycodone/ibuprofen* *oxymorphone HCl* *Panlor®* *pentazocine/naloxone* *PrimLev™*	

Preferred Agents	Non-Preferred Agents	SA Criteria
	tramadol HCL/APAP *Ultracet®* *Ultram®* *Zamicet ®soln*	
Opioid Dependency		***All Buprenorphine Containing Drugs (preferred and non-preferred) require submission of Clinical SA. Refer to (Sublocade Form) or (Oral Buprenorphine SA Form)**
***buprenorphine SL** ***Suboxone® film**	**Bunavail ™* **buprenorphine/naloxone tab* **Sublocade ™ SQ* **Zubsolv™*	**Quantity Limits**
naloxone syringe & vial **naltrexone tab** **Narcan® Nasal Spray** **Vivitrol®**	*Evzio®*	

Bunavail™ 2.1–0.3mg buccal film	1/day
Bunavail™ 4.2–0.7mg buccal film	2/day
Bunavail™ 6.3–1mg buccal film	2/day
buprenorphine SL tab 2mg	3/day
buprenorphine SL tab 8mg	2/day
buprenorphine/naloxone SL tab 2–0.5mg	3/day
buprenorphine/naloxone SL tab 8–2mg	2/day
Suboxone® SL film 2–0.5mg	3/day
Suboxone® SL film 4–1mg	1/day
Suboxone® SL film 8–2mg	2/day
Suboxone® SL film 12–3mg	1/day
Zubsolv™ SL tab 0.7–0.18 mg	2/day
Zubsolv™ SL tab 1.4–0.36mg	2/day
Zubsolv™ SL tab 2.9–0.71mg	2/day
Zubsolv™ SL tab 5.7–1.4mg	2/day
Zubsolv™ SL tab 8.6–2.1mg	2/day
Zubsolv™ SL tab 11.4–2.9mg	2/day

Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)

Oral NSAIDs		**LENGTH OF AUTHORIZATIONS: 1 year**
Children's Motrin® susp (OTC) **ibuprofen cap** **ibuprofen tab (OTC & Rx)** **Infant's ibuprofen drops**	*Anaprox® IR & DS®* *Advil®* *Aleve®* *Arthrotec®* *Cataflam®*	**Routine PDL edits plus** ***Step edit required for Celebrex® and celecoxib** • History of a trial of a minimum of two (2) different non-COX2 NSAIDs within the past year**; OR**

	Preferred Agents	Non-Preferred Agents	SA Criteria
	meloxicam tab **naproxen tab** **naproxen sodium (OTC)** **naproxen EC (Rx)** **sulindac**	**Celebrex[c] & *celecoxib* *Daypro®* *diclofenac potassium* *diclofenac sodium SR* *diclofenac sodium/misoprostol* *diflunisalDuexis®* *etodolac IR & SR* *Feldene®* *fenoprofen* *flurbiprofen* *ibuprofen tab chew OTC* *Indocin® supp* *indomethacin IR, SR & rectal* *ketoprofen IR & ER* *ketorolac* *meclofenamate* *mefenamic* *meloxicam susp* *Mobic®* *Motrin®* *nabumetone* *Nalfon®* *Naprelan®* *Naprosyn®* *naproxen CR (generic Naprelan®)* *naproxen sodium (RX)* *naproxen susp* *oxaprozin* *piroxicam* *Ponstel®* *Prevacid Naprapac®* *Sprix® nasal spray* *Tivorbex™* *tolmetin sodium* *Vimovo®*	• Concurrent use of anticoagulants (i.e., warfarin, heparin, etc.)**,** methotrexate, oral corticosteroids; **OR** • History of previous GI bleed or conditions associated with GI toxicity risk factors (i.e., PUD, GERD, etc.); **OR** • Specific indication for Celebrex® for which preferred drugs are not indicated.

	Preferred Agents	Non-Preferred Agents	SA Criteria
		Vivlodex™ *Voltaren®XR* *Zipsor®* *Zorvolex™*	
	Topical NSAIDs		**LENGTH OF AUTHORIZATIONS:** **1 year** **Routine PDL edits plus** **Clinical Criteria for Non-Preferred Topical NSAIDs; *Flector®, Pennsaid®, Vopac MDS, & Xrylix™ Kit:** • Approval is based on member failing the oral generic of the desired drug and at least one other preferred NSAID (to equal a total of at least two preferred). For example, a member who failed ibuprofen or naproxen will still need to try oral diclofenac for approval of Flector®. • Pennsaid®, Vopac MDS, and Xrylix™ Kit can only be approved for the FDA approved indication of osteoarthritis of the knee. ***Quantity limit for Flector® = 30 patches per RX*** ****Solaraze® 3% & Diclofenac Sodium 3 % Clinical Criteria**: • Approved only for the topical treatment of actinic keratosis
	Voltaren® 1% gel	**diclofenac sodium 1 % gel* ***diclofenac sodium 3 % gel* **Flector® patch (QL)* **Pennsaid® top soln, soln pkt & pump* ***Solaraze 3% top gel* **Vopac MDS* **Xrylix™ Kit*	
Antibiotic-Anti-Infective			
	***Antibiotics, Inhaled**		
	Bethkis® *(QL, AG)* **Kitabis™ PAK *(QL, AG)*** ****Tobi Podhaler® *(QL, AG)***	*Cayston® (QL, AG)* *Tobi® inhalation neb soln (QL, AG)* *tobramycin inhalation neb soln (generic Tobi® inhalation) (QL, AG)* *tobramycin Pak (generic Kitabis™ PAK) (QL, AG)*	**LENGTH OF AUTHORIZATIONS:** **1 year** **Routine PDL edits plus** *Minimum age for use is 6 years for **all** tobramycin inhalation nebulizer solution (Bethkis®, Kitabis™ Pak, Tobi® and Tobi Podhaler®) and 7 years for Cayston®. ****Tobi Podhaler® requires a clinical reason as to why one of the preferred tobramycin inhalation nebulizer solutions cannot be used (Bethkis® or Kitabis™). **Quantity Limits:**

Preferred Agents	Non-Preferred Agents	SA Criteria
		Bethkis® = 224mL (56 amps)/28 days Cayston® = 84 mL/(56 amps)/28 days Kitabis™ PAK = 280mL (56 amps)/28 days Tobi Podhaler® = 224 capsule/28 day Tobi® inhalation *neb* = 280mL (56 amps)/28 days tobramycin = 280mL (56 amps)/28 days
Antifungals, Oral		
fluconazole tab/susp **Griseofulvin ® susp** **nystatin tab/susp** **terbinafine**	*Ancobon ®* *clotrimazole (mucous mem)* *Cresemba®* *Diflucan® tab/susp* *flucytosine* *Gris-Peg®* *griseofulvin tab* *griseofulvin ultramicrosize* *itraconazole* *ketoconazole* *Lamisil ® tab/granules* *Noxafil®* **Onmel®* **Sporanox® cap/soln* *Vfend® tab/susp* *voriconazole tab & powder for susp*	**LENGTH OF AUTHORIZATIONS**: Duration of the prescription (up to 12 months) **Routine PDL edits plus** *** Clinical Criteria for all Non-Preferred oral Antifungals. Requires the submission of a Clinical SA. Refer to Antifungal Oral SA Form**
Cephalosporins, Oral		
Second Generation Cephalosporins		**LENGTH OF AUTHORIZATIONS**: Date of service only; no refills. **Routine PDL edits plus** **Clinical Criteria for Non-Preferred Cephalosporins** • Infection caused by an organism resistant to preferred drugs, OR • A therapeutic failure to no less than a three-day trial of **one preferred cephalosporin**; **OR**
cefaclor cap **cefprozil tab/susp** **cefuroxime tab**	*cefaclor ER* *cefaclor susp* *Ceftin® tab/susp*	
Third Generation Cephalosporins		
cefdinir cap/susp **cefixime suspension**	*Cedax® cap/susp* *ceftibuten* *cefditoren pivoxil*	

Preferred Agents	Non-Preferred Agents	SA Criteria
	cefpodoxime proxetil cap/susp *Spectracef®* *Suprax® chewable tab/cap/susp*	• The member is completing a course of therapy with a non-preferred drug initiated in the hospital.
Macrolides, Oral		
Macrolides & Ketolides		**LENGTH OF AUTHORIZATIONS**: Date of service only; no refills **Routine PDL edits plus** **Clinical Criteria for Non-Preferred Macrolides and Ketolides** • Infection caused by an organism resistant to preferred drugs; **OR** • A therapeutic failure to no less than a **three-day trial of one preferred drug within the same class**; **OR** • The member is completing a course of therapy with a non-preferred drug which was initiated in the hospital. *** Ketek® Clinical Criteria** • Treatment of community-acquired pneumonia (of mild to moderate severity) **AND** • Infection is caused by one of the following microorganism: *Streptococcus pneumoniae, Haemophilus influenzae, Moraxella catarrhalis, Chlamydophila pneumoniae, or Mycoplasma pneumoniae.* **AND** • A therapeutic failure to no less than a **three-day trial of one preferred drug within the same class**; **OR** • The member is completing a course of therapy with a non-preferred drug initiated in the hospital.
azithromycin pack/susp/tab **clarithromycin tab/susp** **Ery-tab®** **E.E.S.® 400 tab** **Eryped® 200** **erythromycin base cap DR** **erythrocin stearate** **erythromycin stearate**	*Biaxin® tab* *clarithromycin ER* *Eryped® 400 susp* *E.E.S.® 200 susp* *erythromycin base tab* *erythromycin ethylsuccinate 200mg susp* **Ketek®* *PCE®* *Zithromax® pac/tab/susp* *ZMAX® susp*	
Otic		
Ciprodex®	*Cetraxal®* *Cipro HC®* *ofloxacin* *Otovel*	**LENGTH OF AUTHORIZATIONS:** Date of service only; no refills **Routine PDL edits**

	Preferred Agents	Non-Preferred Agents	SA Criteria
	Quinolones, Oral		
	Second Generation Quinolones		**LENGTH OF AUTHORIZATIONS**: Date of service only; no refills **Routine PDL edits plus**: **Clinical Criteria for Non-Preferred Quinolones** • Infection caused by an organism resistant to preferred drugs; **OR** • A therapeutic failure to no less than a **three-day trial of one preferred quinolone**; **OR** • The member is completing a course of therapy with a non-preferred drug initiated in the hospital.
	ciprofloxacin susp/tab	*Baxdela™ IV* *Cipro® IR & XR & susp* *ciprofloxacin ER* *Noroxin®* *ofloxacin*	
	Third Generation Quinolones		
	levofloxacin tab	*Avelox®* *Levaquin® tab/susp* *levofloxacin susp* *moxifloxacin*	
	Topical Antibiotics		
	mupirocin ointment	**Altabax™ (QL)* *Bactroban® cr/ointment* *Centany®* *Centany AT® Kit*	**LENGTH OF AUTHORIZATIONS**: Date of service only; no refills **Routine PDL edits** **Quantity Limit = 15 grams per 34 days*
	Vaginal Antibiotics		
	Cleocin® Ovules **Clindesse® cr** **metronidazole gel**	*Cleocin® cr* *clindamycin cr* *Metrogel®* *Nuvessa®* *Vandazole™ gel*	**LENGTH OF AUTHORIZATIONS**: Date of Service **Routine PDL edits**
Antivirals			
	***Hepatitis C Agents**		
	Interferon		**LENGTH OF AUTHORIZATIONS**: 8 weeks (initial approval) ***ALL Hepatitis C Drugs (preferred and non-Preferred) require the submission of a Clinical SA. Refer to Hepatitis C Antivirals SA Form or Mavyret SA Form**
	Peg-Intron® **Peg-Intron Redipen®**	*Pegasys® Proclick/syringe/kit/vial*	

Preferred Agents	Non-Preferred Agents	SA Criteria
Protease Inhibitor		
	Olysio™ (discontinued)	
***Nucleotide Analog NS5A & NS5B Polymerase Inhibitors & Combinations**		
	Daklinza® *Epclusa®* *Sovaldi®* *Vosevi™*	
***NS5A, NS3/4A Inhibitor Combinations**		
Mavyret™	*Technivie™* *Viekira Pak™* *Viekira XR™* *Zepatier™*	
***NS5B & Protease Inhibitor combinations**		
	Harvoni®	
Herpes Oral		
acyclovir cap/tab/susp **famciclovir** **valacyclovir**	*Famvir®* *Sitavig® buccal tab* *Valtrex®* *Zovirax® tab/susp*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits**
Herpes Topical		
Abreva OTC® **Zovirax® cr**	*acyclovir oint* *Denavir®* *Xerese® cr* *Zovirax® oint*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits**
Influenza		
amantadine cap/tab/syrup **oseltamivir susp** **Relenza Disk®** **rimantadine**	*Flumadine® tab* *oseltamivir cap* *Tamiflu® susp*	**LENGTH OF AUTHORIZATIONS:** Date of service only **Routine PDL edits**

	Preferred Agents	Non-Preferred Agents	SA Criteria
	Tamiflu® cap		
Blood Modifiers			
	Bile Salts		
	ursodiol 300 mg tab	*Actigal®* *Chenodal®* *Cholbam®* *Ocaliva®* *ursodiol cap* *Urso®* *Urso® Forte tab*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits**
	Phosphate Binders		
	calcium acetate 667mg cap **Renagel®** **Renvela® tablet**	*Auryxia™* *calcium acetate 667mg tab* *Eliphos®* *Ferric citrate* *Fosrenol®* chewable tab lanthanum carbonate chewable tab *Phoslo®* *Phoslyra®* *Renvela® powder* *sevelamer carbonate powder packet* *Velphoro® chewable tab*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits**
Bone Resorption Suppression and Related Agents			
	Bisphosphonates		
	alendronate tab	*Actonel®* *alendronate soln* *Atelvia DR®* *Boniva®* *Binosto™* *etidronate* *Fosamax®tab & Fosamax® plus D*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits** .

	Preferred Agents	Non-Preferred Agents	SA Criteria
		ibandronate *risedronate DR*	
	Calcitonins		
	calcitonin-salmon nasal	*Miacalcin®*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits**
	Others		
	raloxifene	*Evista®* **Forteo®* **Tymlos™* **Clinical SA must be completed for (Forteo® OR Tymlos™ SA Form)**	**LENGTH OF AUTHORIZATIONS**: Initial approval will be for 1 year **Routine PDL edits for Evista®**
Cardiac			
	Anticoagulants		
	Low Molecular Weight Heparin includes FactorXA Inhibitor		**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits plus**
	enoxaparin	*Arixtra®* *fondaparinux* *Fragmin® syringe & vial* *Lovenox®*	

	Oral Anticoagulants		**Clinicial Criteria for Savaysa™**
			• Diagnosis of:
			  • Non-valvular Atrial Fibrillation, **OR**
			  • deep vein thrombosis, **OR**
			  • pulmonary embolism ; **AND**
			• Documentation that CrCl is NOT ≥ 95mL/min calculated by Cockcroft-Gault equation

	Eliquis™ **Jantoven** **Pradaxa®** **Xarelto®** **warfarin**	*Coumadin®* *Eliquis™ Dose Pack* **Savaysa™* *Xarelto® Starter Pack*	
	Antihypertensive Agents		
	ACE Inhibitors		**LENGTH OF AUTHORIZATIONS: 1 year** **Routine PDL edits**
	benazepril **enalapril** **lisinopril** **ramipril**	*Accupril®* *Altace®* *captopril* *Epaned™ soln* *fosinopril*	

Preferred Agents	Non-Preferred Agents	SA Criteria
	Lotensin® *Mavik®* *moexipril* *Monopril®* *perindopril* *Prinivil®* *Qbrelis™* *quinapril* *ramipril* *trandolapril* *Univasc®* *Vasotec®* *Zestril®*	
ACE Inhibitors + Calcium Channel Blocker Combinations		
amlodipine/benazepril	*Lotrel®* *Tarka®* *trandolapril-verapamil ER*	
ACE Inhibitors + Diuretic Combinations		
benazepril/HCTZ **lisinopril/HCTZ** **enalapril/HCTZ**	*Accuretic®* *captopril/HCTZ* *fosinopril/HCTZ* *Lotensin HCT®* *moexipril/HCTZ* *quinapril/HCTZ* *Vaseretic®* *Zestoretic®*	
Angiotensin Receptor Blockers		**LENGTH OF AUTHORIZATIONS:** **1 year** **Routine PDL edits plus** ***Clinical Criteria for Entresto™** • Diagnosis of chronic heart failure (NYHA Class II-IV); **AND** • Member must be ≥ 18 years; **AND**
Entresto™** ***(QL) **losartan** **valsartan**	*Atacand®* *Avapro®* *Benicar®* *Byvalson™* *candesartan* *Cozaar®*	

Preferred Agents	Non-Preferred Agents	SA Criteria
	Diovan® *Edarbi®* *eprosartan mesylate* *irbesartan* *Micardis®* *olmesartan* *Teveten®*	• Left ventricular ejection fraction ≤ 40% *Quantity Limit = 2 per day for Entresto™*
Angiotensin Receptor Blockers + Calcium Channel Blocker Combinations		
amlodipine/valsartan	*Azor®* *amlodipine/olmesartan* *amlodipine/olmesartan/HCTZ* *amlodipine/valsartan/HCTZ* *Exforge® & Exforge® HCT* *Tribenzor®*	
Angiotensin Receptor Blockers + Diuretic Combinations		
losartan/HCTZ **valsartan/HCTZ**	*Atacand HCT®* *Avalide®* *Benicar HCT®* *candesartan/HCTZ* *Diovan HCT®* *Edarbyclor®* *Hyzaar®* *irbesartan/HCTZ* *Micardis HCT®* *olmesartan/HCTZ* *telmisartan/HCTZ* *Teveten HCT®*	
Antihypertensives, Sympatholytics		
Catapres®-TTS **clonidine tab** **guanfacine** **methyldopa** **reserpine**	*Catapres®* *clonidine (transdermal)* *Clorpres®* *methyldopa/HCTZ* *Tenex®*	

Preferred Agents	Non-Preferred Agents	SA Criteria
Beta Blockers		***Clinical Criteria for Hemangeol™** • Diagnosis treatment of proliferating infantile hemangioma requiring systemic therapy; **AND** • Member's age must be between 5 weeks and 5 months.
atenolol **carvedilol** **labetalol** **metoprolol tartrate** **metoprolol succinate** **propranolol tab/soln** **Sorine®** **sotalol AF** **sotalol HCL**	*acebutaolol* *Betapace®IR & AF®* *betaxolol* *bisoprolol* *Bystolic®* *Coreg® IR & CR®* *Corgard®* **Hemangeol™* *Inderal® XL* *Innopran® XL* *Levatol®* *Lopressor®* *nadolol* *pindolol* *propranolol LA* *Sectral®* *Sotylize ™* *Tenormin®* *timolol maleate* *Toprol XL®* *Trandate®* *Zebeta®*	
Beta Blockers + Diuretic Combinations		
atenolol/chlorthalidone **bisoprolol/HCTZ**	*Corzide®* *Dutoprol®* *Lopressor HCT®* *metoprolol/HCTZ* *nadolol/bendroflumethiazide* *propranolol/HCTZ* *Tenoretic®* *Ziac®*	

Preferred Agents	Non-Preferred Agents	SA Criteria
Calcium Channel Blockers -Dihydropyridine		
Afeditab CR® **amlodipine** **Nifedical XL®** **nifedipine** **nifedipine ER**	*Adalat CC®* *felodipine ER* *isradipine* *nisoldipine* *nicardipine* *Norvasc®* *Procardia®* *Procardia XL®* *Sular®*	
Calcium Channel Blockers- Non-Dihydropyridine		
Cartia XT® **diltiazem IR, ER q12 hr & 24 hr** **Taztia XT®** **verapamil tab IR & ER**	*Calan® IR & SR* *Cardizem® IR, CD & LA* *Isoptin SR®* *Matzim LA* *Tiazac®* *verapamil ER cap* *Verelan® & Verelan PM®*	
Direct Renin Inhibitors (includes combination)		
	Tekamlo® *Tekturna®* *Tekturna HCT®* *Twynsta®* *telmisartan/amlodipine*	
Lipotropics		
Bile Acid Sequestrants		**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits plus**
cholestyramine powder reg & light **colestipol tab** **Prevalite®** **Welchol ® tab**	*Colestid® granule/packet/tab* *colestipol HCl granules* *Questran® powder/powder Light* *Welchol® packet*	

Preferred Agents	Non-Preferred Agents	SA Criteria
Cholesterol Absorption Inhibitor (CAI)		
Zetia®	*Ezetimibe*	
Fibric Acid Derivatives		
fenofibrate (generic Tricor® 48mg 145mg) **gemfibrozil**	*Antara®* *fenofibrate (generics for Antara®, Fenoglide® & Lipofen®)* *fenofibric acid* *Fenoglide®* *Fibricor®* *Lipofen®* *Lofibra®* *Lopid®* *Tricor®* *Triglide®* *Trilipix™*	
HMG CoA Reductase Inhibitors and Combo (High Potency Statins)		
atorvastatin **rosuvastatin** **simvastatin**	*amlodipine/atorvastatin* *Caduet®* *Crestor®* *Lipitor®* *Liptruzet®* *Livalo®* *simvastatin/ezetimibe* *Vytorin®* *Zocor®*	
HMG CoA Reductase Inhibitors and Combinations (Statins)		
lovastatin **pravastatin**	*Advicor®* *Altoprev®* *fluvastatin* *Lescol®and Lescol XL®*	

Preferred Agents	Non-Preferred Agents	SA Criteria
	Mevacor® *Pravachol®*	
Microsomal Triglyceride Transfer Protein Inhibitor		
	**Juxtapid ™*	***Clinical Criteria for Juxtapid™. Refer to Juxtapid™ SA Fax Form**
Niacin Derivatives		
niacin ER	*Niaspan®* *Niacor®*	
Omega 3 Fatty Acid Agent		
	****Lovaza® (ST)* ****omega-3 acid ethyl esters(ST)* *Vascepa®*	*****Clinical Criteria for Lovaza® and omega-3 acid ethyl esters** • Step edit requires trial and failure of any other lipotropic; **OR** • Documented high triglycerides of ≥ 500 mg/dL.
Oligonucleotide Inhibitor		
	*****Kynamro™*	******Clinical SA for Kynamro™. Refer to Kynamro™ SA Fax Form**
***Proprotein Convertase Subtilisin Kexin Type 9 (PCSK9) Inhibitors**		**LENGTH OF AUTHORIZATIONS**: Three months for initial approval; six months for renewal ***ALL PCSK9 Inhibitors require the submission of a Clinical SA. Refer to PCSK9 SA Form**
	Praluent® *Repatha®*	
Platelet Inhibitors		
Brilinta® **clopidogrel** **dipyridamole** **prasugrel (generic Effient®)** **ticlopidine HCL**	**Aggrenox®* **ASA/dipyridamole* ***Durlaza ER™* *Effient®* *Persantine®* *Plavix®* ***Yosprala® Tab* ****Zontivity™*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits plus** **Clinical Criteria for Select Non-Preferred Platelet Inhibitors** ***Aggrenox® & ASA/dipyridamole** • Aspirin and dipyridamole are covered as separate drugs without SA; clinical reason as to why the individual drugs cannot be used separately. ****Durlaza ER™ & *Yosprala® Tab** • Aspirin is covered without SA; clinical reason as to why aspirin cannot be used.

Preferred Agents	Non-Preferred Agents	SA Criteria
		*** **Zontivity™** • Diagnosis of MI (myocardial infarction) or PAD (peripheral arterial disease); **AND** • Members must not have a history of stroke, TIA, ICH, GI bleed and peptic ulcer; **AND** • Must have concomitant therapy with clopidogrel, unless member has a contraindication to clopidogrel in which case member must have concomitant therapy with aspirin; **AND** • Member is 18 years of age or older; **AND** • Prescribed by or in consultation with a cardiologist.
***Pulmonary Arterial Hypertension Agents**		
Inhaled Prostacyclin Analogues		**LENGTH OF AUTHORIZATIONS: 1 year**
Ventavis®	*Tyvaso®*	
Oral Endothelin Receptor Antagonist		**Routine PDL edits plus**
Letairis® **Tracleer®**	*Opsumit®*	
***Phosphodiesterase 5 Inhibitors (PDE-5)**		***Clinical Criteria for all preferred and non-preferred PDE-5** • Diagnosis of pulmonary hypertension in members >18 years is required; **AND** • The prescriber must be a pulmonary specialist or cardiologist; **AND** • Must have a rationale for not taking the sildenafil tablet to receive a SA for injectable Revatio®
Adcirca™ **sildenafil tab**	*Revatio® tab/susp/inj*	
Prostacyclin Vasodilator and Receptor Agonist		
	Orenitram™ *Uptravi®*	
Soluble Guanylate Cyclase Stimulators		
	Adempas®	

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Central Nervous System			
	Alzheimer's Agents		
	Cholinesterase Inhibitors		**LENGTH OF AUTHORIZATIONS**: Length of prescription (up to 3 months) **Routine PDL edits**
	donepezil OTD & tab **Exelon® (transderm)**	*Aricept® ODT, tab* *Exelon® cap* *galantamine IR, ER tab/soln* *Namzaric® (donepezil/memantine)* *Razadyne® IR, ER* *rivastigmine cap & patch*	
	NMDA Receptor Antagonist		
	memantine tab/soln	*memantine Dose Pack* *Namenda® Dose Pack/XR tab* *Namenda® tab*	
	Anticonvulsants		
	Barbiturates		**LENGTH OF AUTHORIZATIONS:** **1 year** **Routine PDL edits plus** ***Clinicial Criteria for Onfi®** • Patient is at least two years of age or older; **AND** • Patient must have a diagnosis of seizures associated with Lennox-Gastaut syndrome (LGS) **AND** • Using as adjunctive therapy with other anticonvulsants; **AND** • Prescribing physician should submit documentation of an insufficient response to another medication used for LGS
	phenobarbital elixir/tab **primidone**	*Mysoline®*	
	Benzodiazepines		
	clonazepam **Diastat® rectal** **Diastat® AcuDial™ rectal**	*clonazepam ODT* *diazepam rectal & Device rectal* **Onfi®susp/tab*	
	Carbamazepine Derivatives		
	carbamazepine chewable tab/susp/tab **carbamazepine ER (generic for Carbatrol®)** **oxcarbazepine susp & tab** **Tegretol®XR**	*Aptiom®* *carbamazepine XR* *Carbatrol®* *Equetro® cap* *Oxtellar™ XR* *Tegretol® susp/tab*	

Preferred Agents	Non-Preferred Agents	SA Criteria
	Trileptal® susp/tab *vigabatrin powder pack*	
Hydantoins		
Dilantin® cap/Infatab **phenytoin cap/ chew tab/susp** **phenytoin ext cap** **Phenytek®**	*Dilantin® susp* *Peganone®*	
Succinimides		
ethosuximide cap/syrup	*Celontin®* *Zarontin® cap/syrup*	
Valproic Acid and Derivatives		
divalproex tab/sprinkle **divalproex ER** **valproic acid**	*Depakene® cap/syrup* *Depakote® ER & sprinkle* *Stavzor®*	
Other Anticonvulsants		
felbamate susp/tab **Gabitril®** **lamotrigine tab** **lamotrigine XR** **levetiracetam soln/tab** **levetiracetam ER** **Vimpat® soln/tab** **topiramate tab/sprinkle** **zonisamide**	*Banzel® susp/tab* *Briviact®* *Felbatol® susp/tab* *Fycompa® susp/tab* *Keppra® soln/tab* *Keppra® XR* *Lamictal® XR* *Lamictal® ODT/ODT dose pk* *Lamictal® tab/dose pk* *Lamictal® XR dose pk* *lamotrigine tab dose pk & ODT* *Potiga®* *Qudexy™ XR* *Sabril® powder pack/tab* *tiagabine* *Topamax® tab/sprinkle*	

Preferred Agents	Non-Preferred Agents	SA Criteria
	Trokendi™ XR *Zonegran®*	
Antidepressants		
Other		**LENGTH OF AUTHORIZATIONS:** **1 year** **Routine PDL edits**
bupropion IR, SR &XL **desvenlafaxine ER** **mirtazapine ODT/tab** **trazodone** **venlafaxine IR & ER cap**	*Aplenzin®* *Brintellix®* *Effexor® XR* *Emsam® transdermal* *Fetzima®* *Forfivo® XL* *Khedezla™* *Marplan®* *Nardil®* *nefazodone* *Oleptro® ER* *Parnate®* *phenelzine* *Pristiq®* *Remeron® ODT/tab* *tranylcypromine sulfate* *Trintellix* *venlafaxine ER tab* *Viibryd® tab/dose pk* *Wellbutrin® IR, SR & XL*	
SSRI		
citalopram soln/tab **escitalopram tab** **fluoxetine cap/soln** **fluvoxamine** **paroxetine tab** **sertraline tab**	*Brisdelle®* *Celexa® tab* *escitalopram soln* *fluoxetine DR cap/tab* *fluvoxamine ER* *Lexapro® soln/tab* *Luvox® CR* *paroxetine CR* *Paxil® tab/susp & Paxil® CR*	

	Preferred Agents	Non-Preferred Agents	SA Criteria
		Pexeva® *Prozac® cap/weekly* *Sarafem®* *sertraline conc* *Zoloft® conc/tab*	
	Antimigraine Agents		
	Relpax® **sumatriptan succinate tab cartridge/nasal/vial/pen** **rizatriptan tab/MLT**	*almotriptan* *Alsuma®* *Amerge®* *Axert®* *Cambia®* *eletriptan (generic Relpax®)* *Frova®* *frovatriptan (generic Frova®)* *Imitrex® cartridge/nasal/pen/tab/vial* *Maxalt® tab & MLT* *Migranow™ Kit* *naratriptan* *Onzetra™ Xsail™* *sumatriptan KITS* *Sumavel® Dosepro* *Treximet®* *Zembrace ™ SymTouch ™* *Zomig® tab/nasal spray/ZMT*	**LENGTH OF AUTHORIZATIONS:** **1 year** **Routine PDL edits**
	***Antipsychotics** (AG)*		
	Atypical		**LENGTH OF AUTHORIZATIONS: 1 year or 6 months for members < 18 yrs**
	aripiprazole soln/tab **clozapine tab** **Geodon® IM** **Latuda®** **olanzapine ODT/tab** **olanzapine/fluoxetine** **quetiapine tab** **quetiapine fumarate ER**	*Abilify® tab/IM inj* *aripiprazole ODT* *Clozaril®* *clozapine ODT* *Fanapt® tab & titration pk* *Fazaclo®* *Geodon®* *Invega®*	**Routine PDL edits plus** ***ALL antipsychotics for children 0 to 17 years of age (preferred and non-preferred) require the submission of a Clinical SA. Refer to (Antipsychotics In Children Less Than 18 Years SA Form)** ****Clinical Criteria Nuplazid™**

	Preferred Agents	Non-Preferred Agents	SA Criteria
	risperidone ODT/soln/tab **ziprasidone cap**	***Nuplazid™ (QL)(AG)* *olanzapine IM* *paliperidone ER* *Rexulti® tab* *Risperdal® ODT/soln/tab* *Saphris® SL* *Seroquel® IR* *Seroquel® XR* *Symbyax®* *Versacloz™* *Vraylar™* *Zyprexa® tab/IM/Zydis*	• Indicated for the treatment of hallucinations and delusions associated with Parkinson's disease psychosis. *Quantity Limit Nuplazid™ = 2 per day*
	Atypical, Long Acting Injectable		**LENGTH OF AUTHORIZATIONS:** **1 year**
	Abilify Maintena® **Aristada®** **Risperdal Consta®** **Invega Sustenna®** **Invega Trinza®**	*Zyprexa® Relprevv™*	**Routine PDL edits**
	Typical		**LENGTH OF AUTHORIZATIONS:** **1 year**
	amitriptyline/perphenazine **chlorpromazine** **fluphenazine decantate** **haloperidol decantate** **haloperidol tab** **loxapine** **perphenazine** **trifluoperazine** **thiothixene** **thioridazine**	*fluphenazine elixir/soln/tab* *Haldol decanoate (injection)* *pimozide* *Moban®* *molindone* *Orap®*	**Routine PDL edits**

Preferred Agents	Non-Preferred Agents	SA Criteria
Neuropathic Pain		
capsaicin OTC topical **duloxetine 20, 30 & 60 mg** **gabapentin cap/tab/soln** **lidocaine 5% patch** ***Lyrica**® *(ST)*	*Cymbalta*® *duloxetine 40 mg* *Gralise*™ *Horizant* ™ *Irenka*™ *Lidoderm® patch* *Lyrica® soln* *Neurontin® cap/tab/soln* *Savella™ & Savella™ Dose Pak* *Qutenza Kit® (Topical)*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL** ***Step Edit for Lyrica®** • Trial and failure of duloxetine or gabapentin
Non-Ergot Dopamine Receptor Agonist		
pramipexole **ropinirole HCl**	*Mirapex® IR & ER* *Neupro®* *pramipexole ER* *Requip® IR & XR* *ropinirole HCl ER*	**LENGTH OF AUTHORIZATIONS:** **1 year** **Routine PDL edits**
Sedatives / Hypnotics		
temazepam 15 & 30 mg	*estazolam* *flurazepam* *Halcion®* *Restoril®* *temazepam 7.5 mg & 22.5 mg* *triazolam*	**LENGTH OF AUTHORIZATIONS**: Length of the prescription (up to 3 months) **Routine PDL edits**
Sedatives / Hypnotics (Non-Benzodiazepine)		
zolpidem	*Ambien® IR & CR* *Belsomra®* *Edluar™* *eszopiclone* **Hetlioz™* *Intermezzo®* *Lunesta®* *Rozerem®*	**LENGTH OF AUTHORIZATIONS**: 6 months. **For Renewal -** must document therapeutic benefit and confirm compliance Routine PDL edits plus ***Clinical Criteria for Hetlioz™** • For the treatment of Non-24-Hour Sleep-Wake Disorder (Non-24), **AND** • The member is completely blind, **AND**

Preferred Agents	Non-Preferred Agents	SA Criteria
	Silenor® *Sonata®* *Zaleplon®* *zolpidem CR* *Zolpimist ™ spray* *zolpidem (generic Intermezzo®)*	• Member must be age 18 years of age or older. • Quantity limit = 1 tablet per day.
Skeletal Muscle Relaxants		
baclofen **chlorzoxazone** **cyclobenzaprine HCL** **dantrolene sodium** **methocarbamol** **tizanidine tab**	*Amrix®* ***carisoprodol*** **carisoprodol/ASA* **carisoprodol/ASA/codeine* *cyclobenzaprine ER* *Dantrium®* *Fexmid®* *Lorzone®* *metaxalone* *orphenadrine citrate* *orphenadrine/ASA/caffeine* *Parafon Forte® DSC* *Robaxin®* *Skelaxin®* **Soma®* *tizanidine cap* *Zanaflex®*	**LENGTH OF AUTHORIZATIONS:** • 1 year for chronic conditions • Duration of prescription (up to 3 months) for acute conditions • One month per every 6 months for carisoprodol drugs **Routine PDL edits plus** ***Clinical Criteria for Carisoprodol Drugs. Refer to Soma/carisoprodol SA Fax Form**
Smoking Cessation		
bupropion SR **Chantix®** **Chantix® DS PK** **nicotine gum/lozenge/patch**	*Nicoderm CQ® Patch* *Nicorette® Gum/Lozenges* *Nicotrol® Inhaler & NS* *Zyban®*	**LENGTH OF AUTHORIZATIONS:** 6 months **Routine PDL edits**
***Stimulants/ADHD Medications** *(AG)*		
Amphetamine Drugs		**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits**
Adderall®XR **amphetamine salts combo** *(generic for Adderall IR)*	*Adderall® IR (amphetamine salts combo)* *Adzenys XR ODT™* *Adzenys ER™ susp*	

	Preferred Agents	Non-Preferred Agents	SA Criteria
	dextroamphetamine *(generic for Dexedrine)* **Vyvanse® cap/chewable tab** (lisdexamfetamine)	*amphetamine salts combo XR* *Desoxyn®* *Dexedrine®* *dextroamphetamine SR & soln* *Dyanavel™ XR susp* *Evekeo™* *methamphetamine* *Mydayis ER™* *Procentra® soln* *Zenzedi™*	*All stimulants (preferred and non-preferred) require the submission of Clinical SA if prescribed for a child less than four or an adult 18 years and older. Refer to Stimulant SA form (Stimulant/ADHD Medications SA Form)
	Methylphenidate Drugs		
	All methylphenidate IR generic **Concerta®** **Daytrana® Transdermal** **Focalin® IR & XR** **QuilliChew ER™** **Quillivant™ XR susp**	*Aptensio ™ XR* *Cotempla XR-ODT™* *dexmethylphenidate IR & XR* *Metadate CD®* *Metadate ER®* *Methylin ER®, soln IR* *methylphenidate chew & soln* *methylphenidate ER, LA, SR* *Ritalin® IR, LA® & SR®*	
	Miscellaneous Drugs		
	atomoxetine *(generic for Strattera®)* **guanfacine ER** ****Kapvay® SR 12H** *(ST)*	****armodafinil (generic Nuvigil™)* *clonidine ER (generic Kapvay®)* ****modafinil* ****Nuvigil ™ (AG)* ****Provigil®(AG)* *Strattera®* *Intuniv®*	**Step Edit for****Kapvay® SR 12H** Requires trail and failure of one preferred drug. ****Nuvigil™/Provigil®/armodafinil/modafinil:**: **Length of Authorizations:** 1 year for sleep apnea and narcolepsy; 6 months for shift work sleep disorder. • Approvable diagnoses include: ○ **Sleep Apnea:** Requires documentation/confirmation via sleep study or that C-PAP has been maximized; **OR** ○ **Narcolepsy:** Documentation of diagnosis via sleep study; **OR** ○ **Shift Work Sleep disorder: ONLY APPROVABLE FOR 6 MONTHS**, work schedule must be verified and documented. Shift work is defined as working the all night shift.

	Preferred Agents	Non-Preferred Agents	SA Criteria
			• Nuvigil™ age edit > 17 years • Provigil® age edit > 16 years
Dermatologic			
	***Acne Agents, Topical** *(AG)*		
	Combo Benzoyl Peroxide , Clindamycin , Erythromycin Topical		**LENGTH OF AUTHORIZATIONS:** 1 year
	benzoyl peroxide wash/cr/gel /lot (OTC) **clindamycin/benzoyl peroxide (Duac®)** **clindamycin phosphate soln/swab** **erythromycin solution** **Panoxyl-4 Acne Cr Wash (OTC)** **Panoxyl 10 OTC**	*Acanya™ w/pump* *Acne Clearing System® (OTC)* *Aczone® Gel and Gel Pump* *Avar Cleanser, Medicated Pad* *Avar-E* *Avar-E LS* *Avar LS Cleanser, Medicated Pad* *Azelex®* *Benzaclin®& Benzaclin® Pump* *BP 10-1* *Benzefoam™ regular &Ultra™* *Benzepro* *benzoyl peroxide wash/cr/gel/ lotion/foam/towelette (RX)* *benzoyl peroxide 6% , 9% cleanser (OTC)* *BPO Kit* *Cleocin T®* *Clindacin™ Pac Kit* *Clindagel®* *clindamycin/benzoyl peroxide (generics for Benzaclin®)* *clindamycin phosphate foam, el, lotion, med swab* *clindamycin/tretinoin (generic Veltin®)*	**Routine PDL edits plus** ***Clinical Criteria for Dermatologic Acne Agents** • Prescriptions for members over the age of 18 years will require the submission of a SA to evaluate treatment diagnosis; **AND** • Drugs are intended for acne **only. SA for a cosmetic indication cannot be approved.**

	Preferred Agents	Non-Preferred Agents	SA Criteria
		Delos™ Lotion™ *Duac® gel* *erythromycin gel/med. swab* *Evoclin™* *Inova™* *Lavoclen ™ Cleanser & Kit* *Neuac™ topical/kit* *Onexton™ gel & w/Pump* *Ovace® Wash* *Ovace® Plus shampoo/cr/lotion/foam* *Pacnex®HP & LP* *Panoxyl® 3% cr (OTC)* *Promiseb ® Complete* *Rosula Cleanser* *Se BPO ® Wash Kit & cleanser* *Sulfacetamide Cleanser ER* *Sulfacetamide Cleanser, Shampoo, Susp* *Sulfacetamide Sodium/Sulfur Cr, Susp, Sunscreen* *SSS 10-5 Foam* *Sulfacetamide/Sulfur/Cleanser, Cleanser Kit, Lotion Med. Pad* *Sulfacetamide / Sulfur / Urea Cleanser* *Sumadan Wash, Kit* *Sumadan XLT* *Sumaxin CP Kit* *Veltin®*	
	Retinoids/Combinations , Topical		
	Differin 0.1% gel (OTC) **Retin®A 0.025., 0.05, 0.1 % cr & 0.01, 0.025,% gel**	*Acnefree® Severe Kit (OTC)* *adapalene 0.1% cr/gel/lot* *adapalene 0.3% gel/gel w/pump* *adapalene-benzoyl peroxide (generic Epiduo®)*	***Age Edit for Fabior™ Foam** • Member must be between the ages of 12 and 18 years of age

	Preferred Agents	Non-Preferred Agents	SA Criteria
		Atralin® 0.05% gel *Avage® 0.1% cr* *Avita® 0.025% cr/gel* *Differin® 0.1% cr/gel/lot RX* *Differin® 0.3% gel pump* *Epiduo® & Epiduo® Forte Gel* **Fabior™ 01% Foam (AG)* *Renova® 0.02% cr/cr pump* *Retin®-A Micro 0.04%, 0.1% gel* *Retin®-A Micro 0.08%, 0.04%, 0.1% pump* *Tazorac® cr/gel* *tazarotene 0.1% cr* *tretinoin 0.025, 0.1% cr & 0.01, 0.025, 0.05% gel* *tretinoin microsphere 0.04% & 0.1% gel* *Ziana® gel*	
	Antifungal Topical		
	ciclopirox soln **clotrimazole cr (OTC & RX)** **clotrimazole soln (OTC)** **ketoconazole shampoo** **ketoconazole cr** **miconazole cr/spray (OTC)** **nystatin cr/oint/ powder** **terbinafine cr (OTC)** **tolnaftate cr/powder/soln (OTC)**	*Alevazol® OTC* *Azolen® Tincture OTC* *Bensal HP®* *Ciclodan® Kit* *ciclopirox cr/shampoo/gel* *ciclopirox kit* *ciclopirox suspension* *clotrimazole soln (RX)* *clotrimazole-betamethasone cr* *clotrimazole-betamethasone lot* **CNL 8™ Kit* *Desenex® Aero Powder (OTC)* *econazole* *Ertaczo®* *Exelderm® cr & soln* *Extina®*	**LENGTH OF AUTHORIZATIONS: 6 months** **Routine PDL edits plus** **Select non-preferred topical Antifungals (CNL-8™, Jublia®, Kerydin™, Luzu®, Penlac®) require the submission of a Clinical SA. Refer to Antifungal Topical SA Form**

	Preferred Agents	Non-Preferred Agents	SA Criteria
		Fungi-Nail® (OTC) *Fungoid® Kit (OTC)* *Fungoid® (OTC)* **Jublia®* *ketoconazole foam* **Kerydin®* *Lamisil AT® cr/gel (OTC)* *Lamisil® Spray (OTC)* *Loprox® Kit/ Shampoo/susp* *Lotrimin AF® cr (OTC)* *Lotrimin Ultra® (OTC)* *Lotrisone® cr* ***Luzu®* *miconazole nitrate (OTC)* *miconazole Oint (OTC)* *Mentax®* *Naftin® cr/gel* *Naftifine CR* *Nyata Kit®* *Nizoral A-D® Shampoo (OTC)* *nystatin-triamcinolone cr/oint* *oxiconazole cr (generic Oxistat®)* *Oxistat® cr* *Oxistat® Lotion* *Pediaderm AF®* *PediPak®* **Penlac®* *Tinactin® Aero powder/spray (OTC)* *tolnaftate aero powde/spray (OTC)* *Vusion®*	
	Immunomodulators Atopic Dermatitis		
	***Elidel®**	**Eucrisa™* ***Dupixent ®(QL, AG)* **Protopic®*	**LENGTH OF AUTHORIZATIONS**: 1 year; EXCEPT Dupixent® 6 months **Routine PDL edits plus**

	Preferred Agents	Non-Preferred Agents	SA Criteria

		*tacrolimus	**Clinical Criteria for Elidel®, Eucrisa™, Protopic®& tacrolimus**
			• Member must have a FDA approved diagnosis:
			  o Atopic dermatitis
			  o Elidel® & Eucisa™: mild to moderate for ages > 2 years.
			  o Protopic® 0.03%: moderate to severe for ages > 2 years.
			  o Protopic® 0.1%: moderate to severe for ages > 18 years; **AND**
			• Failure to topical corticosteroids (i.e., desonide, fluticasone propionate, hydrocortisone butyrate, etc.)
			
			****Clinical Criteria for Dupixent®**
			• ≥ 18 years of age; **AND**
			• Diagnosis of moderate to severe atopic dermatitis with ≥ 1 of the following:
			  o Involvement of at least 10% of body surface area (BSA); **OR**
			  o Scoring Atopic Dermatitis (SCORAD) score of 20 or more; **OR**
			  o Investigator's Global Assessment (IGA) with a score ≥ 3; **OR**
			  o Eczema Area and Severity Index (EASI) score of ≥ 16; **OR**
			  o Incapacitation due to AD lesion location (e.g., head and neck, palms, soles, or genitalia); **AND**
			• Prior documented trial and failure (or contraindication) of 1 topical corticosteroids of medium to high potency (e.g., mometasone, fluocinolone) and 1 topical calcineurin inhibitors (tacrolimus or pimecrolimus); **AND**
			• Inadequant response to a 3 month minimum trial of at least 1 immunosuppressive systemic agent (e.g., cyclosporine, azathioprine, methotrexate, mycophenolate mofetil, etc.); **AND**
			• Inadequant response (or is not a candidate) to a 3 month minimum trial of phototherapy (e.g., psoralens with UVA light [PUVA], UVB, etc) provided member has reasonable access to photo treatment; **AND**
			• Is not pregnant; **AND**
			• Is not concurrently receiving a live vaccine
			Renewal Criteria: Member must:
			• Continue to meet above criteria; **AND**
			• Not have documented toxicity from the agent (e.g., hypersensitivity, conjunctivitis, keratitis, immunogenicity); **AND**

	Preferred Agents	Non-Preferred Agents	SA Criteria
			• Documented response compared to baseline as measured by measures used to qualify moderate to severe AD at baseline (e.g., pruritus, BSA involvement, EASI, IGA, SCORAD). ***Quantity limit Dupixent®*** *2 prefilled syringes for the initial dose, then 1 single-dose syringe every 14 days*
	Psoriasis, Topical		
	calcipotriene cr/oint/soln	*Calcitrene®* *calcitriol* *Dovonex®* **Enstilar ® Foam (AG)* *Micanol®* *Sorilux™* *Taclonex® & Taclonex® Scalp* *Vectical*	**LENGTH OF AUTHORIZATIONS: 1 year** **Routine PDL edits plus** ***Clinical Criteria for Enstilar ® Foam** • Length of Authorization: 4 weeks • Diagnosis of plaque psoriasis**; AND** • Minimum age of 18 years
	Rosacea Agents, Topical		
	Metrocream® **Metrogel®** **Metrolotion®**	*Finacea® foam/gel* *metronidazole cr/gel/lot* *Mirvaso®* *Noritate®* *Rosadan™ Kit* *Soolantra®*	**LENGTH OF AUTHORIZATIONS: 1 year** **Routine PDL edits**
	Steroids		
	Steroids, Topical Low Potency		**LENGTH OF AUTHORIZATIONS: 1 year**
	alclometasone cr/oint **hydrocortisone cr/gel/lot/oint**	*aqua glycolic HC* *Capex® shampoo* *Derma-smoothe-FS* *desonate gel/cr/lot/oint* *Desowen® lot* *fluocinolone 0.01% oil* *Micort™-HC* *Pediaderm® HC* *Pediaderm® TA* *Texacort®*	**Routine PDL edits**

Preferred Agents	Non-Preferred Agents	SA Criteria
Steroids, Topical Medium Potency		
fluticasone propionate cr/oint **hydrocortisone butyrate cr/oint/soln/ emollient** **mometasone furoate cr/oint/soln**	*betamethasone valerate foam* *clocortolone cr* *Cloderm®* *Cordran® tape* *Cutivate® cr/lot* *Dermatop® cr/oint* *Elocon® cr/oint/soln* *fluocinolone acetonide cr/oint/soln* *flurandrenolide cr/oint/tape* *fluticasone propionate lot* *hydrocortisone valerate cr/oint* *Luxiq®* *Momexin®* *Pandel®* *prednicarbate cr/oint* *Synalar ®* *Synalar TS®* *Ticanase kit®*	
Steroids, Topical High Potency		**LENGTH OF AUTHORIZATIONS:** **1 year** **Routine PDL edits plus** ***Clinical Criteria for Sernivo™** • Length of Authorization: 4 weeks (treatment beyond 4 weeks is not recommended). • Member must have diagnosis of mild to moderate plaque psoriasis: **AND** • At least 18 years of age
betamethasone valerate cr/lot/oint **triamcinolone acetonide cr/lot/oint** **fluocinonide soln**	*amcinonide cr/lot/oint* *betamet diprop & prop gly cr/lot/oint* *betamet diprop cr/foam/gel/lot/oint* *DermacinRx® SilaPak™* *DermacinRx® Silazone* *DermacinRx® Therazole Pak* *desoximetasone cr/gel/oint/spray* *diflorasone diacetate cr/oint* *Diprolene® lot/oint* *DiproleneAF®cr* *Ellzia™ Pak Kit* *fluocinonide cr/ emollient/ gel/oint/soln* *Halog® cr/oint* *Kenalog® aerosol*	

	Preferred Agents	Non-Preferred Agents	SA Criteria
		Loprox® Suspension Kit **Sernivo™* *Silazone® II Kit* *Topicort ®cr/gel/oint/spray* *Trianex® oint* *triamcinolone spray* *triamcinolone/dimethicone* *Vanos®cr* *Whytederm®Tdpak*	
	Steroids, Topical Very High Potency		
	clobetasol emollient **clobetasol propionate cr/gel/oint/soln** **halobetasol propionate cr/oint**	*Apexicon™ E* *clobetasol lot/shampoo* *clobetasol propionate foam/spray* *Clobex® lot/shampoo/spray* *Clodan® kit* *Halonate®* *Olux®* *Olux®-E* *Temovate® oint* *Ultravate® cr/lotion/oint* *Ultravate® PAC & Ultravate® X*	
Endocrine and Metabolic Agents			
	Androgenic Agents (Testosterone – Topical)		
	Androgel®	*Androderm®* *Axiron® soln* *Fortesta®* *Natesto Nasal Gel ®* *Testim®* *testosterone (generic for Androgel®)* *testosterone (generic for Axiron®)* *testosterone gel/packet/pump (generic for Vogelxo™)* *testosterone (generic for Fortesta®)*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits Plus** **Clinical Criteria for all preferred and non-preferred** Androgenic Agents INITIAL REVIEW CRITERIA • Patient is > 18 years old; AND • Patient is male; AND • Patient has a diagnosis of primary or secondary hypogonadism; AND • Patient does not have a history of prostate carcinoma or male breast carcinoma; AND

Preferred Agents	Non-Preferred Agents	SA Criteria
	Vogelxo™ gel/packet/pump	• Prescriber has submitted the results of two separate serum testosterone levels, each drawn in the morning, which indicate a serum testosterone level below the normal range within the last 6 months. • Testosterone, normal range = 300 to 1,000 ng/dL • Patients who meet criteria should be approved for the preferred agents -> androgel® gel packet or androgel® gel pump. CONTINUATION OF THERAPY CRITERIA • Patient has been compliant with treatment based on refill history • Prescriber submits labs indicating patient has a normal serum testosterone level on therapy (normal range: 300-1,000 ng/dL) within the last 12 months.
Antihyperuricemics		
allopurinol **colchicine caps** **Probenecid®** **probenecid & colchicine**	*colchicine tabs* *Colcrys®* *Duzallo®* *Mitigare®* *Uloric®* **Zurampic®(QL, AG)*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits plus** ***Clinical Criteria for Zurampic®** • Member has not achieved target serum uric acid levels (< 6 mg per dL; 355 µmol per L) with a xanthine oxidase inhibitor alone, **AND** • Member must take in combination with a xanthine oxidase inhibitor, **AND** • Minimum age restriction of 18 years of age • *Quantity limit of 1 per day*
Contraceptives*(long-acting IUDs & injectable)		
Kyleena™ **Liletta®** **medroxyprogesterone 150mg** **Mirena®** **Nexplanon®** **Paragard®** **Skyla®**	*Depo-Provera® 104 mg and 150 mg*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits**
Diabetes Hypoglycemics: Injectable Amylin Analogs		
	**SymLin®* **SymLin® Pens*	**LENGTH OF AUTHORIZATIONS**: 1 year ***Clinical Criteria for Injectable Amylin Analogs**

	Preferred Agents	Non-Preferred Agents	SA Criteria

			• Member must have a history of at least a 90 day trial of insulin.
			• SymLin® is only indicated as adjunct therapy with insulin.
			• Member meeting ALL of the following criteria may be approved:
			  ○ Diagnosis of Type 1 or 2 diabetes; **AND**
			  ○ On insulin therapy; **AND**
			  ○ Failure to achieve adequate glycemic control (HbA1c ≤ 6.5%)

	Diabetes Hypoglycemics: Injectable Incretin Mimetics		
	Byetta® (exenatide) **Bydureon™ (**exenatide ER) **Victoza®** *(*liraglutide)	*Adlyxin™ (lixisenatide)* *Bydureon™ Bcise SQ* *Soliqua® 100/33 (insulin glargine & lixisenatide inj)* *Ozempic®* *Tanzeum™ (albiglutide)* *Trulicity™ (lixisenatide)* *Xultophy® 100/3.6* (*insulin glargine & lixisenatide inj)*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits**
	Diabetes Hypoglycemics: Injectable Insulins		
	Insulin Mix		**LENGTH OF AUTHORIZATIONS: 1 year** **Routine PDL edits**
	Humalog® Mix 50/50 vial **Humalog® Mix 75/25 vial** **Humulin® 70/30 vial** **Novolog® Mix 70/30 pen/vial**	*Humalog® Mix 50/50 Kwikpen* *Humalog® Mix 75/25 Kwikpen* *Humulin® 70/30 pen (OTC)* *Novolin® 70/30 vial (OTC)*	
	Insulin N		
	Humulin® N vial (OTC)	*Humulin® N pen* *Novolin® N vial (OTC)*	
	Insulin R		
	Humulin® R vial	*Novolin® R vial (OTC)*	
	Long-Acting Insulins		
	Lantus® Solostar® & vial (insulin glargine)	*Basaglar® KwikPen® (insulin glargine)*	

Preferred Agents	Non-Preferred Agents	SA Criteria
Levemir® pen/vial (insulin detemir)	*Toujeo® Solostar®(insulin glargine) 300 Units/mL* *Tresiba® FlexTouch® Pen (insulin degludec) 100 U/ml, 200 U/ml*	
Rapid-Acting Insulins		
Humulin 500 U/M pen/vial **Humalog® vial** **Novolog® cartridge/vial/ Flexpen**	*Admelog®* *Apidra® cartridge/Solostar/vial* *Fiasp®* *Humalog® Cartridge/Kwikpen®* *Humalog Jr. Kwikpen®* *Afrezza® cartridge (inhalation)*	
Diabetes Oral Hypoglycemics		
Oral Hypoglycemics Alpha-Glucosidase Inhibitors		**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits plus** **Metformin Step Edit for all Oral Hypoglycemics (excluding metformin)** • Patients with a **hemoglobin A1C< 9%** must have a minimum 90 day trial of metformin (unless contraindicated*) • Patients with a hemoglobin **A1C ≥ 9%** should be started on metformin (unless contraindicated) p**lus a second agent** (e.g., DPP-IV, SGLT2, GLP-1 receptor agonists, TZDs, sulfonylureas).**A 90 day trial of metformin is NOT required**. ***Contraindications include:** • severe renal impairment (eGFR below 30mL/min/1.73m2) • known hypersensitivity • acute or chronic metabolic acidosis including diabetic ketoacidosis
acarbose	*Glyset®* *miglitol (generic Glyset®)* *Precose®*	
Oral Hypoglycemics Biguanides		
metformin **metformin ER** *(generic for Glucophage® XR)*	*Fortamet®* *Glucophage® IR & XR* *Glutmetza®* *Riomet® susp* *metformin ER (generic Fortamet®)* *metforman ER (generic Glumetza®)*	
Oral Hypoglycemics Biguanide Combination Drugs		
glyburide/metformin	*glipizide/metformin* *Glucovance®*	
Oral Hypoglycemics DPP-IV Inhibitors & Combination		
Janumet® **Janumet XR®** **Januvia®** **Jentadueto™** **Tradjenta™**	*alogliptin (generic Nesina™)* *alogliptin/metformin (generic Kazano™)* *alogliptin/pioglitazone (generic Oseni™)* *Jentadueto XR™* *Kazano™* *Kombiglyze XR™* *Nesina™*	

Preferred Agents	Non-Preferred Agents	SA Criteria
	Onglyza™ *Oseni™*	
Oral Hypoglycemics Meglitinides		
repaglinide **nateglinide**	*Prandin®* *PrandiMet™* *repaglinide/metformin* *Starlix®*	
Oral Hypoglycemics Second Generation Sulfonylureas		
glimepiride **glipizide** **glipizide ER** **glyburide** **glyburide micronized**	*Amaryl®* *Diabeta®* *Glucotrol®* *Glucotrol XL®* *Glynase®*	**Routine PDL Edits plus**
***Oral Hypoglycemics Sodium Glucose Co-Transporter 2 Inhibitor**		***Clinical Criteria/Step edit for non-preferred Sodium Glucose Co-Transporter 2 (SGLT2)**
Farxiga™ (AG) **Glyxambi® (AG)** **Invokana™ (AG)** **Jardiance®(AG)** **Synjardy® (AG)**	*Invokamet™ (AG)* *Invokamet™ XR (AG)* *Segluromet™* *Steglatro™* *Steglujan™* *Synjardy® XR (AG)* *Xigduo™ XR (AG)*	**Length of Authorization: Initial approval for 6 months. Renewals for 1 year.** • Approve for Type 2 diabetics who have been compliant with and have not achieved adequate glycemic control **with metformin** of a HbA1c of equal to or less than 7.5% signifies control, to receive a drug in the Sodium Glucose Co-Transporter 2 Inhibitor class the HbA1c must be above 7.6% ; **OR** • Are intolerant to metformin; **AND** • Member must be > 18 years of age.
Oral Hypoglycemics Thiazolidinediones		
pioglitazone	*Avandia®* *Actoplus Met® IR & XR* *Actos®* *Avandaryl®* *Avandamet®* *Duetact®* *pioglitazone/metformin*	

Preferred Agents	Non-Preferred Agents	SA Criteria
	pioglitazone/glimepiride	
Erythropoiesis Stimulating Proteins		
Aranesp® **Procrit®**	*Epogen®* *Mircera®*	**LENGTH OF AUTHORIZATIONS**: for duration of the prescription up to 6 months **Routine PDL edits** *Omontys® is not PDL eligible, may be covered under medical benefit*
Glucocorticoids, Oral		
budesonide EC **dexamethasone soln/tab** **hydrocortisone** **methylprednisolone dose pk** **methylprednisolone 4 mg tab** **prednisolone sodium phosphate soln** **prednisolone soln** **prednisone soln/tab/dose pk**	*Cortef®* *cortisone acetate* *dexamethasone elixir/intensol* *Dexpak®* **Emflaza™ (AG)* *Entocort® EC* *Flo-Pred®* *Medrol ® dose pk/tab* *methylprednisolone 8,16 & 32mg tab* *Millipred DP® tab Does Pk* *Millipred® soln/tab* *Orapred ®ODT* *prednisolone sod phosphate ODT/ soln* *prednisone intensol* *Rayos® DR tab* *Veripred®*	**LENGTH OF AUTHORIZATIONS**: **1 year** **Routine PDL edits plus** ***Clinical Criteria for Emflaza™** • Trial and failure of all drugs does not apply to Emflaza™ • Indicated for the treatment of Duchenne muscular dystrophy (DMD) in members 5 years of age and older. • Minimum Age Limit = 5 years of age

Preferred Agents	Non-Preferred Agents	SA Criteria
***Growth Hormone**		
Genotropin® **Nutropin AQ® NuSpin™**	*Humatrope® cartridge/vial* *Norditropin cartridge®* *Norditropin FlexPro®& Nordiflex®* *Omnitrope®* *Saizen® cartridge/vial* *Serostim®* *Tev-Tropin®* *Zomacton®* *Zorbtive®*	**LENGTH OF AUTHORIZATIONS**: 1 year **ALL Growth Hormone drugs (preferred and non-preferred) require the submission of a Clinical SA. Refer to (Growth Hormone SA Fax Form)**
***Hereditary Angioedema (HAE) Agents**		
Berinert® **Cinryze™** **Kalbitor®**	*Firazyr®* *Haegarda®* *Ruconest®*	**LENGTH OF AUTHORIZATIONS:** Date of service **Routine PDL edits plus** *** ALL Hereditary Angioedema drugs (preferred and non-preferred) require the submission of a Clinical SA. Refer to Hereditary Angioedema (HAE) SA Form**
Pancreatic Enzymes		
***Creon®** ***Zenpep®**	*Pancreaze®* *Pertzye®* *Ultresa®* *Viokace®*	**LENGTH OF AUTHORIZATION:** 1 year **Routine PDL edits plus** **Clinical Criteria for Pancreatic Enzymes** ***Creon®and Zenpep®:** diagnosis of pancreatic insufficiency due to cystic fibrosis or chronic pancreatitis or pancreatectomy. • For all drugs if member has a diagnosis of Cystic Fibrosis they do not have to try and fail a preferred. • If member has a feeding tube then two different pancreatic enzymes can be approved for use together.
Progestational Agents		
Makena® Auto-injector & Single Dose Vial (SDV)	*Aygestin®* *Crinone (Vaginal)* *Depo-Provera 400 MG/ML*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits**

	Preferred Agents	Non-Preferred Agents	SA Criteria
	medroxyprogesterone acetate (tab only) **norethindrone acetate** **progesterone cap/inj**	*hydroxyprogesterone caproate IM* *Makena® Multi Dose Vial (MDV)* *Prometrium®* *Provera®*	
	Progestins Used For Cachexia		
	megestrol acetate	*Megace®* *Megace® ES* *megestrol suspension ES*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits**
	Vaginal/Oral Estrogens		
	Premarin® Vaginal cr **Vagifem® Vaginal tab**	*Estrace ®Vaginal cr* *Estring® Vaginal ring* *Femring® Vaginal ring* *Intrarosa™* *Osphena® tab* *Yuvafem®*	**LENGTH OF AUTHORIZATIONS**: 6 months **Routine PDL edits**
Gastrointestinal			
	G I Antibiotics		
	metronidazole tab **vancomycin cap**	*Alinia®* *Dificid®* *Firvanq™* *Flagyl® cap/tab/ER* *metronidazole cap* *neomycin* *paromomycin* *Solosec™* *Tindamax®* *tinidazole* *Xifaxan®* *vancomycin compounded oral soln kit* *Vancocin®*	**Length of authorization:** 1 year **Routine PDL edits plus**
	Antiemetic/Antivertigo Agents		
	Cannabinoids (delta-9THC derivatives)		**LENGTH OF AUTHORIZATIONS:** 6 months
	***dronabinol**	**Cesamet®*	

Preferred Agents	Non-Preferred Agents	SA Criteria
	**Marinol* ® **Syndros*™	***Dronabinol plus all non-preferred Antiemetic/Antivertigo agents require submission of a Clinical SA. Refer to Antiemetic/Antivertigo SA form**
5HT3 Receptor Blockers		**LENGTH OF AUTHORIZATIONS:** 3 months, unless otherwise noted
ondansetron ODT/tab	*Anzemet*® *Akynzeo*® *granisetron Granisol* ® *soln/tab* *Kytril*® *ondansetron soln* *Sancuso*® ® *patch* *Zofran*®ODT/soln/tab *Zuplenz*® *film*	**Routine PDL edits plus**
NK-1 Receptor Antagonist		**LENGTH OF AUTHORIZATIONS:** Length of chemotherapy regimen or a maximum of 6 months
	aprepitant capsule/pack *Cinvanti™ (Intraven)* *Emend*® *Bi Pak/ cap* *Emend*® *Tri-fold pack/susp* *Varubi ™ IV, Tab*	
Other		**LENGTH OF AUTHORIZATIONS:** 1 year, unless otherwise noted
meclizine **metoclopramide** **ondansetron tab/ODT** **prochlorperazine** ****promethazine** *(AG)*	*Antivert*® *Compazine*®*supp/tab* *Compro*® *Diclegis*® *dimenhydrinate* *hydroxyzine* *Metozolv*® *ODT* *metoclopramide ODT* ***Phenergan*® *(AG)* *prochlorperazine supp* ***promethazine 50mg supp (AG)* *Reglan*® *scopolamine (generic Transderm-Scop*® *)* *Tigan*® *Transderm-Scop*®	******Promethazine approved for members ≥ 2 years

Preferred Agents	Non-Preferred Agents	SA Criteria
	trimethobenzamide *Vistaril®*	
***GI Motility, Chronic**		
Amitiza® **Linzess™** **Movantik®**	*alosetron* *Lotronex®* *Relistor®* *Symproic®* *Trulance™* *Viberzi™*	**LENGTH OF AUTHORIZATIONS**: 6 months **Routine PDL edits plus** ***All GI Motility drugs (preferred and non-preferred) require the submission of a Clinical SA. Refer to Chronic GI Motility SA form**
H. Pylori Treatment		
Pylera®	*Omeclamox®-Pak* *lansoprazole/amoxicillin/ clarithromycin* *Prevpac®*	**LENGTH OF AUTHORIZATIONS**: 14 days **Routine PDL edits**
Histamine-2 Receptor Antagonists (H-2 RA)		
famotidine (OTC & RX) **ranitidine tab/syrup (OTC & RX)**	*cimetidine tab/syrup (OTC/RX)* *famotidine oral susp (OTC/RX)* *nizatidine cap/susp* *Pepcid ® susp/tab (OTC/RX)* *ranitidine cap (OTC/RX)* *Zantac® syrup/tab (OTC/RX)*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits**
Proton Pump Inhibitors		
omeprazole (RX & OTC) **pantoprazole**	*Aciphex® DR tab/sprinkle* *Dexilant®* *esomeprazole magnesium* *esomeprazole strontium* *lansoprazole cap* *Nexium®* *omeprazole/sodium bicarbonate* *Prevacid® RX, OTC& Solutab* *rabeprazole DR tab* *Prilosec® Rx & Susp* *Protonix®*	**LENGTH OF AUTHORIZATIONS**: 12 weeks; unless member meets an exception; then 1 year **Routine PDL edits plus** ***All non-preferred Proton Pump Inhibitors require submission of a Clinical SA. Refer to Proton Pump Inhibitor SA form**

	Preferred Agents	Non-Preferred Agents	SA Criteria
		Zegerid® cap/OTC/susp packet	
	Ulcerative Colitis Oral and Rectal Preparations (5-ASA DERIVATIVES)		
	Ulcerative Colitis – Oral		**LENGTH OF AUTHORIZATIONS:** **1 year**
	Apriso® ***Lialda®*** **Pentasa®** **sulfasalazine DR & IR**	*Asacol ®HD* *Azulfidine® IR &DR* *balsalazide disodium* *Colazal®* *Delzicol™* *Dipentum* **Giazo™ (QL)* *mesalamine (generic Asacol® HD)* *mesalamine (generic Lialda®)* *Uceris™*	**Routine PDL edits** *Giazo is limited to an 8 week supply
	Ulcerative Colitis – Rectal		
	Canasa® rectal supp **mesalamine enema**	*mesalamine kit* *Rowasa® enema/kit* *SFRowasa®* *Uceris®*	
Genitourinary			
	Alpha-Blockers and Androgen Hormone Inhibitors For Benign Prostatic Hypertrophy (BPH)		
	Alpha-Blockers for BPH		**LENGTH OF AUTHORIZATIONS:** **1 year**
	alfuzosin **tamsulosin HCL**	*Flomax ®* *Rapaflo®* *Uroxatral®*	**Routine PDL edits plus**
	Androgen Hormone Inhibitors for BPH		
	dutasteride **finasteride**	*Avodart ®* *Dutasteride/tamsulosin* *Jalyn®* *Proscar®*	
	Phosphodiesterase (PDE) 5 Inhibitor for BPH		***Step edit for Cialis® -** trial and failure of Alpha Blockers and Androgen Inhibitors for BPH. Prescriber must attest that the member is not on the state's sex offenders list. Consult or evaulation by Urologist.
		**Cialis® (ST)*	

Preferred Agents	Non-Preferred Agents	SA Criteria
Urinary Antispasmodics (Bladder Relaxant)		
oxybutynin tab/syrup **Toviaz™** **VESIcare®**	*darifenacin ER (generic Enablex®)* *Detrol® & Detrol® LA* *Ditropan® & *Ditropan® XL* *Enablex®* *flavoxate* *Gelnique™ gel/gel Pump* *Myrbetriq™* **oxybutynin ER* *Oxytrol® transdermal* *Sanctura XR* *trospium IR & ER* *tolterodine IR & ER*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits plus** ***Clinical Criteria for Oxybutynin ER, Ditropan XL®:** • Allow PDL exception for children age 6-18 with a diagnosis of neurogenic bladder.
Immunological Agents		
Multiple Sclerosis		
Avonex® **Avonex® Adm Pack** **Betaseron®** **Copaxone 20 mg syringe®** ***Gilenya® *(ST)*** **Rebif® SQ** **Rebif® Rebi dose Pen®**	***Ampyra®* *Aubagio®* *Copaxone® 40 mg syringe®* *Extavia® Kit* *Glatopa™* *Plegridy®* *Tecfidera™* ****Zinbryta™ (QL)*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits plus** ***Step Edit for Gilenya®** - a trial and failure of a preferred injectable drug. In order to receive a non-preferred oral drug both an injectable preferred and Gilenya® must have been tried and failed. ****Select non-preferred MS drugs (Amprya®, Zinbryta™) require the submission of a Clinical SA. Refer to MS - Ampyra® SA form; and Zinbryta™ SA Form** ****Zinbryta™* Quantity Limit = 1 ml per 28 days (0.036 ml per day).
Cytokine and CAM Antagonists And Related Agents		
Enbrel® **Humira®** **methotrexate tab/PFvial/ MDVvial**	*Actemra® SQ* *Cimzia® & Cimzia® Syringe Kit* *Cosentyx™* *Kevzara®* *Kineret®* *Otezla®*	**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edits plus**

	Preferred Agents	Non-Preferred Agents	SA Criteria
		Otrexup® *Orencia*® *Rasuvo*™ *Siliq*® *Simponi*® *Stelara*® *Taltz*® *Tremfya*™ *Trexall*® *Xatmep*™ *Xeljanz*™ *& Xeljanz*™ *XR*	***All non-preferred Cytokine and CAM Antagonists require submission of a Clinical SA. Refer to Cytokine and CAM Antagonists SA form Otrexup® SA Form; (Xeljanz™ SA Form)**
Ophthalmic			
	Antibiotics		
	ciprofloxacin drops **erythromycin** **gentamicin drops/oint** **Moxeza® drops** **neomycin/polymix/gramicidin** **ofloxacin drops** **polymyxin/trimethoprim** **sulfacetamide soln** **tobramycin** **Vigamox®**	*AzaSite™ drops* *bacitracin* *bacitracin/polymyxin b sulfate oint* *Besivance® drops* *Bleph®-10* *Ciloxan® drops/oint* *Garamycin ®drops/oint* *gatifloxacin 0.5% soln* *Ilotycin®* *levofloxacin drops* *moxifloxacin drops (generic Vigamox®)* *Natacyn®* *neomycin/bacitracin/polymyxin oint* *Neosporin ®* *Ocuflox® s* *Polytrim®* *sulfacetamide oint* *Tobrex® drops/oint* *Zymaxid®*	**LENGTH OF AUTHORIZATIONS**: Date of service only; no refills **Routine PDL edits**
	Antibiotic/Steroid Combinations		

Preferred Agents	Non-Preferred Agents	SA Criteria
neomycin/polymyxin/dexamethasone oint/susp **Tobradex® oint/susp**	*Blephamide®* *Blephamide® S.O.P.* *Maxitrol® oint/susp* *neomycin/bacitracin/poly/HC* *neomycin/polymyxin/HC* *Pred-G®oint/susp* *sulfacetamide/prednisolone* *Tobradex® ST* *tobramycin/dexamethasone susp* *Zylet®*	**LENGTH OF AUTHORIZATION**: Date of service only; no refills **Routine PDL edits**
Antihistamines/Mast Cell Stabilizers		
Antihistamines		**LENGTH OF AUTHORIZATIONS:** 1 year **Routine PDL edits** *Ilevro™ is limited to 1 bottle plus 1 refill
Alaway OTC® **ketotifen fumerate** **Pazeo®** **Zaditor® OTC**	*Bepreve®* *Elestat®* *Emadine®* *epinastine 0.05% eye drops* **Ilevro™ 0.3% (QL)* *Lastacaft®* *olopatadine* *Optivar®* *Patanol®* *Pataday® s*	
Mast Cell Stabilizers		
cromolyn sodium	*Alocril®* *Alomide®*	
Anti-inflammatory Agents		
NSAIDS		**LENGTH OF AUTHORIZATIONS**: Date of service only; no refills **Routine PDL edits** *Ilevro™ is limited to 1 bottle plus 1 refill
diclofenac sodium **flurbiprofen sodium** **ketorolac 0.4%& 0.5%**	*Acular® 0.5% & LS® 0.4%* *Acuvail®* *bromfenac 0.09%* *BromSite ™* **Ilevro™0.3% (QL)* *Nevanac®* *Ocufen®* *Prolensa™*	

Preferred Agents	Non-Preferred Agents	SA Criteria
Corticosteriods		
Durezol® **fluorometholone** **prednisolone acetate**	*Alrex™* *dexamethasone* *Flarex®* *FML®, FML Forte® & FML® S.O.P.* *Lotemax™ drops/gel/oint* *Maxidex®* *Omnipred®* *Pred Forte® & Pred Mild®* *prednisolone sod phosphate* *Vexol®*	
Glaucoma Agents		
Alpha 2 Adrenergic Agents		**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits**
Alphagan P® 0.1 & 0.15% **brimonidine 0.2%**	*apraclonidine 0.5% drops* *brimonidine tartrate 0.15%* *Iopidine® 0.5% & 1%*	
Beta Blockers		
Betoptic-S® 0.25% **carteolol 1%** **Combigan®** **levobunolol 0.5%** **metipranolol 0.3%** **timolol maleate**	*Betagan® 0.5%* *betaxolol 0.5%* *Istalol® 0.5%* *Timoptic® drops 0.25% & 0.5%* *Timoptic® XE 0.25% & 0.5% sol-gel*	
Carbonic Anhydrase Inhibitors		
Azopt® 1% **dorzolamide** **dorzolamide/timolol** **Simbrinza™**	*Cosopt® 0.5%-2%* *Cosopt® PF* *Trusopt® 2%*	
Prostaglandin Analogs		
latanoprost	*bimatoprost*	

	Preferred Agents	Non-Preferred Agents	SA Criteria
	Travatan Z®	*Lumigan® 0.03% & 0.01%* *Rescula®* *travoprost 0.004%* *Vyzulta™* *Xalatan® 0.005%* *Zioptan™*	
Respiratory			
	***Anti-Allergens, Oral**		
		**Grastek® SL* *Odactra ® SL* ***Oralair® SL* ****Ragwitek™ SL*	**LENGTH OF AUTHORIZATIONS**: 1 year ***All non-preferred Anti-Allergen drugs require the submission of a Clinical SA. Refer to (Anti-Allergens, Oral SA Form)**
	Antihistamines: First and Second Generation		
	First Generation Antihistamines		**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits**
	Generic only class	*All Brands require a SA*	
	Second Generation Antihistamines and Combinations		
	cetirizine liquid 1mg/1mL (RX/OTC) **cetirizine tabs OTC** **levocetirizine Tablets** **loratadine tab/syrup OTC**	*Allegra-D®* *cetirizine chew tab (OTC)* *cetirizine liquid 5mg/5mL (OTC)* *cetirizine D tab (OTC)* *Clarinex®* *Clarinex-D®* *Claritin®* *Claritin® D* *desloratadine ODT* *fexofenadine* *fexofenadine/PSE ER* *fexofenadine suspension*	

Preferred Agents	Non-Preferred Agents	SA Criteria
	loratadine ODT *loratadine D 12 & 24 hr* *Xyzal® soln/tab (RX ,OTC)*	
Beta-Adrenergic Agents		
Long Acting Beta Adrenergic s (LABA) MDIs or Nebulizers		**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits plus**
Foradil® *(AG)* **Serevent Diskus®** *(AG)*	*Arcapta DS(AG)* *Brovana®(AG)* *Perforomist® (AG)* *Striverdi® Respimat (AG)*	**Clinical Criteria for LABAs for Children** **LENGTH OF AUTHORIZATION: 3 months** Each drug listed below will require a SA for ages less than the FDA/PI indicated age.

Brand Name	Age where SA is required	FDA Indications
Advair ®Diskus2 50/50, & 500/50	Children < 12	Asthma & COPD
Advair ®HFA	Children < 12	Asthma & COPD
Advair® Diskus 100/50	Children < 4	Asthma & COPD
Airduo ™ Respiclick®	Children < 12	Asthma only
Anoro™ Ellipta	Children & Adolescents < 18	COPD only
Arcapta® Neohaler	Children & Adolescents < 18	COPD only
Bevespi Aerosphere™	Children & Adolescents < 18	COPD only
Breo®Ellipta™	Children & Adolescents < 18	Asthma & COPD
Brovana®	Children & Adolescents < 18	COPD only
Dulera®	Children < 12	Asthma only
fluticasone/salmeterol pow	Children < 12	Asthma only
Foradil® Aerolizer	Children < 5	Asthma & COPD
Perforomist®	Children & Adolescents < 18	COPD only
Serevent® Diskus	Children < 4	Asthma & COPD
Stiolto™ Respimat®	Children < 18 years	COPD only
Striverdi® Respimat	Children < 18 years	COPD only
Symbicort®	Children < 12	Asthma & COPD

Preferred Agents	Non-Preferred Agents	SA Criteria
Short Acting Metered Dose Inhalers or Devices		
Proair® HFA **Proventil® HFA**	*levalbuterol tartrate HFA* *ProAir® RespiClick* *Ventolin® HFA* *Xopenex® HFA*	
Short Acting Nebulizers		
albuterol sulfate (premixed)	*levalbuterol soln* *Xopenex®*	
COPD: Bronchodilators and Phosphodiesterase 4 (PDE4) Inhibitors		
Atrovent HFA® ***Bevespi Aerosphere™*** **Combivent® Respimat** **ipratropium bromide soln** **ipratropium/albuterol nebs** **Spiriva®**	*Anoro™ Ellipta® (AG)* **Daliresp®* *Incruse™ Ellipta®* *Seebri Neohaler™* *Spiriva® Respimat* *Stiolto Respimat™ (AG)* *Tudorza™* *Utibron Neohaler™*	**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edits plus** ***Clinical Criteria for Daliresp®** • If the member has a diagnosis of severe COPD associated with chronic bronchitis and a history of exacerbations; **AND** • Trial/failure on at least one first-line or second-line agent (inhaled anticholinergics, long acting beta agonists or inhaled corticosteroids); **AND** • Adjunctive therapy (Daliresp® must be used in conjunction with first-line or second-line agent).
Corticosteroids: Inhaled and Nasal Steroids		
Inhaled Corticosteroids: Combination Drugs (Glucocorticoid and Long Acting Beta Adrenergic)		**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits**
Advair® Diskus** *(AG)* ***Dulera®(AG)* ***Symbicort®***(AG)*	*Advair® HFA(AG)* *Airduo ™ Respiclick® (AG)* *Breo® Ellipta™ (AG)* *fluticasone/salmeterol powder (AG)*	
Inhaled Corticosteroids: Metered Dose Inhalers		
Asmanex® **Flovent® Diskus & HFA** **Pulmicort Flexhaler®** **QVAR®**	*Alvesco®* *Aerospan™* *Armonair™ Respiclick®* *Arnuity™ Ellipta®* *Asmanex HFA®* *Trelegy® Ellipta*	

Preferred Agents	Non-Preferred Agents	SA Criteria
	QVAR® Redihaler	**LENGTH OF AUTHORIZATIONS**: 1 year
Inhaled Corticosteroids: Nebulizer Solution		
Pulmicort® Respules	*Budesonide*	**Routine PDL edits**
Nasal Steroids		
fluticasone	*Beconase AQ®* *budesonide (generic for Rhinocort® Aqua)* *budesonide (generic Rhinocort® Allergy OTC)* *Children's Qnasl™* *Clarispray OTC* *Dymista™* *Flonase®* *Flonase Sensimist (OTC)* *flunisolide* *fluticasone OTC* *mometasone(generic Nasonex®)* *Nasonex®* *Omnaris®* *Qnasl™* *Rhinocort Aqua®* *Rhinocort® Allergy OTC* *Ticanase®* *triamcinolone OTC* *triamcinolone acetonide* *Veramyst®* *Xhance™* *Zetonna™*	
***Cough and Cold Drugs**		
Ala-Hist DM **benzonatate cap** **codeine/ promethazine**	*lohist-DM syrup* *All other Legend cough and cold drugs are non-preferred* *Tessalon ® perle*	**LENGTH OF AUTHORIZATION**: Date of Service Only **Routine PDL edits**

	Preferred Agents	Non-Preferred Agents	SA Criteria
	guaifenesin/codeine phosphate **hydrocodone/ homatropine** **Iophen-C NR** **phenylephrine HCl/promethazine HCl** **promethazine DM syrup** **Tusnel® Pediatric Drops**		*** Children under the age of 6 years are not eligible for cough and cold drugs.**
	Epinephrine, Self-Injected		
	epinephrine 0.15 mg & 0.3 mg (authorized generic EpiPen & EpiPen Jr)	**Auvi-Q®** **Epipen®** **Epipen® Jr** **epinephrine 0.15 mg & 0.3mg (generic Adrenaclick)**	**LENGTH OF AUTHORIZATIONS**: **1 year** **Routine PDL edits**
	Intranasal Antihistamines		
	azelastine 0.1% **Patanase®**	*Astepro® 0.15%* *olopatadine*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits**
	Leukotriene Receptor Antagonists		
	montelukast tabs/chewable tabs	*Accolate®* *Singulair® tabs/chew tabs/granules* *montelukast granules* *zafirlukast* *Zyflo™* *Zyflo CR™* *zileuton ER*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits**