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

1/1/20

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

General Information:

- **Virginia Medicaid's Preferred Drug List (PDL)/ Common Core Formulary only includes select drug classes, other classes will pay such as but not limited to diuretics, many cardiac agents, many antibiotics etc.**
- 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.

**Members currently receiving aripiprazole oral solution, Geodon® (IM), Nuplazid or olanzapine/fluoxetine will be "grandfathered" for a period not to exceed one year. After that time, the prescriber will need to submit a service authorization request documenting the medical necessity of the non-preferred drug.

LEGEND

AG = age edit
CE= clinical edit
ST = step edit
QL = quantity limit
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

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	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* *hydromorphone ER* *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™*	

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***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:** • Up to 3 months for (includes HIV/AIDS, Chronic back pain, Arthritis, Fibomyaigia, Diabethic Neurophy, Postherpetic Neuraliga). • Up to 6 months for chronic pain (includes Cancer, Sickle Cell Disease, Palliative Care, End-Of-Life Care, Hospice).
	Actiq® *Fentora®* *fentanyl citrate* *Lazanda®* *Subsys®*	
Short-Acting Opioids		
codeine/APAP **hydrocodone/APAP** **hydrocodone/ibuprofen** **hydromorphone** **morphine IR** **oxycodone IR** **oxycodone/APAP** **tramadol HCl** **tramadol HCl/APAP**	*Abstral®* *Apadaz™* *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™* *RoxyBond ™*	***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)**

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

Bunavail™ 2.1–0.3mg buccal film	1/day
Bunavail™ 4.2–0.7mg buccal film	2/day
Bunavail™ 6.3–1mg buccal film	3/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	3/day
buprenorphine/naloxone SL film 2–0.5mg	3/day
buprenorphine/naloxone SL film 8–2mg	3/day
Cassipa® 16mg-4mg	1/day
Suboxone® SL film 2–0.5mg	3/day
Suboxone® SL film 4–1mg	1/day
Suboxone® SL film 8–2mg	3/day
Suboxone® SL film 12–3mg	2/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**	*Anaprox® IR & DS®* *Advil®* *Aleve®*	**Routine PDL edits plus** ***Step edit required for Celebrex® and celecoxib**

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	ibuprofen tab (OTC & Rx) **Infant's ibuprofen drops** **meloxicam tab** **naproxen tab** **naproxen sodium (OTC)** **naproxen EC (Rx)** **sulindac**	*Arthrotec®* *Cataflam®* **Celebrex® & *celecoxib* *Daypro®* *diclofenac potassium* *diclofenac sodium SR* *diclofenac sodium/misoprostol* *diflunisal* *Duexis®* *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™*	• History of a trial of a minimum of two (2) different non-COX2 NSAIDs within the past year**; OR** • 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*
		tolmetin sodium *Vimovo®* *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**	**CLOSED CLASS**	
	Bethkis® *(QL, AG)* **Kitabis™ Pak *(QL, AG)*** ****Tobi Podhaler® *(QL, AG, SE)***	****Arikayce®(amikacin liposome)* *Cayston®* *Tobi® inhalation neb soln (QL, AG)* *tobramycin Pak (generic Kitabis™ Pak) (QL, AG)* tobramycin inhalation neb soln (generic Tobi® inhalation) (QL, AG)	**LENGTH OF AUTHORIZATIONS:** **1 year** **Routine PDL edits plus** ****Tobi Podhaler®** • Requires a clinical reason as to why one of the preferred tobramycin inhalation nebulizer solutions cannot be used (Bethkis® or Kitabis™). *****Clinical Criteria for Arikayce®** Duration of Approval: 12 months

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
			Initial Approval Criteria • Patient is ≥ 18 years of age; AND • Diagnosis of Mycobacterium avium complex (MAC) lung disease as determined by the following: o chest radiography or high-resolution computed tomography (HRCT) scan; AND o at least 2 positive sputum cultures; AND o other conditions such as tuberculosis and lung malignancy have been ruled out; AND • Patient has failed a multi-drug regimen with a macrolide (clarithromycin or azithromycin), rifampin, and ethambutol. (Failure is defined as continual positive sputum cultures for MAC while adhering to a multi-drug treatment regimen for a minimum duration of 6 months); AND • Patient has documented failure or intolerance to aerosolized administration of amikacin solution for injection, including pretreatment with a bronchodilator; AND • Arikayce will be prescribed in conjunction with a multi-drug antimycobacterial regimen *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®. **<u>Quantity Limits:</u>** *Arikayce = 590 mg/8.4 mL(28 vials)/28 days* *Each carton contains a 28-day supply of medication (28 vials)* 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

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Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
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* *itraconazole solution (generic for Sporanox® soln)* *ketoconazole* *Lamisil* ® *tab/granules* *Noxafil*® **Onmel*® **Sporanox*® *cap/soln* *Tolsura™* *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** • The member is completing a course of therapy with a non-preferred drug initiated in the hospital.
Cefaclor cap **cefprozil tab/susp** **cefuroxime tab**	*cefaclor ER* *cefaclor susp* *Ceftin*® *tab/susp*	
Third Generation Cephalosporins		
cefdinir cap/susp	*Cedax*® *cap/susp* *ceftibuten* *cefditoren pivoxil* *cefixime suspension* *cefpodoxime proxetil cap/susp* *Spectracef*® *Suprax*® *chewable tab/cap/susp*	

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Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
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 9nfluenza, 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** **Eryped® 200 susp** **E.E.S.® 200 susp** **erythromycin base cap DR** **erythromycin stearate**	*Biaxin® tab* *clarithromycin ER* *Eryped® 400 susp* *Ery-tab®* *E.E.S.® 400 tab* *Erythrocin® Stearate* *erythromycin base tab* *erythromycin ethylsuccinate 400mg tab(Generic E.E.S.® 400)* *erythromycin ethylsuccinate 200mg susp* **Ketek®* *PCE®* *Zithromax® pac/tab/susp* *ZMAX® susp*	
Otic		
Ciprodex® **ofloxacin** **neomycin/polymyxin/hc soln/ sus**	*Cetraxal®* *Cipro HC®* *Otovel*	**LENGTH OF AUTHORIZATIONS:** Date of service only; no refills **Routine PDL edits**

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	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	*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** **Vandazole™ gel**	*Cleocin® cr* *clindamycin cr* *Metrogel®* *Nuvessa®*	**LENGTH OF AUTHORIZATIONS**: Date of Service **Routine PDL edits**
Antivirals			
	***Hepatitis C Agents** **CLOSED CLASS**		
	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 Preferred SA Form or Hepatitis C Antivirals Non-Preferred SA Form**
	Peg-Intron® **Peg-Intron Redipen®**	*Pegasys® Proclick/syringe/kit/vial*	
	Protease Inhibitor		
		Olysio™ (discontinued)	
	***Nucleotide Analog NS5A & NS5B Polymerase Inhibitors & Combinations**		
	sofosbuvir /velpatasvir (generic Epclusa®)	*Epclusa®* *Sovaldi®*	

	Preferred Agents	Non-Preferred Agents	SA Criteria
		Vosevi™	
	***NS5A, NS3/4A Inhibitor Combinations**		
	Mavyret™	*Technivie™* *Viekira Pak™* *Viekira XR™* *Zepatier®*	
	***NS5B & Protease Inhibitor combinations**		
		Harvoni® *Ledipasvir/Sofosbuvir (generic 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/** *cap*	*Flumadine® tab* *rimantadine* *Relenza Disk®* *Tamiflu® susp/cap* *Xofluza™*	**LENGTH OF AUTHORIZATIONS:** Date of service only **Routine PDL edits**
Blood Modifiers			
	Bile Salts		
	ursodiol mg tab	*Actigal®*	**LENGTH OF AUTHORIZATIONS**: 1 year

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
		Chenodal® *Cholbam®* *Ocaliva®* *ursodiol cap* *Urso®* *Urso® Forte tab*	**Routine PDL edits**
	Phosphate Binders		
	calcium acetate 667mg cap **Renagel®**	*Auryxia™* *calcium acetate 667mg tab* *Eliphos* ~~*Ferric citrate*~~ *Fosrenol®* chewable tab *lanthanum carbonate chewable tab* ~~*Phoslo®*~~ *Phoslyra®* *Renvela® powder, tab* *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* *ibandronate* *risedronate DR*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits** .
	Calcitonins		
	calcitonin-salmon nasal	*Miacalcin®*	**LENGTH OF AUTHORIZATIONS**: 1 year

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
			Routine PDL edits
	Others		
	raloxifene	*Evista®* **Forteo®* **Tymlos™*	**LENGTH OF AUTHORIZATIONS**: Initial approval will be for 1 year **Routine PDL edits for Evista®** ***Clinical SA must be completed for (Forteo® OR Tymlos™ SA Form)**
Cardiac			
	Anticoagulants **CLOSED CLASS**		
	Low Molecular Weight Heparin includes FactorXA Inhibitor		**LENGTH OF AUTHORIZATIONS**: 1 year
	enoxaparin	*Arixtra®* *fondaparinux* *Fragmin® syringe & vial* *Lovenox®*	**Routine PDL edits plus**
	Oral Anticoagulants		**Clinicial Criteria for Savaysa™**
	Eliquis™ **Jantoven** **Pradaxa®** **Xarelto®** **Xarelto® Starter Pack** **warfarin**	*Coumadin®* *Eliquis™ Dose Pack* **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
	Antihypertensive Agents		
	ACE Inhibitors		**LENGTH OF AUTHORIZATIONS: 1 year**
	benazepril **enalapril** **lisinopril** **ramipril**	*Accupril®* *Altace®* *captopril* *Epaned™ soln* *fosinopril* *Lotensin®* *Mavik®* *moexipril*	**Routine PDL edits**

Preferred Agents	Non-Preferred Agents	SA Criteria
	Monopril® *perindopril* *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**
Entresto™** ***(QL) **irbesartan** **losartan** **olmesartan** **valsartan**	*Atacand®* *Avapro®* *Benicar®* *candesartan* *Cozaar®* *Diovan®* *Edarbi®* *eprosartan mesylate* *Micardis®*	***~~Clinical Criteria for Entresto~~™** • ~~Diagnosis of chronic heart failure (NYHA Class II-IV);~~ **~~AND~~** • ~~Member must be ≥ 18 years;~~ **~~AND~~** • ~~Left ventricular ejection fraction ≤ 40%~~ *Quantity Limit = 2 per day for Entresto™*

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	Teveten®	
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		
irbesartan/HCTZ **losartan/HCTZ** **olmesartan/HCTZ** **valsartan/HCTZ**	*Atacand HCT®* *Avalide®* *Benicar HCT®* *candesartan/HCTZ* *Diovan HCT®* *Edarbyclor®* *Hyzaar®* *Micardis HCT®* *telmisartan/HCTZ* *Teveten HCT®*	
Antihypertensives, Sympatholytics CLOSED CLASS		
Catapres®-TTS **clonidine tab** **guanfacine** **methyldopa** **reserpine**	*Catapres®* *clonidine (transdermal)* *Clorpres®* *methyldopa/HCTZ* *Tenex®*	
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 **bisoprolol** **carvedilol** **labetalol**	*acebutaolol* *Betapace®IR & AF®* *betaxolol* *Bystolic®*	

	Preferred Agents	Non-Preferred Agents	SA Criteria
	metoprolol tartrate **metoprolol succinate** **propranolol tab & ER/soln** **Sorine®** **sotalol AF** **sotalol HCL**	*Carvedilol ER* *Coreg® IR & CR®* *Corgard®* **Hemangeol™* *Inderal® XL* *Innopran® XL* *Kapspargo™ Sprinkle* *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®*	
	Calcium Channel Blockers –Dihydropyridine		
	Afeditab CR® **amlodipine** **Nifedical XL®** **nifedipine** **nifedipine ER**	*Adalat CC®* *felodipine ER* *isradipine* *Katerzia™oral suspension* *nisoldipine*	

Preferred Agents	Non-Preferred Agents	SA Criteria
	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®* diltiazem LA *Matzim LA* *Tiazac®* *verapamil 360 cap* *verapamil ER cap* *Verelan® & Verelan PM®*	
Direct Renin Inhibitors (includes combination)		
	aliskiren 150 & 300mg (generic for Tekturna) *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* *colesevelam tab and Pkt (generic Welchol)* *colestipol HCl granules* *Questran® powder/powder Light* *Welchol® Chewable bar/ packet*	

Preferred Agents	Non-Preferred Agents	SA Criteria
Cholesterol Absorption Inhibitor (CAI)		
ezetimibe	**Zetia®**	
Fibric Acid Derivatives		
fenofibrate (generic Tricor® 48mg 145mg) **gemfibrozil**	*Antara®* *fenofibrate (generics for Antara®, Fenoglide® & Lipofen®)* *fenofibrate (generics for Triglide®)* *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®* *Ezallor Sprinkle (rosuvastatin)* *Lipitor®* *Liptruzet®* *Livalo®* *Zypitamag ™* *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. ***** Zontivity™** • Diagnosis of MI (myocardial infarction) or PAD (peripheral arterial disease); **AND**

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
		• 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® tab**	*ambrisentan (generic Letairis)* *bosentan (generic Tracleer®)* *Opsumit®* *Tracleer® susp*	
***Phosphodiesterase 5 Inhibitors (PDE-5)**		***Clinical Criteria for all preferred and non-preferred PDE-5**
Alyq(tadalafil) **sildenafil tab** **tadalafil**	*Adcirca™* *Revatio® tab/susp/inj*	• Diagnosis of pulmonary hypertension in members >18 years is required; **AND** • The prescriber must be a pulmonary specialist or cardiologist; **AND**
Prostacyclin Vasodilator and Receptor Agonist		• Must have a rationale for not taking the sildenafil tablet to receive a SA for injectable Revatio®
	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* *Memantine ER (generic Namenda XR)* *Namzaric® (donepezil/memantine)* *Razadyne® IR, ER* *rivastigmine cap & patch*	
	NMDA Receptor Antagonist		
	memantine tab	*memantine Dose Pack* memantine soln *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 ***Clinical Criteria for Epidiolex®** Duration of Approval: 1 year Approval Criteria: • Patient must be ≥ 2 years of age; AND
	phenobarbital elixir/tab **primidone**	*Mysoline®*	
	Benzodiazepines		
	clobazam tab (generic Onfi®tab) **clonazepam tab** **diazepam rectal & Device rectal**	*clobazam (generic Onfi®susp)* *clonazepam ODT* *Diastat® rectal* *Diastat® AcuDial™ rectal* *Nayzilam®* **Onfi®susp/tab* *Sympazan™ (clobazam)*	
	Cannabidiol		
		**Epidiolex® (cannabidiol)*	

	Preferred Agents	Non-Preferred Agents	SA Criteria
			• Patient has been diagnosed with Lennox-Gastaut syndrome (LGS) OR Dravet syndrome (DS) • Prescribing physician is or has consulted with a neurologist or epileptologist appropriate for age
	Carbamazepine Derivatives		
	carbamazepine chewable tab/susp/tab **carbamazepine ER** **carbamazepine XR** **oxcarbazepine susp & tab**	*Aptiom®* *Carbatrol®* *Equetro® cap* *Oxtellar™ XR* *Tegretol® susp/tab* *Tegretol®XR* *Trileptal® susp/tab* *vigabatrin powder pack*	
	Hydantoins		
	phenytoin cap/chew tab/ susp **phenytoin ext cap**	*Dilantin® cap* *Dilantin® Infatab, susp* *Peganone®* *Phenytek®*	
	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*	
	Other Anticonvulsants		
	Gabitril® **lamotrigine tab** **lamotrigine chew tab** **lamotrigine XR** **levetiracetam soln/tab** **levetiracetam ER** **Vimpat® soln/tab** **topiramate tab/sprinkle** **zonisamide**	*Banzel® susp/tab* *Briviact®* *Diacomit®* *Elepsia™XR* *felbamate susp/tab* *Felbatol® susp/tab* *Fycompa® susp/tab* *Keppra® soln/tab* *Keppra® XR*	

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
		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* *Trokendi™ XR* *vigabatrin (generic Sabril® tab)* *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®* *bupropion XL(generic Forfivo® XL)* *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*	

Preferred Agents	Non-Preferred Agents	SA Criteria
	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* *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*	**LENGTH OF AUTHORIZATIONS:** **1 year** **Routine PDL edits**

Preferred Agents	Non-Preferred Agents	SA Criteria
	sumatriptan/naproxen (generic Treximet®) *Tosymra* *Treximet®* *Zembrace ™ SymTouch ™* *Zomig® tab/nasal spray/ZMT*	
Antimigraine Agents, Others **Calcitonin Gene-related Peptide Antagonist (CGRP)**		
Emgality™ Syringe **Emgality™ Pen**	*Aimovig™* *Ajovy™*	**All CGRPs require the submission of a Clinical SA. Refer to Antimigraine Agents, Others SA Form**
***Antipsychotics** *(AG)*		
Atypical		**LENGTH OF AUTHORIZATIONS: 1 year or 6 months for members < 18 yrs** **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™*** • Indicated for the treatment of hallucinations and delusions associated with Parkinson's disease psychosis. *Quantity Limit Nuplazid™ = 2 per day* *****Clinical Criteria for Abilify Mycite®*** **Initial Approval Criteria: For Three months SA** Patient must: • Be ≥ 18 years of age; AND • Have tolerability to oral aripiprazole with suboptimal effects (as assessed by prescriber) that may be due to adherence problems; AND
aripiprazole tab **clozapine tab** **Latuda®** **olanzapine ODT,tab, IM** **quetiapine tab** **quetiapine fumarate ER** **risperidone ODT/soln/tab** **ziprasidone cap**	*Abilify® tab/IM inj* ****Abilify Mycite®(with sensor)* ***aripiprazole ODT, soln* *Clozaril®* *clozapine ODT* *Fanapt® tab & titration pk* *Fazaclo®* ***Geodon® tab, IM* *Invega®* ***Nuplazid™ tab, cap (QL)(AG)* ***olanzapine/fluoxetine* *paliperidone ER* *Rexulti® tab* *Risperdal® ODT/soln/tab* *Saphris® SL* *Seroquel® IR* *Seroquel® XR* *Symbyax®* *Versacloz™*	

	Preferred Agents	Non-Preferred Agents	SA Criteria
		Vraylar™ *Zyprexa® tab/IM/Zydis*	• Have a smart phone compatible with the device; AND • Give consent to a healthcare provider and caregiver (if applicable) to monitor the portal; AND • There is a documented intervention by prescriber if nonadherence is detected **Renewal Criteria: Every 3 Months Reevaluate** • Patient must: • Continue to meet initial criteria; AND • Have prescriber attestation that patient benefited from therapy; AND • Have prescriber attestation that there is a continued need for device (e.g., continued suboptimal effects and/or compliance); AND • Have a healthcare provider and caregiver (if applicable) agree to continue to monitor device; AND • Not have worsened target symptoms; AND • Not have had any treatment-limited adverse effects (e.g., • Not have had any treatment-limited adverse effects (e.g., hypersensitivity, suicidality, neuroleptic malignant syndrome, tardive dyskinesia, metabolic changes, pathological gambling and other compulsive behaviors, orthostatic hypotension, falls, seizures, cognitive and motor impairment, dysphagia, disruption in body temperature regulation, and leukopenia, neutropenia, and agranulocytosis); AND • Have a healthcare provider state reason why the patient cannot use long acting injectable atypical antipsychotic if there is continued nonadherence.
	Atypical, Long Acting Injectable	**CLOSED CLASS**	**LENGTH OF AUTHORIZATIONS:** **1 year**
	Abilify Maintena® **Aristada®** **Aristada® Initio** **Risperdal Consta®** **Invega Sustenna® &Trinza®**	*Perseris™ (risperidone)* *Zyprexa® Relprevv™*	**Routine PDL edits**
	Typical		**LENGTH OF AUTHORIZATIONS:** **1 year**
	amitriptyline/perphenazine **chlorpromazine** **fluphenazine decantate** **haloperidol decantate**	*fluphenazine elixir/soln/tab* *Haldol decanoate (injection)* *pimozide* *Moban®*	**Routine PDL edits**

	Preferred Agents	Non-Preferred Agents	SA Criteria
	haloperidol lactate conc **haloperidol tab** **loxapine** **perphenazine** **trifluoperazine** **thiothixene** **thioridazine**	*molindone* ~~*Orap*®~~	
	Neuropathic Pain		
	capsaicin OTC topical **duloxetine 20, 30 & 60 mg** **gabapentin cap/tab/soln** **lidocaine 5% patch** **pregabalin cap**	*Cymbalta®* *Dermacinrx® PHN Pak™ Kit* *duloxetine 40 mg (generic for Irenka™)* *Drizalma™ Sprinkle* *Gralise™* *Horizant ™* *Lidoderm® patch* *Lyrica CR* *Lyrica® soln* *Lyrica®* *Neurontin® cap/tab/soln* *pregabalin sol* *Qutenza Kit® (Topical)* *Savella™ & Savella™ Dose Pak* *Ztlido™ (lidocaine topical system)*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL** ***~~Step Edit for Lyrica®/pregabalin~~** • ~~Trial and failure of duloxetine or gabapentin~~
	Non-Ergot Dopamine Receptor Agonist		
	pramipexole **ropinirole HCl**	*Mirapex® IR & ER* *Neupro®* *pramipexole ER* *Requip® XR* *ropinirole HCl ER*	**LENGTH OF AUTHORIZATIONS:** **1 year** **Routine PDL edits**
	Sedatives / Hypnotics		
	temazepam 15 & 30 mg	*estazolam* *flurazepam*	**LENGTH OF AUTHORIZATIONS**: Length of the prescription (up to 3 months)

Preferred Agents	Non-Preferred Agents	SA Criteria
	Halcion® *Restoril®* *temazepam 7.5 mg & 22.5 mg* *triazolam*	**Routine PDL edits**
Sedatives / Hypnotics (Non-Benzodiazepine)		
zolpidem	*Ambien® IR & CR* *Belsomra®* *Edluar™* *eszopiclone* **Hetlioz™* *Intermezzo®* *Lunesta®* *Rozerem®* *Silenor®* *Sonata®* *Zaleplon®* *zolpidem CR* *Zolpimist ™ spray* *zolpidem (generic Intermezzo®)*	**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** • 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®*	**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**

Preferred Agents	Non-Preferred Agents	SA Criteria
	**Soma®* *tizanidine cap* *Zanaflex®*	
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)* **CLOSED CLASS**		
Amphetamine Drugs		**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits** *All stimulants (preferred and non-preferred) require the submission of Clinical SA if prescribed for a child less than four or an adult eighteen years and older. Refer to Stimulant SA form (Stimulant/ADHD Medications SA Form) ***This does not include nonstimulant agents such as* atomoxetine *(generic for Strattera®,)clonidine ER,* guanfacine ER or others**
Adderall®XR **amphetamine salts combo** *(generic for Adderall IR)* **dextroamphetamine** *(generic for Dexedrine)* **Dyanavel® XR susp** **Vyvanse® cap/chewable tab** (lisdexamfetamine)	*Adderall® IR (amphetamine salts combo)* *Adzenys XR ODT™* *Adzenys ER™ susp* *Adzenys® ER* *amphetamine salts combo XR* *amphetamine sulfate (generic Evekeo™)* *Desoxyn®* *Dexedrine®* *dextroamphetamine SR & soln* *Evekeo™* *Evekeo™ ODT* *methamphetamine* *Mydayis ER™* *Procentra® soln* *Zenzedi™*	
Methylphenidate Drugs		
All methylphenidate IR generic **Concerta®** **Daytrana® Transdermal** **Focalin® IR & XR** **QuilliChew ER™** **Quillivant™ XR susp**	*Adhansia™XR* *Aptensio ™ XR* *Cotempla XR-ODT™* *dexmethylphenidate IR & XR* *Metadate CD®* *Metadate ER®*	

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
		Methylin ER®, soln IR *methylphenidate chew & soln* *methylphenidate ER, LA, SR* *Ritalin® IR, LA® & SR®*	
	Miscellaneous Drugs		
	atomoxetine *(generic for Strattera®)* **clonidine ER** **guanfacine ER**	****armodafinil (generic Nuvigil™)* ****modafinil* ****Nuvigil ™ (AG)* ****Provigil®(AG)* *Sunosi™* *Strattera®* *Intuniv®*	*****Nuvigil™/Provigil®/armodafinil/modafinil:** **Refer to Narcolepsy Medications SA Form** ~~**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.~~
Dermatologic			
	***Acne Agents, Topical** *(AG)*		
	Combo Benzoyl Peroxide , Clindamycin, Erythromycin Topical		**LENGTH OF AUTHORIZATIONS:** 1 year **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.**
	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™*	

	Preferred Agents	Non-Preferred Agents	SA Criteria
		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 phosphate(generic for Clindagel®)* *clindamycin/benzoyl peroxide (generic for Acanya® Pump)* *clindamycin/benzoyl peroxide (generics for Benzaclin®)* *clindamycin phosphate foam, el, lotion, med swab* *clindamycin/tretinoin (generic Veltin®)* *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*	

	Preferred Agents	Non-Preferred Agents	SA Criteria
		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®)* *Altreno™* *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*	***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
	tretinoin microsphere 0.04% & 0.1% gel *Ziana® gel*	
Antifungal Topical		
ciclopirox soln **clotrimazole cr (OTC & RX)** **clotrimazole soln (OTC)** **clotrimazole-betamethasone cr** **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 lot* **CNL 8™ Kit* *Desenex® Aero Powder (OTC)* *econazole* *Ertaczo®* *Exelderm® cr & soln* *Extina®* *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* *luliconazole (generic for Luzu)* ***Luzu®* *miconazole nitrate (OTC)*	**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
		miconazole Oint/ powder (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)*
		pimecrolimus (new generic for Elidel)
		**Protopic®*
		**tacrolimus*
			LENGTH OF AUTHORIZATIONS: 1 year; EXCEPT Dupixent® 6 months
			
			Routine PDL edits plus
			
			***Clinical Criteria for Elidel®, Eucrisa™, Protopic®& tacrolimus**
			• Member must have a FDA approved diagnosis:
			  ○ Atopic dermatitis
			  ○ Elidel® & Eucisa™: mild to moderate for ages > 2 years.
			  ○ Protopic® 0.03%: moderate to severe for ages > 2 years.
			  ○ 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®**
			❖ **Atopic Dermatitis**

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
			• ≥ 12 years of age; **AND** • Diagnosis of moderate to severe atopic dermatitis ; **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** • Inadequate response to a 3 month minimum trial of at least 1 immunosuppressive systemic agent (e.g., cyclosporine, azathioprine, methotrexate, mycophenolate mofetil, etc.); **AND** • Inadequate 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** ***Quantity limit Dupixent®*** *2 prefilled syringes for the initial dose, then 1 single-dose syringe every 14 days* ❖ **Chronic Rhinosinusitis with Nasal Polyposis** • ≥ 18 years of age; AND • Diagnosis of In adequately controlled Chronic Rhinosinusitis with Nasal Polyposis (CRSwNP) • Is Add to current maintenance treatment
Psoriasis, Topical			
calcipotriene cr/oint/soln	*Calcitrene®* *calcitriol* *Dovonex®* *Duobrii ™* **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

Preferred Agents	Non-Preferred Agents	SA Criteria
Rosacea Agents, Topical		
Metrocream® **Metrogel®** **Metrolotion®**	*azelaic acid (generic for Finacea®)* *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** **Routine PDL edits**
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®*	
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*	

Preferred Agents	Non-Preferred Agents	SA Criteria
	hydrocortisone butyrate (generic for locoid lotion) *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* *desoximetasone (generic Topicort® spray)* *diflorasone diacetate cr/oint* *Diprolene® lot/oint* *DiproleneAF®cr* *Ellzia™ Pak Kit* *fluocinonide cr/ emollient/ gel/oint/soln* *Halog® cr/oint* *Kenalog® aerosol* *Loprox® Suspension Kit* **Sernivo™* *Silazone® II Kit* *Topicort® cr/gel/oint/spray* *Trianex® oint* *triamcinolone spray* *triamcinolone/dimethicone*	

	Preferred Agents	Non-Preferred Agents	SA Criteria
		Vanos®cr *Whytederm®Tdpak*	
	Steroids, Topical Very High Potency		
	clobetasol emollient **clobetasol propionate cr/gel/oint/soln** **halobetasol propionate cr/oint**	*Apexicon™E* *Bryhali™ (halobetasol propionate)* *clobetasol lot/shampoo* *clobetasol propionate foam/spray* *Clobex® lot/shampoo/spray* *Clodan® kit* *Halonate®* *halobetasol propionate(generic for Lexette®)* *Olux®* *Olux®-E* *Temovate® oint* *Ultravate® cr/lotion/oint* *Ultravate® PAC & Ultravate® X*	
Endocrine and Metabolic Agents			
	Androgenic Agents (Testosterone – Topical)		
	testosterone (generic for AndroGel®)	*Androderm®* *AndroGel®* *Axiron® soln* *Fortesta®* *Natesto Nasal Gel ®* *Testim®* *testosterone (generic for Axiron®)* *testosterone gel/packet/pump (generic for Vogelxo™)* *testosterone (generic for Fortesta®)* *Vogelxo™ gel/packet/pump* *Xyosted™*	**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 • 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.

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
			• 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®* *Gloperba ®* *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** • 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:

Preferred Agents	Non-Preferred Agents	SA Criteria
		○ 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 CLOSED CLASS		
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) ***Levemir® pen/vial*** *(insulin detemir)*	*Basaglar® KwikPen® (insulin glargine)* *Toujeo® Solostar®(insulin glargine) 300 Units/mL* *Tresiba® FlexTouch® Pen (insulin degludec) 100 U/ml, 200 U/ml*	

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Rapid-Acting Insulins		
Humulin 500 U/M pen/vial **Humalog® vial** **Novolog® cartridge/vial/ Flexpen**	*Admelog® Solostar Pen/vial* *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) **plus 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®)* *metformin ER (generic Glumetza®)* *metformin (generic Riomet®)*	
Oral Hypoglycemics Biguanide Combination Drugs		
glyburide/metformin	*glipizide/metformin* *Glucovance®*	
Oral Hypoglycemics DPP-IV Inhibitors & Combination CLOSED		
Janumet® **Janumet XR®** **Januvia®** **Jentadueto™** **Tradjenta™**	*alogliptin (generic Nesina™)* *alogliptin/metformin (generic Kazano™)* *alogliptin/pioglitazone (generic Oseni™)* *Jentadueto XR™* *Kazano™* *Kombiglyze XR™* *Nesina™* *Onglyza™*	

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	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 CLOSED CLASS**		***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™* *(ertugliflozin/metformin)* *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* *pioglitazone/glimepiride*	

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	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	Erythropoiesis Stimulating Proteins		
	Epogen® **Retacrit™**	*Aranesp® vial/syringe* *Procrit®* *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* *Ortikos®* *prednisolone sod phosphate ODT/ soln* *prednisone intensol* *Rayos® DR tab* *TaperDex®* *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
	***Growth Hormone** **CLOSED CLASS**		
	Genotropin® *Norditropin FlexPro®*	*Humatrope® cartridge/vial* *Nutropin AQ® NuSpin™* *Omnitrope® cartridge/vial* *Saizen® cartridge/vial* *Serostim® vial* *Zomacton® vial* *Zorbtive® vial*	**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)**

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	***Hereditary Angioedema (HAE) Agents**		
	Berinert® **Cinryze™** **Kalbitor®**	*Firazyr®* *Haegarda®* *icatibant(generic Firazyr®)* *Ruconest®* *Takhzyro™*	**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) **medroxyprogesterone acetate (tab only)** **norethindrone acetate** **progesterone cap/inj**	*Aygestin®* *Crinone (Vaginal)* *Depo-Provera 400 MG/ML* *hydroxyprogesterone caproate SDV* *hydroxyprogesterone caproate (generic for Makena MDV)* *Makena® Multi Dose Vial (MDV)* *Prometrium®* *Provera®*	**LENGTH OF AUTHORIZATIONS:** 1 year **Routine PDL edits**
	Progestins Used For Cachexia		
	megestrol acetate	*Megace®*	**LENGTH OF AUTHORIZATIONS:** 1 year

	Preferred Agents	Non-Preferred Agents	SA Criteria
		Megace® ES *megestrol suspension ES*	**Routine PDL edits**
	Vaginal Estrogens		
	Premarin® Vaginal cr **Vagifem® Vaginal tab**	*Estrace ®Vaginal cr* *estradiol cream (generic Estrace ®)* *Estring® Vaginal ring* *Femring® Vaginal ring* *Imvexxy®* *Intrarosa™* *Osphena® tab* *Yuvafem®*	**LENGTH OF AUTHORIZATIONS**: 6 months **Routine PDL edits**
Gastrointestinal			
	G I Antibiotics		
	Firvanq™ **metronidazole tab** **vancomycin cap**	*Aemcolo™* *Alinia®* *Dificid®* *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™* **Marinol ®* **Syndros®*	***Dronabinol plus all non-preferred Antiemetic/Antivertigo agents require submission of a Clinical SA. Refer to Antiemetic/Antivertigo SA form**

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Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
5HT3 Receptor Blockers		**LENGTH OF AUTHORIZATIONS:** 3 months, unless otherwise noted
ondansetron ODT/tab	*Aloxi®* *Anzemet®* *Akynzeo®* *granisetron Granisol ® soln/tab* *Kytril®* *ondansetron soln* *palonosetron (generic Aloxi®)* *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** ****promethazine** *(AG)*	*Antivert®* *Bonjesta™* *Compazine®supp/tab* *Compro®* *Diclegis®* *dimenhydrinate* *doxylamine succinate/ vit B6* *hydroxyzine* *Metozolv® ODT* *metoclopramide ODT* ***Phenergan® (AG)* *prochlorperazine supp* ***promethazine 50mg supp (AG)* *Reglan®*	****Promethazine approved for members ≥ 2 years

Preferred Agents	Non-Preferred Agents	SA Criteria
	scopolamine (generic Transderm-Scop®) *Tigan®* *Transderm-Scop®* *trimethobenzamide* *Vistaril®*	
***GI Motility, Chronic**		
Amitiza® **Linzess™** **Movantik®**	*alosetron* *Lotronex®* *Motegrity™* *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®	*Helidac®* *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 **pantoprazole**	*Aciphex® DR tab/sprinkle* *Dexilant®* *esomeprazole magnesium*	**LENGTH OF AUTHORIZATIONS**: 12 weeks; unless member meets an exception; then 1 year

	Preferred Agents	Non-Preferred Agents	SA Criteria
		esomeprazole strontium *lansoprazole cap* *Nexium®* *Omeprazole OTC* *omeprazole magnesium OTC* *omeprazole/sodium bicarbonate* *Prevacid® RX, OTC& Solutab* *rabeprazole DR tab* *Prilosec® Rx & Susp* *Protonix®* *Zegerid® cap/OTC/susp packet*	**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 require a SA for use over 90 days**
Ulcerative Colitis Oral and Rectal Preparations (5-ASA DERIVATIVES)			
Ulcerative Colitis – Oral			**LENGTH OF AUTHORIZATIONS: 1 year** ***Routine PDL edits*** **Giazo is limited to an 8 week supply*
	Apriso® **Pentasa®** **sulfasalazine DR & IR**	*Asacol ®HD* *Azulfidine® IR &DR* *balsalazide disodium* *budesonide ER (generic Uceris™)* *Colazal®* *Delzicol™* *Dipentum* **Giazo™ (QL)* *Lialda®* *mesalamine (generic Asacol® HD)* *mesalamine (generic Lialda®)* *Uceris™*
Ulcerative Colitis – Rectal			
	mesalamine rectal supp **mesalamine enema**	*Canasa® rectal supp* *mesalamine kit* *Rowasa® enema/kit* *SFRowasa®* *Uceris®*

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	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
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®* *Silodosin (generic 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®** & tadalafil 5mg **-** 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)* *tadalafil 5mg (ST)*	
	Urinary Antispasmodics (Bladder Relaxant)		
	oxybutynin tab/syrup **oxybutynin ER** **Toviaz™** **VESIcare®**	*darifenacin ER (generic Enablex®)* *Detrol® & Detrol® LA* *Ditropan® & *Ditropan® XL* *Enablex®* *flavoxate* *Gelnique™ gel/gel Pump* *Myrbetriq™* *Oxytrol® transdermal includes for Woman OTC* *Sanctura XR* *trospium IR & ER* *tolterodine IR & ER*	

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Immunological Agents			
Multiple Sclerosis			
	Avonex® **Avonex® Adm Pack** **Betaseron®** **Copaxone 20 mg syringe®** ***Gilenya®** ***(ST)*** **Rebif® SQ** **Rebif® Rebidose Pen®**	***Ampyra®* *Aubagio®* *Copaxone® 40 mg syringe®* *dalfampridine ER (generic for Ampyra®)* *Extavia® Kit* *Glatopa™* *****Mavenclad®* *****Mayzent®* *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). *****Mayzent® or Mavenclad® SA Form**
Cytokine and CAM Antagonists And Related Agents			**CLOSED CLASS**
	Enbrel® **Humira®** **methotrexate tab/PFvial/ MDVvial**	*Actemra® SQ & ACTPEN* *Cimzia® & Cimzia® Syringe Kit* *Cosentyx™* *Entyvio®* *Ilaris®* *Ilumya™* *Kevzara® inj, pen* *Kineret®* *Olumiant®* *Otezla®* *Otrexup®* *Orencia®* *Remicade®* *Rasuvo™* *Skyrizi™* *Siliq®* *Simponi®*	**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edits plus** ***All non-preferred Cytokine and CAM Antagonists require submission of a Clinical SA. Refer to Cytokine and CAM Antagonists and Related Agents SA Form** For a list of Cytokine and CAM Antagonists and criteria for approval see **Appendix A**

	Preferred Agents	Non-Preferred Agents	SA Criteria
		Stelara® vial/syringe *Taltz®* *Tremfya™* *Trexall®* *Xatmep™* *Xeljanz™ & Xeljanz™ XR*	
Ophthalmic			
	Antibiotics		
	bacitracin/polymyxin b sulfate ointment **ciprofloxacin drops** **erythromycin** **gentamicin drops/oint** **Moxeza® drops** **ofloxacin drops** **polymyxin/trimethoprim** **tobramycin**	*AzaSite™ drops* *bacitracin* *Besivance® drops* *Bleph®-10* *Ciloxan® drops/oint* *Garamycin ®drops/oint* *gatifloxacin 0.5% soln* *Ilotycin®* *levofloxacin drops* *moxifloxacin drops (generic Vigamox®)* *Natacyn®* *neomycin/polymix/gramicidin* *neomycin/bacitracin/polymyxin oint* *Neosporin ®* *Ocuflox® s* *Polytrim®* *sulfacetamide oint/ soln* *Tobrex® drops/oint* *Vigamox®* *Zymaxid®*	**LENGTH OF AUTHORIZATIONS**: Date of service only; no refills **Routine PDL edits**
	Antibiotic/Steroid Combinations		
	neomycin/polymyxin/dexamethasone oint/susp **sulfacetamide/prednisolone** **Tobradex® oint/susp**	*Blephamide®* *Blephamide® S.O.P.* *Maxitrol® oint/susp* *neomycin/bacitracin/poly/HC*	**LENGTH OF AUTHORIZATION**: Date of service only; no refills **Routine PDL edits**

Preferred Agents	Non-Preferred Agents	SA Criteria
	neomycin/polymyxin/HC *Pred-G® oint/susp* *Tobradex® ST* *tobramycin/dexamethasone susp* *Zylet®*	
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®* *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)* *Inveltys ™(loteprednol etabonate)* *Nevanac®* *Ocufen®* *Prolensa™*	
Corticosteriods		
Durezol® **fluorometholone** **prednisolone acetate**	*Alrex™* *Dexamethasone* *Flarex®*	

Preferred Agents	Non-Preferred Agents	SA Criteria
	FML®, FML Forte® & FML® S.O.P. *loteprednol etabonate (generic for Lotemax™)* *Lotemax™ drops/gel/oint* *Maxidex®* *Omnipred®* *Pred Forte® & Pred Mild®* *prednisolone sod phosphate* *Vexol®* *Yutiq® (fluocinolone acetonide intravitreal implant)*	
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		
carteolol 1% **Combigan®** **levobunolol 0.5%** **metipranolol 0.3%** **timolol maleate**	*Betagan® 0.5%* *betaxolol 0.5%* Betoptic-S® 0.25% *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**	*Cosopt® 0.5%-2%* *Cosopt® PF* *Simbrinza™* *Trusopt® 2%*	
Rho Kinase Inhibitor		
Rhopressa® **Rocklatan ®**		
Prostaglandin Analogs		

	Preferred Agents	Non-Preferred Agents	SA Criteria
	latanoprost **Travatan Z®**	*bimatoprost* *Lumigan® 0.03% & 0.01%* *Rescula®* *travoprost 0.004%* *Vyzulta™* *Xalatan® 0.005%* *Xelpros® (latanoprost)* *Zioptan™*	
Respiratory			
	***Anti-Allergens, Oral**		
		*~~*Grastek® SL~~* **Oralair® SL* *~~*Ragwitek™ SL~~* *~~*Odactra®~~*	**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** **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* *levocetirizine Tablets*	

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	loratadine ODT *loratadine D 12 & 24 hr* *Semprex-D®* ~~*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)* *Performist® (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 ®Diskus 250/50, & 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
Dupixent®	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® 80/4.5	Children < 6	Asthma & COPD
Symbicort® 160/4.5	Children < 12	Asthma & COPD

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Short Acting Metered Dose Inhalers or Devices		
Proair® HFA **Proventil® HFA**	*albuterol HFA (PROAIR)* *albuterol HFA (VENTOLIN)* *levalbuterol tartrate HFA* *ProAir® RespiClick* *Ventolin® HFA* *Xopenex® HFA*	
Short Acting Nebulizers		
albuterol sulfate (premixed)	*levalbuterol soln* *Xopenex®*	
Biologic: Human Monoclonal IgG4 Antibody Inhibits Interleukin-4 (IL-4) and Interleukin-13 (IL-13)		

	Dupixent®	**LENGTH OF AUTHORIZATION**: 1 year
		Routine PDL edits plus
		• Routine PDL
		• ≥ 12 years of age; AND
		• Diagnosis Moderate to severe Asthma with
		  ○ eosinophilic phenotype; OR
		  ○ Oral corticosteroid dependent; AND
		• Prescribing provider is a pulmonologist or
		• An allergy/asthma specialist; AND
		• Have a diagnosis of step 5 or higher (moderate to severe) asthma; AND
		• Inadequately controlled asthma despite treatment with high dose inhaled or oral corticosteroid daily for at least 3 consecutive months; AND
		• Along-acting beta agonist (unless is not a candidate) daily for at least 3 consecutive months; AND
		• Is Add to current maintenance treatment; AND
		• Is not pregnant

COPD: Bronchodilators and Phosphodiesterase 4 (PDE4) Inhibitors CLOSED CLASS		
Atrovent HFA® **Anoro™ Ellipta®** (AG) **Bevespi Aerosphere™** **Combivent® Respimat** **ipratropium bromide soln**	**Daliresp®* *Incruse™ Ellipta®* *Lonhala™ Magnair™* *Seebri Neohaler™* *Spiriva® Respimat*	**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edits plus** ***Clinical Criteria for Daliresp®**

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
ipratropium/albuterol nebs **Spiriva®** **Stiolto Respimat™ (AG)**	*Tudorza™* *Utibron Neohaler™* *Yupelri™ (revefenacin)*	• 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) CLOSED CLASS		**LENGTH OF AUTHORIZATIONS**: 1 year
Dulera®(AG)* **fluticasone/salmeterol powder (AG)** ***Symbicort®***(AG)*	*Advair® Diskus *(AG)* *Advair® HFA(AG)* *Airduo ™ Respiclick®(AG)* *Breo®Ellipta™ (AG)* *WixelaTM Inhub™(fluticasone/ salmeterol)*	**Routine PDL edits**
Inhaled Corticosteroids: Metered Dose Inhalers CLOSED CLASS		
Asmanex® **Flovent® Diskus & HFA** **Pulmicort Flexhaler®**	*Alvesco®* *Aerospan™* *Armonair™ Respiclick®* *Arnuity™Ellipta®* *Asmanex HFA®* *QVAR® & QVAR® Redihaler* *Trelegy® Ellipta*	
Inhaled Corticosteroids: Nebulizer Solution CLOSED CLASS		**LENGTH OF AUTHORIZATIONS**: 1 year
budesonide respules	*Pulmicort® Respules*	
Nasal Steroids		**Routine PDL edits**
fluticasone	*Beconase AQ®* *budesonide (generic for Rhinocort® Aqua)* *budesonide (generic Rhinocort® Allergy OTC)*	

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
		Children's Qnasl™ *Clarispray OTC* *Dymista™* *Flonase®* *Flonase Sensimist (OTC)* *flunisolide* *fluticasone OTC* *mometasone(generic Nasonex®)* *Nasonex®* *Omnaris®* *Qnasl™* *Rhinocort Aqua®* *Rhinocort® Allergy OTC* *Sinuva®* *Ticanase®* *triamcinolone OTC* *triamcinolone acetonide* *Veramyst®* *Xhance™* *Zetonna™*	
	***Cough and Cold Drug**		
	Ala-Hist DM **benzonatate cap** **codeine/ promethazine** **guaifenesin/codeine phosphate** **hydrocodone/ homatropine** **Iophen-C NR** **phenylephrine HCl/promethazine HCl** **promethazine DM syrup** **Tusnel® Pediatric Drops**	*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** *** Children under the age of 6 years are not eligible for cough and cold drugs.**
	Epinephrine, Self-Injected		

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	epinephrine 0.15 mg & 0.3 mg (authorized generic EpiPen® & EpiPen® Jr)	*Auvi-Q®* *Epipen®* *Epipen® Jr* *epinephrine 0.15mg & 0.3mg (generic Adrenaclick)* *Symjepi™ (epinephrine)*	**LENGTH OF AUTHORIZATIONS**: **1 year** **Routine PDL edits**
	Intranasal Antihistamines		
	azelastine 0.1%	*Astepro® 0.15%* *olopatadine* *Patanase®*	**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**