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

1/1/23

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, e-PA. 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 the last post will be highlighted in yellow.

LEGEND

AGE = 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 tab
oint = ointment
soln = solution
supp = suppository
susp = suspension
tab = tab

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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 3 months for (includes HIV/AIDS, Chronic back pain, Arthritis, Fibromyalgia, Diabetic neuropathy, Postherpetic Neuralgia). • Up to 6 months for chronic pain (includes Cancer pain, Sickle cell disease, Palliative care, End-of-Life Care, Hospice). 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 (gen Butrans®)* *buprenorphine (gen Belbuca)* *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* *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, Fibromyalgia, Diabetic neuropathy, Postherpetic Neuralgia). • Up to 6 months for chronic pain (includes Cancer pain, 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 50mg** **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(gen PrimLev™)* *oxycodone conc* *oxycodone oral syringe* *oxycodone/ASA* *oxycodone/ibuprofen* *oxymorphone HCl*	***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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	Panlor® *pentazocine/naloxone* *PrimLev™* *RoxyBond™* *Seglentis®* *tramadol 100 Mg* *tramadol soln (AG for Qdolo®)* *Ultracet®* *Ultram®* *Zamicet ®soln*	
Opioid Dependency **CLOSED CLASS**		***All Buprenorphine Containing Drugs (non-preferred) require submission of Clinical SA. Refer (Oral Buprenorphine SA Form)** **Quantity Limits**
***buprenorphine SL** *** buprenorphine/naloxone tab SL** ***Suboxone® film** ***Sublocade™ SQ**	**buprenorphine/naloxone film SL* **Probuphine® implant* **Zubsolv™*	
Kloxxado™ Spray **naloxone syringe & vial** **naloxone nasal spray** **Naloxone Carpuject** **naltrexone tab** **Narcan® Nasal Spray** **Vivitrol®** **Zimhi™**	*Evzio® injection*	
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)		
Oral NSAIDs		**LENGTH OF AUTHORIZATIONS: 1 year**
Children's Motrin® susp (OTC)	*Anaprox® IR & DS®*	

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 4–1mg	1/day
buprenorphine/naloxone SL film 8–2mg	3/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

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ibuprofen cap **ibuprofen tab (OTC & Rx)** **Infant's ibuprofen drops** **meloxicam tab** **naproxen tab** **naproxen sodium (OTC)** **naproxen EC (Rx)** **sulindac**	*Advil®* *Aleve®* *Arthrotec®* *Cataflam®* **Celebrex® & *celecoxib* *Daypro®* *diclofenac potassium* *diclofenac potassium gen Zipsor™* *diclofenac sodium SR* *diclofenac sodium/misoprostol* *diflunisal* *Duexis®* *etodolac IR & SR* *Feldene®* *fenoprofen* *flurbiprofen* *ibuprofen tab chew OTC* *ibuprofen-famotidine (gen Duexis®)* *Indocin® supp* *indomethacin IR, SR & rectal* *ketoprofen IR & ER* *ketorolac* *ketorolac tromethamine (generic Sprix® nasal spray)* *meclofenamate* *mefenamic* *meloxicam susp* *meloxicam (generic Vivlodex™)* *Mobic® susp* *Motrin®* *nabumetone* *Nalfon®* *Naprelan®* *Naprosyn®*	**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** • 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*
	naproxen CR (generic Naprelan®) *naproxen-esomeprazole mag (generic Vimovo®)DR* *naproxen sodium (RX)* *naproxen susp* *oxaprozin* *piroxicam* *Ponstel®* *Prevacid Naprapac®* *Sprix® nasal spray* *Tivorbex™* *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® and Licart™ patch = 30 patches per RX***
diclofenac sodium 1% gel **diclofenac sodium 1% gel (OTC)**	***diclofenac sodium 3 % gel* *diclofenac 2% topical sol gen* *Pennsaid®* **Flector® patch (QL)* *Licart™ patch (diclofenac epolamine 0.013gm (QL)* **Pennsaid® top soln, soln pkt & pump* **Vopac MDS* **Voltaren® 1% gel* **Voltaren® 1% gel (OTC)* **XrylixTM Kit*	

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	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Antibiotic-Anti-Infective			
	***Antibiotics, Inhaled (QL, AGE) CLOSED CLASS**		
	Bethkis® **Kitabis™ Pak** ****Tobi Podhaler® *(SE)*** **tobramycin inhalation neb soln (generic Tobi® inh)**	****Arikayce® (amikacin liposome)* *Cayston®* *Tobi® inh neb soln* *tobramycin (generic Bethkis®)* *tobramycin Pak (generic Kitabis™ Pak)*	**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 **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®. **Quantity ~~Limits~~ Limitations:** Arikayce®= 590 mg/8.4 Ml (28 vials)/28 days Each carton contains a 28-day supply of medication (28 vials)

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 nebs = 280Ml (56 amps)/28 days
Antifungals, Oral		
fluconazole tab/susp **griseofulvin susp** **nystatin tab/susp** **terbinafine tab**	*Ancobon ®* *Brexafemme®* *clotrimazole (mucous mem)* *Cresemba®* *Diflucan® tab/susp* *flucytosine* *Gris-Peg®* *griseofulvin tab* *griseofulvin ultramicrosize* *itraconazole* *itraconazole soln (generic for Sporanox® soln)* *ketoconazole* *Lamisil ® tab/granules* *Noxafil®* *Noxafil® Powdermix* *posaconazole tab (generic for Noxafil)* **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**

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Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
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 capsule **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*	
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** **E.E.S.® 200 susp** **erythromycin base cap DR** **erythromycin ethylsuccinate 200mg susp** **erythromycin stearate**	*Biaxin® tab* *clarithromycin ER* *Eryped® 200 susp* *Eryped® 400 susp* *Ery-tab®* *E.E.S.® 400 tab* *Erythrocin® Stearate* *erythromycin base tab* *erythromycin ethylsuccinate 400mg tab(Generic E.E.S.® 400)* **Ketek®* *PCE®* *Zithromax® pac/tab/susp* *ZMAX® susp*	

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Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Otic		
Ciprodex® **ofloxacin** **neomycin/polymyxin/hc soln/ sus**	*Cetraxal®* *Cipro HC®* *ciprofloxacin/dexamethasone (generic Ciprodex)* *ciprofloxacin and fluocinolone acetonide (generic Otovel)* *Otovel*	**LENGTH OF AUTHORIZATIONS:** Date of service only; no refills **Routine PDL edits**
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	*Cipro® IR, XR & susp* *ciprofloxacin ER* *Noroxin®* *ofloxacin*	
Third Generation Quinolones		
levofloxacin tab	*Baxdela™ 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** **Nuvessa™** **Vandazole™ gel**	*Cleocin® cr* *clindamycin cr* *Metrogel®*	**LENGTH OF AUTHORIZATIONS**: Date of Service **Routine PDL edits**

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	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Antivirals			
	***Hepatitis C Agents** **CLOSED CLASS**		
	Interferon		**LENGTH OF AUTHORIZATIONS**:
	Peg-Intron®	*Pegasys®* *Proclick/syringe/kit/vial*	***Non-preferred agents require the submission of a Clinical SA. Preferred agents do not require submission of any SA. Refer to** Hepatitis C Antivirals Non-Preferred SA Form
	***Nucleotide Analog NS5A & NS5B Polymerase Inhibitors & Combinations**		
	sofosbuvir /velpatasvir (generic Epclusa®)	*Epclusa®* *Epclusa® Pellet packs* *Sovaldi®* *Vosevi™*	***Hepatitis C Therapies are limited to 3 one-month fills (total 84 day supply) with out SA** • **Mavyret™** • **sofosbuvir /velpatasvir (generic Epclusa®)**
	***NS5A, NS3/4A Inhibitor Combinations**		
	Mavyret™ **Mavyret™ Pellet packs**	*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		
	acyclovir oint **docosanol**	*Abreva OTC®* *acyclovir cr (generic Zovirax cr)* *Denavir®* *Xerese® cr* *Zovirax® oint* *Zovirax® cr*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits**

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Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
HIV/AIDS CLOSED CLASS		
abacavir tab/soln **abacavir-lamivudine tab** **abacavir-lamivudine-zidov tab** **Apretude** **Aptivus® cap/soln** **atazanavir sulfate cap** **Atripla® tab** **Biktarvy® tab** **Cabenuva** **Cimduo® tab** **Combivir® tab** **Complera® tab** **Delstrigo™ tab** **Descovy® tab** **didanosine cap DR** **Dovato® tab** **Edurant® tab** **efavirenz cap, tab** **efavir-emtri-tenof tab** **efavirenz-lamiv-tenof tab** **emtricitabine cap** **emtricitabine-tenofv** **Emtriva™ cap/soln** **Epivir® tab/soln** **Epzicom® tab** **etravirine tab** **Evotaz® tab** **fosamprenavir tab** **Fuzeon® Vial** **Genvoya® tab** **Intelence® tab** **Invirase® tab** **Isentress® chew tab/ tab/powder pack**	*Trogarzo® (intraven)*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits** **Quantity limits see list here HIV Quantity Limits**

	Preferred Agents	*Non-Preferred Agents*		*SA Criteria*
	Juluca® tab **Kaletra® tab/soln** **lamivudine tab/soln** **lamivudine-zidovudine tab** **Lexiva® tab/susp** **lopinavir-ritonavir soln/tab** **Maraviroc** **nevirapine IR tab/ ER tab/susp** **Norvir® tab/soln/powder pack** **Odefsey® tab** **Pifeltro™ tab** **Prezcobix® tab** **Prezista® tab/susp** **Retrovir® cap/syrup/vial** **Reyataz® cap/ powder pack** **Rilpivirine ER vial** **ritonavir tab** **Rukobia™ ER tab** **Selzentry® tab/soln** **stavudine cap** **Stribild® tab** **Sunlenca® tab/vial** **Sustiva® tab/cap** **Symfi® and Symfi Lo® tab** **Symtuza® tab** **Temixys™ tab** **tenofovir disoproxil fum tab** **Tivicay® tab/tab for susp** **Triumeq® tab** **Triumeq® PD** **Trizivir® tab** **Truvada® tab** **Tybost® tab** **Viracept® tab** **Viramune® tab/susp** **Viread® tab/powder**			

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	Vocabria **Ziagen® tab/soln** **zidovudine tab/cap/syrup**		
	Influenza		
	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 cap, tab	*Bylvay™* *Chenodal®* *Cholbam®* *Livmarli™* *Ocaliva®* *Reltone®* *Urso® & Urso® Forte tab*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits**
	Hemophilia Treatment (Closed Class)		
	Factor VIII Products		**LENGTH OF AUTHORIZATIONS**: N/A All products are preferred with out EDITs
	Advate® **Adynovate®** **Afstyla®** **Alphanate®** **Eloctate®** **Esperoct®** **Hemofil-M®** **Humate-P®** **Jivi®** **Koate-DVI®** **Kogenate FS®** **Kovaltry®** **Novoeight®**		

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Nuwiq® Obizur® Recombinate® Xyntha® Kit & Solofuse Syr		
Factor IX Products		
AlphaNine SD® Alprolix® BeneFIX® Idelvion® Ixinity® Profilnine SD® Rebinyn® Rixubis®		
Factor VIIa & Activated Prothrombin Complex Concentrate		
Feiba NF® NovoSeven RT® Sevenfact®		
Factor IXa and Factor X Directed Antibody		
Hemlibra®		
Factor X and Factor XIII Products		
Coagadex® Corifact® Kit Tretten®		
Von Willebrand		
Vonvendi® Wilate®		
Phosphate Binders		

	Preferred Agents	*Non-Preferred Agents*		*SA Criteria*
	calcium acetate 667mg cap **calcium acetate 668 mg** **sevelamer carbonate tab**	*Auryxia™* *calcium acetate 667mg tab* *Calphron* *Eliphos* *Fosrenol® chewable tab* *lanthanum carbonate chewable tab* *Phoslyra® powder, tab* *Renagel®* *Renvela®* *sevelamer carbonate powder packet* *sevelamer HCL (gen Renagel)* *Velphoro® chewable tab*	**LENGTH OF AUTHORIZATIONS**: **Routine PDL edits**	1 year
	Sickle Cell (CLOSED CLASS)			
	Droxia **Endari** **Oxbryta**	*Adakveo IV* *Siklos*	*Non-preferred agents require the submission of a Clinical SA. Preferred agents do not require submission of any SA. Refer to **Sickle Cell SA Form**	
Bone Resorption Suppression and Related Agents				
	Bisphosphonates			
	alendronate tab **ibandronate**	*Actonel®* *alendronate soln* *Atelvia DR®* *Boniva®* *Binosto™* *etidronate* *Fosamax®tab & Fosamax®plusD* *risedronate DR*	**LENGTH OF AUTHORIZATIONS**: **Routine PDL edits** .	1 year
	Calcitonins			
	calcitonin-salmon nasal	*Miacalcin® spray*	**LENGTH OF AUTHORIZATIONS**:	1 year

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	calcitonin-salmon (gen Miacalcin®)	**Routine PDL edits**
Others		
raloxifene	*Evista®* **Forteo®* *teriparatide* **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 (generic Lovenox®)	*Arixtra®* *fondaparinux* *Fragmin® syringe & vial*	**Routine PDL edits plus**
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™ **Eliquis™ Dose Pack** **Jantoven ®** **Pradaxa®** **warfarin** **Xarelto® & Starter Pack susp**	*apixaban (generic Eliquis™)* **Savaysa™*	
Antihypertensive Agents		
ACE Inhibitors		**LENGTH OF AUTHORIZATIONS: 1 year** **Routine PDL edits**
benazepril **enalapril** **lisinopril** **ramipril** **quinapril**	*Accupril®* *Altace®* *captopril* *Epaned™ soln* *enalapril soln* *fosinopril* *Lotensin®* *Mavik®* *moexipril*	

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	Monopril® *perindopril* *Qbrelis™* *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* *quinapril-HCTZ (gen Accuretic)* *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*	*Quantity Limit = 2 per day for Entresto™*

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	Micardis® *Teveten®*	
Angiotensin Receptor Blockers + Calcium Channel Blocker Combinations		
amlodipine/olmesartan **amlodipine/valsartan**	*Azor®* *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 (transdermal)** **clonidine tab** **guanfacine** **methyldopa**	*Clorpres®* *methyldopa/HCTZ* *Tenex®*	
Beta Blockers		***Clinical Criteria for Hemangeol™** • Diagnosis of proliferating infantile hemangioma requiring systemic therapy
atenolol **bisoprolol** **carvedilol** **labetalol** **metoprolol tartrate**	*acebutolol* *Betapace®IR & AF®* *betaxolol* ~~*Bystolic®*~~ *Carvedilol ER*	

Preferred Agents	Non-Preferred Agents	SA Criteria
metoprolol succinate **propranolol tab & ER/soln** **Sorine®** **sotalol AF** **sotalol HCL**	*Coreg® IR & CR®* *Corgard®* **Hemangeol™* *Inderal® XL* *Innopran® XL* *Kapspargo™ Sprinkle* *Levatol®* *Lopressor®* *nebivolol* *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**	*Adalat CC®* *Conjupri®* *Consensi®* *(amlodipine/celecoxib)*	

Preferred Agents	Non-Preferred Agents	SA Criteria
nifedipine ER	*felodipine ER* *isradipine* *Katerzia™oral suspension* *levamlodipine (generic Conjupri®)* *nisolndipine* *nicardipine* *Norliqva®* *Norvasc®* *Procardia XL®* *Sular®*	
Calcium Channel Blockers- Non-Dihydropyridine		
Cartia XT® **diltiazem IR, ER q12hr & 24hr** **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*	

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Lipotropics		
Bile Acid Sequestrants		**LENGTH OF AUTHORIZATIONS**: 1 year
cholestyramine powder reg & light **colestipol tab** **Prevalite®**	*Colestid® granule/packet/tab* *colesevelam tab and Pkt (generic Welchol)* *colestipol HCl granules* *Questran® powder/powder Light* *Welchol® pack, tab*	**Routine PDL edits plus**
Cholesterol Absorption Inhibitor (CAI) and /or ACL Inhibitor (adenosine triphosphate citrate lyase)		**Routine PDL Plus** **Clinical criteria Nexletol™ or Nexlizet™** **Initial Approval Criteria** • Patient is ≥ 18 years of age; AND • Patient has diagnosis of heterozygous familial hypercholesterolemia (HeFH) or established atherosclerotic cardiovascular disease (ASCVD); AND • Patient has failed to achieve a target LDL-C despite physician attestation that the patient is adherent to maximally tolerated doses of statins prior to the lipid panel demonstrating suboptimal reduction; AND • Patient can be classified into ONE of the following risk factor groups: o Extremely high risk ASCVD: (defined as extensive or active burden of ASCVD, or ASCVD with extremely high burden of adverse or poorly controlled risk cardio-metabolic risk factors including HeFH or severe hypercholesterolemia [SH] LDL-C > 220 mg/dl) with an LDL-C ≥ 70 mg/dL; OR o Very high risk ASCVD: (defined as less extensive ASCVD and poorly controlled cardiometabolic risk factors) with an LDL-C ≥ 100 mg/dL; OR o High risk ASCVD: (defined as either less extensive ASCVD and well-controlled risk factors or primary prevention HeFH or SH >220 mg/dl with poorly controlled risk factors) with LDL-C ≥ 130 mg/dL; AND • Therapy will be used in conjunction with maximally tolerated doses of a statin; AND
ezetimibe	*Nexletol® (bempedoic acid)* *Nexlizet® (bempedoic acid/ ezetimibe)* *Zetia®*	

Preferred Agents	Non-Preferred Agents	SA Criteria
		• Therapy will not be used with concurrent doses of simvastatin > 20 mg or pravastatin > 40mg; **Renewal Criteria** • Laboratory analyses demonstrate a reduction in LDL-C when compared to the baseline values (prior to initiating bempedoic acid or bempedoic acid/ezetimibe); AND • Patient has shown continued adherence to maximally tolerated statin dosage
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®*	

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	rosuvastatin-ezetimibe *simvastatin soln (generic Flolipid)* *simvastatin/ezetimibe* *Vytorin®* *Zocor®* *Zypitamag ™*	
HMG CoA Reductase Inhibitors and Combinations (Statins)		
lovastatin **pravastatin**	*Altoprev®* *fluvastatin* *Lescol®and Lescol XL®* *Mevacor®* *Pravachol®*	
Microsomal Triglyceride Transfer Protein Inhibitor		***Clinical Criteria for Juxtapid™. Refer to Juxtapid™ SA Fax Form**
	**Juxtapid ™*	
Niacin Derivatives		
niacin ER	*Niaspan®* *Niacor®*	
Omega 3 Fatty Acid Agent		*****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. **LENGTH OF AUTHORIZATIONS**: Three months for initial approval; six months for renewal
omega-3 acid ethyl esters (ST) **Omega-3 OTC**	*icosapent ethyl (generic Vascepa®)* ****Lovaza® (ST)* *Vascepa®(ST)*	
***Proprotein Convertase Subtilisin Kexin Type 9 (PCSK9) Inhibitors**		***ALL PCSK9 Inhibitors require the submission of a Clinical SA. Refer to Lipotropics, Other SA Form**
	Leqvio® *Praluent®* *Repatha®*	
Platelet Inhibitors		
Brilinta® **clopidogrel** **dipyridamole** **prasugrel (generic Effient®)**	**Aggrenox®* **ASA/dipyridamole* ***ASA/omeprazole (generic Yosprala®)* ***Durlaza ER™*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits plus** **Clinical Criteria for Select Non-Preferred Platelet Inhibitors** ***Aggrenox® & ASA/dipyridamole**

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	Effient® *Persantine®* *Plavix®* ***Yosprala® Tab* ****Zontivity™*	• 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** • 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®* *Tyvaso DPI™ (treprostinil)*	
Oral Endothelin Receptor Antagonist		**Routine PDL edits plus**
ambrisentan (generic Letairis) 5 & 10mg **Tracleer® tab**	*bosentan (generic Tracleer®)* *Letairis® 5 & 10 mg* *Opsumit®* *Tracleer® susp*	
***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 tab to receive a SA for injectable Revatio®
Alyq (tadalafil) **sildenafil tab/susp** **tadalafil**	*Adcirca®* *Revatio® tab/inj/susp*	
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 **rivastigmine (transderm)**	*Adlarity®* *Aricept® ODT, tab* *Exelon® cap &Exelon® (transderm)* *galantamine IR, ER tab/soln* *Namzaric®* **(***donepezil/memantine)* *Razadyne® IR, ER* *rivastigmine cap*	
NMDA Receptor Antagonist		
memantine tab	*memantine Dose Pack,* soln *memantine ER* *Namenda® Dose Pack/XR tab* *Namenda® tab*	
Anticonvulsants **CLOSED CLASS**		
Barbiturates		**LENGTH OF AUTHORIZATIONS:** **1 year** **Routine PDL**
phenobarbital elixir/tab **primidone**	*Mysolnine®*	
Benzodiazepines		
clobazam tab/susp **clonazepam tab** **Diastat® rectal** **Diastat® AcuDial™ rectal** **diazepam rectal & Device rectal** **Valtoco® Nasal**	*clonazepam ODT* *clorazepate* *Klonopin Tab* *Nayzilam®* *Onfi®susp/tab* *Sympazan ™ (clobazam)* *Tranxene®*	
Cannabidiol		
***Epidioex® (cannabidiol)**		***Clinical Criteria for Epidiolex®** (reviewed electronically, AutoPA) Duration of Approval: 1 year • Patient must be ≥ 1 years of age; AND

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
		• Patient has been diagnosed with: o Epilepsy and recurrent seizures including Lennox-Gastaut syndrome, o Dravet syndrome, or tuberous sclerosis complex
Carbamazepine Derivatives		
carbamazepine chewable **tab/susp/tab** **Carbatrol®** **Epitol** **oxcarbazepine tab** **Tegretol®XR** **Trileptal® susp**	*Aptiom®* *carbamazepine ER* *carbamazepine XR* *Equetro® cap* *Oxtellar™ XR* *oxcarbazepine susp* *Tegretol® susp/tab* *Trileptal®tab*	
Hydantoins		
Dilantin 30mg **phenytoin cap/chew tab/ susp** **phenytoin ext cap**	*Dilantin® cap & Infatab, susp* *Peganone®* *Phenytek®*	
Succinimides		
ethosuximide cap/syrup	*Celontin®* *Zarontin® cap/syrup*	
Valproic Acid and Derivatives		
divalproex tab/sprinkle **divalproex ER** **valproic acid cap, soln**	*Depakote® ER & sprinkle*	
Other Anticonvulsants		
Gabitril® **lacosamide soln/tab (gen Vimpat®)** **Lamictal® ODT/ODT dose pk** **lamotrigine tab** **lamotrigine chew tab** **lamotrigine XR** **levetiracetam soln/tab** **levetiracetam ER**	*Banzel® susp/tab* *Briviact®* tab/soln *Diacomit®* cap/powder pack *Elepsia®XR tab* *Eprontia ™* *felbamate susp/tab* *Felbatol® susp/tab* ***** *Fintepla®* *Fycompa® susp/tab* *Keppra® soln/tab*	***Clinical Criteria for Fintepla®** • Patient is at least two years of age or older; AND • Patient must have a diagnosis of Dravet syndrome

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
roweepra (generic levetiracetam) **subvenite tab (generic lamotrigine)** **topiramate tab/sprinkle cap** **zonisamide cap**	*Keppra® XR* *Lamictal® XR & XR dose pk* *Lamictal® tab/dose pk* *lamotrigine tab dose pk & ODT* *rufinamide susp/tab (generic Banzel®)* *Qudexy ™ XR* *Sabril® powder pack/tab* *Spritam®* *subvenite dose pk* *tiagabine* *Topamax® tab/sprinkle* *topiramate ER cap* *Trokendi™ XR* *vigabatrin tab/ powder pack (generic Sabril®)* *Vimpat® soln/tab* *Xcopri®*	
Antidepressants		
Other		**LENGTH OF AUTHORIZATIONS:** **1 year** **Routine PDL edits**
bupropion IR, SR &XL **desvenlafaxine ER tab (generic for Pristiq®)** **mirtazapine ODT/tab** **trazodone tab** **venlafaxine IR tab & ER cap**	*Aplenzin®* *Brintellix®* *bupropion XL (generic Forfivo® XL)* *desvenlafaxine ER tab (generic for Khedezla™)* *Effexor® XR* *Emsam® transdermal* *Fetzima®* *Forfivo® XL* *Khedezla™* *Marplan®* *Nardil®* *nefazodone* *Parnate®*	

Preferred Agents	Non-Preferred Agents	SA Criteria
	phenelzine *Pristiq®* *Remeron® ODT/tab* *tranylcypromine sulfate* *Trintellix* *venlafaxine ER tab* *Viibryd® tab/dose pk* *vilazodone tab gen for Viibryd®* *Wellbutrin® IR, SR & XL*	
SSRI		
citalopram soln/tab **escitalopram tab** **fluoxetine cap/soln** **fluvoxamine tab** **paroxetine tab** **sertraline conc, soln, tab**	*Brisdelle®* *Celexa® tab* *citalopram HBR 30mg* *escitalopram soln* *fluoxetine DR cap/tab* *fluvoxamine ER* *Lexapro® tab* *Luvox® CR* *paroxetine CR* *paroxetine susp* *Paxil® tab/susp & Paxil® CR* *Pexeva®* *Prozac® cap/weekly* *Sarafem®* *sertraline cap* *Zoloft® conc/tab*	
Antimigraine Agents		
sumatriptan succinate tab **cartridge/vial/pen** **Imitrex® nasal** **rizatriptan tab/MLT**	*almotriptan* *Alsuma®* *Amerge®* *Axert®* *Cambia®* *eletriptan (generic Relpax®)* *Frova®* *frovatriptan (generic Frova®)*	**LENGTH OF AUTHORIZATIONS:** **1 year** **Routine PDL edi**

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	Imitrex® cartridge/pen/tab/vial *Maxalt® tab & MLT* *Migranow™ Kit* *naratriptan* *Onzetra™ Xsail™* *Relpax®* *sumatriptan KITS* *Sumavel® Dosepro* *sumatriptan/naproxen (generic Treximet®)* *Tosymra* *Treximet®* *Zembrace ™ SymTouch ™* *zolmitriptan nasal* *Zomig® tab/nasal spray/ZMT*	
Antimigraine Agents, Others CLOSED CLASS **Calcitonin Gene-related Peptide Antagonist (CGRP)**		
Ajovy® Autoinjector & Syringe **Ajovy Autoinjector 3-Pk** **Emgality™ Syringe** **Emgality™ Pen** **Nurtec™ ODT**	*Aimovig™* *Emgality™ 100MG Syringe* *Qulipta™*	***All Nonpreferred CGRPs require the submission of a Clinical SA. Refer to fax form Antimigraine Agents, Others SA Form** **Preferred Ajovy®, Emgality™, Nurtec™ ODT requires a trial of 2 generic triptans, no clinical SA (AutoPA)**
Acute treatment of migraine		
Nurtec™ ODT	*Reyvow®* *Trudhesa™ Nasal Spray* *Ubrelvy®*	**Nurtec™ ODT has a quantity limit of 17 tablets per 34 days**
***Antipsychotics *(AGE)* CLOSED CLASS**		
Atypical		**LENGTH OF AUTHORIZATIONS: 1 year or 6 months for members < 18 yrs**
aripiprazole tab **clozapine tab** **Latuda®** **olanzapine ODT, tab, IM**	*Abilify® tab/IM inj* ****Abilify Mycite®(with sensor)* ***aripiprazole ODT, soln*	**Routine PDL edits plus**

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
quetiapine tab **quetiapine fumarate ER** **risperidone ODT/soln/tab** **ziprasidone cap**	*asenapine (generic for Saphris®)* *Caplyta Capsule™* *Clozaril®* *clozapine ODT* *Fanapt® tab & titration pk* *Fazaclo®* ***Geodon® tab, IM* *Invega®* *Lybalvi®* ***Nuplazid™ tab, cap (QL)* ***olanzapine/fluoxetine* *paliperidone ER* *quetiapine fumarate ER (authorized generic only)* *Rexulti® tab* *Risperdal® ODT/soln/tab* *Saphris®* *Secuado®Patch* *Seroquel® IR* *Seroquel® XR* *Versacloz™* *Vraylar™* *ziprasidone IM (gen Geodon®)* *Zyprexa® tab/IM/Zydis*	***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 • 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,

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
		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		**LENGTH OF AUTHORIZATIONS:** **1 year**
Abilify Maintena® **Aristada®** **Aristada® Initio** **Risperdal Consta®** **Invega Hafyera™, Sustenna® &Trinza®**	*Perseris™ (risperidone)* *Zyprexa® Relprevv™*	**Routine PDL edits**
Typical		**LENGTH OF AUTHORIZATIONS:** **1 year**
amitriptyline/perphenazine **chlorpromazine** **fluphenazine elixir/soln/tab** **fluphenazine decantate** **haloperidol decantate** **haloperidol lactate conc** **haloperidol tab** **loxapine** **perphenazine** **trifluoperazine** **thiothixene** **thioridazine**	*Adasuve®* *Haldol decanoate (injection)* *pimozide* *Moban®* *molindone*	**Routine PDL edits**
***Movement Disorders** **CLOSED CLASS**		
Austedo® tab **Ingrezza® cap** **Ingrezza® Initiation Pack**		**LENGTH OF AUTHORIZATIONS:** **1 year** ***Clinical Criteria for Movement Disorders** • Diagnoses of Tardive Dyskinesia or Huntington's disease

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
tetrabenazine tab (generic Xenazine®) **Xenazine® tab**		• Prescribed by or in consult with a neurologist or psychiatrist • Quantity limit o 4 tabs/day, for Austedo® o 1 cap/day Ingrezza® o 4 tabs/day Xenazine®
Neuropathic Pain		
capsaicin OTC topical **duloxetine 20, 30 & 60 mg (generic for Cymbalta®)** **gabapentin cap/tab/soln** **lidocaine 5% patch** **pregabalin cap**	*Cymbalta®* *Dermacinrx® PHN Pak™ Kit* *Drizalma™ Sprinkle* *duloxetine 40 mg (generic Irenka™)* *Gralise™ (gabapentin, ER)* *Horizant ™ (gabapentin enacarbil ER)* *Irenka™* *Lidoderm® patch* *LidoPure Patch* *Lyrica® / CR/ soln* *Neurontin® cap/tab/soln* *pregabalin soln, ER* *Qutenza Kit® (Topical) (capsaicin)* *Savella™ & Savella™ Dose Pak* *Zilacaine Patch* *Ztlido™ 1.8% (lidocaine topical system)*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL** Plus **Criteria for Lyrica solution:** − If diagnosis is epilepsy/seizures, patient must have a problem swallowing tabs/capsules AND clinical reason why at least TWO preferred seizure medications cannot be used. − For other diagnoses, patient must have a problem swallowing tabs/capsules AND routine PDL • If Lyrica CR is requested, routine PDL applies. Note – This is NOT indicated for epilepsy/seizures.
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*	**LENGTH OF AUTHORIZATIONS**: Length of the prescription (up to 3 months)

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	flurazepam *Halcion®* *Restoril®* *temazepam 7.5 mg & 22.5 mg* *triazolam*	**Routine PDL edits**
Sedatives / Hypnotics (Non-Benzodiazepine)		
eszopiclone **zaleplon** **zolpidem**	*Ambien®IR & CR* *Belsomra®* *Dayvigo™* *doxepin (generic for Silenor®)* *Edluar™* **Hetlioz®* ***Hetlioz™ LQ* *Intermezzo®* *Lunesta®* *Quviviq™* *Rozerem®* *Silenor®* *Sonata®* *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 16 years of age or older. • Quantity limit = 1 capsule per day. ****Clinical Criteria for Hetlioz™** LQ oral suspension • For the treatment Nighttime sleep disturbances in SMS in pediatric patients **AND** • Member must be 3 years to 15 years of age.
Skeletal Muscle Relaxants		
baclofen **chlorzoxazone** **cyclobenzaprine HCL** **dantrolene sodium** **methocarbamol** **tizanidine tab**	*Amrix®* *baclofen soln* **carisoprodol* **carisoprodol/ASA* **carisoprodol/ASA/codeine* *cyclobenzaprine ER* *Dantrium®* *Fexmid®* *Fleqsuvy™* *Lorzone®* *Lyvispah™*	**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
	metaxalone *orphenadrine citrate* *orphenadrine/ASA/caffeine* *Parafon Forte® DSC* *Robaxin®* *Skelaxin®* **Soma®* *tizanidine cap* *Zanaflex®*	
Smoking Cessation		
bupropion SR **Chantix®** **Chantix® DS PK** **nicotine gum/lozenge/patch** **varenicline**	*Nicoderm CQ® Patch* *Nicorette® Gum/Lozenges* *Nicotrol® Inhaler & NS* *Zyban®*	**LENGTH OF AUTHORIZATIONS:** 6 months **Routine PDL edits**
***Stimulants/ADHD Medications** *(AGE)* **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)* **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®)* *amphetamine susp (generic Adzenys ER™ susp)* *Desoxyn®* *Dexedrine®* *dextroamphetamine SR & soln* *Dyanavel® XR susp* *Evekeo®* *Evekeo™ ODT*	

Preferred Agents	Non-Preferred Agents	SA Criteria
	methamphetamine *Mydayis ER™* *Procentra® soln* *Zenzedi™*	
Methylphenidate Drugs		
All methylphenidate IR generic **Concerta®** **Daytrana® Transdermal** **dexmethylphenidate IR** **dexmethylphenidate XR**	*Adhansia™XR* *Aptensio ™ XR* *Azstarys ™* *Cotempla XR-ODT™* *Focalin® IR & Focalin® XR* *Jornay PM* *Metadate CD® & Metadate ER®* *Methylin ER®, soln IR* *methylphenidate chew & soln* *methylphenidate ER, LA, SR* *methylphenidate ER(generic Relexxii®)* *methylphenidate ER(generic Aptensio™ XR)* *Ritalin® IR, LA® & SR®* *Relexxii®* *QuilliChew ER™* *Quillivant™ XR susp*	
Miscellaneous Drugs		
atomoxetine (generic for Strattera®) **clonidine ER** **guanfacine ER**	***armodafinil (generic Nuvigil™)* ****modafinil* ****Nuvigil ™* ****Provigil®* *Intuniv®* *Qelbree®* *Sunosi™* *Strattera®*	****Nuvigil™/Provigil®/armodafinil/modafinil:** **Refer to Narcolepsy Medications SA Form**

	Preferred Agents	Non-Preferred Agents	SA Criteria
		Wakix®	
Dermatologic			
	***Acne Agents, Topical** *(AGE)*		
	Combo Benzoyl Peroxide, Clindamycin, Erythromycin & other Top		**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.**
	Acne Medication gel, lot **benzoyl peroxide wash, cr, gel, lot (OTC)** **clindacin ETZ 1% pledget** **clindamycin ph 1% solution** **clindamycin Phos 1% pledget, swab** **clindamycin/benzoyl peroxide (Duac®)** **erythromycin solution** **Panoxyl 4 Acne Cr Wash (OTC)** **Panoxyl 10 cleansing bar, foaming wash (OTC)**	*Acanya™ w/pump* *Acne Clearing System® (OTC)* *Aczone® Gel and Gel Pump* *Aklief®* *Amzeeq™* *Arazlo™* *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 phosphate (generic for Clindagel®)* *clindamycin/benzoyl peroxide (generic for Acanya® Pump)*	

	Preferred Agents	Non-Preferred Agents	SA Criteria
		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* *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*	

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	Veltin® *Winlevi®*	
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 (gen Epiduo® and Epiduo® Forte)* *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™0.1% Foam* *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, foam* *tretinoin 0.025, 0.1% cr & 0.01, 0.025, 0.05% gel* *tretinoin microsphere 0.04% & 0.1% gel* *Twyneo®* *Ziana® gel*	***Age Edit for Fabior™ Foam** • Members must be between the ages of 12 and 18 years of age
Antifungal Topical		
antifungal 1% cr, powder **antifungal 2% cr** **ciclopirox soln** **ciclodan 8% soln** **clotrimazole cr (OTC & RX)**	*Alevazol® OTC* *Azolen® Tincture OTC* *Bensal HP®* *Ciclodan® Kit* *ciclopirox cr/shampoo/gel*	**LENGTH OF AUTHORIZATIONS: 6 months** **Routine PDL edits plus**

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	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)**	*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)* **Julia®* *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)* *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*	**Select non-preferred topical Antifungals (CNL-8™, Julia®, Kerydin™, Luzu®, Penlac®) require the submission of a Clinical SA. Refer to Antifungal Topical SA Form**

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	Pediaderm AF® *PediPak®* **Penlac®* *tavaborole (generic Kerydin®)* *Tinactin® Aero powder/spray(OTC)* *tolnaftate aero powde/spray (OTC)* *Vusion®*	
Immunomodulators Atopic Dermatitis **CLOSED CLASS**		
****Dupixent ®*** ****Elidel®*** ****Eucrisa™*** *****tacrolimus***	*****Adbry™*** *pimecrolimus (generic Elidel)* *****Opzelura™*** *Protopic®*	LENGTH OF AUTHORIZATIONS: 1 year; ~~EXCEPT Dupixent®~~ Routine PDL edits plus Clinical Criteria for Atopic Dermatitis-all drugs • Member must have an FDA approved diagnosis: Atopic dermatitis AND • Age and severity for drug as follows below: o Adbry™: moderate to severe for ages ≥ 18 years o Elidel®: tacrolimus mild to moderate for ages > 2 years o Eucisa™: mild to moderate for ages > 3months o Dupixent; moderate to severe for ages > 6 months o Opzelura™: mild to moderate for ages equal to or > 12 years o Protopic® 0.03%: moderate to severe for ages > 2 years. o Protopic® 0.1%: moderate to severe for ages > 18 years. AND the one that applies: ***Clinical Criteria for Elidel® or tacrolimus*** • Prior documented trial & failure of 8 weeks of one (1) topical corticosteroid of medium to high potency (e.g., mometasone, fluocinolone) ****Clinical Criteria for Eucrisa™ and Dupixent®*** (reviewed electronically, AutoPA look back of 180 days for no more than a 30 day) • Prior documented trial & failure of 30-day trial (or contraindication) of o One (1) topical corticosteroid of medium to high potency (e.g., mometasone, fluocinolone) OR o One (1) topical calcineurin inhibitors (tacrolimus or pimecrolimus)

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
			***** Clinical Criteria for Opzelura™ (topical Janus kinase inhibitor)** • Prior documented trial & failure of 8 weeks of each o One (1) topical corticosteroid of medium to high potency (e.g., mometasone, fluocinolone) AND o One (1) topical calcineurin inhibitors (tacrolimus or pimecrolimus) AND o A trial and failure of Dupixent ® AND o A trial and failure of Eucrisa™ ***** Clinical Criteria for Adbry®** • Prior documented trial & failure of 8 weeks of each o One (1) topical corticosteroid of medium to high potency (e.g., mometasone, fluocinolone) AND o One (1) topical calcineurin inhibitors (tacrolimus or pimecrolimus) AND o A trial and failure of Dupixent ® AND o A trial and failure of Eucrisa™ **QUANTITY LIMITS for Atopic Dermatitis** **Drug** / **Rolling qty limit** Adbry® — 4 syringes/28 days (initial dose) 2 syringes/28 days Dupixent — 2 300 mg inj), Maintance 300 mg (Q2W) Elidel® (pimecrolimus) — 30gm per 30 days Eucrisa® (crisaborole) — 300gm per year Opzelura (ruxolitinib) — 240 gm (4 x 60gm) per 30 days Protopic® (tacrolimus) — 30gm per 30 days **Dupixent other Diagnosis: Fax Form** **Diagnosis of moderate to severe asthma** Patient must have moderate to severe asthma diagnosed as ONE of the following types: o Asthma with eosinophilic phenotype with eosinophil count ≥ 150 cells/mcL; OR o Oral corticosteroid dependent asthma with at least 1 month of daily oral corticosteroid use within the last 3 months; AND o Patient must be 6 years of age or older

Preferred Agents	Non-Preferred Agents	SA Criteria
		Diagnosis of eosinophilic esophagitis (EoE); o Patient ≥12 years old; AND o Patient weighs ≥ 40 kg; AND o Prescribed by or consultation with an allergist or gastroenterologist; AND o Patient did not respond clinically to treatment with a topical glucocorticosteroid or proton pump inhibitor **Diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP);** o Patient ≥ 18 years old o Patient has inadequate response after 3 consistent months use of preferred PDL intranasal steroids or oral corticosteroids; AND o Patient is concurrently treated with intranasal corticosteroids **Diagnosis of Prurigo Nodularis for the treatment of adult patients with prurigo nodularis (PN)** o Age 18 or older o Diagnosis of (PN)
Psoriasis, Topical		
calcipotriene cr/oint/soln	*betamethasone/ calcipotriene* *Calcitrene®* *calcitriol* *calcipotriene/betamethasone (generic for Taclonex®)* *Dovonex®* *Duobrii ™* **Enstilar ® Foam (AGE)* *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		

Preferred Agents	Non-Preferred Agents		SA Criteria
Metrocream® **Metrogel®** **Metrolotion®**	*azelaic acid (generic for Finacea®)* *Epsolay®* *Finacea® foam/gel* *ivermectin (generic Soolantra)* *metronidazole cr/gel/lot* *Mirvaso®* *Noritate®* *Rhofade®* *Rosadan™ Kit* *Soolantra®* *Zilxi™*	**LENGTH OF AUTHORIZATIONS:** **Routine PDL edits**	**1 year**
Steroids			
Steroids, Topical Low Potency		**LENGTH OF AUTHORIZATIONS:** **Routine PDL edits**	**1 year**
hydrocortisone cr/gel/lot/oint **hydrocortisone cr/oint OTC** **hydrocortisone/aloe cr OTC**	*anusoln-hc 2.5% cr* *alclometasone cr/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* *Scalpicin OTC* *Texacort®*		
Steroids, Topical Medium Potency			
fluticasone propionate cr/oint **mometasone furoate cr/oint/soln**	*betamethasone valerate foam* *Beser Lotion and Kit* *clocortolone cr* *Cloderm®* *Cordran® tape*		

	Preferred Agents	Non-Preferred Agents	SA Criteria
		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* *hydrocortisone butyrate (generic for Locoid Lotion)* *hydrocortisone butyrate cr/oint/soln/ emollient* *Locoid Lipocream* *Locoid Lotion* *Luxiq®* *Momexin®* *Pandel®* *prednicarbate cr/oint* *Synalar®* *Synalar TS®* *Ticanase kit®*	
	Steroids, Topical High Potency		**LENGTH OF AUTHORIZATIONS:** **1 year**
	betamethasone valerate cr/lot/oint **triamcinolone acetonide cr/lot/oint**	*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*	**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

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
		Diprolene® lot/oint *DiproleneAF®cr* *Ellzia™ Pak Kit* *fluocinonide cr/ emollient/ gel/oint/soln* *halcinonide cr* *Halog® cr/oint/soln* *Kenalog® aerosoln* *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**	*Apexicon™E* *Bryhali™ (halobetasol propionate)* *clobetasol lot/shampoo* *clobetasol propionate foam/spray* *Clobex® lot/shampoo/spray* *Clobetex® Kit* *Clodan® kit* *Halonate®* *halobetasol propionate oint (generic for Lexette®)* *Impeklo™* *Olux®* *Olux®-E* *Temovate® oint*	

	Preferred Agents	Non-Preferred Agents	SA Criteria
		Ultravate® cr/lotion/oint *Ultravate® PAC & Ultravate® X*	
Endocrine and Metabolic Agents			
	Androgenic Agents (Testosterone – Topical)		
	AndroGel® Pump **Androderm® Patch**	*AndroGel® packet, patch* *Axiron® soln* *Fortesta®* *Natesto Nasal Gel ®* *Testim®* *testosterone pump (generic for AndroGel® Pump)* *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**
	Antihyperuricemics		
	Allopurinol **colchicine tabs** **Probenecid®** **probenecid & colchicine**	*colchicine caps* *Colcrys®* *febuxostat (generic Uloric®)* *Gloperba ®* *Mitigare®* *Uloric®*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits plus**
	Contraceptives*(long-acting IUDs & injectable)		

Preferred Agents	Non-Preferred Agents	SA Criteria
Kyleena™ **Liletta®** **medroxyprogesterone 150mg** **Mirena®** **Nexplanon®** **Paragard®** **Skyla®**	*Depo-Provera® 104mg and 150mg*	**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 90day 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 and Oral Incretin Mimetics CLOSED CLASS		
Byetta® (exenatide) **Trulicity™ (lixisenatide)** **Victoza®** (liraglutide)	*Adlyxin™ (lixisenatide)* *Bydureon™ Bcise SQ* *Mounjaro®* *Ozempic®* *Rybelsus Tab®* *Solniqua® 100/33 (insulin glargine & lixisenatide inj)* *Tanzeum™ (albiglutide)* *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**
Humalog® Mix 50/50 vial **Humalog® Mix 75/25 vial**	*Humalog® Mix 50/50 Kwikpen* *Humalog® Mix 75/25 Kwikpen*	

Preferred Agents	Non-Preferred Agents	SA Criteria
Humulin® 70/30 pen/vial(OTC) **insulin lispro protamine mix kwikpen** **insulin aspart/insulin aspart protamine vial**	*Novolin® 70/30 vial (OTC)* *Novolog® Mix 70/30 pen/vial*	**Routine PDL edits**
Insulin N		
Humulin® N pen/vial (OTC)	*Humulin® N pen* *Novolin® N vial (OTC)*	
Insulin R		
Humulin® R pen/vial	*Novolin® R vial (OTC)*	
Long-Acting Insulins		
Lantus® Solostar® & vial (*insulin glargine)* **Levemir® pen/vial** *(insulin detemir)*	*Basaglar® KwikPen® (insulin glargine)* *(insulin glargine Solostar gen Lantus® and Lantus Solostar®)* *Semglee™ (insulin glargine)* *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/pen** **Humalog® Cartridge** **Humalog Kwikpen 100 unit/ml** **Humalog Jr. Kwikpen** **Novolog® cart/vial/Flexpen** **insulin lispro vial** **insulin lispro Jr. Kwikpen** **insulin lispro Pen** **insulin aspart cartridge pen/vial**	*Admelog® Solostar Pen/vial* *Afrezza® cartridge (inhalation)* *Apidra® cartridge/Solostar/vial* *Fiasp®/FlexTouch® Pen/PenFill®* *Humalog Kwikpen 200 unit/ml* *Lyumjev™*	

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
insulin aspart/insulin aspart protamine insulin pen		
Diabetes Oral Hypoglycemics		
Oral Hypoglycemics Alpha-Glucosidase Inhibitors		**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits plus** Age edit for all Oral Hypoglycemics is 18 years of age or older, except Metformin which is 10 years of age.
acarbose	*Glyset®* *miglitol (generic Glyset®)*	
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™)* *Glyxambi®* *Jentadueto XR™*	

Preferred Agents	Non-Preferred Agents	SA Criteria
	Kazano™ *Kombiglyze XR™* *Nesina™* *Onglyza™* *Oseni™* *Qtern®* *Steglujan™* *Trijardy™ XR*	
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®*	
***Oral Hypoglycemics Sodium Glucose Co-Transporter 2 Inhibitor CLOSED CLASS**		
Farxiga™ **Invokana™** **Invokamet™** **Invokamet™ XR** **Jardiance®** **Synjardy®** **Xigduo™ XR**	*Synjardy® XR* *Segluromet™* *Steglatro™*	

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

1/1/23

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Oral Hypoglycemics Thiazolidinediones		
pioglitazone	*Avandia®* *Actoplus Met® IR & XR* *Actos®* *Avandaryl®* *Avandamet®* *Duetact®* *pioglitazone/metformin* *pioglitazone/glimepiride*	
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*
Glucagon Agents (CLOSED CLASS)		
Baqsimi nasal **Glucagon inj** **Glucagon emergency kit (Fresenius) inj** **Gvoke pen, syringe, vial SQ** **Proglycem suspension oral**	*Diazoxide suspension oral* *Glucagon emergency kit (Lilly) inj* *Zegalogue Autoinjector & syringe SQ*	**LENGTH OF AUTHORIZATIONS**: **1 year** **Routine PDL**
Glucocorticoids, Oral		
budesonide EC **dexamethasone soln/tab** **hydrocortisone** **methylprednisolnone dose pk** **methylprednisolnone 4 mg tab** **prednisolnone sodium phosphate soln** **prednisolone soln** **prednisone soln/tab/dose pk**	*Alkindi® Sprinkle* *Cortef®* *cortisone acetate* *dexamethasone elixir/intensoln* *Dexpak®* **Emflaza™ (AGE)* *Entocort® EC* *Flo-Pred®* *Hemady®* *Medrol ® dose pk/tab* *methylprednisolnone 8,16 & 32mg tab*	**LENGTH OF AUTHORIZATIONS**: **1 year** **Routine PDL edits plus** ***Clinical Criteria for Emflaza™** • Trial and failure of all drugs does not apply to Emflaza™ • Diagnosis for treatment of Duchenne muscular dystrophy (DMD) • Minimum Age Limit = 2 years of age

Preferred Agents	Non-Preferred Agents	SA Criteria
	Millipred DP® tab Does Pk *Millipred® soln/tab* *Orapred ®ODT* *Ortikos™* *prednisolnone sod phosphate ODT/ soln* *prednisone intensoln* *Rayos® DR tab* *TaperDex®* *Tarpeyo™* *Veripred®*	
***Growth Hormone**	**CLOSED CLASS**	
Genotropin® Cartridge, Miniquick **Norditropin FlexPro®**	*Humatrope® cartridge/vial* *Nutropin AQ® NuSpin™* *Omnitrope® cartridge/vial* *Saizen® cartridge/vial* *Serostim® vial* *Skytrofa™* *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)**
***Hereditary Angioedema (HAE) Agents**		
Berinert® **Cinryze™** **Kalbitor®**	*Firazyr®* *Haegarda®* *icatibant (generic Firazyr®)* *Orladeyo™* *Ruconest®* *Takhzyro™*	**LENGTH OF AUTHORIZATIONS:** 1 year **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** ****Black box warning KALBITOR®** **Anaphylaxis has been reported after administration of KALBITOR®. Because of the risk of anaphylaxis, KALBITOR should only be administered by a healthcare professional with appropriate medical support to manage anaphylaxis and hereditary angioedema. Healthcare professionals should be aware of the similarity of symptoms between hypersensitivity reactions and hereditary angioedema and patients should**

Preferred Agents	Non-Preferred Agents	SA Criteria
		be monitored closely.
***Pancreatic Enzymes**		

Creon®
Zenpep®
	Pancreaze®
	Pertzye®
	Ultresa®
	Viokace®
		LENGTH OF AUTHORIZATION: 1 year
		Routine PDL edits plus
		***Clinical Criteria for Pancreatic Enzymes**
		• All drugs preferred and non preferred require a diagnosis of pancreatic insufficiency due to cystic fibrosis or chronic pancreatitis or pancreatectomy.
		  • If a member has a diagnosis of Cystic Fibrosis they do not have to try and fail of a preferred.
		  • If member has a feeding tube, then two different pancreatic enzymes can be approved for use together.

Progestational Agents CLOSED CLASS		
Makena® Auto-injector **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)& Single Dose Vial (SDV)* *Prometrium®* *Provera®*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits**
Progestins Used For Cachexia		
megestrol acetate	*Megace®* *Megace® ES*	**LENGTH OF AUTHORIZATIONS**: 1 year

	Preferred Agents	Non-Preferred Agents	SA Criteria
		megestrol suspension ES	**Routine PDL edits**
	Vaginal Estrogens		
	Premarin® Vaginal cr **Vagifem® Vaginal tab**	*Estrace ®Vaginal cr* *estradiol cream (gen Estrace®)* *Estring® Vaginal ring* *Femring® Vaginal ring* *Imvexxy®* *Intrarosa™* *Yuvafem®*	**LENGTH OF AUTHORIZATIONS**: 6 months **Routine PDL edits**
	Weight Management Agents (CLOSED CLASS)		
	Contrave **orlistat** **Qsymia** **Saxenda SQ** **Xenical** **Wegovy SQ**	*Imcivree SQ*	**Length of authorization:** As indicated on fax form **Routine PDL edits plus** **Weight Management Agents SA Form**
Gastrointestinal			
	G I Antibiotics		
	Firvanq™ soln **metronidazole tab** **vancomycin cap**	**Aemcolo™* *Alinia®* *Dificid®* *Flagyl® cap/ER* *metronidazole cap* *neomycin* *nitazoxanide (generic Alinia®)* *paromomycin* *Solnosec™* *Tindamax®* *tinidazole* ***Xifaxan®* *vancomycin compounded oral soln kit*	**Length of authorization:** 1 year **Routine PDL edits** ***Clinical Criteria for Aemcolo** • Diagnosis of travelers' diarrhea with moderate diarrhea that is distressing or interfereswith planned activities AND • Documentation of a history of failure, contraindication, or intolerance to one or moreof the following: Azithromycin (generic Zithromax), Ciprofloxacin (generic Cipro), Levofloxacin (generic Levaquin), Ofloxacin (generic Floxin) ****Clinical Criteria for Xifaxan** Xifaxan®: 200 mg tabs: –

Preferred Agents	Non-Preferred Agents	SA Criteria
	Vancocin®	• Treatment of travelers' diarrhea caused by noninvasive strains of E. coli in patients • ≥ 12 years of age – • Quantity limit = 9 tabs per claim • Length of authorization 1 month Xifaxan®550 mg tabs: – • Reduction in risk of overt hepatic encephalopathy recurrence in patients o ≥ 18 years of age. o 2 tablets/day OR – • Treatment of irritable bowel syndrome with diarrhea (IBS-D) in patients o ≥ 18 years of age – o 3 times a day for 14 days. o 42 tablets /14 days, can be retreated up to two times with the same regimen o Max 126 tablets per 365 days Length of authorization = 3 months
Antiemetic/Antivertigo Agents		
Cannabinoids (delta-9THC derivatives)		**LENGTH OF AUTHORIZATIONS:** 6 months
***dronabinol cap**	**Cesamet™* **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/soln/tab	*Aloxi®* *Anzemet®* *Akynzeo®* *granisetron tab, vial* *Kytril® tab* *ondansetron vial, amp, syringe* *palonosetron vial, syringe* *Sancuso® patch* *Sustol®* *Zofran® ODT/soln/tab* *Zuplenz® film*	**Routine PDL**

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
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* *Emend® vial* *fosaprepitant vial* *Varubi™ IV, Tab*	
Other		**LENGTH OF AUTHORIZATIONS**: 1 year, unless otherwise noted
meclizine (OTC, Rx) **metoclopramide soln, syr, tab, vial** ****Phenadoz® supp** **prochlorperazine tab** ****promethazine soln, syrp, tab** *(AGE)*	*Antivert®* *Barhemsys®* *Bonjesta™* *Compazine® supp/tab* *Compro®* *Diclegis®* *dimenhydrinate tab, vial* *doxylamine succinate/ vit B6* *Metozolv® ODT* *metoclopramide ODT* ***Phenergan® (AGE)* *prochlorperazine supp, vial* ***promethazine 50mg supp (AGE)* *Reglan®* *scopolamine (gen Transderm-Scop®)* *Tigan®* *Transderm-Scop®* *trimethobenzamide* *Vistaril®*	**Promethazine products approved for members ≥ 2 years
***GI Motility, Chronic**		

Preferred Agents	Non-Preferred Agents	SA Criteria
Amitiza® **Linzess™** **Movantik®**	*alosetron* *lubiprostone (generic Amitiza®)* *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®* *Talicia®*	**LENGTH OF AUTHORIZATIONS**: 14 days **Routine PDL edits**
Histamine-2 Receptor Antagonists (H-2 RA)		
famotidine (OTC & RX) ***famotidine oral susp**	*cimetidine tab/syrup (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 plus** ***AutoPA for famotidine oral susp** • Is under 12 years of age • Continuation of therapy, has a claim in past 90 days • Is using a Tube feeding
Proton Pump Inhibitors		
omeprazole RX **pantoprazole** **Protonix® susp**	*Aciphex® DR tab/sprinkle* *dexlansoprazole dr (gen Dexilant®)* *Dexilant®* *esomeprazole magnesium cap/susp*	**LENGTH OF AUTHORIZATIONS**: 12 weeks; unless member meets an exception; then 1 year **Routine PDL edits plus**

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	esomeprazole strontium *lansoprazole cap* *Nexium®* *omeprazole OTC* *omeprazole magnesium OTC* *omeprazole/sodium bicarbonate* *pantoprazole susp (generic Protonix® susp)* *Prevacid® RX, OTC& SoluTab* *Prilosec® Rx & Susp* *Protonix®* *rabeprazole DR tab* *Zegerid® cap/OTC/susp packet*	***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 8week supply*
Apriso® **balsalazide disodium** **Pentasa®** **sulfasalazine DR & IR**	*Asacol ®HD* *Azulfidine® IR &DR* *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®*	

	Preferred Agents	Non-Preferred Agents	SA Criteria
		Uceris®	
Genitourinary			
	Alpha-Blockers and Androgen Hormone Inhibitors For Benign Prostatic Hypertrophy (BPH)		
	Alpha-Blockers for BPH		**LENGTH OF AUTHORIZATIONS:** **1 year** **Routine PDL edits plus**
	alfuzosin **tamsulosin HCL**	*Flomax ®* *Rapaflo®* *silodosin (generic Rapaflo)* *Uroxatral®*	
	Androgen Hormone Inhibitors for BPH		
	dutasteride **finasteride**	*Avodart ®* *dutasteride/tamsulosin* *Jalyn®* *Proscar®*	
	Phosphodiesterase (PDE) 5 Inhibitor for BPH		***Step edit for Cialis®** & tadalafil 2.5 and 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** **solnifenacin** **Toviaz™**	*darifenacin ER (generic Enablex®)* *Detrol® & Detrol® LA* *Ditropan® & *Ditropan® XL* *flavoxate* *Gelnique™ gel/gel Pump* *Gemtesa®* *Myrbetriq™ tab, Granules* *Oxytrol® transdermal includes OTC* *Sanctura XR* *trospium IR & ER* *tolterodine IR & ER*	

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
		VESIcare® and LS	
Immunological Agents			
	***Multiple Sclerosis** **CLOSED CLASS**		
	Avonex® **Avonex® Adm Pack** **Betaseron®** **Copaxone 20 mg syringe®** **dimethyl fumarate and Starter Pack** ****Kesimpta® (ST)**	****Ampyra®* *Aubagio®* *Bafiertam™ (monomethyl fumarate)* *Copaxone® 40 mg syringe®* *Extavia® Kit* **Gilenya®* *Glatopa™* *****Mavenclad®* *****Mayzent®* *Plegridy®* *****Ponvory™* *Rebif® SQ* *Rebif® Rebidose Pen®* *Tecfidera®* *Tecfidera® Starter Pack* *****Vumerity™* *****Zeposia®*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits plus.** ***All agents require adherence to the documented PI age and diagnosis.** ****Kesimpta® requires step trial of dimethyl fumarate (generic Tecfidera®) or a preferred Injectable agent, to be determined by an AutoPA.** **Multiple Sclerosis SA Form** *****Select non-preferred MS drugs (Amprya®) require the submission of a Clinical SA. Refer to MS - Ampyra® SA form**
	Drugs to improve walking in patients with (MS)		
		****Ampyra®* ****dalfampridine ER (generic Ampyra®)*	
	Cytokine and CAM Antagonists And Related Agents **CLOSED CLASS**		
	Enbrel® Pen, Sureclick, Syringe, Vial **Humira® Pen, Syringe** **Inflectra®** **methotrexate tab/PF vial/MDV**	*Actemra® SQ & ACTPEN* *Arcalyst®* *Avsola™* *Cibinqo™* *Cimzia® & Cimzia® Syringe Kit*	**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**

	Preferred Agents	Non-Preferred Agents	SA Criteria
		Cosentyx™ *Enspryng™* *Entyvio®* *Ilaris®* *Ilumya™* *infliximab (gen Remicade®)* *Kevzara® inj, pen* *Kineret®* *Olumiant®* *Orencia®* *Otezla®* *Otrexup®* *Rasuvo™* *RediTrex®* *Remicade®* *Renflexis®* *Rinvoq™* *Skyrizi™ syringe, Pen* *Siliq®* *Simponi®* *Stelara® vial/syringe* *Taltz®* *Tremfya™* *Trexall®* *Uplizna®* *Xatmep™* *Xeljanz™, Xeljanz™ XR and solution*	**** See Cytokine and CAM Antagonists Appendix A for Clinical Criteria**** For a list of Cytokine and CAM Antagonists and criteria for approval see **Appendix A**
Ophthalmic			
	Antibiotics		
	bacitracin/polymyxin b sulfate oint **ciprofloxacin drops** **erythromycin**	*AzaSite™ drops* *bacitracin* *Besivance® drops* ~~*Bleph® -10*~~	**LENGTH OF AUTHORIZATIONS**: Date of service only; no refills **Routine PDL edits**

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
gentamicin drops/oint **moxifloxacin drops (generic Vigamox)** **ofloxacin drops** **polymyxin/trimethoprim** **tobramycin**	*Ciloxan® drops/oint* *Garamycin ®drops/oint* *gatifloxacin 0.5% soln* *Ilotycin®* *levofloxacin drops* *moxifloxacin drops (generic Moxeza®)* *Natacyn®* *neomycin/polymix/gramicidin* *neomycin/bacitracin/polymyxin oint* *Neosporin ®* *Ocuflox®* *Polytrim®* *sulfacetamide oint/ soln* *Tobrex® drops/oint* *Vigamox®* *Zymaxid®*	
Antibiotic/Steroid Combinations		
neomycin/polymyxin/dexamethasone oint/susp **sulfacetamide/prednisolnone** **Tobradex® oint/susp**	~~*Blephamide®*~~ *Blephamide® S.O.P.* *Maxitrol® oint/susp* *neomycin/bacitracin/poly/HC* *neomycin/polymyxin/HC* *Pred-G®oint/~~susp~~* *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**	*bepotastine (gen Bepreve®)* *Bepreve®* *Elestat®*	

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
olopatadine (generic Patanol & Pataday) **Zaditor® OTC**	*epinastine 0.05% eye drops* **Ilevro™ 0.3% (QL)* *Lastacaft®* *Optivar®* *Patanol® Rx and OTC* *Pataday® Rx and OTC* *Zerviate ™*	
Mast Cell Stabilizers		
cromolyn sodium	*Alocril®* *Alomide®*	
Anti-inflammatory Agents		
Corticosteroids		
Durezol® **fluorometholone** **prednisolnone acetate**	*Alrex™* *Dexamethasone* *difluprednate (gen Durezol®)* *Flarex®* *FML®, FML Forte® & ~~FML® S.O.P~~.* *loteprednol etabonate (generic Lotemax™gel)* *Lotemax™ drops/gel/oint* *Maxidex®* *Omnipred®* *Pred Forte® & Pred Mild®* *prednisolnone sod phosphate* *Vexol®*	
Immunomodulators	CLOSED CLASS	
Restasis® **Restasis Multidose®** **Xiidra®**	*Cequa™* *cyclosporine* **Eysuvis* *Tyrvaya™ Nasal Spray*	*DUR DURATION LIMIT Eysuvis 1 bottle in 3 months, message returned to pharmacist stating "Limitation Exceeded: Quantity Limit of 1 Bottle per 3 Months. Patient needs Intraocular Pressure (IOP) Test. If IOP test completed, Physician to call 1-800-932-6648 for a Clinical SA"

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
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™*	
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%* *brimonidine-timolol (gen Combigan®)* *Istalol® 0.5%* *timolol (generic for Timoptic Ocudose)* *Timoptic® drops 0.25% & 0.5%* *Timoptic® XE 0.25% & 0.5% soln-gel*	
Carbonic Anhydrase Inhibitors		
Azopt® 1% **dorzolamide** **dorzolamide/timolol**	*Cosopt® 0.5%-2%* *Cosopt® PF* *Simbrinza™*	

	Preferred Agents	Non-Preferred Agents	SA Criteria
		Trusopt® 2% *dorzolamide/timolol PF*	
	Cholinergic Muscarinic Receptor Agonist		
		**Vuity™*	*Indicated for the treatment of presbyopia in adults
	Rho Kinase Inhibitor		
	Rhopressa® **Rocklatan**		
	Prostaglandin Analogs		
	latanoprost **Travatan Z®**	*bimatoprost* *Lumigan® 0.03% & 0.01%* *Rescula®* *travoprost 0.004%* *Vyzulta™* *Xalatan® 0.005%* *Xelpros® (latanoprost)* *Zioptan™*	
Respiratory			
	***Anti-Allergens, Oral**		
	Grass Pollen		**LENGTH OF AUTHORIZATIONS**: 1 year
		**Oralair® SL*	
	Peanut		
		**Palforzia™*	***All non-preferred Anti-Allergen drugs require the submission of a Clinical SA. Refer to Oralair SA Form or Palforzia SA Form**
	Antihistamines: First and Second Generation		
	First Generation Antihistamines		**LENGTH OF AUTHORIZATIONS**: 1 year
	Generic only class	*All Brands require a SA*	**Routine PDL edits**

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Second Generation Antihistamines and Combinations		
cetirizine liquid 1mg/1mL (RX/OTC) **cetirizine tabs OTC** **levocetirizine tab/OTC** **loratadine tab/syrup OTC**	*cetirizine chew tab (OTC)* *cetirizine liquid 5mg/5mL (OTC)* *cetirizine D tab (OTC)* *Clarinex®* *Clarinex-D®* *desloratadine ODT* *fexofenadine* *fexofenadine/PSE ER* *fexofenadine suspension* *loratadine ODT* *loratadine D 12 & 24 hr*	
Beta-Adrenergic Agents		
Long Acting Beta Adrenergic s (LABA) MDIs or Nebulizers		**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits plus**
arformoterol (authorized generic Brovana®) **Serevent Diskus®**	*arformoterol (generic Brovana®)* *Arcapta DS* *Brovana®* *formoterol fumarate (generic Perforomist®)* *Perforomist®* *Striverdi® Respimat*	
Short Acting Metered Dose Inhalers or Devices		
Proair® HFA **Ventolin® HFA**	*albuterol HFA (Proair®)* *albuterol HFA (Ventolin®)* *albuterol HFA (Proventil®)* *levalbuterol tartrate HFA* *ProAir® Digihaler™* *ProAir® RespiClick* *Proventil® HFA* *Xopenex® HFA*	
Short Acting Nebulizers		
albuterol sulfate (premixed)	*levalbuterol soln*	

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	Xopenex®	
COPD: Bronchodilators and Phosphodiesterase 4 (PDE4) Inhibitors CLOSED CLASS		
Atrovent HFA® **Anoro™ Ellipta® (AGE)** **Combivent® Respimat** **ipratropium bromide soln** **ipratropium/albuterol nebs** **Spiriva®** **Spiriva® Respimat** **Stiolto Respimat™ (AGE)**	*Bevespi Aerosphere™* **Daliresp®* *Duaklir Pressair* *Incruse™ Ellipta®* *Lonhala™ Magnair™* *Tudorza™* *Yupelri™ (revefenacin)*	**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) CLOSED CLASS		**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits**
Advair® Diskus **Advair® HFA** **Dulera®** **Symbicort®**	*AirDuo® Digihaler®* *Airduo ™ Respiclick®* *budesonide-formoterol (generic Symbicort®)* *Breo®Ellipta™* *Breztri Aerosphere™* *fluticasone/salmeterol (generic Airduo)* *fluticasone/salmeterol powder (generic Advair)* *fluticasone-vilanterol (generic Breo®Ellipta™)* *Trelegy® Ellipta* *Wixela® (fluticasone/salmeterol)*	
Inhaled Corticosteroids: Metered Dose Inhalers CLOSED CLASS		
Asmanex Twisthaler **Flovent® Diskus**	*Alvesco®* *Aerospan™*	

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Flovent® HFA **Pulmicort Flexhaler®**	*ArmonAir® Digihaler™* *Arnuity™ Ellipta®* *Asmanex HFA®* *fluticasone HFA(gen Flovent® HFA)* *QVAR® & QVAR® Redihaler*	
Inhaled Corticosteroids: Nebulizer Solution CLOSED CLASS		**LENGTH OF AUTHORIZATIONS**: 1 year
budesonide respules	*Pulmicort® Respules*	
Nasal Steroids		**Routine PDL edits**
fluticasone Rx	*azelastine/fluticasone nasal spray (generic for Dymista®)* *Beconase AQ®* *budesonide (generic for Rhinocort® Aqua)* *budesonide (generic Rhinocort® Allergy OTC)* *Children's Qnasl™* *Clarispray OTC* *Dymista®* *Flonase®* *Flonase Sensimist (OTC)* *flunisolnide* *fluticasone OTC* *ipratropium bromide spray* *mometasone (generic Nasonex®)* *Nasonex OTC* *Omnaris®* *Qnasl™* *Rhinocort Aqua®* *Rhinocort® Allergy OTC* *Ticanase®* *triamcinolone OTC* *triamcinolone acetonide*	

Preferred Agents	Non-Preferred Agents	SA Criteria
	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.** **FDA advisory: cough and cold medicines containing codeine or hydrocodone are limited to adults 18 years and older because the risks of these medicines outweigh their benefits in children younger than 18**
Epinephrine, Self-Injected		
epinephrine 0.15 mg & 0.3 mg (authorized generic EpiPen® & EpiPen® Jr) **Epipen®** **Epipen® Jr**	*Auvi-Q®* *epinephrine 0.15 mg & 0.3mg (generic EpiPen® and 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**

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	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**