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

10/1/24

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

General Information:

- **Virginia's Medicaid 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
♦ = Clinical Utilization Edit

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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™*	

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
***Methadone Drugs**		
	Dolophine® *Methadose® oral soln & tab* *methadone oral soln & tab*	*Methadone requires the completion of the Clinical SA form **(Methadone SA Form)** unless prescribed for neonatal abstinence syndrome for an infant under the age of one.
***♦ Opioids – Short Acting**		
***Transmucosal Immediate Release Fentanyl**		**LENGTH OF AUTHORIZATIONS:** • 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).
	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* *Panlor®* *pentazocine/naloxone*	***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
	PrimLev™ *RoxyBond ™* *Seglentis®* *tramadol 100 Mg* *tramadol soln (AG for Qdolo®)* *Ultracet®* *Ultram®* *Zamicet ®soln*	
♦ Opioid Dependency CLOSED CLASS		
***buprenorphine SL** **buprenorphine/naloxone tab SL** **Brixadi™** **Suboxone® film** **Sublocade™ SQ** **Kloxxado™ Spray** **naloxone syringe & vial** **naloxone nasal spray** **naloxone nasal spray OTC** **Naloxone Carpuject** **naltrexone tab** **Narcan® Nasal Spray Rx/OTC** **Opvee®** **Vivitrol®** **Zimhi™**	**buprenorphine/naloxone film SL* **Probuphine® implant* **Zubsolv™* ***Lucemyra®*	***Buprenorphine Containing Drugs require submission of Clinical SA. Refer (Oral Buprenorphine SA Form)** **Lucemyra (lofexidine) (PDL criteria do not apply) -Member is 18 years of age or older AND -Medication used for the mitigation of opioid withdrawal symptoms to facilitate abrupt opioid discontinuation Limitation: No more than one (14 day) treatment course every 6 months **Quantity Limits** 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

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
		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** **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.
Children's Motrin® susp (OTC) **diclofenac sodium** **ibuprofen cap** **ibuprofen tab (OTC & Rx)** **Infant's ibuprofen drops** **meloxicam tab** **naproxen tab** **naproxen sodium (OTC)** **naproxen EC (Rx)** **sulindac**	*Anaprox® IR & DS®* *Advil®* *Aleve®* *Arthrotec®* *Cataflam®* **Celebrex® & *celecoxib* *Daypro®* *diclofenac potassium* *diclofenac potassium gen Zipsor™* *diclofenac sodium ER* *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*	

Preferred Agents	Non-Preferred Agents	SA Criteria
	Motrin® *nabumetone* *Nalfon®* *Naprelan®* *Naprosyn®* *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®, diclofenac 2% topical sol, 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®. • diclofenac 2% topical sol, 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 **Clinical Criteria for Arikayce®** Duration of Approval: 12 months **Initial Approval Criteria** • Member 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 • Member 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 • Member 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 Limitations:** 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

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
		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* **Vivjoa®* *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** ***Clinical Criteria for Vivjoa:** Duration of approval: Date of service • Member is 10 years of age or older; AND • Documentation member has diagnosis of recurrent vulvovaginal candidiasis with ≥3 episodes of vulvovaginal candidiasis (VVC) in a 12-month period; AND • Member is a biological female who is postmenopausal or has another reason for permanent infertility (e.g., tubal ligation, hysterectomy, salpingo-oophorectomy); AND • Member has tried and failed or has a contraindication or intolerance to maintenance antifungal therapy with oral fluconazole. Quantity limit: 18 tablets per treatment course
Cephalosporins, Oral		
Second Generation Cephalosporins		**LENGTH OF AUTHORIZATIONS**: Date of service only; no refills. **Routine PDL edits plus** **Clinical Criteria for Non-Preferred Cephalosporins**
cefaclor capsule **cefprozil tab/susp** **cefuroxime tab**	*cefaclor ER* *cefaclor susp* *Ceftin® tab/susp*	

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Third Generation 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.
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.
azithromycin pack/susp/tab **clarithromycin tab/susp** **E.E.S.® 200 susp** **erythromycin base tab 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 cap DR* *erythromycin base tab* *erythromycin ethylsuccinate 400mg tab(Generic E.E.S.® 400)* *PCE®* *Zithromax® pac/tab/susp* *ZMAX® susp*	
Otic		
Ciprodex® **ciprofloxacin/dexamethasone (generic Ciprodex)** **ofloxacin** **neomycin/polymyxin/hc soln/sus**	*Cetraxal®* *Cipro HC®* *ciprofloxacin and fluocinolone acetonide (generic Otovel)* *Otovel*	**LENGTH OF AUTHORIZATIONS:** Date of service only; no refills **Routine PDL edits**

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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™**	*Cleocin® cr* *clindamycin cr* *Metrogel®* *metronidazole gel (generic for Nuvessa™)* *Vandazole™ gel* *Xaciato™ gel*	**LENGTH OF AUTHORIZATIONS**: Date of Service **Routine PDL edits**

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Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Antivirals		
Hepatitis B Agents **CLOSED CLASS**		
entecavir (generic for Baraclude®) tab	*adefovir dipivoxil (generic for Hepsera®) tab* *Baraclude® (entecavir) soln* *Baraclude® (entecavir) tab* *Epivir HBV® (lamivudine) soln* *lamivudine HBV (generic for Epivir HBV®) tab* **Vemlidy® (tenofovir alafenamide)*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits plus** ***Vemlidy®** ○ Member has a diagnosis of chronic hepatitis B infection; **AND** ○ Member has tried and failed or is intolerant to tenofovir disoproxil fumarate (generic Viread)
***Hepatitis C Agents** **CLOSED CLASS**		
Interferon		**LENGTH OF AUTHORIZATIONS**: ***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 *** Hepatitis C Therapies may filled:** 1. Monthly a. Mavyret™ (28 days supply x 2 months) b. Mavyret™ Pellet packs (28 days supply x 2 months) c. sofosbuvir /velpatasvir (generic Epclusa®) (28 days supply x 3 months) **OR** 2. Full duration of the regimen: a. Mavyret™ (56 days supply) b. Mavyret™ Pellet packs (56 days supply) c. sofosbuvir/velpatasvir (generic Epclusa®) (84 day supply)
	Pegasys® syringe/vial	
***Nucleotide Analog NS5A & NS5B Polymerase Inhibitors & Combinations**		
sofosbuvir /velpatasvir (generic Epclusa®)	*Epclusa®* *Epclusa® Pellet packs* *Sovaldi®* *Vosevi™*	
***NS5A, NS3/4A Inhibitor Combinations**		
Mavyret™ **Mavyret™ Pellet packs**	*Zepatier®*	
***NS5B & Protease Inhibitor Combinations**		
	Harvoni® *ledipasvir/sofosbuvir (generic Harvoni®)*	

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Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
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®* *penciclovir* *Xerese® cr* *Zovirax® oint* *Zovirax® cr*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits**
HIV/AIDS CLOSED CLASS		
abacavir tab/soln **abacavir-lamivudine tab** **abacavir-lamivudine-zidov tab** **Apretude** **Aptivus® soln** **atazanavir sulfate cap** **Biktarvy® tab** **Cabenuva** **Cimduo® tab** **Complera® tab** **darunavir** **Delstrigo™ tab** **Descovy® tab** **Dovato® tab** **Edurant® tab** **efavirenz tab** **efavir-emtri-tenof tab** **emtricitabine cap** **emtricitabine-tenofv** **Emtriva™ cap/soln** **Epivir® soln** **etravirine tab**	*Aptivus® cap* *Atripla® tab* *Combivir® tab* *didanosine cap DR* *efavirenz cap* *efavirenz-lamiv-tenof tab* *Epivir® tab* *Epzicom® tab* *Kaletra® tab/soln* *Lexiva® susp* *Norvir® tab* *Prezista® tab/susp* *Retrovir® syrup* *Reyataz® cap* *stavudine cap* *Trizivir® tab* *Trogarzo® (intraven)* *Viracept® tab* *Viread® tab* *Ziagen® tab*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits** **Quantity limits see list here HIV Quantity Limits**

	Preferred Agents	*Non-Preferred Agents*		*SA Criteria*
	Evotaz® tab **fosamprenavir tab/susp** **Fuzeon® Vial** **Genvoya® tab** **Intelence® tab** **Invirase® tab** **Isentress® chew tab/** **tab/powder pack** **Juluca® tab** **lamivudine tab/soln** **lamivudine-zidovudine tab** **Lexiva® tab** **lopinavir-ritonavir soln/tab** **Maraviroc** **nevirapine IR tab/ ER tab/susp** **Norvir® powder pack** **Odefsey® tab** **Pifeltro™ tab** **Prezcobix® tab** **Retrovir® cap/vial** **Reyataz® powder pack** **Rilpivirine ER vial** **ritonavir tab/soln** **Rukobia™ ER tab** **Selzentry® tab/soln** **Stribild® tab** **Sunlenca® tab/vial** **Symfi® and Symfi Lo® tab** **Symtuza® tab** **Temixys™ tab** **tenofovir disoproxil fum tab** **Tivicay® tab/tab for susp** **Triumeq® tab** **Triumeq® PD** **Truvada® tab** **Tybost® tab** **Viramune® tab**			

	Preferred Agents	Non-Preferred Agents	SA Criteria
	Viread® powder **Vocabria** **Ziagen® 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 cap, tab	**Bylvay™* *Chenodal®* *Cholbam®* *Iqirvo®* ***Livmarli™* *Ocaliva®* *Reltone®* *Urso® & Urso® Forte tab*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits** *Livmarli™ (PDL criteria do not apply) • Must have a confirmed diagnosis of cholestatic pruritus in: ○ Members 3 months of age and older with Alagille syndrome (ALGS) ○ Members 12 months of age and older with progressive familial intrahepatic cholestasis (PFIC). ** Bylvay™ (PDL criteria do not apply) • Must have a confirmed diagnosis of cholestatic pruritus in: ○ Members 12 months of age and older with Alagille syndrome (ALGS) ○ Members 3 months of age and older with progressive familial intrahepatic cholestasis (PFIC)
	Colony Stimulating Factors CLOSED CLASS		

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	Fulphila **Neupogen Disp Syrin** **Neupogen Vial**	*Fylnetra* *Granix Syringe* *Granix Vial* *Leukine* *Neulasta Kit* *Neulasta Syringe* *Nivestym Syringe* *Nivestym Vial* *Nyvepria* *Releuko Syringe* *Releuko Vial* *Rolvedon Syringe* *Stimufend Syringe* *Udenyca* *Udenyca Autoinjector* *Udenyca Onbody* *Zarxio* *Ziextenzo Syringe*	**LENGTH OF AUTHORIZATIONS**: **Routine PDL edits plus** **♦All Non-Preferred Colony Stimulating Factors require submission of Clinical SA.** **Refer to: Non-Preferred Colony Stimulating Factors SA Form**
	Hemophilia Treatment CLOSED CLASS		
	Factor VIII Products		**LENGTH OF AUTHORIZATIONS**: N/A All products are preferred without EDITS
	Advate® **Adynovate®** **Afstyla®** **Alphanate®** **Altuviiio™** **Eloctate®** **Esperoct®** **Hemofil-M®** **Humate-P®** **Jivi®** **Koate-DVI®** **Kogenate FS®** **Kovaltry®** **Novoeight®** **Nuwiq®**		

Preferred Agents	Non-Preferred Agents	SA Criteria
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		
calcium acetate 667mg cap **calcium acetate 668 mg**	*Auryxia™* *calcium acetate 667mg tab*	**LENGTH OF AUTHORIZATIONS**: 1 year

Preferred Agents	Non-Preferred Agents	SA Criteria
sevelamer carbonate 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* *Xphozah™*	**Routine PDL edits**
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**: 1 year **Routine PDL edits** .
Calcitonins		
calcitonin-salmon nasal	*Miacalcin® spray* *calcitonin-salmon (gen Miacalcin®)*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits**

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	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	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 **Routine PDL edits**
	enoxaparin (generic Lovenox®)	*Arixtra®* *fondaparinux* *Fragmin® syringe & vial* *Lovenox®*	
	Oral Anticoagulants		**Clinicial Criteria for Savaysa™** • Diagnosis of: Non-valvular Atrial Fibrillation, **OR** • Deep vein thrombosis, **OR** • Pulmonary embolism; **AND** • Documentation that CrCl is NOT ≥ 95mL/min calculated by Cockcroft-Gault equation
	Eliquis™ **Eliquis™ Dose Pack** **Jantoven ®** **Pradaxa®** **warfarin** **Xarelto® & Starter Pack, susp**	*dabigatran* *Pradaxa® Pellet Pack* **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* *Monopril®* *perindopril*	

Preferred Agents	Non-Preferred Agents	SA Criteria
	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**
***Entresto™ (QL)** **irbesartan** **losartan** **olmesartan** **valsartan**	*Atacand®* *Avapro®* *Benicar®* *candesartan* *Cozaar®* *Diovan®* *Edarbi®* *eprosartan mesylate* *Micardis®* *Teveten®* *valsartan solution*	**Routine PDL edits plus** *Quantity Limit = 2 per day for Entresto™*

Preferred Agents	Non-Preferred Agents	SA Criteria
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®*	
Beta Blockers		***Clinical Criteria for Hemangeol™** • Diagnosis of proliferating infantile hemangioma requiring systemic therapy
atenolol **bisoprolol** **carvedilol** **labetalol** **metoprolol tartrate** **metoprolol succinate** **propranolol tab & ER/soln** **Sorine®** **sotalol AF** **sotalol HCL**	*acebutolol* *Betapace®IR & AF®* *betaxolol* *Carvedilol ER* *Coreg® IR & CR®* *Corgard®* **Hemangeol™* *Inderal® XL* *Innopran® XL* *Kapspargo™ Sprinkle* *Levatol®* *Lopressor®* *nebivolol* *nadolol*	

Preferred Agents	Non-Preferred Agents	SA Criteria
	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®* *Conjupri®* *Consensi® (amlodipine/celecoxib)* *felodipine ER* *isradipine* *Katerzia™oral suspension* *levamlodipine (generic Conjupri®)* *nisoldipine* *nicardipine* *Norliqva®* *Norvasc®* *Procardia XL®* *Sular®*	

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
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*	
Lipotropics		
Bile Acid Sequestrants		**LENGTH OF AUTHORIZATIONS**: 1 year
cholestyramine powder reg & light **colestipol tab** **Prevalite®**	*Colestid® packet/tab* *colesevelam tab and Pkt (generic Welchol)* *colestipol HCl granules* *Questran® powder/powder Light* *Welchol® pack, tab*	**Routine PDL edits**
Cholesterol Absorption Inhibitor (CAI) and /or ACL Inhibitor (adenosine triphosphate citrate lyase)		**Routine PDL edits plus** ♦ **Clinical criteria Nexletol™ or Nexlizet™** **Initial Approval Criteria** • Member is ≥ 18 years of age; AND
ezetimibe	*Nexletol® (bempedoic acid)*	

Preferred Agents	Non-Preferred Agents	SA Criteria
	Nexlizet® (bempedoic acid/ ezetimibe) *Zetia®*	• Member has diagnosis of heterozygous familial hypercholesterolemia (HeFH) or established atherosclerotic cardiovascular disease (ASCVD); AND • Member has failed to achieve a target LDL-C despite physician attestation that the member is adherent to maximally tolerated doses of statins prior to the lipid panel demonstrating suboptimal reduction; AND • Member 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 • 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 • Member 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®*	

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	Fibricor® *Lipofen®* *Lofibra®* *Lopid®* *Tricor®* *Triglide®* *Trilipix™*	
HMG CoA Reductase Inhibitors and Combo (High Potency Statins)		
atorvastatin **rosuvastatin** **simvastatin**	*Atorvaliq®* *amlodipine/atorvastatin* *Caduet®* *Crestor®* *Ezallor Sprinkle (rosuvastatin)* *Lipitor®* *Livalo®* *pitavastatin calcium (generic Livalo®)* *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®*	

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	Niacor®	
Omega 3 Fatty Acid Agent		
icosapent ethyl (gen Vascepa®) ****omega-3 acid ethyl esters (ST)*** **Omega-3 OTC** ~~**Vascepa®**~~	*****Lovaza® (ST)***	***♦ **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 *♦ **ALL PCSK9 Inhibitors require the submission of a Clinical SA. Refer to Lipotropics, Other SA Form**
***Proprotein Convertase Subtilisin Kexin Type 9 (PCSK9) Inhibitors**		
	Leqvio® *Praluent®* *Repatha®*	
Platelet Inhibitors		
Brilinta® **clopidogrel** **dipyridamole** **prasugrel (generic Effient®)**	**Aggrenox®* **ASA/dipyridamole* ***ASA/omeprazole (generic Yosprala®)* ***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** • 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)*	

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	Oral Endothelin Receptor Antagonist		
	ambrisentan (generic Letairis) 5 & 10mg **Tracleer® tab**	*bosentan (generic Tracleer®)* *Letairis® 5 & 10 mg* *Opsumit®* *Tracleer® susp*	
	***Phosphodiesterase 5 Inhibitors (PDE-5)**		**Routine PDL edits plus** ***♦ Clinical Criteria for all preferred and non-preferred PDE-5 and PDE-5 inhibitor combinations** • Diagnosis of pulmonary hypertension in members >18 years is required (≥1 years oral Revatio® only); **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(generic Adcirca®)**	*Adcirca®* *Liqrev®* *Revatio® tab/inj/susp* *Tadliq® Suspension*	
	***Phosphodiesterase 5 Inhibitors (PDE-5) Combinations**		
		Opsynvi	
	Prostacyclin Vasodilator and Receptor Agonist		
		Orenitram™ *Orenitram™ titration kit* *Uptravi®*	
	Soluble Guanylate Cyclase Stimulators		
		Adempas®	
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*	

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Preferred Agents	Non-Preferred Agents	SA Criteria
	memantine ER *Namenda® Dose Pack/XR tab* *Namenda® tab*	
Anticonvulsants **CLOSED CLASS**		
Barbiturates		**LENGTH OF AUTHORIZATIONS:** **1 year** **Routine PDL**
phenobarbital elixir/tab **primidone**	*Mysoline®*	
Benzodiazepines		
clobazam tab/susp **clonazepam tab** **Diastat® rectal** **Diastat® AcuDial™ rectal** **diazepam rectal & Device rectal** **Nayzilam®** **Valtoco® Nasal**	*clonazepam ODT* *clorazepate* *Klonopin Tab* *Libervant™* *Onfi®susp/tab* *Sympazan™ (clobazam)* *Tranxene®*	
Cannabidiol		

***Epidioex® (cannabidiol)**		***♦ **Clinical Criteria for Epidiolex®** (reviewed electronically, AutoPA)
		Duration of Approval: 1 year
		• Member must be ≥ 1 years of age; AND
		• Member has been diagnosed with:
		  ○ Epilepsy and recurrent seizures including Lennox-Gastaut syndrome,
		  ○ Dravet syndrome, or tuberous sclerosis complex

Carbamazepine Derivatives		
carbamazepine chewable tab/susp/tab **carbamazepine XR** **Carbatrol®** **Epitol** **oxcarbazepine tab** **Tegretol®XR** **Trileptal® susp**	*Aptiom®* *carbamazepine ER* *carbamazepine XR (authorized generic only)* *Equetro® cap* *Oxtellar™ XR* *oxcarbazepine susp*	

Preferred Agents	Non-Preferred Agents	SA Criteria
	oxcarbazepine ER (generic Oxtellar XR) *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 dose pk** **lamotrigine ODT** **lamotrigine tab** **lamotrigine chew tab** **lamotrigine XR** **levetiracetam soln/tab** **levetiracetam ER** **roweepra (generic levetiracetam)** **subvenite tab (generic lamotrigine)** **tiagabine** **topiramate tab/sprinkle cap** **zonisamide cap**	*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* *Keppra® XR* *lacosamide solution unit dose* *Lamictal® XR & XR dose pk* *Lamictal® tab/dose pk* *Lamictal® ODT* *lamotrigine tab dose pk* *lamotrigine ODT dose pk* *Motpoly XR™* *rufinamide susp/tab (generic Banzel®)*	*♦ **Clinical Criteria for Fintepla®** • Member is at least two years of age or older; AND • Member must have a diagnosis of Dravet syndrome or Lennox-Gastaut syndrome ** ♦ **Clinical Criteria for Ztalmy:** • Initial: o Member is two years of age or older; AND o Documented diagnosis of cyclin-dependent kinase-like 5 deficiency disorder AND o Documentation that seizures have been inadequately controlled by a trial of at least 2 antiepileptic drugs (e.g., clobazam, valproate, lamotrigine, levetiracetam, topiramate, felbamate, vigabatrin) or member has labeled contraindications to other antiepileptic drugs • Renewal:

Preferred Agents	Non-Preferred Agents	SA Criteria
	Qudexy™ XR *Sabril® powder pack/tab* *Spritam®* *subvenite dose pk* *Topamax® tab/sprinkle* *topiramate ER cap* *Trokendi™ XR* *vigabatrin tab/ powder pack (generic Sabril®)* *Vimpat® soln/tab* *Xcopri®* *Zonisade™ Solution* ***Ztalmy®*	○ Documentation of positive clinical response as demonstrated by low disease activity and/or improvements in the condition's signs and symptoms (e.g., reduced seizure activity, frequency, and/or duration) • Prescriber Requirements: Prescribed by or in consultation with a neurologist, geneticist, or physician who specialized in treatment of epileptic disorders
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
vilazodone tab
	Aplenzin®
	Auvelity™
	Brintellix®
	bupropion XL (gen Forfivo® XL)
	desvenlafaxine ER tab (gen Khedezla™)
	Effexor® XR
	Emsam® transdermal
	Fetzima®
	Forfivo® XL
	Khedezla™
	Marplan®
	Nardil®
	nefazodone
	Parnate®
	phenelzine
	Pristiq®
	Remeron® ODT/tab
	tranylcypromine sulfate
	Trintellix
	venlafaxine ER tab
		***♦ Zurzuvae criteria (PDL criteria do not apply)**
		• Initial Criteria:
		  • Member is ≥ 18 years of age; AND
		  • Member has a diagnosis of postpartum depression (PPD) based on Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria for a major depressive episode (DSM-5); AND
		  • Member is not currently pregnant and is using effective contraception
		
		LENGTH OF AUTHORIZATIONS: 14 days
		Renewal Criteria: Not applicable
		Quantity limit: 28 capsules per 14 days

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	Viibryd®dose pk *Viibryd® tab* *Wellbutrin® IR, SR & XL* **Zurzuvae™*	
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®)* *Imitrex® cartridge/pen/tab/vial* *Maxalt® tab & MLT* *Migranow™ Kit* *naratriptan* *Onzetra™ Xsail™* *Relpax®*	**LENGTH OF AUTHORIZATIONS:** **1 year** **Routine PDL edit**

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	sumatriptan KITS *Sumavel® Dosepro* *sumatriptan/nap (gen Treximet®)* *Tosymra* *Treximet®* *Zembrace ™ SymTouch ™* *zolmitriptan nasal* *Zomig® tab/nasal spray/ZMT*	
Antimigraine Agents, Others CLOSED CLASS **Calcitonin Gene-related Peptide Antagonist (CGRP)**		**Routine PDL edits plus** ***♦ All CGRPs require the submission of a Clinical SA. Refer to fax form Antimigraine Agents, Others SA Form** ****Vyepti SA Form** **Preferred Agents *step edit required**
Preventive Treatment		
Aimovig™ **Ajovy® Autoinjector & Syringe** **Ajovy Autoinjector 3-Pk** **Emgality™ Syringe** **Emgality™ Pen** **Nurtec™ ODT** **Qulipta™**	*Emgality™ 100MG Syringe* ***Vyepti®*	**Quantity limit for preventive treatment** Aimovig™ = 70 mg/mL autoinjector = 1 mL or 140 mg/mL autoinjector = 1 mL per 30 days Ajovy® = 1 Injection: 225 mg/1.5 mL single-dose prefilled autoinjector per 30 days. Ajovy 3 pack = one 3 pack per 90 days Emgality™ = 120 mg/mL pen and syringe = 1 mL per 30 days 100 mg/1 mL syringe = 1 mL per 30 days Nurtec® ODT = 16 tabs per 30 days Qulipta™ = 1 tab per day
Acute treatment of migraine		
Nurtec™ ODT **Ubrelvy®**	*Reyvow®* *Zavzpret™*	**Quantity limit for acute treatment** Nurtec® ODT = 16 tabs per 30 days Reyvow® = 50mg or 100mg - 8 tabs per strength per 30 days Ubrelvy® = 50mg or 100mg can have up to 16 tabs per strength per 30 days
***Antipsychotics *(AGE)* CLOSED CLASS**		
Atypical		**LENGTH OF AUTHORIZATIONS: 1 year or 6 months for members < 18 yrs** **Routine PDL edits plus**
aripiprazole tab **clozapine tab** **lurasidone** **olanzapine ODT, tab, IM** **quetiapine fumarate ER** **quetiapine tab**	*Abilify® tab/IM inj* ****Abilify Mycite®(with sensor)* ***aripiprazole ODT, soln* *asenapine (generic for Saphris®)* *Caplyta Capsule™* *Clozaril®*	

Preferred Agents	Non-Preferred Agents	SA Criteria
risperidone ODT/soln/tab **Vraylar™** **ziprasidone cap**	*clozapine ODT* *Fanapt® tab & titration pk* *Fazaclo®* ***Geodon® tab, IM* *Invega®* *Latuda®* *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™* *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** Member 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** • Member must: • Continue to meet initial criteria; AND • Have prescriber attestation that member 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., 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

Preferred Agents	Non-Preferred Agents	SA Criteria
		• Have a healthcare provider state reason why the member cannot use long-acting injectable atypical antipsychotic if there is continued nonadherence.
Atypical, Long-Acting Injectable		**LENGTH OF AUTHORIZATIONS:** **1 year** **Routine PDL edits**
Abilify Asimtufii® **Abilify Maintena®** **Aristada®** **Aristada® Initio** **Invega Hafyera™, Sustenna® &Trinza®** **Perseris™** **Risperdal Consta®** **Uzedy™**	*Rykindo™* *Zyprexa® Relprevv™*	
Typical		**LENGTH OF AUTHORIZATIONS:** **1 year** **Routine PDL edits**
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*	
Duchenne Muscular Dystrophy CLOSED CLASS		
****Emflaza**	**Agamree* *Amondys-45* ***deflazacort* *Exondys-51* *Viltepso* *Vyondys-53*	**LENGTH OF AUTHORIZATIONS:** **1 year** ***Clinical Criteria for Agamree®** • Member is 2 years of age or older • Member has a diagnosis of Duchenne Muscular Dystrophy (DMD) • Member has tried and failed or is intolerant to prednisone or prednisolone • Member has tried and failed or is intolerant to Emflaza™

Preferred Agents	Non-Preferred Agents	SA Criteria
		****Clinical Criteria for Emflaza™ and deflazacort** • Member is 2 years of age or older • Member has a diagnosis of Duchenne Muscular Dystrophy (DMD) • Member has tried and failed or is intolerant to prednisone or prednisolone • For generic deflazacort, the member has tried and failed or is intolerant to Emflaza™ **Routine PDL edits plus** **All Antisense Oligonucleotides require submission of Clinical SA.** Refer to: Antisense Oligonucleotides SA Form
***Movement Disorders CLOSED CLASS**		

Austedo® tab
Austedo XR® tab
Austedo XR® titration pack
Ingrezza® cap
Ingrezza® Sprinkle
Ingrezza® Initiation Pack
tetrabenazine tab (generic Xenazine®)
Xenazine® tab
		LENGTH OF AUTHORIZATIONS: 1 year
		
		***Clinical Criteria for Movement Disorders**
		• Diagnoses of Tardive Dyskinesia or Huntington's disease
		• Prescribed by or in consult with a neurologist or psychiatrist
		• Quantity limit
		  ○ 4 tabs/day Austedo®
		  ○ 1 tab per day Austedo XR®
		  ○ 42 tablets per 365 Austedo XR® titration pack
		  ○ 1 cap/day Ingrezza®/Ingrezza Sprinkle®
		  ○ 4 tabs/day Xenazine®

Preferred Agents	Non-Preferred Agents	SA Criteria
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® (capsaicin)* *Savella™ & Savella™ Dose Pak* *Zilacaine Patch* *Ztlido™ 1.8% (lidocaine topical system)*	**LENGTH OF AUTHORIZATIONS**: **1 year** **Routine PDL edits plus** **Criteria for Lyrica solution:** − If diagnosis is epilepsy/seizures, member must have a problem swallowing tabs/capsules AND clinical reason why at least TWO preferred seizure medications cannot be used. − For other diagnoses, member 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* *flurazepam* *Halcion®* *quazepam 15 mg* *Restoril®* *temazepam 7.5 mg & 22.5 mg* *triazolam*	**LENGTH OF AUTHORIZATIONS**: Length of the prescription (up to 3 months) **Routine PDL edits**

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

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Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
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®* *tasimelteon* *zolpidem CR* *zolpidem (generic Intermezzo®)* *zolpidem tartrate capsule*	**LENGTH OF AUTHORIZATIONS**: 6 months. **For Renewal -** must document therapeutic benefit and confirm compliance **Routine PDL edits plus** *♦ **Clinical Criteria for Hetlioz® and tasimelteon** • 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 members **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* *baclofen susp (gen Fleqsuvy™)* **carisoprodol* **carisoprodol/ASA* **carisoprodol/ASA/codeine* *cyclobenzaprine ER* *Dantrium®* *Fexmid®* *Fleqsuvy™* *Lorzone®* *Lyvispah™* *metaxalone* *orphenadrine citrate* *orphenadrine/ASA/caffeine* *Parafon Forte® DSC*	**LENGTH OF AUTHORIZATIONS:** • 1 year for chronic conditions • Duration of prescription (up to 3 months) for acute conditions **Routine PDL edits plus** *♦ **Clinical Criteria for Carisoprodol Drugs** • Member is at least 16 years old • Only approve for ACUTE, painful musculoskeletal conditions. • Length of Authorization: One month per every 6 months for carisoprodol drugs • Quantity limit = 4 tablets per day

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	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** ***Clinical Criteria for Vyvanse® chewable tab** • Member must have tried and failed methylphenidate solution
amphetamine salts combo *(generic for Adderall IR)* **amphetamine salts combo XR** *(generic for Adderall XR)* **dextroamphetamine tab** *(generic for Dexedrine)* **dextroamphetamine cap SR** *(generic for Dexdrine Spansule)* **Vyvanse® capsule** (lisdexamfetamine)	*Adderall® IR (amphetamine salts combo)* *Adderall®XR* *Adzenys XR ODT™* *Adzenys ER™ susp* *Adzenys® ER* *amphetamine sulfate (generic Evekeo®)* *amphetamine susp (generic Adzenys ER™ susp)* *Desoxyn®* *Dexedrine®* *dextroamphetamine soln* *Dyanavel® XR susp* *Evekeo®* ~~*Evekeo™ ODT*~~ *lisdexamfetamine(generic Vyvanse®)* *methamphetamine* *Mydayis ER™* *Procentra® soln*	

Preferred Agents	Non-Preferred Agents	SA Criteria
	Vyvanse® chewable tab *Xelstrym™* *Zenzedi™*	
Methylphenidate Drugs		
All methylphenidate IR generic **methylphenidate soln** **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* *methylphenidate ER, LA, SR* *methylphenidate ER(generic Relexxii®)* *methylphenidate ER(generic Aptensio™ XR)* *methylphenidate (generic Daytrana®)* *Ritalin® IR, LA® & SR®* *Relexxii®* *QuilliChew ER™* *Quillivant™ XR susp*	
Miscellaneous Drugs		
atomoxetine (generic for Strattera®) **clonidine ER** **guanfacine ER**	*Intuniv®* *Qelbree®* *Strattera®*	
♦ Narcolepsy Drugs		
armodafinil **modafinil** **Sunosi™**	*Nuvigil ™* *Provigil®* *Wakix®*	**Routine PDL edits plus**

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
			♦**All Narcolepsy Drugs require submission of Clinical SA. Refer to: Narcolepsy Medications SA Form**

Dermatologic

*Acne Agents, Topical *(AGE)*

Combo Benzoyl Peroxide, Clindamycin, Erythromycin & other Top	
Acne Medication gel, lot **benzoyl peroxide wash, cr, gel, lot (OTC)** **clindacin ETZ 1% pledget** **clindamycin ph 1% solution, pledget, swab, gel** **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* *Cabtreo* *Cleocin T®* *Clindacin™ Pac Kit* *Clindagel®* *clindamycin phosphate (generic for Clindagel®)*

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.**

	Preferred Agents	Non-Preferred Agents	SA Criteria
		clindamycin/benzoyl peroxide (generic for Acanya® Pump, Benzaclin®, Onexton) *clindamycin phosphate foam, el, lotion, med swab* *clindamycin/tretinoin (generic Veltin®)* *dapsone 5% gel* *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*	

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	Sumaxin CP Kit *Veltin®* *Winlevi®* *ZMA Clear Cleanser*	
Retinoids/Combinations, Topical		
adapalene 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* *Differin 0.1% gel (OTC)* *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%, 0.08%, & 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**	*Alevazol® OTC* *Azolen® Tincture OTC* *Bensal HP®*	**LENGTH OF AUTHORIZATIONS: 6 months** **Routine PDL edits plus**

Preferred Agents	Non-Preferred Agents	SA Criteria
ciclodan 8% soln **clotrimazole cr (OTC & RX)** **clotrimazole soln (OTC & RX)** **clotrimazole-betamethasone cr** **ketoconazole shampoo** **ketoconazole cr** **miconazole cr/spray (OTC)** **nystatin cr/oint/ powder** **terbinafine cr (OTC)** **tolnaftate cr/powder(OTC)**	*Ciclodan® Kit* *ciclopirox cr/shampoo/gel* *ciclopirox kit* *ciclopirox suspension* *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)* *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®*	**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
	PediPak® **Penlac®* *tavaborole (generic Kerydin®)* *Tinactin® Aero powder/ spray(OTC)* *tolnaftate aero powde/spray (OTC)* *tolnaftate soln (OTC)* *Vusion®*	
Immunomodulators Atopic Dermatitis **CLOSED CLASS**		
****Adbry™** ****Dupixent ®** ***Elidel®** ****Eucrisa™** ***tacrolimus**	****Opzelura™* *pimecrolimus (generic Elidel)* *Protopic®*	LENGTH OF AUTHORIZATIONS: 1 year 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 ≥ 12 years o Elidel®: 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 > 16 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™, Dupixent® and Adbry®**(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
  - One (1) topical corticosteroid of medium to high potency (e.g., mometasone, fluocinolone) AND
  - One (1) topical calcineurin inhibitors (tacrolimus or pimecrolimus) AND
  - A trial and failure of Dupixent ® AND
  - A trial and failure of Eucrisa™
- **Other indications: Opzelura cream can not be approved for the indication of nonsegmental vitiligo in adult and pediatric members ≥ 12 years old**

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**

Member 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 Member must be 6 years of age or older

♦ **Diagnosis of eosinophilic esophagitis (EoE);**
- o Member ≥1 years old; AND
- o Member weighs ≥ 15 kg; AND
- o Prescribed by or consultation with an allergist or gastroenterologist; AND
- o Member did not respond clinically to treatment with a topical glucocorticosteroid or proton pump inhibitor

Preferred Agents	Non-Preferred Agents	SA Criteria
		♦ **Diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP)**; o Member ≥ 12 years old o Member has inadequate response after 3 consistent months use of preferred PDL intranasal steroids or oral corticosteroids; AND o Member is concurrently treated with intranasal corticosteroids ♦ **Diagnosis of Prurigo Nodularis for the treatment of adult members 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™* *Vtama®* *Zoryve®*	**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
metronidazole cr/gel	*azelaic acid (generic for Finacea®)* *brimonidine gel pump (generic Mirvaso®)* *Epsolay®* *Finacea® foam/gel* *ivermectin (generic Soolantra)* *Metrocream®* *Metrogel®* *metronidazole lot* *Mirvaso®* *Noritate®* *Rhofade®* *Rosadan™ Kit* *Soolantra®* *Zilxi™*	**LENGTH OF AUTHORIZATIONS:** **1 year** **Routine PDL edits**
Steroids		
Steroids, Topical Low Potency		**LENGTH OF AUTHORIZATIONS:** **1 year**
hydrocortisone cr/gel/lot/oint **hydrocortisone cr/oint OTC** **hydrocortisone/aloe cr OTC**	*anusol-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®*	**Routine PDL edits**
Steroids, Topical Medium Potency		
fluticasone propionate cr/oint **mometasone furoate cr/oint/soln**	*betamethasone valerate foam* *Beser Lotion and Kit* *clocortolone cr*	

Preferred Agents	Non-Preferred Agents	SA Criteria
	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* *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)*	**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
	diflorasone diacetate cr/oint *Diprolene® lot/oint* *DiproleneAF®cr* *Ellzia™ Pak Kit* *fluocinonide cr/ emollient/ gel/oint/soln* *halcinonide cr* *Halog® cr/oint/soln* *Kenalog® aerosol* *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* *Ultravate® cr/lotion/oint*	

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
		Ultravate® PAC & Ultravate® X	
Endocrine and Metabolic Agents			
	Androgenic Agents (Testosterone – Topical)		
	AndroGel® Pump **Androderm® Patch** **testosterone pump (generic for AndroGel® Pump)**	*AndroGel® packet, patch* *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**
	Antihyperuricemics		
	allopurinol 100mg and 300mg **colchicine tabs** **Probenecid®** **probenecid & colchicine**	*allopurinol 200MG* *colchicine caps* *Colcrys®* *febuxostat (generic Uloric®)* *Gloperba ®* *Mitigare®* *Uloric®*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits**
	Contraceptives*(long-acting IUDs & injectable)		
	Depo-Provera® 104mg **Kyleena™** **Liletta®** **medroxyprogesterone 150mg** **Mirena®** **Nexplanon®** **Paragard®**	*Depo-Provera® 150mg*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits**

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Skyla®		
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® **Trulicity™** **Victoza®**	*Bydureon™ Bcise SQ* *Mounjaro®* *Ozempic®* *Rybelsus Tab®* *Soliqua® 100/33* *Tanzeum™* *Xultophy® 100/3.6*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits** **Preferred Agents Clinical Criteria:** • **Diagnosis of type II diabetes** **Non-Preferred Incretin Mimetics SA Form**
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 pen/vial(OTC)** **insulin aspart/insulin aspart protamine vial**	*Humalog® Mix 50/50 Kwikpen* *Humalog® Mix 75/25 Kwikpen* *insulin lispro protamine mix kwikpen* *Novolin® 70/30 vial (OTC)* *Novolog® Mix 70/30 pen/vial*	

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Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
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		
insulin glargine pen and vial **Lantus® Solostar® & vial** **Levemir® pen/vial**	*Basaglar® KwikPen®* *insulin degludec* *insulin glargine-yfgn* *Rezvoglar® Kwikpen* *Semglee™* *Toujeo® Solostar®300 Units/mL* *Tresiba® FlexTouch® Pen 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** **insulin aspart/insulin aspart protamine insulin pen**	*Admelog® Solostar Pen/vial* *Afrezza® cartridge (inhalation)* *Apidra® cartridge/Solostar/vial* *Fiasp®/FlexTouch®Pen/PenFill®* *Humalog Kwikpen 200 unit/ml* *Lyumjev™*	
Diabetes Oral Hypoglycemics		
Oral Hypoglycemics Alpha-Glucosidase Inhibitors		**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits plus**
acarbose	*Glyset®* *miglitol (generic Glyset®)*	

Preferred Agents	Non-Preferred Agents	SA Criteria
		♦Age edit for all Oral Hypoglycemics is 18 years of age or older, except Metformin which is 10 years of age.
Oral Hypoglycemics Biguanides		
metformin **metformin ER** *(generic for Glucophage® XR)*	*Fortamet®* *Glucophage® IR & XR* *Glutmetza®* *Riomet® susp* *metformin 625 mg* *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™** **Jentadueto XR™** **Kombiglyze XR™** **Onglyza™** **Tradjenta™**	*alogliptin (generic Nesina™)* *alogliptin/metformin (generic Kazano™)* *alogliptin/pioglitazone (generic Oseni™)* *Glyxambi®* *Kazano™* *Nesina™* *Oseni™* *Qtern®* *saxagliptin hcl(generic Onglyza™)* *saxagliptin/metformin ER (generic Kombiglyze XR™)* *Steglujan™* *Trijardy™ XR* *Zituvio™*	
Oral Hypoglycemics Meglitinides		
nateglinide	*Prandin® & PrandiMet™*	

Preferred Agents	Non-Preferred Agents	SA Criteria
repaglinide	*repaglinide/metformin* *Starlix*	
Oral Hypoglycemics Second Generation Sulfonylureas		
glimepiride **glipizide** **glipizide ER** **glyburide** **glyburide micronized**	*Amaryl®* *Diabeta®* *Glucotrol®* *Glucotrol XL®*	
***Oral Hypoglycemics Sodium Glucose Co-Transporter 2 Inhibitor CLOSED CLASS**		
Farxiga™ **Jardiance®** **Synjardy®** **Synjardy® XR** **Xigduo™ XR**	*Inpefa™* *Invokana™* *Invokamet™* *Invokamet™ XR* *Segluromet™* *Steglatro™*	
Oral Hypoglycemics Thiazolidinediones		
pioglitazone	*Avandia®* *Actoplus Met® IR & XR* *Actos®* *Avandaryl®* *Avandamet®* *Duetact®* *pioglitazone/metformin* *pioglitazone/glimepiride*	
Erythropoiesis Stimulating Proteins		
Epogen® **Retacrit™ (PFIZER)**	*Aranesp® vial/syringe* *Jesduvroq®* *Procrit®* *Reblozyl®* *Retacrit™ (VIFOR)* *Mircera®*	**LENGTH OF AUTHORIZATIONS**: for duration of the prescription up to 6 months **Routine PDL edits**

Preferred Agents	Non-Preferred Agents	SA Criteria
Glucagon Agents (CLOSED CLASS)		
Baqsimi nasal **Proglycem suspension oral** **Zegalogue Autoinjector & syringe SQ**	*Diazoxide suspension oral* *Glucagon emergency kit (Lilly) inj* *Glucagon inj* *Glucagon emergency kit (Fresenius and Amphastar) inj* *Gvoke pen, syringe, vial SQ*	**LENGTH OF AUTHORIZATIONS**: **1 year** **Routine PDL edits**
Glucocorticoids, Oral		
budesonide EC **dexamethasone soln/tab** **hydrocortisone** **methylprednisolone dose pk** **methylprednisolone 4 mg tab** **prednisolone sod phosph soln** **prednisolone soln** **prednisone soln/tab/dose pk**	*Alkindi® Sprinkle* *Cortef®* *cortisone acetate* *dexamethasone elixir/intensol* *Dexpak®* *Entocort® EC* *Eohilia™* *Flo-Pred®* *Hemady®* *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®* *Tarpeyo™* *Veripred®*	**LENGTH OF AUTHORIZATIONS**: **1 year** **Routine PDL edits**

Preferred Agents	Non-Preferred Agents	SA Criteria
***Growth Hormone**	**CLOSED CLASS**	
Genotropin® Cartridge, Miniquick **Norditropin FlexPro®**	*Humatrope® cartridge/vial* *Ngenla™* *Nutropin AQ® NuSpin™* *Omnitrope® cartridge/vial* *Serostim® vial* *Skytrofa™* *Sogroya®* *Zomacton® 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™** **icatibant (generic Firazyr®)** **Kalbitor®** **Sajazir™**	*Firazyr®* *Haegarda®* *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 members should 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.

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	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	Progestational Agents CLOSED CLASS		
	medroxyprogesterone acetate (tab only) **norethindrone acetate** **progesterone cap/inj**	*Aygestin®* *Crinone (Vaginal)* *Depo-Provera 400 MG/ML* *Prometrium®* *Provera®*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits**
	Vaginal Estrogens		
	Premarin® Vaginal cr **Vagifem® Vaginal tab**	*Estrace ®Vaginal cr* *estradiol cream (gen Estrace®)* *estradiol vaginal tab* *Estring® Vaginal ring* *Femring® Vaginal ring* *Imvexxy®* *Intrarosa™* *Yuvafem®*	**LENGTH OF AUTHORIZATIONS**: 6 months **Routine PDL edits**
	Weight Management Agents (CLOSED CLASS)		
	orlistat **Xenical** **phendimetrazine IR and ER** **phentermine** **benzphetamine** **diethylpropion IR and ER**	*Imcivree SQ* Saxenda® Wegovy® *Zepbound™*	**Length of authorization:** As indicated on fax form **Routine PDL edits plus** **Weight Management Agents SA Form** **GLP-1 Receptor Agonist For Cardiovascular Risk Reduction SA Form** ♦ The selected GLP-1 Receptor Agonist is Saxenda
Gastrointestinal			
	G I Antibiotics		
	Firvanq™ soln **metronidazole tab** **vancomycin cap**	**Aemcolo™* *Alinia®* *Dificid®* *Flagyl® cap/ER* *Likmez™* *metronidazole cap* *neomycin*	**Length of authorization:** 1 year **Routine PDL edits** ***♦Clinical Criteria for Aemcolo** • Diagnosis of travelers' diarrhea with moderate diarrhea that is distressing or interferes with planned activities AND

Preferred Agents	Non-Preferred Agents	SA Criteria

	nitazoxanide (generic Alinia®)
	paromomycin
	Solosec®
	Tindamax®
	tinidazole
	***Xifaxan®*
	vancomycin compounded oral soln kit
	vancomycin sol
	Vancocin®
	****Vowst™*
		• Documentation of a history of failure, contraindication, or intolerance to one or more of the following: Azithromycin (generic Zithromax), Ciprofloxacin (generic Cipro), Levofloxacin (generic Levaquin), Ofloxacin (generic Floxin)
		
		****♦Clinical Criteria for Xifaxan**
		Xifaxan®: 200 mg tabs: −
		• Treatment of travelers' diarrhea caused by noninvasive strains of E. coli in members
		• ≥ 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 members
		  ○ ≥ 18 years of age.
		  ○ 2 tablets/day
		OR –
		• Treatment of irritable bowel syndrome with diarrhea (IBS-D) in members
		  ○ ≥ 18 years of age –
		  ○ 3 times a day for 14 days.
		  ○ 42 tablets /14 days, can be retreated up to two times with the same regimen.
		  ○ Max 126 tablets per 365 days
		Length of authorization = 3 months
		
		*****♦ Clinical Criteria for Vowst™:**
		• Member ≥ 18 years of age; AND
		• Member has a confirmed diagnosis of recurrent Clostridioides difficile infection (CDI) with a total of ≥3 episodes of CDI within 12 months; AND
		• Antibiotic treatment for recurrent CDI must be completed 2 to 4 days prior to initiation of Vowst therapy; AND
		• Member will take 10 oz of magnesium citrate (or 250 mL polyethylene glycol electrolyte solution for members with impaired kidney function) the evening prior to initiation of Vowst therapy; AND
		• Member must not have absolute neutrophil count (ANC) < 500 cells/mm3 , toxic megacolon, or small bowel ileus

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
		• Quantity limit = 12 capsules per 3 days • Renewal Criteria: Not applicable Length of authorizations: 30 Days
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 edits plus** **For ondansetron 16mg ODT:** The member has tried and failed or is intolerant to ondansetron 8mg ODT.
NK-1 Receptor Antagonist		**LENGTH OF AUTHORIZATIONS:** Length of chemotherapy regimen or a maximum of 6 months
	Aponvie™ *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
***Diclegis®**	*Antivert®* *Barhemsys®*	**♦Promethazine products approved for members ≥ 2 years

Preferred Agents	Non-Preferred Agents	SA Criteria
meclizine (OTC, Rx) **metoclopramide soln, tab, vial** ****Phenadoz® supp** **prochlorperazine tab** ****promethazine soln, syrp, tab** *(AGE)*	**Bonjesta™* *Compazine® supp/tab* *Compro®* *dimenhydrinate tab, vial* *doxylamine succinate/ vit B6* *Metozolv® ODT* *metoclopramide ODT* *****Phenergan® (AGE)* *prochlorperazine supp, vial* *****promethazine 50mg supp, vial, ampul (AGE)* *Reglan®* *scopolamine (gen Transderm-Scop®)* *Tigan®* *Transderm-Scop®* *trimethobenzamide*	*♦**Bonjesta®/Diclegis®:** Approve through EDD. member must be pregnant and at least 18 years of age.
***GI Motility, Chronic**		
****Linzess™** **lubiprostone and AG** **Movantik®**	*alosetron* *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** ****Pediatric use of Linzess 72 mcg only:** 1. Diagnosis of functional constipation (FC) 2. Member is 6 to 17 years of age 3. Prescriber attestation that other causes of constipation have been ruled out 4. Member has had treatment failure on at least TWO of the following: Osmotic Laxatives (i.e., lactulose, polyethylene glycol, sorbitol), OR Bulk Forming Laxatives (i.e., psyllium, fiber), OR Stimulant Laxatives (i.e., bisacodyl, senna)
H. Pylori Treatment		

Preferred Agents	Non-Preferred Agents		SA Criteria
Pylera®	*bismuth-metronidazole-tetracycline (gen Pylera®)* *Helidac®* *Omeclamox®-Pak* *lansoprazole/amoxicillin/clarithromycin* *Prevpac®* *Talicia®* *Voquezna®*	**LENGTH OF AUTHORIZATIONS**: **Routine PDL edits**	14 days
Proton Pump Inhibitors			
omeprazole RX **pantoprazole** **Protonix® susp**	*Aciphex® DR tab/sprinkle* *dexlansoprazole dr (gen Dexilant®)* *Dexilant®* *esomeprazole magnesium cap/susp* *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*	**LENGTH OF AUTHORIZATIONS**: then 1 year **Routine PDL edits plus** ***♦All non-preferred Proton Pump Inhibitors require submission of a Clinical SA. Refer to Proton Pump Inhibitor SA form** **Preferred agents require a SA for use over 90 days**	12 weeks; unless member meets an exception;
Ulcerative Colitis Oral and Rectal Preparations (5-ASA DERIVATIVES)			
Ulcerative Colitis – Oral		**LENGTH OF AUTHORIZATIONS**: **Routine PDL edits**	**1 year**
Apriso® **balsalazide disodium** **Pentasa®** **sulfasalazine DR & IR**	*Asacol ®HD* *Azulfidine® IR &DR* *budesonide ER (generic Uceris™)* *Colazal®*		

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
		Delzicol™ *Dipentum* *Lialda®* *mesalamine (generic Apriso®)* *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® foam*	
Genitourinary			
	Alpha-Blockers and Androgen Hormone Inhibitors For Benign Prostatic Hypertrophy (BPH)		
	Alpha-Blockers for BPH		**LENGTH OF AUTHORIZATIONS:** **1 year** **Routine PDL edits** ***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.
	alfuzosin **tamsulosin HCL**	*Flomax ®* *Rapaflo®* *silodosin (generic Rapaflo)* *Uroxatral®*	
	Androgen Hormone Inhibitors for BPH		
	dutasteride **finasteride**	*Avodart ®* *dutasteride/tamsulosin* *Jalyn®* *Proscar®*	
	Androgen Hormone Inhibitors and Phosphodiesterase (PDE) 5 Inhibitor forBPH		
		Entadfi™	
	Phosphodiesterase (PDE) 5 Inhibitor for BPH		
		**Cialis® (ST)* *tadalafil 5 mg (ST)*	

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	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Urinary Antispasmodics (Bladder Relaxant)			
	oxybutynin tab/syrup **oxybutynin ER** **solifenacin** **Toviaz™**	*darifenacin ER (generic Enablex®)* *Detrol® & Detrol® LA* *Ditropan® & *Ditropan® XL* *fesoterodine fumarate er* *flavoxate* *Gelnique™ gel/gel Pump* *Gemtesa®* *Myrbetriq™ tab, Granules* *Oxytrol® transdermal includes OTC* *Sanctura XR* *trospium IR & ER* *tolterodine IR & ER* *VESIcare® and LS*	
Immunological Agents			
	***♦Multiple Sclerosis** **CLOSED CLASS**		
	Avonex® **Avonex® Adm Pack** **Betaseron®** **Copaxone 20 mg syringe®** **dimethyl fumarate and Starter Pack** **fingolimod** ****Kesimpta® (ST)** **teriflunomide (generic Aubagio®)**	*Aubagio®* *Bafiertam™* *Briumvi™* *Copaxone® 40 mg syringe®* *Extavia® Kit* *Gilenya®* *glatiramer 20 mg/ml syringe* *Glatopa™* *Mavenclad®* *Mayzent®* *Ocrevus®* *Plegridy®* *Ponvory™* *Rebif® SQ* *Rebif® Rebidose Pen®* *Tascenso ODT™*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits plus** ***Adherence to the documented PI age and diagnosis required, reviewed electronically, AutoPA** ****Kesimpta® requires step trial of dimethyl fumarate (generic Tecfidera®) or a preferred Injectable agent, to be determined by an AutoPA.** **Multiple Sclerosis SA Form** **Briumvi SA Form** **Ocrevus SA Form** **Tysabri SA Form**

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	Tecfidera® *Tecfidera® Starter Pack* *Tysabri®* *Vumerity™* *Zeposia®*	
Drugs to improve walking in members with (MS)		
dalfampridine ER (generic Ampyra®)	*Ampyra®*	**Amprya® and dalfampridine ER require the submission of a Clinical SA.** **Refer to MS - Ampyra® SA form**
♦Cytokine and CAM Antagonists And Related Agents		**CLOSED CLASS**
Enbrel® Pen, Sureclick, Syringe, Vial **Humira® Pen, Syringe** **infliximab (gen Remicade®)** **methotrexate tab/PF vial/MDV**	*Abrilada™* *Actemra® SQ & ACTPEN* *Adalimumab-Adaz* *Adalimumab-Fkjp Pen* *Amjevita™* *Amjevita™ Autoinjector* *Arcalyst®* *Avsola™* *Bimzelx®* *Cibinqo™* *Cimzia® & Cimzia® Syringe Kit* *Cosentyx™* *Cosentyx™ UnoReady pen* *Cyltezo®* *Enspryng™* *Entyvio®* *Hadlima™* *Hulio®* *Hyrimoz®* *Idacio®* *Ilaris®* *Ilumya™* *Inflectra®* *Kevzara® inj, pen* *Kineret®*	**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** **** 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**

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
		Olumiant® *Omvoh™* *Orencia®* *Otezla®* *Otrexup®* *Rasuvo™* *RediTrex®* *Remicade®* *Renflexis®* *Rinvoq™* *Skyrizi™ syringe, Pen* *Siliq®* *Simlandi™* *Simponi®* *Simponi®Aria* *Spevigo®* *Stelara® vial/syringe* *Sotyktu™* *Taltz®* *Tremfya™* *Trexall®* *Tyenne®* *Uplizna®* *Velsipity®* *Xatmep™* *Xeljanz™, Xeljanz™ XR and solution* *Yuflyma®* *Yusimry™* *Zymfentra™*	
Ophthalmic			
	Antibiotics		
	bacitracin/polymyxin b sulfate oint **ciprofloxacin drops** **erythromycin**	*AzaSite™ drops* *bacitracin* *Besivance® drops* *Ciloxan® drops/oint*	**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**	*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/prednisolone** **Tobradex® oint/susp** **tobramycin/dexamethasone susp**	*Blephamide® S.O.P.* *Maxitrol® oint/susp* *neomycin/bacitracin/poly/HC* *neomycin/polymyxin/HC* *Pred-G®oint* *Tobradex® ST* *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**
Alaway OTC® **ketotifen fumerate** **olopatadine (generic Patanol & Pataday)** **Zaditor® OTC**	*bepotastine (gen Bepreve®)* *Bepreve®* *Elestat®* *epinastine 0.05% eye drops* *Lastacaft®* *Optivar®* *Patanol® Rx and OTC*	

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	Pataday® Rx and OTC *Zerviate ™*	
Mast Cell Stabilizers		
cromolyn sodium	*Alocril®* *Alomide®*	
Anti-inflammatory Agents		
Corticosteroids		
Durezol® **fluorometholone** **prednisolone acetate**	*Alrex™* *Dexamethasone* *difluprednate (gen Durezol®)* *Flarex®* *FML®, FML Forte®* *loteprednol etabonate (generic Lotemax™gel)* *Lotemax™ drops/gel/oint* *Maxidex®* *Omnipred®* *Pred Forte® & Pred Mild®* *prednisolone sod phosphate* *Vexol®*	
Immunomodulators	CLOSED CLASS	
Restasis® **Restasis Multidose®** **Xiidra®**	*Cequa™* *cyclosporine* **Eysuvis* *Miebo™* *Tyrvaya™ Nasal Spray* ***Verkazia®*	*♦DUR DURATION LIMIT Eysuvis 1 bottle in 3 months, message returned to pharmacist stating "Limitation Exceeded: Quantity Limit of 1 Bottle per 3 Months. Member needs Intraocular Pressure (IOP) Test. If IOP test completed, Physician to call 1-800-932-6648 for a Clinical SA" **♦**Verkazia criteria (PDL criteria do not apply)** • Member is ≥4 years of age; **AND** • Diagnosis of moderate to severe vernal keratoconjunctivitis; **AND**

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
		• Trial and failure, contraindication, or intolerance to one of the following: o Topical ophthalmic "dual-action" mast cell stabilizer and antihistamine (e.g., olopatadine, azelastine) **OR** o Topical ophthalmic mast cell stabilizers (e.g., cromolyn); **AND** • Prescribed by ophthalmologist or optometrist in consultation with an ophthalmologist • Quantity Limit: 120 single-dose vials per 30 days • Length of approval: 1 year
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 sodium 0.075%* *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 0.1 &0.15%* *Iopidine® 0.5% & 1%*	
Beta Blockers		
carteolol 1% **Combigan®**	*Betagan® 0.5%* *betaxolol 0.5%*	

Preferred Agents	Non-Preferred Agents	SA Criteria
levobunolol 0.5% **metipranolol 0.3%** **timolol maleate**	*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® **dorzolamide** **dorzolamide/timolol**	*brinzolamide* *Cosopt® 0.5%-2%* *Cosopt® PF* *Simbrinza™* *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* *Iyuzeh™* *Lumigan® 0.03% & 0.01%* *Rescula®* *tafluprost* *travoprost 0.004%* *Vyzulta™* *Xalatan® 0.005%* *Xelpros® (latanoprost)* *Zioptan™*	

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

10/1/24

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Respiratory		
***Anti-Allergens, Oral**		
Grass Pollen		**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 or Palforzia SA Form**
	**Grastek®* **Odactra®* **Oralair® SL* **Ragwitek™*	
Peanut		
	**Palforzia™*	
Antihistamines: First and Second Generation		
First Generation Antihistamines		**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits**
Generic only class	*All Brands require a SA*	
Second Generation Antihistamines and Combinations		
cetirizine liquid 1mg/1mL (RX/OTC) **cetirizine tabs OTC** **levocetirizine 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**
arformoterol (authorized generic Brovana®) **Serevent Diskus®**	*arformoterol (generic Brovana®)* *Arcapta DS* *Brovana®*	

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	formoterol fumarate (generic Perforomist®) *Perforomist®* *Striverdi® Respimat*	
Short Acting Metered Dose Inhalers or Devices		
Proair® HFA **ProAir® RespiClick** **Ventolin® HFA**	*albuterol HFA (Proair®)* *albuterol HFA (Ventolin®)* *albuterol HFA (Proventil®)* *levalbuterol tartrate HFA* ~~*ProAir® Digihaler™*~~ ~~*Proventil® HFA*~~ *Xopenex® HFA*	
Short Acting Nebulizers		
albuterol sulfate (premixed)	*levalbuterol soln* *Xopenex®*	
COPD: Anticholinergics, Bronchodilators and Phosphodiesterase 4 (PDE4) Inhibitors CLOSED CLASS		
Short Acting Anticholinergics/Short ActingBronchodilators CLOSED CLASS		
Atrovent HFA® **ipratropium bromide soln**		
Short Acting Anticholinergics/Short ActingBronchodilators CLOSED CLASS		
Combivent® Respimat **ipratropium/albuterol nebs**	*Bevespi Aerosphere™* *Duaklir Pressair*	**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edits**
Long Acting Anticholinergics CLOSED CLASS		
Spiriva® **Spiriva® Respimat**	*Incruse™ Ellipta®* *Lonhala™ Magnair™* *tiotropium (generic for Spiriva®)* *Tudorza™* **Yupelri™ (revefenacin)*	**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edits plus** ***Clinical Criteria Yupelri™ (**reviewed electronically, AutoPA**)** • Diagnosis of COPD **AND** • Trial/failure of Spiriva® Handihaler OR Spiriva® Respimat

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Long Acting Anticholinergics/Long ActingBronchodilators CLOSED CLASS		
Anoro™ Ellipta® (AGE) **Stiolto Respimat™ (AGE)**		**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edits**
Phosphodiesterase 4 (PDE4) Inhibitors CLOSED CLASS		
***roflumilast**	**Daliresp®*	**LENGTH OF AUTHORIZATION**: 1 year ***Clinical Criteria for Daliresp® and roflumilast** • 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®** **Trelegy® Ellipta**	*AirDuo® Digihaler®* *Airduo ™ Respiclick®* *budesonide-formoterol (generic Symbicort®)* *Breo®Ellipta™* *Breyna™ (generic Symbicort®)* *Breztri Aerosphere™* *fluticasone/salmeterol (generic Airduo)* *fluticasone/salmeterol powder (generic Advair)* *fluticasone/salmeterol HFA (generic Advair HFA)* *fluticasone-vilanterol (generic Breo®Ellipta™)* *Wixela® (fluticasone/salmeterol)*	

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Inhaled Corticosteroids: Metered Dose Inhalers CLOSED CLASS		
Alvesco® **Arnuity™ Ellipta®** **Asmanex Twisthaler** **Asmanex HFA®** **Flovent® Diskus** **Flovent® HFA** **QVAR® Redihaler** **Pulmicort Flexhaler®**	*Aerospan™* *ArmonAir® Digihaler™* *fluticasone HFA(gen Flovent® HFA)* *fluticasone Diskus (gen Flovent® Diskus)*	
Inhaled Corticosteroids: Nebulizer Solution CLOSED CLASS		**LENGTH OF AUTHORIZATIONS**: 1 year
budesonide respules	*Pulmicort® Respules*	
Nasal Steroids		**Routine PDL edits**
Dymista® **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* *Flonase®* *Flonase Sensimist (OTC)* *flunisolide* *fluticasone OTC* *ipratropium bromide spray* *mometasone (generic Nasonex®)* *Nasonex OTC* *Omnaris®* *Qnasl™* *Rhinocort Aqua®* *Rhinocort® Allergy OTC*	

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	Ryaltris® *Ticanase®* *triamcinolone OTC* *triamcinolone acetonide* *Veramyst®* *Xhance™* *Zetonna™*	
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**
***♦ Immunomodulators, Asthma CLOSED CLASS**		
Fasenra Pen **Fasenra Syringe** **Xolair Autoinjector** **Xolair Syringe** **Xolair Vial**	*Cinqair* *Nucala Auto-Injector* *Nucala Syringe* *Nucala Vial* *Tezspire Pen* *Tezspire Syringe*	**LENGTH OF AUTHORIZATIONS**: **see fax forms** **Routine PDL edits plus** ***♦ All Agents require the submission of a Clinical SA. Refer to fax forms below:** **Cinqair SA Form** **Fasenra SA Form** **Nucala SA Form** **Tezspire SA Form** **Xolair SA Form**
Intranasal Antihistamines		
azelastine 0.1%	*Astepro® 0.15%*	**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**