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

1/1/26

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.
Drugs highlighted in blue indicate where brand is preferred over generic.

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®* *Oramorph ® SR®* *oxycodone-long acting* *OxyContin®* *oxymorphone ER* *Xartemis™ XR* *Zohydro ER™*	

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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).
	fentanyl citrate *Lazanda®* *Subsys®*	
Short-Acting Opioids		***All Short-Acting Opioids (preferred and non-preferred) require the submission of a Clinical SA if prescribed for > 7 days or if more than two 7-day supply prescriptions within 60 days. Refer to combined short/long-acting opioid SA form (Short & Long Acting Opioid SA Form)**
codeine/APAP **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* *Oxaydo®* *oxycodone/APAP(gen PrimLev™)* *oxycodone conc* *oxycodone oral syringe* *oxycodone/ASA* *oxycodone/ibuprofen* *oxymorphone HCl* *Panlor®* *pentazocine/naloxone* *PrimLev™*	

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Preferred Agents	Non-Preferred Agents	SA Criteria
	RoxyBond™ *Seglentis®* *tramadol 25mg, 75mg, 100 Mg* *tramadol soln (AG for Qdolo®)* *Ultracet®* *Zamicet ®soln*	
♦ Opioid Dependency	CLOSED CLASS	
***buprenorphine SL** **buprenorphine/naloxone tab SL** **Brixadi™** **Suboxone® film** **Sublocade™ SQ**	**buprenorphine/naloxone film SL* **Probuphine® implant* **Zubsolv™* ***Lucemyra®* ***lofexidine*	***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**
Kloxxado™ Spray **naloxone syringe & vial** **naloxone nasal spray** **naloxone nasal spray OTC** **Naloxone Carpuject** **naltrexone tab** **Narcan® Nasal Spray Rx/OTC** **Opvee®** **Rextovy™ Nasal Spray** **Vivitrol®** **Zimhi™** **Zurnai™**		

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®, celecoxib and Vyscoxa™** • 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®, celecoxib and Vyscoxa™ for which preferred drugs are not indicated.
Children's Motrin® susp (OTC) **diclofenac sodium** **ibuprofen cap** **ibuprofen tab 100mg, 200mg, 400mg, 600mg, 800mg (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* *etodolac IR & SR* *Feldene®* *fenoprofen* *flurbiprofen* *ibuprofen 300mg tab* *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™)*	

Preferred Agents	Non-Preferred Agents	SA Criteria
	Mobic® susp *Motrin®* *nabumetone* *Nalfon®* *Naprelan®* *Naprosyn®* *naproxen CR (generic Naprelan®)* *naproxen-esomeprazole mag (generic Vimovo®)DR* *naproxen susp* *oxaprozin* *piroxicam* *Ponstel®* *Prevacid Naprapac®* *Sprix® nasal spray* *Tivorbex™* *tolmetin sodium* *Vimovo®* *Vivlodex™* **Vyscoxa™* *Voltaren®XR* *Zipsor®* *Zorvolex™*	
Topical NSAIDs		**LENGTH OF AUTHORIZATIONS: 1 year** **Routine PDL edits plus** ***Clinical Criteria for Non-Preferred Topical NSAIDs; Flector®, diclofenac epolamine 1.3% patch, diclofenac 1.5% and 2% topical sol, Licart™ patch, Lixofen 1.5% Kit Pennsaid®, & 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 1.5% and 2% topical sol, Lixofen 1.5% Kit, Pennsaid® and Xrylix™ Kit can only be approved for the FDA approved indication of osteoarthritis of the knee.
diclofenac sodium 1% gel **diclofenac sodium 1% gel (OTC)**	**diclofenac 1.5% topical soln* **diclofenac 2% topical soln gen* **diclofenac epolamine 1.3% ptch(QL)* *Diclogen Kit* **Flector® patch (QL)* **Licart™ patch (diclofenac epolamine 0.013gm (QL)* **Lixofen 1.5% Kit* **Pennsaid® top soln, soln pkt & pump*	

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
		**Xrylix™ Kit*	***Quantity limit for diclofenac epolamine 1.3%, Flector® and Licart™ patch = 30 patches per RX***
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:
			  ○ chest radiography or high-resolution computed tomography (HRCT) scan; AND
			  ○ at least 2 positive sputum cultures; AND
			  ○ 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®.

Preferred Agents	Non-Preferred Agents	SA Criteria
		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 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**	*Brexafemme®* *clotrimazole (mucous mem)* *Cresemba®* *Diflucan® tab/susp* *flucytosine* *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

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Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Cephalosporins, Oral		
Second Generation Cephalosporins		**LENGTH OF AUTHORIZATIONS**: Date of service only; no refills. **Routine PDL edits plus** **Clinical Criteria for Non-Preferred Cephalosporins** • Infection caused by an organism resistant to preferred drugs, **OR** • A therapeutic failure to no less than a three-day trial of **one preferred cephalosporin**; **OR** • The member is completing a course of therapy with a non-preferred drug initiated in the hospital.
cefaclor capsule **cefprozil tab/susp** **cefuroxime tab**	*cefaclor ER* *cefaclor susp* *Ceftin® tab/susp*	
Third Generation Cephalosporins		
cefdinir cap/susp	*Cedax® cap/susp* *ceftibuten* *cefditoren pivoxil* *cefixime suspension* *cefpodoxime proxetil cap/susp* *Spectracef®* *Suprax® chewable tab/cap/susp*	
Macrolides, Oral		
Macrolides & Ketolides		**LENGTH OF AUTHORIZATIONS**: Date of service only; no refills **Routine PDL edits plus** **Clinical Criteria for Non-Preferred Macrolides and Ketolides** • Infection caused by an organism resistant to preferred drugs, **OR** • A therapeutic failure to no less than a **three-day trial of one preferred drug within the same class**; **OR** • The member is completing a course of therapy with a non-preferred drug which was initiated in the hospital.
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®	*Cipro HC®*	**LENGTH OF AUTHORIZATIONS:** Date of service only; no refills

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
ciprofloxacin/dexamethasone (generic Ciprodex) **ofloxacin** **neomycin/polymyxin/hc soln/ sus**	*ciprofloxacin 0.2% otic soln* *ciprofloxacin and fluocinolone acetonide (generic Otovel)* *Cortisporin TC* *Otovel*	**Routine PDL edits**
Quinolones, Oral		
Second Generation Quinolones		**LENGTH OF AUTHORIZATIONS**: Date of service only; no refills **Routine PDL edits plus**: **Clinical Criteria for Non-Preferred Quinolones** • Infection caused by an organism resistant to preferred drugs; **OR** • A therapeutic failure to no less than a **three-day trial of one preferred quinolone**; **OR** • The member is completing a course of therapy with a non-preferred drug initiated in the hospital.
ciprofloxacin susp/tab	*Cipro® IR, XR & susp* *ciprofloxacin ER* *Noroxin®* *ofloxacin*	
Third Generation Quinolones		
levofloxacin tab	*Baxdela™ tab* *Levaquin® tab/susp* *levofloxacin susp* *moxifloxacin*	
Topical Antibiotics		
mupirocin ointment	*Centany®* *Centany AT® Kit* *mupirocin cream*	**LENGTH OF AUTHORIZATIONS**: Date of service only; no refills **Routine PDL edits**
Vaginal Antibiotics		
Cleocin® Ovules **Clindesse® cr** **metronidazole gel**	*Cleocin® cr* *clindamycin cr* *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®*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits**
Herpes Topical		
acyclovir oint **docosanol**	*Abreva OTC®* *acyclovir cr (generic Zovirax cr)* *Denavir®* *penciclovir*	**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* *emtricit-rilp-tenof* *Kaletra® tab* *Lexiva® susp* *Norvir® tab* *Prezista® tab/susp* *Retrovir® syrup* *Reyataz® cap* *stavudine cap* *Trizivir® tab* *Trogarzo® (intraven)* *Viracept® tab* *Viread® tab* *Ziagen® tab* *Yeztugo®*	**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** **Kaletra® soln** **lamivudine tab/soln** **lamivudine-zidovudine tab** **Lexiva® tab** **lopinavir-ritonavir 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**			

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	Triumeq® PD **Truvada® tab** **Tybost® tab** **Viramune® tab** **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**
	COVID-19 **CLOSED CLASS**		
	Paxlovid		**LENGTH OF AUTHORIZATIONS:** Date of service only
Blood Modifiers			
	Bile Salts		
	ursodiol cap, tab	**Bylvay™* *Chenodal®* *Cholbam®* *Iqirvo®* *Livdelzi®* ***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).

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
			* Bylvay™ (PDL criteria do not apply) • Must have a confirmed diagnosis of cholestatic pruritus in: o Members 12 months of age and older with Alagille syndrome (ALGS) o Members 3 months of age and older with progressive familial intrahepatic cholestasis (PFIC)
	Colony Stimulating Factors CLOSED CLASS		
	Fulphila **Neupogen Disp Syrin** **Neupogen Vial**	*Fylnetra* *Granix Syringe* *Granix Vial* *Leukine* *Neulasta Kit* *Neulasta Syringe* *Nivestym Syringe* *Nivestym Vial* *Nypozi* *Nyvepria* *Releuko Syringe* *Releuko Vial* *Rolvedon Syringe* *Ryzneuta 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
	Advate® **Adynovate®** **Afstyla®**		All products are preferred without EDITS

Preferred Agents	Non-Preferred Agents	SA Criteria
Alphanate® Altuviiio™ Eloctate® Esperoct® Hemofil-M® Humate-P® Jivi® Koate-DVI® Kogenate FS® Kovaltry® Novoeight® Nuwiq® Obizur® Recombinate® Xyntha® Kit & Solofuse Syr		
Factor IX Products		
AlphaNine SD® Alprolix® BeneFIX® Idelvion® Ixinity® Profilnine SD® Rebinyn® Rixubis®		
Factor VIIa & Activated Prothrombin Complex Concentrate		
Feiba NF® NovoSeven RT® Sevenfact®		
Factor IXa and Factor X Directed Antibody		
Hemlibra®		

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Factor X and Factor XIII Products		
Coagadex® **Corifact® Kit** **Tretten®**		
Antithrombin Lowering Agents		
Qfitlia		
Prothrombin Complex Concentrate		
Balfaxar®		
Tissue Factor Pathway Inhibitor Antagonist		
Alhemo® **Hympavzi™**		
Von Willebrand		
Vonvendi® **Wilate®**		
Phosphate Binders		
calcium acetate 667mg cap **calcium acetate 668 mg** **sevelamer carbonate tab**	*Auryxia™* *calcium acetate 667mg tab* *Calphron* *Eliphos* *Fosrenol® chewable tab* *lanthanum carbonate chewable tab* *Phoslyra® powder, tab* *Renvela®* *sevelamer carbonate powder packet* *sevelamer HCL (gen Renagel)* *Velphoro® chewable tab*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits**

	Preferred Agents	Non-Preferred Agents	SA Criteria
		Xphozah™	
	Sickle Cell CLOSED CLASS		
	Droxia **Endari** ****Siklos** ***Xromi**	*Adakveo IV* *l-glutamine(generic Endari)*	*Non-preferred agents, **Siklos® (if 18 years of age and older), and *Xromi (if 2 years of age and older) require the submission of a Clinical SA. Preferred agents do not require submission of any SA. Refer to **Sickle Cell SA Form** ****Clinical Criteria for Siklos (hydroxyurea):** • Member must be 2-17 years old ***Clinical Criteria for Xromi (hydroxyurea):** Member must be < 2 years old
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		**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits**
	Others		
	raloxifene	*Evista®* **Forteo®* **teriparatide* **Tymlos™*	**LENGTH OF AUTHORIZATIONS**: Initial approval will be for 1 year **Routine PDL edits for Evista®** *♦ **Clinical SA must be completed for (Forteo, teriparatide or Tymlos SA Form)**

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

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	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
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™ tab, sprinkle cap, susp **Eliquis™ Dose Pack** **Jantoven ®** **Pradaxa®** **warfarin** **Xarelto® & Starter Pack, susp**	*dabigatran* *Pradaxa® Pellet Pack* *rivaroxaban* **Savaysa™*		
Antihypertensive Agents			
ACE Inhibitors		**LENGTH OF AUTHORIZATIONS: 1 year** **Routine PDL edits**	
benazepril **enalapril** **lisinopril** **ramipril**	*Accupril®* *Altace®* *captopril* *Epaned™ soln* *enalapril soln* *fosinopril* *Lotensin®* *Mavik®* *moexipril* *Monopril®* *perindopril* *Qbrelis™* *quinapril*		

Preferred Agents	Non-Preferred Agents	SA Criteria
	trandolapril *Univasc®* *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)* *Zestoretic®*	
Angiotensin Receptor Blockers		**LENGTH OF AUTHORIZATIONS:** **1 year** **Routine PDL edits plus** *Quantity Limit = 2 per day for Entresto™ and sacubitril/valsartan generics* ****Entresto Sprinkle capsule:** • The member is intolerant to solid oral dosage forms
Entresto™ (QL) **irbesartan** **losartan** **olmesartan** **telmisartan** **valsartan**	*Arbli™* *Atacand®* *Avapro®* *Benicar®* *candesartan* *Cozaar®* *Diovan®* *Edarbi®* ***Entresto Sprinkle™* *eprosartan mesylate* *Micardis®* *sacubitril/valsartan (QL)* *Teveten®*	

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

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Preferred Agents	Non-Preferred Agents	SA Criteria
	valsartan solution	
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** **telmisartan/HCTZ** **valsartan/HCTZ**	*Atacand HCT®* *Avalide®* *Benicar HCT®* *candesartan/HCTZ* *Diovan HCT®* *Edarbyclor®* *Hyzaar®* *Micardis HCT®* *Teveten HCT®*	
Beta Blockers		***Clinical Criteria for Hemangeol™** • Diagnosis of proliferating infantile hemangioma requiring systemic therapy
atenolol **bisoprolol** **carvedilol** **labetalol** **metoprolol tartrate** **metoprolol succinate** **nadolol** **nebivolol** **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®* *pindolol*	

Preferred Agents	Non-Preferred Agents	SA Criteria
	propranolol LA *Sectral®* *Sotylize ™* *Tenormin®* *timolol maleate* *Toprol XL®* *Zebeta®*	
Beta Blockers + Diuretic Combinations		
atenolol/chlorthalidone **bisoprolol/HCTZ**	*Corzide®* *Dutoprol®* *Lopressor HCT®* *metoprolol/HCTZ* *nadolol/bendroflumethiazide* *propranolol/HCTZ* *Tenoretic®*	
Calcium Channel Blockers –Dihydropyridine		
amlodipine **nifedipine** **nifedipine ER**	*Conjupri®* *Consensi® (amlodipine/celecoxib)* *felodipine ER* *isradipine* *Katerzia™oral suspension* *levamlodipine (generic Conjupri®)* *nisoldipine* *nicardipine* *Norliqva®* *Norvasc®* *Procardia XL®* *Sular®*	
Calcium Channel Blockers- Non-Dihydropyridine		

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

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Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Cartia XT® **diltiazem IR, ER q12hr & 24hr** **verapamil tab IR & ER**	*Calan® IR & SR* *Isoptin SR®* *diltiazem LA* *Matzim LA* *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 • Member has diagnosis of heterozygous familial hypercholesterolemia (HeFH) or established atherosclerotic cardiovascular disease (ASCVD); AND
ezetimibe	*Nexletol® (bempedoic acid)* *Nexlizet® (bempedoic acid/ ezetimibe)* *Zetia®*	

Preferred Agents	Non-Preferred Agents	SA Criteria

		• 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:
		  ○ 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
		  ○ Very high risk ASCVD: (defined as less extensive ASCVD and poorly controlled cardiometabolic risk factors) with an LDL-C ≥ 100 mg/dL; OR
		  ○ 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* *Fibricor®* *Lipofen®* *Lofibra®*	

Preferred Agents	Non-Preferred Agents	SA Criteria
	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/ezetimibe* *Vytorin®* *Zocor®* *Zypitamag™*	
HMG CoA Reductase Inhibitors and Combinations (Statins)		
lovastatin **pravastatin**	*Altoprev®* *fluvastatin* *Lescol®and Lescol XL®* *Mevacor®* *Pravachol®*	
Microsomal Triglyceride Transfer Protein Inhibitor		***♦ Clinical Criteria for Juxtapid™. Refer to Juxtapid™ SA Fax Form**
	**Juxtapid ™*	
Niacin Derivatives		
niacin ER	*Niaspan®* *Niacor®*	
Omega 3 Fatty Acid Agent		*****♦ Clinical Criteria for Lovaza® and omega-3 acid ethyl esters** • Step edit requires trial and failure of any other lipotropic; **OR**
icosapent ethyl (gen Vascepa®)	****Lovaza®*	

Preferred Agents	Non-Preferred Agents	SA Criteria
***omega-3 acid ethyl esters Omega-3 OTC		• 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®* *ticagrelor* ***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™, ASA/omeprazole & 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**		
Activin Signaling Inhibitor		**LENGTH OF AUTHORIZATIONS: 1 year** **Routine PDL edits for all Pulmonary Arterial Hypertension Agents**
	Winrevair™	
Inhaled Prostacyclin Analogues		
Ventavis®	*Tyvaso®* *Tyvaso DPI™ (treprostinil)* *Yutrepia™*	

	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*	
	***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 & transderm* *galantamine IR, ER tab/soln* *memantine/donepezil* *Namzaric® (memantine/donepezil)* *Razadyne® IR, ER* *rivastigmine cap* *Zunveyl®*	

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

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Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
NMDA Receptor Antagonist		
memantine tab	*memantine Dose Pack, soln* *memantine ER*	
Anticonvulsants **CLOSED CLASS**		
Barbiturates		**LENGTH OF AUTHORIZATIONS:** **1 year** **Routine PDL**
phenobarbital elixir/tab **primidone** **Sezaby**		
Benzodiazepines		
clobazam tab/susp **clonazepam tab** **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**	*Aptiom®* *carbamazepine 200mg chewable tab* *carbamazepine ER* *carbamazepine XR (authorized generic only)*	

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Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Tegretol®XR **Trileptal® susp**	*eslicarbazepine acetate* *Equetro® cap* *Oxtellar™ XR* *oxcarbazepine susp* *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		
Depakote® sprinkle **divalproex tab** **divalproex ER** **valproic acid cap, soln**	*Depakote® ER* *divalproex sprinkle*	
Other Anticonvulsants		
lacosamide soln/tab (gen Vimpat®) **lamotrigine tab** **lamotrigine chew tab** **lamotrigine XR** **levetiracetam soln/tab** **levetiracetam ER** **roweepra (generic levetiracetam)** **subvenite tab (generic lamotrigine)** **topiramate tab** **topiramate 15, 25 mg sprinkle cap**	*Banzel® susp/tab* *Briviact®* tab/soln *Diacomit®* cap/powder pack *Elepsia®XR tab* *Eprontia ™* *felbamate susp/tab* *Felbatol® tab* ** Fintepla®* *Fycompa® susp/tab* *Keppra® soln/tab* *Keppra® XR* *lacosamide solution unit dose* *Lamictal® XR & XR dose pk* *Lamictal® tab/dose pk*	*♦ **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,

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
zonisamide cap	*Lamictal® ODT* *Lamictal® ODT dose pk* *lamotrigine tab dose pk* *lamotrigine ODT* *lamotrigine ODT dose pk* *Motpoly XR™* *perampanel* *rufinamide susp/tab (generic Banzel®)* *Qudexy™ XR* *Sabril® powder pack/tab* *Spritam®* *subvenite dose pk/susp* *tiagabine* *Topamax® tab/sprinkle* *topiramate ER cap* *topiramate soln* *topiramate 50mg sprinkle cap* *Trokendi™ XR* *vigabatrin tab/ powder pack (generic Sabril®)* *Vigafyde™* *Vimpat® soln/tab* *Xcopri®* *Zonisade™ Solution* ***Ztalmy®*	topiramate, felbamate, vigabatrin) or member has labeled contraindications to other antiepileptic drugs • Renewal: ○ 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**	*Auvelity™* *Brintellix®* *bupropion XL (gen Forfivo® XL)* *desvenlafaxine ER tab (gen Khedezla™)* *Effexor® XR*	

Preferred Agents	Non-Preferred Agents	SA Criteria

vilazodone tab	*Emsam® transdermal*
	Exxua ™
	Fetzima®
	Forfivo® XL
	Khedezla™
	Marplan®
	Nardil®
	nefazodone
	Parnate®
	phenelzine
	Pristiq®
	Raldesy™
	Remeron® ODT/tab
	tranylcypromine sulfate
	Trintellix
	venlafaxine ER tab
	Viibryd®dose pk
	Viibryd® tab
	Wellbutrin® SR
	**Zurzuvae™*
		*♦ **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

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*	

Preferred Agents	Non-Preferred Agents	SA Criteria
	Sarafem® *sertraline cap* *Zoloft® conc/tab*	
Antimigraine Agents		
sumatriptan succinate tab cartridge/vial/pen **rizatriptan tab/MLT**	*almotriptan* *Alsuma®* *Amerge®* *Axert®* *Cambia®* *eletriptan (generic Relpax®)* *Elyxyb®* *Frova®* *frovatriptan (generic Frova®)* *Imitrex® cartridge/pen/tab/vial* *Maxalt® tab & MLT* *Migranow™ Kit* *naratriptan* *Onzetra™ Xsail™* *Relpax®* *sumatriptan KITS* *Sumavel® Dosepro* *sumatriptan/nap (gen Treximet®)* *Symbravo®* *Tosymra®* *Treximet®* *Zembrace ™ SymTouch ™* *zolmitriptan nasal* *Zomig® tab/nasal spray/ZMT*	**LENGTH OF AUTHORIZATIONS:** **1 year** **Routine PDL edit**
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**

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Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Preventive Treatment		**Preferred Agents *step edit required** **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 = 3 mL per 30 days (Episodic cluster headache treatment) Nurtec® ODT = 16 tabs per 30 days Qulipta™ = 1 tab per day **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
Aimovig™ **Ajovy® Autoinjector & Syringe** **Ajovy Autoinjector 3-Pk** **Emgality™ Syringe** **Emgality™ Pen** **Nurtec™ ODT** **Qulipta™**	*Emgality™ 100MG Syringe* ***Vyepti®*	
Acute treatment of migraine		
Nurtec™ ODT **Ubrelvy®**	*Reyvow®* *Zavzpret™*	
Antipsychotics *(AGE) **CLOSED CLASS**		
Atypical		**LENGTH OF AUTHORIZATIONS: 1 year or 6 months for members < 18 yrs** **Routine PDL edits plus** ***♦ ALL antipsychotics for children 0 to 17 years of age (preferred and non-preferred) require the submission of a Clinical SA. Refer to (Antipsychotics In Children Less Than 18 Years SA Form)** ****Clinical Criteria Nuplazid™** • Indicated for the treatment of hallucinations and delusions associated with Parkinson's disease psychosis. *Quantity Limit Nuplazid™ = 2 per day* ***♦ Clinical Criteria for Abilify Mycite®** **Initial Approval Criteria: For Three months SA** Member must:
aripiprazole tab **clozapine tab** **lurasidone** **olanzapine ODT, tab, IM** **quetiapine fumarate ER** **quetiapine tab** **risperidone ODT/soln/tab** *****Vraylar™** **ziprasidone cap**	*Abilify® tab/IM inj* ****Abilify Mycite®(with sensor)* *aripiprazole ODT, soln* *asenapine (generic for Saphris®)* *Caplyta Capsule™* *Clozaril®* *clozapine ODT* *Cobenfy™* *Cobenfy™ Starter pk* *Fanapt® tab & titration pk* *Fazaclo®* *Geodon® tab, IM* *Invega®* *Latuda®* *Lybalvi®* ***Nuplazid™ tab, cap (QL)*	

Preferred Agents	Non-Preferred Agents	SA Criteria
	***olanzapine/fluoxetine* *Opipza™* *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*	• 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 • Have a healthcare provider state reason why the member cannot use long-acting injectable atypical antipsychotic if there is continued nonadherence. ******Clinical Criteria for Vraylar as adjunct treatment for Major Depressive Disorder (reviewed electronically, AutoPA)** • Member must be ≥ 18 years of age; AND • Member must have a diagnosis of Major Depressive Disorder; AND • Member must be adherent to complementary therapy with an antidepressant (e.g. selective serotonin reuptake inhibitor (SSRI) or serotonin/norepinephrine reuptake inhibitor (SNRI)) (80% of fills in the last 90 days) • Length of Authorization: 1 year

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

1/1/26

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Atypical, Long-Acting Injectable		**LENGTH OF AUTHORIZATIONS:** **1 year**
Abilify Asimtufii® **Abilify Maintena®** **Aristada®** **Aristada® Initio** **Invega Hafyera™, Sustenna® &Trinza®** **Perseris™** **Risperdal Consta®** **Uzedy™**	*Erzofri®* *Rykindo™* *Zyprexa® Relprevv™*	**Routine PDL edits**
Typical		**LENGTH OF AUTHORIZATIONS:** **1 year**
amitriptyline/perphenazine **chlorpromazine** **fluphenazine elixir/soln/tab** **fluphenazine decantate** **haloperidol decantate** **haloperidol lactate conc** **haloperidol tab** **loxapine** **perphenazine** **trifluoperazine** **thiothixene** **thioridazine**	*Adasuve®* *Haldol decanoate (injection)* *pimozide* *Moban®* *molindone*	**Routine PDL edits**
Duchenne Muscular Dystrophy CLOSED CLASS		
****Emflaza**	***Agamree* *Amondys-45* ***deflazacort* ***Duvyzat* *Exondys-51* *Jaythari* *Kymbee* *Pyquvi*	**LENGTH OF AUTHORIZATIONS:** **1 year** ****Clinical Criteria for oral Duchenne Muscular Dystrophy agents** • Member is 2 years of age or older for Agamree®, Emflaza™ and deflazacort • Member is 5 years of age or older for Jaythari, Pyquvi and Kymbee • Member is 6 years of age or older for Duvyzat™ • Member has a diagnosis of Duchenne Muscular Dystrophy (DMD)

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	Viltepso *Vyondys-53*	• For all oral agents, the member has tried and failed or is intolerant to prednisone or prednisolone • For non-preferred agents, 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 o 4 tabs/day Austedo® o 1 tab per day Austedo XR® o 42 tablets per 365 Austedo XR® titration pack o 1 cap/day Ingrezza®/Ingrezza Sprinkle® o 4 tabs/day Xenazine®

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

1/1/26

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Neuropathic Pain and Select Agents		
capsaicin OTC topical **duloxetine 20, 30 & 60 mg** **(generic for Cymbalta®)** **gabapentin cap/tab/soln** **lidocaine 5% patch** **pregabalin cap**	*Dermacinrx® PHN Pak™ Kit* *Drizalma™ Sprinkle* *duloxetine 40 mg (generic Irenka™)* *gabapentin ER* *Gralise™ (gabapentin, ER)* *Horizant ™ (gabapentin enacarbil ER)* *Irenka™* *Journavx™* *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** **Journavx SA Form** **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*	**LENGTH OF AUTHORIZATIONS**: Length of the prescription (up to 3 months) **Routine PDL edits**

Preferred Agents	Non-Preferred Agents	SA Criteria
	Restoril® *temazepam 7.5 mg & 22.5 mg* *triazolam*	
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®*	**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*
	Lyvispah™ *metaxalone* *orphenadrine citrate* *orphenadrine/ASA/caffeine* *Ozobax® DS* *Parafon Forte® DSC* **Soma®* *tizanidine cap* *Tonmya™* *Zanaflex®*	
Smoking Cessation		
bupropion SR **Chantix®** **Chantix® DS PK** **nicotine gum/lozenge/patch** **varenicline**	*Nicoderm CQ® Patch* *Nicorette® Gum/Lozenges* *Nicotrol® Inhaler & NS*	**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. Member must meet the minimum FDA approved age. Refer to Stimulant SA form (Stimulant/ADHD Medications SA Form) **This does not include nonstimulant agents such as atomoxetine, 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*	

Preferred Agents	Non-Preferred Agents	SA Criteria
	Evekeo® *lisdexamfetamine(generic Vyvanse®)* *methamphetamine* *Mydayis ER™* *Procentra® soln* *Vyvanse® chewable tab* *Xelstrym™* *Zenzedi™*	
Methylphenidate Drugs		
All methylphenidate IR generic **methylphenidate soln** **methylphenidate ER tab (Metadate ER tab)** **methylphenidate ER (Concerta)** **Daytrana® Transdermal** **dexmethylphenidate IR** **dexmethylphenidate XR**	*Aptensio ™ XR* *Azstarys ™* *Concerta®* *Cotempla XR-ODT™* *Focalin® IR & Focalin® XR* *Jornay PM* *methylphenidate CD cap (generic Medadate CD)* *Methylin ER®, soln IR* *methylphenidate chew* *methylphenidate LA, SR* *methylphenidate ER(generic Relexxii®)* *methylphenidate ER(generic Aptensio™ XR)* *methylphenidate (generic Daytrana®)* *Ritalin® IR, LA®* *Relexxii®* *QuilliChew ER™* *Quillivant™ XR susp*	

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	Miscellaneous Drugs		
	atomoxetine (generic for Strattera®) **clonidine ER** **guanfacine ER**	*Intuniv®* *Onyda™ XR* *Qelbree®*	
	♦ Narcolepsy Drugs		
	armodafinil **modafinil** **Sunosi™**	*Nuvigil ™* *Provigil®* *Wakix®*	**Routine PDL edits plus** **♦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		**LENGTH OF AUTHORIZATIONS:** 1 year **Routine PDL edits plus** ***♦ Clinical Criteria for Dermatologic Acne Agents** • Prescriptions for members over the age of 18 years will require the submission of a SA to evaluate treatment diagnosis; **AND** • Drugs are intended for acne **only. SA for a cosmetic indication cannot be approved.**
	Acne Medication gel, lot **benzoyl peroxide wash, cr, gel, lot (OTC)** **clindacin ETZ 1% pledget** **clindamycin ph 1% solution, pledget, swab, gel, lotion** **clindamycin/benzoyl peroxide (Duac®)** **erythromycin solution**	*Acne Clearing System® (OTC)* *Aklief®* *Avar Cleanser* *Avar-E* *Avar LS Cleanser* *Azelex®* *BP 10-1* *benzoyl peroxide wash/cr/gel/ lotion/foam/towelette (RX)* *BPO* *Cleocin T®* *Clindacin™ Pac Kit* *clindamycin phosphate (generic for Clindagel®)* *clindamycin/benzoyl peroxide*	

Preferred Agents	Non-Preferred Agents	SA Criteria
	(generic for Benzaclin®) *clindamycin phosphate foam, el, med swab* *clindamycin/tretinoin (generic Veltin®)* *dapsone 5% gel* *erythromycin gel/med. swab* *Evoclin™* *Neuac™ topical/kit* *Ovace® Wash* *Ovace® Plus shampoo/cr/lotion/ foam* *Sulfacetamide Cleanser ER* *Sulfacetamide Cleanser, Shampoo, Susp* *Sulfacetamide Sodium/Sulfur Cr, Susp, Sunscreen* *SSS 10-5 Foam* *Sulfacetamide/Sulfur/Cleanser, Cleanser Kit, Lotion Med. Pad* *Sulfacetamide/Sulfur/Urea Cleanser* *Sumadan Wash, Kit* *Sumadan XLT* *Sumaxin CP Kit* *Winlevi®*	
Retinoids/Combinations, Topical		
adapalene gel OTC **tretinoin 0.025, 0.05, 0.1% cream**	*adapalene 0.1% cr/gel/lot* *adapalene 0.3% gel/gel w/pump* *adapalene-benzoyl peroxide (gen Epiduo® and Epiduo® Forte)* *Avage® 0.1% cr* *Avita® 0.025% cr/gel*	*♦ **Age Edit for Fabior™ Foam** • Members must be between the ages of 12 and 18 years of age

Preferred Agents	Non-Preferred Agents	SA Criteria
	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* *Tazorac® cr/gel* *tazarotene 0.1% cr, foam* *tretinoin 0.01, 0.025% gel* *tretinoin microsphere 0.04%, 0.08%, & 0.1% gel* *Twyneo®*	
Antifungal Topical		
antifungal 1% cr, powder **antifungal 2% cr** **ciclopirox soln** **ciclodan 8% soln** **clotrimazole cr (OTC & Rx)** **clotrimazole soln (Rx)** **clotrimazole-betamethasone cr** **ketoconazole shampoo** **ketoconazole cr** **miconazole cr/spray (OTC)** **nystatin cr/oint/ powder** **terbinafine cr (OTC)** **tolnaftate cr/powder(OTC)**	*Alevazol® OTC* *Azolen® Tincture OTC* *Ciclodan® Kit* *ciclopirox cr/shampoo/gel* *ciclopirox kit* *ciclopirox suspension* *clotrimazole soln (OTC)* *clotrimazole-betamethasone lot* *econazole* *Ertaczo®* *Exelderm® cr & soln* *Extina®* *Fungi-Nail® (OTC)* *ketoconazole foam* *Loprox®* *Lotrimin AF® cr (OTC)* *Lotrisone® cr* *miconazole Oint/ powder (OTC)* *Mentax®* *Naftin® cr/gel* *Naftifine CR*	**LENGTH OF AUTHORIZATIONS:** **6 months** **Routine PDL edits**

Preferred Agents	Non-Preferred Agents	SA Criteria
	Nyata Kit® *Nizoral A-D® Shampoo (OTC)* *nystatin-triamcinolone cr/oint* *oxiconazole cr (generic Oxistat®)* *Pediaderm AF®* *PediPak®* *tavaborole (generic Kerydin®)* *tolnaftate aero powde/spray (OTC)* *tolnaftate soln (OTC)* *Vusion®*	
♦Immunomodulators, Atopic Dermatitis	**CLOSED CLASS**	
****Adbry™** ****Dupixent ®** ****Eucrisa™** ***pimecrolimus** ***tacrolimus**	******Anzupgo®* **** Ebglyss™* **** Nemluvio®* ****Opzelura™* *Protopic®* *****Vtama®* ****Zoryve cream, 0.15%* ****Zoryve cream, 0.05%* *****Zoryve foam 0.3%*	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: ○ Adbry™: moderate to severe for ages ≥ 12 years ○ Ebglyss™: moderate to severe for ages ≥ 12 years ○ Eucisa™: mild to moderate for ages ≥ 3 months ○ Dupixent®: moderate to severe for ages ≥ 6 months ○ Nemluvio®: moderate to severe for ages ≥ 12 years ○ Opzelura™: mild to moderate for ages ≥ 2 years ○ pimecrolimus: mild to moderate for ages ≥ 2 years ○ Protopic® 0.03%: moderate to severe for ages ≥ 2 years ○ Protopic® 0.1%: moderate to severe for ages ≥ 16 years ○ Vtama® for ages ≥ 2 years ○ Zoryve® cream 0.15%: mild to moderate for ages ≥ 6 years ○ Zoryve cream, 0.05%: mild to moderate atopic dermatitis in ages 2 to 5 AND the one that applies: ***Clinical Criteria for pimecrolimus, or tacrolimus**

	Preferred Agents	Non-Preferred Agents	SA Criteria

			• Prior documented trial & failure of 8 weeks of one (1) topical corticosteroid of medium to high potency (e.g., mometasone, fluocinolone)
			
			<u>Clinical Criteria for Eucrisa™, Dupixent® and Adbry®**</u> (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
			• One (1) topical corticosteroid of medium to high potency (e.g., mometasone, fluocinolone) OR
			• One (1) topical calcineurin inhibitors (tacrolimus or pimecrolimus)
			
			<u>* Clinical Criteria for Ebglyss™, Nemluvio® Opzelura™ (topical Janus kinase inhibitor), Vtama and Zoryve cream 0.05% and 0.15%</u>**
			• Prior documented trial & failure of 8 weeks of each
			  o One (1) topical corticosteroid of medium to high potency (e.g., mometasone, fluocinolone) AND
			  o One (1) topical calcineurin inhibitors (tacrolimus or pimecrolimus) AND
			  o A trial and failure of Dupixent®
			• **Other indications: Opzelura cream can not be approved for the indication of nonsegmental vitiligo in adult and pediatric members ≥ 12 years old**
			
			<u>**Clinical Criteria for Zoryve foam 0.3%</u>**
			• Member is 9 years of age or older and has a diagnosis of seborrheic dermatitis
			• Member has a history of failure, contraindication, or intolerance to BOTH of the following therapies:
			  o 30 days of therapy with ONE (1) topical corticosteroid (i.e., clobetasol, fluocinonide or mometasone cream/ointment/solution) in the past 180 days AND
			  o 30 days of therapy with ONE (1) topical antifungal (ciclopirox shampoo/gel, ketoconazole cream/shampoo, selenium sulfide 2.25% shampoo) in the past 180 days
			
			OR
			
			• Member is 12 years of age or older and has a diagnosis of plaque psoriasis

	Preferred Agents	Non-Preferred Agents	SA Criteria

- Member has a history of failure, contraindication, or intolerance to calcipotriene cr/oint/soln

*****Clinical Criteria for Nemluvio® for Prurigo nodularis**

- Age 18 or older
- A diagnosis of prurigo nodularis
- An 8-week trial and failure of Dupixent

*******Clinical Criteria for Vtama® for Plaque Psoriasis**

- Age 18 or older
- A diagnosis of plaque psoriasis

******* Clinical Criteria for Anzupgo (delgocitinib 2% topical cream)**

- The member is 18 years of age or older, **AND**
- The member has a diagnosis of moderate to severe chronic hand atopic dermatitis, **AND**
- The member has had inadequate response to or has been unable to use topical steroids

QUANTITY LIMITS for Atopic Dermatitis

Drug	Rolling qty limit
Adbry®	4 syringes/14 days (initial dose) 4 syringes/28 days (maintenance)
Dupixent	2 syringes (or pens)/14 days (initial dose), 2 syringes (or pens)/28 days (maintenance)
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

	Preferred Agents	Non-Preferred Agents	SA Criteria
			♦ **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 ♦ **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 o Prescribed by or in consultation with dermatologist, allergist, or immunologist ♦ **Diagnosis of inadequately controlled chronic obstructive pulmonary disease (COPD) and an eosinophilic phenotype:** o Age 18 or older o Prescribed by or in consultation with a pulmonologist o Member has a diagnosis of COPD that is inadequately controlled and a minimum blood eosinophil count of 300 cells/mcL at screening, measured within the past 12 months o Member is receiving maximal inhaled therapy consisting of a long-acting muscarinic antagonist (LAMA), long-acting beta agonist (LABA), and inhaled corticosteroid (ICS) (or therapy of LAMA plus LABA if ICS is contraindicated) ~~o Member has a history of at least 2 moderate (requiring treatment with systemic corticosteroids and/or antibiotics) or 1 severe exacerbation(s) (resulting in hospitalization or observation for~~

	Preferred Agents	Non-Preferred Agents	SA Criteria
			~~over 24 hours in an emergency department or urgent care facility) in the previous year, with 1 exacerbation occurring while the member was on maximal inhaled therapy~~ ♦ **Diagnosis of Chronic Spontaneous Urticaria:** o Age 12 or older o Diagnosis of Chronic Spontaneous Uriticaria o Member had a 30 day trial and failure, or intolerance to H1 antihistamine treatment ♦ **Diagnosis of Bullous Pemphigoid:** o Age 18 or older o Diagnosis of Bullous Pemphigoid
	Psoriasis, Topical		
	calcipotriene cr/oint/soln	*betamethasone/ calcipotriene* *Calcitrene®* *calcitriol* *calcipotriene/betamethasone (generic for Taclonex®)* *calcipotriene foam* *Dovonex®* **Enstilar ® Foam (AGE)* *Micanol®* *Sorilux™* *Taclonex® & Taclonex® Scalp* *Vectical™* *Zoryve® 0.3% cream*	**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 12 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* *ivermectin (generic Soolantra)* *Metrocream®* *Metrogel®* *metronidazole lot, gel pump* *Mirvaso®* *Rhofade®* *Rosadan™ Kit* *Soolantra®* *Zilxi™*	**LENGTH OF AUTHORIZATIONS:** **Routine PDL edits**	**1 year**
Steroids			
Steroids, Topical Low Potency		**LENGTH OF AUTHORIZATIONS:** **Routine PDL edits**	**1 year**
hydrocortisone cr/gel/lot/oint **hydrocortisone cr/oint OTC** **hydrocortisone/aloe cr OTC**	*alclometasone cr/oint* *aqua glycolic HC* *Capex® shampoo* *Derma-smoothe-FS* *Desowen® lot* *fluocinolone 0.01% oil* *Micort™-HC* *Pediaderm® HC & Pediaderm® TA* *Scalpicin OTC* *Texacort®*		
Steroids, Topical Medium Potency			
fluticasone propionate cr/oint **mometasone furoate cr/oint/soln**	*betamethasone valerate foam* *Beser Lotion and Kit* *clocortolone cr* *Cordran® tape* *Elocon® cr/oint/soln*		

Preferred Agents	Non-Preferred Agents	SA Criteria
	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* *Luxiq®* *Momexin®* *prednicarbate oint* *Synalar®* *Synalar TS®* *Ticanase kit®*	
Steroids, Topical High Potency		**LENGTH OF AUTHORIZATIONS:** **1 year**
betamethasone valerate cr/lot/oint **triamcinolone acetonide cr/lot/oint**	*amcinonide cr/lot/oint* *betamet diprop & prop gly cr/lot/oint* *betamet diprop cr/foam/gel/lot/oint* *DermacinRx® SilaPak™* *DermacinRx® Silazone* *DermacinRx® Therazole Pak* *desoximetasone cr/gel/oint/spray* *desoximetasone (generic Topicort® spray)* *diflorasone diacetate cr/oint* *Diprolene® lot/oint* *DiproleneAF®cr* *Ellzia™ Pak Kit* *fluocinonide cr/ emollient/ gel/oint/soln* *halcinonide cr/soln*	**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
		Halog® cr/oint/soln *Kenalog® aerosol* **Sernivo™* *Silazone® II Kit* *Topicort® cr/gel/oint/spray* *Trianex® oint* *triamcinolone spray* *triamcinolone/dimethicone* *Whytederm®Tdpak*	
	Steroids, Topical Very High Potency		
	clobetasol emollient **clobetasol propionate cr/gel/oint/soln** **halobetasol propionate cr**	*Apexicon™E* *clobetasol lot/shampoo* *clobetasol propionate foam/spray* *Clobex® lot/shampoo/spray* *Clobetex® Kit* *Clodan® kit* *Halonate®* *halobetasol prop foam* *halobetasol prop oint (generic for Lexette®)* *Impeklo™* *Olux®* *Olux®-E* *Ultravate® cr/lotion/oint* *Ultravate® PAC & Ultravate® X*	
Endocrine and Metabolic Agents			
	Androgenic Agents (Testosterone – Topical)		
	Androderm® Patch **testosterone pump (generic for AndroGel® Pump)**	*AndroGel® packet, patch, pump* *Axiron® soln* *Fortesta®* *Natesto Nasal Gel ®* *Testim®*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits**

Preferred Agents	Non-Preferred Agents	SA Criteria
	testosterone (generic for Axiron®) *testosterone gel/packet/pump (generic for Vogelxo™)* *testosterone (generic for Fortesta®)* *Vogelxo™ gel/packet/pump* *Xyosted™*	
Antihyperuricemics		
allopurinol 100mg and 300mg **colchicine tabs** **Probenecid®** **probenecid & colchicine**	*allopurinol 200MG* *colchicine caps* *Colcrys®* *febuxostat (generic Uloric®)* *Gloperba ®* *Mitigare®* *Uloric®* *Zyloprim®*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits**
Contraceptives*(long-acting IUDs & injectable)		
Depo-Provera® 104mg **Kyleena™** **Liletta®** **medroxyprogesterone 150mg** **Mirena®** **Nexplanon®** **Paragard®** **Skyla®**	*Depo-Provera® 150mg*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits**
Diabetes Hypoglycemics: Injectable Amylin Analogs		
	**SymLin®* **SymLin® Pens*	**LENGTH OF AUTHORIZATIONS**: 1 year ***Clinical Criteria for Injectable Amylin Analogs** • Member must have a history of at least a 90day trial of insulin. • SymLin® is only indicated as adjunct therapy with insulin.

Preferred Agents	Non-Preferred Agents	SA Criteria
		• 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®* *exenatide* *liraglutide* *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**
Humulin® 70/30 pen/vial(OTC) **insulin aspart/insulin aspart protamine vial** **insulin lispro protamine mix kwikpen (Authorized Generic)**	*Humalog® Mix 50/50 Kwikpen* *Humalog® Mix 75/25 Kwikpen* *Humalog Mix 75/25 vial* *Novolin® 70/30 vial (OTC)* *Novolog® Mix 70/30 pen/vial*	
Insulin N		
Humulin® N pen/vial (OTC)	*Humulin® N pen* *Novolin® N vial (OTC)*	
Insulin R		
Humulin® R pen/vial	*Novolin® R vial (OTC)*	

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Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Long-Acting Insulins		***Clinical Criteria for Toujeo Solostar:** • The member has tried and failed or is intolerant to Lantus
Lantus® Solostar® & vial ***Toujeo Solostar ® pen**	*Basaglar® KwikPen®* *insulin degludec* *insulin glargine max solo u300* *insulin glargine solostar u300* *insulin glargine-yfgn* *Rezvoglar® Kwikpen* *Semglee™* *Toujeo® Max Solostar®300 Units/mL* *Tresiba® FlexTouch® Pen 100 U/ml, 200 U/ml*	
Rapid-Acting Insulins		
Humulin 500 U/M pen/vial **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* *Humalog vial/pen* *Humalog Cartridge* *Humalog Kwikpen 100 unit/ml* *Humalog Jr. Kwikpen* *Kirsty vial/pen* *Lyumjev™* *Merilog™* *Novolog® cart/vial/Flexpen*	
Diabetes Oral Hypoglycemics		
Oral Hypoglycemics Alpha-Glucosidase Inhibitors		**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits plus** ♦Age edit for all Oral Hypoglycemics is 18 years of age or older, except Metformin which is 10 years of age.
acarbose	*Glyset®* *miglitol (generic Glyset®)*	
Oral Hypoglycemics Biguanides		
metformin 500, 850, 1000mg	*Riomet® susp*	

Preferred Agents	Non-Preferred Agents	SA Criteria
metformin ER *(generic for Glucophage® XR)*	*metformin 625 mg* *metformin 750 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™** **Tradjenta™**	*alogliptin (generic Nesina™)* *alogliptin/metformin (generic Kazano™)* *alogliptin/pioglitazone (generic Oseni™)* *Brynovin™* *Glyxambi®* *linagliptin/metformin* *Kazano™* *Nesina™* *Oseni™* *Qtern®* *saxagliptin hcl(generic Onglyza™)* *saxagliptin/metformin ER (generic Kombiglyze XR™)* *Steglujan™* *Trijardy™ XR* *Zituvio™* *Zituvimet™* *Zituvimet™ XR*	

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Oral Hypoglycemics Meglitinides		
nateglinide **repaglinide**	*repaglinide/metformin* *Starlix*	
Oral Hypoglycemics Second Generation Sulfonylureas		
glimepiride 1,2,4 mg **glipizide** **glipizide ER** **glyburide** **glyburide micronized**	*glimepiride 3mg* *Glucotrol®* *Glucotrol XL®*	
Oral Hypoglycemics Sodium Glucose Co-Transporter 2 Inhibitor CLOSED CLASS		
Farxiga™ **Jardiance®** **Synjardy®** **Synjardy® XR** **Xigduo™ XR**	*dapagliflozin* *dapagliflozin-metformin ER* *Inpefa™* *Invokana™* *Invokamet™* *Invokamet™ XR* *Segluromet™* *Steglatro™*	
Oral Hypoglycemics Thiazolidinediones		
pioglitazone	*Actoplus Met® IR & XR* *Actos®* *Avandaryl®* *Avandamet®* *Duetact®* *pioglitazone/metformin* *pioglitazone/glimepiride*	
Erythropoiesis Stimulating Proteins		
Epogen® **Retacrit™ (PFIZER)**	*Aranesp® vial/syringe* *Mircera®* *Procrit®* *Reblozyl®*	**LENGTH OF AUTHORIZATIONS**: for duration of the prescription up to 6 months **Routine PDL edits**

Preferred Agents	Non-Preferred Agents	SA Criteria
	Retacrit™ (VIFOR) *Vafseo®*	
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* *Entocort® EC* *Eohilia™* *Flo-Pred®* *Hemady®* *Khindivi* *Medrol ® dose pk/tab* *methylprednisolone 8,16 & 32mg tab* *Millipred DP® tab Does Pk* *Millipred® tab* *Orapred ®ODT* *Ortikos™* *prednisolone sod phosphate ODT/ soln* *prednisone intensol* *Rayos® DR tab* *TaperDex®*	**LENGTH OF AUTHORIZATIONS**: **1 year** **Routine PDL edits**

Preferred Agents	Non-Preferred Agents	SA Criteria
	Tarpeyo™ *Veripred®*	
***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™**	*Andembry®* *Dawnzera™* *Ekterly®* *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.

	Preferred Agents	Non-Preferred Agents	SA Criteria
			• If member has a feeding tube, then two different pancreatic enzymes can be approved for use together.
	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* *liraglutide(gen Saxenda®)* *Lomaira™* *phentermine/topiramate ER* *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** **GLP-1 Receptor Agonist For Obstructive Sleep Apnea SA Form** **GLP-1 Receptor Agonists for Metabolic Dysfunction-Associated Steatohepatitis SA Form** ♦ The selected GLP-1 Receptor Agonist is brand Saxenda

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	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Gastrointestinal			
G I Antibiotics			
	metronidazole 250mg, 500mg tab **vancomycin cap** **vancomycin for reconstitution oral soln kit (Firvanq™ soln)**	**Aemcolo™* *Alinia®* *Dificid®* *Firvanq™ soln* *Flagyl® cap/ER* *Likmez™* *metronidazole 125mg* *metronidazole cap* *neomycin* *nitazoxanide (generic Alinia®)* *paromomycin* *Solosec®* *Tindamax®* *tinidazole* *vancomycin sol* *Vancocin®* ****Vowst™*	**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 • 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 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 • 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**	**Marinol ®*	

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	**Syndros®*	***Dronabinol plus all non-preferred Antiemetic/Antivertigo agents require submission of a Clinical SA. Refer to Antiemetic/Antivertigo SA form** **LENGTH OF AUTHORIZATIONS:** 3 months, unless otherwise noted **Routine PDL edits plus:** **For ondansetron 16mg ODT:** The member has tried and failed or is intolerant to ondansetron 8mg ODT.
5HT3 Receptor Blockers		
ondansetron ODT/soln/tab	*Anzemet®* *Akynzeo®* *granisetron tab, vial* *ondansetron vial, amp, syringe* *palonosetron vial, syringe* *Posfrea™* *Sancuso® patch* *Sustol®*	
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* *Focinvez™* *fosaprepitant vial*	
Other		**LENGTH OF AUTHORIZATIONS:** 1 year, unless otherwise noted
***Diclegis®** **meclizine (OTC, Rx)** **metoclopramide soln, tab, vial** **prochlorperazine tab** ****promethazine soln, syrp, tab, 12.5mg&25mg supp** *(AGE)*	*Antivert®* *Barhemsys®* **Bonjesta™* *Compazine® supp/tab* *Compro®* *dimenhydrinate tab, vial* *doxylamine succinate/ vit B6* *metoclopramide ODT* *metoclopramide syringe* ***Phenergan® (AGE)* *prochlorperazine supp, vial*	**♦Promethazine products approved for members ≥ 2 years *♦**Bonjesta®/Diclegis®:** Approve through EDD. member must be pregnant and at least 18 years of age.

Preferred Agents	Non-Preferred Agents	SA Criteria
	***promethazine vial, ampul (AGE)* ***Promethegan 50 mg supp(AGE)* *Reglan®* *scopolamine (gen Transderm-Scop®)* *Tigan®* *Transderm-Scop®* *trimethobenzamide*	
***GI Motility, Chronic**		
****Linzess™** **lubiprostone and AG** **Movantik®**	*alosetron* *Amitiza®* *Ibsrela®* *Lotronex®* *Motegrity™* *prucalopride* *Symproic®* *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		
Pylera®	*bismuth-metronidazole-tetracycline (gen Pylera®)* *Helidac®* *Omeclamox®-Pak* *lansoprazole/amoxicillin/ clarithromycin*	**LENGTH OF AUTHORIZATIONS**: 14 days **Routine PDL edits**

Preferred Agents	Non-Preferred Agents	SA Criteria
	Prevpac® *Talicia®* *Voquezna®*	
Laxatives & Cathartics CLOSED CLASS		
Bowel Prep Agents		**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits**
Gavilyte-C solution **Gavilyte-G solution** **PEG 3350/electrolytes solution for reconstitution** **PEG-3350/flavor packs solution for reconstitution** **sodium, potassium, mag sulfates(Authorized Generic Suprep)**	*Clenpiq* *Golytely* *Nulytely With Flavor Packs* *PEG 3350/electrolytes powder pack (gen Moviprep)* *Suflave Powder* *Suprep* *Sutab*	
Constipation		
lactulose solution	**lactulose packet* **Kristalose Packet*	*** Kristalose:** • Must have tried, failed or be intolerant to generic lactulose solution
Proton Pump Inhibitors		
omeprazole RX **pantoprazole** **Protonix® susp**	*Aciphex® DR tab/sprinkle* *dexlansoprazole dr (gen Dexilant®)* *Dexilant®* *esomeprazole magnesium cap/susp/tab* *esomeprazole strontium* *lansoprazole cap* *Konvomep®* *Nexium®* *omeprazole OTC* *omeprazole magnesium OTC* *omeprazole/sodium bicarbonate* *pantoprazole susp (generic Protonix® susp)*	**LENGTH OF AUTHORIZATIONS**: 12 weeks; unless member meets an exception; then 1 year **Routine PDL edits plus** ***♦All non-preferred Proton Pump Inhibitors require submission of a Clinical SA. Refer to Proton Pump Inhibitor SA form** **Preferred agents require a SA for use over 90 days**

	Preferred Agents	Non-Preferred Agents	SA Criteria
		Prevacid® RX, OTC& SoluTab *Prilosec® Rx & Susp* *Protonix®* *rabeprazole DR tab*	
	Ulcerative Colitis Oral and Rectal Preparations (5-ASA DERIVATIVES)		
	Ulcerative Colitis – Oral		**LENGTH OF AUTHORIZATIONS:** **1 year** **Routine PDL edits**
	balsalazide disodium **mesalamine ER (AG of Apriso)** **Pentasa®** **sulfasalazine DR & IR**	*Asacol ®HD* *Azulfidine® IR &DR* *budesonide ER (gen Uceris™)* *Delzicol™* *Dipentum* *Lialda®* *mesalamine (gen Apriso®)* *mesalamine (gen Asacol® HD)* *mesalamine (gen Delzicol)* *mesalamine (gen Lialda®)* *mesalamine ER (gen Pentasa®)*	
	Ulcerative Colitis – Rectal		
	mesalamine rectal supp **mesalamine enema**	*budesonide (generic Uceris foam)* *Canasa® rectal supp* *mesalamine kit* *Rowasa® enema/kit* *SFRowasa®*	
Genitourinary			
	Alpha-Blockers and Androgen Hormone Inhibitors For Benign Prostatic Hypertrophy (BPH)		
	Alpha-Blockers for BPH		**LENGTH OF AUTHORIZATIONS:** **1 year** **Routine PDL edits**
	alfuzosin **tamsulosin HCL**	*Flomax ®* ~~*Rapaflo*~~*®* *silodosin (generic Rapaflo)* *Uroxatral®*	

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Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Androgen Hormone Inhibitors for BPH		
dutasteride **finasteride 5 mg**	*Avodart ®* *dutasteride/tamsulosin* *Jalyn®* *Proscar®*	
Androgen Hormone Inhibitors and Phosphodiesterase (PDE) 5 Inhibitor forBPH		
	Entadfi™	
Phosphodiesterase (PDE) 5 Inhibitor for BPH		***Step edit for Cialis®** & tadalafil 2.5 and 5mg - trial and failure of Alpha Blockers and Androgen Inhibitors for BPH. Prescriber must attest that the member is not on the state's sex offenders list. Consult or evaluation by Urologist.
	**Cialis® (ST)* *tadalafil 5 mg (ST)*	
Urinary Antispasmodics (Bladder Relaxant)		
fesoterodine fumarate ER **Myrbetriq™ tab** **oxybutynin tab/syrup** **oxybutynin ER** **solifenacin**	*darifenacin ER (generic Enablex®)* ~~*Detrol® & Detrol® LA*~~ *Ditropan® & *Ditropan® XL* *flavoxate* *Gelnique™ gel/gel Pump* *Gemtesa®* *Myrbetriq™ Granules* *Oxytrol® transdermal includes OTC* *Sanctura XR* *trospium IR & ER* *tolterodine IR & ER* *Toviaz™* *VESIcare®and LS*	
Immunological Agents		
***♦Multiple Sclerosis**	**CLOSED CLASS**	
Avonex® **Avonex® Adm Pack** **Copaxone 20 mg syringe®**	*Aubagio®* *Bafiertam™* *Betaseron®*	**LENGTH OF AUTHORIZATIONS**: 1 year

Preferred Agents	Non-Preferred Agents	SA Criteria
dimethyl fumarate and Starter Pack **fingolimod** ****Kesimpta® (ST)** **teriflunomide (generic Aubagio®)**	*Briumvi™* *Copaxone® 40 mg syringe®* *Extavia® Kit* *Gilenya®* *glatiramer 20 mg/ml syringe* *Glatopa™* *Mavenclad®* *Mayzent®* *Ocrevus®* *Ocrevus Zunovo™* *Plegridy®* *Ponvory™* *Rebif® SQ* *Rebif® Rebidose Pen®* *Tascenso ODT™* *Tecfidera®* *Tecfidera® Starter Pack* *Tyruko* *Tysabri®* *Vumerity™* *Zeposia®*	**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/Ocrevus Zunovo SA Form** **Tysabri and biosimilars SA Form**
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**
adalimumab-adbm (unbranded version of Cyltezo made by Boehringer Ingelheim) **Enbrel® Pen, Sureclick, Hadlima™ Pyzchiva® Syringe, Vial**	*Abrilada™* *Actemra® SQ & ACTPEN* *adalimumab-aacf* *adalimumab-aaty* *adalimumab-adbm(Quallent)* *adalimumab-adaz* *adalimumab-fkjp Pen* *adalimumab-ryvk*	**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edits plus** **For preferred agents members must meet FDA approved age and indication. (reviewed electronically, AutoPA look back of 180 days for diagnosis)** **For Pyzchiva members must also have tried and failed ONE TNF inhibitor (such as adalimumab-adbm or Enbrel)**

Preferred Agents	Non-Preferred Agents	SA Criteria
	Amjevita™ *Amjevita™ Autoinjector* *Arcalyst®* *Avsola™* *Avtozma®* *Bimzelx®* *Cibinqo™* *Cimzia® & Cimzia® Syringe Kit* *Cosentyx™* *Cosentyx™ UnoReady pen* *Cyltezo®* *Enspryng™* *Entyvio®* *Hulio®* *Humira® Pen, Syringe* *Hyrimoz®* *Idacio®* *Ilaris®* *Ilumya™* *Inflectra®* *infliximab (gen Remicade®)* *Kevzara® inj, pen* *Kineret®* *Olumiant®* *Omvoh™* *Orencia®* *Otezla®* *Otezla XR™* *Otulfi®* *Remicade®* *Renflexis®* *Rinvoq®* *Rinvoq® LQ* *Selarsdi®* *Simlandi™*	***All non-preferred Cytokine and CAM Antagonists require submission of a Clinical SA. For brand name Humira and Stelara please see additional instructions in the SA form.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
		Simponi® *Simponi®Aria* *Skyrizi™ syringe, Pen* *Spevigo®* *Starjemza™* *Stelara® vial/syringe* *Steqeyma®* *Sotyktu™* *Taltz®* *Tofidence™* *Tremfya™* *Tyenne®* *Uplizna®* *ustekinumab-aauz* *Velsipity®* *Xeljanz™, Xeljanz™ XR and solution* *Yesintek™* *Yuflyma®* *Yusimry™* *Zymfentra™*	
	♦Methotrexate CLOSED CLASS		**LENGTH OF AUTHORIZATIONS: 1 year** **Routine PDL edits**
	methotrexate tab/PF vial/MDV	*Jylamvo®* *Otrexup®* *Rasuvo™* *Trexall®* *Xatmep™*	
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* *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** **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) (OTC)**	*alcaftadine (gen Lastacaft®)* *azelastine* *bepotastine (gen Bepreve®)* *Bepreve®* *Elestat®* *epinastine 0.05% eye drops*	

Preferred Agents	Non-Preferred Agents	SA Criteria
	Lastacaft® *olopatadine (generic Patanol & Pataday) (Rx)* *Optivar®* *Patanol® Rx and OTC* *Pataday® Rx and OTC* *Zaditor® OTC* *Zerviate™*	
Mast Cell Stabilizers		
cromolyn sodium	*Alocril®* *Alomide®*	
Anti-inflammatory Agents		
Corticosteroids		
Durezol® **prednisolone acetate**	*Alrex™* *Dexamethasone* *difluprednate (gen Durezol®)* *Flarex®* *fluorometholone* *FML®, FML Forte®* *loteprednol etabonate* *Maxidex®* *Omnipred®* *Pred Forte® & Pred Mild®* *prednisolone sod phosphate* *Vexol®*	
Immunomodulators **CLOSED CLASS**		
Restasis® **Xiidra®**	*Cequa™* *cyclosporine* **Eysuvis*	*♦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

	Preferred Agents	Non-Preferred Agents	SA Criteria
		Miebo™ *Restasis Multidose®* *Tryptyr®* *Tyrvaya™ Nasal Spray* ***Verkazia®*	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** • 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 0.5%**	*Acular® 0.5% & LS® 0.4%* *Acuvail®* *bromfenac sodium 0.07%* *bromfenac sodium 0.075%* *bromfenac 0.09%* *BromSite ™* **Ilevro™0.3% (QL)* *Inveltys ™ (loteprednol etabonate)* *ketorolac LS 0.4%* *Nevanac®* *Ocufen®* *Prolensa™*	

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Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
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®** **levobunolol 0.5%** **metipranolol 0.3%** **timolol maleate**	*Betagan® 0.5%* *Betimol®* *betaxolol 0.5%* *brimonidine-timolol (gen Combigan®)* *Istalol® 0.5%* *timolol (generic for Betimol®)* *timolol (generic for Timoptic Ocudose)*	
Carbonic Anhydrase Inhibitors		
Azopt® **dorzolamide** **dorzolamide/timolol**	*brinzolamide* *Cosopt® 0.5%-2%* *Cosopt® PF* *Simbrinza™* *Trusopt® 2%* *dorzolamide/timolol PF*	
Cholinergic Muscarinic Receptor Agonist		
	pilocarpine **Vuity™*	*Indicated for the treatment of presbyopia in adults
Rho Kinase Inhibitor		
Rhopressa® **Rocklatan**		
Prostaglandin Analogs		
latanoprost **Travatan Z®**	*bimatoprost* *Iyuzeh™*	

	Preferred Agents	Non-Preferred Agents	SA Criteria
		Lumigan® 0.03% & 0.01% *Rescula®* *tafluprost* *travoprost 0.004%* *Vyzulta™* *Xalatan® 0.005%* *Xelpros® (latanoprost)* *Zioptan™*	
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** **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*	

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	levocetirizine sol *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®* *formoterol fumarate (generic Perforomist®)* *Perforomist®* *Striverdi® Respimat*	
Short Acting Metered Dose Inhalers or Devices		
albuterol HFA (Proair) (Authorized Generic) *albuterol HFA (Proventil) and (Authorized Generic)* **Ventolin® HFA**	*albuterol HFA (Proair®)* *albuterol HFA (Ventolin®)* *levalbuterol tartrate HFA* *ProAir® RespiClick* *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

Preferred Agents	Non-Preferred Agents	SA Criteria
		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
Long Acting Anticholinergics/Long ActingBronchodilators CLOSED CLASS		
Anoro™ Ellipta® **Stiolto Respimat™**	*umeclidinium-vilanterol*	**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edits**
Phosphodiesterase 3 (PDE3) inhibitor and Phosphodiesterase 4 (PDE4) inhibitor CLOSED CLASS		
	Ohtuvayre™	

Preferred Agents	Non-Preferred Agents	SA Criteria
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™ Respiclick®* *Airsupra* *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)*	

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Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Inhaled Corticosteroids: Metered Dose Inhalers CLOSED CLASS		
Alvesco® **Arnuity™ Ellipta®** **Asmanex Twisthaler** **Asmanex HFA®** **QVAR® Redihaler** **Pulmicort Flexhaler®**	*Aerospan™* *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 and OTC**	*azelastine/fluticasone nasal spray (generic for Dymista®)* *budesonide (generic for Rhinocort® Aqua)* *budesonide (generic Rhinocort® Allergy OTC)* *Children's Qnasl™* *Clarispray OTC* *Flonase®* *Flonase Sensimist (OTC)* *flunisolide* *ipratropium bromide spray* *mometasone (generic Nasonex®)* *Nasonex OTC* *Omnaris®* *Qnasl™* *Rhinocort Aqua®* *Rhinocort® Allergy OTC* *Ryaltris®* *Ticanase®* *triamcinolone OTC*	

Preferred Agents	Non-Preferred Agents	SA Criteria
	triamcinolone acetonide *Veramyst®* *Xhance™* *Zetonna™*	
Epinephrine, Self-Administered		
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)* *Neffy®* *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**	