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

10/1/26

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.
- Drugs with criteria linked to Appendix B: Physician Administered Drug (PAD) Criteria are medical benefit drugs and may be submitted through the medical benefit.
- 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

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

10/1/26

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 AUTHORIZATION** • Up to 3 months for chronic pain (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)* *tramadol ER* *Ultram ER® (tramadol ER)*	
Preferred (Sch II)	***Non-Preferred***	
fentanyl 12, 25, 50, 75 & 100 mcg patches **morphine sulfate ER tab**	*fentanyl 37.5 mcg, 62.5 mcg, and 87.5 mcg patches* *hydromorphone ER* *Hysingla ER™* *morphine ER cap (generic Avinza®)* *morphine ER cap (generic Kadian®)* *MS Contin®* *oxycodone-long acting* *OxyContin®* *oxymorphone ER* *tapentadol ER*	
***Methadone Drugs**		
	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**		
Short-Acting Opioids		**LENGTH OF AUTHORIZATION:** • Up to 3 months for chronic pain (includes HIV/AIDS, Chronic back pain, Arthritis, Fibromyalgia, Diabetic neuropathy, Postherpetic Neuralgia).
codeine/APAP **hydrocodone/APAP**	*codeine tab/soln* *butalbital comp with codeine*	

Preferred Agents	Non-Preferred Agents	SA Criteria
hydrocodone/ibuprofen **hydromorphone** **morphine IR** **oxycodone IR** **oxycodone/APAP** **tramadol HCl 50mg** **tramadol HCl/APAP**	*butalbital/caffeine/APAP w/codeine* *butorphanol tartrate nasal* *dihydrocodeine/APAP/caffeine* *hydrocodone/APAP soln (Zolvit)* *hydromorphone liq/supp* *meperidine tab* *morphine supp* *oxycodone/APAP(gen PrimLev™)* *oxycodone conc* *oxycodone oral syringe* *oxycodone/ASA* *oxycodone/ibuprofen* *oxymorphone HCl* *pentazocine/naloxone* *RoxyBond™* *tapentadol tab, soln* *tramadol 25mg, 75mg, 100 mg* *tramadol soln (AG for Qdolo®)* *Xyvona*	• Up to 6 months for chronic pain (includes Cancer pain, Sickle cell disease, Palliative care, End-of-Life Care, Hospice). ***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)**
♦ Opioid Dependency	**CLOSED CLASS**	
***buprenorphine SL** **buprenorphine/naloxone tab SL** **Brixadi™** **Suboxone® film** **Sublocade™ SQ** **Kloxxado™ Spray** **naloxone syringe & vial** **naloxone nasal spray**	**buprenorphine/naloxone film SL* **Zubsolv™* ***Lucemyra®* ***lofexidine*	***Buprenorphine Containing Drugs require submission of Clinical SA. Refer to (Oral Buprenorphine SA Form)** **Lucemyra/lofexidine (PDL criteria do not apply) -Member is 18 years of age or older AND -Medication used for the mitigation of opioid withdrawal symptoms to facilitate abrupt opioid discontinuation Limitation: No more than one (14 day) treatment course every 6 months **Quantity Limits** buprenorphine SL tab 2mg | 3/day

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
naloxone nasal spray OTC **Naloxone Carpuject** **naltrexone tab** **Narcan® Nasal Spray Rx/OTC** **Opvee®** **Rextovy™ Nasal Spray** **Vivitrol®** **Zurnai™**		buprenorphine SL tab 8mg: 2/day buprenorphine/naloxone SL tab 2–0.5mg: 3/day buprenorphine/naloxone SL tab 8–2mg: 3/day buprenorphine/naloxone SL film 2–0.5mg: 3/day buprenorphine/naloxone SL film 4–1mg: 1/day buprenorphine/naloxone SL film 8–2mg: 3/day Suboxone® SL film 2–0.5mg: 3/day Suboxone® SL film 4–1mg: 1/day Suboxone® SL film 8–2mg: 3/day Suboxone® SL film 12–3mg: 2/day Zubsolv™ SL tab 0.7–0.18 mg: 2/day Zubsolv™ SL tab 1.4–0.36mg: 2/day Zubsolv™ SL tab 2.9–0.71mg: 2/day Zubsolv™ SL tab 5.7–1.4mg: 2/day Zubsolv™ SL tab 8.6–2.1mg: 2/day Zubsolv™ SL tab 11.4–2.9mg: 2/day

Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)

Oral NSAIDs

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**	*Advil®* *Aleve®* *Arthrotec®* **Celebrex® & *celecoxib* *Coxanto* *diclofenac potassium* *diclofenac potassium (gen Zipsor)* *diclofenac sodium ER* *diclofenac sodium/misoprostol* *diflunisal* *etodolac IR & SR* *fenoprofen* *flurbiprofen* *ibuprofen/APAP* *ibuprofen 300mg tab*

LENGTH OF AUTHORIZATION: 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.

Preferred Agents	Non-Preferred Agents	SA Criteria
	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 acid* *meloxicam susp* *meloxicam (generic Vivlodex™)* *nabumetone* *Naprelan®* *naproxen CR (generic Naprelan®)* *naproxen-esomeprazole mag (generic Vimovo®)DR* *naproxen susp* *Orudis®* *oxaprozin* *piroxicam* *tolmetin sodium* **Vyscoxa™* *Zybic™*	
Topical NSAIDs		**LENGTH OF AUTHORIZATION:** **1 year** **Routine PDL edits plus**
diclofenac sodium 1% gel **diclofenac sodium 1% gel (OTC)**	**diclofenac 1.5% topical soln* **diclofenac 2% topical soln gen* **diclofenac epolamine 1.3% patch(QL)* **Diclogen Kit* **Lixofen 1.5% Kit*	***Clinical Criteria for Non-Preferred Topical NSAIDs:** • 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). • diclofenac 1.5% and 2% topical sol, Lixofen 1.5% Kit and Diclogen Kit can only be approved for the FDA approved indication of osteoarthritis of the knee. ***Quantity limit for diclofenac epolamine 1.3% patch = 30 patches per RX***

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

10/1/26

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Antibiotic-Anti-Infective			
	***♦ Antibiotics, Inhaled (QL, AGE) CLOSED CLASS**		
	Bethkis® **Kitabis™ Pak** ****Tobi Podhaler®** ***(SE)*** **tobramycin inhalation neb soln (generic Tobi® inh)**	*****Arikayce®** *(amikacin liposome)* *Cayston®* *Tobi® inh neb soln* *tobramycin (generic Bethkis®)* *tobramycin Pak (generic Kitabis™ Pak)*	**LENGTH OF AUTHORIZATION:** **1 year** **Routine PDL edits plus** **Tobi Podhaler® • Requires a clinical reason as to why one of the preferred tobramycin inhalation nebulizer solutions cannot be used *****Clinical Criteria for Arikayce®** Duration of Approval: 12 months **Initial Approval Criteria** • Member is ≥ 18 years of age; AND • Diagnosis of Mycobacterium avium complex (MAC) lung disease as determined by the following: o chest radiography or high-resolution computed tomography (HRCT) scan; AND o at least 2 positive sputum cultures; AND o other conditions such as tuberculosis and lung malignancy have been ruled out; AND • Member has failed a multi-drug regimen with a macrolide (clarithromycin or azithromycin), rifampin, and ethambutol. (Failure is defined as continual positive sputum cultures for MAC while adhering to a multi-drug treatment regimen for a minimum duration of 6 months); AND • Member has documented failure or intolerance to aerosolized administration of amikacin solution for injection, including pretreatment with a bronchodilator; AND • Arikayce will be prescribed in conjunction with a multi-drug antimycobacterial regimen *Minimum age for use is 6 years for all tobramycin inhalation nebulizer solution (Bethkis®, Kitabis™ Pak, Tobi® and Tobi Podhaler®) and 7 years for Cayston®. **Quantity Limitations:** Arikayce®= 590 mg/8.4 mL (28 vials)/28 days Each carton contains a 28-day supply of medication (28 vials)

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
		Bethkis® = 224 mL (56 amps)/28 days Cayston® = 84 mL (56 amps)/28 days Kitabis™ Pak = 280 mL (56 amps)/28 days Tobi Podhaler® = 224 capsule/28 day Tobi® inhalation neb = 280 mL (56 amps)/28 days tobramycin nebs = 280 mL (56 amps)/28 days
Antifungals, Oral		
fluconazole tab/susp **griseofulvin susp** **nystatin tab/susp** **terbinafine tab**	*clotrimazole (mucous mem)* *Cresemba®* *Diflucan® susp* *flucytosine* *griseofulvin tab* *griseofulvin ultramicrosize* *itraconazole cap, soln* *ketoconazole* *Noxafil® Powdermix* *posaconazole tab (generic for Noxafil)* *Sporanox® cap* *Tolsura™* *Vfend® susp* **Vivjoa®* *voriconazole tab & powder for susp*	**LENGTH OF AUTHORIZATION**: Duration of the prescription (up to 12 months) **Routine PDL edits plus** **Clinical Criteria for all Non-Preferred oral Antifungals. Requires the submission of a Clinical SA. Refer to Antifungal Oral SA Form** ***Clinical Criteria for Vivjoa:** Duration of approval: Date of service • Member is 10 years of age or older; AND • Documentation member has diagnosis of recurrent vulvovaginal candidiasis with ≥3 episodes of vulvovaginal candidiasis (VVC) in a 12-month period; AND • Member is a biological female who is postmenopausal or has another reason for permanent infertility (e.g., tubal ligation, hysterectomy, salpingo-oophorectomy); AND • Member has tried and failed or has a contraindication or intolerance to maintenance antifungal therapy with oral fluconazole. Quantity limit: 18 tablets per treatment course
Cephalosporins, Oral		
Second Generation Cephalosporins		**LENGTH OF AUTHORIZATION**: Date of service only; no refills. **Routine PDL edits plus** **Clinical Criteria for Non-Preferred Cephalosporins**
cefaclor capsule **cefprozil tab/susp** **cefuroxime tab**	*cefaclor ER* *cefaclor susp*	

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

10/1/26

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Third Generation Cephalosporins		• Infection caused by an organism resistant to preferred drugs, **OR** • A therapeutic failure to no less than a three-day trial of **one preferred cephalosporin**; **OR** • The member is completing a course of therapy with a non-preferred drug initiated in the hospital.
cefdinir cap/susp	*ceftibuten* *cefditoren pivoxil* *cefixime susp, tab, cap* *cefpodoxime proxetil cap/susp*	
Macrolides, Oral		
Macrolides & Ketolides		**LENGTH OF AUTHORIZATION**: 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** **erythromycin base tab DR** **erythromycin ethylsuccinate 200mg susp**	*clarithromycin ER* *Eryped® 200 susp* *Eryped® 400 susp* *Ery-tab®* *E.E.S.® 200 susp* *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*	
Otic		
ciprofloxacin/dexamethasone (generic Ciprodex) **ofloxacin** **neomycin/polymyxin/hc soln/susp**	*Cipro HC®* *ciprofloxacin 0.2% otic soln* *ciprofloxacin-hydrocortisone (generic Cipro HC)* *Cortisporin TC*	**LENGTH OF AUTHORIZATION:** Date of service only; no refills **Routine PDL edits**

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

10/1/26

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Quinolones, Oral		
Second Generation Quinolones		**LENGTH OF AUTHORIZATION**: 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, susp* *ciprofloxacin ER* *ofloxacin*	
Third Generation Quinolones		
levofloxacin tab	*Baxdela™ tab* *levofloxacin susp* *moxifloxacin*	
Topical Antibiotics		
mupirocin ointment	*Centany®* *Centany AT® Kit* *mupirocin cream* *Xepi*	**LENGTH OF AUTHORIZATION**: Date of service only; no refills **Routine PDL edits**
Vaginal Antibiotics		
Cleocin® Ovules **Clindesse® cr** **metronidazole gel** **Nuvessa™**	*Cleocin® cr* *clindamycin cr* *Vandazole™ gel* *Xaciato™ gel*	**LENGTH OF AUTHORIZATION**: Date of Service **Routine PDL edits**

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

10/1/26

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 AUTHORIZATION**: 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 AUTHORIZATION**: ***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 be filled:** 1. Monthly a. Mavyret™ (28 days supply x 2 months) b. Mavyret™ Pellet packs (28 days supply x 2 months) **OR** 2. Full duration of the regimen: a. Mavyret™ (56 days supply) b. Mavyret™ Pellet packs (56 days supply)
	Pegasys® syringe/vial	
***Nucleotide Analog NS5A & NS5B Polymerase Inhibitors & Combinations**		
	Epclusa® *Epclusa® Pellet packs* *sofosbuvir /velpatasvir (generic Epclusa®)* *Sovaldi®* *Vosevi™*	
***NS5A, NS3/4A Inhibitor Combinations**		
Mavyret™ **Mavyret™ Pellet packs**	*Zepatier®*	
***NS5B & Protease Inhibitor Combinations**		
	Harvoni® *ledipasvir/sofosbuvir (generic Harvoni®)*	

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

10/1/26

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Herpes Oral		
acyclovir cap/tab/susp **famciclovir** **valacyclovir**	*Valtrex®*	**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edits**
Herpes Topical		
acyclovir oint **docosanol**	*acyclovir cr (generic Zovirax cr)* *Denavir®* *penciclovir*	**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edits**
HIV/AIDS CLOSED CLASS		
abacavir tab/soln **abacavir-lamivudine tab** **abacavir-lamivudine-zidov tab** **Apretude** **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** **Evotaz® tab** **fosamprenavir tab/susp**	*Aptivus® cap* *efavirenz-lamiv-tenof tab* *emtricit-rilp-tenof* *Epivir® tab* *Idvynso* *Kaletra® tab* *Norvir® tab* *Prezista® tab/susp* *Retrovir® syrup* *Reyataz® cap* *rilpivirine tab* *Trogarzo® (intraven)* *Viracept® tab* *Viread® tab*	**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edits plus** **Quantity limits see list here HIV Quantity Limits**

	Preferred Agents	*Non-Preferred Agents*		*SA Criteria*
	Genvoya® tab **Intelence® tab** **Isentress® chew tab/ tab/powder pack** **Juluca® tab** **Kaletra® soln** **lamivudine tab/soln** **lamivudine-zidovudine 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** **tenofovir disoproxil fum tab** **Tivicay® tab/tab for susp** **Triumeq® tab** **Triumeq® PD** **Truvada® tab** **Tybost® tab** **Viramune® tab** **Viread® powder** **Vocabria**			

	Preferred Agents	Non-Preferred Agents	SA Criteria
	Yeztugo® **Ziagen® soln** **zidovudine tab/cap/syrup**		
	Influenza		
	oseltamivir susp/ cap	*Flumadine® tab* *rimantadine* *Relenza Disk®* *Tamiflu® susp/cap* *Xofluza™*	**LENGTH OF AUTHORIZATION:** Date of service only **Routine PDL edits**
	COVID-19 **CLOSED CLASS**		
	Paxlovid	*Xocova®*	**LENGTH OF AUTHORIZATION:** Date of service only
Blood Modifiers			
	Bile Salts		
	ursodiol cap, tab	**Bylvay™* *Chenodal®* *Cholbam®* *Ctexli* *Iqirvo®* *Livdelzi®* ***Livmarli™* *Lynavoy* *Reltone®* *Urso® & Urso® Forte tab* *Ursolign™*	**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edits** **Livmarli™ (PDL criteria do not apply) • Must have a confirmed diagnosis of cholestatic pruritus in: ○ Members 3 months of age and older with Alagille syndrome (ALGS) ○ Members 12 months of age and older with progressive familial intrahepatic cholestasis (PFIC). * Bylvay™ (PDL criteria do not apply) • Must have a confirmed diagnosis of cholestatic pruritus in: ○ Members 12 months of age and older with Alagille syndrome (ALGS) ○ Members 3 months of age and older with progressive familial intrahepatic cholestasis (PFIC)

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

10/1/26

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Colony Stimulating Factors CLOSED CLASS		
Fulphila **Neupogen Disp Syrin** **Neupogen Vial**	*Filkri* *Fylnetra* *Granix Syringe* *Granix Vial* *Leukine* *Neulasta Kit* *Neulasta Syringe* *Neulasta Vial* *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 AUTHORIZATION**: 6 months (initial), 12 months (renewal) **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 AUTHORIZATION**: N/A All products are preferred without EDITS
Advate® **Adynovate®** **Afstyla®** **Alphanate®** **Altuviiio™** **Eloctate®** **Esperoct®**		

Preferred Agents	Non-Preferred Agents	SA Criteria
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®		
Factor X and Factor XIII Products		
Coagadex® Corifact® Kit Tretten®		

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

10/1/26

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
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* *ferric citrate tab* *Fosrenol® chewable tab* *lanthanum carbonate chewable tab* *Phoslyra® powder, tab* *Renvela®* *sevelamer carbonate powder packet* *sevelamer HCL (gen Renagel)* *Velphoro® chewable tab* *Xphozah™*	**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edits**
Sickle Cell CLOSED CLASS		

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	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®* *Binosto™* *etidronate* *Fosamax®tab & Fosamax®plusD* *risedronate DR*	**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edits**
	Calcitonins		
	calcitonin-salmon nasal		**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edits**
	Others		
	raloxifene	**Bonsity®* *Evista®* **Forteo®* **teriparatide* **Tymlos™*	**LENGTH OF AUTHORIZATION**: Initial approval will be for 1 year **Routine PDL edits for Evista®** ***♦ Clinical SA must be completed for select non-preferred agents (Bonsity, Forteo, teriparatide or Tymlos SA Form)**
	♦ RANK Ligand Inhibitors		
	Enoby™ **Xtrenbo™**	*Aukelso™* *Bildyos®* *Bilprevda®* *Bomyntra®*	***♦ ALL RANK Ligand Inhibitors require the submission of a Clinical SA. Refer to denosumab SA Form**

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
		Bosaya™ *Conexxence*® *Jubbonti*® *Jubereq* *Osenvelt*® *Osvyrti*® *Prolia*® *Stoboclo*® *Wyost*® *Xgeva*®	
Cardiac			
Anticoagulants	**CLOSED CLASS**		
Low Molecular Weight Heparin includes FactorXA Inhibitor			**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edits**
enoxaparin (generic Lovenox®)		*Arixtra*® *fondaparinux* *Fragmin*® *syringe & vial* *Lovenox*®	
Oral Anticoagulants			***Clinical 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
dabigatran **Eliquis™ tab, sprinkle cap, susp** **Eliquis™ Dose Pack** **Jantoven®** **warfarin** **Xarelto® tab, susp & Starter Pack**		*Pradaxa*® *Pradaxa® Pellet Pack* *rivaroxaban* **Savaysa*™	
Antihypertensive Agents			
ACE Inhibitors			**LENGTH OF AUTHORIZATION: 1 year** **Routine PDL edits**
benazepril **enalapril** **lisinopril**		*Altace*® *captopril* *Epaned™ soln*	

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

10/1/26

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
ramipril	*enalapril soln* *fosinopril* *Lotensin®* *moexipril* *perindopril* *Qbrelis™* *quinapril* *trandolapril* *Zestril®*	
ACE Inhibitors + Calcium Channel Blocker Combinations		
amlodipine/benazepril	*Lotrel®* *trandolapril-verapamil ER*	
ACE Inhibitors + Diuretic Combinations		
benazepril/HCTZ **lisinopril/HCTZ** **enalapril/HCTZ**	*captopril/HCTZ* *fosinopril/HCTZ* *Lotensin HCT®* *moexipril/HCTZ* *quinapril /HCTZ* *quinapril-HCTZ (gen Accuretic)* *Zestoretic®*	
Angiotensin Receptor Blockers		**LENGTH OF AUTHORIZATION:** **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
irbesartan **losartan** **olmesartan** **sacubitril/valsartan (QL)** **telmisartan** **valsartan**	*Arbli™* *Atacand®* *Avapro®* *azilsartan* *Benicar®* *candesartan* *Cozaar®* *Diovan®* *Edarbi®* **Entresto™ (QL)*	

Preferred Agents	Non-Preferred Agents	SA Criteria
	**Entresto Sprinkle™ eprosartan mesylate Micardis® valsartan solution	
Angiotensin Receptor Blockers + Calcium Channel Blocker Combinations		
amlodipine/olmesartan **amlodipine/valsartan**	Azor® amlodipine/olmesartan/HCTZ amlodipine/valsartan/HCTZ Exforge® & Exforge® HCT telmisartan/amlodipine Tribenzor® Widaplik	
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** **sotalol AF**	acebutolol Betapace®IR & AF® betaxolol Carvedilol ER *Hemangeol™ Inderal® XL Innopran® XL Kapspargo™ Sprinkle Lopressor® pindolol	

Preferred Agents	Non-Preferred Agents	SA Criteria
sotalol HCL	*propranolol LA* *Sotylize™* *Tenormin®* *timolol maleate* *Toprol XL®*	
Beta Blockers + Diuretic Combinations		
atenolol/chlorthalidone **bisoprolol/HCTZ**	*Lopressor HCT®* *metoprolol/HCTZ* *nadolol/bendroflumethiazide* *propranolol/HCTZ* *Tenoretic®*	
Calcium Channel Blockers –Dihydropyridine		
amlodipine **nifedipine** **nifedipine ER**	*felodipine ER* *isradipine* *Katerzia™oral suspension* *nisoldipine* *nicardipine* *Norliqva®* *Norvasc®* *Procardia XL®* *Sdamlo* *Sular®*	
Calcium Channel Blockers- Non-Dihydropyridine		
Cartia XT® **diltiazem IR, ER q12hr & 24hr** **verapamil tab IR & ER**	*diltiazem LA* *Matzim LA* *verapamil 360 cap* *verapamil ER cap*	
Direct Renin Inhibitors (includes combination)		
	aliskiren 150 & 300mg (generic for Tekturna) *Tekturna®*	

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

10/1/26

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Lipotropics		
***Apolipoprotein A Inhibitors**		**LENGTH OF AUTHORIZATION**: 1 year ***♦ ALL Apolipoprotein A Inhibitors require the submission of a Clinical SA. Refer to Apolipoprotein A Inhibitors SA Form**
	Redemplo *Tryngolza*	
Bile Acid Sequestrants		
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*	
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 • Member has failed to achieve a target LDL-C despite physician attestation that the member is adherent to maximally tolerated doses of statins prior to the lipid panel demonstrating suboptimal reduction; AND • Member can be classified into ONE of the following risk factor groups: o Extremely high risk ASCVD: (defined as extensive or active burden of ASCVD, or ASCVD with extremely high burden of adverse or poorly controlled risk cardio-metabolic risk factors including HeFH or severe hypercholesterolemia [SH] LDL-C > 220 mg/dl) with an LDL-C ≥ 70 mg/dL; OR o Very high risk ASCVD: (defined as less extensive ASCVD and poorly controlled cardiometabolic risk factors) with an LDL-C ≥ 100 mg/dL; OR o High risk ASCVD: (defined as either less extensive ASCVD and well-controlled risk factors or primary prevention HeFH or SH >220 mg/dl with poorly controlled risk factors) with LDL-C ≥ 130 mg/dL; AND
ezetimibe	*Nexletol® (bempedoic acid)* *Nexlizet® (bempedoic acid/ ezetimibe)* *Zetia®*	

Preferred Agents	Non-Preferred Agents	SA Criteria
		• 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**	*fenofibrate (generics for Antara®, Fenoglide® & Lipofen®)* *fenofibrate (generics for Triglide®)* *fenofibric acid* *Fibricor®* *Lipofen®* *Lopid®* *Tricor®*	
HMG CoA Reductase Inhibitors and Combo (High Potency Statins)		
atorvastatin **rosuvastatin** **simvastatin**	*Atorvaliq®* *amlodipine/atorvastatin* *Caduet®* *Crestor®* *Lipitor®* *Livalo®* *pitavastatin calcium (generic Livalo®)* *rosuvastatin-ezetimibe* *simvastatin/ezetimibe* *Vytorin®* *Zocor®* *Zypitamag™*	

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

10/1/26

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
HMG CoA Reductase Inhibitors and Combinations (Statins)		
lovastatin **pravastatin**	*fluvastatin* *Lescol XL®*	
Microsomal Triglyceride Transfer Protein Inhibitor		
	**Juxtapid ™*	***♦ Clinical Criteria for Juxtapid™. Refer to Juxtapid™ SA Fax Form**
Niacin Derivatives		
niacin ER		
Omega 3 Fatty Acid Agent		
icosapent ethyl (gen Vascepa®) *****omega-3 acid ethyl esters** **Omega-3 OTC**	***Lovaza®*	*****♦ Clinical Criteria for Lovaza® and omega-3 acid ethyl esters** • Step edit requires trial and failure of any other lipotropic; **OR** • Documented high triglycerides of ≥ 500 mg/dL. **LENGTH OF AUTHORIZATION**: Three months for initial approval; six months for renewal
***Proprotein Convertase Subtilisin Kexin Type 9 (PCSK9) Inhibitors**		
	Leqvio® *Lipfendra®* *Praluent®* *Repatha®*	***♦ ALL PCSK9 Inhibitors require the submission of a Clinical SA. Refer to Lipotropics, Other SA Form**
Platelet Inhibitors		
clopidogrel **dipyridamole** **prasugrel (generic Effient®)** **ticagrelor**	**ASA/dipyridamole* ***ASA/omeprazole (generic Yosprala®)* *Brilinta®* *Effient®* *Plavix®*	**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edits plus** **Clinical Criteria for Select Non-Preferred Platelet Inhibitors** *** ASA/dipyridamole** • Aspirin and dipyridamole are covered as separate drugs without SA; clinical reason as to why the individual drugs cannot be used separately. ****ASA/omeprazole** • Aspirin is covered without SA; clinical reason as to why aspirin cannot be used.

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

10/1/26

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
***Pulmonary Arterial Hypertension Agents**		
Activin Signaling Inhibitor		**LENGTH OF AUTHORIZATION: 1 year** **Routine PDL edits for all Pulmonary Arterial Hypertension Agents**
	Winrevair™	
Inhaled Prostacyclin Analogues		
	Tyvaso® *Tyvaso DPI™ (treprostinil)* *Yutrepia™*	
Oral Endothelin Receptor Antagonist		
ambrisentan (generic Letairis) 5 & 10mg **bosentan (generic Tracleer®)**	*bosentan susp* *Letairis® 5 & 10 mg* *macitentan* *Opsumit®* *Tracleer® susp* *Tracleer® tab*	
***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®* *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®	

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

10/1/26

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Central Nervous System		
Alzheimer's Agents		
Cholinesterase Inhibitors		**LENGTH OF AUTHORIZATION**: Length of prescription (up to 3 months) **Routine PDL edits**
donepezil OTD & tab **rivastigmine (transderm)**	*Aricept® ODT, tab* *Exelon® transderm* *galantamine IR, ER tab/soln* *memantine/donepezil* *Namzaric® (memantine/donepezil)* *rivastigmine cap* *Zunveyl®*	
NMDA Receptor Antagonist		
memantine tab	*memantine Dose Pack, soln* *memantine ER*	
Anticonvulsants **CLOSED CLASS**		
Barbiturates		**LENGTH OF AUTHORIZATION:** **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* *Onfi®susp/tab* *Sympazan ™ (clobazam)*	
Cannabidiol		
***Epidiolex® (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

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
		○ Lennox-Gastaut syndrome (ICD-10: G40.81), Dravet syndrome (ICD-10: G40.83, G40.833, G40.834) or Tuberous sclerosis complex (ICD-10: Q85.1)
Carbamazepine Derivatives		
carbamazepine chewable tab/susp/tab **carbamazepine XR** **Carbatrol®** **Epitol** **oxcarbazepine tab** **Tegretol®XR** **Trileptal® susp**	*Aptiom®* *carbamazepine 200mg chewable tab* *carbamazepine ER* *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* *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**	*Banzel® susp/tab* *brivaracetam tab/soln* *Briviact®* tab/soln *Diacomit®* cap/powder pack *Elepsia®XR tab* *Eprontia ™*	*♦ **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

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

10/1/26

Preferred Agents	Non-Preferred Agents	SA Criteria
levetiracetam ER **roweepra (generic levetiracetam)** **subvenite tab (generic lamotrigine)** **topiramate tab** **topiramate 15, 25 mg sprinkle cap** **zonisamide cap**	*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* *Lamictal® ODT* *Lamictal® ODT dose pk* *lamotrigine tab dose pk* *lamotrigine ODT* *lamotrigine ODT dose pk* *levetiracetam (generic Spritam®)* *Motpoly XR™* *perampanel* *rufinamide susp/tab (generic Banzel®)* *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®*	** ♦ **Clinical Criteria for Ztalmy:** • Initial: o Member is two years of age or older; AND o Documented diagnosis of cyclin-dependent kinase-like 5 deficiency disorder AND o Documentation that seizures have been inadequately controlled by a trial of at least 2 antiepileptic drugs (e.g., clobazam, valproate, lamotrigine, levetiracetam, topiramate, felbamate, vigabatrin) or member has labeled contraindications to other antiepileptic drugs • Renewal: o 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 specializes in treatment of epileptic disorders

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

10/1/26

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Antidepressants		
Other		**LENGTH OF AUTHORIZATION:** **1 year** **Routine PDL edits** **♦ **Auvelity criteria for the treatment of agitation associated with dementia due to Alzheimer's disease (Routine PDL edits do not apply)** • Initial criteria: • Member is ≥ 18 years of age; AND • Member has a diagnosis of Alzheimer's disease; AND • Member has a diagnosis of agitation and exhibits moderate to severe symptoms *♦ **Zurzuvae criteria (Routine PDL edits 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 AUTHORIZATION: 14 days Renewal Criteria: Not applicable Quantity limit: 28 capsules per 14 days
bupropion IR, SR &XL **desvenlafaxine ER tab** **(generic for Pristiq®)** **mirtazapine ODT/tab** **trazodone tab** **venlafaxine IR tab & ER cap** **vilazodone tab**	**Auvelity™* *bupropion XL (gen Forfivo® XL)* *desvenlafaxine ER tab (gen Khedezla™)* *Effexor® XR* *Emsam® transdermal* *Exxua ™* *Fetzima®* *Khedezla™* *Marplan®* *Nardil®* *nefazodone* *phenelzine* *Pristiq®* *Raldesy™* *Remeron® ODT/tab* *tranylcypromine sulfate* *Trintellix* *venlafaxine ER tab* *Viibryd®dose pk* *Viibryd® tab* *Wellbutrin® SR* **Zurzuvae™*	
SSRI		
citalopram soln/tab **escitalopram tab** **fluoxetine cap/soln** **fluvoxamine tab** **paroxetine tab** **sertraline conc, soln, tab**	*Brisdelle®* *Celexa® tab* *citalopram HBR 30mg* *escitalopram soln* *fluoxetine DR cap/tab* *fluvoxamine ER* *Lexapro® tab* *paroxetine CR* *paroxetine susp*	

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	Paxil® tab/susp & Paxil® CR *Prozac® cap/weekly* *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®* *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**

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

10/1/26

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Preventive Treatment		**Preferred Agents *step edit required** **<u>Quantity limit for preventive treatment</u>** 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 **<u>Quantity limit for acute treatment</u>** Nurtec® ODT = 16 tabs 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®**	*Zavzpret™*	
Antipsychotics *(AGE) **CLOSED CLASS**		
Atypical		**<u>LENGTH OF AUTHORIZATION:</u> 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)** ****<u>Clinical Criteria Nuplazid™</u>** • Indicated for the treatment of hallucinations and delusions associated with Parkinson's disease psychosis. *Quantity Limit Nuplazid™ = 2 per day* ******<u>Clinical Criteria for Vraylar as adjunct treatment for Major Depressive Disorder, reviewed electronically, AutoPA (ICD-10 Code: F33.xx - Depression and subtypes)</u>**
aripiprazole tab **clozapine tab** **lurasidone** **olanzapine ODT, tab, IM** **paliperidone ER** **quetiapine fumarate ER** **quetiapine tab** **risperidone ODT/soln/tab** ******Vraylar™** **ziprasidone cap, vial**	*Abilify® tab/IM inj* *aripiprazole ODT, soln* *asenapine (generic for Saphris®)* *Bysanti™* *Caplyta Capsule™* *Clozaril®* *clozapine ODT* *Cobenfy™* *Cobenfy™ Starter pk* *Fanapt® tab & titration pk* *Fazaclo®* *Geodon® tab, IM* *Invega®* *Latuda®* *Lybalvi®* ***Nuplazid™ tab, cap (QL)* ***olanzapine/fluoxetine*	

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

10/1/26

Preferred Agents	Non-Preferred Agents	SA Criteria
	Opipza™ *quetiapine fumarate ER (authorized generic only)* *Rexulti® tab* *Risperdal® ODT/soln/tab* *Saphris®* *Secuado®Patch* *Seroquel® IR* *Seroquel® XR* *Versacloz™* *Zyprexa® Zydis®*	• 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
Atypical, Long-Acting Injectable		**LENGTH OF AUTHORIZATIONS:** **1 year**
Abilify Asimtufii® **Abilify Maintena®** **Aristada®** **Aristada® Initio** **Erzofri®** **Invega Hafyera™,** **Sustenna® &Trinza®** **Perseris™** **Risperdal Consta®** **Uzedy™**	*risperidone ER* *Rykindo™* *Zyprexa® Relprevv™*	**Routine PDL edits**
Typical		**LENGTH OF AUTHORIZATION:** **1 year**
amitriptyline/perphenazine **chlorpromazine** **fluphenazine elixir/soln/tab** **fluphenazine decanoate** **haloperidol decanoate** **haloperidol lactate conc** **haloperidol tab** **loxapine** **perphenazine** **trifluoperazine** **thiothixene**	*Adasuve®* *Haldol decanoate (injection)* *pimozide* *molindone*	**Routine PDL edits**

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
thioridazine		
Duchenne Muscular Dystrophy CLOSED CLASS		
****Emflaza**	***Agamree* *Amondys-45* *****deflazacort*** ***Duvyzat* ****Elevidys* *Exondys-51* ***Jaythari* ***Kymbee* ***Pyquvi* *Viltepso* *Vyondys-53*	**LENGTH OF AUTHORIZATION:** **1 year** ****Clinical Criteria for oral Duchenne Muscular Dystrophy agents** • Member is 2 years of age or older for Agamree®, Emflaza™ • Member is 5 years of age or older for Jaythari, Pyquvi, Kymbee and deflazacort • Member is 6 years of age or older for Duvyzat™ • Member has a diagnosis of Duchenne Muscular Dystrophy (DMD) • 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 *****Elevidys requires submission of Clinical SA through the medical benefit. Refer to Appendix B: Physician Administered Drug (PAD) Criteria**
***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 AUTHORIZATION:** **1 year** ***Clinical Criteria for Movement Disorders** • Diagnoses of Tardive Dyskinesia or Huntington's disease • Prescribed by or in consult with a neurologist or psychiatrist • Quantity limit ○ 4 tabs/day Austedo® ○ 1 tab per day Austedo XR® ○ 42 tablets per 365 days Austedo XR® titration pack ○ 1 cap/day Ingrezza®/Ingrezza Sprinkle® ○ 4 tabs/day Xenazine®

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

10/1/26

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**	*Drizalma™ Sprinkle* *duloxetine 40 mg (generic Irenka™)* *gabapentin ER* *gabapentin 200mg* *Gralise™ (gabapentin, ER)* *Horizant ™ (gabapentin enacarbil ER)* *Journavx™* *Lidoderm® patch* *Lyrica® / CR/ soln* *milnacipran* *Neurontin® cap/tab/soln* *pregabalin soln, ER* *Qutenza Kit® (capsaicin)* *Relgaabi* *Savella™ & Savella™ Dose Pak* *Tonmya™* *Ztlido™ 1.8% (lidocaine topical system)*	**LENGTH OF AUTHORIZATION**: **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**	*Neupro®* *pramipexole ER* *ropinirole HCl ER*	**LENGTH OF AUTHORIZATION:** **1 year** **Routine PDL edits**
Sedatives / Hypnotics		
temazepam 15 & 30 mg	*estazolam* *flurazepam* *Halcion®* *quazepam 15 mg* *Restoril®* *temazepam 7.5 mg & 22.5 mg* *triazolam*	**LENGTH OF AUTHORIZATION**: Length of the prescription (up to 3 months) **Routine PDL edits**

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

10/1/26

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Sedatives / Hypnotics (Non-Benzodiazepine)		
eszopiclone **zaleplon** **zolpidem**	*Ambien®IR & CR* *Belsomra®* *Dayvigo™* *doxepin (generic for Silenor®)* *Edluar™* **Hetlioz®* ***Hetlioz™ LQ* *Intermezzo®* *Lunesta®* *Quviviq™* *Rozerem®* *Silenor®* *Sonata®* *tasimelteon* *zolpidem CR* *zolpidem (generic Intermezzo®)* *zolpidem tartrate capsule*	**LENGTH OF AUTHORIZATION**: 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 of Nighttime sleep disturbances in SMS in pediatric members **AND** • Member must be 3 years to 15 years of age.
Skeletal Muscle Relaxants		
baclofen **cyclobenzaprine HCL** **methocarbamol** **tizanidine tab**	*Amrix®* *Atmeksi®* *baclofen soln* *baclofen susp (gen Fleqsuvy™)* **carisoprodol* **carisoprodol/ASA* **carisoprodol/ASA/codeine* *chlorzoxazone* *cyclobenzaprine ER* *dantrolene sodium* *Dantrium®* *Fexmid®* *Fleqsuvy™* *metaxalone* *Ontralfy™*	**LENGTH OF AUTHORIZATION:** • 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 approved 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*
	orphenadrine citrate *orphenadrine/ASA/caffeine* *Ozobax® DS* **Soma®* *tizanidine cap* *Zanaflex®*	
Smoking Cessation		
bupropion SR **Chantix®** **Chantix® DS PK** **nicotine gum/lozenge/patch** **varenicline**	*Nicoderm CQ® Patch* *Nicorette® Gum/Lozenges* *Nicotrol® Inhaler & NS*	**LENGTH OF AUTHORIZATION:** 6 months **Routine PDL edits**
***Spinal Muscular Atrophy CLOSED CLASS**		
Evrysdi **Spinraza** **Itvisma** **Zolgensma**		**LENGTH OF AUTHORIZATION:** see criteria ***♦All Spinal Muscular Atrophy drugs require submission of Clinical SA, see below:** **Evrysdi SA Form** **Spinraza, Itvisma and Zolgensma require submission of Clinical SA through the medical benefit. Refer to Appendix B: Physician Administered Drug (PAD) Criteria**
***Stimulants/ADHD Medications** *(AGE)* **CLOSED CLASS**		
Amphetamine Drugs		**LENGTH OF AUTHORIZATION**: 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**
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 Dexedrine Spansule)*	*Adderall® IR (amphetamine salts combo)* *Adderall®XR* *Adzenys XR ODT™* *amphetamine sulfate (generic Evekeo®)* *amphetamine susp (generic Adzenys ER™ susp)* *Arynta™* *Dexedrine®* *dextroamphetamine soln*	

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

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	Miscellaneous Drugs		
	atomoxetine (generic Strattera®) **clonidine ER** **guanfacine ER**	*atomoxetine sol (generic Atoncy)* *Atoncy™* *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 AUTHORIZATION:** 1 year
	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 (generic for Benzaclin®)*	**Routine PDL edits plus** ***♦ Clinical Criteria for Dermatologic Acne Agents** • Prescriptions for members over the age of 18 years will require the submission of a SA to evaluate treatment diagnosis; **AND** • Drugs are intended for acne **only. SA for a cosmetic indication cannot be approved.**

Preferred Agents	Non-Preferred Agents	SA Criteria
	clindamycin phosphate foam, el, med swab *clindamycin/tretinoin (generic Veltin®)* *dapsone 5% gel* *erythromycin gel/med. swab* *Evoclin™* *Neuac™ topical/kit* *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* *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)* *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*	*♦ **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*
	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** **Klayesta powder** **miconazole cr/spray (OTC)** **nystatin cr/oint/ powder** **Nystop powder** **terbinafine cr (OTC)** **tolnaftate cr/powder(OTC)**	*Alevazol® OTC* *Ciclodan® Kit* *ciclopirox cr/shampoo/gel* *ciclopirox kit* *ciclopirox suspension* *clotrimazole soln (OTC)* *clotrimazole-betamethasone lot* *econazole* *Ertaczo®* *Extina®* *ketoconazole foam* *Lasolex™ AG, AL, soln* *Lasolex AC cr* *Loprox®* *Lotrimin AF® cr (OTC)* *miconazole Oint/ powder (OTC)* *Naftifine CR* *nystatin-triamcinolone cr/oint* *oxiconazole cr (generic Oxistat®)* *tavaborole (generic Kerydin®)* *tolnaftate aero powder/spray (OTC)* *tolnaftate soln (OTC)* *Vusion®*	**LENGTH OF AUTHORIZATION:** **6 months** **Routine PDL edits**
♦Immunomodulators, Atopic Dermatitis **CLOSED CLASS**		
****Adbry™** ****Dupixent®** **** Ebglyss™** ****Eucrisa™** ***pimecrolimus**	******Anzupgo®** *** Nemluvio®** ****Opzelura™** *Protopic®* ****Zoryve cream, 0.15%**	**LENGTH OF AUTHORIZATION: 1 year** **Routine PDL edits plus** ♦ Clinical Criteria for Atopic Dermatitis-all drugs • Member must have an FDA approved diagnosis: Atopic dermatitis (ICD-10: L20.9x)

Preferred Agents	Non-Preferred Agents	SA Criteria
***tacrolimus** *******Vtama®**	****Zoryve cream, 0.05%*	AND • Age and severity for drug as follows below: o Adbry™: moderate to severe for ages ≥ 12 years ◦ Ebglyss™: moderate to severe for ages ≥ 12 years o Eucrisa™: mild to moderate for ages ≥ 3 months o Dupixent®: moderate to severe for ages ≥ 6 months o Nemluvio®: moderate to severe for ages ≥ 12 years o Opzelura™: mild to moderate for ages ≥ 2 years o pimecrolimus: mild to moderate for ages ≥ 2 years o Protopic® 0.03%: moderate to severe for ages ≥ 2 years o Protopic® 0.1%: moderate to severe for ages ≥ 16 years o Vtama® for ages ≥ 2 years o Zoryve® cream 0.15%: mild to moderate for ages ≥ 6 years o 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** • Prior documented trial & failure of 8 weeks of one (1) topical corticosteroid of medium to high potency (e.g., mometasone, fluocinolone) ****Clinical Criteria for Eucrisa™, Vtama®, Dupixent® Ebglyss™ and Adbry®** (reviewed electronically, AutoPA look back of 180 days for no more than a 30 day trial) • Prior documented trial & failure of 30-day trial (or contraindication) of • One (1) topical corticosteroid of medium to high potency (e.g., mometasone, fluticasone) OR • One (1) topical calcineurin inhibitor (tacrolimus or pimecrolimus) ***** Clinical Criteria for Nemluvio®, Opzelura™ (topical Janus kinase inhibitor), and Zoryve cream 0.05% and 0.15%** • 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 inhibitor (tacrolimus or pimecrolimus) AND o A trial and failure of Dupixent®

	Preferred Agents	Non-Preferred Agents	SA Criteria

- **Other indications: Opzelura cream can not be approved for the indication of nonsegmental vitiligo in adult and pediatric members ≥ 12 years old**

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

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

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

- Age 18 or older, AND
- A diagnosis of plaque psoriasis

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

- Age 18 or older, AND
- A diagnosis of moderate to severe chronic hand atopic dermatitis, AND
- 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

♦ **Diagnosis of moderate to severe asthma**

- o Age 6 or older
- o Member must have moderate to severe asthma diagnosed as ONE of the following types:
  - Asthma with eosinophilic phenotype with eosinophil count ≥ 150 cells/mcL; OR

Preferred Agents	Non-Preferred Agents	SA Criteria
		○ Oral corticosteroid dependent asthma with at least 1 month of daily oral corticosteroid use within the last 3 months ♦ **Diagnosis of eosinophilic esophagitis (EoE);** o Age 1 or older o Member weighs ≥ 15 kg o Prescribed by or consultation with an allergist or gastroenterologist o Member had insufficient clinical response to treatment with a topical glucocorticosteroid or proton pump inhibitor ♦ **Diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP)**; o Age 12 or older o Member has inadequate response after 3 consistent months use of preferred PDL intranasal steroids or oral corticosteroids 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) ♦ **Diagnosis of Chronic Spontaneous Urticaria:** o Age 2 or older o Diagnosis of Chronic Spontaneous Urticaria o Member had a 30 day trial and failure, or intolerance to H1 antihistamine treatment

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
			♦ **Diagnosis of Bullous Pemphigoid:** o Age 18 or older o Diagnosis of Bullous Pemphigoid ♦ **Diagnosis of Allergic Fungal Rhinosinusitis:** o Age 6 or older o Diagnosis of Allergic Fungal Rhinosinusitis o Member has a history of sino-nasal surgery
	Psoriasis, Topical		
	calcipotriene cr/oint/soln	*betamethasone/ calcipotriene* *calcitriol* *calcipotriene/betamethasone (generic for Taclonex®)* *calcipotriene foam* **Enstilar ® Foam (AGE)* *Sorilux™* *Taclonex® & Taclonex® Scalp* *Zoryve® 0.3% cream* ***Zoryve foam 0.3%*	**LENGTH OF AUTHORIZATION:** **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 **♦**Clinical Criteria for Zoryve foam 0.3% for Seborrheic Dermatitis** • 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
	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®* *oxymetazoline hcl* *Rhofade®* *Rosadan™ Kit* *Soolantra®*	**LENGTH OF AUTHORIZATION:** **Routine PDL edits**	**1 year**
Steroids			
Steroids, Topical Low Potency		**LENGTH OF AUTHORIZATION:** **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* *Texacort®*		
Steroids, Topical Medium Potency			
fluticasone propionate cr/oint **mometasone furoate cr/oint/soln**	*betamethasone valerate foam* *Beser Lotion and Kit* *clocortolone cr* *fluocinolone acetonide cr/oint/soln* *flurandrenolide cr/oint/tape* *fluticasone propionate lot* *hydrocortisone valerate cr/oint* *hydrocortisone butyrate (generic for Locoid Lotion)* *hydrocortisone butyrate*		

Preferred Agents	Non-Preferred Agents	SA Criteria
	cr/oint/soln/ emollient *Synalar®, TS*	
Steroids, Topical High Potency		**LENGTH OF AUTHORIZATION:** **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* *desoximetasone cr/gel/oint/spray* *diflorasone diacetate cr/oint* *Diprolene® oint* *fluocinonide cr/ emollient/ gel/oint/soln* *halcinonide cr/soln* *Halog® cr/oint/soln* *Kenalog® aerosol* *Topicort® cr/gel/oint/spray* *triamcinolone spray* *triamcinolone/dimethicone*	**Routine PDL edits plus**
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* *Clodan® kit* *halobetasol prop foam* *halobetasol prop lotion* *halobetasol prop oint (generic for Lexette®)* *Ultravate® lotion*	

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

10/1/26

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Endocrine and Metabolic Agents		
Androgenic Agents (Testosterone – Topical)		
testosterone pump (generic for AndroGel® Pump) **testosterone packet (authorized generic for Vogelxo™)**	*Natesto Nasal Gel ®* *Testim®* *testosterone (generic for Axiron®)* *testosterone gel/pump (generic for Vogelxo™)* *testosterone (generic for Fortesta®)* *Vogelxo™ gel/packet/pump*	**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edits**
Antihyperuricemics		
allopurinol 100mg and 300mg **colchicine tabs** **Probenecid®** **probenecid & colchicine**	*allopurinol 200mg* *colchicine caps* *febuxostat (generic Uloric®)* *Gloperba ®* *Mitigare®* *Zyloprim®*	**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edits**
Contraceptives*(long-acting IUDs & injectable)		
Depo-Provera® 104mg **Kyleena™** **Liletta®** **medroxyprogesterone 150mg** **Mirena®** **Nexplanon®** **Paragard®** **Skyla®**	*Depo-Provera® 150mg* *Miudella®*	**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edits**
♦Diabetes Hypoglycemics: Injectable and Oral Incretin Mimetics CLOSED CLASS		
Trulicity™ **Victoza®**	*exenatide* *liraglutide* *Mounjaro®*	**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edits**

Preferred Agents	Non-Preferred Agents	SA Criteria
	Ozempic® *Rybelsus Tab®* *Soliqua® 100/33* *Tanzeum™* *Xultophy® 100/3.6*	**Preferred Agents Clinical Criteria:** • **Diagnosis of type II diabetes** **Non-Preferred Incretin Mimetics SA Form**
Diabetes Hypoglycemics: Injectable Insulins		
Insulin Mix		**LENGTH OF AUTHORIZATION: 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)*	
Long-Acting Insulins		
Lantus® Solostar® & vial ***Toujeo Solostar® pen**	*Awiqli® Flextouch* *Basaglar® KwikPen®* *insulin glargine max solo u300* *insulin glargine solostar u300* *insulin glargine-yfgn* *Rezvoglar® Kwikpen* *Semglee (yfgn)* *Toujeo® Max Solostar®300 Units/mL* *Tresiba® FlexTouch®, vial*	***Clinical Criteria for Toujeo Solostar:** • The member has tried and failed or is intolerant to Lantus

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

10/1/26

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
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** **Novolog® cart/vial/Flexpen**	*Admelog® Solostar Pen/vial* *Afrezza® cartridge (inhalation)* *Apidra® cartridge/Solostar/vial* *Fiasp®/FlexTouch®Pen/PenFill®* *Humalog Kwikpen 100 unit/mL* *Humalog Kwikpen 200 unit/mL* *Humalog vial* *Humalog Cartridge* *Humalog Jr. Kwikpen* *Kirsty vial/pen* *Lyumjev™* *Merilog™*	
Diabetes Oral Hypoglycemics		
Oral Hypoglycemics Alpha-Glucosidase Inhibitors		**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edits**
acarbose	*miglitol (generic Glyset®)*	
Oral Hypoglycemics Biguanides		
metformin 500, 850, 1000mg **metformin ER** *(generic for Glucophage® XR)*	*metformin 625 mg* *metformin 750 mg* *metformin ER (generic Fortamet®)* *metformin ER (generic Glumetza®)* *metformin (generic Riomet®)* *Riomet® susp*	
Oral Hypoglycemics Biguanide Combination Drugs		
glyburide/metformin	*glipizide/metformin*	
Oral Hypoglycemics DPP-IV Inhibitors & Combination CLOSED		
Glyxambi® **Janumet®** **Januvia®** **Jentadueto XR™**	*alogliptin (generic Nesina™)* *alogliptin/metformin (generic Kazano™)*	

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Jentadueto™ **Tradjenta™** **Trijardy™ XR**	*alogliptin/pioglitazone (generic Oseni™)* *Brynovin™* *dapagliflozin-saxagliptin* *Janumet XR®* *linagliptin/metformin* *Kazano™* *Nesina™* *saxagliptin (generic Onglyza™)* *saxagliptin/metformin ER (generic Kombiglyze XR™)* *sitagliptin (generic Januvia®)* *sitagliptin (generic Zituvio™)* *sitagliptin/metformin (generic Janumet®)* *sitagliptin/metformin (generic Janumet®XR)* *sitagliptin/metformin (generic Zituvimet™)* *sitagliptin/metformin ER (generic Zituvimet™ XR)* *Steglujan™* *Zituvio™* *Zituvimet™, XR*	
Oral Hypoglycemics Meglitinides		
nateglinide **repaglinide**		
Oral Hypoglycemics Second Generation Sulfonylureas		
glimepiride 1,2,4 mg **glipizide** **glipizide ER** **glyburide** **glyburide micronized**	*glimepiride 3mg* *glipizide 15mg*	

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

10/1/26

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Oral Hypoglycemics Sodium Glucose Co-Transporter 2 Inhibitor CLOSED CLASS		
dapagliflozin **Jardiance®** **Synjardy®** **Synjardy® XR** **Xigduo™ XR**	*dapagliflozin-metformin ER* *Farxiga™* *Inpefa™* *Invokana™* *Invokamet™* *Invokamet™ XR* *Segluromet™* *Steglatro™*	
Oral Hypoglycemics Thiazolidinediones		
pioglitazone	*Actoplus Met® IR* *Actos®* *Duetact®* *pioglitazone/metformin* *pioglitazone/glimepiride*	
Erythropoiesis Stimulating Proteins		
Epogen® **Retacrit™ (PFIZER)**	*Aranesp® vial/syringe* *Mircera®* *Procrit®* *Reblozyl®* *Retacrit™ (VIFOR)* *Vafseo®*	**LENGTH OF AUTHORIZATION**: for duration of the prescription up to 6 months **Routine PDL edits**
Estrogen Agents		
NK Antagonists CLOSED CLASS		
Lynkuet	*Veozah*	**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edits plus** ***Clinical Criteria for NK Receptor Antagonists** Member must be experiencing vasomotor symptoms related to menopause

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

10/1/26

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Oral CLOSED CLASS		
estradiol *Premarin*	*Duavee* *estrogens, conjugated* *Osphena*	**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edits**
Transdermal CLOSED CLASS		
Climara *Divigel* *Elestrin* *Evamist* *Vivelle-Dot*	*Dotti* *estradiol TD Patch Twice Weekly* *estradiol TD Patch Weekly* *estrodiol packet/ pump* *EstroGel* *Lyllana* *Menostar*	**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edits**
Vaginal		
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**
Glucagon Agents CLOSED CLASS		
Baqsimi nasal **Gvoke pen, syringe, vial** **Proglycem suspension oral** **Zegalogue Autoinjector & syringe SQ**	*diazoxide suspension oral* *Glucagon emergency kit inj* *Glucagon inj*	**LENGTH OF AUTHORIZATION**: **1 year** **Routine PDL edits**
Glucocorticoids, Oral		
budesonide EC	*Alkindi® Sprinkle*	**LENGTH OF AUTHORIZATION**: **1 year**

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

10/1/26

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
dexamethasone soln/tab **hydrocortisone** **methylprednisolone dose pk** **methylprednisolone 4 mg tab** **prednisolone sod phosph soln** **prednisolone soln** **prednisone soln/tab/dose pk**	*Cortef®* *cortisone acetate* *dexamethasone elixir/intensol* *Dexlyt™* *Eohilia™* *Hemady®* *Khindivi* *Medrol® dose pk/tab* *methylprednisolone 8,16 & 32mg tab* *Millipred DP® tab Dose Pk* *Millipred® tab* *prednisolone sod phosphate ODT/ (10 mg/5mL&20 mg/5mL soln)* *prednisone intensol* *prednisone DR tab*	**Routine PDL edits**
***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 AUTHORIZATION**: 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® **icatibant (generic Firazyr®)** **Haegarda®** **Kalbitor®**	*Andembry®* *Cinryze™* *Dawnzera™* *Ekterly®* *Firazyr®* *Orladeyo™* *Ruconest®* *Sajazir™*	**LENGTH OF AUTHORIZATION:** 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**

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	Takhzyro™	
***Pancreatic Enzymes**		
Creon® **Zenpep®**	*Pertzye®* *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. • If a member has a diagnosis of Cystic Fibrosis they do not have to try and fail a preferred. • If member has a feeding tube, then two different pancreatic enzymes can be approved for use together.
***Phenylketonuria CLOSED CLASS**		
Kuvan powder packet	*Javygtor* *Kuvan tab* *Palynziq* *sapropterin* *Sephience* *Zelvysia*	**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edits plus** ***Clinical Criteria for Phenylketonuria** • Member must have a diagnosis of Phenylketonuria **Palynziq SA Form**
Progestational Agents CLOSED CLASS		
medroxyprogesterone acetate (tab only) **norethindrone acetate** **progesterone cap/inj**	*Crinone (Vaginal)* *Prometrium®* *Provera®*	**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edits**
Weight Management Agents CLOSED CLASS		
orlistat **Xenical** **phendimetrazine IR and ER** **phentermine** **benzphetamine**	*Foundayo™* *Imcivree SQ* *liraglutide(gen Saxenda®)* *Lomaira™* *phentermine/topiramate ER*	**LENGTH OF AUTHORIZATION:** As indicated on fax form **Routine PDL edits plus** **Weight Management Agents SA Form**

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	diethylpropion IR and ER	*Saxenda®* *Wegovy®* *Wegovy HD®* *Zepbound™*	**GLP-1 Receptor Agonist For Cardiovascular Risk Reduction in Members with Obesity or Overweight 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 injectable brand Wegovy, excluding the high dose formulation
Gastrointestinal			
	G I Antibiotics		
	metronidazole 250mg, 500mg tab **vancomycin cap** **vancomycin for reconstitution oral soln kit (Firvanq™ soln)**	*Dificid®* *fidaxomicin* *Firvanq™ soln* *Likmez™* *metronidazole 125mg* *metronidazole cap* *neomycin* *nitazoxanide (generic Alinia®)* *Solosec®* *Tindamax®* *tinidazole* *vancomycin sol* *Vancocin®* ***Vowst™*	**LENGTH OF AUTHORIZATION:** 1 year **Routine PDL edits** ****♦ 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 authorization: 30 Days

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

10/1/26

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Antiemetic/Antivertigo Agents		
Cannabinoids (delta-9THC derivatives)		**LENGTH OF AUTHORIZATION:** 6 months
***dronabinol cap**	**dronabinol soln* **Marinol ®*	***Dronabinol plus all non-preferred Antiemetic/Antivertigo agents require submission of a Clinical SA. Refer to Antiemetic/Antivertigo SA form**
5HT3 Receptor Blockers		**LENGTH OF AUTHORIZATION:** 3 months, unless otherwise noted
ondansetron ODT/soln/tab	*Akynzeo®* *granisetron tab, vial* *Granisol soln* *ondansetron vial, amp, syringe* *ondansetron 16mg ODT* *palonosetron vial, syringe* *Posfrea™* *Sancuso® patch* *Sustol®*	**Routine PDL edits plus:** **For ondansetron 16mg ODT:** The member has tried and failed or is intolerant to ondansetron 8mg ODT.
NK-1 Receptor Antagonist		**LENGTH OF AUTHORIZATION:** 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* *Navitrux* *Nereus*	
Other		**LENGTH OF AUTHORIZATION:** 1 year, unless otherwise noted
***Diclegis®** **meclizine (OTC, Rx)** **metoclopramide soln, tab, vial** **prochlorperazine tab**	*Antivert®* *Barhemsys®* **Bonjesta™* *Compazine® supp/tab* *Compro®*	**♦Promethazine products approved for members ≥ 2 years ***♦Bonjesta®/Diclegis®/doxylamine succinate/vit B6:** Approve through EDD. member must be pregnant and at least 18 years of age.

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
****promethazine soln, syrp, tab, 12.5mg&25mg supp** *(AGE)*	*dimenhydrinate tab, vial* **doxylamine succinate/ vit B6* *metoclopramide ODT* *metoclopramide syringe* ***Phenergan® (AGE)* *prochlorperazine supp, vial* ***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 AUTHORIZATION**: 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 2 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®)*	**LENGTH OF AUTHORIZATION**: 14 days

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	Helidac® *Omeclamox®-Pak* *lansoprazole/amoxicillin/ clarithromycin* *Prevpac®* *Talicia®* *Voquezna®*	**Routine PDL edits**
Laxatives & Cathartics CLOSED CLASS		
Bowel Prep Agents		**LENGTH OF AUTHORIZATION**: 1 year
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*	**Routine PDL edits**
Constipation		
lactulose solution	**lactulose packet* **Kristalose Packet*	*** Kristalose/lactulose packet:** • Must have tried, failed or be intolerant to generic lactulose solution
Proton Pump Inhibitors		
omeprazole RX **pantoprazole** **Protonix® susp**	*dexlansoprazole dr (gen Dexilant®)* *Dexilant®* *esomeprazole magnesium cap/susp/tab* *esomeprazole strontium* *lansoprazole cap* *Konvomep®* *Nexium®* *omeprazole OTC* *omeprazole magnesium OTC*	**LENGTH OF AUTHORIZATION**: 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*
		omeprazole/sodium bicarbonate *pantoprazole susp (generic Protonix® susp)* *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 AUTHORIZATION:** **1 year**
	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®)*	**Routine PDL edits**
	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 AUTHORIZATION:** **1 year**
	alfuzosin **tamsulosin HCL**	*Flomax ®* *Rapaflo®*	**Routine PDL edits**

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	silodosin (generic Rapaflo) *Uroxatral®*	
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		
	**Cialis® (ST)* *tadalafil 5 mg (ST)*	***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.
Urinary Antispasmodics (Bladder Relaxant)		
fesoterodine fumarate ER **Myrbetriq™ tab** **oxybutynin tab/syrup** **oxybutynin ER** **solifenacin**	*darifenacin ER (generic Enablex®)* *flavoxate* *Gelnique™ gel/gel Pump* *Gemtesa®* *mirabegron ER* *mirabegron granules* *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**	*Aubagio®* *Bafiertam™*	**LENGTH OF AUTHORIZATION**: 1 year

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Copaxone 20 mg syringe® **dimethyl fumarate and Starter Pack** **fingolimod** ****Kesimpta® (ST)** **teriflunomide (generic Aubagio®)**	*Betaseron®* *Briumvi™* *cladribine* *Copaxone® 40 mg syringe®* *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 (ICD-10 Code: G35.A)** ****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™**	*Abrilada™* *Actemra® SQ & ACTPEN* *adalimumab-aacf* *adalimumab-aaty* *adalimumab-adbm(Quallent)* *adalimumab-adaz*	**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)**

Preferred Agents	Non-Preferred Agents	SA Criteria
Pyzchiva® Syringe, Vial **Starjemza™**	*adalimumab-fkjp Pen* *adalimumab-ryvk* *Amjevita™* *Amjevita™ Autoinjector* *Arcalyst®* *Avsola™* *Avtozma®* *Bimzelx®* *Cibinqo™* *Cimzia® & Cimzia® Syringe Kit* *Cosentyx™* *Cosentyx™ UnoReady pen* *Cyltezo®* *Enspryng™* *Entyvio®* *Hulio®* *Humira® Pen, Syringe* *Hyrimoz®* *Icotyde* *Ilaris®* *Ilumya™* *Inflectra®* *infliximab (gen Remicade®)* *Kevzara® inj, pen* *Kineret®* *Olumiant®* *Omvoh™* *Orencia®* *Otezla®* *Otezla XR™* *Otulfi®* *Remicade®* *Renflexis®* *Rinvoq®* *Rinvoq® LQ*	**For preferred ustekinumab products members must also have tried and failed ONE preferred TNF inhibitor** ***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
		Selarsdi® *Simlandi*™ *Simponi*® *Simponi*®*Aria* *Skyrizi*™ *syringe, Pen* *Spevigo*® *Stelara*® *vial/syringe* *Steqeyma*® *Sotyktu*™ *Taltz*® *tofacitinib* *Tofidence*™ *Tremfya*™ *Tyenne*® *Uplizna*® *ustekinumab-aauz* *ustekinumab-aekn* *ustekinumab-ttwe* *Velsipity*® *Xeljanz*™*, Xeljanz*™ *XR and sol* *Yesintek*™ *Yuflyma*® *Yusimry*™ *Zymfentra*™	
	♦Methotrexate CLOSED CLASS		**LENGTH OF AUTHORIZATION: 1 year**
	methotrexate tab/PF vial/MDV	*Jylamvo*® *Rasuvo*™ *Trexall*® *Xatmep*™	**Routine PDL edits**

	Preferred Agents	Non-Preferred Agents	SA Criteria
Ophthalmic			
Antibiotics			
	bacitracin/polymyxin b sulfate oint **ciprofloxacin drops** **erythromycin** **gentamicin drops/oint** **moxifloxacin drops (generic Vigamox)** **ofloxacin drops** **polymyxin/trimethoprim** **tobramycin**	*AzaSite™ drops* *bacitracin* *besifloxacin susp* *Besivance® drops* *Ciloxan® drops/oint* *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®*	**LENGTH OF AUTHORIZATION**: Date of service only; no refills **Routine PDL edits**
Antibiotic/Steroid Combinations			
	neomycin/polymyxin/dexamethasone oint/susp **sulfacetamide/prednisolone** **Tobradex® oint** **tobramycin/dexamethasone susp**	*Blephamide® S.O.P.* *loteprednol/tobramycin ophthalmic (generic Zylet)* *Maxitrol® 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**

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Antihistamines/Mast Cell Stabilizers		
Antihistamines		**LENGTH OF AUTHORIZATION:** 1 year **Routine PDL edits**
Alaway OTC® **ketotifen fumarate** **olopatadine (generic Patanol & Pataday) (OTC)**	*alcaftadine (gen Lastacaft®)* *azelastine* *bepotastine (gen Bepreve®)* *Bepreve®* *Elestat®* *epinastine 0.05% eye drops* *Lastacaft®* *olopatadine (generic Patanol & Pataday) (Rx)* *olopatadine 0.7%* *Optivar®* *Patanol® Rx and OTC* *Pataday® Rx and OTC* *Zaditor® OTC* *Zerviate™*	
Mast Cell Stabilizers		
cromolyn sodium		
Anti-inflammatory Agents		
Corticosteroids		
Durezol® **prednisolone acetate**	*Alrex™* *Byqlovi* *dexamethasone* *difluprednate (gen Durezol®)* *Flarex®* *fluorometholone* *FML®, FML Forte®* *loteprednol etabonate* *Maxidex®* *Pred Forte® & Pred Mild®*	

Preferred Agents	Non-Preferred Agents	SA Criteria
	prednisolone sod phosphate	
Immunomodulators CLOSED CLASS		
Restasis® **Xiidra®**	*Cequa™* *cyclosporine* **Eysuvis* *Miebo™* *Restasis Multidose®* *Tryptyr®* *Tyrvaya™ Nasal Spray* ***Verkazia®*	*♦DUR DURATION LIMIT Eysuvis 1 bottle in 3 months, message returned to pharmacist stating "Limitation Exceeded: Quantity Limit of 1 Bottle per 3 Months. Member needs Intraocular Pressure (IOP) Test. If IOP test completed, Physician to call 1-800-932-6648 for a Clinical SA" **♦**Verkazia criteria (PDL criteria do not apply)** • Member is ≥4 years of age; **AND** • Diagnosis of moderate to severe vernal keratoconjunctivitis; **AND** • 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 AUTHORIZATION**: 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®* *Prolensa™*	

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

10/1/26

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Glaucoma Agents		
Alpha 2 Adrenergic Agents		**LENGTH OF AUTHORIZATION**: 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**	*Betimol®* *betaxolol 0.5%* *brimonidine-timolol (gen Combigan®)* *Istalol® 0.5%* *timolol (generic for Betimol®)* *timolol (generic for Istalol®)* *timolol (generic for Timoptic Ocudose)*	
Carbonic Anhydrase Inhibitors		
Azopt® **dorzolamide** **dorzolamide/timolol**	*brinzolamide* *Cosopt® 0.5%-2%* *Cosopt® PF* *Simbrinza™* *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™* *Lumigan® 0.03% & 0.01%*	

	Preferred Agents	Non-Preferred Agents	SA Criteria
		tafluprost *travoprost 0.004%* *Vyzulta™* *Xalatan® 0.005%* *Zioptan™* *Zolymbus*	
Respiratory			
	***Anti-Allergens, Oral**		
	Grass Pollen		**LENGTH OF AUTHORIZATION**: 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 AUTHORIZATION**: 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, sol* *fexofenadine* *fexofenadine/PSE ER* *fexofenadine suspension* *levocetirizine sol* *loratadine ODT, chew*	

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

10/1/26

Preferred Agents	Non-Preferred Agents	SA Criteria
	loratadine D 12 & 24 hr	
Beta-Adrenergic Agents		
Long Acting Beta Adrenergic s (LABA) MDIs or Nebulizers		**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edits**
formoterol fumarate (generic Perforomist®) **Serevent Diskus®**	*arformoterol (generic Brovana®)* *Brovana®* *Perforomist®* *Striverdi® Respimat*	
Short Acting Metered Dose Inhalers or Devices		
albuterol HFA (Proair)* and *(Authorized Generic) albuterol HFA (Proventil) and (Authorized Generic) **Ventolin® HFA**	*albuterol HFA (Ventolin®)* *levalbuterol tartrate HFA* *ProAir® RespiClick* *Xopenex® HFA*	
Short Acting Nebulizers		
albuterol sulfate (premixed)	*levalbuterol soln*	
COPD: Anticholinergics, Bronchodilators and Phosphodiesterase 4 (PDE4) Inhibitors CLOSED CLASS		
Short Acting Anticholinergics/Short ActingBronchodilators CLOSED CLASS		
Atrovent HFA® **ipratropium bromide soln**	*ipratropium bromide HFA*	
Short Acting Anticholinergics/Short ActingBronchodilators CLOSED CLASS		
Combivent® Respimat **ipratropium/albuterol nebs**	*Bevespi Aerosphere™* *Duaklir Pressair*	**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edits**
Long Acting Anticholinergics CLOSED CLASS		
Spiriva® **Spiriva® Respimat**	*Incruse™ Ellipta®* *tiotropium (generic for Spiriva®)* *Tudorza™* *umeclidinium Ellipta* ***Yupelri™ (revefenacin)*	**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edits plus** ***Clinical Criteria Yupelri™ (**reviewed electronically, AutoPA**)** (ICD-10 Code: J44.xx)

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
		• 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™	
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 AUTHORIZATION**: 1 year
Advair® Diskus **Advair® HFA** **Breztri Aerosphere™** **Dulera®** **Symbicort®**	*Airsupra* *budesonide-formoterol (generic Symbicort®)* *Breo®Ellipta™* *Breyna™ (generic Symbicort®)* *fluticasone/salmeterol (generic Airduo)*	**Routine PDL edits plus** **For triple therapy inhaled products (ICS/LABA/LAMA) for asthma:** • Member must be diagnosed with asthma **AND** • Member must have tried and failed (30-day trial) a preferred combination inhaled glucocorticoid and long-acting beta agonist such as Symbicort and a preferred long-acting muscarinic antagonist agent such as Spiriva **AND**

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

10/1/26

Preferred Agents	Non-Preferred Agents	SA Criteria
	fluticasone/salmeterol powder (generic Advair) *fluticasone/salmeterol HFA (generic Advair HFA)* *fluticasone-vilanterol (generic Breo®Ellipta™)* *Trelegy® Ellipta* *Wixela® (fluticasone/salmeterol)*	• For non-preferred agents; member must have tried and failed a preferred triple therapy inhaler **OR** **For triple therapy inhaled products (ICS/LABA/LAMA) for COPD:** • Member must be diagnosed with COPD **AND** • Member must have tried and failed (30-day trial) a preferred combination inhaled glucocorticoid and long-acting beta agonist such as Symbicort and a preferred long-acting muscarinic antagonist agent such as Spiriva **AND** • For non-preferred agents; member must have tried and failed a preferred triple therapy inhaler
Inhaled Corticosteroids: Metered Dose Inhalers CLOSED CLASS		
Arnuity™ Ellipta® **Asmanex Twisthaler** **Asmanex HFA®** **QVAR® Redihaler**	*Aerospan™* *Alvesco®* *beclomethasone HFA* *fluticasone HFA(gen Flovent® HFA)* *fluticasone Diskus (gen Flovent® Diskus)*	
Inhaled Corticosteroids: Nebulizer Solution CLOSED CLASS		**LENGTH OF AUTHORIZATION**: 1 year
budesonide respules	*Pulmicort® Respules*	
Nasal Steroids		**Routine PDL edits**
azelastine/fluticasone nasal spray (generic for Dymista®) **fluticasone Rx and OTC**	*budesonide (generic for Rhinocort® Aqua)* *budesonide (generic Rhinocort® Allergy OTC)* *Children's Qnasl™* *Dymista®* *Flonase®* *Flonase Sensimist (OTC)* *flunisolide* *ipratropium bromide spray*	

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	mometasone (generic Nasonex®) *Nasonex OTC* *Omnaris®* *Qnasl™* *Rhinocort Aqua®* *Rhinocort® Allergy OTC* *Ryaltris®* *triamcinolone OTC* *triamcinolone acetonide* *Veramyst®* *Xhance™*	
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 AUTHORIZATION**: **1 year** **Routine PDL edits**
***♦ Immunomodulators, Asthma CLOSED CLASS**		
Fasenra Pen **Fasenra Syringe** **Tezspire Pen and Syringe** **Xolair Autoinjector** **Xolair Syringe** **Xolair Vial**	*Cinqair* *Exdensur* *Nucala Auto-Injector* *Nucala Syringe* *Nucala Vial*	**LENGTH OF AUTHORIZATION**: **see fax forms** **Routine PDL edits plus** ***♦ All Agents require the submission of a Clinical SA. Refer to fax forms below:** **Cinqair SA Form** **Exdensur SA Form** **Fasenra SA Form** **Nucala SA Form** **Tezspire SA Form** **Xolair SA Form**
Intranasal Antihistamines		
azelastine 0.1%	*azelastine 0.15% nasal spray*	**LENGTH OF AUTHORIZATION**: 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™* *zileuton ER*	**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edits**