



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

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) <u>LENGTH OF AUTHORIZATION</u> - 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	<i>Belbuca (buprenorphine buccal film)</i> <i>buprenorphine (gen Butrans[®])</i> <i>buprenorphine (gen Belbuca)</i> <i>ConZip[®] (tramadol ER)</i> <i>tramadol ER</i> <i>Ultram ER[®] (tramadol ER)</i>		
Preferred (Sch II)	Non-Preferred		
fentanyl 12, 25, 50, 75 & 100 mcg patches morphine sulfate ER tab	<i>fentanyl 37.5 mcg, 62.5 mcg, and 87.5 mcg patches</i> <i>hydromorphone ER</i> <i>Hysingla ERTM</i> <i>morphine ER cap (generic Avinza[®])</i> <i>morphine ER cap (generic Kadian[®])</i> <i>MS Contin[®]</i> <i>oxycodone-long acting</i> <i>OxyContin[®]</i> <i>oxymorphone ER</i> <i>tapentadol ER</i>		
*Methadone Drugs			
	<i>Methadose[®] oral soln & tab</i> <i>methadone oral soln & tab</i>		*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			
codeine/APAP hydrocodone/APAP	<i>codeine tab/soln</i> <i>butalbital comp with codeine</i>		<u>LENGTH OF AUTHORIZATION:</u> Up to 3 months for chronic pain (includes HIV/AIDS, Chronic back pain, Arthritis, Fibromyalgia, Diabetic neuropathy, Postherpetic Neuralgia).

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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 <table><tr><td>buprenorphine SL tab 2mg</td><td>3/day</td></tr></table>	buprenorphine SL tab 2mg	3/day
buprenorphine SL tab 2mg	3/day				

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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		LENGTH OF AUTHORIZATION: 1 year			
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	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.			

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		ibuprofen tab chew OTC ibuprofen-famotidine (gen <i>Duexis[®]</i>) <i>Indocin[®]</i> supp indomethacin IR, SR & rectal ketoprofen IR & ER ketorolac ketorolac tromethamine (generic <i>Sprix[®]</i> nasal spray) meclofenamate mefenamic acid meloxicam susp meloxicam (generic <i>Vivlodex[™]</i>) nabumetone <i>Naprelan[®]</i> naproxen CR (generic <i>Naprelan[®]</i>) naproxen-esomeprazole mag (generic <i>Vimovo[®]</i>)DR naproxen susp <i>Orudis[®]</i> oxaprozin piroxicam tolmetin sodium * <i>Vyscoxa[™]</i> <i>Zybic[™]</i>	
Topical NSAIDs			LENGTH OF AUTHORIZATION: 1 year Routine PDL edits plus *Clinical Criteria for <i>Non-Preferred Topical NSAIDs</i>: - 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.
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	Quantity limit for diclofenac epolamine 1.3% patch = 30 patches per RX

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: - chest radiography or high-resolution computed tomography (HRCT) scan; AND - at least 2 positive sputum cultures; AND - other conditions such as tuberculosis and lung malignancy have been ruled out; AND - Member has failed a multi-drug regimen with a macrolide (clarithromycin or azithromycin), rifampin, and ethambutol. (Failure is defined as continual positive sputum cultures for MAC while adhering to a multi-drug treatment regimen for a minimum duration of 6 months); AND - Member has documented failure or intolerance to aerosolized administration of amikacin solution for injection, including pretreatment with a bronchodilator; AND - Arikayce will be prescribed in conjunction with a multi-drug antimycobacterial regimen *Minimum age for use is 6 years for all tobramycin inhalation nebulizer solution (Bethkis[®], Kitabis[™] Pak, Tobi[®] and Tobi Podhaler[®]) and 7 years for Cayston[®]. Quantity Limitations: Arikayce[®]= 590 mg/8.4 mL (28 vials)/28 days Each carton contains a 28-day supply of medication (28 vials)

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			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	<i>clotrimazole (mucous mem)</i> <i>Cresemba®</i> <i>Disflucan® susp</i> <i>flucytosine</i> <i>griseofulvin tab</i> <i>griseofulvin ultramicrosize</i> <i>itraconazole cap, soln</i> <i>ketoconazole</i> <i>Noxafil® Powdermix</i> <i>posaconazole tab (generic for Noxafil)</i> <i>Sporanox® cap</i> <i>Tolsura™</i> <i>Vfend® susp</i> <i>*Vivjoa®</i> <i>voriconazole tab & powder for susp</i>	<u>LENGTH OF AUTHORIZATION:</u> Duration of the prescription (up to 12 months) Routine PDL edits plus <u>Clinical Criteria for all Non-Preferred oral Antifungals.</u> Requires the submission of a Clinical SA. Refer to Antifungal Oral SA Form <u>*Clinical Criteria for Vivjoa:</u> 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			<u>LENGTH OF AUTHORIZATION:</u> Date of service only; no refills. Routine PDL edits plus <u>Clinical Criteria for Non-Preferred Cephalosporins</u>
cefaclor capsule cefprozil tab/susp cefuroxime tab	<i>cefaclor ER</i> <i>cefaclor susp</i>		

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Third Generation Cephalosporins			
cefdinir cap/susp	<i>ceftibuten</i> <i>cefditoren pivoxil</i> <i>cefixime susp, tab, cap</i> <i>cefpodoxime proxetil cap/susp</i>		• 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.
Macrolides, Oral			
Macrolides & Ketolides			LENGTH OF AUTHORIZATION: Date of service only; no refills
azithromycin pack/susp/tab clarithromycin tab/susp erythromycin base tab DR erythromycin ethylsuccinate 200mg susp	<i>clarithromycin ER</i> <i>Eryped[®] 200 susp</i> <i>Eryped[®] 400 susp</i> <i>Ery-tab[®]</i> <i>E.E.S.[®] 200 susp</i> <i>E.E.S.[®] 400 tab</i> <i>Erythrocin[®] Stearate</i> <i>erythromycin base cap DR</i> <i>erythromycin base tab</i> <i>erythromycin ethylsuccinate 400mg tab(Generic E.E.S.[®] 400 PCE[®])</i> <i>Zithromax[®] pac/tab/susp</i>		Routine PDL edits plus Clinical Criteria for <u>Non-Preferred Macrolides and Ketolides</u> • 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.
Otic			
ciprofloxacin/dexamethasone (generic Ciprodex) ofloxacin neomycin/polymyxin/hc soln/ susp	<i>Cipro HC[®]</i> <i>ciprofloxacin 0.2% otic soln</i> <i>ciprofloxacin-hydrocortisone (generic Cipro HC)</i> <i>Cortisporin TC</i>		LENGTH OF AUTHORIZATION: Date of service only; no refills Routine PDL edits

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Preferred Agents		Non-Preferred Agents	SA Criteria
Quinolones, Oral			
Second Generation Quinolones		<u>LENGTH OF AUTHORIZATION:</u> Date of service only; no refills Routine PDL edits plus: <u>Clinical Criteria for Non-Preferred Quinolones</u> • 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	<u>LENGTH OF AUTHORIZATION:</u> Date of service only; no refills Routine PDL edits	
Vaginal Antibiotics			
Cleocin [®] Ovules Clindesse [®] cr metronidazole gel Nuversa [™]	Cleocin [®] cr clindamycin cr Vandazole [™] gel Xaciato [™] gel	<u>LENGTH OF AUTHORIZATION:</u> Date of Service Routine PDL edits	

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:			
		Pegasys® syringe/vial		*Non-preferred agents require the submission of a Clinical SA. Preferred agents do not require submission of any SA. Refer to Hepatitis C Antivirals Non-Preferred SA Form	
*Nucleotide Analog NS5A & NS5B Polymerase Inhibitors & Combinations		* Hepatitis C Therapies may be filled:			
		Epclusa® Epclusa® Pellet packs sofosbuvir /velpatasvir (generic Epclusa®) Sovaldi® Vosevi™		1. Monthly a. Mavyret™ (28 days supply x 2 months) b. Mavyret™ Pellet packs (28 days supply x 2 months)	
*NS5A, NS3/4A Inhibitor Combinations		OR			
Mavyret™ Mavyret™ Pellet packs		Zepatier®		2. Full duration of the regimen: a. Mavyret™ (56 days supply) b. Mavyret™ Pellet packs (56 days supply)	
*NS5B & Protease Inhibitor Combinations					
		Harvoni® ledipasvir/sofosbuvir (generic Harvoni®)			

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Herpes Oral			
acyclovir cap/tab/susp famciclovir valacyclovir	Valtrex®	LENGTH OF AUTHORIZATION: Routine PDL edits	1 year
Herpes Topical			
acyclovir oint docosanol	acyclovir cr (generic Zovirax cr) Denavir® penciclovir	LENGTH OF AUTHORIZATION: Routine PDL edits	1 year
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: Routine PDL edits plus Quantity limits see list here HIV Quantity Limits	1 year



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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		

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Yeztugo[®] Ziagen[®] soln zidovudine tab/cap/syrup			
Influenza			
oseltamivir susp/ cap	<i>Flumadine[®] tab</i> <i>rimantadine</i> <i>Relenza Disk[®]</i> <i>Tamiflu[®] susp/cap</i> <i>Xofluza[™]</i>	<u>LENGTH OF AUTHORIZATION:</u> Routine PDL edits	Date of service only
COVID-19 CLOSED CLASS			
Paxlovid	<i>Xocova[®]</i>	<u>LENGTH OF AUTHORIZATION:</u>	Date of service only
Blood Modifiers			
Bile Salts			
ursodiol cap, tab	<i>*Bylvay[™]</i> <i>Chenodal[®]</i> <i>Cholbam[®]</i> <i>Ctexli</i> <i>Iqirvo[®]</i> <i>Livdelzi[®]</i> <i>**Livmarli[™]</i> <i>Lynavoy</i> <i>Reltone[®]</i> <i>Urso[®] & Urso[®] Forte tab</i> <i>Ursolign[™]</i>	<u>LENGTH OF AUTHORIZATION:</u> 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)	1 year



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Colony Stimulating Factors CLOSED CLASS			
Fulphila Neupogen Disp Syrin Neupogen Vial		<i>Filkri</i> <i>Fynetra</i> <i>Granix Syringe</i> <i>Granix Vial</i> <i>Leukine</i> <i>Neulasta Kit</i> <i>Neulasta Syringe</i> <i>Neulasta Vial</i> <i>Nivestym Syringe</i> <i>Nivestym Vial</i> <i>Nypozi</i> <i>Nyvepria</i> <i>Releuko Syringe</i> <i>Releuko Vial</i> <i>Rolvedon Syringe</i> <i>Ryzneuta Syringe</i> <i>Stimufend Syringe</i> <i>Udenyca</i> <i>Udenyca Autoinjector</i> <i>Udenyca Onbody</i> <i>Zarxio</i> <i>Ziextenzo Syringe</i>	<u>LENGTH OF AUTHORIZATION:</u> 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			<u>LENGTH OF AUTHORIZATION:</u> N/A All products are preferred without EDITS
Advate® Adynovate® Afstyla® Alphanate® Altuviiio™ Eloctate® Esperoct®			



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<i>Preferred Agents</i>		<i>Non-Preferred Agents</i>	<i>SA Criteria</i>
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[®] Rebinyln[®] 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[®]			



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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	<i>Auryxia[™]</i> <i>calcium acetate 667mg tab</i> <i>Calphron</i> <i>Eliphos</i> <i>ferric citrate tab</i> <i>Fosrenol[®] chewable tab</i> <i>lanthanum carbonate chewable tab</i> <i>Phoslyra[®] powder, tab</i> <i>Renvela[®]</i> <i>sevelamer carbonate powder packet</i> <i>sevelamer HCL (gen Renagel)</i> <i>Velphoro[®] chewable tab</i> <i>Xphozah[™]</i>	<u>LENGTH OF AUTHORIZATION:</u> Routine PDL edits	1 year
Sickle Cell CLOSED CLASS			

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Preferred Agents		Non-Preferred Agents	SA Criteria
Droxia Endari **Siklos *Xromi		<i>Adakveo IV</i> <i>l-glutamine(generic Endari)</i>	*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	<i>Actonel®</i> <i>alendronate soln</i> <i>Atelvia DR®</i> <i>Binosto™</i> <i>etidronate</i> <i>Fosamax®tab & Fosamax®plusD</i> <i>risedronate DR</i>	LENGTH OF AUTHORIZATION: 1 year Routine PDL edits	
Calcitonins			
calcitonin-salmon nasal		LENGTH OF AUTHORIZATION: 1 year Routine PDL edits	
Others			
raloxifene	<i>*Bonsity®</i> <i>Evista®</i> <i>*Forteo®</i> <i>*teriparatide</i> <i>*Tymlos™</i>	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™	<i>Aukelso™</i> <i>Bildyos®</i> <i>Bilprevda®</i> <i>Bomyntra®</i>	*♦ ALL RANK Ligand Inhibitors require the submission of a Clinical SA. Refer to denosumab SA Form	

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Preferred Agents		Non-Preferred Agents	SA Criteria
		Bosaya TM Conexxence [®] Jubbonti [®] Jubereq Osenvelt [®] Osvyrti [®] Prolia [®] Stoboclo [®] Wyost [®] Xgeva [®]	
Cardiac			
Anticoagulants CLOSED CLASS			
Low Molecular Weight Heparin includes FactorXA Inhibitor		<u>LENGTH OF AUTHORIZATION:</u> 1 year	
enoxaparin (generic Lovenox [®])	Arixtra [®] fondaparinux Fragmin [®] syringe & vial Lovenox [®]	Routine PDL edits	
Oral Anticoagulants		<u>*Clinical Criteria for SavaysaTM</u>	
dabigatran Eliquis TM tab, sprinkle cap, susp Eliquis TM Dose Pack Jantoven [®] warfarin Xarelto [®] tab, susp & Starter Pack	Pradaxa [®] Pradaxa [®] Pellet Pack rivaroxaban *Savaysa TM	• Diagnosis of: Non-valvular Atrial Fibrillation, OR • Deep vein thrombosis, OR • Pulmonary embolism; AND • Documentation that CrCl is NOT ≥ 95mL/min calculated by Cockcroft-Gault equation	
Antihypertensive Agents			
ACE Inhibitors		<u>LENGTH OF AUTHORIZATION:</u> 1 year	
benazepril enalapril lisinopril	Altace [®] captopril Epaned TM soln	Routine PDL edits	

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Preferred Agents		Non-Preferred Agents	SA Criteria
ramipril		enalapril soln fosinopril Lotensin® moexipril perindopril Qbrelis™ quinapril trandolapril Zestril®	LENGTH OF AUTHORIZATION: 1 year Routine PDL edits plus <i>Quantity Limit = 2 per day for Entresto™ and sacubitril/valsartan generics</i> **Entresto Sprinkle capsule: The member is intolerant to solid oral dosage forms
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			
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 Kapsargo™ Sprinkle Lopressor® pindolol	



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

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Preferred Agents		Non-Preferred Agents	SA Criteria
Lipotropics			LENGTH OF AUTHORIZATION: 1 year *♦ ALL Apolipoprotein A Inhibitors require the submission of a Clinical SA. Refer to Apolipoprotein A Inhibitors SA Form 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: - Extremely high risk ASCVD: (defined as extensive or active burden of ASCVD, or ASCVD with extremely high burden of adverse or poorly controlled risk cardio-metabolic risk factors including HeFH or severe hypercholesterolemia [SH] LDL-C > 220 mg/dl) with an LDL-C ≥ 70 mg/dL; OR - Very high risk ASCVD: (defined as less extensive ASCVD and poorly controlled cardiometabolic risk factors) with an LDL-C ≥ 100 mg/dL; OR - High risk ASCVD: (defined as either less extensive ASCVD and well-controlled risk factors or primary prevention HeFH or SH >220 mg/dl with poorly controlled risk factors) with LDL-C ≥ 130 mg/dL; AND
*Apolipoprotein A Inhibitors			
		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)			
ezetimibe		Nexletol® (bempedoic acid) Nexlizet® (bempedoic acid/ ezetimibe) Zetia®	

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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 <i>Tricor</i> [®] 48mg 145mg) gemfibrozil		<i>fenofibrate</i> (generics for <i>Antara</i> [®] , <i>Fenoglide</i> [®] & <i>Lipofen</i> [®]) <i>fenofibrate</i> (generics for <i>Triglide</i> [®]) <i>fenofibric acid</i> <i>Fibricor</i> [®] <i>Lipofen</i> [®] <i>Lopid</i> [®] <i>Tricor</i> [®]	
HMG CoA Reductase Inhibitors and Combo (High Potency Statins)			
atorvastatin rosuvastatin simvastatin		<i>Atorvaliq</i> [®] <i>amlodipine/atorvastatin</i> <i>Caduet</i> [®] <i>Crestor</i> [®] <i>Lipitor</i> [®] <i>Livalo</i> [®] <i>pitavastatin calcium</i> (generic <i>Livalo</i> [®]) <i>rosuvastatin-ezetimibe</i> <i>simvastatin/ezetimibe</i> <i>Vytorin</i> [®] <i>Zocor</i> [®] <i>Zypitamag</i> TM	

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

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Preferred Agents		Non-Preferred Agents	SA Criteria
*Pulmonary Arterial Hypertension Agents			LENGTH OF AUTHORIZATION: 1 year Routine PDL edits for all Pulmonary Arterial Hypertension Agents 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®
Activin Signaling Inhibitor			
		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)			
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®	

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	Aricept® ODT, tab Exelon® transderm galantamine IR, ER tab/soln memantine/donepezil Namzaric® (memantine/donepezil) rivastigmine cap Zunveyl®				
rivastigmine (transderm)					
NMDA Receptor Antagonist					
memantine tab	memantine Dose Pack, soln memantine ER				
Anticonvulsants		CLOSED CLASS			
Barbiturates		LENGTH OF AUTHORIZATION: 1 year			
phenobarbital elixir/tab		Routine PDL			
primidone					
Sezaby					
Benzodiazepines					
clobazam tab/susp	clonazepam ODT				
clonazepam tab	clorazepate				
diazepam rectal & Device	Klonopin Tab				
rectal	Onfi®susp/tab				
Nayzilam®	Sympazan™ (clobazam)				
Valtoco® Nasal					
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			

*♦ **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

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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		<i>Aptiom[®]</i>	
carbamazepine XR		<i>carbamazepine 200mg chewable tab</i>	
Carbatrol[®]		<i>carbamazepine ER</i>	
Epitol		<i>eslicarbazepine acetate</i>	
oxcarbazepine tab		<i>Equetro[®] cap</i>	
Tegretol [®] XR		<i>OxtellarTM XR</i>	
Trileptal[®] susp		<i>oxcarbazepine susp</i>	
		<i>oxcarbazepine ER (generic)</i>	
		<i>Oxtellar XR</i>	
		<i>Tegretol[®] susp/tab</i>	
		<i>Trileptal[®] tab</i>	
Hydantoins			
Dilantin 30mg phenytoin cap/chew tab/susp		<i>Dilantin[®] cap & Infatab, susp</i>	
phenytoin ext cap		<i>Phenytek[®]</i>	
Succinimides			
ethosuximide cap/syrup		<i>Celontin[®]</i>	
		<i>Zarontin[®] cap/syrup</i>	
Valproic Acid and Derivatives			
Depakote[®] sprinkle		<i>Depakote[®] ER</i>	
divalproex tab		<i>divalproex sprinkle</i>	
divalproex ER			
valproic acid cap, soln			
Other Anticonvulsants			
lacosamide soln/tab (gen Vimpat [®])		<i>Banzel[®] susp/tab</i>	* 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
lamotrigine tab		<i>brivaracetam tab/soln</i>	
lamotrigine chew tab		<i>Briviact[®] tab/soln</i>	
lamotrigine XR		<i>Diacomit[®] cap/powder pack</i>	
levetiracetam soln/tab		<i>Elepsia[®] XR tab</i>	
		<i>EprontiaTM</i>	

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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	<i>felbamate susp/tab</i> <i>Felbatol® tab</i> <i>* Fintepla®</i> <i>Fycompa® susp/tab</i> <i>Keppra® soln/tab</i> <i>Keppra® XR</i> <i>lacosamide solution unit dose</i> <i>Lamictal® XR & XR dose pk</i> <i>Lamictal® tab/dose pk</i> <i>Lamictal® ODT</i> <i>Lamictal® ODT dose pk</i> <i>lamotrigine tab dose pk</i> <i>lamotrigine ODT</i> <i>lamotrigine ODT dose pk</i> <i>levetiracetam (generic Spritam®)</i> <i>Motpoly XR™</i> <i>perampanel</i> <i>rufinamide susp/tab (generic</i> <i>Banzel®)</i> <i>Sabril® powder pack/tab</i> <i>Spritam®</i> <i>subvenite dose pk/susp</i> <i>tiagabine</i> <i>Topamax® tab/sprinkle</i> <i>topiramate ER cap</i> <i>topiramate soln</i> <i>topiramate 50mg sprinkle cap</i> <i>Trokendi™ XR</i> <i>vigabatrin tab/ powder pack</i> <i>(generic Sabril®)</i> <i>Vigafyde™</i> <i>Vimpat® soln/tab</i> <i>Xcopri®</i> <i>Zonisade™ Solution</i> **Ztalmy®	** ♦ Clinical Criteria for Ztalmy: - Initial: - Member is two years of age or older; AND - Documented diagnosis of cyclin-dependent kinase-like 5 deficiency disorder AND - 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: - 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

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Preferred Agents		Non-Preferred Agents	SA Criteria
Antidepressants			
Other			LENGTH OF AUTHORIZATION: 1 year
bupropion IR, SR & XL desvenlafaxine ER tab (generic for Pristiq®) mirtazapine ODT/tab trazodone tab venlafaxine IR tab & ER cap vilazodone tab	** <i>Auvelity</i> ™ <i>bupropion XL (gen Forfivo® XL)</i> <i>desvenlafaxine ER tab (gen Khedezla™)</i> <i>Effexor® XR</i> <i>Emsam® transdermal</i> <i>Exxua™</i> <i>Fetzima®</i> <i>Khedezla™</i> <i>Marplan®</i> <i>Nardil®</i> <i>nefazodone</i> <i>phenelzine</i> <i>Pristiq®</i> <i>Raldesy™</i> <i>Remeron® ODT/tab</i> <i>tranylcypromine sulfate</i> <i>Trintellix</i> <i>venlafaxine ER tab</i> <i>Viibryd® dose pk</i> <i>Viibryd® tab</i> <i>Wellbutrin® SR</i> <i>*Zurzuva™</i>	Routine PDL edits ** ♦ <u>Auvelity criteria for the treatment of agitation associated with dementia due to Alzheimer's disease (Routine PDL edits do not apply)</u> - 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 * ♦ <u>Zurzuva criteria (Routine PDL edits do not apply)</u> - 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	
SSRI			
citalopram soln/tab escitalopram tab fluoxetine cap/soln fluvoxamine tab paroxetine tab sertraline conc, soln, tab	<i>Brisdelle®</i> <i>Celexa® tab</i> <i>citalopram HBR 30mg</i> <i>escitalopram soln</i> <i>fluoxetine DR cap/tab</i> <i>fluvoxamine ER</i> <i>Lexapro® tab</i> <i>paroxetine CR</i> <i>paroxetine susp</i>		

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Preferred Agents	Non-Preferred Agents	SA Criteria
	<i>Paxil[®] tab/susp & Paxil[®] CR</i> <i>Prozac[®] cap/weekly</i> <i>sertraline cap</i> <i>Zoloft[®] conc/tab</i>	
Antimigraine Agents		
sumatriptan succinate tab cartridge/vial/pen rizatriptan tab/MLT	<i>almotriptan</i> <i>eletriptan (generic Relpax[®])</i> <i>Elyxyb[®]</i> <i>frovatriptan (generic Frova[®])</i> <i>Imitrex[®] cartridge/pen/tab</i> <i>Maxalt[®] tab & MLT</i> <i>naratriptan</i> <i>Relpax[®]</i> <i>sumatriptan/nap (gen Treximet[®])</i> <i>Symbravo[®]</i> <i>Tosymra[®]</i> <i>Zembrace[™] SymTouch[™]</i> <i>zolmitriptan nasal, ODT, tab</i> <i>Zomig[®] tab/nasal spray/ZMT</i>	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
Preventive Treatment		Preferred Agents *step edit required
Aimovig[™] Ajovy[®] Autoinjector & Syringe Ajovy Autoinjector 3-Pk Emgality[™] Syringe Emgality[™] Pen Nurtec[™] ODT Qulipta[™]	Emgality[™] 100MG Syringe **Vyepti[®]	Quantity limit for preventive treatment Aimovig [™] = 70 mg/mL autoinjector = 1 mL or 140 mg/mL autoinjector = 1 mL per 30 days Ajovy [®] = 1 Injection: 225 mg/1.5 mL single-dose prefilled autoinjector per 30 days. Ajovy 3 pack = one 3 pack per 90 days Emgality [™] = 120 mg/mL pen and syringe = 1 mL per 30 days 100 mg/1 mL syringe = 3 mL per 30 days (Episodic cluster headache treatment) Nurtec [®] ODT = 16 tabs per 30 days

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Preferred Agents		Non-Preferred Agents	SA Criteria
			Qulipta™ = 1 tab per day
Acute treatment of migraine			
Nurtec™ ODT Ubrelvy®		Zavzpret™	Quantity limit for acute treatment Nurtec® ODT = 16 tabs per 30 days Ubrelvy® = 50mg or 100mg can have up to 16 tabs per strength per 30 days
*Antipsychotics (AGE) CLOSED CLASS			
Atypical			LENGTH OF AUTHORIZATION: 1 year or 6 months for members < 18 yrs
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 Opipza™ quetiapine fumarate ER (authorized generic only) Rexulti® tab Risperdal® ODT/soln/tab Saphris®	Routine PDL edits plus *♦ ALL antipsychotics for children 0 to 17 years of age (preferred and non-preferred) require the submission of a Clinical SA. Refer to (Antipsychotics In Children Less Than 18 Years SA Form) ** Clinical Criteria Nuplazid™ • Indicated for the treatment of hallucinations and delusions associated with Parkinson's disease psychosis. Quantity Limit Nuplazid™ = 2 per day **** Clinical Criteria for Vraylar as adjunct treatment for Major Depressive Disorder, reviewed electronically, AutoPA (ICD-10 Code: F33.xx - Depression and subtypes) • 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

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Preferred Agents		Non-Preferred Agents	SA Criteria
		Secuado [®] Patch Seroquel [®] IR Seroquel [®] XR Versacloz [™] Zyprexa [®] Zydis [®]	
Atypical, Long-Acting Injectable			LENGTH OF AUTHORIZATIONS: 1 year
Abilify Asimtufii [®] Abilify Maintena [®] Aristada [®] Aristada [®] Initio Erzofri [®] Invega Hafyera [™] , Sustenna [®] & Trinza [®] Perseris [™] Risperdal Consta [®] Uzedi [™]		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 thioridazine		Adasuve [®] Haldol decanoate (injection) pimozide molindone	Routine PDL edits
Duchenne Muscular Dystrophy CLOSED CLASS			
**Emflaza		**Agamree Amondys-45 **deflazacort **Duvyzt	LENGTH OF AUTHORIZATION: 1 year **Clinical Criteria for oral Duchenne Muscular Dystrophy agents Member is 2 years of age or older for Agamree®, Emflaza[™]

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	Preferred Agents	Non-Preferred Agents	SA Criteria
		***Elevidys Exondys-51 **Jaythari **Kymbee **Pyquvi Viltepso Vyondys-53	- 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®

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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

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Preferred Agents		Non-Preferred Agents		SA Criteria	
Sedatives / Hypnotics (Non-Benzodiazepine)					
eszopiclone zaleplon zolpidem		Ambien® IR & CR Belsomra® Dayvigo™ doxepin (generic for Silenor®) Edluar™ *Hetlioz® **Hetlioz™ LQ Intermezzo® Lunesta® Quviviq™ Rozerem® Silenor® Sonata® tasimelteon zolpidem CR zolpidem (generic Intermezzo®) zolpidem tartrate capsule		LENGTH OF 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	

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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
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	*♦ 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

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Preferred Agents		Non-Preferred Agents	SA Criteria
Vyvanse[®] capsule (lisdexamfetamine)		<i>Dyanavel[®] XR susp</i> <i>Evekeo[®]</i> <i>lisdexamfetamine(generic Vyvanse[®])</i> <i>methamphetamine</i> <i>Mydayis ERTM</i> <i>Procentra[®] soln</i> <i>Vyvanse[®] chewable tab</i> <i>XelstrymTM</i> <i>ZenzediTM</i>	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		<i>AptensioTM XR</i> <i>AzstarysTM</i> <i>Concerta[®]</i> <i>Cotempla XR-ODTTM</i> <i>Focalin[®] IR & Focalin[®] XR</i> <i>Jornay PM</i> <i>methylphenidate CD cap (generic Metadate CD)</i> <i>Methylin ER[®], soln IR</i> <i>methylphenidate chew</i> <i>methylphenidate LA, SR</i> <i>methylphenidate ER(generic Relexxii[®])</i> <i>methylphenidate ER(generic AptensioTM XR)</i> <i>methylphenidate (generic Daytrana[®])</i> <i>Ritalin[®] IR</i> <i>Relexxii[®]</i> <i>QuilliChew ERTM</i> <i>QuillivantTM XR susp</i>	

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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.

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Preferred Agents		Non-Preferred Agents	SA Criteria
		<i>clindamycin phosphate foam, el, med swab</i> <i>clindamycin/tretinoin (generic Veltin®)</i> <i>dapsone 5% gel</i> <i>erythromycin gel/med. swab</i> <i>Evoclin™</i> <i>Neuac™ topical/kit</i> <i>Sulfacetamide Cleanser ER</i> <i>Sulfacetamide Cleanser, Shampoo, Susp</i> <i>Sulfacetamide Sodium/Sulfur Cr, Susp, Sunscreen</i> <i>SSS 10-5 Foam</i> <i>Sulfacetamide/Sulfur/Cleanser, Cleanser Kit, Lotion Med. Pad</i> <i>Sumadan Wash, Kit</i> <i>Sumadan XLT</i> <i>Sumaxin CP Kit</i> <i>Winlevi®</i>	
Retinoids/Combinations, Topical			
adapalene gel OTC tretinoin 0.025, 0.05, 0.1% cream	<i>adapalene 0.1% cr/gel/lot</i> <i>adapalene 0.3% gel/gel w/pump</i> <i>adapalene-benzoyl peroxide (gen Epiduo® and Epiduo® Forte)</i> <i>Differin® 0.1% cr/gel/lot RX</i> <i>Differin® 0.3% gel pump</i> <i>Differin 0.1% gel (OTC)</i> <i>Epiduo® & Epiduo® Forte Gel</i> <i>*Fabior™ 0.1% Foam</i> <i>Tazorac® cr/gel</i> <i>tazarotene 0.1% cr, foam</i> <i>tretinoin 0.01, 0.025% gel</i>	*♦ Age Edit for Fabior™ Foam Members must be between the ages of 12 and 18 years of age	

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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®	<u>LENGTH OF AUTHORIZATION:</u> 6 months Routine PDL edits	
♦Immunomodulators, Atopic Dermatitis			
		CLOSED CLASS	
Adbry™ **Dupixent® ** Ebglyss™ **Eucrisa™ *pimecrolimus	***Anzupgo® *** Nemludio® ***Opzelura™ Protopic® ***Zoryve cream, 0.15%	<u>LENGTH OF AUTHORIZATION:</u> 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)	

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Preferred Agents	Non-Preferred Agents	SA Criteria
*tacrolimus *****Vtama®	***Zoryve cream, 0.05%	AND - Age and severity for drug as follows below: - Adbry™: moderate to severe for ages ≥ 12 years - Ebglyss™: moderate to severe for ages ≥ 12 years - Eucrisa™: mild to moderate for ages ≥ 3 months - Dupixent®: moderate to severe for ages ≥ 6 months - Nemluvio®: moderate to severe for ages ≥ 12 years - Opzelura™: mild to moderate for ages ≥ 2 years - pimecrolimus: mild to moderate for ages ≥ 2 years - Protopic® 0.03%: moderate to severe for ages ≥ 2 years - Protopic® 0.1%: moderate to severe for ages ≥ 16 years - Vtama® for ages ≥ 2 years - Zoryve® cream 0.15%: mild to moderate for ages ≥ 6 years - Zoryve® cream, 0.05%: mild to moderate atopic dermatitis in ages 2 to 5 AND the one that applies: *Clinical Criteria for pimecrolimus, or tacrolimus - 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) - Prior documented trial & failure of 8 weeks of each - One (1) topical corticosteroid of medium to high potency (e.g., mometasone, fluocinolone) AND - One (1) topical calcineurin inhibitor (tacrolimus or pimecrolimus) AND - A trial and failure of Dupixent®

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	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 *** Clinical Criteria for Zoryve cream 0.05% and 0.15% • Prior documented trial & failure of 8 weeks of each ○ One (1) topical corticosteroid of medium to high potency (e.g., mometasone, fluocinolone) AND ○ One (1) topical calcineurin inhibitor (tacrolimus or pimecrolimus) <u>QUANTITY LIMITS for Atopic Dermatitis</u> <table><tr><th>Drug</th><th>Rolling qty limit</th></tr><tr><td>Adbry®</td><td>4 syringes/14 days (initial dose) 4 syringes/28 days (maintenance)</td></tr><tr><td>Dupixent</td><td>2 syringes (or pens)/14 days (initial dose), 2 syringes (or pens)/28 days (maintenance)</td></tr><tr><td>pimecrolimus</td><td>30gm per 30 days</td></tr><tr><td>Eucrisa® (crisaborole)</td><td>300gm per year</td></tr><tr><td>Opzelura (ruxolitinib)</td><td>240 gm (4 x 60gm) per 30 days</td></tr></table>	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
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														



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	Preferred Agents	Non-Preferred Agents	SA Criteria		
			<table><tr><td>Protopic® (tacrolimus)</td><td>30gm per 30 days</td></tr></table> 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: - o Asthma with eosinophilic phenotype with eosinophil count ≥ 150 cells/mcL; OR - o Oral corticosteroid dependent asthma with at least 1 month of daily oral corticosteroid use within the last 3 months ♦ 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	Protopic® (tacrolimus)	30gm per 30 days
Protopic® (tacrolimus)	30gm per 30 days				

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	Preferred Agents	Non-Preferred Agents	SA Criteria
			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 ♦ 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	<i>betamethasone/ calcipotriene</i> <i>calcitriol</i> <i>calcipotriene/betamethasone</i> <i>(generic for Taclonex®)</i> <i>calcipotriene foam</i> <i>*Enstilar® Foam (AGE)</i> <i>Sorilux™</i> <i>Taclonex® & Taclonex® Scalp</i> <i>Zoryve® 0.3% cream</i> <i>**Zoryve foam 0.3%</i>	<u>LENGTH OF AUTHORIZATION:</u> 1 year Routine PDL edits plus *♦ <u>Clinical Criteria for Enstilar® Foam</u> • Length of Authorization: 4 weeks • Diagnosis of plaque psoriasis; AND • Minimum age of 12 years **♦ <u>Clinical Criteria for Zoryve foam 0.3% for Seborrheic Dermatitis</u> • Member is 9 years of age or older and has a diagnosis of seborrheic dermatitis • Member has a history of failure, contraindication, or intolerance to BOTH of the following therapies: - o 30 days of therapy with ONE (1) topical corticosteroid (i.e., clobetasol, fluocinonide or mometasone cream/ointment/solution) in the past 180 days AND

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Preferred Agents		Non-Preferred Agents	SA Criteria
			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			
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	
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	betamethasone valerate foam Beser Lotion and Kit clocortolone cr		

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Preferred Agents		Non-Preferred Agents	SA Criteria
mometasone furoate cr/oint/soln		fluocinolone acetonide cr/oint/soln flurandrenolide cr/oint/tape fluticasone propionate lot hydrocortisone valerate cr/oint hydrocortisone butyrate (generic for Locoid Lotion) hydrocortisone butyrate cr/oint/soln/ emollient Synalar [®] , TS	LENGTH OF AUTHORIZATION: 1 year Routine PDL edits plus
Steroids, Topical High Potency			
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	
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	

Preferred Agents		Non-Preferred Agents	SA Criteria
		<i>halobetasol prop oint (generic for Lexette®)</i> <i>Ultravate® lotion</i>	
Endocrine and Metabolic Agents			
Androgenic Agents (Testosterone – Topical)			
testosterone pump (generic for AndroGel® Pump) testosterone packet (authorized generic for Vogelxo™)	<i>Natesto Nasal Gel®</i> <i>Testim®</i> <i>testosterone (generic for Axiron®)</i> <i>testosterone gel/pump (generic for Vogelxo™)</i> <i>testosterone (generic for Fortesta®)</i> <i>Vogelxo™ gel/packet/pump</i>	LENGTH OF AUTHORIZATION: 1 year Routine PDL edits	
Antihyperuricemics			
allopurinol 100mg and 300mg colchicine tabs Probenecid® probenecid & colchicine	<i>allopurinol 200mg</i> <i>colchicine caps</i> <i>febuxostat (generic Uloric®)</i> <i>Gloperba®</i> <i>Mitigare®</i> <i>Zyloprim®</i>	LENGTH OF AUTHORIZATION: 1 year Routine PDL edits	
Contraceptives*(long-acting IUDs & injectable)			
Depo-Provera® 104mg Kyleena™ Liletta® medroxyprogesterone 150mg Mirena® Nexplanon® Paragard® Skyla®	<i>Depo-Provera® 150mg</i> <i>Miudella®</i>	LENGTH OF AUTHORIZATION: 1 year Routine PDL edits	

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Preferred Agents		Non-Preferred Agents	SA Criteria
♦Diabetes Hypoglycemics: Injectable and Oral Incretin Mimetics CLOSED CLASS			
Trulicity TM Victoza [®]	exenatide liraglutide Mounjaro [®] Ozempic [®] Rybelsus Tab [®] Soliqua [®] 100/33 Tanzeum TM Xultophy [®] 100/3.6	LENGTH OF AUTHORIZATION: 1 year Routine PDL edits Preferred Agents Clinical Criteria: • Diagnosis of type II diabetes Non-Preferred Incretin Mimetics SA Form	
Diabetes Hypoglycemics: Injectable Insulins			
Insulin Mix		LENGTH OF AUTHORIZATION: 1 year	
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	Routine PDL edits	
Insulin N			
Humulin [®] N pen/vial (OTC)	Humulin [®] N pen Novolin [®] N vial (OTC)		
Insulin R			
Humulin [®] R pen/vial	Novolin [®] R vial (OTC)		
Long-Acting Insulins			
Lantus [®] Solostar [®] & vial *Toujeo Solostar [®] pen	Awiqli [®] Flextouch Basaglar [®] KwikPen [®] insulin glargine max solo u300 insulin glargine solostar u300 insulin glargine-yfgn Rezvoglar [®] Kwikpen Semglee (yfgn)	*Clinical Criteria for Toujeo Solostar: • The member has tried and failed or is intolerant to Lantus	

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Preferred Agents		Non-Preferred Agents	SA Criteria
		Toujeo [®] Max Solostar [®] 300 Units/mL Tresiba [®] FlexTouch [®] , vial	
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 TM Merilog TM	
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 [®]		alogliptin (generic Nesina TM)	

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Preferred Agents		Non-Preferred Agents	SA Criteria
Janumet[®] Januvia[®] Jentadueto XR[™] Jentadueto[™] Tradjenta[™] Trijardy[™] XR		alogliptin/metformin (generic Kazano [™]) 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			

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Preferred Agents		Non-Preferred Agents	SA Criteria
Oral Hypoglycemics Second Generation Sulfonylureas			
glimepiride 1,2,4 mg glipizide glipizide ER glyburide glyburide micronized		glimepiride 3mg glipizide 15mg	
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			

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Preferred Agents		Non-Preferred Agents	SA Criteria
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
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 once weekly patch, pump(Climara) estradiol packet (Divigel) estradiol twice weekly (Minivelle) estradiol twice weekly (Vivelle-Dot) Lyllana Menostar Minivelle Twice Weekly	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™ Yuvaferm®	LENGTH OF AUTHORIZATIONS: 6 months Routine PDL edits

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Preferred Agents	Non-Preferred Agents	SA Criteria
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 dexamethasone soln/tab hydrocortisone methylprednisolone dose pk methylprednisolone 4 mg tab prednisolone sod phosph soln prednisolone soln prednisone soln/tab/dose pk	Alkindi® Sprinkle Cortef® cortisone acetate dexamethasone elixir/intensol 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	LENGTH OF AUTHORIZATION: 1 year 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)

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Preferred Agents	Non-Preferred Agents	SA Criteria
*Hereditary Angioedema (HAE) Agents		
Berinert[®] icatibant (generic Firazyr[®]) Haegarda[®] Kalbitor[®]	<i>Andembry[®]</i> <i>Cinryze[™]</i> <i>Dawnzera[™]</i> <i>Ekterly[®]</i> <i>Firazyr[®]</i> <i>Orladeyo[™]</i> <i>Ruconest[®]</i> <i>Sajazir[™]</i> <i>Takhzyro[™]</i>	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
*Pancreatic Enzymes		
Creon[®] Zenpep[®]	<i>Pertzye[®]</i> <i>Viokace[®]</i>	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	<i>Javygtor</i> <i>Kuvan tab</i> <i>Palynziq</i> <i>sapropterin</i> <i>Sephience</i> <i>Zelvysia</i>	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)	<i>Crinone (Vaginal)</i> <i>Prometrium[®]</i>	LENGTH OF AUTHORIZATION: 1 year Routine PDL edits

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Preferred Agents		Non-Preferred Agents	SA Criteria
norethindrone acetate progesterone cap/inj		Provera [®]	
Weight Management Agents CLOSED CLASS			
orlistat Xenical phendimetrazine IR and ER phentermine benzphetamine diethylpropion IR and ER		Foundayo [™] Imcivree SQ liraglutide(gen Saxenda [®]) Lomaira [™] phentermine/topiramate ER Saxenda [®] Wegovy [®] Wegovy HD [®] Zepbound [™]	LENGTH OF AUTHORIZATION: As indicated on fax form Routine PDL edits plus Weight Management Agents SA Form GLP-1 Receptor Agonist For Cardiovascular Risk Reduction 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

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Preferred Agents		Non-Preferred Agents	SA Criteria
			- 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
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 LENGTH OF AUTHORIZATION: 3 months, unless otherwise noted	
5HT3 Receptor Blockers			
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 Navitrox Nereus		

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Preferred Agents		Non-Preferred Agents		SA Criteria	
Other				<u>LENGTH OF AUTHORIZATION:</u> 1 year, unless otherwise noted	
*Diclegis® meclizine (OTC, Rx) metoclopramide soln, tab, vial prochlorperazine tab **promethazine soln, syrp, tab, 12.5mg&25mg supp (AGE)		Antivert® Barhemsys® *Bonjesta™ Compazine®supp/tab Compro® dimenhydrinate tab, vial *doxylamine succinate/ vit B6 metoclopramide ODT metoclopramide syringe **Phenergan® (AGE) prochlorperazine supp, vial **promethazine vial, ampul (AGE) **Promethegan 50 mg supp(AGE) Reglan® scopolamine (gen Transderm-Scop®) Tigan® Transderm-Scop® trimethobenzamide		**♦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.	
*GI Motility, Chronic					
**Linzess™ lubiprostone and AG Movantik®		alosetron Amitiza® Ibsrela® Lotronex® Motegrity™ prucalopride Symproic® Viberzi™		<u>LENGTH OF AUTHORIZATION:</u> 6 months Routine PDL edits plus *♦All GI Motility drugs (preferred and non-preferred) require the submission of a Clinical SA. Refer to <u>Chronic GI Motility SA form</u> **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	

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Preferred Agents		Non-Preferred Agents	SA Criteria
			(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®	<i>bismuth-metronidazole-tetracycline (gen Pylera®)</i> <i>Helidac®</i> <i>Omeclamox®-Pak</i> <i>lansoprazole/amoxicillin/clarithromycin</i> <i>Prevpac®</i> <i>Talicia®</i> <i>Voquezna®</i>		LENGTH OF AUTHORIZATION: 14 days 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)	<i>Clenpiq</i> <i>Golytely</i> <i>Nulytely With Flavor Packs</i> <i>PEG 3350/electrolytes powder pack (gen Moviprep)</i> <i>Suflave Powder</i> <i>Suprep</i> <i>Sutab</i>		Routine PDL edits
Constipation			
lactulose solution	<i>*lactulose packet</i> <i>*Kristalose Packet</i>		* Kristalose/lactulose packet: • Must have tried, failed or be intolerant to generic lactulose solution
Proton Pump Inhibitors			
omeprazole RX pantoprazole Protonix® susp	<i>dexlansoprazole dr (gen Dexilant®)</i> <i>Dexilant®</i> <i>esomeprazole magnesium cap/susp/tab</i>		LENGTH OF AUTHORIZATION: 12 weeks; unless member meets an exception; then 1 year Routine PDL edits plus

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Preferred Agents		Non-Preferred Agents	SA Criteria
		esomeprazole strontium lansoprazole cap Konvomep [®] Nexium [®] omeprazole OTC omeprazole magnesium OTC omeprazole/sodium bicarbonate pantoprazole susp (generic Protonix [®] susp) Prevacid [®] RX, OTC& SoluTab Prilosec [®] Rx & Susp Protonix [®] rabeprazole DR tab	*♦All non-preferred Proton Pump Inhibitors require submission of a Clinical SA. Refer to Proton Pump Inhibitor SA form Preferred agents require a SA for use over 90 days
Ulcerative Colitis Oral and Rectal Preparations (5-ASA DERIVATIVES)			
Ulcerative Colitis – Oral			LENGTH OF 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 [®]		

Preferred Agents		Non-Preferred Agents		SA Criteria	
Genitourinary					
Alpha-Blockers and Androgen Hormone Inhibitors For Benign Prostatic Hypertrophy (BPH)					
Alpha-Blockers for BPH			LENGTH OF AUTHORIZATION: 1 year		
alfuzosin tamsulosin HCL		Flomax [®] Rapaflo [®] silodosin (generic Rapaflo) Uroxatral [®]		Routine PDL edits	
Androgen Hormone Inhibitors for BPH					
dutasteride finasteride 5 mg		Avodart [®] dutasteride/tamsulosin Jalyn [®] Proscar [®]			
Androgen Hormone Inhibitors and Phosphodiesterase (PDE) 5 Inhibitor forBPH			*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.		
		Entadfi™			
Phosphodiesterase (PDE) 5 Inhibitor for BPH					
		*Cialis [®] (ST) tadalafil 5 mg (ST)			
Urinary Antispasmodics (Bladder Relaxant)					
fesoterodine fumarate ER Myrbetriq™ tab oxybutynin tab/syrup oxybutynin ER solifenacin		darifenacin ER (generic Enablex [®]) 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			

Preferred Agents	Non-Preferred Agents	SA Criteria
Immunological Agents		
*♦Multiple Sclerosis		
CLOSED CLASS Avonex® Avonex® Adm Pack Copaxone 20 mg syringe® dimethyl fumarate and Starter Pack fingolimod **Kesimpta® (ST) teriflunomide (generic Aubagio®)	Aubagio® Bafiertam™ 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®	LENGTH OF AUTHORIZATION: 1 year 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®	Ampyra® and dalfampridine ER require the submission of a Clinical SA. Refer to MS - Ampyra® SA form

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Preferred Agents	Non-Preferred Agents	SA Criteria
♦Cytokine and CAM Antagonists And Related Agents		
adalimumab-adbm (unbranded version of Cyltezo made by Boehringer Ingelheim) Enbrel® Pen, Sureclick, Hadlima™ Pyzchiva® Syringe, Vial Starjemza™	<i>Abrilada™</i> <i>Actemra® SQ & ACTPEN</i> <i>adalimumab-aacf</i> <i>adalimumab-aaty</i> <i>adalimumab-adbm(Quallent)</i> <i>adalimumab-adaz</i> <i>adalimumab-fkjp Pen</i> <i>adalimumab-ryvk</i> <i>Amjevita™</i> <i>Amjevita™ Autoinjector</i> <i>Arcalyst®</i> <i>Avsola™</i> <i>Avtozma®</i> <i>Bimzelx®</i> <i>Cibinqo™</i> <i>Cimzia® & Cimzia® Syringe Kit</i> <i>Cosentyx™</i> <i>Cosentyx™ UnoReady pen</i> <i>Cyltezo®</i> <i>Enspryng™</i> <i>Entyvio®</i> <i>Hulio®</i> <i>Humira® Pen, Syringe</i> <i>Hyrimoz®</i> <i>Icotyde</i> <i>Ilaris®</i> <i>Ilumya™</i> <i>Inflectra®</i> <i>infliximab (gen Remicade®)</i> <i>Kevzara® inj, pen</i> <i>Kineret®</i> <i>Olumiant®</i> <i>Omvoh™</i> <i>Orencia®</i>	CLOSED CLASS LENGTH OF AUTHORIZATION: 1 year Routine PDL edits plus For preferred agents members must meet FDA approved age and indication. (reviewed electronically, AutoPA look back of 180 days for diagnosis) For 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

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	Preferred Agents	Non-Preferred Agents	SA Criteria
		<i>Otezla[®]</i> <i>Otezla XR[™]</i> <i>Otulf[®]</i> <i>Remicade[®]</i> <i>Renflexis[®]</i> <i>Rinvoq[®]</i> <i>Rinvoq[®] LQ</i> <i>Selarsdi[®]</i> <i>Simlandi[™]</i> <i>Simponi[®]</i> <i>Simponi[®] Aria</i> <i>Skyrizi[™] syringe, Pen</i> <i>Spevigo[®]</i> <i>Stelara[®] vial/syringe</i> <i>Steqeyma[®]</i> <i>Sotyktu[™]</i> <i>Taltz[®]</i> <i>tofacitinib</i> <i>Tofidence[™]</i> <i>Tremfya[™]</i> <i>Tyenne[®]</i> <i>Uplizna[®]</i> <i>ustekinumab-aaaz</i> <i>ustekinumab-aekn</i> <i>ustekinumab-ttwe</i> <i>Velsipity[®]</i> <i>Xeljanz[™], Xeljanz[™] XR and sol</i> <i>Yesintek[™]</i> <i>Yuflyma[®]</i> <i>Yusimry[™]</i> <i>Zymfentra[™]</i>	
	♦Methotrexate CLOSED CLASS	<u>LENGTH OF AUTHORIZATION: 1 year</u>	

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<i>Preferred Agents</i>		<i>Non-Preferred Agents</i>	<i>SA Criteria</i>
methotrexate tab/PF vial/MDV		Jylamvo [®] Rasuvo [™] Trexall [®] Xatmep [™]	Routine PDL edits
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 [®]	<u>LENGTH OF AUTHORIZATION:</u> Date of service only; no refills Routine PDL edits
Antibiotic/Steroid Combinations			
neomycin/polymyxin/dexame thasone oint/susp sulfacetamide/prednisolone Tobradex [®] oint		Blephamide [®] S.O.P. loteprednol/tobramycin ophthalmic (generic Zylet) Maxitrol [®] susp	<u>LENGTH OF AUTHORIZATION:</u> Date of service only; no refills Routine PDL edits

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Preferred Agents		Non-Preferred Agents		SA Criteria	
tobramycin/dexamethasone susp		neomycin/bacitracin/poly/HC neomycin/polymyxin/HC Pred-G [®] oint Tobradex [®] ST Zylet [®]			
Antihistamines/Mast Cell Stabilizers					
Antihistamines			<u>LENGTH OF AUTHORIZATION:</u> 1 year		
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 [™]		Routine PDL edits	
Mast Cell Stabilizers					
cromolyn sodium					
Anti-inflammatory Agents					
Corticosteroids					
Durezol [®] prednisolone acetate		Alrex [™] Byqlovi dexamethasone difluprednate (gen Durezol [®]) Flarex [®]			

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Preferred Agents		Non-Preferred Agents	SA Criteria
		fluorometholone FML [®] , FML Forte [®] loteprednol etabonate Maxidex [®] Pred Forte [®] & Pred Mild [®] prednisolone sod phosphate	*♦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” **♦ <u>Verkazia criteria (PDL criteria do not apply)</u> • 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 <u>LENGTH OF AUTHORIZATION:</u> Date of service only; no refills Routine PDL edits *Ilevro TM is limited to 1 bottle plus 1 refill
Immunomodulators CLOSED CLASS			
Restasis [®] Xiidra [®]	Cequa TM cyclosporine *Eysuvis Miebo TM Restasis Multidose [®] Tryptyr [®] Tyrvaya TM Nasal Spray **Verkazia [®]		
NSAIDs			
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 TM *Ilevro TM 0.3% (OL)		

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		<i>Inveltys™ (loteprednol etabonate)</i> <i>ketorolac LS 0.4%</i> <i>Nevanac®</i> <i>Prolensa™</i>	
Glaucoma Agents			
Alpha 2 Adrenergic Agents			LENGTH OF AUTHORIZATION: 1 year
Alphagan P® 0.1 & 0.15% brimonidine 0.2%		<i>apraclonidine 0.5% drops</i> <i>brimonidine tartrate 0.1 & 0.15%</i> <i>Iopidine® 0.5% & 1%</i>	Routine PDL edits
Beta Blockers			
carteolol 1% Combigan® levobunolol 0.5% metipranolol 0.3% timolol maleate		<i>Betimol®</i> <i>betaxolol 0.5%</i> <i>brimonidine-timolol (gen Combigan®)</i> <i>Istalol® 0.5%</i> <i>timolol (generic for Betimol®)</i> <i>timolol (generic for Istalol®)</i> <i>timolol (generic for Timoptic Ocudose)</i>	
Carbonic Anhydrase Inhibitors			
Azopt® dorzolamide dorzolamide/timolol		<i>brinzolamide</i> <i>Cosopt® 0.5%-2%</i> <i>Cosopt® PF</i> <i>Simbrinza™</i> <i>dorzolamide/timolol PF</i>	
Cholinergic Muscarinic Receptor Agonist			
		<i>pilocarpine</i> <i>*Vuity™</i>	*Indicated for the treatment of presbyopia in adults
Rho Kinase Inhibitor			
Rhopressa® Rocklatan			

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Preferred Agents		Non-Preferred Agents	SA Criteria
Prostaglandin Analogs			
latanoprost Travatan Z®		bimatoprost Iyuzeh™ Lumigan® 0.03% & 0.01% 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) Clarinet® Clarinet-D® desloratadine ODT, sol	

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Preferred Agents		Non-Preferred Agents	SA Criteria
		<i>fexofenadine</i> <i>fexofenadine/PSE ER</i> <i>fexofenadine suspension</i> <i>levocetirizine sol</i> <i>loratadine ODT, chew</i> <i>loratadine D 12 & 24 hr</i>	
Beta-Adrenergic Agents			
Long Acting Beta Adrenergic s (LABA) MDIs or Nebulizers			LENGTH OF AUTHORIZATION: 1 year
formoterol fumarate (generic Perforomist®) Serevent Diskus®		<i>arformoterol (generic Brovana®)</i> <i>Brovana®</i> <i>Perforomist®</i> <i>Striverdi® Respimat</i>	Routine PDL edits
Short Acting Metered Dose Inhalers or Devices			
<i>albuterol HFA (Proair) and (Authorized Generic)</i> <i>albuterol HFA (Proventil) and (Authorized Generic)</i> Ventolin® HFA		<i>albuterol HFA (Ventolin®)</i> <i>levalbuterol tartrate HFA</i> <i>ProAir® RespiClick</i> <i>Xopenex® HFA</i>	
Short Acting Nebulizers			
albuterol sulfate (premixed)		<i>levalbuterol soln</i>	
COPD: Anticholinergics, Bronchodilators and Phosphodiesterase 4 (PDE4) Inhibitors CLOSED CLASS			
Short Acting Anticholinergics/Short Acting Bronchodilators CLOSED CLASS			
Atrovent HFA® ipratropium bromide soln		<i>ipratropium bromide HFA</i>	
Short Acting Anticholinergics/Short Acting Bronchodilators CLOSED CLASS			
Combivent® Respimat ipratropium/albuterol nebs		<i>Bevespi Aerosphere™</i> <i>Duaklir Pressair</i>	LENGTH OF AUTHORIZATION: 1 year
Long Acting Anticholinergics CLOSED CLASS			Routine PDL edits

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Preferred Agents		Non-Preferred Agents	SA Criteria
Spiriva[®] Spiriva[®] Respimat Long Acting Anticholinergics/Long Acting Bronchodilators CLOSED CLASS		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) • Diagnosis of COPD AND • Trial/failure of Spiriva[®] Handihaler OR Spiriva[®] Respimat
		Anoro[™] Ellipta[®] Stiolto Respimat[™]	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 Routine PDL edits plus For triple therapy inhaled products (ICS/LABA/LAMA) for asthma:
Advair[®] Diskus Advair[®] HFA		Airsupra	

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Preferred Agents		Non-Preferred Agents	SA Criteria
Breztri Aerosphere™ Dulera® Symbicort®		<i>budesonide-formoterol (generic Symbicort®)</i> <i>Breo® Ellipta™</i> <i>Breyna™ (generic Symbicort®)</i> <i>fluticasone/salmeterol (generic Airduo)</i> <i>fluticasone/salmeterol powder (generic Advair)</i> <i>fluticasone/salmeterol HFA (generic Advair HFA)</i> <i>fluticasone-vilanterol (generic Breo® Ellipta™)</i> <i>Trelegy® Ellipta</i> <i>Wixela® (fluticasone/salmeterol)</i>	- 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 - 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 Twister® Asmanex HFA® QVAR® Redihaler		<i>Aerospan™</i> <i>Alvesco®</i> <i>beclomethasone HFA</i> <i>fluticasone HFA (gen Flovent® HFA)</i> <i>fluticasone Diskus (gen Flovent® Diskus)</i>	
Inhaled Corticosteroids: Nebulizer Solution CLOSED CLASS			
budesonide respules		<i>Pulmicort® Respules</i>	
Nasal Steroids			LENGTH OF AUTHORIZATION: 1 year Routine PDL edits
azelastine/fluticasone nasal spray (generic for Dymista®) fluticasone Rx and OTC		<i>budesonide (generic for Rhinocort® Aqua)</i> <i>budesonide (generic Rhinocort® Allergy OTC)</i> <i>Children's Qnasl™</i> <i>Dymista®</i>	

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		<i>Flonase[®]</i> <i>Flonase Sensimist (OTC)</i> <i>flunisolide</i> <i>ipratropium bromide spray</i> <i>mometasone (generic Nasonex[®])</i> <i>Nasonex OTC</i> <i>Omnanis[®]</i> <i>Qnasl[™]</i> <i>Rhinocort Aqua[®]</i> <i>Rhinocort[®] Allergy OTC</i> <i>Ryaltris[®]</i> <i>triamcinolone OTC</i> <i>triamcinolone acetonide</i> <i>Veramyst[®]</i> <i>Xhance[™]</i>	
Epinephrine, Self-Administered			
epinephrine 0.15 mg & 0.3 mg (authorized generic EpiPen [®] & EpiPen [®] Jr)	<i>Auvi-Q[®]</i> <i>epinephrine 0.15 mg & 0.3mg (generic EpiPen[®] and EpiPen[®] Jr)</i> <i>epinephrine 0.15mg & 0.3mg (generic Adrenaclick)</i> <i>Neffy[®]</i> <i>Symjepi[™] (epinephrine)</i>	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	<i>Cinqair</i> <i>Exdensur</i> <i>Nucala Auto-Injector</i> <i>Nucala Syringe</i> <i>Nucala Vial</i>	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	



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Intranasal Antihistamines					
azelastine 0.1%		azelastine 0.15% nasal spray		<u>LENGTH OF AUTHORIZATION:</u>	1 year
				Routine PDL edits	
Leukotriene Receptor Antagonists					
montelukast tabs/chewable tabs		Accolate® Singulair® tabs/chew tabs/ granules montelukast granules zafirlukast Zyflo™ zileuton ER		<u>LENGTH OF AUTHORIZATION:</u>	1 year
				Routine PDL edits	