• Prior authorization for a non-preferred agent in any category will be given only if there has been a trial of the preferred brand/generic equivalent or preferred formulation of the active ingredient, at a therapeutic dose, that resulted in a partial response with a documented intolerance.

• Prior authorization of a non-preferred isomer, pro-drug, or metabolite will be considered with a trial of a preferred parent drug of the same chemical entity, at a therapeutic dose, that resulted in a partial response with documented intolerance or a previous trial and therapy failure, at a therapeutic dose, with a preferred drug of a different chemical entity indicated to treat the submitted diagnosis. (The required trial may be overridden when documented evidence is provided that the use of these preferred agent(s) would be medically contraindicated.)

• Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC drugs are not covered unless specified.

• PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.

• The use of pharmaceutical samples will not be considered when evaluating the members’ medical condition or prior prescription history for drugs that require prior authorization.

• Prior Authorization Criteria that applies among multiple sub-categories will be listed directly under the main category’s name. PA Criteria specific to a sub-category will be listed in the sub-category.

• Quantity limits may apply. Refer to the Limits List on the BMS Website by clicking the hyperlink.

• Unless otherwise indicated, non-preferred combination products require medical reasoning beyond convenience or enhanced compliance as to why the clinical need cannot be met with a preferred agent or combination of preferred single-ingredient agents.

• Acronyms
  o CL - Requires clinical PA. For detailed clinical criteria, please go to the PA criteria page by clicking the hyperlink.
  o NR - New drug has not been reviewed by P & T Committee
  o AP - Non-preferred and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA criteria column.
This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

<table>
<thead>
<tr>
<th>CLASSES CHANGING</th>
<th>Status Changes</th>
<th>PA Criteria Changes</th>
<th>New Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANALGESICS, NARCOTIC LONG ACTING (Non-parenteral)</td>
<td></td>
<td>XXXX</td>
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<tr>
<td>ANALGESICS, NARCOTIC SHORT ACTING (Non-parenteral)</td>
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<tr>
<td>ANIEMETICS, 5HT3 RECEPTOR BLOCKERS</td>
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<td>ANTICONVULSANTS (BENZODIAZEPINES)</td>
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<td>ANTIHYPERURICEMICS, URICOSURIC</td>
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<td>ANTIMIGRAINE AGENTS, TRIPTANS</td>
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<td>HEPATITIS C TREATMENTS</td>
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<td>HYPOGLYCEMICS, DPP-4 INHIBITORS</td>
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<td>HYPOGLYCEMICS, GLP-1 AGONISTS</td>
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<td>HYPOGLYCEMICS, MEGLITINIDES</td>
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<td>HYPOGLYCEMICS, SGLT2 INHIBITORS – SGLT2 COMBINATIONS</td>
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<td>HYPOGLYCEMICS, TZD</td>
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<tr>
<td>IRRITABLE BOWEL SYNDROME/SHORT BOWEL SYNDROME/SELECTED GI AGENTS</td>
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<td>MULTIPLE SCLEROSIS AGENTS</td>
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<tr>
<td>OPTHALMICS, ANTI-INFLAMMATORIES</td>
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<tr>
<td>OPIATE DEPENDENCE TREATMENTS</td>
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<tr>
<td>STIMULANTS AND RELATED AGENTS</td>
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<tr>
<td>ANALGESICS, NARCOTIC LONG ACTING (Non-parenteral)</td>
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<tr>
<td>ANALGESICS, NARCOTIC SHORT ACTING (Non-parenteral)</td>
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</table>
### THERAPEUTIC DRUG CLASS

<table>
<thead>
<tr>
<th>THERAPEUTIC DRUG CLASS</th>
<th>PREFERRED AGENTS</th>
<th>NON-PREFERRED AGENTS</th>
<th>PA CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ACNE AGENTS, TOPICAL</strong>&lt;sup&gt;AP&lt;/sup&gt;</td>
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<tr>
<td>CATEGORY PA CRITERIA: Thirty (30) day trials each of one (1) preferred retinoid and two (2) unique chemical entities in two (2) other subclasses, including the generic version of the requested non-preferred product, are required before the non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.</td>
<td>clindamycin gel, lotion, medicated swab, solution erythromycin gel, solution</td>
<td>ACZONE (dapsone)</td>
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<td></td>
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<td>AKNE-MYcin (erythromycin)</td>
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<td></td>
<td>AZELEX (azelaic acid)</td>
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<td>CLEOCIN-T (clindamycin)</td>
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<td>CLINDACIN PAC (clindamycin)</td>
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<td>CLINDAGEL (clindamycin)</td>
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<td></td>
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<td>clindamycin foam</td>
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<td></td>
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<td>erythromycin medicated swab</td>
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<td>EVOCLIN (clindamycin)</td>
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<td>FABIOR (tazarotene)</td>
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<td>KLARON (sulfacetamide)</td>
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<td>OVACE/PLUS (sulfacetamide)</td>
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<td></td>
<td>sodium sulfacetamide 10% cleansing gel</td>
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<td>sulfacetamide cleanser</td>
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<td>sulfacetamide cleanser ER</td>
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<td>sulfacetamide shampoo</td>
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<td>sulfacetamide suspension</td>
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<td>In addition to the Category Criteria: In cases of pregnancy, a trial of retinoids will not be required. For Members eighteen (18) years of age or older, a trial of retinoids will not be required. Acne kits are non-preferred. Specific Criteria for sub-categories will be listed below.</td>
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<td><strong>ANTI-INFECTIVE</strong></td>
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</table>
### THERAPEUTIC DRUG CLASS

<table>
<thead>
<tr>
<th>PREFERRED AGENTS</th>
<th>NON-PREFERRED AGENTS</th>
<th>PA CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>BP WASH 7% LIQUID</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PACNEX/HP/LP (benzoyl peroxide)</td>
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<tr>
<td>PAN-XYL-4, -8 OTC (benzoyl peroxide)</td>
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<tr>
<td>PERSA-GEL OTC (benzoyl peroxide)</td>
<td></td>
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<tr>
<td>SULPHO-LAC (sulfur)</td>
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**COMBINATION AGENTS**

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<table>
<thead>
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</thead>
<tbody>
<tr>
<td>erythromycin/benzoyl peroxide</td>
<td></td>
<td></td>
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<tr>
<td>ACANYA (clindamycin phosphate/benzoyl peroxide)</td>
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<td></td>
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<tr>
<td>AVAR/E/LS (sulfur/sulfacetamide)</td>
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<tr>
<td>BENZAACLIN GEL (benzoyl peroxide/clindamycin)</td>
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<tr>
<td>BENZAMYCIN PAK (benzoyl peroxide/erythromycin)</td>
<td></td>
<td></td>
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<tr>
<td>benzoyl peroxide/clindamycin gel</td>
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<td></td>
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<tr>
<td>benzoyl peroxide/urea</td>
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<tr>
<td>CERISA (sulfacetamide sodium/sulfur)</td>
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<tr>
<td>CLARIFOAM EF (sulfacetamide/sulfur)</td>
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<tr>
<td>CLENIA (sulfacetamide sodium/sulfur)</td>
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<tr>
<td>DUAC (benzoyl peroxide/clindamycin)</td>
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<tr>
<td>EPIDUO (adapalene/benzoyl peroxide)*</td>
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<tr>
<td>INOVA 4/1, 5/2 (benzoyl peroxide/salicylic acid)</td>
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<tr>
<td>NEUAC (clindamycin phosphate/benzoyl peroxide)</td>
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<tr>
<td>NUOX (benzoyl peroxide/sulfur)</td>
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<tr>
<td>ONEXTON (clindamycin phosphate/benzoyl peroxide)</td>
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<tr>
<td>PRASCION (sulfacetamide sodium/sulfur)</td>
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<tr>
<td>SE 10-5 SS (sulfacetamide/sulfur)</td>
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<tr>
<td>SSS 10-4 (sulfacetamide/sulfur)</td>
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<tr>
<td>SSS 10-5 foam (sulfacetamide/sulfur)</td>
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<tr>
<td>sulfacetamide sodium/sulfur cloths, lotion, pads, suspension</td>
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<tr>
<td>sulfacetamide/sulfur wash/cleanser</td>
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<tr>
<td>sulfacetamide/sulfur wash kit</td>
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<tr>
<td>sulfacetamide sodium/sulfur/urea</td>
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<tr>
<td>SUMADAN/XLT (sulfacetamide/sulfur)</td>
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<td>SUMAXIN/TS (sulfacetamide sodium/sulfur)</td>
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<tr>
<td>VELTIN (clindamycin/tretinoin)*</td>
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<tr>
<td>ZIANA (clindamycin/tretinoin)*</td>
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**In addition to the Category PA:** Thirty (30) day trials of combinations of the corresponding preferred single agents available are required before non-preferred combination agents will be authorized.

*PA required for combination agents with Retinoid products for members eighteen (18) years of age or older.
# Therapeutic Drug Class

## Alzheimer’s Agents

**Category PA Criteria:** A thirty (30) day trial of a preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.

Prior authorization is required for members up to forty-five (45) years of age if there is no diagnosis of Alzheimer’s disease.

### Cholinesterase Inhibitors

<table>
<thead>
<tr>
<th>Preferred Agents</th>
<th>Non-Preferred Agents</th>
<th>PA Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aricept (donepezil)</td>
<td>EXELON (donepezil)</td>
<td>*Donepezil 23 mg tablets will be authorized if the following criteria are met: 1. There is a diagnosis of moderate-to-severe Alzheimer’s Disease and 2. There has been a trial of donepezil 10 mg daily for at least three (3) months and donepezil 20 mg daily for an additional one (1) month.</td>
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<tr>
<td>donepezil 5 and 10 mg</td>
<td>EXELON CAPSULE (rivastigmine)</td>
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<tr>
<td>EXELON PATCH (rivastigmine)</td>
<td>EXELON PATCH (rivastigmine)</td>
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<tr>
<td>galantamine</td>
<td>galantamine ER</td>
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<tr>
<td>galantamine ER</td>
<td>RAZADYNE (galantamine)</td>
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<tr>
<td>RAZADYNE ER (galantamine)</td>
<td>rivastigmine</td>
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### NMDA Receptor Antagonist

<table>
<thead>
<tr>
<th>Preferred Agent</th>
<th>Non-Preferred Agent</th>
<th>PA Criteria</th>
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<tbody>
<tr>
<td>Memantine</td>
<td>NAMENDA (memantine)</td>
<td>*Namenda XR requires ninety (90) days of compliant therapy with NAMENDA.</td>
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<tr>
<td>NAMENDA XR (memantine)</td>
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### Cholinesterase Inhibitor/NMDA Receptor Antagonist Combinations

<table>
<thead>
<tr>
<th>Preferred Agent</th>
<th>Non-Preferred Agent</th>
<th>PA Criteria</th>
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<tbody>
<tr>
<td>Namzaric (donepezil/memantine)</td>
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## Analgesics, Narcotic Long Acting (Non-parenteral)

**Category PA Criteria:** Six (6) day trials of two (2) chemically distinct preferred agents are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PDL form is present. In addition, a six (6) day trial of the generic form of the requested non-preferred agent, if available, is required before the non-preferred agent will be authorized. If no generic form is available for the requested non-preferred brand agent, then another generic non-preferred agent must be trialed instead. **Note:** All long-acting opioid agents require a prior authorization for children aged 18 years and younger. Requests must be for an FDA approved age and indication and specify previous opioid and non-opioid therapies attempted.

### Analgesics

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<thead>
<tr>
<th>Preferred Agent</th>
<th>Non-Preferred Agent</th>
<th>PA Criteria</th>
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<tbody>
<tr>
<td>BUTRANS (buprenorphine)</td>
<td>BELBUCA (buprenorphine buccal film)</td>
<td>*Belbuc prior authorization requires manual review. Full PA criteria may be found on the <a href="#">PA Criteria</a> page by clicking the hyperlink.</td>
</tr>
<tr>
<td>EMBEDA (morphine/naltrexone)</td>
<td>CONZIP ER (tramadol)</td>
<td><strong>Methadone, oxycodone ER and oxymorphone ER will be authorized without a trial of the preferred agents if a diagnosis of cancer is submitted.</strong></td>
</tr>
<tr>
<td>fentanyl transdermal 12, 25, 50, 75, 100 mcg/hr morphine ER tablets</td>
<td>DOLOPHINE (methadone)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>DURAGESIC (fentanyl)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>EXALGO ER (hydromorphone)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>fentanyl transdermal 37.5, 62.5, 87.5 mcg/hr hydromorphone ER</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HYSINGLA ER (hydrocodone)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>KADIAN (morphine)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>LAZANDA SPRAY (fentanyl)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>methadone</td>
<td><strong>Tramadol ER requires a manual review and may be authorized for ninety (90) days with submission of a detailed treatment plan including anticipated duration of treatment and scheduled follow-ups with the prescriber.</strong></td>
</tr>
<tr>
<td></td>
<td>morphine ER capsules (generic for Avinza)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>morphine ER capsules (generic for Kadian)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>MS CONTIN (morphine)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NUCYNTA ER (tapentadol)</td>
<td></td>
</tr>
<tr>
<td>THERAPEUTIC DRUG CLASS</td>
<td>PREFERRED AGENTS</td>
<td>NON-PREFERRED AGENTS</td>
</tr>
<tr>
<td>------------------------</td>
<td>------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>ANALGESICS, NARCOTIC SHORT ACTING (Non-parenteral)</td>
<td>OPANA ER (oxymorphone)</td>
<td>oxycodone ER**</td>
</tr>
<tr>
<td></td>
<td>OXYCONTIN (oxycodone)</td>
<td>oxymorphone ER**</td>
</tr>
<tr>
<td></td>
<td>tramadol ER***</td>
<td>ULTRAM ER (tramadol)</td>
</tr>
<tr>
<td></td>
<td>XARTEMIS XR (oxycodone/ acetaminophen)</td>
<td>XTAMPZA ER (oxycodone)</td>
</tr>
<tr>
<td></td>
<td>ZOHYDRO ER (hydrocodone)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ABSTRAL (fentanyl)</td>
<td>ACTIQ (fentanyl)</td>
</tr>
<tr>
<td></td>
<td>butalbital/APAP/caffeine/codeine</td>
<td>butalbital/ASA/caffeine/codeine</td>
</tr>
<tr>
<td></td>
<td>hydrocodone/APAP 2.5/325 mg, 5/325 mg, 7.5/325 mg, 10/325 mg</td>
<td>DEMEROL (meperidine)</td>
</tr>
<tr>
<td></td>
<td>hydrocodone/APAP solution</td>
<td>dihydrocodeine/APAP/caffeine</td>
</tr>
<tr>
<td></td>
<td>hydrocodone/ibuprofen</td>
<td>DILAUDID (hydromorphone)</td>
</tr>
<tr>
<td></td>
<td>hydromorphone tablets</td>
<td>fentanyl</td>
</tr>
<tr>
<td></td>
<td>morphine</td>
<td>FENTORA (fentanyl)</td>
</tr>
<tr>
<td></td>
<td>oxycodone tablets, concentrate, solution</td>
<td>FIORICET W/ CODEINE (butalbital/APAP/caffeine/codeine)</td>
</tr>
<tr>
<td></td>
<td>oxycodone/APAP</td>
<td>FIORINAL W/ CODEINE (butalbital/ASA/caffeine/codeine)</td>
</tr>
<tr>
<td></td>
<td>oxycodone/ASA</td>
<td>hydrocodone/APAP 5/300 mg, 7.5/300 mg, 10/300 mg</td>
</tr>
<tr>
<td></td>
<td>pentazocine/naloxone</td>
<td>hydromorphone liquid, suppositories</td>
</tr>
<tr>
<td></td>
<td>tramadol</td>
<td>IBUDONE (hydrocodone/ibuprofen)</td>
</tr>
<tr>
<td></td>
<td>tramadol/APAP</td>
<td>LAZANDA (fentanyl)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>levorphanol</td>
</tr>
<tr>
<td></td>
<td></td>
<td>LORCET (hydrocodone/APAP)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>LORTAB (hydrocodone/APAP)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>meperidine</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NORCO (hydrocodone/APAP)</td>
</tr>
<tr>
<td></td>
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<td>NUCYNTA (tapentadol)</td>
</tr>
<tr>
<td></td>
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<td>ONSOLIS (fentanyl)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>OPANA (oxymorphone)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>OXECTA (oxycodone)</td>
</tr>
</tbody>
</table>

Fentanyl buccal, nasal and sublingual products will only be authorized for a diagnosis of cancer and as an adjunct to a long-acting agent. These dosage forms will not be authorized for monotherapy.

Limits: Unless the patient has escalating cancer pain or another diagnosis supporting increased quantities of short-acting opioids, all short acting solid forms of the narcotic analgesics are limited to 120 tablets per thirty (30) days for the purpose of maximizing the use of longer acting medications to prevent unnecessary breakthrough pain in chronic pain therapy. Immediate-release tramadol is limited to 240 tablets per thirty (30) days.
<table>
<thead>
<tr>
<th>THERAPEUTIC DRUG CLASS</th>
<th>PREFERRED AGENTS</th>
<th>NON-PREFERRED AGENTS</th>
<th>PA CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>oxycodone capsules</td>
<td>oxycodone/ibuprofen</td>
<td></td>
</tr>
<tr>
<td></td>
<td>oxycodone/ibuprofen</td>
<td>oxymorphone</td>
<td></td>
</tr>
<tr>
<td></td>
<td>PERCOCET (oxycodone/APAP)</td>
<td>PRIMLEV (oxycodone/APAP)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>REPREXAIN (hydrocodone/ibuprofen)</td>
<td>ROXICODONE (oxycodone)</td>
<td></td>
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<tr>
<td></td>
<td>RYBIX ODT (tramadol)</td>
<td>SUBSYS (fentanyl)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SYNALGOS-DC (dihydrocodeine/ASA/caffeine)</td>
<td>TYLENOL W/CODEINE (APAP/codeine)</td>
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</tr>
<tr>
<td></td>
<td>ULTRACET (tramadol/APAP)</td>
<td>ULTRAM (tramadol)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>VERDROCET (hydrocodone/APAP)</td>
<td>VICODIN (hydrocodone/APAP)</td>
<td></td>
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<tr>
<td></td>
<td>VICOPROFEN (hydrocodone/ibuprofen)</td>
<td>XODOL (hydrocodone/acetaminophen)</td>
<td></td>
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<tr>
<td></td>
<td>XYLON (hydrocodone/ibuprofen)</td>
<td>ZAMICET (hydrocodone/APAP)</td>
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</tr>
<tr>
<td>ANDROGENIC AGENTS</td>
<td>ANDRODERM (testosterone)</td>
<td>ANDRODERM (testosterone)</td>
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<tr>
<td></td>
<td>ANDROGEL (testosterone)</td>
<td>ANDROGEL (testosterone)</td>
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</tr>
<tr>
<td></td>
<td>METHITEST (methyltestosterone)</td>
<td>METHITEST (methyltestosterone)</td>
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</tr>
<tr>
<td></td>
<td>AXIRON (testosterone)</td>
<td>AXIRON (testosterone)</td>
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<tr>
<td></td>
<td>FORTESTA (testosterone)</td>
<td>FORTESTA (testosterone)</td>
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<tr>
<td></td>
<td>methyltestosterone capsule</td>
<td>methyltestosterone capsule</td>
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</tr>
<tr>
<td></td>
<td>NATESTO (testosterone)</td>
<td>NATESTO (testosterone)</td>
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<td></td>
<td>TESTIM (testosterone)</td>
<td>TESTIM (testosterone)</td>
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<tr>
<td></td>
<td>TESTRED (methyltestosterone)</td>
<td>TESTRED (methyltestosterone)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>testosterone gel</td>
<td>testosterone gel</td>
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<td></td>
<td>VOGELXO (testosterone)</td>
<td>VOGELXO (testosterone)</td>
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<tr>
<td>ANESTHETICS, TOPICALAP</td>
<td>lidocaine</td>
<td>lidocaine/prilocaine</td>
<td></td>
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<tr>
<td></td>
<td>xylocaine</td>
<td>xylocaine</td>
<td></td>
</tr>
<tr>
<td></td>
<td>EMLA (lidocaine/prilocaine)</td>
<td>EMLA (lidocaine/prilocaine)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>LIDAMANTLE (lidocaine)</td>
<td>LIDAMANTLE (lidocaine)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>LIDAMANTLE HC (lidocaine/hydrocortisone)</td>
<td>LIDAMANTLE HC (lidocaine/hydrocortisone)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>lidocaine/hydrocortisone</td>
<td>lidocaine/hydrocortisone</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SYNERA (lidocaine/tetracaine)</td>
<td>SYNERA (lidocaine/tetracaine)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>VOPAC MDS (ketoprofen/lidocaine)NR</td>
<td>VOPAC MDS (ketoprofen/lidocaine)NR</td>
<td></td>
</tr>
</tbody>
</table>
## ANGIOTENSIN MODULATORS

### CATEGORY PA CRITERIA: Fourteen (14) day trials of each of the preferred agents in the corresponding group, with the exception of the Direct Renin Inhibitors, are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.

### ACE INHIBITORS

<table>
<thead>
<tr>
<th>Preferred Agents</th>
<th>Non-Preferred Agents</th>
<th>PA Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>benazepril</td>
<td>ACCUPRIL (quinapril)</td>
<td>*Epaned will be authorized with a diagnosis of hypertension, symptomatic heart failure or asymptomatic left ventricular dysfunction provided that the patient is less than seven (7) years of age OR is unable to ingest a solid dosage form due to documented oral-motor difficulties or dysphagia.</td>
</tr>
<tr>
<td>captopril</td>
<td>ACEON (perindopril)</td>
<td>**Qbrelis solution may be authorized for children ages 6-10 who are unable to tolerate a solid dosage form. Qbrelis may also be authorized for older patients with clinical documentation indicating oral-motor difficulties or dysphagia.</td>
</tr>
<tr>
<td>enalapril</td>
<td>ALTACE (ramipril)</td>
<td></td>
</tr>
<tr>
<td>fosinopril</td>
<td>EPANED (enalapril)*</td>
<td></td>
</tr>
<tr>
<td>lisinopril</td>
<td>LOTENSIN (benazepril)</td>
<td></td>
</tr>
<tr>
<td>quinapril</td>
<td>MAVIK (trandolapril)</td>
<td></td>
</tr>
<tr>
<td>ramipril</td>
<td>moexipril</td>
<td></td>
</tr>
<tr>
<td></td>
<td>perindopril</td>
<td></td>
</tr>
<tr>
<td></td>
<td>PRINIVIL (lisinopril)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>QBRELIS SOLUTION (lisinopril)**</td>
<td></td>
</tr>
<tr>
<td></td>
<td>trandolapril</td>
<td></td>
</tr>
<tr>
<td></td>
<td>UNIVASC (moexipril)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>VASOTEC (enalapril)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ZESTRIL (lisinopril)</td>
<td></td>
</tr>
</tbody>
</table>

### ACE INHIBITOR COMBINATION DRUGS

<table>
<thead>
<tr>
<th>Preferred Agents</th>
<th>Non-Preferred Agents</th>
<th>PA Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>benazepril/amlo</td>
<td>ACCURETIC (quinapril/HCTZ)</td>
<td></td>
</tr>
<tr>
<td>dpine</td>
<td>CAPOZIDE (captopril/HCTZ)</td>
<td></td>
</tr>
<tr>
<td>benazepril/HCTZ</td>
<td>LOTENSIN HCT (benazepril/HCTZ)</td>
<td></td>
</tr>
<tr>
<td>captopril/HCTZ</td>
<td>LOTREL (benazepril/amlo</td>
<td></td>
</tr>
<tr>
<td>enalapril/HCTZ</td>
<td>moexipril/HCTZ</td>
<td></td>
</tr>
<tr>
<td>fosinopril/HCTZ</td>
<td>PRESTALIA (perindopril/amlo</td>
<td></td>
</tr>
<tr>
<td>lisinopril/HCTZ</td>
<td>PRINZIDE (lisinopril/HCTZ)</td>
<td></td>
</tr>
<tr>
<td>quinapril/HCTZ</td>
<td>TARKA (trandolapril/verapamil)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>VASERETIC (enalapril/HCTZ)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ZESTORETIC (lisinopril/HCTZ)</td>
<td></td>
</tr>
</tbody>
</table>

### ANGIOTENSIN II RECEPTOR BLOCKERS (ARBs)

<table>
<thead>
<tr>
<th>Preferred Agents</th>
<th>Non-Preferred Agents</th>
<th>PA Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>irbesartan</td>
<td>ATACAND (candesartan)</td>
<td></td>
</tr>
<tr>
<td>losartan</td>
<td>AVAPRO (irbesartan)</td>
<td></td>
</tr>
<tr>
<td>valsartan</td>
<td>BENICAR (olmesartan)</td>
<td></td>
</tr>
<tr>
<td>olmesartan</td>
<td>candesartan</td>
<td></td>
</tr>
<tr>
<td></td>
<td>COZAAR (losartan)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>DIOVAN (valsartan)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>EDARBRI (azilsartan)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>eprosartan</td>
<td></td>
</tr>
<tr>
<td></td>
<td>MiCARDIS (telmisartan)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>telmisartan</td>
<td></td>
</tr>
<tr>
<td></td>
<td>TEVETEN (eprosartan)</td>
<td></td>
</tr>
</tbody>
</table>
**THERAPEUTIC DRUG CLASS**

<table>
<thead>
<tr>
<th>PREFERRED AGENTS</th>
<th>NON-PREFERRED AGENTS</th>
<th>PA CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ARB COMBINATIONS</strong></td>
<td>ATACAND-HCT (candesartan/HCTZ)</td>
<td>*Entresto will only be authorized for patients diagnosed with heart-failure NYHA classification 2-4 with an EF &lt; 40%. No preferred drug trial is required to receive authorization.</td>
</tr>
<tr>
<td>ENTRESTO (valsartan/sucubitril)*</td>
<td>AVALIDE (irbesartan/HCTZ)</td>
<td></td>
</tr>
<tr>
<td>irbesartan/HCTZ</td>
<td>AZOR (olmesartan/amlodipine)</td>
<td></td>
</tr>
<tr>
<td>losartan/HCTZ</td>
<td>BENICAR-HCT (olmesartan/HCTZ)</td>
<td></td>
</tr>
<tr>
<td>olmesartan/amlodipine</td>
<td>BYVALSON (nebivolol/valsartan)</td>
<td></td>
</tr>
<tr>
<td>olmesartan/HCTZ</td>
<td>candesartan/HCTZ</td>
<td></td>
</tr>
<tr>
<td>valsartan/amlodipine</td>
<td>DIOVAN-HCT (valsartan/HCTZ)</td>
<td></td>
</tr>
<tr>
<td>valsartan/HCTZ</td>
<td>EDARBYCLOR (azilsartan/chlorthalidone)</td>
<td></td>
</tr>
<tr>
<td>valsartan/amlodipine</td>
<td>EXFORGE (valsartan/amlodipine)</td>
<td></td>
</tr>
<tr>
<td>valsartan/HCTZ</td>
<td>EXFORGE HCT (valsartan/amlodipine/HCTZ)</td>
<td></td>
</tr>
<tr>
<td>olmesartan/amlodipine</td>
<td>HYZAAR (losartan/HCTZ)</td>
<td></td>
</tr>
<tr>
<td>olmesartan/amlodipine/HCTZ</td>
<td>MICARDIS-HCT (telmisartan/HCTZ)</td>
<td></td>
</tr>
<tr>
<td>telmisartan/HCTZ</td>
<td>TEVETEN-HCT (eprosartan/HCTZ)</td>
<td></td>
</tr>
<tr>
<td>valsartan/amlodipine</td>
<td>TEKTURNAR (aliskiren/HCTZ)</td>
<td>Substitute for Category Criteria: A thirty (30) day trial of one (1) preferred ACE, ARB, or combination agent, at the maximum tolerable dose, is required before Tekturna will be authorized unless one (1) of the exceptions on the PA form is present.</td>
</tr>
<tr>
<td>telmisartan HCTZ</td>
<td>TWYNSTA (telmisartan/amlodipine)</td>
<td></td>
</tr>
<tr>
<td>valsartan/amlodipine/HCTZ</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| **DIRECT RENIN INHIBITORS** | AMTURNIDE (aliskiren/amlodipine/HCTZ) | |
| TEKAMLO (aliskiren/amlodipine) | TEKTURNAR (aliskiren) | |
| TEKTURNAR HCT (aliskiren/HCTZ) | |
| VALTURNAR (aliskiren/valsartan) | |

**ANTIANGINAL & ANTI-ISCHEMIC**

**CATEGORY PA CRITERIA:** Ranexa will be authorized for patients with angina who are also taking a calcium channel blocker, a beta blocker, or a nitrite as single agents or a combination agent containing one (1) of these ingredients.

**RANEXA (ranolazine)**

**ANTIBIOTICS, GI & RELATED AGENTS**

**CATEGORY PA CRITERIA:** A fourteen (14) day trial of a preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.

| metronidazole tablet | tindamax (tinidazole) | |
| neomycin | | |
| paromomycin | | |

**ALINIA (nitazoxanide)**

**DIFICID (fidaxomicin)**

**FLAGYL (metronidazole)**

**FLAGYL ER (metronidazole ER)**

**metronidazole capsule**

**paromomycin**

**TINDAMAX (tinidazole)**

*Dificid will be authorized if the following criteria are met:

1. There is a diagnosis of severe *C. difficile* infection; and
2. There is no response to prior treatment with vancomycin for ten (10) to fourteen (14) days.

**Vancomycin will be authorized for treatment of mild to moderate...**
This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

**THERAPEUTIC DRUG CLASS**

<table>
<thead>
<tr>
<th>PREFERRED AGENTS</th>
<th>NON-PREFERRED AGENTS</th>
<th>PA CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>VANCOCIN (vancomycin)</td>
<td>C. difficile infections after a fourteen (14) day trial of metronidazole. Severe <em>C. difficile</em> infections do <strong>not</strong> require a trial of metronidazole for authorization.</td>
<td></td>
</tr>
<tr>
<td>vancomycin**</td>
<td>**Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.</td>
<td></td>
</tr>
<tr>
<td>XIFAXAN (rifaximin)**</td>
<td>**</td>
<td></td>
</tr>
<tr>
<td>ZINPLAVA (bezlotoxumab)**</td>
<td>**</td>
<td></td>
</tr>
</tbody>
</table>

**ANTIBIOTICS, INHALED**

**CATEGORY PA CRITERIA:** A twenty-eight (28) day trial of the preferred agent and documentation of therapeutic failure is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.

<table>
<thead>
<tr>
<th>PREFERRED AGENTS</th>
<th>NON-PREFERRED AGENTS</th>
<th>PA CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>BETHKIS (tobramycin)</td>
<td>CAYSTON (aztreonam)</td>
<td></td>
</tr>
<tr>
<td>KITABIS PAK (tobramycin)</td>
<td>TOBI (tobramycin)</td>
<td></td>
</tr>
<tr>
<td> </td>
<td>TOBI PODHALER (tobramycin)</td>
<td></td>
</tr>
<tr>
<td> </td>
<td>tobramycin</td>
<td></td>
</tr>
</tbody>
</table>

**ANTIBIOTICS, TOPICAL**

**CATEGORY PA CRITERIA:** Ten (10) day trials of at least one (1) preferred agent, including the generic formulation of a requested non-preferred agent, are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.

<table>
<thead>
<tr>
<th>PREFERRED AGENTS</th>
<th>NON-PREFERRED AGENTS</th>
<th>PA CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>bacitracin (Rx, OTC)</td>
<td>ALTABAX (retapamulin)</td>
<td></td>
</tr>
<tr>
<td>gentamicin sulfate</td>
<td>BACTROBAN (mupirocin)</td>
<td></td>
</tr>
<tr>
<td>mupirocin ointment</td>
<td>CENTANY (mupirocin)</td>
<td></td>
</tr>
<tr>
<td> </td>
<td>CORTISPORIN (bacitracin/neomycin/polymyxin/HC)</td>
<td></td>
</tr>
<tr>
<td> </td>
<td>mupirocin cream</td>
<td></td>
</tr>
<tr>
<td> </td>
<td>neomycin/polymyxin/pramoxine</td>
<td></td>
</tr>
</tbody>
</table>

**ANTIBIOTICS, VAGINAL**

**CATEGORY PA CRITERIA:** A trial, the duration of the manufacturer’s recommendation, of each preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.

<table>
<thead>
<tr>
<th>PREFERRED AGENTS</th>
<th>NON-PREFERRED AGENTS</th>
<th>PA CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>clindamycin cream</td>
<td>AVC (sulfanilamide)</td>
<td></td>
</tr>
<tr>
<td>metronidazole</td>
<td>CLEOCIN CREAM (clindamycin)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CLEOCIN OVULE (clindamycin)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CLINDESSE (clindamycin)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>METROGEL (metronidazole)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NUVESSA (metronidazole)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>VANDAZOLE (metronidazole)</td>
<td></td>
</tr>
</tbody>
</table>
### THERAPEUTIC DRUG CLASS

#### ANTICOAGULANTS

**CATEGORY PA CRITERIA:** Trials of each preferred agent will be required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.

<table>
<thead>
<tr>
<th>INJECTABLE</th>
<th>ORAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>enoxaparin</td>
<td>SAVAYSA (edoxaban)</td>
</tr>
<tr>
<td>ARIXTRA (fondaparinux)</td>
<td>*Eliquis will be authorized for the following indications:</td>
</tr>
<tr>
<td>fondaparinux</td>
<td>1. Non-valvular atrial fibrillation or</td>
</tr>
<tr>
<td>FRAGMIN (dalteparin)</td>
<td>2. Deep vein thrombosis (DVT) and pulmonary embolism (PE) or</td>
</tr>
<tr>
<td>LOVENOX (enoxaparin)</td>
<td>3. DVT prophylaxis if treatment is limited to thirty-five (35) days for hip replacement surgeries or twelve (12) days for knee replacement surgeries.</td>
</tr>
</tbody>
</table>

**COUMADIN (warfarin)**

**ELIQUIIS (apixaban)**

**PRADAXA (dabigatran)**

**warfarin**

**XARELTO (rivaroxaban)**

**INJECTABLE**

**ELIQUIIS**

**PRADAXA**

**XARELTO**

**SAVAYSA (edoxaban)**

*Eliquis will be authorized for the following indications:*

1. Non-valvular atrial fibrillation or
2. Deep vein thrombosis (DVT) and pulmonary embolism (PE) or
3. DVT prophylaxis if treatment is limited to thirty-five (35) days for hip replacement surgeries or twelve (12) days for knee replacement surgeries.

**PRADAXA**

**XARELTO**

**SAVAYSA**
# THERAPEUTIC DRUG CLASS

## ANTICONVULSANTS

**CATEGORY PA CRITERIA:** A fourteen (14) day trial of one (1) of the preferred agents in the corresponding group is required for treatment naïve patients with a diagnosis of a seizure disorder before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.

A thirty (30) day trial of one (1) of the preferred agents in the corresponding group is required for patients with a diagnosis other than seizure disorders unless one (1) of the exceptions on the PA form is present.

Non-preferred anticonvulsants will be authorized for patients on established therapies with a diagnosis of seizure disorders with no trials of preferred agents required. In situations where AB-rated generic equivalent products are available, “Brand Medically Necessary” must be hand-written by the prescriber on the prescription in order for the brand name product to be reimbursed.

<table>
<thead>
<tr>
<th>PREferred AGENTS</th>
<th>non-preferred AGENTS</th>
<th>PA CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carbamazepine</td>
<td>APTIOM (eslicarbazepine)</td>
<td></td>
</tr>
<tr>
<td>Carbamazepine ER</td>
<td>BANZEL (rufinamide)</td>
<td></td>
</tr>
<tr>
<td>Carbamazepine XR</td>
<td>BRIVIACT (brivaracetam)</td>
<td></td>
</tr>
<tr>
<td>DEPAKOTE SPRINKLE (divalproex)</td>
<td>CARBATROL (carbamazepine)</td>
<td></td>
</tr>
<tr>
<td>Divalproex</td>
<td>DEPAKEN (valproic acid)</td>
<td></td>
</tr>
<tr>
<td>Divalproex ER</td>
<td>DEPAKOTE (divalproex)</td>
<td></td>
</tr>
<tr>
<td>Epitol (carbamazepine)</td>
<td>DEPAKOTE ER (divalproex)</td>
<td></td>
</tr>
<tr>
<td>Gabitril (tiagabine)</td>
<td>Divalproex sprinkle</td>
<td></td>
</tr>
<tr>
<td>Lamotrigine</td>
<td>Equetro (carbamazepine)</td>
<td></td>
</tr>
<tr>
<td>Levetiracetam IR</td>
<td>FANTELOX SUSPENSION (gabapentin)</td>
<td></td>
</tr>
<tr>
<td>Levetiracetam ER</td>
<td>Felbamate</td>
<td></td>
</tr>
<tr>
<td>Oxcarbazepine suspension and tablets</td>
<td>Felbatol (felbamate)***</td>
<td></td>
</tr>
<tr>
<td>Topiramate IR</td>
<td>Fycompa (perampanel)</td>
<td></td>
</tr>
<tr>
<td>Topiramate ER*</td>
<td>KepPRA (levetiracetam)</td>
<td></td>
</tr>
<tr>
<td>Valproic acid</td>
<td>KEPPRA (levetiracetam)</td>
<td></td>
</tr>
<tr>
<td>Vimpact (lacosamide)AP**</td>
<td>Lamictal (lamotrigine)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ADJUVANTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carbamazepine ER*</td>
</tr>
<tr>
<td>Oxcarbazepine suspension and tablets</td>
</tr>
<tr>
<td>Valproic acid</td>
</tr>
<tr>
<td>Vimpact (lacosamide)AP**</td>
</tr>
</tbody>
</table>

*Topiramate ER will be authorized after a thirty (30) day trial of topiramate IR.

**Vimpat will be approved as monotherapy or adjunctive therapy for members seventeen (17) years of age or older with a diagnosis of partial-onset seizure disorder.

***Patients stabilized on Felbatol will be grandfathered.
## BUREAU FOR MEDICAL SERVICES
## WEST VIRGINIA MEDICAID
## PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA

This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

### EFFECTIVE
07/01/2017
Version 2017.3c

<table>
<thead>
<tr>
<th>THERAPEUTIC DRUG CLASS</th>
<th>PREFERRED AGENTS</th>
<th>NON-PREFERRED AGENTS</th>
<th>PA CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TRILEPTAL SUSPENSION</strong></td>
<td>TRILEPTAL SUSPENSION and TABLETS (oxcarbazepine)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TROKENDI XR (topiramate)</strong></td>
<td>TROKENDI XR (topiramate)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>ZONEGRAN (zonisamide)</strong></td>
<td>ZONEGRAN (zonisamide)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>BARBITURATES</strong>&lt;sup&gt;AP&lt;/sup&gt;</td>
<td>phenobarbital</td>
<td>MYSOLINE (primidone)</td>
<td></td>
</tr>
<tr>
<td><strong>MYSOLINE (primidone)</strong></td>
<td>phenobarbital</td>
<td>MYSOLINE (primidone)</td>
<td></td>
</tr>
<tr>
<td><strong>BENZODIAZEPINES</strong>&lt;sup&gt;AP&lt;/sup&gt;</td>
<td>clonazepam</td>
<td>clonazepam OD</td>
<td></td>
</tr>
<tr>
<td><strong>DIASTAT (diazepam rectal)</strong></td>
<td>diazepam OD</td>
<td>diazepam rectal gel</td>
<td></td>
</tr>
<tr>
<td><strong>KLONOPIN (clonazepam)</strong></td>
<td>clonazepam OD</td>
<td>diazepam rectal gel</td>
<td></td>
</tr>
<tr>
<td><strong>ONFI (clobazam)</strong>&lt;sup&gt;*&lt;/sup&gt;</td>
<td>ONFI SUSPENSION (clobazam)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>VALIUM TABLETS (diazepam)</strong></td>
<td>VALIUM TABLETS (diazepam)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>HYDANTOINS</strong>&lt;sup&gt;AP&lt;/sup&gt;</td>
<td>DILANTIN (phenytoin sodium, extended)</td>
<td>DILANTIN INFATABS (phenytoin)</td>
<td></td>
</tr>
<tr>
<td><strong>PEGANONE (ethotoin)</strong></td>
<td>PEGANONE (ethotoin)</td>
<td>PHENYTEK (phenytoin)</td>
<td></td>
</tr>
<tr>
<td><strong>phenytoin capsules, chewable tablets, suspension</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CELONTIN (methsuximide)</strong></td>
<td>ethosuximide capsules</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>ZARONTIN (ethosuximide) capsules</strong></td>
<td>ZARONTIN (ethosuximide) syrup</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Succinimides</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>ANTIDEPRESSANTS, OTHER</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CATEGORY PA CRITERIA:</strong> See below for individual sub-class criteria.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>MAOIs</strong>&lt;sup&gt;AP&lt;/sup&gt;</td>
<td>MARPLAN (isocarboxazid)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>NARDIL (phenelzine)</strong></td>
<td>NARDIL (phenelzine)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>PARNATE (tranylcypromine)</strong></td>
<td>PARNATE (tranylcypromine)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>pheinelzine tranylcypromine</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SNRIS</strong>&lt;sup&gt;**&lt;/sup&gt;</td>
<td>duloxetine capulses</td>
<td>CYMBALTA (duloxetine)</td>
<td>A thirty (30) day trial each of a preferred agent and an SSRI is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.</td>
</tr>
<tr>
<td><strong>venlafaxine ER capsules</strong></td>
<td>venlafaxine ER</td>
<td>desvenlafaxine ER</td>
<td></td>
</tr>
<tr>
<td><strong>desvenlafaxine fumarate ER</strong></td>
<td>desvenlafaxine fumarate ER</td>
<td></td>
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</tbody>
</table>
**THERAPEUTIC DRUG CLASS**

<table>
<thead>
<tr>
<th>PREFERRED AGENTS</th>
<th>NON-PREFERRED AGENTS</th>
<th>PA CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SECOND GENERATION NON-SSRI, OTHER</strong>&lt;sup&gt;AP&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>bupropion IR</td>
<td>APLENZIN (bupropion hbr)</td>
<td>A thirty (30) day trial each of a preferred agent and an SSRI is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.</td>
</tr>
<tr>
<td>bupropion SR</td>
<td>EMSAM (selegiline)</td>
<td></td>
</tr>
<tr>
<td>bupropion XL</td>
<td>FORFIVO XL (bupropion)</td>
<td></td>
</tr>
<tr>
<td>mirtazapine</td>
<td>nefazodone</td>
<td></td>
</tr>
<tr>
<td>trazodone</td>
<td>OLEPTRO ER (trazodone)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>REMERON (mirtazapine)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>TRINTELLIX (vortioxetine)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>VIIBRYD (vilazodone hcl)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>WELLBUTRIN (bupropion)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>WELLBUTRIN SR (bupropion)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>WELLBUTRIN XL (bupropion)</td>
<td></td>
</tr>
</tbody>
</table>

| SELECTED TCAs | | |
| imipramine hcl | imipramine pamoate | A twelve (12) week trial of imipramine hcl is required before a non-preferred TCA will be authorized unless one (1) of the exceptions on the PA form is present. |
| | TOFRANIL (imipramine hcl) | |
| | TOFRANIL PM (imipramine pamoate) | |

**CATEGORY PA CRITERIA:** Thirty (30) day trials each of two (2) of the preferred agents are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.

Upon hospital discharge, patients admitted with a primary mental health diagnosis who have been stabilized on a non-preferred SSRI will receive an authorization to continue that drug.
### THERAPEUTIC DRUG CLASS

#### ANTIEMETICS

**CATEGORY PA CRITERIA:** A three (3) day trial of a preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. PA is required for ondansetron when limits are exceeded.

<table>
<thead>
<tr>
<th>THERAPEUTIC DRUG CLASS</th>
<th>PREFERRED AGENTS</th>
<th>NON-PREFERRED AGENTS</th>
<th>PA CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ANTIEMETICS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CATEGORY PA CRITERIA</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>5HT3 RECEPTOR BLOCKERS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ondansetron ODT, solution, tablets</td>
<td>ANZETM (dolasetron)</td>
<td></td>
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<tr>
<td></td>
<td>granisetron</td>
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<tr>
<td></td>
<td>GRANISOL (granisetron)</td>
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<tr>
<td></td>
<td>ondansetron vials</td>
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<tr>
<td></td>
<td>SANCUSO (granisetron)</td>
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<td></td>
<td>SUSTOL (granisetron)</td>
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<td></td>
<td>ZOFTRAN (ondansetron)</td>
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<tr>
<td></td>
<td>ZUPLENZ (ondansetron)</td>
<td></td>
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</tr>
<tr>
<td><strong>CANNABINOIDS</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>CESAMET (nabilone)*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>dronabinol</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MARINOL (dronabinol)**</td>
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</tbody>
</table>

*Cesamet will be authorized only for the treatment of nausea and vomiting associated with cancer chemotherapy for patients who have failed to respond adequately to three (3) day trials of conventional treatments such as promethazine or ondansetron and are eighteen (18) years of age or older.

**Marinol (dronabinol) will only be authorized for:

1. The treatment of anorexia associated with weight loss in patients with AIDS or cancer and unresponsive to megestrol or
2. The prophylaxis of chemotherapy induced nausea and vomiting unresponsive to three (3) day trials of ondansetron or promethazine for patients from eighteen (18) up to sixty-five (65) years of age.

| **SUBSTANCE P ANTAGONISTS** |                  |                      |             |
| EMEND (aprepitant)         |                  |                      |             |
| aprepitant                 |                  |                      |             |
| VARUBI (rolapitant)        |                  |                      |             |

| **COMBINATIONS**          |                  |                      |             |
| AKYNZEO (netupitant/ palonosetron) |                  |                      |             |

| **ANTIFUNGALS, ORAL**     |                  |                      |             |
| clotrimazole              |                  |                      |             |
| fluconazole*              |                  |                      |             |
| nystatin                  |                  |                      |             |
| terbinafine CL**          |                  |                      |             |
| ANCOBON (flucytosine)     |                  |                      |             |
| CRESEMA (isovucazonium)CL** |                  |                      |             |
| DIFLUCAN (fluconazole)    |                  |                      |             |
| flucytosine               |                  |                      |             |
| GRIFULVIN V TABLET (griseofulvin) |               |                      |             |
| griseofulvin***           |                  |                      |             |
| GRIS-PEG (griseofulvin)   |                  |                      |             |

*PA is required when limits are exceeded.

**Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.

***PA is not required for griseofulvin suspension for children up to eighteen (18) years of age for the treatment of tinea capitis.
BUREAU FOR MEDICAL SERVICES
WEST VIRGINIA MEDICAID
PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA

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**THERAPEUTIC DRUG CLASS**

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<thead>
<tr>
<th>PREFERRED AGENTS</th>
<th>NON-PREFERRED AGENTS</th>
<th>PA CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>itraconazole</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ketoconazole****</td>
<td>LAMISIL (terbinafine)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>MYCELEX (clotrimazole)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>MYCOSTATIN Tablets (nystatin)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NIZORAL (ketoconazole)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NOXAFIL (posaconazole)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ONMEL (itraconazole)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ORAVIG (miconazole)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SPORANOX (itraconazole)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>VFEND (voriconazole)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>voriconazole suspension</td>
<td></td>
</tr>
<tr>
<td></td>
<td>voriconazole tablets</td>
<td></td>
</tr>
</tbody>
</table>

****Ketoconazole will be authorized if the following criteria are met:
1. Diagnosis of one of the following fungal infections: blastomycosis, coccidioidomycosis, histoplasmosis, chromomycosis, or paracoccidioidomycosis and
2. Documented failure or intolerance of all other diagnosis-appropriate antifungal therapies, i.e. itraconazole, fluconazole, flucytosine, etc and
3. Baseline assessment of the liver status including alanine aminotransferase (ALT), aspartate aminotransferase (AST), total bilirubin, alkaline phosphatase, prothrombin time, and international normalized ration (INR) before starting treatment and
4. Weekly monitoring of serum ALT for the duration of treatment (If ALT values increase to a level above the upper limit of normal or 30% above baseline, or if the patient develops symptoms of abnormal liver function, treatment should be interrupted and a full set of liver tests be obtained. Liver tests should be repeated to ensure normalization of values.) and
5. Assessment of all concomitant medications for potential adverse drug interactions with ketoconazole.

Ketoconazole will not be authorized for treatment for fungal infections of the skin and nails.

**ANTIFUNGALS, TOPICAL**

**CATEGORY PA CRITERIA:** Fourteen (14) day trials of two (2) of the preferred agents are required before a non-preferred agents will be authorized unless one (1) of the exceptions on the PA form is present. If a non-preferred shampoo is requested, a fourteen (14) day trial of one (1) preferred product (ketoconazole shampoo) is required.

<table>
<thead>
<tr>
<th>ANTIMICROBIALS</th>
<th>PREFERRED AGENTS</th>
<th>NON-PREFERRED AGENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>econazole</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ketoconazole cream, shampoo</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MENTAX (butenafine)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>miconazole (OTC) nystatin</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CICLODAN (ciclopirox)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ciclopirox</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ERTACZO (sertaconazole)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>EXELDERM (sulconazole)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>EXTINA (ketoconazole)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>JUBLIA (efinaconazole)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ketoconazole foam</td>
<td></td>
</tr>
<tr>
<td></td>
<td>KERYDIN (tavaborole)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>KETODAN (ketoconazole)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>LOPROX (ciclopirox)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>LUZU (luliconazole)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>MYCOSTATIN (nystatin)</td>
<td></td>
</tr>
</tbody>
</table>

*Koistat cream will be authorized for children up to thirteen (13) years of age for tinea corporis, tinea cruris, tinea pedis, and tinea (pityriasis) versicolor.*
### Therapeutic Drug Class

#### Preferred Agents

<table>
<thead>
<tr>
<th>Preferred Agents</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAFTIN CREAM (naftifine)</td>
</tr>
<tr>
<td>NAFTIN GEL (naftifine)</td>
</tr>
<tr>
<td>NIZORAL (ketoconazole)</td>
</tr>
<tr>
<td>OXISTAT (oxiconazole)*</td>
</tr>
<tr>
<td>PEDIPIROX-4 (ciclopirox)</td>
</tr>
<tr>
<td>PENLAC (ciclopirox)</td>
</tr>
<tr>
<td>VUSION (miconazole/petrolatum/zinc oxide)</td>
</tr>
<tr>
<td>XOLEGEL (ketoconazole)</td>
</tr>
</tbody>
</table>

#### Non-Preferred Agents

<table>
<thead>
<tr>
<th>Non-Preferred Agents</th>
</tr>
</thead>
<tbody>
<tr>
<td>clotrimazole/betamethasone</td>
</tr>
<tr>
<td>nystatin/triamcinolone</td>
</tr>
<tr>
<td>KETOCON PLUS (ketoconazole/hydrocortisone)</td>
</tr>
<tr>
<td>LOTRISONE (clotrimazole/betamethasone)</td>
</tr>
</tbody>
</table>

#### PA Criteria

<table>
<thead>
<tr>
<th>Therapeutic Drug Class</th>
<th>Preferred Agents</th>
<th>Non-Preferred Agents</th>
<th>PA Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>THERAPEUTIC DRUG CLASS</td>
<td>NAFTIN CREAM</td>
<td>clotrimazole/betamethasone</td>
<td>CATAPRES-TTS (clonidine)</td>
</tr>
<tr>
<td></td>
<td>NAFTIN GEL</td>
<td></td>
<td>clonidine tablets</td>
</tr>
<tr>
<td></td>
<td>NIZORAL</td>
<td></td>
<td>CATAPRES TABLETS (clonidine)</td>
</tr>
<tr>
<td></td>
<td>OXISTAT</td>
<td></td>
<td>clonidine patch</td>
</tr>
<tr>
<td></td>
<td>PEDIPIROX-4</td>
<td></td>
<td>NEXICOLON XR (clonidine)</td>
</tr>
<tr>
<td></td>
<td>PENLAC</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>VUSION</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>XOLEGEL</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Antifungal/steroid combinations

<table>
<thead>
<tr>
<th>Antifungal/steroid combinations</th>
</tr>
</thead>
<tbody>
<tr>
<td>clotrimazole/betamethasone</td>
</tr>
<tr>
<td>nystatin/triamcinolone</td>
</tr>
<tr>
<td>KETOCON PLUS (ketoconazole/hydrocortisone)</td>
</tr>
<tr>
<td>LOTRISONE (clotrimazole/betamethasone)</td>
</tr>
</tbody>
</table>

#### Antihypertensives, sympatholytics

**Category PA Criteria:** A thirty (30) day trial of each preferred unique chemical entity in the corresponding formulation is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.

<table>
<thead>
<tr>
<th>Antihypertensives, sympatholytics</th>
<th>CATAPRES-TTS (clonidine)</th>
<th>CATAPRES TABLETS (clonidine)</th>
</tr>
</thead>
<tbody>
<tr>
<td>clonidine tablets</td>
<td>clonidine patch</td>
<td>NEXICOLON XR (clonidine)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Antihyperuricemics

**Category PA Criteria:** A thirty (30) day trial of one (1) of the preferred agents for the prevention of gouty arthritis attacks (colchicine/probenecid, probenecid, or allopurinol) is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.

<table>
<thead>
<tr>
<th>Antihyperuricemics</th>
</tr>
</thead>
<tbody>
<tr>
<td>colchicine/probenecid</td>
</tr>
</tbody>
</table>

#### Antimitotics

<table>
<thead>
<tr>
<th>Antimitotics</th>
</tr>
</thead>
<tbody>
<tr>
<td>MITIGARE (colchicine)</td>
</tr>
<tr>
<td>colchicine capsules*</td>
</tr>
<tr>
<td>colchicine tablets</td>
</tr>
<tr>
<td>COLCRYS (colchicine)</td>
</tr>
</tbody>
</table>

*In the case of acute gouty attacks, a ten (10) day supply (twenty (20) capsules) of colchicine will be authorized per ninety (90) days.

#### Antimitotic-uricosuric combination

<table>
<thead>
<tr>
<th>Antimitotic-uricosuric combination</th>
</tr>
</thead>
<tbody>
<tr>
<td>colchicine/probenecid</td>
</tr>
</tbody>
</table>

#### Uricosuric

<table>
<thead>
<tr>
<th>Uricosuric</th>
</tr>
</thead>
<tbody>
<tr>
<td>probenecid</td>
</tr>
</tbody>
</table>

* ZURAMPIC (lesinurad) |

* Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.

#### Xanthine oxidase inhibitors

<table>
<thead>
<tr>
<th>Xanthine oxidase inhibitors</th>
</tr>
</thead>
<tbody>
<tr>
<td>allopurinol</td>
</tr>
</tbody>
</table>

| ULORIC (febuxostat) |
| ZYLOPRIM (allopurinol) |

*
# Preferred Drug List with Prior Authorization Criteria

This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

## Therapeutic Drug Class

<table>
<thead>
<tr>
<th>Preferred Drug Class</th>
<th>Preferred Agents</th>
<th>Non-PREFERRED Agents</th>
<th>PA CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Antimigraine Agents, Other</strong>&lt;sup&gt;AP&lt;/sup&gt;</td>
<td>naratriptan</td>
<td>almotriptan</td>
<td>CAMBIA (diclofenac)</td>
</tr>
<tr>
<td>Category PA Criteria:</td>
<td>rizatriptan ODT</td>
<td>AMERGE (naratriptan)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>sumatriptan injection&lt;sup&gt;CL&lt;/sup&gt;</td>
<td>AXERT (almotriptan)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>sumatriptan nasal spray</td>
<td>FROVA (frovatriptan)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>sumatriptan tablets</td>
<td>frovatriptan</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>IMITREX INJECTION (sumatriptan)&lt;sup&gt;CL&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>IMITREX NASAL SPRAY (sumatriptan)</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>IMITREX tablets (sumatriptan)</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>MAXALT MLT (rizatriptan)</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>MAXALT (rizatriptan)</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td><strong>ONZETRA XSAIL</strong> (sumatriptan)</td>
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<tr>
<td></td>
<td></td>
<td>RELPAX (eletriptan)</td>
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<tr>
<td></td>
<td></td>
<td>SUMAVEL (sumatriptan)</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>ZECUITY PATCH (sumatriptan)</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>ZEMBRACE SYMTOUCH (sumatriptan)</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>zolmitriptan</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>zolmitriptan ODT</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>ZOMIG (zolmitriptan)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>ZOMIG ZMT (zolmitriptan)</td>
<td></td>
</tr>
<tr>
<td><strong>Antimigraine Agents, Triptans</strong>&lt;sup&gt;AP&lt;/sup&gt;</td>
<td>naratriptan</td>
<td>almotriptan</td>
<td>CAMBIA (diclofenac)</td>
</tr>
<tr>
<td>Category PA Criteria:</td>
<td>rizatriptan ODT</td>
<td>AMERGE (naratriptan)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>sumatriptan injection&lt;sup&gt;CL&lt;/sup&gt;</td>
<td>AXERT (almotriptan)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>sumatriptan nasal spray</td>
<td>FROVA (frovatriptan)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>sumatriptan tablets</td>
<td>frovatriptan</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>IMITREX INJECTION (sumatriptan)&lt;sup&gt;CL&lt;/sup&gt;</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>IMITREX NASAL SPRAY (sumatriptan)</td>
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<td></td>
<td></td>
<td>IMITREX tablets (sumatriptan)</td>
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<td></td>
<td></td>
<td>MAXALT MLT (rizatriptan)</td>
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<tr>
<td></td>
<td></td>
<td>MAXALT (rizatriptan)</td>
<td></td>
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<td></td>
<td></td>
<td><strong>ONZETRA XSAIL</strong> (sumatriptan)</td>
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<td></td>
<td></td>
<td>RELPAX (eletriptan)</td>
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<td></td>
<td>SUMAVEL (sumatriptan)</td>
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<tr>
<td></td>
<td></td>
<td>ZECUITY PATCH (sumatriptan)</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>ZEMBRACE SYMTOUCH (sumatriptan)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>zolmitriptan</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>zolmitriptan ODT</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>ZOMIG (zolmitriptan)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>ZOMIG ZMT (zolmitriptan)</td>
<td></td>
</tr>
<tr>
<td><strong>Triptan Combinations</strong></td>
<td>TREXIMET (sumatriptan/naproxen sodium)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Antiparasitics, Topical</strong>&lt;sup&gt;AP&lt;/sup&gt;</td>
<td>permethrin 5% cream</td>
<td>EURAX (crotamiton)</td>
<td></td>
</tr>
<tr>
<td>Category PA Criteria:</td>
<td>permethrin 1% lotion (OTC)</td>
<td>LICE EGG REMOVER OTC (benzalkonium chloride)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>pyrethrins-piperonyl butoxide OTC</td>
<td>lindane</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SKLICE (ivermectin)</td>
<td>malathion</td>
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<tr>
<td></td>
<td>spinosad</td>
<td>NATROBA (spinosad)</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>OVIDE (malathion)</td>
<td></td>
</tr>
</tbody>
</table>

*In addition to the Category Criteria: Onzeta Xsail requires three (3) day trials of each of the preferred oral, nasal and injectable forms of sumatriptan.*
**Therapeutic Drug Class**

<table>
<thead>
<tr>
<th>Therapeutic Drug Class</th>
<th>Preferred Agents</th>
<th>Non-Preferred Agents</th>
<th>PA Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Antiparkinson's Agents</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Category PA Criteria:</strong> Patients starting therapy on drugs in this class must show a documented allergy to all of the preferred agents in the corresponding class, before a non-preferred agent will be authorized.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anticholinergics</td>
<td>benzotropine</td>
<td>COGENTIN (benztropine)</td>
<td></td>
</tr>
<tr>
<td>trihexyphenidyl</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>COMT Inhibitors</td>
<td>COMTAN (entacapone)</td>
<td>entacapone</td>
<td>TASMAR (tolcapone)</td>
</tr>
<tr>
<td>Dopamine Agonists</td>
<td>pramipexole</td>
<td>MIRAPEX (pramipexole)</td>
<td></td>
</tr>
<tr>
<td>ropinirole</td>
<td>MIRAPEX ER (pramipexole)</td>
<td>NEUPRO (rotigotine)</td>
<td>pramipexole ER</td>
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<td></td>
<td></td>
<td>REQUIP (ropinirole)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>REQUIP XL (ropinirole)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>ropinirole ER</td>
<td></td>
</tr>
<tr>
<td>Other Antiparkinson's Agents</td>
<td>amantadine&lt;sup&gt;AP&lt;/sup&gt;</td>
<td>AZILECT (rasagiline)</td>
<td></td>
</tr>
<tr>
<td>bromocriptine</td>
<td>carbidopa</td>
<td>ELDEPRYL (selegiline)</td>
<td></td>
</tr>
<tr>
<td>carbidopa/levodopa</td>
<td>levodopa/carbidopa ODT</td>
<td>LODOSYN (carbidopa)</td>
<td></td>
</tr>
<tr>
<td>levodopa/carbidopa/entacapone</td>
<td>PARCOPA (levodopa/carbidopa)</td>
<td>PARLODEL (bromocriptine)</td>
<td>rasagiline&lt;sup&gt;NR&lt;/sup&gt;</td>
</tr>
<tr>
<td>selegiline</td>
<td>RYTARY (levodopa/carbidopa)</td>
<td>SINEMET (levodopa/carbidopa)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>STALEVO (levodopa/carbidopa/entacapone)</td>
<td>ZELAPAR (selegiline)</td>
<td></td>
</tr>
<tr>
<td>Antipsoriatics, Topical</td>
<td>calcipotriene ointment</td>
<td>calcipotriene cream</td>
<td></td>
</tr>
<tr>
<td>calcipotriene/betamethasone ointment</td>
<td>calcipotriene solution</td>
<td>CALCITRENE (calcipotriene)</td>
<td></td>
</tr>
<tr>
<td>TAZORAC (tazarotene)</td>
<td>calcitriol</td>
<td>DOVONEX (calcipotriene)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>ENSTILAR (calcipotriene/betamethasone)</td>
<td></td>
</tr>
</tbody>
</table>
# THERAPEUTIC DRUG CLASS

<table>
<thead>
<tr>
<th>PREFERRED AGENTS</th>
<th>NON-PREFERRED AGENTS</th>
<th>PA CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>SORILUX (calcipotriene)</td>
<td>TACLONEX (calcipotriene/ betamethasone)</td>
<td>VECTICAL (calcitriol)</td>
</tr>
</tbody>
</table>

## ANTIPSYCHOTICS, ATYPICAL

**CATEGORY PA CRITERIA:** All antipsychotic agents require prior authorization for children up to eighteen (18) years of age. All PA requests for antipsychotics for children 6 years of age and younger will be reviewed by Medicaid’s consultant psychiatrist.

A fourteen (14) day trial of a preferred generic agent is required before a Preferred Brand will be authorized.

Non-preferred agents will be authorized if the following criteria have been met:

1. A fourteen (14) day trial of a preferred generic agent **and**
2. Two (2) fourteen (14) day trials of additional preferred products unless one (1) of the exceptions on the PA form is present.

In the event there are not three preferred drugs with FDA-approved labels for the patient’s age range or diagnosis, the drug may still receive approval at the discretion of RDTP or by BMS on appeal.

Upon discharge, a hospitalized patient stabilized on a non-preferred agent may receive authorization to continue this drug for labeled indications and at FDA recommended dosages. Requests for off-label use will be given at least a 30 day prior-authorization so that BMS may properly review the requested therapy.

## SINGLE INGREDIENT

- **ABILIFY MAINTENA** (aripiprazole)*
- **ABILIFY DISCMELT & ORAL SOLUTION** (aripiprazole)
- Clozapine
- INVEGA SUSTENNA (paliperidone)*
- INVEGA TRINZA (paliperidone)**
- LATUDA (lurasidone)** AP
- Olanzapine
- Olanzapine ODT
- Quetiapine*** AP for the 25 mg Tablet Only
- RISPERDAL CONSTA (risperidone) * CL
- Risperidone
- Ziprasidone
- **ABILIFY TABLETS** (aripiprazole)
- ADASUVE (loxapine)
- aripiprazole discmelt & oral solution
- ARISTADA (aripiprazole)****
- Clozapine ODT
- CLOZARIL (clozapine)
- FANAPT (iloperidone)
- FAZACLO (clozapine)
- GEODON (ziprasidone)
- GEODON IM (ziprasidone)
- INVEGA ER (paliperidone)******
- NUPLAZID (pimavanserin)******
- Olanzapine IM*
- Paliperidone ER******
- Quetiapine ERNR
- REXULTI (brexipiprazole)
- RISPERDAL (risperidone)
- SAPHRIS (asenapine)
- SEROQUEL (quetiapine)
- SEROQUEL XR (quetiapine)
- VERSACLOZ (clozapine)
- VRAYLAR (cariprazine)

*All injectable antipsychotic products require clinical prior authorization and will be approved on a case-by-case basis.

**Invega Trinza will be authorized after four months' treatment with Invega Sustenna

***Latuda will be authorized for patients only after a trial of one other preferred drug

****Quetiapine 25 mg will be authorized:
1. For a diagnosis of schizophrenia **or**
2. For a diagnosis of bipolar disorder **or**
3. When prescribed concurrently with other strengths of Seroquel in order to achieve therapeutic treatment levels.

Quetiapine 25 mg will not be authorized for use as a sedative hypnotic.

*****Aristada is only approveable on appeal and requires that tolerability has been previously established with oral aripiprazole for at least 2 weeks **AND** that there is a clinically compelling reason why Abilify Maintena cannot be used.
**THERAPEUTIC DRUG CLASS**

<table>
<thead>
<tr>
<th>PREFERRED AGENTS</th>
<th>NON-PREFERRED AGENTS</th>
<th>PA CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>VRAYLAR DOSE PAK (capriprazine)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ZYPREXA (olanzapine)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ZYPREXA IM (olanzapine)*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ZYPREXA RELPREVV (olanzapine)</td>
<td></td>
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</tr>
</tbody>
</table>

******Nuplazid will only be authorized for the treatment of Parkinson Disease Induced Psychosis after documented treatment failure with quetiapine.******

******Invega ER is preferred over paliperidone ER******

**ATYPICAL ANTIPSYCHOTIC/SSRI COMBINATIONS**

- olanzapine/fluoxetine
- SYMBYAX (olanzapine/fluoxetine)

**ANTIRETROVIRALS**

**CATEGORY PA CRITERIA:** Non-preferred drugs require medical reasoning beyond convenience or enhanced compliance as to why the clinical need cannot be met with a preferred agent or combination of preferred agents. **NOTE:** Regimens consisting of preferred agents will result in no more than one additional unit per day over equivalent regimens composed of non-preferred agents. Patients already on a non-preferred regimen shall be grandfathered.

**INTEGRASE STRAND TRANSFER INHIBITORS**

- ISENTRESS (raltegravir potassium)
- TIVICAY (dolutegravir sodium)
- VITEKTA (elvitegravir)

**NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTI)**

- abacavir sulfate
- didanosine DR capsule
- EMTRIVA (emtricitabine)
- EPIVIR SOLUTION (lamivudine)
- lamivudine
- stavudine
- VIDEK SOLUTION (didanosine)
- VIREAD (tenofovir disoproxil fumarate)
- ZIAGEN SOLUTION (abacavir sulfate)
- zidovudine

- EPIVIR TABLET (lamivudine)
- RETROVIR (zidovudine)
- VIDEK EC (didanosine)
- ZERIT (stavudine)
- ZIAGEN TABLET (abacavir sulfate)

**NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITOR (NNRTI)**

- EDURANT (rilpivirine)
- SUSTIVA (efavirenz)

- INTELENCE (etavirine)
- nevirapine
- nevirapine ER
- REScriptor (delavirdine mesylate)
- VIRAMUNE ER 24H (nevirapine)
- VIRAMUNE SUSPENSION (nevirapine)

- PHARMACOENHANCER – CYTOCHROME P450 INHIBITOR

- TYBOST (cobicistat)
<table>
<thead>
<tr>
<th>THERAPEUTIC DRUG CLASS</th>
<th>PREFERRED AGENTS</th>
<th>NON-PREFERRED AGENTS</th>
<th>PA CRITERIA</th>
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<tbody>
<tr>
<td><strong>PROTEASE INHIBITORS (PEPTIDIC)</strong></td>
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<tr>
<td>EVOTAZ (atazanavir/cobicistat)</td>
<td>CRIXIVAN (indinavir)</td>
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<tr>
<td>NORVIR (ritonavir)</td>
<td>INVIRASE (saquinavir mesylate)</td>
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<tr>
<td>REYATAZ (atazanavir)</td>
<td>LEXIVA (fosamprenavir)</td>
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<td></td>
<td>VIRACEPT (nelfinavir mesylate)</td>
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<tr>
<td><strong>PROTEASE INHIBITORS (NON-PEPTIDIC)</strong></td>
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<tr>
<td>PREZISTA (darunavir ethanolate)</td>
<td>APTIVUS (tipranavir)</td>
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<tr>
<td></td>
<td>PREZCOBIX (darunavir/cobicistat)</td>
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</tr>
<tr>
<td><strong>ENTRY INHIBITORS – CCR5 CO-RECEPTOR ANTAGONISTS</strong></td>
<td></td>
<td>SELZENTRY (maraviroc)</td>
<td></td>
</tr>
<tr>
<td><strong>ENTRY INHIBITORS – FUSION INHIBITORS</strong></td>
<td></td>
<td>FUZEON (enfuvirtide)</td>
<td></td>
</tr>
<tr>
<td><strong>COMBINATION PRODUCTS - NRTIs</strong></td>
<td></td>
<td>abacavir/lamivudine/zidovudine</td>
<td></td>
</tr>
<tr>
<td>EPZICOM (abacavir/lamivudine)</td>
<td>COMBIVIR (lamivudine/zidovudine)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>lamivudine/zidovudine</td>
<td>TRIZIVIR (abacavir/lamivudine/zidovudine)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>COMBINATION PRODUCTS – NUCLEOSIDE &amp; NUCLEOTIDE ANALOG RTIs</strong></td>
<td>DESCOVY (emtricitabine/tenofovir)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TRUVADA (emtricitabine/tenofovir)</td>
<td><strong>COMBINATION PRODUCTS – NUCLEOSIDE &amp; NUCLEOTIDE ANALOGS &amp; INTEGRASE INHIBITORS</strong></td>
<td><strong>STRIIBILD</strong> (elvitegravir/cobicistat/emtricitabine/tenofovir)</td>
<td>* Stribild requires medical reasoning beyond convenience or enhanced compliance as to why the medical need cannot be met with the preferred agent Genvoya.</td>
</tr>
<tr>
<td></td>
<td>TRIUMEQ (abacavir/lamivudine/ dolutegravir)**</td>
<td><strong>TРИУМЕК</strong> (abacavir/lamivudine/ dolutegravir)**</td>
<td>** Truumeq requires medical reasoning beyond convenience or enhanced compliance as to why the medical need cannot be met with the preferred agents Epzicom and Tivicay.</td>
</tr>
<tr>
<td><strong>COMBINATION PRODUCTS – NUCLEOSIDE &amp; NUCLEOTIDE ANALOGS &amp; NON-NUCLEOSIDE RTIs</strong></td>
<td><strong>ATRIPLA</strong> (efavirenz/emtricitabine/tenofovir)</td>
<td>COMPLERA (emtricitabine/rilpivirine/tenofovir)*</td>
<td>* Complera requires medical reasoning beyond convenience or enhanced compliance as to why the medical need cannot be met with the preferred agents Truvada and Edurant.</td>
</tr>
<tr>
<td></td>
<td>ODEFSEY (emtricitabine/rilpivirine/tenofovir)**</td>
<td><strong>Одефсей</strong> (emtricitabine/rilpivirine/tenofovir)**</td>
<td>**Odefsey requires medical reasoning beyond convenience or enhanced compliance as to why the medical need cannot be met with the preferred agents Descovy and Edurant.</td>
</tr>
<tr>
<td><strong>COMBINATION PRODUCTS – PROTEASE INHIBITORS</strong></td>
<td>KALETRA (lopinavir/ritonavir)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Effective 07/01/2017
Version 2017.3c
### THERAPEUTIC DRUG CLASS

<table>
<thead>
<tr>
<th><strong>PREFERRED AGENTS</strong></th>
<th><strong>NON-PREFERRED AGENTS</strong></th>
<th><strong>PA CRITERIA</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ANTIVIRALS, ORAL</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CATEGORY PA CRITERIA:</strong> Five (5) day trials each of the preferred agents are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.</td>
<td></td>
<td></td>
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<tr>
<td><strong>ANTI HERPES</strong></td>
<td>famciclovir</td>
<td><strong>PA CRITERIA:</strong></td>
</tr>
<tr>
<td>acyclovir</td>
<td>FAMVIR (famciclovir)</td>
<td><strong>ANTIVALVIRAL</strong></td>
</tr>
<tr>
<td>valacyclovir</td>
<td>SITAVIG (acyclovir)</td>
<td><strong>PA CRITERIA:</strong></td>
</tr>
<tr>
<td></td>
<td>VALTREX (acyclovir)</td>
<td>Five (5) day trials each of the preferred agents are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.</td>
</tr>
<tr>
<td><strong>ANTI INFLUENZA</strong></td>
<td>FLUMADINE (rimantadine)</td>
<td><strong>PA CRITERIA:</strong></td>
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<tr>
<td>RELENZA (zanamivir)</td>
<td></td>
<td><strong>NON-PREFERRED AGENTS:</strong></td>
</tr>
<tr>
<td>TAMIFLU (oseltamivir)</td>
<td>oseltamivir</td>
<td><strong>PA CRITERIA:</strong></td>
</tr>
<tr>
<td></td>
<td>rimantadine</td>
<td>In addition to the Category Criteria: The anti-influenza agents will be authorized only for a diagnosis of influenza.</td>
</tr>
<tr>
<td><strong>ANTIVIRALS, TOPICAL</strong></td>
<td>ABREVA (docosanol)</td>
<td><strong>PA CRITERIA:</strong></td>
</tr>
<tr>
<td></td>
<td>acyclovir ointment</td>
<td><strong>NON-PREFERRED AGENTS:</strong></td>
</tr>
<tr>
<td><strong>BETA BLOCKERS</strong></td>
<td>DENAVIR (penciclovir)</td>
<td><strong>PA CRITERIA:</strong></td>
</tr>
<tr>
<td></td>
<td>ZOVIRAX OINTMENT (acyclovir)</td>
<td>Fourteen (14) day trials each of three (3) chemically distinct preferred agents, including the generic formulation of a requested non-preferred agent, are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.</td>
</tr>
<tr>
<td>acebutolol</td>
<td>BETAPACE (sotalol)</td>
<td><strong>BETA BLOCKERS</strong></td>
</tr>
<tr>
<td>atenolol</td>
<td>BYSTOLIC (nebivolol)</td>
<td><strong>PA CRITERIA:</strong></td>
</tr>
<tr>
<td>betaxolol</td>
<td>CORVARD (nadolol)</td>
<td>*Hemangeol will be authorized for the treatment of proliferating infantile hemangioma requiring systemic therapy.</td>
</tr>
<tr>
<td>bisoprolol</td>
<td>HEMANGEOL (propranolol)*</td>
<td><strong>NON-PREFERRED AGENTS:</strong></td>
</tr>
<tr>
<td>metoprolol</td>
<td>INDERAL LA (propranolol)</td>
<td><strong>PA CRITERIA:</strong></td>
</tr>
<tr>
<td>metoprolol ER</td>
<td>INDERAL XL (propranolol)</td>
<td><strong>NON-PREFERRED AGENTS:</strong></td>
</tr>
<tr>
<td>nadolol</td>
<td>INNOPRAN XL (propranolol)</td>
<td><strong>PA CRITERIA:</strong></td>
</tr>
<tr>
<td>pindolol</td>
<td>KERLONE (betaxolol)</td>
<td><strong>NON-PREFERRED AGENTS:</strong></td>
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<tr>
<td>propranolol</td>
<td>LEVATOL (penbutolol)</td>
<td><strong>PA CRITERIA:</strong></td>
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<tr>
<td>sotalol</td>
<td>LOPRESSOR (metoprolol)</td>
<td><strong>NON-PREFERRED AGENTS:</strong></td>
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<tr>
<td>timolol</td>
<td>propranolol ER**</td>
<td><strong>PA CRITERIA:</strong></td>
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<tr>
<td></td>
<td>SECTRAL (acebutolol)</td>
<td><strong>NON-PREFERRED AGENTS:</strong></td>
</tr>
<tr>
<td></td>
<td>TENORMIN (atenolol)</td>
<td><strong>PA CRITERIA:</strong></td>
</tr>
<tr>
<td></td>
<td>TOPROL XL (metoprolol)</td>
<td><strong>NON-PREFERRED AGENTS:</strong></td>
</tr>
<tr>
<td></td>
<td>ZEBETA (bisoprolol)</td>
<td><strong>PA CRITERIA:</strong></td>
</tr>
</tbody>
</table>

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*Hemangeol will be authorized for the treatment of proliferating infantile hemangioma requiring systemic therapy.

**Propranolol ER shall be authorized for patients with a diagnosis of migraines. Existing users will be grandfathered for use in migraine prophylaxis.
# Therapeutic Drug Class

<table>
<thead>
<tr>
<th>Preferred Agents</th>
<th>Non-Preferred Agents</th>
<th>PA Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Beta Blocker/Diuretic Combination Drugs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>atenolol/chlorthalidone</td>
<td>CORZIDE (nadolol/bendroflumethiazide)</td>
<td></td>
</tr>
<tr>
<td>bisoprolol/HCTZ</td>
<td>DUTOPROL (metoprolol ER/HCTZ ER)</td>
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<tr>
<td>metoprolol/HCTZ</td>
<td>LOPRESSOR HCT (metoprolol/HCTZ)</td>
<td></td>
</tr>
<tr>
<td>nadolol/bendroflumethiazide</td>
<td>metoprolol/HCTZ ER&lt;sup&gt;RR&lt;/sup&gt;</td>
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</tr>
<tr>
<td>propranolol/HCTZ</td>
<td>TENORETIC (atenolol/chlorthalidone)</td>
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</tr>
<tr>
<td></td>
<td>ZIAC (bisoprolol/HCTZ)</td>
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<tr>
<td><strong>Beta- and Alpha-Blockers</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>carvedilol</td>
<td>COREG (carvedilol)</td>
<td></td>
</tr>
<tr>
<td>labetalol</td>
<td>COREG CR (carvedilol)</td>
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<td></td>
<td>TRANDATE (labetalol)</td>
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</tr>
<tr>
<td><strong>Bladder Relaxant Preparations</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CATEGORY PA CRITERIA: A thirty (30) day trial of each chemically distinct preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.</td>
<td></td>
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</tr>
<tr>
<td>oxybutynin IR</td>
<td>DETROL (tolterodine)</td>
<td></td>
</tr>
<tr>
<td>oxybutynin ER</td>
<td>DETROL LA (tolterodine)</td>
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</tr>
<tr>
<td>VESICARE (solifenacin)</td>
<td>DITROPAI XL (oxybutynin)</td>
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</tr>
<tr>
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<td>ENABLEX (darifenacin)</td>
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<tr>
<td></td>
<td>flavoxate</td>
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<tr>
<td></td>
<td>GELNIQUE (oxybutynin)</td>
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<tr>
<td></td>
<td>MYRBEETIQ (mirabegron)</td>
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<tr>
<td></td>
<td>OXYTROL (oxybutynin)</td>
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<td></td>
<td>SANCTURA (tropium)</td>
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<tr>
<td></td>
<td>SANCTURA XR (tropium)</td>
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<td></td>
<td>tolterodine</td>
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<tr>
<td></td>
<td>tolterodine ER</td>
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<tr>
<td></td>
<td>TOVIAZ (fesoterodine)</td>
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<tr>
<td></td>
<td>trospium</td>
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<tr>
<td></td>
<td>trospium ER</td>
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<tr>
<td><strong>Bone Resorption Suppression and Related Agents</strong></td>
<td></td>
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</tr>
<tr>
<td>CATEGORY PA CRITERIA: A thirty (30) day trial of the preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.</td>
<td></td>
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</tr>
<tr>
<td>alendronate tablets</td>
<td>ACTONEL (risedronate)</td>
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<tr>
<td></td>
<td>ACTONEL WITH CALCIUM (risedronate/calcium)</td>
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<tr>
<td></td>
<td>alendronate solution</td>
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</tr>
<tr>
<td></td>
<td>ATELVIA (risedronate)</td>
<td></td>
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<tr>
<td></td>
<td>BINOSTO (alendronate)</td>
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</tr>
<tr>
<td></td>
<td>BONIVA (ibandronate)</td>
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</table>
**THERAPEUTIC DRUG CLASS**

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<tr>
<th>PREFERRED AGENTS</th>
<th>NON-PREFERRED AGENTS</th>
<th>PA CRITERIA</th>
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<tr>
<td>DIDRONEL (etidronate)</td>
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<tr>
<td>etidronate</td>
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<tr>
<td>FOSAMAX TABLETS (alendronate)</td>
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<tr>
<td>FOSAMAX PLUS D (alendronate/vitamin D)</td>
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</tr>
<tr>
<td>ibandronate</td>
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<tr>
<td>risedronate</td>
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**OTHER BONE RESORPTION SUPPRESSION AND RELATED AGENTS**

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<th>Drug</th>
<th>PA CRITERIA</th>
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</thead>
<tbody>
<tr>
<td>calcitonin</td>
<td>EVISTA (raloxifene)*</td>
</tr>
<tr>
<td></td>
<td>FORTEO (teriparatide)</td>
</tr>
<tr>
<td></td>
<td>FORTICAL (calcitonin)</td>
</tr>
<tr>
<td></td>
<td>MIACALCIN (calcitonin)</td>
</tr>
<tr>
<td></td>
<td>raloxifene</td>
</tr>
</tbody>
</table>

*Evista will be authorized for postmenopausal women with osteoporosis or at high risk for invasive breast cancer.

**BPH TREATMENTS**

**CATEGORY PA CRITERIA:** Thirty (30) day trials each of at least two (2) chemically distinct preferred agents, including the generic formulation of the requested non-preferred agent, are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.

**5-ALPHA-REDUCTASE (5AR) INHIBITORS**

<table>
<thead>
<tr>
<th>Drug</th>
<th>PA CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>finasteride</td>
<td>AVODART (dutasteride)</td>
</tr>
<tr>
<td></td>
<td>CIALIS 5 mg (tadalafil)</td>
</tr>
<tr>
<td></td>
<td>dutasteride</td>
</tr>
<tr>
<td></td>
<td>PROSCAR (finasteride)</td>
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</table>

**ALPHA BLOCKERS**

<table>
<thead>
<tr>
<th>Drug</th>
<th>PA CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>alfuzosin</td>
<td>CARDURA (doxazosin)</td>
</tr>
<tr>
<td>doxazosin</td>
<td>CARDURA XL (doxazosin)</td>
</tr>
<tr>
<td>tamsulosin</td>
<td>FLOMAX (tamsulosin)</td>
</tr>
<tr>
<td>terazosin</td>
<td>HYTRIN (terazosin)</td>
</tr>
<tr>
<td></td>
<td>RAPAFLO (silodosin)</td>
</tr>
<tr>
<td></td>
<td>UROXATRAL (alfuzosin)</td>
</tr>
<tr>
<td>dutasteride/tamsulosin</td>
<td>Substitute for Category Criteria: Concurrent thirty (30) day trials of dutasteride and tamsulosin are required before the non-preferred agent will be authorized.</td>
</tr>
</tbody>
</table>

**BRONCHODILATORS, BETA AGONIST**

**CATEGORY PA CRITERIA:** Thirty (30) day trials each of the chemically distinct preferred agents in their corresponding groups are required before a non-preferred agent in that group will be authorized unless one (1) of the exceptions on the PA form is present.

**INHALATION SOLUTION**

<table>
<thead>
<tr>
<th>Drug</th>
<th>PA CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>albuterol</td>
<td>BROVANA (arformoterol)</td>
</tr>
<tr>
<td></td>
<td>levalbuterol</td>
</tr>
<tr>
<td></td>
<td>metaproterenol</td>
</tr>
<tr>
<td></td>
<td>PERFOROMIST (formoterol)</td>
</tr>
<tr>
<td></td>
<td>XOPENEX (levalbuterol)</td>
</tr>
</tbody>
</table>

*No PA is required for Accuneb for children up to five (5) years of age.
**BUREAU FOR MEDICAL SERVICES**  
**WEST VIRGINIA MEDICAID**  
**PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA**

This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

**EFFECTIVE**  
**07/01/2017**  
**Version 2017.3c**

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### THERAPEUTIC DRUG CLASS

#### PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA
---|---|---
**INHALERS, LONG-ACTING**
FORADIL (formoterol)  
SEREVENT (salmeterol) | ARCAPTA (indacaterol maleate)  
STRIVERDI RESPIMAT (olodaterol) |  
**INHALERS, SHORT-ACTING**
PROAIR HFA (albuterol)  
PROVENTIL HFA (albuterol) | MAXAIR (pirbuterol)  
PROAIR RESPICLICK (albuterol)  
VENTOLIN HFA (albuterol)  
XOPENEX HFA (levalbuterol) | Xopenex Inhalation Solution will be authorized for twelve (12) months for a diagnosis of asthma or COPD for patients on concurrent asthma controller therapy (either oral or inhaled) with documentation of failure on a trial of albuterol or documented intolerance of albuterol, or for concurrent diagnosis of heart disease.

#### ORAL
albuterol IR, ER  
terbutaline | metaproterenol  
VOSPIRE ER (albuterol) |  
**CALCIUM CHANNEL BLOCKERS**
CATEGORY PA CRITERIA: A fourteen (14) day trial of each preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.

#### LONG-ACTING
amlodipine  
diltiazem ER  
felodipine ER  
nifedipine ER  
verapamil ER | ADALAT CC (nifedipine)  
CALAN SR (verapamil)  
CARDENE SR (nicardipine)  
CARDIZEM CD, LA (diltiazem)  
COVERA-HS (verapamil)  
diltiazem LA  
DYNACIRC CR (isradipine)  
ISOPTIN SR (verapamil)  
MATZIM LA (diltiazem)  
nisoldipine  
NORVASC (amlodipine)  
PLENDIL (felodipine)  
PROCARDIA XL (nifedipine)  
SULAR (nisoldipine)  
TIAZAC (diltiazem)  
verapamil ER PM  
VERELAN/VERELAN PM (verapamil) |  
**SHORT-ACTING**
diltiazem  
verapamil | CALAN (verapamil)  
CARDIZEM (diltiazem)  
isradipine  
nicardipine |
**Therapeutic Drug Class**

<table>
<thead>
<tr>
<th>Preferred Agents</th>
<th>Non-Preferred Agents</th>
<th>PA Criteria</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>nifedipine</td>
<td></td>
</tr>
<tr>
<td></td>
<td>nimodipine</td>
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<tr>
<td></td>
<td>NIMOTOP (nimodipine)</td>
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<td></td>
<td>NYMALIZE SOLUTION (nimodipine)</td>
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<tr>
<td></td>
<td>PROCARDIA (nifedipine)</td>
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</tbody>
</table>

**Cephalosporins and Related Antibiotics**

**Category PA Criteria:** A five (5) day trial of the preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.

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<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>CEFTIN (cefuroxime)</td>
<td>CEFTRIAXONE (ceftiraxone)</td>
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<tr>
<td>CEFDINIR (cefadroxil)</td>
<td>CEFDINIR (cefadroxil)</td>
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<td>CEFDITOR (cefditor)</td>
<td>CEFDITOR (cefditor)</td>
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<td>CEFPODOXIME (cefodoxime)</td>
<td>CEFPODOXIME (cefodoxime)</td>
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<td>CEF PERTURO (cefperturo)</td>
<td>CEF PERTURO (cefperturo)</td>
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**Beta Lactams and Beta Lactam/Beta-Lactamase Inhibitor Combinations**

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<thead>
<tr>
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<tbody>
<tr>
<td>amoxicillin/clavulanate IR</td>
<td>amoxicillin/clavulanate ER</td>
<td>AUGMENTIN (amoxicillin/clavulanate)</td>
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<td></td>
<td></td>
<td>AUGMENTIN XR (amoxicillin/clavulanate)</td>
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<td></td>
<td></td>
<td>MOXATAG (amoxicillin)</td>
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</table>

**Cephalosporins**

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<table>
<thead>
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<tbody>
<tr>
<td>cefaclor capsule</td>
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<tr>
<td>cefadroxil capsule, tablet</td>
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<td>cefdinir</td>
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<tr>
<td>cefuroxime tablet</td>
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<tr>
<td>cephalaxin capsule, suspension</td>
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<td>CEDAX (ceftibuten)</td>
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<td>cefaclor suspension</td>
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<td>cefaclor ER tablet</td>
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<td>cefadroxil suspension</td>
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<td>cefpodoxime</td>
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</table>

**Colony Stimulating Factors**

**Category PA Criteria:** A thirty (30) day trial of one (1) of the preferred agents is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>GRANIX (tbo-filgrastim)</td>
<td>NEULASTA (pegfilgrastim)</td>
<td></td>
</tr>
<tr>
<td>LEUKINE (sargramostim)</td>
<td>ZARXIO (filgrastim)</td>
<td></td>
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<tr>
<td>NEUPOGEN (filgrastim)</td>
<td></td>
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</tr>
</tbody>
</table>
**THERAPEUTIC DRUG CLASS**

### COPD AGENTS

**CATEGORY PA CRITERIA:** A thirty (30) day trial of a preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.

<table>
<thead>
<tr>
<th>THERAPEUTIC DRUG CLASS</th>
<th>PREFERRED AGENTS</th>
<th>NON-PREFERRED AGENTS</th>
<th>PA CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ANTICHOLINERGIC</strong>AP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ipratropium</td>
<td>ATROVENT HFA (ipratropium)</td>
<td>Substitute for Category Criteria: A thirty (30) day trial of tiotropium is required before a non-preferred agent will be authorized.</td>
<td></td>
</tr>
<tr>
<td>SPIRIVA (tiotropium)</td>
<td>INCRUSE ELLIPTA (umeclidinium)</td>
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<tr>
<td></td>
<td>SPIRIVA RESPIMAT (tiotropium)</td>
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<tr>
<td></td>
<td>TUDORZA (aclidinium)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>ANTICHOLINERGIC-BETA AGONIST COMBINATIONS</strong>AP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>albuterol/ipratropium</td>
<td>ANORO ELLIPTA (umeclidinium/vilanterol)*</td>
<td>*Anoro Ellipta and Stiolto Respimat will be authorized if the following criteria are met:</td>
<td></td>
</tr>
<tr>
<td>COMBIVENT RESPIMAT (albuterol/ipratropium)</td>
<td>BEVESPI (glycopyrrolate/formoterol)</td>
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<tr>
<td></td>
<td>DUONEB (albuterol/ipratropium)</td>
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<tr>
<td></td>
<td>STIOLTO RESPIMAT (tiotropium/olodaterol)*</td>
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<tr>
<td></td>
<td>*Daliresp will be authorized if the following criteria are met:</td>
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<tr>
<td></td>
<td>1. Patient is forty (40) years of age or older and</td>
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<tr>
<td></td>
<td>2. Diagnosis of severe chronic obstructive pulmonary disease (COPD) associated with chronic bronchitis and multiple exacerbations requiring systemic glucocorticoids in the preceding six (6) months and</td>
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<td></td>
<td>3. Concurrent therapy with an inhaled corticosteroid and long-acting bronchodilator and evidence of compliance and</td>
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<td></td>
<td>4. No evidence of moderate to severe liver impairment (Child-Pugh Class B or C) and</td>
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<td></td>
<td>5. No concurrent use with strong cytochrome P450 inducers (rifampicin, phenobarbital, carbamazepine or phenytoin)</td>
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</tbody>
</table>

**PDE4 INHIBITOR**

<table>
<thead>
<tr>
<th>THERAPEUTIC DRUG CLASS</th>
<th>PREFERRED AGENTS</th>
<th>NON-PREFERRED AGENTS</th>
<th>PA CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>DALIRESP (roflumilast)*</td>
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</tbody>
</table>
**BUREAU FOR MEDICAL SERVICES**  
**WEST VIRGINIA MEDICAID**  
**PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA**  
This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

**EFFECTIVE**  
07/01/2017  
Version 2017.3c

**THERAPEUTIC DRUG CLASS**

<table>
<thead>
<tr>
<th>THERAPEUTIC DRUG CLASS</th>
<th>PREFERRED AGENTS</th>
<th>NON-PREFERRED AGENTS</th>
<th>PA CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>CYTOKINE &amp; CAM ANTAGONISTS&lt;sup&gt;CL&lt;/sup&gt;</td>
<td></td>
<td></td>
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<tr>
<td>CATEGORY PA CRITERIA:</td>
<td>Non-preferred agents require ninety (90) day trials of both Humira and Enbrel unless one (1) of the exceptions on the PA form is present. For FDA-approved indications, an additional ninety (90) day trial of Cosentyx will also be required.</td>
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<tr>
<td><strong>ANTI-TNFs</strong></td>
<td></td>
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<tr>
<td>ENBREL (etanercept)*</td>
<td>CIMZIA (certolizumab pegol)</td>
<td></td>
<td>* Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.</td>
</tr>
<tr>
<td>HUMIRA (adalimumab)*</td>
<td>SIMPONI (golimumab)</td>
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<tr>
<td><strong>OTHERS</strong></td>
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</tr>
<tr>
<td>COSENTYX (secukinumab)*</td>
<td>ACTEMRA syringe (tocilizumab)</td>
<td></td>
<td>*Cosentyx will be authorized for treatment of plaque psoriasis, psoriatic arthritis and ankylosing spondylitis only after inadequate response to a ninety (90) day trial of Humira.</td>
</tr>
<tr>
<td></td>
<td>ILARIS (canakinumab)&lt;sup&gt;NR&lt;/sup&gt;</td>
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<tr>
<td></td>
<td>KINERET (anakinra)</td>
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<td></td>
<td>ORENCIA syringe (abatacept)</td>
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<td></td>
<td>OTEZLA (apremilast)</td>
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<td></td>
<td>STELARA Subcutaneous syringe (ustekinumab)</td>
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<td>TALTZ (ixekizumab)</td>
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<td></td>
<td>XELJANZ (tofacitinib)</td>
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<td></td>
<td>XELJANZ XR (tofacitinib)</td>
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<tr>
<td><strong>EPINEPHRINE, SELF-INJECTED</strong></td>
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<tr>
<td>CATEGORY PA CRITERIA:</td>
<td>A non-preferred agent will be authorized upon documentation showing the patient’s inability to follow the instructions, or the patient’s failure to understand the training for both preferred agents.</td>
<td></td>
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</tr>
<tr>
<td>epinephrine (generic ADRENACLICK – labeler 54505 and 00115)</td>
<td>ADRENACLICK (epinephrine) epinephrine (generic EPIPEN – labeler 49502)&lt;sup&gt;NR&lt;/sup&gt;</td>
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<td></td>
<td>EPIPEN (epinephrine) EPIPEN JR (epinephrine)</td>
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<tr>
<td><strong>ERYTHROPOIESIS STIMULATING PROTEINS&lt;sup&gt;CL&lt;/sup&gt;</strong></td>
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<tr>
<td>CATEGORY PA CRITERIA:</td>
<td>A thirty (30) day trial of the preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.</td>
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<tr>
<td>PROCRIT (rHuEPO)</td>
<td>ARANESP (darbepoetin) EPOGEN (rHuEPO)</td>
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</table>

Erythropoiesis agents will be authorized if the following criteria are met:
1. Hemoglobin or Hematocrit less than 10/30 respectively. For renewal, hemoglobin or hematocrit levels greater than 12/36 will require dosage reduction or discontinuation. Exceptions will be considered on an individual basis after medical documentation is reviewed. (Lab oratory values must be dated within six (6) weeks of request.) and
**FLUOROQUINOLONES (Oral)**

<table>
<thead>
<tr>
<th>THERAPEUTIC DRUG CLASS</th>
<th>PREFERRED AGENTS</th>
<th>NON-PREFERRED AGENTS</th>
<th>PA CRITERIA</th>
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<tbody>
<tr>
<td><strong>PA CRITERIA</strong></td>
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<td>2. Transferrin saturation ≥ 20%, ferritin levels ≥100 mg/ml, or on concurrent therapeutic iron therapy. (Laboratory values must be dated within three (3) weeks of request. For re-authorization, transferrin saturation or ferritin levels are not required if the patient has been responsive to the erythropoietin agent and 3. For HIV-infected patients, endogenous serum erythropoietin level must be ≤ 500mU/ml to initiate therapy and 4. No evidence of untreated GI bleeding, hemolysis, or Vitamin B-12, iron or folate deficiency.</td>
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<tr>
<td>FLUOROQUINOLONES (Oral)**AP</td>
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<tr>
<td><strong>CATEGORY PA CRITERIA:</strong></td>
<td>A five (5) day trial of a preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.</td>
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<tr>
<td>CIPRO SUSPENSION (ciprofloxacin)</td>
<td>AVELOX (moxifloxacin)</td>
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<tr>
<td>ciprofloxacin</td>
<td>CIPRO TABLETS (ciprofloxacin)</td>
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<tr>
<td>levofloxacin tablet</td>
<td>CIPRO XR (ciprofloxacin)</td>
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<td>ciprofloxacin ER</td>
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<td>ciprofloxacin suspension</td>
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<td>FACTIVE (gemifloxacin)</td>
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<td></td>
<td>LEVAQUIN (levofloxacin)</td>
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<td></td>
<td>levofloxacin solution</td>
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<td></td>
<td>moxifloxacin</td>
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<td></td>
<td>NOROXIN (norfloxacin)</td>
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<td>ofloxacin</td>
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**GLUCOCORTICOIDS, INHALED**

**PA CRITERIA:** Thirty (30) day trials of each of the preferred agents are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.

<table>
<thead>
<tr>
<th>THERAPEUTIC DRUG CLASS</th>
<th>PREFERRED AGENTS</th>
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<tbody>
<tr>
<td><strong>GLUCOCORTICOIDS</strong></td>
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<tr>
<td>ASMANEX TWISTHALER (mometasone)</td>
<td>AEROSPAN (flunisolide)**</td>
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<tr>
<td>FLOVENT HFA (fluticasone)</td>
<td>ALVESCO (ciclesonide)</td>
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<tr>
<td>FLOVENT DISKUS (fluticasone)</td>
<td>ARNUITY ELLIPTA (fluticasone)</td>
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<tr>
<td>PULMICORT RESPULES (budesonide)**</td>
<td>ASMANEX HFA (mometasone)</td>
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<tr>
<td>QVAR (beclomethasone)</td>
<td>budesonide</td>
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<tr>
<td>PULMICORT FLEXHALER (budesonide)</td>
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<td></td>
<td>* Pulmicort Respules are preferred for children up to nine (9) years of age.</td>
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<td>* Brand Pulmicort Respules are preferred over the generic formulation.</td>
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<td></td>
<td>* Pulmicort Respules may be prior authorized in children and adults nine (9) years of age and older for severe nasal polyps.</td>
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<td></td>
<td>**Aerospan will be authorized for children ages 6 through 11 years old without a trial of a preferred agent.</td>
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</tbody>
</table>

**Note:**
- The document refers to the Bureau for Medical Services and West Virginia Medicaid Preferred Drug List with Prior Authorization Criteria. It is not an all-inclusive list and includes only managed categories. Refer to the cover page for the complete list of rules governing this PDL.
**THERAPEUTIC DRUG CLASS**

<table>
<thead>
<tr>
<th>PREFERRED AGENTS</th>
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<th>PA CRITERIA</th>
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<tbody>
<tr>
<td>GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS</td>
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**GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS**

<table>
<thead>
<tr>
<th>Preferred Drug</th>
<th>Non-Preferred Drug</th>
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</thead>
<tbody>
<tr>
<td>ADVAIR DISKUS (fluticasone/salmeterol)</td>
<td></td>
</tr>
<tr>
<td>ADVAIR HFA (fluticasone/salmeterol)</td>
<td></td>
</tr>
<tr>
<td>BREO ELLIPTA (fluticasone/vilanerol)</td>
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</tr>
<tr>
<td>DULERA (mometasone/formoterol)</td>
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<tr>
<td>SYMBICORT (budesonide/formoterol)</td>
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</tbody>
</table>

| Substitute for Category Criteria: | For a diagnosis of COPD, thirty (30) day trials of each of the preferred agents in this category indicated for COPD are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. |

### GROWTH HORMONE

**CATEGORY PA CRITERIA:** A trial of each preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.

<table>
<thead>
<tr>
<th>Preferred Drug</th>
<th>Non-Preferred Drug</th>
</tr>
</thead>
<tbody>
<tr>
<td>GENOTROPIN (somatropin)</td>
<td></td>
</tr>
<tr>
<td>NORDITROPIN (somatropin)</td>
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<tr>
<td>NUTROPIN AQ (somatropin)</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Preferred Drug</th>
<th>Non-Preferred Drug</th>
</tr>
</thead>
<tbody>
<tr>
<td>HUMATROPE (somatropin)</td>
<td></td>
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<tr>
<td>INCRELEX (mecasermin)</td>
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<tr>
<td>OMNITROPE (somatropin)</td>
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<tr>
<td>SAIZEN (somatropin)</td>
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<tr>
<td>SEROSTIM (somatropin)</td>
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<tr>
<td>TEV-TROPIN (somatropin)</td>
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<tr>
<td>ZORBTIVE (somatropin)</td>
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</tbody>
</table>

| Patients already on a non-preferred agent will receive authorization to continue therapy on that agent for the duration of the existing PA. |

### H. PYLORI TREATMENT

**CATEGORY PA CRITERIA:** A trial of the preferred agent or individual preferred components of the non-preferred agent (with omeprazole or pantoprazole) at the recommended dosages, frequencies and duration is required before the brand name combination packages will be authorized unless one (1) of the exceptions on the PA form is present.

<table>
<thead>
<tr>
<th>Preferred Drug</th>
<th>Non-Preferred Drug</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please use individual dosages:</td>
<td></td>
</tr>
<tr>
<td>preferred PPI (omeprazole or pantoprazole)</td>
<td></td>
</tr>
<tr>
<td>amoxicillin</td>
<td></td>
</tr>
<tr>
<td>tetracycline</td>
<td></td>
</tr>
<tr>
<td>metronidazole</td>
<td></td>
</tr>
<tr>
<td>clarithromycin</td>
<td></td>
</tr>
<tr>
<td>bismuth</td>
<td></td>
</tr>
<tr>
<td>HELIDAC (bismuth/metronidazole/tetracycline)</td>
<td></td>
</tr>
<tr>
<td>lansoprazole/amoxicillin/clarithromycin</td>
<td></td>
</tr>
<tr>
<td>OMECLAMOX-PAK (omeprazole/amoxicillin/clarithromycin)</td>
<td></td>
</tr>
<tr>
<td>PREVPAC (lansoprazole/amoxicillin/clarithromycin)</td>
<td></td>
</tr>
<tr>
<td>PYLERA (bismuth/metronidazole/tetracycline)</td>
<td></td>
</tr>
</tbody>
</table>

### HEPATITIS B TREATMENTS

**CATEGORY PA CRITERIA:** A thirty (30) day trial of the preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.

<table>
<thead>
<tr>
<th>Preferred Drug</th>
<th>Non-Preferred Drug</th>
</tr>
</thead>
<tbody>
<tr>
<td>BARACLUBE (entecavir)</td>
<td></td>
</tr>
<tr>
<td>lamivudine HBV</td>
<td></td>
</tr>
<tr>
<td>TYZEKA (telbivudine)</td>
<td></td>
</tr>
<tr>
<td>adeovir</td>
<td></td>
</tr>
<tr>
<td>entecavir</td>
<td></td>
</tr>
<tr>
<td>EPIVIR HBV (lamivudine)</td>
<td></td>
</tr>
<tr>
<td>HEPBSERA (adefovir)</td>
<td></td>
</tr>
<tr>
<td>VEMLIDY (tenofovir alafenamide fumarate)</td>
<td></td>
</tr>
</tbody>
</table>

**NR**
This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

<table>
<thead>
<tr>
<th>THERAPEUTIC DRUG CLASS</th>
<th>PREFERRED AGENTS</th>
<th>NON-PREFERRED AGENTS</th>
<th>PA CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HEPATITIS C TREATMENTS</strong>&lt;sup&gt;GL&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CATEGORY PA CRITERIA:</strong> For patients starting therapy in this class, a trial of the preferred agent of a dosage form is required before a non-preferred agent of that dosage form will be authorized.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EPCLUSA (sofosbuvir/velpatasvir)*</td>
<td>COPEGUS (ribavirin)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HARVONI (ledipasvir/sofosbuvir)*</td>
<td>DAKLINZA (daclatasvir)*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PEGASYS (pegylated interferon)</td>
<td>MODERIBA 400 mg, 600 mg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PEG-INTRON (pegylated interferon)</td>
<td>MODERIBA DOSE PACK</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ribavirin</td>
<td>OLYSIO (simeprevir)*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SOVALDI (sofosbuvir)*</td>
<td>REBETOL (ribavirin)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TECHNIVIE (ombitasvir/paritaprevir/ritonavir)*</td>
<td>RIBAPAK (ribavirin)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VIEKIRA PAK (dasabuvir/ombitasvir/paritaprevir/ritonavir)*</td>
<td>RIBASPHERE 400 mg, 600 mg (ribavirin)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VIEKIRA XR (dasabuvir/ombitasvir/paritaprevir/ritonavir)*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ZEPATIER (elbasvir/grazoprevir)*</td>
<td></td>
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<tr>
<td></td>
<td>* Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| **HYPERPARATHYROID AGENTS**<sup>AP</sup> | | | |
| **CATEGORY PA CRITERIA:** A thirty (30) day trial of all chemically unique preferred agents will be required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. | | | |
| doxercalciferol | HECTOROL (doxercalciferol) | | |
| paricalcitol capsule | paricalcitol injection | | |
| | RAYALDEE (calcifediol)<sup>NR</sup> | | |
| | SENSIAR (cinacalcet) | | |
| | ZEMPLAR (paricalcitol) | | |

| **HYPOGLYCEMICS, BIGUANIDES** | | | |
| **CATEGORY PA CRITERIA:** A ninety (90) day trial of one (1) preferred agent will be required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. | | | |
| metformin | FORTAMET (metformin ER) | | |
| metformin ER (generic Glucophage XR) | GLUCOPHAGE (metformin) | | |
| | GLUCOPHAGE XR (metformin ER) | | |
| | GLUMETZA (metformin ER) | | |
| | metformin ER (generic Glumetza & Fortamet) | | |
| | RIOMET (metformin) | | |
| | Glumetza will be approved only after a 30-day trial of Fortamet. | | |
# Therapeutic Drug Class

<table>
<thead>
<tr>
<th>Preferred Agents</th>
<th>Non-Preferred Agents</th>
<th>PA Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hypoglycemics, DPP-4 Inhibitors</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CATEGORY PA CRITERIA: Non-preferred agents are available only on appeal.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>NOTE:</strong> DPP-4 inhibitors will NOT be approved in combination with a GLP-1 agonist.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>JANUMET (sitagliptin/metformin)</td>
<td>alogliptin</td>
<td>*Symlin will be authorized with a history of bolus insulin utilization in the past ninety (90) days with no gaps in insulin therapy greater than thirty (30) days.</td>
</tr>
<tr>
<td>JANUVIA (sitagliptin)</td>
<td>alogliptin/metformin</td>
<td></td>
</tr>
<tr>
<td>JENTADUETO (linagliptin/metformin)</td>
<td>alogliptin/pioglitazone</td>
<td></td>
</tr>
<tr>
<td>TRADJENTA (linagliptin)</td>
<td>JANUMET XR (sitagliptin/metformin)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>JENTADUETO XR (linagliptin/metformin)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>KAZANO (alogliptin/metformin)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>KOMBIGLYZE XR (saxagliptin/metformin)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NESINA (alogliptin)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ONGLYZA (saxagliptin)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>OSENI (alogliptin/pioglitazone)</td>
<td></td>
</tr>
</tbody>
</table>

| **Hypoglycemics, GLP-1 Agonists** | | |
| CATEGORY PA CRITERIA: Patients with a starting A1C < 7% are not eligible for coverage. Non-preferred agents are available only on appeal. | | |
| **NOTE:** GLP-1 agents will NOT be approved in combination with a DPP-4 inhibitor. | | |
| Preferred agents in this class shall be approved in six (6) month intervals if the following criteria are met: | | |
| • Initial starts require a diagnosis of Type 2 Diabetes and an A1C taken within the last 30 days reflecting the patient’s current and stabilized regimen. Current A1C must be less than or equal to ≤ 9% | | |
| • No agent in this category shall be approved except as add on therapy to a regimen consisting of two other agents prescribed at the maximum tolerable doses for at least 90 days. | | |
| • Re-authorizations require continued maintenance on a regimen consisting of two other agents at the maximum tolerable doses AND an A1C of ≤8%. | | |
| BYDUREON (exenatide) | ADLYXIN (lixisenatide)* | In addition to the Category Criteria: A ninety (90) day trial of the corresponding (single drug vs. combination drug) preferred agent is required before a non-preferred agent will be approved. |
| BYETTA (exenatide) | SYMLIN (pramlintide)* |
| VICTOZA (liraglutide) | TANZEUM (albiglutide) |
| | TRULICITY (dulaglutide) |
**HYPOGLYCEMICS, INSULIN AND RELATED AGENTS**

**CATEGORY PA CRITERIA:** A ninety (90) day trial of a pharmacokinetically similar agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.

Humulin pens and Humalog Mix pens will be authorized only for patients who cannot utilize vials due to impaired vision or dexterity.

HUMALOG (insulin lispro)
HUMALOG MIX VIALS (insulin lispro/lispro protamine)
HUMULIN VIALS (insulin)
LANTUS (insulin glargine)
LEVEMIR (insulin detemir)
NOVOLOG (insulin aspart)
NOVOLOG MIX (insulin aspart/aspart protamine)

**PA CRITERIA:**

<table>
<thead>
<tr>
<th>PREFERRED AGENTS</th>
<th>NON-PREFERRED AGENTS</th>
<th>PA CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>AFREZZA (insulin)</td>
<td>HUMALOG PEN/KWIKPEN (insulin lispro)</td>
<td></td>
</tr>
<tr>
<td>APIDRA (insulin glulisine)</td>
<td>HUMALOG MIX VIALS (insulin lispro/lispro protamine)</td>
<td></td>
</tr>
<tr>
<td>BASAGLAR (insulin glargine)</td>
<td>HUMALOG MIX PENS (insulin lispro/lispro protamine)</td>
<td></td>
</tr>
<tr>
<td>HUMALOG PEN/KWIKPEN (insulin lispro)</td>
<td>HUMULIN PENS (insulin)</td>
<td></td>
</tr>
<tr>
<td>HUMULIN VIALS (insulin)</td>
<td>NOVOLIN (insulin)</td>
<td></td>
</tr>
<tr>
<td>LANTUS (insulin glargine)</td>
<td>SOLIQUA (insulin glargine/lixisenatide)</td>
<td></td>
</tr>
<tr>
<td>LEVEMIR (insulin detemir)</td>
<td>TRESIBA (insulin degludec)</td>
<td></td>
</tr>
<tr>
<td>NOVOLOG (insulin aspart)</td>
<td>XULTOPHY (insulin degludec/liraglutide)</td>
<td></td>
</tr>
<tr>
<td>NOVOLOG MIX (insulin aspart/aspart protamine)</td>
<td>*Apidra will be authorized if the following criteria are met:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Patient is four (4) years of age or older; <strong>and</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Patient is currently on a regimen including a longer acting or basal insulin, <strong>and</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Patient has had a trial of a similar preferred agent, Novolog or Humalog, with documentation that the desired results were not achieved.</td>
<td></td>
</tr>
</tbody>
</table>

**HYPOGLYCEMICS, MEGLITINIDES**

**CATEGORY PA CRITERIA:** Non-preferred agents are available only on appeal.

<table>
<thead>
<tr>
<th>MEGLITINIDES</th>
</tr>
</thead>
<tbody>
<tr>
<td>nateglinide</td>
</tr>
<tr>
<td>repaglinide</td>
</tr>
<tr>
<td>PRANDIN (repaglinide)</td>
</tr>
<tr>
<td>STARLIX (nateglinide)</td>
</tr>
</tbody>
</table>

**MEGLITINIDE COMBINATIONS**

<table>
<thead>
<tr>
<th>MEGLITINIDE COMBINATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRANDIMET (repaglinide/metformin)</td>
</tr>
<tr>
<td>repaglinide/metformin</td>
</tr>
</tbody>
</table>

**Tresiba U-100** will be authorized only for patients with a 6-month history of compliance on preferred long-acting insulin.

Tresiba U-200 and Toujeo Solostar will **only** be approved for patients with a 6-month history of compliance on preferred long-acting insulin who require once-daily doses of at least 60 units of insulin.

**All insulin combination products require that the patient must already be established on the individual agents at doses not exceeding the maximum dose achievable with the combination product.**

Soliqua is available only on appeal and requires medical reasoning beyond convenience or enhanced compliance as to why the clinical need cannot be met with a combination of preferred single-ingredient agents.
**BUREAU FOR MEDICAL SERVICES**  
**WEST VIRGINIA MEDICAID**  
**PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA**  
This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

### EFFECTIVE 07/01/2017  
Version 2017.3c

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## THERAPEUTIC DRUG CLASS

<table>
<thead>
<tr>
<th>PREFERRED AGENTS</th>
<th>NON-PREFERRED AGENTS</th>
<th>PA CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HYPOGLYCEMICS, BILE ACID SEQUESTRANTS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CATEGORY PA CRITERIA: Welchol will be authorized for add-on therapy for type 2 diabetes when there is a previous history of a thirty (30) day trial of an oral agent (sulfonylurea, thiazolidinedione (TZD) or metformin).</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| WELCHOL (colesevelam) | | |
| | | |

**HYPOGLYCEMICS, SGLT2 INHIBITORS**

**CATEGORY PA CRITERIA:** Preferred agents in this class shall be approved in six (6) month intervals if the following criteria are met:

- Initial starts require a diagnosis of Type 2 Diabetes and an A1C taken within the last 30 days reflecting the patient’s current and stabilized regimen. Current A1C must be less than or equal to ≤ 9%
- No agent in this category shall be approved except as add on therapy to a regimen consisting of two other agents prescribed at the maximum tolerable doses for at least 90 days.
- Re-authorizations require continued maintenance on a regimen consisting of two other agents at the maximum tolerable doses AND an A1C of ≤8%.

**NOTE:** Patients with a starting A1C < 7% are not eligible for coverage. Non-preferred agents are available only on appeal.

### SGLT2 INHIBITORS

- FARXIGA (dapagliflozin)
- INVOKANA (canagliflozin)
- JARDIANCE (empagliflozin)

### SGLT2 COMBINATIONS

- GLYXAMBI (empagliflozin/linagliptin)
- INVOKAMET (canagliflozin/metformin)
- INVOKAMET XR (canagliflozin/metformin)
- SYNJARDY (empagliflozin/metformin)
- XIGDUO XR (dapagliflozin/metformin)

### HYPOGLYCEMICS, TZD

**CATEGORY PA CRITERIA:** Non-preferred agents are available only on appeal.

### THIAZOLIDINEDIONES

- pioglitazone
- ACTOS (pioglitazone)
- AVANDIA (rosiglitazone)

### TZD COMBINATIONS

- ACTOPLUS MET (pioglitazone/ metformin)
- ACTOPLUS MET XR (pioglitazone/ metformin)
- AVANDAMET (rosiglitazone/metformin)
- AVANDARYL (rosiglitazone/glimepiride)
- DUETACT (pioglitazone/glimepiride)
- pioglitazone/glimepiride
- pioglitazone/ metformin

Patients are required to use the components of Actoplus Met and Duetact separately. Exceptions will be handled on a case-by-case basis.
# IMMUNE GLOBULINS, IV\textsuperscript{CL}

**CATEGORY PA CRITERIA:** Immune globulin agents will be authorized according to FDA approved indications.

- BIVIGAM (human immunoglobulin gamma)
- CARIMUNE NF (human immunoglobulin gamma)
- FLEBOGAMMA DIF (human immunoglobulin gamma)
- GAMMAGARD LIQUID (human immunoglobulin gamma)
- GAMMAGARD S-D (human immunoglobulin gamma)
- GAMMAKED (human immunoglobulin gamma)
- GAMMAPLEX (human immunoglobulin gamma)
- GAMUNEX-C (human immunoglobulin gamma)
- OCTAGAM (human immunoglobulin gamma)
- PRIVIGEN (human immunoglobulin gamma)

**IMMUNE GLOBULINS, OTHER\textsuperscript{CL}

**CATEGORY PA CRITERIA:** Immune globulin agents will be authorized according to FDA approved indications.

- CYTOGAM (human cytomegalovirus immune globulin)
- GAMASTAN S-D VIAL (human immunoglobulin gamma)
- HEPAGAM B (hepatitis b immune globulin (human))
- HIZENTRA (human immunoglobulin gamma)
- VARIZIG (varicella zoster immune globulin (human))
- HYQVIA (human immune globulin G and hyaluronidase)

# IMMUNOMODULATORS, ATOPIC DERMATITIS\textsuperscript{AP}

**CATEGORY PA CRITERIA:** A thirty (30) day trial of a preferred medium or high potency topical corticosteroid is required before coverage of Elidel will be considered; additionally, a thirty (30) day trial of Elidel is required before a non-preferred agent will be considered, unless one (1) of the exceptions on the PA form is present.

- ELIDEL (pimecrolimus)\textsuperscript{AP}
- PROTOPIC (tacrolimus) tacrolimus ointment

A thirty (30) day trial of a preferred medium or high potency topical corticosteroid is required before coverage of Elidel will be considered; additionally, a thirty (30) day trial of Elidel is required before Protopic will be considered, unless one (1) of the exceptions on the PA form is present.
## THERAPEUTIC DRUG CLASS

<table>
<thead>
<tr>
<th>IMMUNOMODULATORS, GENITAL WARTS &amp; ACTINIC KERATOSIS AGENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CATEGORY PA CRITERIA:</strong> A thirty (30) day trial of both preferred agents is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preferred Agents</th>
<th>Non-Preferred Agents</th>
<th>PA CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>CONDYLOX GEL (podofilox)</td>
<td>ALDARA (imiquimod)</td>
<td>*Zyclara will be authorized for a diagnosis of actinic keratosis.</td>
</tr>
<tr>
<td>EFUDEX (fluorouracil)</td>
<td>CARAC (fluorouracil)</td>
<td></td>
</tr>
<tr>
<td>imiquimod</td>
<td>CONDYLOX SOLUTION (podofilox)</td>
<td></td>
</tr>
<tr>
<td>diclofenac 3% gel</td>
<td>fluorouracil 0.5% cream</td>
<td></td>
</tr>
<tr>
<td>fluorouracil 5% cream</td>
<td>podofilox</td>
<td></td>
</tr>
<tr>
<td>SOLARAZE (diclofenac)</td>
<td>TOLAK (fluorouracil 4% cream)</td>
<td></td>
</tr>
<tr>
<td>VEREGEN (sinecatechins)</td>
<td>ZYCLARA (imiquimod)*</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>IMMUNOSUPPRESSIVES, ORAL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CATEGORY PA CRITERIA:</strong> A fourteen (14) day trial of a preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Preferred Agents</th>
<th>Non-Preferred Agents</th>
<th>PA CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>azathioprine</td>
<td>ASTAGRAF XL (tacrolimus)</td>
<td></td>
</tr>
<tr>
<td>cyclosporine</td>
<td>AZASAN (azathioprine)</td>
<td></td>
</tr>
<tr>
<td>cyclosporine, modified</td>
<td>CELLCEPT (mycophenolate mofetil)</td>
<td></td>
</tr>
<tr>
<td>mycophenolate mofetil</td>
<td>ENVARSUS XR (tacrolimus)</td>
<td></td>
</tr>
<tr>
<td>sirolimus</td>
<td>IMURAN (azathioprine)</td>
<td></td>
</tr>
<tr>
<td>tacrolimus capsule</td>
<td>mycophenolic acid</td>
<td></td>
</tr>
<tr>
<td></td>
<td>mycophenolic acid suspension</td>
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</tr>
<tr>
<td></td>
<td>MYFORTIC (mycophenolic acid)</td>
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</tr>
<tr>
<td></td>
<td>NEORAL (cyclosporine, modified)</td>
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<tr>
<td></td>
<td>PROGRAF (tacrolimus)</td>
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<tr>
<td></td>
<td>RAPAMUNE (sirolimus)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SANDIMMUNE (cyclosporine)</td>
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<td></td>
<td>ZORTRESS (everolimus)</td>
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</tbody>
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<table>
<thead>
<tr>
<th>INTRANASAL RHINITIS AGENTS<strong>AP</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CATEGORY PA CRITERIA:</strong> See below for individual sub-class criteria.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preferred Agents</th>
<th>Non-Preferred Agents</th>
<th>PA CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>ipratropium</td>
<td>ATROVENT(ipratropium)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Thirty (30) day trials each of one (1) of the nasal anti-cholinergic, one (1) of the antihistamine, and one (1) of the corticosteroid preferred agents are required before a non-preferred anti-cholinergic will be authorized unless one (1) of the exceptions on the PA form is present.</td>
</tr>
</tbody>
</table>
# THERAPEUTIC DRUG CLASS

## ANTIHISTAMINES

<table>
<thead>
<tr>
<th>PREFERRED AGENTS</th>
<th>NON-PREFERRED AGENTS</th>
<th>PA CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>azelastine PATANASE (olopatadine)</td>
<td>ASTEPRO (azelastine)</td>
<td>Thirty (30) day trials of each preferred intranasal antihistamines and a thirty (30) day trial of one (1) of the preferred intranasal corticosteroids are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.</td>
</tr>
</tbody>
</table>

## COMBINATIONS

<table>
<thead>
<tr>
<th>PREFERRED AGENTS</th>
<th>NON-PREFERRED AGENTS</th>
<th>PA CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>DYMISTA (azelastine / fluticasone)</td>
<td></td>
<td>A concurrent thirty (30) day trial of each of the preferred components is required before Dymista will be authorized unless one (1) of the exceptions on the PA form is present.</td>
</tr>
</tbody>
</table>

## CORTICOSTEROIDS

<table>
<thead>
<tr>
<th>PREFERRED AGENTS</th>
<th>NON-PREFERRED AGENTS</th>
<th>PA CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>fluticasone propionate QNASL HFA (beclomethasone)</td>
<td>BECONASE AQ (beclomethasone) budesonide FLONASE (fluticasone propionate) flunisolide NASACORT AQ (triamcinolone) NASONEX (mometasone) OMNARIS (ciclesonide) RHINOCORT AQUA (budesonide) triamcinolone VERAMYST (fluticasone furoate) ZETONNA (ciclesonide)</td>
<td>Thirty (30) day trials of each preferred agent in the corticosteroid group are required before a non-preferred corticosteroid agent will be authorized unless one (1) of the exceptions on the PA form is present.</td>
</tr>
</tbody>
</table>

## IRRITABLE BOWEL SYNDROME/SHORT BOWEL SYNDROME/SELECTED GI AGENTS

**CATEGORY PA CRITERIA:** Thirty (30) day trial of the preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.

<table>
<thead>
<tr>
<th>PREFERRED AGENTS</th>
<th>NON-PREFERRED AGENTS</th>
<th>PA CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMITIZA (lubiprostone) CL* LINZESS (linclotide) CL*</td>
<td>alosetron** FULYZAQ (crofelemer)* LOTRONEX (alosetron)** MOVANTIK (naloxegol)* RELISTOR INJECTION (methylnaltrexone)* RELISTOR TABLET (methylnaltrexone)* VIBERZI (eluxadoline)**</td>
<td>* Full PA criteria may be found on the <a href="#">PA Criteria</a> page by clicking the hyperlink. **For the indication of IBS-diarrhea, alosetron (Lotronex) and Viberzi have specific PA criteria which may be found on the <a href="#">PA Criteria</a> page by clicking the hyperlink.</td>
</tr>
</tbody>
</table>

## LAXATIVES AND CATHARTICS

**CATEGORY PA CRITERIA:** Thirty (30) day trial of each of the preferred agents are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.

<table>
<thead>
<tr>
<th>PREFERRED AGENTS</th>
<th>NON-PREFERRED AGENTS</th>
<th>PA CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>COLYTE GOLYTELY NULYTELY peg 3350</td>
<td>HALFLYTELY-BISACODYL KIT MOVIPREP OSMOPREP PREPOPIK SUPREP</td>
<td></td>
</tr>
</tbody>
</table>
## THERAPEUTIC DRUG CLASS

### LEUKOTRIENE MODIFIERS

**CATEGORY PA CRITERIA:** Thirty (30) day trials each of the preferred agents are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.

<table>
<thead>
<tr>
<th>PREFERRED AGENTS</th>
<th>NON-PREFERRED AGENTS</th>
<th>PA CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>montelukast</td>
<td>ACCOLATE (zafirlukast)</td>
<td></td>
</tr>
<tr>
<td>zafirlukast</td>
<td>SINGULAIR (montelukast)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ZYFLO (zileuton)</td>
<td></td>
</tr>
</tbody>
</table>

### LIPOTROPICS, OTHER (Non-statins)

**CATEGORY PA CRITERIA:** A twelve (12) week trial of one (1) of the preferred agents is required before a non-preferred agent in the corresponding category will be authorized.

### BILE ACID SEQUESTRANTS

<table>
<thead>
<tr>
<th>Cholesterol Absorption Inhibitors</th>
<th>Lipids from Fatty Acids</th>
<th>Fibrin Acid Derivatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>COLESTID (colestipol)</td>
<td>LIPOFIBRA (fenofibric acid)</td>
<td>ANTARA (fenofibrate)</td>
</tr>
<tr>
<td>colestipol granules</td>
<td>LOFIBRA (fenofibrate)</td>
<td>FENOGLIDE (fenofibrate)</td>
</tr>
<tr>
<td>KYNAMRO (mipomersen)</td>
<td>LOPID (gemfibrozil)</td>
<td>FIBRICOR (fenofibric acid)</td>
</tr>
<tr>
<td>QUESTRAN (cholestyramine)</td>
<td>TRICOR (fenofibrate nanocrystallized)</td>
<td>fenofibrate 40 mg</td>
</tr>
<tr>
<td>WELCHOL (colesevelam)**</td>
<td>TRIGLIDE (fenofibrate)</td>
<td>fenofibrate 54, 150 and 160 mg</td>
</tr>
</tbody>
</table>

*Kynamro requires a 24-week trial of Repatha.

**Welchol will be authorized for add-on therapy for type 2 diabetes when there is a previous history of a thirty (30) day trial of an oral agent (metformin, sulfonylurea or thiazolidinedione (TZD)). See HYPOGLYCEMICS, MISCELLANEOUS.

**These agents shall only be authorized when the patient has an initial triglyceride level ≥ 500 mg/dL and has had inadequate response or intolerance to trials of BOTH a nicotinic acid and a fibrate, unless otherwise contraindicated.

Zetia will be authorized with prior use of a HMG-CoA reductase inhibitor within the previous six (6) months.
BUREAU FOR MEDICAL SERVICES
WEST VIRGINIA MEDICAID
PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA
This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

EFFECTIVE
07/01/2017
Version 2017.3c

<table>
<thead>
<tr>
<th>THERAPEUTIC DRUG CLASS</th>
<th>PREFERRED AGENTS</th>
<th>NON-PREFERRED AGENTS</th>
<th>PA CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MTP INHIBITORS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>JUXTAPID (lomitapide)*</td>
<td></td>
<td></td>
<td>* Full PA criteria may be found on the <a href="#">PA Criteria</a> page by clicking the hyperlink.</td>
</tr>
</tbody>
</table>

| NIAIN                  | niacin           | niacin ER            |             |

| PCSK-9 INHIBITORS      | PRALUENT (alirocumab)* | REPATHA (evolocumab)* | * Full PA criteria may be found on the [PA Criteria](#) page by clicking the hyperlink. |

| LIPOTROPICS, STATINS*  |                  |                      |             |

| CATEGORY PA CRITERIA: | See below for individual sub-class criteria. |

<table>
<thead>
<tr>
<th>STATINS</th>
<th>ALTOPREV (lovastatin)</th>
<th>CRESTOR (rosuvastatin)</th>
<th>fluvastatin</th>
<th>fluvastatin ER</th>
<th>LESCOL (fluvastatin)</th>
<th>LESCOL XL (fluvastatin)</th>
<th>LIPITOR (atorvastatin)</th>
<th>LIVALO (pitavastatin)</th>
<th>MEVACOR (lovastatin)</th>
<th>PRAVACHOL (pravastatin)</th>
<th>ZOCOR (simvastatin)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>atorvastatin</td>
<td></td>
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<tr>
<td>lovastatin</td>
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<tr>
<td>pravastatin</td>
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<tr>
<td>rosvastatin</td>
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<td></td>
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<tr>
<td>simvastatin</td>
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</tbody>
</table>

Twelve (12) week trials each of two (2) of the preferred statins, including the generic formulation of a requested non-preferred agent, are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.

*Zocor/simvastatin 80mg tablets will require a clinical PA

<table>
<thead>
<tr>
<th>STATIN COMBINATIONS</th>
<th>ADVICOR (lovastatin/niacin)</th>
<th>amlodipine/atorvastatin</th>
<th>CADUET (atorvastatin/amlopidine)</th>
<th>LIPTRUZET (atorvastatin/ezetimibe)</th>
<th>SIMCOR (simvastatin/niacin ER)</th>
<th>VYTORIN (simvastatin/ezetimibe)*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

Thirty (30) day concurrent trials of the appropriate single agents are required before a non-preferred Statin combination will be authorized.

*Vytoring will be authorized only after an insufficient response to the maximum tolerable dose of atorvastatin or rosuvastatin after twelve (12) weeks, unless one (1) of the exceptions on the PA form is present.

Vytoring 80/10mg tablets will require a clinical PA
**THERAPEUTIC DRUG CLASS**

<table>
<thead>
<tr>
<th>MACROLIDES/KETOLIDES</th>
<th>NON-PREFERRED AGENTS</th>
<th>PA CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CATEGORY PA CRITERIA:</strong> See below for individual sub-class criteria.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**KETOLIDES**

- KETEK (telithromycin)

**MACROLIDES**

- azithromycin
- clarithromycin suspension
- erythromycin base

- BIAxin (clarithromycin)
- clarithromycin tablets
- clarithromycin ER
- E.E.S. (erythromycin ethylsuccinate)
- E-MYCIN (erythromycin)
- ERYC (erythromycin)
- ERYPED (erythromycin ethylsuccinate)
- ERY-TAB (erythromycin)
- ERYTHROCIN (erythromycin stearate)
- erythromycin estolate
- PCE (erythromycin)
- ZITHROMAX (azithromycin)
- ZMAX (azithromycin)

Requests for telithromycin will be authorized if there is documentation of the use of any antibiotic within the past twenty-eight (28) days.

Five (5) day trials each of the preferred agents are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.

**MULTIPLE SCLEROSIS AGENTS**

**CATEGORY PA CRITERIA:** Unless one (1) of the exceptions on the PA form is present, prior authorization of any non-preferred agent in this category requires a diagnosis of multiple sclerosis and thirty (30) day trials of all chemically unique preferred agents in the corresponding subclass from which the non-preferred agent is being selected (interferon or non-interferon). Additional criteria may still apply.

**INTERFERONS**

- AVONEX (interferon beta-1a)<sup>AP</sup>
- AVONEX PEN (interferon beta-1a)<sup>AP</sup>
- BETASERON (interferon beta-1b)<sup>AP</sup>
- EXTAVIA KIT (interferon beta-1b)
- EXTAVIA VIAL (interferon beta-1b)
- PLEGRIDY (peginterferon beta-1a)
- REBIF (interferon beta-1a)
- REBIF REBIDOSE (interferon beta-1a)

**NON-INTERFERONS**

- COPAXONE 20 mg (glatiramer)<sup>AP</sup>
- GILENYA (fingolimod)<sup>AP</sup>
- AMPYRA (dalfampridine)<sup>CL**</sup>
- AUBAGIO (teriflunomide)<sup>CL***</sup>
- COPAXONE 40 mg (glatiramer)<sup>CL****</sup>
- GLATOPA (glatiramer)
- TECFIDERA (dimethyl fumarate)<sup>CL*****</sup>
- ZINBRYTA (daclizumab)

In addition to category PA criteria, the following conditions and criteria also apply:

*Gilenya will be approved after a thirty (30) day trial of a preferred injectable agent.

**Ampyra will be authorized if the following criteria are met:
1. Diagnosis of multiple sclerosis and
2. No history of seizures and
**THERAPEUTIC DRUG CLASS**

<table>
<thead>
<tr>
<th>PREFERRED AGENTS</th>
<th>NON-PREFERRED AGENTS</th>
<th>PA CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>3. No evidence of moderate or severe renal impairment and 4. Initial prescription will be authorized for thirty (30) days only.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>***Aubagio will be authorized if the following criteria are met: 1. Diagnosis of relapsing multiple sclerosis and 2. Measurement of transaminase and bilirubin levels within the (6) months before initiation of therapy and ALT levels at least monthly for six (6) months after initiation of therapy and 3. Complete blood cell count (CBC) within six (6) months before initiation of therapy and 4. Female patients must have a negative pregnancy test before initiation of therapy and be established on a reliable method of contraception if appropriate and 5. Patient is from eighteen (18) up to sixty-five (65) years of age and 6. Negative tuberculin skin test before initiation of therapy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>****Copaxone 40mg will only be authorized for documented injection site issues.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>*****Tecfidera will be authorized if the following criteria are met: 1. Diagnosis of relapsing multiple sclerosis and 2. Complete blood count (CBC) annually during therapy.</td>
</tr>
</tbody>
</table>

**NEUROPATHIC PAIN**

CATEGORY PA CRITERIA: A trial of a preferred agent in the corresponding dosage form (oral or topical) will be required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.

<table>
<thead>
<tr>
<th>capsaicin OTC</th>
<th>CYMBALTA (duloxetine)</th>
<th>GLRIS (duloxetine)***</th>
</tr>
</thead>
<tbody>
<tr>
<td>duloxetine</td>
<td>gabapentin tablets</td>
<td>IREX (duloxetine)***</td>
</tr>
<tr>
<td>gabapentin capsules, solution</td>
<td>GRALISE (gabapentin)**</td>
<td>LIDODERM (lidocaine)</td>
</tr>
<tr>
<td>lidocaine patch</td>
<td>HORIZANT (gabapentin)</td>
<td>LYRICA CAPSULE (pregabalin)***</td>
</tr>
</tbody>
</table>

*lidocaine patches will be authorized for a diagnosis of post-herpetic neuralgia.**

**Gralise will be authorized if the following criteria are met: 1. Diagnosis of post herpetic neuralgia and 2. Trial of a tricyclic antidepressant for a least thirty (30) days and 3. Trial of gabapentin immediate release formulation (positive response without adequate duration) and
**THERAPEUTIC DRUG CLASS**

<table>
<thead>
<tr>
<th>PREFERRED AGENTS</th>
<th>NON-PREFERRED AGENTS</th>
<th>PA CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>QUTENZA (capsaicin)</td>
<td>SAVELLA (milnacipran)****</td>
<td>4. Request is for once daily dosing with 1800 mg maximum daily dosage.</td>
</tr>
<tr>
<td>SAVELLA (milnacipran)****</td>
<td>ZOSTRIX OTC (capsaicin)</td>
<td></td>
</tr>
<tr>
<td>4. Request is for once daily dosing with 1800 mg maximum daily dosage.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**NSAIDSAp**

**CATEGORY PA CRITERIA:** Thirty (30) day trials of each of the preferred agents are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.

<table>
<thead>
<tr>
<th>NON-SELECTIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>diclofenac (IR, SR)</td>
</tr>
<tr>
<td>flurbiprofen</td>
</tr>
<tr>
<td>ibuprofen (Rx and OTC)</td>
</tr>
<tr>
<td>INDOCIN SUSPENSION (indomethacin)</td>
</tr>
<tr>
<td>indomethacin</td>
</tr>
<tr>
<td>ketoprofen</td>
</tr>
<tr>
<td>ketorolac</td>
</tr>
<tr>
<td>meloxicam tablet</td>
</tr>
<tr>
<td>MOBIC SUSPENSION (meloxicam)</td>
</tr>
<tr>
<td>nabumetone</td>
</tr>
<tr>
<td>naproxen (Rx and OTC)</td>
</tr>
<tr>
<td>piroxicam</td>
</tr>
<tr>
<td>sulindac</td>
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<tr>
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</table>

****Lyrica will be authorized if the following criteria are met:
1. Diagnosis of seizure disorders or neuropathic pain associated with a spinal cord injury or
2. Diagnosis of fibromyalgia, postherpetic neuralgia, or diabetic neuropathy AND a history of a trial of duloxetine at the generally accepted maximum therapeutic dose of 60 mg/day OR gabapentin at a therapeutic dose range between 900 mg and 2,400 mg per day for thirty (30) days within the previous twenty-four (24) month period or an intolerance due to a potential adverse drug-drug interaction, drug-disease interaction, or intolerable side effect (In cases of renal impairment, doses may be adjusted based on the degree of impairment.)

****Savella will be authorized for a diagnosis of fibromyalgia or a previous thirty (30) day trial of a drug that infers fibromyalgia: duloxetine, gabapentin, amitriptyline or nortriptyline.
BUREAU FOR MEDICAL SERVICES  
WEST VIRGINIA MEDICAID  
PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA  
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**THERAPEUTIC DRUG CLASS**

<table>
<thead>
<tr>
<th>PREFERRED AGENTS</th>
<th>NON-PREFERRED AGENTS</th>
<th>PA CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>meloxicam suspension</td>
<td>MOBIC TABLET (meloxicam)</td>
<td>PA CRITERIA</td>
</tr>
<tr>
<td>MOTRIN (ibuprofen)</td>
<td>NALFON (fenoprofen)</td>
<td></td>
</tr>
<tr>
<td>NAPRELAN (naproxen)</td>
<td>NAPROSYN (naproxen)</td>
<td></td>
</tr>
<tr>
<td>naproxen CR</td>
<td>oxaprozin</td>
<td></td>
</tr>
<tr>
<td>PONSTEL (meclomenamate)</td>
<td>SPRIX (ketorolac)</td>
<td></td>
</tr>
<tr>
<td>TIVORBEX (indomethacin)</td>
<td>Tolmetin</td>
<td></td>
</tr>
<tr>
<td>VIVLODEX (meloxicam)</td>
<td>VOLTAREN (diclofenac)</td>
<td></td>
</tr>
<tr>
<td>VLODEX (meloxicam)</td>
<td>ZIPSOR (diclofenac potassium)</td>
<td></td>
</tr>
<tr>
<td>VOLTAREN (diclofenac)</td>
<td>ZORVOLEX (diclofenac)</td>
<td></td>
</tr>
</tbody>
</table>

**NSAID/GI PROTECTANT COMBINATIONS**

<table>
<thead>
<tr>
<th>NSAID/GI PROTECTANT COMBINATIONS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>ARTHROTEC (diclofenac/misoprostol)</td>
<td></td>
</tr>
<tr>
<td>diclofenac/misoprostol</td>
<td></td>
</tr>
<tr>
<td>VIMOVO (naproxen/esomeprazole)</td>
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</tbody>
</table>

**COX-II SELECTIVE**

<table>
<thead>
<tr>
<th>COX-II SELECTIVE</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>CELEBREX (celecoxib)</td>
<td></td>
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<tr>
<td>celecoxib</td>
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</tr>
</tbody>
</table>

COX-II Inhibitor agents will be authorized if the following criteria are met:

- Patient has a history or risk of a serious GI complication **or**
- Agent is requested for treatment of a chronic condition **and**
  1. Patient is seventy (70) years of age or older, **or**
  2. Patient is currently on anticoagulation therapy.

**TOPICAL**

<table>
<thead>
<tr>
<th>TOPICAL</th>
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</thead>
<tbody>
<tr>
<td>VOLTAREN GEL (diclofenac)*</td>
<td></td>
</tr>
<tr>
<td>diclofenac gel</td>
<td></td>
</tr>
<tr>
<td>diclofenac solution</td>
<td></td>
</tr>
<tr>
<td>FLECTOR PATCH (diclofenac)**</td>
<td></td>
</tr>
<tr>
<td>PENNSAID (diclofenac)</td>
<td></td>
</tr>
</tbody>
</table>

In addition to the Category Criteria: Thirty (30) day trials of each of the preferred oral NSAIDs are required before a topical NSAID gel or solution will be authorized unless one (1) of the exceptions on the PA form is present.

*Voltaren Gel will be authorized if the following criteria are met:
  1. Thirty (30) day trials of two (2) of the preferred oral NSAIDs, **or**
  2. The patient is on anticoagulant therapy **or**
  3. The patient has had a GI bleed or ulcer diagnosed in the last two (2) years.

Prior authorizations will be limited to 100 grams per month.
**OPHTHALMIC ANTIBIOTICS**

**CATEGORY PA CRITERIA:** Three (3) day trials of each of the preferred agents are required before non-preferred agents will be authorized unless one (1) of the exceptions on the PA form is present.

<table>
<thead>
<tr>
<th>PREFERRED AGENTS</th>
<th>NON-PREFERRED AGENTS</th>
<th>PA CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>bacitracin/polymyxin ointment</td>
<td>AZASITE (azithromycin)</td>
<td><strong>Flecto</strong>r patches will be authorized for a diagnosis of acute strain, sprain or injury after a five (5) day trial of one (1) of the preferred oral NSAIDs and for a maximum duration of fourteen (14) days unless one (1) of the exceptions on the PA form is present.</td>
</tr>
<tr>
<td>BESIVANCE (besifloxacin)*</td>
<td>bacitracin</td>
<td></td>
</tr>
<tr>
<td>ciprofloxacin*</td>
<td>BLEPH-10 (sulfacetamide)</td>
<td></td>
</tr>
<tr>
<td>erythromycin</td>
<td>CILOXAN (ciprofloxacin)</td>
<td></td>
</tr>
<tr>
<td>gentamicin</td>
<td>GARAMYCIN (gentamicin)</td>
<td></td>
</tr>
<tr>
<td>MOXEZA (moxifloxacin)*</td>
<td>gatifloxacin</td>
<td></td>
</tr>
<tr>
<td>ofloxacin*</td>
<td>ILOTYCIN (erythromycin)</td>
<td></td>
</tr>
<tr>
<td>polymyxin/trimethoprim</td>
<td>levofloxacin</td>
<td></td>
</tr>
<tr>
<td>tobramycin</td>
<td>NATACYN (natamycin)</td>
<td></td>
</tr>
<tr>
<td>VIGAMOX (moxifloxacin)*</td>
<td>neomycin/bacitracin/polymyxin</td>
<td></td>
</tr>
<tr>
<td></td>
<td>neomycin/polymyxin/gramicidin</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NEOSPORIN (neomycin/polymyxin/gramicidin)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>OCUFLOX (ofloxacin)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>POLYTRIM (polymyxin/trimethoprim)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>sulfacetamide drops</td>
<td></td>
</tr>
<tr>
<td></td>
<td>sulfacetamide ointment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>TOBREX (tobramycin)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ZYMAR (gatifloxacin)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ZYMAXID (gatifloxacin)</td>
<td></td>
</tr>
</tbody>
</table>

**OPHTHALMIC ANTIBIOTIC/STEROID COMBINATIONS**

**CATEGORY PA CRITERIA:** Three (3) day trials of each of the preferred agents are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.

<table>
<thead>
<tr>
<th>PREFERRED AGENTS</th>
<th>NON-PREFERRED AGENTS</th>
<th>PA CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>BLEPHAMIDE (prednisolone/sulfacetamide)</td>
<td>BLEPHAMIDE S.O.P. (prednisolone/ sulfacetamide)</td>
<td><strong>Prior authorization of any fluoroquinolone agent requires three (3) day trials of all other preferred agents unless definitive laboratory cultures exist indicating the need to use a fluoroquinolone.</strong></td>
</tr>
<tr>
<td>neomycin/polymyxin/dexamethasone</td>
<td>MAXITROL ointment (neomycin/polymyxin/ dexamethasone)</td>
<td></td>
</tr>
<tr>
<td>sulfacetamide/prednisolone</td>
<td>MAXITROL suspension (neomycin/polymyxin/ dexamethasone)</td>
<td></td>
</tr>
<tr>
<td>TOBRADEX OINTMENT (tobramycin/ dexamethasone)</td>
<td>neomycin/bacitracin/polymyxin/ hydrocortisone</td>
<td></td>
</tr>
<tr>
<td>TOBRADEX ST (tobramycin/ dexamethasone)</td>
<td>neomycin/polymyxin/hydrocortisone</td>
<td></td>
</tr>
<tr>
<td>tobramycin/dexamethasone suspension</td>
<td>PRED-G (prednisolone/gentamicin)</td>
<td></td>
</tr>
</tbody>
</table>
BUREAU FOR MEDICAL SERVICES
WEST VIRGINIA MEDICAID
PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA

This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

**THERAPEUTIC DRUG CLASS**

<table>
<thead>
<tr>
<th>PREFERRED AGENTS</th>
<th>NON-PREFERRED AGENTS</th>
<th>PA CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOBRADEX SUSPENSION (tobramycin/dexamethasone)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ZYLET (loteprednol/tobramycin)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS**

**CATEGORY PA CRITERIA:** Thirty (30) day trials of each of three (3) of the preferred agents are required before a non-preferred agent will be authorized, unless one (1) of the exceptions on the PA form is present.

- ALAWAY (ketotifen)
- cromolyn
- ketotifen
- olopatadine (Sandoz brand only)
- ZADITOR OTC (ketotifen)

- ALAMAST (pemirolast)
- ALOCRIL (nedocromil)
- ALOMIDE (lodoxamide)
- ALREX (loteprednol)
- azelastine
- BEPREVE (bepotastine)
- CROLOM (cromolyn)
- ELESTAT (epinastine)
- EMADINE (emedastine)
- epinastine
- LASTACAFT (alcaftadine)
- olopatadine (all labelers except Sandoz)
- OPTICROM (cromolyn)
- OPTIVAR (azelastine)
- PATADAY (olopatadine)
- PATANOL (olopatadine)
- PAZEO (olopatadine)

**OPHTHALMICS, ANTI-INFLAMMATORIES- IMMUNOMODULATORS**

**CATEGORY PA CRITERIA:** See below for individual sub-class criteria.

- RESTASIS (cyclosporine)
- XIIDRA (lifitegrast)

The following prior authorization criteria apply to both Restasis and Xiidra:
1. Patient must be sixteen (16) years of age or greater; **AND**
2. Prior Authorization must be requested by an ophthalmologist or optometrist; **AND**
3. Clinically diagnosed tear deficiency due to ocular inflammation in patients with keratoconjunctivitis sicca or dry eye syndrome (also known as dry eye); **AND**
4. Patient must have a functioning lacrimal gland; **AND**
5. Patient using artificial tears at least four (4) times a day over the last thirty (30) days; **AND**
6. Patient must not have an active ocular infection
### THERAPEUTIC DRUG CLASS

#### OPHTHALMICS, ANTI-INFLAMMATORIES<sup>AP</sup>

**CATEGORY PA CRITERIA:** Five (5) day trials of each of the preferred agents are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.

<table>
<thead>
<tr>
<th>PREferred Agents</th>
<th>NON-PREFERRED AGENTS</th>
<th>PA CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>dexamethasone</td>
<td>ACULAR (ketorolac)</td>
<td></td>
</tr>
<tr>
<td>diclofenac</td>
<td>ACULAR LS (ketorolac)</td>
<td></td>
</tr>
<tr>
<td>DUREZOL (difluprednate)</td>
<td>ACUVAIL (ketorolac tromethamine)</td>
<td></td>
</tr>
<tr>
<td>fluorometholone</td>
<td>BROMDAY (bromfenac)</td>
<td></td>
</tr>
<tr>
<td>flurbiprofen</td>
<td>bromfenac</td>
<td></td>
</tr>
<tr>
<td>ketorolac</td>
<td></td>
<td></td>
</tr>
<tr>
<td>prednisolone acetate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>prednisolone sodium phosphate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BROMSITE (bromfenac)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FLAREX (fluorometholone)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FML (fluorometholone)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FML FORTE (fluorometholone)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FML S.O.P. (fluorometholone)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ILEVRO (nepafenac)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LOTE MAX DROPS, OINTMENT (loteprednol)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LOTE MAX GEL (loteprednol)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MAXIDEX (dexamethasone)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NEVANAC (nepafenac)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OMNIPRED (prednisolone)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OZURDEX (dexamethasone)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PRED FORTE (prednisolone)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PRED MILD (prednisolone)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PROLENSA (bromfenac)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RETISERT (fluocinolone)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TRIESENCE (triamcinolone)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VEXOL (rimexolone)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>XIBROM (bromfenac)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### OPHTHALMICS, GLAUCOMA AGENTS

**CATEGORY PA CRITERIA:** A non-preferred agent will only be authorized if there is an allergy to the preferred agents.

**COMBINATION AGENTS**

<table>
<thead>
<tr>
<th>COMBIGAN (brimonidine/timolol)</th>
<th>COSOPT (dorzolamide/timolol)</th>
<th>COSOPT PF (dorzolamide/timolol)</th>
</tr>
</thead>
<tbody>
<tr>
<td>dorzolamide/timolol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SIMBRINZA (brinzolamide/brimonidine)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BETA BLOCKERS**

<table>
<thead>
<tr>
<th>BETOPTIC S (betaxolol)</th>
<th>BETAGAN (levobunolol)</th>
</tr>
</thead>
<tbody>
<tr>
<td>carteolol</td>
<td>betaxolol</td>
</tr>
<tr>
<td>levobunolol</td>
<td>BETIMOL (timolol)</td>
</tr>
<tr>
<td>timolol drops</td>
<td>ISTALOL (timolol)</td>
</tr>
</tbody>
</table>
# Therapeutic Drug Class

<table>
<thead>
<tr>
<th>Preferred Agents</th>
<th>Non-Preferred Agents</th>
<th>PA Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OPTIPRANOLOL</strong> (metipranolol)</td>
<td><strong>timolol gel</strong></td>
<td><strong>TIMOPTIC</strong> (timolol)</td>
</tr>
<tr>
<td><strong>CARBONIC ANHYDRASE HIBITORS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>AZOPT</strong> (brinzolamide) Dorzolamide</td>
<td><strong>TRUSOPT</strong> (dorzolamide)</td>
<td></td>
</tr>
<tr>
<td><strong>PARASYMPATHOMIMETICS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>PHOSPHOLINE IODIDE</strong> (echothiophate iodide)</td>
<td><strong>pilocarpine</strong></td>
<td></td>
</tr>
<tr>
<td><strong>PROSTAGLANDIN ANALOGS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>latanoprost</td>
<td>bimatoprost LUMIGAN (bimatoprost) RESCULA (unoprostone) travoprost XALATAN (latanoprost) ZIOPTAN (tafluprost)</td>
<td></td>
</tr>
<tr>
<td><strong>SYMPATHOMIMETICS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>brimonidine 0.2%</td>
<td>ALPHAGAN P 0.1% Solution (brimonidine) ALPHAGAN P 0.15% Solution (brimonidine) apraclonidine brimonidine 0.15% IOPIDINE (apraclonidine)</td>
<td></td>
</tr>
<tr>
<td><strong>OPIATE DEPENDENCE TREATMENTS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CATEGORY PA CRITERIA:</strong> Buprenorphine/naloxone tablets, Bunavail and Zubsolv will only be approved with a documented intolerance of or allergy to Suboxone strips. See below for further criteria. NARCAN NASAL SPRAY (naloxone) SUBOXONE FILM (buprenorphine/naloxone)CL* VIVITROL (naltrexone)</td>
<td>buprenorphine tablets buprenorphine/naloxone tablets BUNAVAIL (buprenorphine/naloxone) EVZIO (naloxone)* ZUBSOLV (buprenorphine/naloxone) * Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. VIVITROL no longer requires a PA.</td>
<td></td>
</tr>
<tr>
<td><strong>OTIC ANTIBIOTICS</strong>&lt;sup&gt;AP&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CATEGORY PA CRITERIA:</strong> Five (5) day trials of each of the preferred agents are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. CIPRO HC (ciprofloxacin/hydrocortisone) CIPRODEX (ciprofloxacin/dexamethasone)</td>
<td>CORTISPORIN-TC (colistin/hydrocortisone/neomycin)</td>
<td></td>
</tr>
<tr>
<td>THERAPEUTIC DRUG CLASS</td>
<td>PREFERRED AGENTS</td>
<td>NON-PREFERRED AGENTS</td>
</tr>
<tr>
<td>------------------------</td>
<td>------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td><strong>PAH AGENTS – ENDOTHELIN RECEPTOR ANTAGONISTS</strong>&lt;sup&gt;CL&lt;/sup&gt;</td>
<td>ciprofloxacin COLY-MYCIN S (colistin/hydrocortisone/neomycin/thonzonium bromide) neomycin/polymyxin/HC solution/suspension</td>
<td>ofloxacin OTOVEL (ciprofloxacin/fluocinolone)</td>
</tr>
<tr>
<td>CATEGORY PA CRITERIA: A thirty (30) day trial of a preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.</td>
<td>LETAIRIS (ambrisentan) TRACLEER (bosentan)</td>
<td>OPSUMIT (macitentan)</td>
</tr>
<tr>
<td><strong>PAH AGENTS – GUANYLATE CYCLASE STIMULATOR</strong>&lt;sup&gt;CL&lt;/sup&gt;</td>
<td></td>
<td>ADEMPAS (riociguat)</td>
</tr>
<tr>
<td>CATEGORY PA CRITERIA: A thirty (30) day trial of a preferred PAH agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>PAH AGENTS – PDE5s</strong>&lt;sup&gt;CL&lt;/sup&gt;</td>
<td>sildenafil</td>
<td>ADCIRCA (tadalafil) REVATIO IV (sildenafil) REVATIO SUSPENSION (sildenafil) REVATIO TABLETS (sildenafil)</td>
</tr>
<tr>
<td>CATEGORY PA CRITERIA: A thirty (30) day trial of the preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.</td>
<td>Patients stabilized on non-preferred agents will be grandfathered.</td>
<td></td>
</tr>
<tr>
<td><strong>PAH AGENTS – PROSTACYCLINS</strong>&lt;sup&gt;CL&lt;/sup&gt;</td>
<td>epoprostenol VENTAVIS (iloprost)*</td>
<td>FLOLAN (epoprostenol) ORENITRAM ER (treprostinil) REMODULIN (treprostinil sodium) TYVASO (treprostinil) UPRAVI (selexipag) VELASCTI (epoprostenol)</td>
</tr>
<tr>
<td>CATEGORY PA CRITERIA: A thirty (30) day trial of a preferred agent, including the preferred generic form of the non-preferred agent, is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**THERAPEUTIC DRUG CLASS**

<table>
<thead>
<tr>
<th>PREFERRED AGENTS</th>
<th>NON-PREFERRED AGENTS</th>
<th>PA CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PANCREATIC ENZYMES</strong>&lt;sup&gt;AP&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CATEGORY PA CRITERIA: A thirty (30) day trial of a preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. Non-preferred agents will be authorized for members with cystic fibrosis.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CREON</td>
<td>PANCREAZE</td>
<td></td>
</tr>
<tr>
<td>ZENPEP</td>
<td>PERTZYE</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ULTRESA</td>
<td></td>
</tr>
<tr>
<td></td>
<td>VIOKACE</td>
<td></td>
</tr>
<tr>
<td><strong>PHOSPHATE BINDERS</strong>&lt;sup&gt;AP&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CATEGORY PA CRITERIA: Thirty (30) day trials of at least two (2) preferred agents are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>calcium acetate</td>
<td>AURYXIA (ferric citrate)</td>
<td></td>
</tr>
<tr>
<td>MAGNEBIND RX (calcium carbonate, folic acid, magnesium carbonate)</td>
<td>ELIPHOS (calcium acetate)</td>
<td></td>
</tr>
<tr>
<td>PHOSLYRA (calcium acetate)</td>
<td>FOSRENOL (lanthanum)</td>
<td></td>
</tr>
<tr>
<td>RENAGEL (sevelamer)</td>
<td>PHOSLO (calcium acetate)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>RENVELA (sevelamer carbonate)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>sevelamer carbonate</td>
<td></td>
</tr>
<tr>
<td></td>
<td>VELPHORO (sucroferric oxyhydroxide)</td>
<td></td>
</tr>
<tr>
<td><strong>PLATELET AGGREGATION INHIBITORS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CATEGORY PA CRITERIA: A thirty (30) day trial of a preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AGGRENOX (dipyridamole/ASA)</td>
<td>dipyridamole</td>
<td></td>
</tr>
<tr>
<td>BRILINTA (ticagrelor)</td>
<td>dipyridamole/ aspirin</td>
<td></td>
</tr>
<tr>
<td>clopidogrel</td>
<td>DURLAZA ER (aspirin)</td>
<td></td>
</tr>
<tr>
<td>EFFIENT (prasugrel)</td>
<td>PERSANTINE (dipyridamole)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>PLAVIX (clopidogrel)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>TICLID (ticlopidine)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ticlopidine</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ZONTIVITY (vorapaxar)</td>
<td></td>
</tr>
<tr>
<td><strong>PROGESTINS FOR CACHEXIA</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CATEGORY PA CRITERIA: A thirty (30) day trial of the preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>megestrol</td>
<td>MEGACE (megestrol)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>MEGACE ES (megestrol)</td>
<td></td>
</tr>
</tbody>
</table>
## THERAPEUTIC DRUG CLASS

### PROTON PUMP INHIBITORS\(^\text{AP}\)

<table>
<thead>
<tr>
<th>PREFERRED AGENTS</th>
<th>NON-PREFERRED AGENTS</th>
<th>PA CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>omeprazole (Rx)</td>
<td>ACIPHEX (rabeprazole)</td>
<td>* Maximum recommended doses of the PPIs and H(_2)-receptor antagonists may be located at the BMS Pharmacy PA criteria page titled &quot;Max PPI and H(_2)RA&quot; by clicking on the hyperlink.</td>
</tr>
<tr>
<td>pantoprazole</td>
<td>ACIPHEX SPRINKLE (rabeprazole)</td>
<td></td>
</tr>
<tr>
<td>PREVACID SOLUTABS (lansoprazole)**</td>
<td>DEXILANT (dexlansoprazole)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>esomeprazole magnesium</td>
<td></td>
</tr>
<tr>
<td></td>
<td>esomeprazole strontium</td>
<td></td>
</tr>
<tr>
<td></td>
<td>lansoprazole Rx</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NEXIUM (esomeprazole)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>omeprazole/sodium bicarbonate (Rx)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>PREVACID CAPSULES (lansoprazole)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>PRILOSEC Rx (omeprazole)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>PROTONIX (pantoprazole)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>rabeprazole</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ZGERID Rx (omeprazole/sodium bicarbonate)</td>
<td></td>
</tr>
</tbody>
</table>

**Prior authorization is required for Prevacid Solutabs for members nine (9) years of age or older.

### SEDATIVE HYPNOTICS\(^\text{AP}\)

<table>
<thead>
<tr>
<th>PREFERRED AGENTS</th>
<th>NON-PREFERRED AGENTS</th>
<th>PA CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>temazepam 15, 30 mg</td>
<td>DALMANE (flurazepam)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>DORAL (quazepam)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>estazolam</td>
<td></td>
</tr>
<tr>
<td></td>
<td>flurazepam</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HALCION (triazolam)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>quazepam</td>
<td></td>
</tr>
<tr>
<td></td>
<td>RESTORIL (temazepam)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>temazepam 7.5, 22.5 mg</td>
<td></td>
</tr>
<tr>
<td></td>
<td>triazolam</td>
<td></td>
</tr>
</tbody>
</table>

### BENZODIAZEPINES

<table>
<thead>
<tr>
<th>PREFERRED AGENTS</th>
<th>NON-PREFERRED AGENTS</th>
<th>PA CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>zolpidem 5, 10 mg</td>
<td>AMBIEN (zolpidem)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>AMBIEN CR (zolpidem)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>BELSOMRA (suvorexant)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>chloral hydrate</td>
<td></td>
</tr>
<tr>
<td></td>
<td>EDLURAR (zolpidem)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>eszopiclone</td>
<td></td>
</tr>
</tbody>
</table>

Strengths of zolpidem that are non-preferred (6.25 and 12.5 mg) must be created by combining or splitting the preferred doses (5 and 10 mg) of zolpidem, if appropriate.

For treatment naïve female patients, zolpidem and zolpidem ER maximum dosages will be limited to 5 mg and 6.25 mg.
## THERAPEUTIC DRUG CLASS

<table>
<thead>
<tr>
<th>PREFERRED AGENTS</th>
<th>NON-PREFERRED AGENTS</th>
<th>PA CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>HETLIOZ (tasimelteon)</td>
<td></td>
<td>respectively per day.</td>
</tr>
<tr>
<td>INTERMEZZO (zolpidem)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LUNESTA (eszopiclone)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ROZEREM (ramelteon)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SILENOR (doxepin)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SOMNOTE (chloral hydrate)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SONATA (zaleplon)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>zaleplon</td>
<td></td>
<td></td>
</tr>
<tr>
<td>zolpidem ER 6.25, 12.5 mg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ZOLPIMIST (zolpidem)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Full PA criteria may be found on the [PACriteria](#) page by clicking the hyperlink.

## SKELETAL MUSCLE RELAXANTS*

### CATEGORY PA CRITERIA:
See below for individual sub-class criteria.

### ACUTE MUSCULOSKELETAL RELAXANT AGENTS

<table>
<thead>
<tr>
<th>Preferred Agents</th>
<th>Non-Preferred Agents</th>
<th>PA Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>chlorozoxazone</td>
<td>AMRIX (cyclobenzaprine)</td>
<td>Thirty (30) day trials of each of the preferred acute musculoskeletal relaxants are required before a non-preferred acute musculoskeletal agent will be authorized, with the exception of carisoprodol.</td>
</tr>
<tr>
<td>cyclobenzaprine IR 5, 10 mg</td>
<td>carisoprodol</td>
<td>Thirty (30) day trials of each of the preferred acute musculoskeletal relaxants and Skelaxin are required before carisoprodol will be authorized.</td>
</tr>
<tr>
<td>methocarbamol</td>
<td>carisoprodol/ASA</td>
<td></td>
</tr>
<tr>
<td></td>
<td>carisoprodol/ASA/codeine</td>
<td></td>
</tr>
<tr>
<td></td>
<td>cyclobenzaprine ER</td>
<td></td>
</tr>
<tr>
<td></td>
<td>FEXMID (cyclobenzaprine)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>FLEXERIL (cyclobenzaprine)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>LORZONE (chlorzoxazone)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>metaxalone</td>
<td></td>
</tr>
<tr>
<td></td>
<td>orphenadrine</td>
<td></td>
</tr>
<tr>
<td></td>
<td>orphenadrine/ASA/caffeine</td>
<td></td>
</tr>
<tr>
<td></td>
<td>orphenadrine ER</td>
<td></td>
</tr>
<tr>
<td></td>
<td>PARAFON FORTE (chlorzoxazone)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ROBAXIN (methocarbamol)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SKELAXIN (metaxalone)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SOMA (carisoprodol)</td>
<td></td>
</tr>
</tbody>
</table>

### MUSCULOSKELETAL RELAXANT AGENTS USED FOR SPASTICITY

<table>
<thead>
<tr>
<th>Preferred Agents</th>
<th>Non-Preferred Agents</th>
<th>PA Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>baclofen</td>
<td>DANTRIUM (dantrolene)</td>
<td>Thirty (30) day trials of both preferred skeletal muscle relaxants associated with the treatment of spasticity are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.</td>
</tr>
<tr>
<td>tizanidine tablets</td>
<td>dantrolene</td>
<td></td>
</tr>
<tr>
<td></td>
<td>tizanidine capsules</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ZANAFLEX (tizanidine)</td>
<td></td>
</tr>
</tbody>
</table>
## THERAPEUTIC DRUG CLASS

### STEROIDS, TOPICAL

**CATEGORY PA CRITERIA:** Five (5) day trials of one (1) form of each preferred unique active ingredient in the corresponding potency group are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.

<table>
<thead>
<tr>
<th>PREFERRED AGENTS</th>
<th>NON-PREFERRED AGENTS</th>
<th>PA CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>betamethasone dipropionate cream</td>
<td>amcinonide</td>
<td></td>
</tr>
<tr>
<td>betamethasone valerate cream</td>
<td>APEXICON (diflorasone diacetate)</td>
<td></td>
</tr>
<tr>
<td>clobetasol propionate</td>
<td>APEXICON E (diflorasone diacetate)</td>
<td></td>
</tr>
<tr>
<td>cream/gel/ointment/solution</td>
<td>betamethasone dipropionate gel, lotion, ointment</td>
<td></td>
</tr>
<tr>
<td>clobetasol emollient</td>
<td>betamethasone valerate lotion, ointment, clobetasol lotion, shampoo</td>
<td></td>
</tr>
<tr>
<td>fluocinonide cream, gel, solution</td>
<td>clobetasol propionate foam</td>
<td></td>
</tr>
<tr>
<td>fluocinonide/emollient</td>
<td>CLOBEX (clobetasol propionate)</td>
<td></td>
</tr>
<tr>
<td>halobetasol propionate</td>
<td>CLODAN (clobetasol propionate)</td>
<td></td>
</tr>
<tr>
<td>triamcinolone acetonide cream, ointment</td>
<td>CORMAX (clobetasol propionate)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>desoximetasone cream/gel/ointment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>diflorasone diacetate</td>
<td></td>
</tr>
<tr>
<td></td>
<td>DIPROLENE (betamethasone dipropionate/propylene glycol)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>DIPROLENE AF (betamethasone dipropionate/propylene glycol)</td>
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</tr>
<tr>
<td></td>
<td>DIPROSONE (betamethasone dipropionate)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>fluocinonide ointment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>halcinonide</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HALAC (halobetasol propionate)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HALOG (halcinonide)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HALONATE (halobetasol propionate)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>KENALOG (triamcinolone acetonide)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>LIDEX (fluocinonide)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>LIDEX-E (fluocinonide)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>OLUX (clobetasol propionate)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>OLUX-E (clobetasol propionate/emollient)</td>
<td></td>
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<tr>
<td></td>
<td>PSORCON (diflorasone diacetate)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SERNIVO SPRAY (betamethasone dipropionate)</td>
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<tr>
<td></td>
<td>TEMOVATE (clobetasol propionate)</td>
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<td></td>
<td>TEMOVATE-E (clobetasol propionate/emollient)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>TOPICORT CREAM, GEL, OINTMENT (desoximetasone)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>TOPICORT SPRAY (desoximetasone)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>triamcinolone acetonide lotion</td>
<td></td>
</tr>
</tbody>
</table>
This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this PDL.

<table>
<thead>
<tr>
<th>THERAPEUTIC DRUG CLASS</th>
<th>PREFERRED AGENTS</th>
<th>NON-PREFERRED AGENTS</th>
<th>PA CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MEDIUM POTENCY</strong></td>
<td></td>
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<tr>
<td>fluticasone propionate cream, ointment</td>
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<tr>
<td>hydrocortisone butyrate ointment, solution</td>
<td></td>
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</tr>
<tr>
<td>hydrocortisone valerate</td>
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<td></td>
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<tr>
<td>mometasone furoate</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>triamcinolone acetonide 0.025% and 0.1%</td>
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<td></td>
</tr>
<tr>
<td>cream</td>
<td></td>
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<tr>
<td>fluticasone propionate lotion</td>
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</tr>
<tr>
<td>hydrocortisone butyrate cream</td>
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<tr>
<td>LOCOID (hydrocortisone butyrate)</td>
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<tr>
<td>LOCOID LIPOCREAM (hydrocortisone butyrate/vehicle)</td>
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<tr>
<td>LUXIQ (betamethasone valerate)</td>
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<tr>
<td>MOMEXIN (mometasone)</td>
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<tr>
<td>PANDEL (hydrocortisone probutate)</td>
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<tr>
<td>prednicarbate</td>
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<tr>
<td>TOPICORT LP (desoximetasone)</td>
<td></td>
<td></td>
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<tr>
<td>TRIDERM (triamcinolone acetonide)</td>
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<tr>
<td>WESTCORT (hydrocortisone valerate)</td>
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<tr>
<td><strong>LOW POTENCY</strong></td>
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</tr>
<tr>
<td>desonide cream, ointment</td>
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</tr>
<tr>
<td>hydrocortisone acetate (Rx, OTC)</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>hydrocortisone cream (Rx, OTC)</td>
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<tr>
<td>hydrocortisone lotion OTC</td>
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<tr>
<td>hydrocortisone ointment (Rx, OTC)</td>
<td></td>
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<tr>
<td>hydrocortisone solution OTC</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>hydrocortisone-aloe cream OTC</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>hydrocortisone-aloe ointment OTC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACLOVATE (alclometasone dipropionate)</td>
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<tr>
<td>alclometasone dipropionate</td>
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<tr>
<td>AQUA GLYCOLIC HC (hydrocortisone)</td>
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<tr>
<td>CAPEX (fluocinolone acetonide)</td>
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</tr>
<tr>
<td>DERMA-SMOOTHE FS (fluocinolone acetonide)</td>
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<td></td>
</tr>
<tr>
<td>DESONATE (desonide)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>desonide lotion</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>DESOWEN (desonide)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>fluocinolone oil</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>hydrocortisone/mineral oil/petrolatum</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>hydrocortisone acetate/urea</td>
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</tbody>
</table>
**THERAPEUTIC DRUG CLASS**

<table>
<thead>
<tr>
<th>THERAPEUTIC DRUG CLASS</th>
<th>PREFERRED AGENTS</th>
<th>NON-PREFERRED AGENTS</th>
<th>PA CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>-</td>
<td>hydrocortisone lotion</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>-</td>
<td>hydrocortisone/aloevera gel</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>-</td>
<td>LOKARA (desonide)</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>-</td>
<td>PEDIADERM HG (hydrocortisone)</td>
<td>-</td>
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<tr>
<td>-</td>
<td>PEDIADERM TA (hydrocortisone)</td>
<td>-</td>
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<tr>
<td>-</td>
<td>SCALPICIN OTC (hydrocortisone)</td>
<td>-</td>
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</tr>
<tr>
<td>-</td>
<td>SYNALAR (fluocinolone)</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>-</td>
<td>TEXACORT (hydrocortisone)</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>-</td>
<td>VERDESO (desonide)</td>
<td>-</td>
<td></td>
</tr>
</tbody>
</table>

**STIMULANTS AND RELATED AGENTS**

**CATEGORY PA CRITERIA:** A PA is required for adults eighteen (18) years of age or older.

Non-preferred agents require a thirty (30) day trial of at least one of the preferred agents in the same subclass and with a similar duration of effect (i.e., Long-acting agents require a trial of a long-acting preferred agent; similarly, short-acting agents require a preferred short-acting agent).

Patients stabilized on non-preferred agents will be grandfathered.

**AMPHETAMINES**

<table>
<thead>
<tr>
<th>Amphetaamines</th>
<th>Adderall (amphetamine salt combination)</th>
<th>Adderall XR* (amphetamine salt combination)</th>
<th>In addition to the Category Criteria: Thirty (30) day trials of at least three (3) antidepressants are required before amphetamines will be authorized for depression.</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADZENYS XR ODT (amphetamine)</td>
<td>ADDERALL (amphetamine salt combination)</td>
<td>ADDERALL XR* (amphetamine salt combination)</td>
<td>*Adderall XR is preferred over its generic equivalents.</td>
</tr>
<tr>
<td>amphetamine salt combination IR</td>
<td>DEXEDRINE ER (dextroamphetamine)</td>
<td>DEXEDRINE IR (dextroamphetamine)</td>
<td></td>
</tr>
<tr>
<td>dextroamphetamine ER</td>
<td>DYANAVEL XR SUSP (amphetamine)</td>
<td>EVEKEO (amphetamine)</td>
<td></td>
</tr>
<tr>
<td>PROCENTRA solution (dextroamphetamine)</td>
<td>methamphetamine</td>
<td>methamphetamine</td>
<td></td>
</tr>
<tr>
<td>VYVANSE CAPSULE (lisdexamfetamine)</td>
<td>VYVANSE CHEWABLE (lisdexamfetamine)</td>
<td>ZENZEDI (dextroamphetamine)</td>
<td></td>
</tr>
</tbody>
</table>
# THERAPEUTIC DRUG CLASS

## PREferred AGENTS
<table>
<thead>
<tr>
<th>NON-PREFERRED AGENTS</th>
<th>PA CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NON-AMPHETAMINE</strong></td>
<td></td>
</tr>
<tr>
<td>clonidine IR</td>
<td></td>
</tr>
<tr>
<td>DAYTRANA (methylphenidate)</td>
<td></td>
</tr>
<tr>
<td>dexmethylphenidate IR</td>
<td></td>
</tr>
<tr>
<td>FOCALIN XR (dexmethylphenidate)</td>
<td></td>
</tr>
<tr>
<td>guanfacine ER</td>
<td></td>
</tr>
<tr>
<td>guanfacine IR</td>
<td></td>
</tr>
<tr>
<td>METADATE CD (methylphenidate)</td>
<td></td>
</tr>
<tr>
<td>METHYLIN SOLUTION (methylphenidate)</td>
<td></td>
</tr>
<tr>
<td>methylphenidate ER (generic CONCERTA)</td>
<td></td>
</tr>
<tr>
<td>methylphenidate IR</td>
<td></td>
</tr>
<tr>
<td>QUILLICHEW ER (methylphenidate)</td>
<td></td>
</tr>
<tr>
<td>QUILLIVANT XR (methylphenidate)</td>
<td></td>
</tr>
<tr>
<td>STRATTERA (atomoxetine)*</td>
<td></td>
</tr>
</tbody>
</table>

*Strattera does not require a PA for adults eighteen (18) years of age or older. Strattera will not be authorized for concurrent administration with amphetamines or methylphenidates, except for thirty (30) days or less for tapering purposes. Strattera is limited to a maximum of 100 mg per day.

**Kapvay/clonidine ER will be authorized only after fourteen (14) day trials of at least one (1) preferred product from the amphetamine and non-amphetamine class. These trials must include a fourteen (14) day trial of clonidine IR unless one (1) of the exceptions on the PA form is present.

*NOTE:* In cases of a diagnosis of Tourette’s syndrome, tics, autism or disorders included in the autism spectrum, only a fourteen (14) day trial of clonidine (for Kapvay) will be required for approval.

***Provigil is preferred over its generic equivalent and Nuvigil. These drugs will only be authorized for patients sixteen (16) years of age or older with a diagnosis of narcolepsy.

## TETRACYCLINES

**CATEGORY PA CRITERIA:** A ten (10) day trial of each of the preferred agents is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.

<table>
<thead>
<tr>
<th>doxycycline hyclate capsules, tablets</th>
<th>ADOXA (doxycycline monohydrate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>doxycycline monohydrate 50, 100 mg capsules</td>
<td>demeclocycline*</td>
</tr>
<tr>
<td>minocycline capsules</td>
<td>DORYX (doxycycline hyclate)</td>
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<tr>
<td>tetracycline</td>
<td>doxycycline hyclate tablet DR</td>
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<tr>
<td></td>
<td>doxycycline monohydrate 40, 75, 150 mg capsule</td>
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<td></td>
<td>doxycycline monohydrate tablet</td>
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<tr>
<td></td>
<td>doxycycline monohydrate suspension</td>
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<tr>
<td></td>
<td>DYNACIN (minocycline)</td>
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<tr>
<td></td>
<td>MINOCIN (minocycline)</td>
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<tr>
<td></td>
<td>minocycline ER capsules</td>
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<td></td>
<td>minocycline tablets</td>
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<tr>
<td></td>
<td>MONODOX (doxycycline monohydrate)</td>
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<tr>
<td></td>
<td>MORGIDOX KIT (doxycycline)</td>
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<tr>
<td></td>
<td>ORACEA (doxycycline monohydrate)</td>
</tr>
<tr>
<td></td>
<td>SOLODYN (minocycline)</td>
</tr>
</tbody>
</table>

*Demeclocycline will be authorized for conditions caused by susceptible strains of organisms designated in the product information supplied by the manufacturer. A C&S report must accompany this request. Demeclocycline will also be authorized for SIADH.
<table>
<thead>
<tr>
<th>THERAPEUTIC DRUG CLASS</th>
<th>PREFERRED AGENTS</th>
<th>NON-PREFERRED AGENTS</th>
<th>PA CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ULCERATIVE COLITIS AGENTS</strong>&lt;sup&gt;A&lt;/sup&gt;</td>
<td></td>
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<tr>
<td><strong>CATEGORY PA CRITERIA:</strong> Thirty (30) day trials of each of the preferred dosage form or chemical entity must be tried before the corresponding non-preferred agent of that dosage form or chemical entity will be authorized unless one (1) of the exceptions on the PA form is present.</td>
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<tr>
<td><strong>ORAL</strong></td>
<td>APRISO (mesalamine) balsalazide DELZICOL (mesalamine) PENTASA (mesalamine) 250 mg sulfasalazine</td>
<td>ASACOL HD (mesalamine) AZULFIDINE (sulfasalazine) COLAZAL (balsalazide) DIPENTUM (olsalazine) GIAZO (balsalazide) LIALDA (mesalamine) mesalamine PENTASA (mesalamine) 500 mg UCERIS (budesonide)</td>
<td></td>
</tr>
<tr>
<td><strong>RECTAL</strong></td>
<td>CANASA (mesalamine) mesalamine</td>
<td>DELZICOL DR (mesalamine) mesalamine kit ROWASA (mesalamine) SF ROWASA (mesalamine) UCERIS (budesonide)</td>
<td></td>
</tr>
<tr>
<td><strong>VASODILATORS, CORONARY</strong></td>
<td></td>
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</tr>
<tr>
<td><strong>CATEGORY PA CRITERIA:</strong> A thirty (30) day trial of each preferred dosage form will be required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.</td>
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<tr>
<td><strong>SUBLINGUAL NITROGLYCERIN</strong></td>
<td>nitroglycerin spray (generic NITROLINGUAL) nitroglycerin sublingual NITROSTAT SUBLINGUAL (nitroglycerin)</td>
<td>GONITRO SPRAY POWDER (nitroglycerin)&lt;sup&gt;NK&lt;/sup&gt; nitroglycerin spray (generic NITROMIST) NITROLINGUAL SPRAY (nitroglycerin) NITROMIST (nitroglycerin)</td>
<td></td>
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</tbody>
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