- 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 at the BMS Website by clicking the hyperlink.
- Acronyms
- CL - Requires clinical PA. For detailed clinical criteria, please refer to the BMS Website by clicking the hyperlink.
    - NR - New drug has not been reviewed by P & T Committee
    - AP - Non-preferred and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA criteria column.

CLASSES CHANGING	Status Changes	PA Criteria Changes	New Drugs
ACNE AGENTS, TOPICAL			XXX
ANALGESICS, NARCOTIC LONG-ACTING	XXX		XXX
ANTIBIOTICS – INHALED FOR CF			XXX
ANTIBIOTICS, VAGINAL			XXX
ANTICOAGULANTS			XXX
ANTIFUNGALS, TOPICAL			XXX
ANTIPARKINSON AGENTS	XXX		XXX
ANTIPSYCHOTICS, ATYPICAL	XXX		
COPD AGENTS			XXX
CYTOKINE MODULATORS			XXX
GLUCOCORTICOIDS, INHALED	XXX		XXX
HYPOGLYCEMICS, INSULIN AND RELATED AGENTS			XXX
HYPOGLYCEMICS, SGLT2			XXX
OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS			XXX
SEDATIVE HYPNOTICS			XXX
ULCERATIVE COLITIS AGENTS			XXX

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ACNE AGENTS, TOPICAL[AP]		
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. 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.		
COMBINATION AGENTS		
erythromycin/benzoyl peroxide	ACANYA (clindamycin phosphate/benzoyl peroxide) AVAR/-E/LS (sulfur/sulfacetamide) BENZACLIN GEL (benzoyl peroxide/ clindamycin) BENZAMYCIN PAK (benzoyl peroxide/ erythromycin) benzoyl peroxide/clindamycin gel benzoyl peroxide/urea CERISA (sulfacetamide sodium/sulfur) CLARIFOAM EF (sulfacetamide/sulfur) CLENIA (sulfacetamide sodium/sulfur) DUAC (benzoyl peroxide/clindamycin) EPIDUO (adapalene/benzoyl peroxide)* INOVA 4/1, 5/2 (benzoyl peroxide/salicylic acid) NEUAC (clindamycin phosphate/benzoyl peroxide) NUOX (benzoyl peroxide/sulfur) ONEXTON (clindamycin phosphate/benzoyl peroxide) PRASCION (sulfacetamide sodium/sulfur) SE 10-5 SS (sulfacetamide/sulfur) SSS 10-4 (sulfacetamide /sulfur) SSS 10-5 foam (sulfacetamide /sulfur) sulfacetamide sodium/sulfur cloths, lotion, pads, suspension sulfacetamide/sulfur wash/cleanser sulfacetamide/sulfur wash kit sulfacetamide sodium/sulfur/ urea SUMADAN/XLT (sulfacetamide/sulfur) SUMAXIN/TS (sulfacetamide sodium/sulfur)	**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		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	VELTIN (clindamycin/tretinoin)* ZIANA (clindamycin/tretinoin)*	
ALZHEIMER'S AGENTS[AP]		
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		
donepezil 5 and 10 mg	ARICEPT (donepezil)* donepezil 23 mg EXELON CAPSULE (rivastigmine) EXELON PATCH (rivastigmine) galantamine galantamine ER RAZADYNE (galantamine) RAZADYNE ER (galantamine) rivastigmine	*Aricept 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.
NMDA RECEPTOR ANTAGONIST		
NAMENDA (memantine)	memantine NAMENDA XR (memantine)	
ANALGESICS, NARCOTIC LONG ACTING (Non-parenteral)[AP]		
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.		
EMBEDA (morphine/naltrexone) fentanyl transdermal morphine ER tablets	AVINZA (morphine) BUTRANS* (buprenorphine) CONZIP ER (tramadol) DOLOPHINE (methadone) EXALGO ER (hydromorphone) hydromorphone ER HYSINGLA ER (hydrocodone) KADIAN (morphine) methadone tablet, solution and concentrate** methadone solutabs morphine ER capsules (generic for Avinza) morphine ER capsules (generic for Kadian) MS CONTIN (morphine) NUCYNTA ER (tapentadol) OPANA ER (oxymorphone) oxycodone ER** OXYCONTIN (oxycodone)	*Butrans will be authorized if the following criteria are met: 1. Diagnosis of moderate to severe chronic pain requiring continuous around-the-clock analgesia **and** 2. Patient cannot take oral medications and has a diagnosis of chronic pain **and** 3. Needs analgesic medication for an extended period of time **and** 4. Has had a previous trial of a non-opioid analgesic medication* **and** 5. Previous trial of one (1) opioid medication* **and** 6. Current total daily opioid dose is less than or equal to (≤) 80 mg morphine equivalents daily or dose of transdermal fentanyl is less than or equal to (≤) 12.5 mcg/hr **and** 7. Patient is not currently being treated with buprenorphine. *Requirement is waived for patients who cannot swallow **Methadone, oxycodone ER and oxymorphone ER will be

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	oxymorphone ER** RYZOLT ER (tramadol) tramadol ER ULTRAM ER (tramadol) XARTEMIS XR (oxycodone/ acetaminophen) ZOHYDRO ER (hydrocodone)	authorized without a trial of the preferred agents if a diagnosis of cancer is submitted.
ANTIBIOTICS, GI		
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 neomycin TINDAMAX (tinidazole)	ALINIA (nitazoxanide) DIFICID (fidaxomicin)* FLAGYL (metronidazole) FLAGYL ER (metronidazole ER) metronidazole capsule paromomycin tinidazole VANCOCIN (vancomycin) Vancomycin** XIFAXAN (rifaximin)***	*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 after a fourteen (14) day trial of metronidazole for *C. difficile* infections of mild to moderate severity. ** Vancomycin will be authorized for severe *C. difficile* infections with no previous trial of metronidazole. *** Xifaxin criteria located at : http://www.dhhr.wv.gov/bms/BMS%20Pharmacy/Documents/Drug%20PA%20Criteria/Xifaxin%20%20Ver%202%20-%20Final.pdf
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.		
BETHKIS (tobramycin) KITABIS PAK (tobramycin) tobramycin (Labeler code 00781)	CAYSTON (aztreonam) TOBI (tobramycin) TOBI PODHALER tobramycin (all other labeler codes)	
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.		
clindamycin cream METROGEL (metronidazole)	AVC (sulfanilamide) CLEOCIN CREAM (clindamycin) CLEOCIN OVULE (clindamycin) CLINDESSE (clindamycin) metronidazole NUVESSA (metronidazole) VANDAZOLE (metronidazole)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
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.		
	INJECTABLE[CL]	
enoxaparin FRAGMIN (dalteparin)	ARIXTRA (fondaparinux) fondaparinux INNOHEP (tinzaparin) LOVENOX (enoxaparin)	
	ORAL	
COUMADIN (warfarin) ELIQUIS (apixaban)[AP]* PRADAXA (dabigatran)[AP]** warfarin XARELTO (rivaroxaban)[AP]***	SAVAYSA (edoxaban)	*Eliquis will be authorized for the following indications: 1. Non-valvular atrial fibrillation **or** 2. Deep vein thombrosis (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 will be authorized for the following indications: 1. Non-valvular atrial fibrillation **or** 2. To reduce the risk of recurrent DVT and PE in patients who have previously been treated **or** 3. Treatment of acute DVT and PE in patients who have been treated with a parenteral anticoagulant for five (5) to (10) days**.** ***Xarelto will be authorized for the following indications:: 1. Non-valvular atrial fibrillation **or** 2. DVT, and PE, and reduction in risk of recurrence of DVT and PE **or** 1. DVT prophylaxis if treatment is limited to thirty-five (35) days for hip replacement surgeries or twelve (12) days for knee replacement surgeries.
ANTIFUNGALS, TOPICAL[AP]		
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.		
	ANTIFUNGALS	
econazole ketoconazole cream, shampoo MENTAX (butenafine) miconazole (OTC)	CICLODAN (ciclopirox) ciclopirox ERTACZO (sertaconazole) EXELDERM (sulconazole)	*Oxistat 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	**NON-PREFERRED AGENTS**	**PA CRITERIA**
nystatin	EXTINA (ketoconazole) JUBLIA (efinaconazole) ketoconazole foam KERYDIN (tavaborole) KETODAN (ketoconazole) LOPROX (ciclopirox) LUZU (luliconazole) MYCOSTATIN (nystatin) NAFTIN CREAM (naftifine) NAFTIN GEL (naftifine) NIZORAL (ketoconazole) OXISTAT (oxiconazole)* PEDIPIROX-4 (ciclopirox) PENLAC (ciclopirox) VUSION (miconazole/petrolatum/zinc oxide) XOLEGEL (ketoconazole)	
ANTIPARKINSON'S AGENTS		
CATEGORY PA CRITERIA: 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.		
DOPAMINE AGONISTS		
pramipexole ropinirole	MIRAPEX (pramipexole) MIRAPEX ER (pramipexole) NEUPRO (rotigotine) pramipexole ER REQUIP (ropinirole) REQUIP XL (ropinirole) ropinirole ER	Mirapex, Mirapex ER, Requip, and Requip XL will be authorized for a diagnosis of Parkinsonism with no trials of preferred agents required.
OTHER ANTIPARKINSON'S AGENTS		
amantadine[AP] bromocriptine carbidopa/levodopa levodopa/carbidopa/entacapone selegiline	AZILECT (rasagiline) ELDEPRYL (selegiline) levodopa/carbidopa ODT carbidopa LODOSYN (carbidopa) PARCOPA (levodopa/carbidopa) PARLODEL (bromocriptine) RYTARY (levodopa/carbidopa) SINEMET (levodopa/carbidopa) STALEVO (levodopa/carbidopa/entacapone) ZELAPAR (selegiline)	Amantadine will be authorized only for a diagnosis of Parkinsonism.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ANTIPSYCHOTICS, ATYPICAL		
CATEGORY PA CRITERIA: A fourteen (14) day trial of a preferred generic agent is required before a Preferred Brand will be authorized. All antipsychotic agents require prior authorization for children up to six (6) years of age. 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. 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.		
SINGLE INGREDIENT		
ABILIFY (aripiprazole)* AP ABILIFY MAINTENA (aripiprazole)** CL clozapine INVEGA SUSTENNA (paliperidone)** CL LATUDA (lurasidone) AP olanzapine quetiapine*** AP for the 25 mg Tablet Only RISPERDAL CONSTA (risperidone) ** CL risperidone SAPHRIS (asenapine)AP ziprasidone	ADASUVE (loxapine) aripiprazole clozapine ODT CLOZARIL (clozapine) FANAPT (iloperidone) FAZACLO (clozapine) GEODON (ziprasidone) GEODON IM (ziprasidone) INVEGA (paliperidone) olanzapine IM** olanzapine ODT RISPERDAL (risperidone) SEROQUEL (quetiapine) SEROQUEL XR (quetiapine) VERSACLOZ (clozapine) ZYPREXA (olanzapine) ZYPREXA IM (olanzapine)** ZYPREXA RELPREVV (olanzapine)	* Abilify will be prior authorized via electronic PA for MDD if the following criteria are met: 1. The patient is eighteen (18) years of age or older **and** 2. Diagnosis of Major Depressive Disorder (MDD) **and** 3. Prescribed as adjunctive therapy with buproprion, an SSRI agent or an SNRI agent **and** 4. The daily dose does not exceed 15 mg **All injectable antipsychotic products require clinical prior authorization and will be approved on a case-by-case basis. ***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.
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.		
ANTICHOLINERGIC[AP]		
ATROVENT HFA (ipratropium) ipratropium SPIRIVA (tiotropium)	INCRUSE ELLIPTA (umeclidinium) SPIRIVA RESPIMAT (tiotropium) TUDORZA (aclidinium)	**Substitute for Category Criteria**: A thirty (30) day trial of tiotropium is required before a non-preferred agent will be authorized.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
CYTOKINE & CAM ANTAGONISTS[CL]		
CATEGORY PA CRITERIA: Ninety (90) day trials of two (2) of the preferred anti-TNF agents are required before a non-preferred **anti-TNF** or "**Other**" agent will be authorized **unless the drug-specific criteria states otherwise** or one (1) of the exceptions on the PA form is present.		
ANTI-TNFs		
ENBREL (etanercept) * HUMIRA (adalimumab) *	CIMZIA (certolizumab pegol) SIMPONI (golimumab)	*Detailed criteria for this category may be found at the BMS Website, by clicking the hyperlink.
OTHERS		
	ACTEMRA syringe (tocilizumab) COSENTYX (secukinumab) KINERET (anakinra) ORENCIA syringe (abatacept) OTEZLA (apremilast)* STELARA syringe (ustekinumab) XELJANZ (tofacitinib)*	*Detailed criteria for this category may be found at the BMS Website, by clicking the hyperlink.
GLUCOCORTICOIDS, INHALED[AP]		
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. A prior authorization will be required for children nine (9) years of age or older, and for individuals unable to use an MDI.		
GLUCOCORTICOIDS		
ASMANEX TWISTHALER (mometasone) FLOVENT HFA (fluticasone) FLOVENT DISKUS (fluticasone) PULMICORT RESPULES (budesonide)* QVAR (beclomethasone)	AEROSPAN (flunisolide) ALVESCO (ciclesonide) ARNUITY ELLIPTA (fluticasone) ASMANEX HFA (mometasone) budesonide PULMICORT FLEXHALER (budesonide)	*Pulmicort Respules are preferred for children up to nine (9) years of age. Brand Pulmicort Respules are preferred over the generic formulation.
HYPOGLYCEMICS, INSULIN AND RELATED AGENTS		
CATEGORY PA CRITERIA: 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) NOVOLIN (insulin) NOVOLOG (insulin aspart) NOVOLOG MIX (insulin aspart/aspart protamine)	AFREZZA (insulin) APIDRA (insulin glulisine)[AP] HUMALOG PEN/KWIKPEN (insulin lispro) HUMALOG MIX PENS (insulin lispro/lispro protamine) HUMULIN PENS (insulin) TOUJEO SOLOSTAR (insulin glargine)	Apidra will be authorized if the following criteria are met: 1. Patient is four (4) years of age or older; **and** 2. Patient is currently on a regimen including a longer acting or basal insulin, **and** 3. Patient has had a trial of a similar preferred agent, Novolog or Humalog, with documentation that the desired results were not achieved.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
HYPOGLYCEMICS, SGLT2		
CATEGORY PA CRITERIA: Non-preferred agents will be authorized for six (6) months if the following criteria are met: 1. Diagnosis of Type 2 Diabetes **AND** 2. A thirty (30) day trial of metformin taken **concurrently** with at least one (1) other preferred oral agent or sulfonylurea within the past six (6) months **AND** 3. HgB A1C levels* are equal or less than (≤) 10.5% **AND** 4. Glomerular filtration rate is greater than or equal to (≥) 45 ml/min/1.73m2 for Invokana, Jardiance and Invokamet **or** ≥ 60ml/min/1.73cm^2 for Farxiga **AND** 5. Prior authorizations will be issued at six (6) month intervals if HgB A1C levels* are less than or equal to (≤) 8% after treatment. 6. Re-authorizations require **continued** maintenance on a regimen consisting of metformin and at least one (1) other preferred oral agent or sulfonylurea. *Submitted HgB A1C levels must have been drawn within thirty (30) days of the requested prior authorization.		
	SGLT2 INHIBITORS	
	FARXIGA (dapagliflozin) INVOKANA (canagliflozin) JARDIANCE (empagliflozin)	
	SGLT2 COMBINATIONS	
	GLYXAMBI (empagliflozin/linagliptin) INVOKAMET (canagliflozin/metformin) XIGDUO XR (dapagliflozin/metformin)	
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.		
	FATTY ACIDS	
	LOVAZA (omega-3-acid ethyl esters) omega-3 acid ethyl esters VASCEPA (icosapent ethyl)	Lovaza and Vascepa shall only be authorized when the patient has had inadequate response or intolerance to trials of BOTH a nicotinic acid and a fibrate, unless otherwise contraindicated.
OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS^{AP}		
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) ALREX (loteprednol) cromolyn ketotifen PATADAY (olopatadine) ZADITOR OTC (ketotifen) ZYRTEC ITCHY EYE (ketotifen)	ALAMAST (pemirolast) ALOCRIL (nedocromil) ALOMIDE (lodoxamide) azelastine BEPREVE (bepotastine) CROLOM (cromolyn) ELESTAT (epinastine) EMADINE (emedastine) epinastine LASTACAFT (alcaftadine) OPTICROM (cromolyn) OPTIVAR (azelastine)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	PATANOL (olopatadine) PAZEO (olopatadine)	
OPIATE DEPENDENCE TREATMENTS		
CATEGORY PA CRITERIA: See below for criteria.		
SUBOXONE FILM (buprenorphine/naloxone)[CL] VIVITROL (naltrexone) [CL] naloxone	EVZIO (naloxone) buprenorphine/naloxone tablets BUNAVAIL (buprenorphine/naloxone) SUBOXONE TABLETS (buprenorphine/naloxone) ZUBSOLV (buprenorphine/naloxone)	Suboxone PA criteria is available at the BMS Website, by clicking the hyperlink. Vivitrol PA criteria is available at the BMS Website, by clicking the hyperlink. Evzio PA criteria is available at the BMS Website, by clicking the hyperlink. *
SEDATIVE HYPNOTICS[AP]		
CATEGORY PA CRITERIA: Fourteen (14) day trials of the preferred agents in both categories are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.		
OTHERS		
zolpidem 5, 10 mg	AMBIEN (zolpidem) AMBIEN CR (zolpidem) BELSOMRA (suvorexant) chloral hydrate EDLUAR (zolpidem) eszopiclone INTERMEZZO (zolpidem) LUNESTA (eszopiclone) ROZEREM (ramelteon) SILENOR (doxepin) SOMNOTE (chloral hydrate) SONATA (zaleplon) zaleplon zolpidem ER 6.25, 12.5 mg ZOLPIMIST (zolpidem)	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, zolpiderm and zolpidem ER maximum dosages will be limited to 5 mg and 6.25 mg respectively per day.
ULCERATIVE COLITIS AGENTS[AP]		
CATEGORY PA CRITERIA: 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.		
RECTAL		
CANASA (mesalamine) mesalamine	mesalamine kit ROWASA (mesalamine) SF ROWASA (mesalamine) UCERIS (budesonide)	