- 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
ALZHEIMER'S AGENTS	XXXX		XXXX
ANALGESICS, NARCOTIC LONG ACTING (NON-PARENTERAL)	XXXX	XXXX	
ANALGESICS, NARCOTIC SHORT ACTING (NON-PARENTERAL)	XXXX		
ANDROGENIC AGENTS	XXXX		XXXX
ANGIOTENSIN MODULATORS	XXXX		
ANTICOAGULANTS	XXXX		
ANTICONVULSANTS	XXXX		
ANTIFUNGALS, ORAL			XXXX
ANTIPSYCHOTICS, ATYPICAL	XXXX		
BETA BLOCKERS	XXXX	XXXX	
BLADDER RELAXANT PREPARATIONS	XXXX		
BRONCHODILATORS, BETA AGONIST			XXXX
COPD AGENTS			XXXX
CYTOKINE &; CAM ANTAGONISTS	XXXX	XXXX	
GLUCOCORTICOIDS, INHALED	XXXX	XXXX	
GROWTH HORMONE	XXXX		
HEPATITIS C TREATMENTS	XXXX	XXXX	XXXX
HYPERPARATHYROID AGENTS			XXXX
HYPOGLYCEMICS, BIGUANIDES		XXXX	
HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS	XXXX	XXXX	
HYPOGLYCEMICS, INSULIN AND RELATED AGENTS	XXXX	XXXX	
HYPOGLYCEMICS, MEGLITINIDES		XXXX	
HYPOGLYCEMICS, SGLT2 INHIBITORS		XXXX	
HYPOGLYCEMICS, TZD		XXXX	
IMMUNE GLOBULINS, IV	XXXX		

INTRANASAL RHINITIS AGENTS	XXXX		
LIPOTROPICS, OTHER (NON-STATINS)	XXXX		XXXX
MULTIPLE SCLEROSIS AGENTS	XXXX		XXXX
NEUROPATHIC PAIN			XXXX
OPHTHALMIC ANTIBIOTICS	XXXX		
OPHTHALMIC ANTIBIOTICS/STEROID COMBINATIONS	XXXX		
OPHTHALMIC ALLERGIC CONJUNCTIVITIS	XXXX		
OPHTHALMICS, GLAUCOMA AGENTS	XXXX		
OPIATE DEPENDENCE TREATMENTS		XXXX	
OTIC ANTIBIOTICS	XXXX		
SEDATIVE HYPNOTICS		XXXX	
STIMULANTS AND RELATED AGENTS	XXXX		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
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	*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.
NMDA RECEPTOR ANTAGONIST		
NAMENDA (memantine)	memantine NAMENDA XR (memantine)	
CHOLINESTERASE INHIBITOR/NMDA RECEPTOR ANTAGONIST COMBINATIONS		
	NAMZARIC (donepezil/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. If no generic form is available for the requested non-preferred brand agent, then another generic non-preferred agent must be trialed instead.		
BUTRANS (buprenorphine) EMBEDA (morphine/naltrexone) fentanyl transdermal 12, 25, 50, 75, 100 mcg/hr morphine ER tablets NUCYNTA ER (tapentadol)	CONZIP ER (tramadol) DOLOPHINE (methadone) DURAGESIC (fentanyl) EXALGO ER (hydromorphone) fentanyl transdermal 37.5, 62.5, 87.5 mcg/hr hydromorphone ER HYSINGLA ER (hydrocodone) KADIAN (morphine) methadone* morphine ER capsules (generic for Avinza) morphine ER capsules (generic for Kadian) MS CONTIN (morphine) OPANA ER (oxymorphone) oxycodone ER*	***Methadone, oxycodone ER and oxymorphone ER will be authorized without a trial of the preferred agents if a diagnosis of cancer is submitted. **Tramadol ER requires a manual review and may be authorized for 90 days with submission of a detailed treatment plan including anticipated duration of treatment and scheduled follow-ups with the prescriber.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	OXYCONTIN (oxycodone) oxymorphone ER* tramadol ER** ULTRAM ER (tramadol) XARTEMIS XR (oxycodone/ acetaminophen) ZOHYDRO ER (hydrocodone)	
ANALGESICS, NARCOTIC SHORT ACTING (Non-parenteral)[AP]		
CATEGORY PA CRITERIA: Six (6) day trials each of at least four (4) chemically distinct preferred agents (based on narcotic ingredient only), 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.		
APAP/codeine butalbital/APAP/caffeine/codeine codeine hydrocodone/APAP 2.5/325 mg, 5/325 mg, 7.5/325 mg,10/325 mg hydrocodone/APAP solution hydrocodone/ibuprofen hydromorphone tablets morphine NUCYNTA (tapentadol) oxycodone tablets, concentrate, solution oxycodone/APAP oxycodone/ASA pentazocine/naloxone ROXICET SOLUTION (oxycodone/ acetaminophen) tramadol tramadol/APAP	ABSTRAL (fentanyl) ACTIQ (fentanyl) butalbital/ASA/caffeine/codeine butorphanol CAPITAL W/CODEINE (APAP/codeine) DEMEROL (meperidine) dihydrocodeine/ APAP/caffeine DILAUDID (hydromorphone) fentanyl FENTORA (fentanyl) FIORICET W/ CODEINE (butalbital/APAP/caffeine/codeine) FIORINAL W/ CODEINE (butalbital/ASA/caffeine/codeine) hydrocodone/APAP 5/300 mg, 7.5/300 mg, 10/300 mg hydromorphone liquid, suppositories IBUDONE (hydrocodone/ibuprofen) LAZANDA (fentanyl) levorphanol LORCET (hydrocodone/APAP) LORTAB (hydrocodone/APAP) meperidine NORCO (hydrocodone/APAP) ONSOLIS (fentanyl) OPANA (oxymorphone) OXECTA (oxycodone) oxycodone capsules oxycodone/ibuprofen oxymorphone PERCOCET (oxycodone/APAP) PRIMLEV (oxycodone/APAP)	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 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.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	REPREXAIN (hydrocodone/ibuprofen) ROXICODONE (oxycodone) RYBIX ODT (tramadol) SUBSYS (fentanyl) SYNALGOS-DC (dihydrocodeine/ASA/ caffeine) TYLENOL W/CODEINE (APAP/codeine) ULTRACET (tramadol/APAP) ULTRAM (tramadol) VEDROCET (hydrocodone/APAP) VICODIN VICOPROFEN (hydrocodone/ibuprofen) XODOL (hydrocodone/acetaminophen) XYLON (hydrocodone/ibuprofen) ZAMICET (hydrocodone/APAP)	
ANDROGENIC AGENTS		
CATEGORY PA CRITERIA: A non-preferred agent will only be authorized if one (1) of the exceptions on the PA form is present.		
ANDRODERM (testosterone) ANDROGEL (testosterone)	AXIRON (testosterone) FORTESTA (testosterone) NATESTO (testosterone) TESTIM (testosterone) testosterone gel VOGELXO (testosterone)	
ANGIOTENSIN MODULATORS[AP]		
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		
benazepril captopril enalapril fosinopril lisinopril quinapril ramipril	ACCUPRIL (quinapril) ACEON (perindopril) ALTACE (ramipril) EPANED* (enalapril) LOTENSIN (benazepril) MAVIK (trandolapril) moexipril perindopril PRINIVIL (lisinopril) trandolapril UNIVASC (moexipril) VASOTEC (enalapril) ZESTRIL (lisinopril)	*Epaned will be authorized if the following critieria are met: 1 Diagnosis of hypertension, symptomatic heart failure or asymptomatic left ventricular dysfunction; **AND** a Patient is less than seven (7) years of age; **OR** b Patient is unable to ingest a solid dosage form (eg. an oral tablet or capsule) due to documented oral-motor difficulties or dysphagia.
ACE INHIBITOR COMBINATION DRUGS		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
benazepril/amlodipine benazepril/HCTZ captopril/HCTZ enalapril/HCTZ fosinopril/HCTZ lisinopril/HCTZ quinapril/HCTZ	ACCURETIC (quinapril/HCTZ) CAPOZIDE (captopril/HCTZ) LOTENSIN HCT (benazepril/HCTZ) LOTREL (benazepril/amlodipine) moexipril/HCTZ PRINZIDE (lisinopril/HCTZ) TARKA (trandolapril/verapamil) trandolapril/verapamil VASERETIC (enalapril/HCTZ) ZESTORETIC (lisinopril/HCTZ)	
ANGIOTENSIN II RECEPTOR BLOCKERS (ARBs)		
BENICAR (olmesartan) irbesartan losartan MICARDIS (telmisartan) valsartan	ATACAND (candesartan) AVAPRO (irbesartan) candesartan COZAAR (losartan) DIOVAN (valsartan) EDARBI (azilsartan) eprosartan telmisartan TEVETEN (eprosartan)	
ARB COMBINATIONS		
AZOR (olmesartan/amlodipine) BENICAR-HCT (olmesartan/HCTZ) EXFORGE HCT (valsartan/amlodipine/HCTZ) irbesartan/HCTZ losartan/HCTZ MICARDIS-HCT (telmisartan/HCTZ) TRIBENZOR (olmesartan/amlodipine/HCTZ) valsartan/amlodipine valsartan/HCTZ	ATACAND-HCT (candesartan/HCTZ) AVALIDE (irbesartan/HCTZ) candesartan/HCTZ DIOVAN-HCT (valsartan/HCTZ) EDARBYCLOR (azilsartan/chlorthalidone) ENTRESTO (valsartan/sucubitril)* EXFORGE (valsartan/amlodipine) HYZAAR (losartan/HCTZ) telmisartan/amlodipine telmisartan HCTZ TEVETEN-HCT (eprosartan/HCTZ) TWYNSTA (telmisartan/amlodipine) valsartan/amlodipine/HCTZ	*Entresto will be only be authorized for patients diagnosed with heart-failure NYHA classification 2-4 with an EF < 40%. No preferred drug trial is required to receive authorization.
DIRECT RENIN INHIBITORS		
	AMTURNIDE (aliskiren/amlodipine/HCTZ) TEKAMLO (aliskiren/amlodipine) TEKTURNA (aliskiren) TEKTURNA HCT (aliskiren/HCTZ) VALTURNA (aliskiren/valsartan)	**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. Amturnide, Tekamlo, Tekturna HCT or Valturna will be authorized if the criteria for Tekturna are met and the patient also needs the other agents in the combination.

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	ARIXTRA (fondaparinux) fondaparinux FRAGMIN (dalteparin) 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.
ANTICONVULSANTS		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
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.		
ADJUVANTS		
carbamazepine carbamazepine ER carbamazepine XR CARBATROL (carbamazepine) DEPAKOTE SPRINKLE (divalproex) divalproex divalproex ER EPITOL (carbamazepine) felbamate FYCOMPA (perampanel) GABITRIL (tiagabine) lamotrigine levetiracetam IR levetiracetam ER oxcarbazepine suspension and tablets TEGRETOL XR (carbamazepine) topiramate IR topiramate ER*** valproic acid VIMPAT(lacosamide)[AP]* zonisamide	APTIOM (eslicarbazepine) BANZEL(rufinamide) DEPAKENE (valproic acid) DEPAKOTE (divalproex) DEPAKOTE ER (divalproex) divalproex sprinkle EQUETRO (carbamazepine) FANATREX SUSPENSION (gabapentin) FELBATOL (felbamate)**** KEPPRA (levetiracetam) KEPPRA XR (levetiracetam) LAMICTAL (lamotrigine) LAMICTAL CHEWABLE (lamotrigine) LAMICTAL ODT (lamotrigine) LAMICTAL XR (lamotrigine) lamotrigine dose pack lamotrigine ER ONFI (clobazam) ** ONFI SUSPENSION (clobazam) ** OXTELLAR XR (oxcarbazepine) POTIGA (ezogabine) QUDEXY XR (topiramate ER) SABRIL (vigabatrin) STAVZOR (valproic acid) TEGRETOL (carbamazepine) tiagabine TOPAMAX (topiramate) TRILEPTAL SUSPENSION and TABLETS (oxcarbazepine) TROKENDI XR (topiramate) ZONEGRAN (zonisamide)	*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. **Onfi will be authorized if the following criteria are met: 1. Adjunctive therapy for Lennox-Gastaut **or** 2. Generalized tonic, atonic or myoclonic seizures **and** 3. Previous failure of at least two (2) non-benzodiazepine anticonvulsants and previous failure of clonazepam. (For continuation, prescriber must include information regarding improved response/effectiveness with this medication) ***Topiramate ER will be authorized after adequate trial of topiramate IR ****Patients stabilized on Felbatol will be grandfathered
BARBITURATES[AP]		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
phenobarbital primidone	MYSOLINE (primidone)	
BENZODIAZEPINES[AP]		
clonazepam DIASTAT (diazepam rectal) diazepam tablets	clonazepam ODT diazepam rectal gel KLONOPIN (clonazepam) VALIUM TABLETS (diazepam)	
HYDANTOINS[AP]		
DILANTIN (phenytoin sodium, extended) PEGANONE (ethotoin) phenytoin capsules, chewable tablets, suspension	DILANTIN INFATABS (phenytoin) PHENYTEK (phenytoin)	
Ssuccinimides		
CELONTIN (methsuximide) ethosuximide syrup ZARONTIN (ethosuximide) capsules	ethosuximide capsules ZARONTIN (ethosuximide) syrup	
ANTIFUNGALS, ORAL		
CATEGORY PA CRITERIA: Non-preferred agents will be authorized only if one (1) of the exceptions on the PA form is present.		
clotrimazole fluconazole* nystatin terbinafine [CL]	ANCOBON (flucytosine) CRESEMBA (isovuconazonium) DIFLUCAN (fluconazole) flucytosine GRIFULVIN V TABLET (griseofulvin) griseofulvin GRIS-PEG (griseofulvin) itraconazole ketoconazole** LAMISIL (terbinafine) MYCELEX (clotrimazole) MYCOSTATIN Tablets (nystatin) NIZORAL (ketoconazole) NOXAFIL (posaconazole) ONMEL (itraconazole) ORAVIG (miconazole) SPORANOX (itraconazole) VFEND (voriconazole) voriconazole suspension voriconazole tablets	*PA is required when limits are exceeded. PA is not required for griseofulvin suspension for children up to six (6) years of age for the treatment of tinea capitis. **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**

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
		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.
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 clozapine ODT INVEGA SUSTENNA (paliperidone)** CL INVEGA TRINZA (paliperidone) CL LATUDA (lurasidone) AP olanzapine olanzapine ODT quetiapine*** AP for the 25 mg Tablet Only RISPERDAL CONSTA (risperidone) ** CL risperidone ziprasidone	ADASUVE (loxapine) aripiprazole CLOZARIL (clozapine) FANAPT (iloperidone) FAZACLO (clozapine) GEODON (ziprasidone) GEODON IM (ziprasidone) INVEGA (paliperidone) olanzapine IM** REXULTI (brexipiprazole) RISPERDAL (risperidone) SAPHRIS (asenapine) 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.
ATYPICAL ANTIPSYCHOTIC/SSRI COMBINATIONS		
	olanzapine/fluoxetine SYMBYAX (olanzapine/fluoxetine)	
BETA BLOCKERS AP		
CATEGORY PA CRITERIA: 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.		
BETA BLOCKERS		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
acebutolol atenolol betaxolol bisoprolol metoprolol metoprolol ER nadolol pindolol propranolol sotalol timolol	BETAPACE (sotalol) BYSTOLIC (nebivolol) CORGARD (nadolol) HEMANGEOL (propranolol)* INDERAL LA (propranolol) INDERAL XL (propranolol) INNOPRAN XL (propranolol) KERLONE (betaxolol) LEVATOL (penbutolol) LOPRESSOR (metoprolol) propranolol ER** SECTRAL (acebutolol) TENORMIN (atenolol) TOPROL XL (metoprolol) ZEBETA (bisoprolol)	*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
BETA BLOCKER/DIURETIC COMBINATION DRUGS		
atenolol/chlorthalidone bisoprolol/HCTZ metoprolol/HCTZ nadolol/bendroflumethiazide propranolol/HCTZ	CORZIDE (nadolol/bendroflumethiazide) DUTOPROL (metoprolol ER/HCTZ ER) LOPRESSOR HCT (metoprolol/HCTZ) TENORETIC (atenolol/chlorthalidone) ZIAC (bisoprolol/HCTZ)	
BETA- AND ALPHA-BLOCKERS		
carvedilol labetalol	COREG (carvedilol) COREG CR (carvedilol) TRANDATE (labetalol)	
BLADDER RELAXANT PREPARATIONS[AP]		
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.		
oxybutynin IR oxybutynin ER VESICARE (solifenacin)	DETROL (tolterodine) DETROL LA (tolterodine) DITROPAN XL (oxybutynin) ENABLEX (darifenacin) flavoxate GELNIQUE (oxybutynin) MYRBETRIQ (mirabegron) OXYTROL (oxybutynin) SANCTURA (trospium) SANCTURA XR (trospium) tolterodine tolterodine ER TOVIAZ (fesoterodine) trospium	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	trospium ER	
BRONCHODILATORS, BETA AGONIST[AP]		
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		
ACCUNEB (albuterol)* albuterol	BROVANA (arformoterol) levalbuterol metaproterenol PERFOROMIST (formoterol) XOPENEX (levalbuterol)	*No PA is required for Accuneb for children up to five (5) years of age.
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)	
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.
ANTICHOLINERGIC-BETA AGONIST COMBINATIONS[AP]		
albuterol/ipratropium COMBIVENT RESPIMAT (albuterol/ipratropium)	ANORO ELLIPTA (umeclidinium/vilanterol) DUONEB (albuterol/ipratropium) STIOLTO RESPIMAT (tiotropium/olodaterol)	*Anoro Ellipta and Stiolto Respimat will be authorized if the following criteria are met: 1) Patient must be eighteen (18) years of age or older; **AND** 2) Patient must have had a diagnosis of COPD; **AND** 3) Patient must have had a thirty (30) day trial of a LABA; **AND** 4) Patient must have had a **concurrent thirty (**30) day trial with a long-acting anticholinergic; Prior-authorization will be denied for patients with a sole diagnosis of asthma.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	PDE4 INHIBITOR	
	DALIRESP (roflumilast)*	*Daliresp will be authorized if the following criteria are met: 1. Patient is forty (40) years of age or older **and** 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** **3.** Concurrent therapy with an inhaled corticosteroid and long-acting bronchodilator and evidence of compliance **and** **4.** No evidence of moderate to severe liver impairment (Child-Pugh Class B or C) **and** 5. No concurrent use with strong cytochrome P450 inducers (rifampicin, phenobarbital, carbamazepine or phenytoin)
CYTOKINE & CAM ANTAGONISTS[CL]		
CATEGORY PA CRITERIA: 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 the indication of plaque psoriasis, Cosentyx must also be trialed for 90 days.		
	ANTI-TNFs	
ENBREL (etanercept) * HUMIRA (adalimumab) *	CIMZIA (certolizumab pegol) SIMPONI (golimumab)	*Additional criteria for this category may be found at the BMS Website, by clicking the hyperlink.
	OTHERS	
COSENTYX (secukinumab)*	ACTEMRA syringe (tocilizumab) KINERET (anakinra) ORENCIA syringe (abatacept) OTEZLA (apremilast) STELARA syringe (ustekinumab) XELJANZ (tofacitinib)*	*Cosentyx will be authorized for treatment of plaque psoriasis only after inadequate response to trial of Humira.
EPINEPHRINE, SELF-INJECTED		
CATEGORY PA CRITERIA: 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.		
epinephrine EPIPEN (epinephrine) EPIPEN JR (epinephrine)	ADRENACLICK (epinephrine) AUVI-Q (epinephrine)	
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	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
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. ** Aerospan will be authorized for children ages 6-11 years old without a trial of a preferred agent.
GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS		
ADVAIR HFA (fluticasone/salmeterol) BREO ELLIPTA (fluticasone/vilanerol) DULERA (mometasone/formoterol) SYMBICORT(budesonide/formoterol)	ADVAIR DISKUS (fluticasone/salmeterol)	**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[CL]		
CATEGORY PA CRITERIA: A trial of each preferred agents is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.		
GENOTROPIN (somatropin) NORDITROPIN (somatropin) NUTROPIN AQ (somatropin)	HUMATROPE (somatropin) INCRELEX (mecasermin) OMNITROPE (somatropin) SAIZEN (somatropin) SEROSTIM (somatropin) TEV-TROPIN (somatropin) ZORBTIVE (somatropin)	Patients already on a non-preferred agent will receive authorization to continue therapy on that agent for the duration of the existing PA.
HEPATITIS C TREATMENTS[CL]		
CATEGORY PA CRITERIA: 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.		
HARVONI (ledipasvir/sofosbuvir)* PEGASYS (pegylated interferon) PEG-INTRON (pegylated interferon) ribavirin SOVALDI (sofosbuvir)* TECHNIVIE (ombitasvir/paritaprevir/ritonavir)* VIEKIRA PAK (dasabuvir/ombitasvir/ paritaprevir/ritonavir)*	COPEGUS (ribavirin) DAKLINZA (daclatasvir) MODERIBA 400 mg, 600 mg MODERIBA DOSE PACK OLYSIO (simeprevir)* REBETOL (ribavirin) RIBASPHERE RIBAPAK (ribavirin) RIBASPHERE 400 mg, 600 mg (ribavirin)	*Full PA criteria may be found at the BMS Website, by clicking the hyperlink.
HYPERPARATHYROID AGENTS[AP]		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
CATEGORY PA CRITERIA: A thirty (30) day trial of a 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.		
HECTOROL (doxercalciferol) paricalcitol capsule	doxercalciferol NATPARA (parathyroid hormone) paricalcitol injection SENSIPAR (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 metformin ER	FORTAMET (metformin ER) GLCOPHAGE (metformin) GLUCOPHAGE XR (metformin ER) GLUMETZA (metformin ER) RIOMET (metformin)	Glumetza will be approved only after a 30-day trial of Fortamet.
HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS		
CATEGORY PA CRITERIA: All agents will 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 60 days reflecting the patient's current and stabilized regimen. Unless contraindicated, no agent in this category shall be approved except as add on therapy to a regimen containing metformin prescribed at the maximum tolerable dose for at least 60 days. **Re-authorizations** require continued maintenance on metformin prescribed at the maximum tolerable dose. Documentation must be submitted indicating that the A1C has decreased by at least 1% or is maintained at ≤8%.		
INJECTABLE		
BYDUREON (exenatide)* BYETTA (exenatide)[AP] VICTOZA (liraglutide)	SYMLIN (pramlintide) ** TANZEUM (albiglutide)[AP] TRULICITY (dulaglutide)	**In addition to the Category Criteria**: A thirty (30) day trial of one (1) preferred agent with a chemical entity distinct from the requested non-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. Concurrent therapy with bolus insulin is contraindicated with all agents in this class. *Bydureon may be authorized after 3 months of compliant therapy with Byetta and will not be authorized with insulin therapy of any kind. **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.
ORAL[AP]		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
JANUMET (sitagliptin/metformin)[AP] JANUMET XR (sitagliptin/metformin) [AP] JANUVIA (sitagliptin) [AP] JENTADUETO (linagliptin/metformin) [AP] TRADJENTA (linagliptin) [AP]	KAZANO (alogliptin/metformin) KOMBIGLYZE XR (saxagliptin/metformin) * NESINA (alogliptin) ONGLYZA (saxagliptin) OSENI (alogliptin/pioglitazone)	**In addition to the Category Criteria**: Thirty (30) day trials of each chemically distinct preferred agent are required before a non-preferred agent will be approved. *Kombiglyze XR will be authorized after thirty (30) day trials of the preferred combination agents.
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) NOVOLOG (insulin aspart) NOVOLOG MIX (insulin aspart/aspart protamine)	AFREZZA (insulin)[CL] APIDRA (insulin glulisine)[AP] HUMALOG PEN/KWIKPEN (insulin lispro) HUMALOG MIX PENS (insulin lispro/lispro protamine) HUMULIN PENS (insulin) NOVOLIN (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. *Toujeo Solostar will be authorized only after 6 months of compliance on a preferred long-acting insulin.
HYPOGLYCEMICS, MEGLITINIDES		
CATEGORY PA CRITERIA: All agents will 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 60 days reflecting the patient's current and stabilized regimen. Unless contraindicated, no agent in this category shall be approved except as add on therapy to a regimen containing metformin prescribed at the maximum tolerable dose for at least 60 days. **Re-authorizations** require continued maintenance on metformin prescribed at the maximum tolerable dose. Documentation must be submitted indicating that the A1C has decreased by at least 1% or is maintained at ≤8%. NOTE: 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.		
MEGLITINIDES		
nateglinide PRANDIN (repaglinide)	repaglinide STARLIX (nateglinide)	
MEGLITINIDE COMBINATIONS		
	PRANDIMET (repaglinide/metformin)	
HYPOGLYCEMICS, SGLT2 INHIBITORS		
CATEGORY PA CRITERIA: All agents will 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 60 days reflecting the patient's current and stabilized regimen. Current A1C must be less than or equal to (≤) 10.5%. No agent in this category shall be approved except as add on therapy to a regimen consisting of metformin and one other		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
oral agent prescribed at the maximum tolerable doses for at least 60 days. **Re-authorizations** require <u>continued</u> maintenance on a regimen consisting of metformin and one other oral agent. Documentation must be submitted that the A1C has decreased by at least 1% or is maintained at ≤8%.		
	SGLT2 INHIBITORS	
	FARXIGA (dapagliflozin) INVOKANA (canagliflozin) JARDIANCE (empagliflozin)	
	SGLT2 COMBINATIONS	
	GLYXAMBI (empagliflozin/linagliptin) INVOKAMET (canagliflozin/metformin) SYNJARDY (empagliflozin/metformin) XIGDUO XR (dapagliflozin/metformin)	
HYPOGLYCEMICS, TZD[AP]		
CATEGORY PA CRITERIA: All agents will 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 60 days reflecting the patient's current and stabilized regimen. Unless contraindicated, no agent in this category shall be approved except as add on therapy to a regimen containing metformin prescribed at the maximum tolerable dose for at least 60 days. **Re-authorizations** require <u>continued</u> maintenance on metformin prescribed at the maximum tolerable dose. Documentation must be submitted indicating that the A1C has decreased by at least 1% or is maintained at ≤8%. NOTE: 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.		
	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[CL]		
CATEGORY PA CRITERIA: Immune globulin agents will be authorized according to FDA approved indications.		
BIVIGAM (human immunoglobulin gamma) CARIMUNE NF (human immunoglobulin gamma)		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
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[CL]		
CATEGORY PA CRITERIA: Immune globulin agents will be authorized according to FDA approved indications. A 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.		
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 immuneglobulin g and hyaluronidase)	
INTRANASAL RHINITIS AGENTS[AP]		
CATEGORY PA CRITERIA: See below for individual sub-class criteria.		
	ANTICHOLINERGICS	
Ipratropium	ATROVENT(ipratropium)	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.
	ANTIHISTAMINES	
ASTEPRO (azelastine) PATANASE (olopatadine)	azelastine	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.
	COMBINATIONS	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	DYMISTA (azelastine / fluticasone)	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.
	CORTICOSTEROIDS	
fluticasone propionate QNASL HFA (beclomethasone)	BECONASE AQ (beclomethasone) budesonide FLONASE (fluticasone propionate) flunisolide NASACORT AQ (triamcinolone) NASONEX (mometasone) OMNARIS (ciclesonide) RHINOCORT AQUA (budesonide) triamcinolone VERAMYST (fluticasone furoate) ZETONNA (ciclesonide)	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.
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	
cholestyramine colestipol tablets	COLESTID (colestipol) colestipol granules KYNAMRO (mipomersen) QUESTRAN (cholestyramine) WELCHOL (colesevelam)*	*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.
	CHOLESTEROL ABSORPTION INHIBITORS	
ZETIA (ezetimibe) AP		Zetia will be authorized with prior use of a HMG-CoA reductase inhibitor within the previous six (6) months.
	FATTY ACIDS	
	LOVAZA (omega-3-acid ethyl esters) omega-3 acid ethyl esters VASCEPA (icosapent ethyl)	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.
	FIBRIC ACID DERIVATIVES	
fenofibrate 54, 150 and 160 mg fenofibrate micronized 67mg, 134mg & 200mg fenofibrate nanocrystallized 48 mg, 145 mg gemfibrozil	ANTARA (fenofibrate) FENOGLIDE (fenofibrate) FIBRICOR (fenofibric acid) fenofibrate 43, 50, 120 and 130 mg fenofibric acid LIPOFEN (fenofibrate) LOFIBRA (fenofibrate) LOPID (gemfibrozil)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	TRICOR (fenofibrate nanocrystallized) TRIGLIDE (fenofibrate) TRILIPIX (fenofibric acid)	
	NIACIN	
niacin NIACOR (niacin) NIASPAN (niacin)	niacin ER	
	PCSK-9 INHIBITORS	
	PRALUENT (alirocumab)	Praluent PA criteria is available at the BMS Website by clicking on this hyperlink.
MULTIPLE SCLEROSIS AGENTS		
CATEGORY PA CRITERIA: A diagnosis of multiple sclerosis and a thirty (30) day trial of a preferred agent in the corresponding class (interferon or non-interferon) will be required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.		
	INTERFERONS[AP]	
AVONEX (interferon beta-1a)[AP] AVONEX PEN (interferon beta-1a)[AP] BETASERON (interferon beta-1b) [AP]	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)[AP] GILENYA (fingolimod) [AP*****]	AMPYRA (dalfampridine)[CL*] AUBAGIO (teriflunomide)[CL**] COPAXONE 40 mg (glatiramer)[CL***] GLATOPA (glatiramer) TECFIDERA (dimethyl fumarate)[CL****]	*Amypra will be authorized if the following criteria are met: 1. Diagnosis of multiple sclerosis **and** 2. No history of seizures **and** 3. No evidence of moderate or severe renal impairment **and** 4. Initial prescription will be authorized for thirty (30) days only. **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 ***Copaxone 40mg will only be authorized for documented injection site issues.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
		****Tecfidera will be authorized if the following criteria are met: 1. Diagnosis of relapsing multiple sclerosis **and** 2. A thirty (30) day trial of a preferred agent in the corresponding class **and** 3. Complete blood count (CBC) within six (6) months of initiation of therapy and six (6) months after initiation **and** 4. Complete blood count (CBC) annually during therapy *****Gilenya will be approved after trial of a preferred injectable agent.
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.		
capsaicin OTC duloxetine gabapentin capsules, solution LIDODERM (lidocaine)[AP]**	CYMBALTA (duloxetine) gabapentin tablets GRALISE (gabapentin)* HORIZANT (gabapentin) IRENKA (duloxetine) lidocaine patch LYRICA CAPSULE (pregabalin)*** LYRICA SOLUTION (pregabalin)*** NEURONTIN (gabapentin) QUTENZA (capsaicin) SAVELLA (milnacipran)**** ZOSTRIX OTC (capsaicin)	*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** 4. Request is for once daily dosing with 1800 mg maximum daily dosage. **Lidoderm patches will be authorized for a diagnosis of post-herpetic neuralgia. ***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:

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
		duloxetine, gabapentin, amitriptyline or nortriptyline.
OPHTHALMIC ANTIBIOTICS[AP]		
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.		
bacitracin/polymyxin ointment BESIVANCE (besifloxacin) ciprofloxacin* erythromycin gentamicin MOXEZA (moxifloxacin)* neomycin/polymyxin/gramicidin ofloxacin* polymyxin/trimethoprim sulfacetamide tobramycin VIGAMOX (moxifloxacin)*	AZASITE (azithromycin) bacitracin BLEPH-10 (sulfacetamide) CILOXAN (ciprofloxacin) GARAMYCIN (gentamicin) gatifloxacin ILOTYCIN (erythromycin) levofloxacin NATACYN (natamycin) neomycin/bacitracin/polymyxin NEOSPORIN (neomycin/polymyxin/gramicidin) OCUFLOX (ofloxacin) POLYTRIM (polymyxin/trimethoprim) sulfacetamide ointment TOBREX (tobramycin) ZYMAR (gatifloxacin) ZYMAXID (gatifloxacin)	The American Academy of Ophthalmology guidelines on treating bacterial conjunctivitis recommend as first line treatment options: erythromycin ointment, sulfacetamide drops, or polymyxin/trimethoprim drops. *A prior authorization is required for the fluoroquinolone agents for patients up to twenty-one (21) years of age unless there has been a trial of a first line treatment option within the past ten (10) days.
OPHTHALMIC ANTIBIOTIC/STEROID COMBINATIONS[AP]		
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.		
BLEPHAMIDE (prednisolone/sulfacetamide) neomycin/polymyxin/dexamethasone sulfacetamide/prednisolone TOBRADEX OINTMENT (tobramycin/ dexamethasone) TOBRADEX ST (tobramycin/ dexamethasone) TOBRADEX SUSPENSION (tobramycin/ dexamethasone)	BLEPHAMIDE S.O.P. (prednisolone/ sulfacetamide) MAXITROL ointment (neomycin/polymyxin/ dexamethasone) MAXITROL suspension (neomycin/polymyxin/ dexamethasone) neomycin/bacitracin/polymyxin/ hydrocortisone neomycin/polymyxin/hydrocortisone PRED-G (prednisolone/gentamicin) tobramycin/dexamethasone suspension ZYLET (loteprednol/tobramycin)	
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.		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ALAWAY (ketotifen) cromolyn ketotifen PATADAY (olopatadine) ZADITOR OTC (ketotifen) ZYRTEC ITCHY EYE (ketotifen)	ALAMAST (pemirolast) ALOCRIL (nedocromil) ALOMIDE (lodoxamide) ALREX (loteprednol) azelastine BEPREVE (bepotastine) CROLOM (cromolyn) ELESTAT (epinastine) EMADINE (emedastine) epinastine LASTACAFT (alcaftadine) OPTICROM (cromolyn) OPTIVAR (azelastine) PATANOL (olopatadine) PAZEO (olopatadine)	
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		
COMBIGAN (brimonidine/timolol) dorzolamide/timolol SIMBRINZA (brinzolamide/brimonidine)	COSOPT (dorzolamide/timolol) COSOPT PF (dorzolamide/timolol)	
BETA BLOCKERS		
BETOPTIC S (betaxolol) carteolol levobunolol metipranolol timolol	BETAGAN (levobunolol) betaxolol BETIMOL (timolol) ISTALOL (timolol) OPTIPRANOLOL (metipranolol) TIMOPTIC (timolol)	
CARBONIC ANHYDRASE INHIBITORS		
AZOPT (brinzolamide) dorzolamide	TRUSOPT (dorzolamide)	
PARASYMPATHOMIMETICS		
PHOSPHOLINE IODIDE (echothiophate iodide)	pilocarpine	
PROSTAGLANDIN ANALOGS		
latanoprost TRAVATAN-Z (travoprost)	bimatoprost LUMIGAN (bimatoprost) RESCULA (unoprostone) travoprost XALATAN (latanoprost) ZIOPTAN (tafluprost)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	SYMPATHOMIMETICS	
brimonidine 0.2%	ALPHAGAN P 0.1% Solution (brimonidine) ALPHAGAN P 0.15% Solution (brimonidine) apraclonidine brimonidine 0.15% IOPIDINE (apraclonidine)	
OPIATE DEPENDENCE TREATMENTS		
CATEGORY PA CRITERIA: 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. All buprenorphine-containing agents will be limited to a maximum of a 6 month prior-authorization during which it is expected that the prescriber will attempt to taper the patient's dose. Reauthorizations will only be granted upon receipt of a detailed treatment plan. If no attempt was made to taper, re-authorization shall only be granted with explicit documentation indicating why a taper was not attempted in addition to a detailed treatment plan.		
SUBOXONE FILM (buprenorphine/naloxone)[CL] VIVITROL (naltrexone) [CL] naloxone	EVZIO (naloxone) buprenorphine/naloxone tablets BUNAVAIL (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.
OTIC ANTIBIOTICS[AP]		
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.		
CIPRO HC (ciprofloxacin/hydrocortisone) CIPRODEX (ciprofloxacin/dexamethasone)* ciprofloxacin COLY-MYCIN S (colistin/hydrocortisone/ neomycin/thonzonium bromide) neomycin/polymyxin/HC solution/suspension	CORTISPORIN-TC (colistin/hydrocortisone/ neomycin) ofloxacin	*Ciprodex is limited to patients up to nine (9) years of age. Age exceptions will be handled on a case-by-case basis.
SEDATIVE HYPNOTICS[~~AP~~]		
CATEGORY PA CRITERIA: All agents require a prior authorization. Preferred agents will be granted a 30 day prior authorization after which documentation must be submitted indicating the patient has been re-assessed for the cause of their sleep disturbance. A maximum of three (3) prior-authorizations may be granted after which a 1 month washout period is required. Re-authorization after this washout period will require a new assessment and diagnosis of insomnia. Thirty (30) day trials of the preferred agents in both categories are required before any non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. All agents in this class will be limited to 15 tablets in a 30 day period.		
	BENZODIAZEPINES	
temazepam 15, 30 mg	DALMANE (flurazepam) DORAL (quazepam)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	estazolam flurazepam HALCION (triazolam) quazepam RESTORIL (temazepam) temazepam 7.5, 22.5 mg triazolam	
	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.
STIMULANTS AND RELATED AGENTS		
CATEGORY PA CRITERIA: A PA is required for adults eighteen (18) years of age or older. A thirty (30) day trial of one of the preferred agents in each group (amphetamines and non-amphetamines) is required before a non-preferred agent will be authorized. In addition, a thirty (30) day trial of a long-acting preferred agent in each class is required before a non-preferred long-acting stimulant will be authorized. Patients stabilized on non-preferred agents will be grandfathered.		
	AMPHETAMINES	
amphetamine salt combination IR DEXEDRINE ER (dextroamphetamine) dextroamphetamine IR PROCENTRA solution (dextroamphetamine) VYVANSE (lisdexamfetamine)	ADDERALL XR* (amphetamine salt combination) amphetamine salt combination ER DESOXYN (methamphetamine) DEXEDRINE IR (dextroamphetamine) dextroamphetamine ER dextroamphetamine solution EVEKEO (amphetamine) methamphetamine ZENZEDI (dextroamphetamine)	**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. *Adderall XR is preferred over its generic equivalents.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	NON-AMPHETAMINE	
clonidine IR DAYTRANA (methylphenidate) dexmethylphenidate IR FOCALIN XR (dexmethylphenidate) guanfacine IR METADATE CD (methylphenidate) METHYLIN SOLUTION (methylphenidate) methylphenidate IR methylphenidate ER (authorized generic Concerta – Actavis labeler 00591) STRATTERA (atomoxetine)*	APTENSIO XR (methylphenidate) clonidine ER CONCERTA (methylphenidate) dexmethylphenidate XR FOCALIN IR (dexmethylphenidate) guanfacine ER** INTUNIV (guanfacine extended-release) KAPVAY (clonidine extended-release)** METHYLIN CHEWABLE TABLETS (methylphenidate) methylphenidate chewable tablets, solution methylphenidate CD methylphenidate ER methylphenidate LA modafinil*** NUVIGIL (armodafinil) *** PROVIGIL (modafinil) *** QUILLIVANT XR (methylphenidate) RITALIN (methylphenidate) RITALIN LA (methylphenidate)	*Strattera does not required 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. ** Guanfacine ER and Kapvay/clonidine ER will be authorized if the following criteria are met: 1. Fourteen (14) day trials of at least one (1) preferred product from the amphetamine and non-amphetamine class **and** 2. A fourteen (14) day trial of clonidine IR (for Kapvay) and guanfacine IR (for guanfacine ER) unless one (1) of the exceptions on the PA form is present**.** 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.