- Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. A current listing of all covered OTC products may be found at the BMS Website by clicking the hyperlink.
- Prior authorization of any non-preferred agent requires that class criteria, and in some cases drug-specific criteria, be followed unless documentation is provided indicating that the use of these agents would be medically contraindicated. "Exceptions" to the PA criteria should be detailed on the PA form for consideration – these include relative contraindications, such as potential drug-drug interactions, adverse effects, intolerance, and drug-disease interactions.
- Required trials of preferred agents are defined as "failed" or otherwise satisfied only when efficacy has not been observed despite patient adherence to a dose and duration which should have produced therapeutic effects.
- Unless otherwise specified, all requests to "grandfather" existing drug therapy will require clinical reasoning from the prescriber detailing why the patient can not be transitioned to a preferred agent from the Medicaid PDL. Please note that this requirement includes therapy that may have been previously preferred on the Medicaid PDL but has since changed to non-preferred status.
- 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.
- Other drug utilization review retrictions may apply, including, but not limited to, therapeutic duplication, drug-drug interaction, ingredient duplication, etc.
- 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 containing the same, or similar, active ingredient.
- Acronyms
    - CL - Requires clinical PA. For detailed clinical criteria, please go to the PA criteria page by clicking the hyperlink.
    - NR – Denotes a new drug which has not yet been reviewed by the P & T Committee. **These agents are available only on appeal to the BMS Medical Director.**
    - 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
DIABETES AGENTS, SGLT2 INHIBITORS	X		
HYPOGLYCEMIA TREATMENTS	X		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ACNE AGENTS, TOPICAL[AP]		
CLASS PA CRITERIA: Non-preferred agents require a thirty (30) day trial 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, before they will be approved, 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-class will be listed below.** NOTE: Non-preferred agents in the Rosacea sub-class are available only on appeal and require at least a 30-day trial of all preferred agents in that sub-class.		
	ANDROGEN RECEPTOR INHIBITORS	
	WINLEVI CREAM (clascoterone)	
	ANTI-INFECTIVE	
CLINDAGEL (clindamycin) clindamycin lotion, medicated swab, solution erythromycin gel, solution	AMZEEQ FOAM (minocycline) CLEOCIN-T (clindamycin) CLINDACIN ETZ kit, medicated swab (clindamycin) CLINDACIN P (clindamycin) CLINDACIN PAC (clindamycin) clindamycin gel, foam dapsone ERYGEL (erythromycin) erythromycin medicated swab EVOCLIN (clindamycin) FABIOR (tazarotene) KLARON (sulfacetamide) OVACE/PLUS (sulfacetamide) sodium sulfacetamide 10% cleansing gel sulfacetamide	
	RETINOIDS	
adapalene gel RETIN-A (tretinoin) RETIN-A MICRO (tretinoin)	adapalene cream, lotion ALTRENO LOTION (tretinoin) ARAZLO (tazarotene) ATRALIN (tretinoin) AVITA (tretinoin) tazarotene cream, foam, gel tretinoin cream, gel tretinoin gel micro	**In addition to the Class Criteria**: PA required for members eighteen (18) years of age or older.
	KERATOLYTICS	
benzoyl peroxide cleanser Rx & OTC, 10% cream OTC, gel Rx & OTC, lotion OTC, wash OTC PANOXYL-4 OTC (benzoyl peroxide)	BENZEFOAM benzoyl peroxide) BP 10-1 (benzoyl peroxide) BPO (benzoyl peroxide)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	COMBINATION AGENTS	
ACANYA (clindamycin phosphate/benzoyl peroxide) BENZAMYCIN PAK (benzoyl peroxide/ erythromycin) benzoyl peroxide/clindamycin gel (generic DUAC only) ONEXTON (clindamycin phosphate/benzoyl peroxide) sulfacetamide sodium/sulfur suspension ZIANA (clindamycin/tretinoin)*	adapalene-benzoyl peroxide* AVAR/-E/LS (sulfur/sulfacetamide) benzoyl peroxide/clindamycin gel (all generics other than DUAC) benzoyl peroxide/erythromycin benzoyl peroxide/urea clindamycin phosphate/benzoyl peroxide (generic Acanya) clindamycin-tretinoin gel* NEUAC (clindamycin phosphate/benzoyl peroxide) SSS 10-4 (sulfacetamide /sulfur) SSS 10-5 foam (sulfacetamide /sulfur) sulfacetamide sodium/sulfur cloths, lotion, pads sulfacetamide/sulfur wash, cleanser sulfacetamide/sulfur wash kit sulfacetamide sodium/sulfur/urea SUMADAN/XLT (sulfacetamide/sulfur) SUMAXIN/TS (sulfacetamide sodium/sulfur) ZMA CLEAR (sulfacetamide sodium/sulfur)	**In addition to the Class Criteria:** Non-preferred combination agents require thirty (30) day trials of the corresponding preferred single agents before they will be approved. *PA required for combination agents with Retinoid products for members eighteen (18) years of age or older.
	ROSACEA AGENTS	
azelaic acid gel FINACEA GEL (azelaic acid) metronidazole cream metronidazole gel 0.75% (NDCs 00115-1474-46, 00713-0637-37, 51672-4116-06, 66993-0962-45 only)	FINACEA FOAM (azelaic acid) ivermectin metronidazole gel (all other NDCs) metronidazole lotion NORITATE CREAM (metronidazole) RHOFADE (oxymetazoline) ROSADAN (metronidazole) ZILXI (minocycline) foam	**Subclass criteria**: Non-preferred agents are available only on appeal and require evidence of 30-day trials of all chemically-unique preferred agents in the sub-class.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ALZHEIMER'S AGENTS[AP]		
CLASS PA CRITERIA: Non-preferred agents require a thirty (30) day trial of a preferred agent in the same sub-class before they will be approved, 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 donepezil ODT EXELON PATCH (rivastigmine) galantamine tablet galantamine ER capsule RAZADYNE ER (galantamine) rivastigmine capsule	ADLARITY PATCH (donepezil) ARICEPT (donepezil) donepezil 23 mg* galantamine solution rivstigmine patch	*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		
memantine NAMENDA (memantine)	memantine ER memantine solution NAMENDA XR (memantine)*	*Namenda XR requires ninety (90) days of compliant therapy with Namenda.
CHOLINESTERASE INHIBITOR/NMDA RECEPTOR ANTAGONIST COMBINATIONS		
	NAMZARIC (donepezil/memantine)	Combination agents require thirty (30) day trials of each corresponding preferred single agent.
ANALGESICS, NARCOTIC LONG ACTING (Non-parenteral)[AP]		
CLASS PA CRITERIA: Non-preferred agents require six (6) day trials of three (3) chemically distinct preferred agents (excluding fentanyl) **AND** a six (6) day trial of the generic form of the requested non-preferred agent (if available) before they will be approved, unless one (1) of the exceptions on the PA form is present. 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 under 18 years of age.** Requests must be for an FDA approved age and indication and specify previous opioid and non-opioid therapies attempted.		
BUTRANS (buprenorphine) fentanyl transdermal 12, 25, 50, 75, 100 mcg/hr [CL/PA] morphine ER tablets tramadol ER tablets (generic Ultram ER) XTAMPZA ER (oxycodone)	ARYMO ER (morphine sulfate) BELBUCA (buprenorphine buccal film)* buprenorphine buccal film buprenorphine patch (all labelers including 00093) CONZIP ER (tramadol) fentanyl transdermal 37.6, 62.5, 87.5 mcg/hr hydrocodone ER capsule and tablet hydromorphone ER HYSINGLA ER (hydrocodone) KADIAN (morphine) methadone** MORPHABOND ER (morphine sulfate) morphine ER capsules (generic for Avinza) morphine ER capsules (generic for Kadian) MS CONTIN (morphine) NUCYNTA ER (tapentadol)****	*Belbuca prior authorization requires manual review. Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. **Methadone will be authorized without a trial of the preferred agents if a diagnosis of cancer is submitted. ***Tramadol ER (generic Conzip) 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. ****Nucynta requires six (6) day trials of three (3) chemically distinct preferred agents

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	oxycodone ER OXYCONTIN (oxycodone) oxymorphone ER tramadol ER (generic Conzip ER)*** ULTRAM ER (tramadol) ZOHYDRO ER (hydrocodone)	
ANALGESICS, NARCOTIC SHORT ACTING (Non-parenteral)[AP]		
CLASS PA CRITERIA: Non-preferred agents require six (6) day trials of at least four (4) chemically distinct preferred agents (based on the narcotic ingredient only), including the generic formulation of the requested non-preferred agent, before they will be approved, unless one (1) of the exceptions on the PA form is present. **NOTE: All tramadol and codeine products require a prior authorization for children under 18 years of age.** Requests must be for an FDA approved age and indication and specify non-opioid therapies attempted.		
APAP/codeine butalbital/APAP/caffeine/codeine 50-325-30 mg codeine hydrocodone/APAP 2.5/325 mg, 5/325 mg, 7.5/325 mg,10/325 mg hydrocodone/APAP solution hydromorphone tablets meperidine oral solution morphine NUCYNTA (tapentadol) oxycodone capsule, tablets, solution oxycodone/APAP oxycodone/ASA tramadol tablets tramadol/APAP	ABSTRAL (fentanyl) ACTIQ (fentanyl) butalbital/APAP/caffeine/codeine 50-300-30 mg butalbital/ASA/caffeine/codeine butorphanol 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 hydrocodone/ibuprofen hydromorphone liquid, suppositories levorphanol LORCET (hydrocodone/APAP) LORTAB (hydrocodone/APAP) LORTAB SOLUTION (hydrocodone/acetaminophen) meperidine tablet morphine rectal suppository NORCO (hydrocodone/APAP) oxycodone concentrate oxycodone/ibuprofen oxymorphone pentazocine/naloxone PERCOCET (oxycodone/APAP) QDOLO SOLUTION (tramadol)	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. Longer-acting medications should be maximized to prevent unnecessary breakthrough pain in chronic pain therapy. Immediate-release tramadol is limited to 240 tablets per thirty (30) days. *Seglentis requires 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

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	ROXICODONE (oxycodone) ROXYBOND (oxycodone) SEGLENTIS (celecoxib/tramadol)* tramadol solution ULTRACET (tramadol/APAP) VICOPROFEN (hydrocodone/ibuprofen)	
ANDROGENIC AGENTS		
CLASS PA CRITERIA: A non-preferred agent will only be authorized if one (1) of the exceptions on the PA form is present.		
ANDRODERM (testosterone) CL/PA* ANDROGEL (testosterone) pump CL/PA* TESTIM (testosterone) testosterone cypionate vial CL/PA* testosterone enanthate vial CL/PA* testosterone gel 1.62%	ANDROGEL (testosterone) packet ANDROID (methyltestosterone) AVEED (testosterone undecanoate) FORTESTA (testosterone) JATENZO (testosterone undecanoate) METHITEST (methyltestosterone) methyltestosterone capsule NATESTO (testosterone) testosterone gel testosterone solution pump TESTRED (methyltestosterone) TLANDO (testosterone undecanoate) VOGELXO (testosterone) XYOSTED (testosterone enanthate)	*Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.
ANESTHETICS, TOPICALAP		
CLASS PA CRITERIA: Non-preferred agents require ten (10) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
lidocaine lidocaine/prilocaine xylocaine	lidocaine/hydrocortisone LIDOTRAL CREAM (lidocaine) LIDOZION LOTION (lidocaine) SYNERA (lidocaine/tetracaine)	
ANGIOTENSIN MODULATORSAP		
CLASS PA CRITERIA: Non-preferred agents require fourteen (14) day trials of each preferred agent in the same sub-class, with the exception of the Direct Renin Inhibitors, before they will be approved, unless one (1) of the exceptions on the PA form is present.		
	ACE INHIBITORS	
benazepril captopril enalapril fosinopril lisinopril quinapril ramipril trandolapril	ACCUPRIL (quinapril) ALTACE (ramipril) enalapril solution EPANED (enalapril)* LOTENSIN (benazepril) moexipril perindopril PRINIVIL (lisinopril) QBRELIS SOLUTION (lisinopril)**	*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. **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

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	VASOTEC (enalapril) ZESTRIL (lisinopril)	documentation indicating oral-motor difficulties or dysphagia.
ACE INHIBITOR COMBINATION DRUGS		
benazepril/amlodipine benazepril/HCTZ captopril/HCTZ enalapril/HCTZ fosinopril/HCTZ lisinopril/HCTZ quinapril/HCTZ	ACCURETIC (quinapril/HCTZ) LOTENSIN HCT (benazepril/HCTZ) LOTREL (benazepril/amlodipine) TARKA (trandolapril/verapamil) trandolapril/verapamil VASERETIC (enalapril/HCTZ) ZESTORETIC (lisinopril/HCTZ)	
ANGIOTENSIN II RECEPTOR BLOCKERS (ARBs)		
irbesartan losartan olmesartan telmisartan valsartan	ATACAND (candesartan) AVAPRO (irbesartan) BENICAR (olmesartan) candesartan COZAAR (losartan) DIOVAN (valsartan) EDARBI (azilsartan) MICARDIS (telmisartan)	
ARB COMBINATIONS		
irbesartan/HCTZ losartan/HCTZ olmesartan/amlodipine olmesartan/amlodipine/HCTZ olmesartan/HCTZ valsartan/amlodipine valsartan/amlodipine/HCTZ valsartan/HCTZ	ATACAND-HCT (candesartan/HCTZ) AVALIDE (irbesartan/HCTZ) AZOR (olmesartan/amlodipine) BENICAR-HCT (olmesartan/HCTZ) candesartan/HCTZ DIOVAN-HCT (valsartan/HCTZ) EDARBYCLOR (azilsartan/chlorthalidone) EXFORGE (valsartan/amlodipine) EXFORGE HCT (valsartan/amlodipine/HCTZ) HYZAAR (losartan/HCTZ) MICARDIS-HCT (telmisartan/HCTZ) telmisartan/amlodipine telmisartan/HCTZ TRIBENZOR (olmesartan/amlodipine/HCTZ)	*Entresto may be authorized only for patients ≥ 1 year of age diagnosed with chronic heart-failure.
DIRECT RENIN INHIBITORS		
	aliskiren TEKTURNA (aliskiren) TEKTURNA HCT (aliskiren/HCTZ)	**Substitute for Class Criteria**: Tekturna requires a thirty (30) day trial of one (1) preferred ACE, ARB, or combination agent, at the maximum tolerable dose, before it 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**
ANTIANGINAL & ANTI-ISCHEMIC		
CLASS PA CRITERIA: Agents in this class may only 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.		
ranolazine[AP]	ASPRUZYO SPRINKLE ER (ranolazine) RANEXA	
ANTIBIOTICS, GI & RELATED AGENTS		
CLASS PA CRITERIA: Non-preferred agents require a fourteen (14) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
FIRVANQ (vancomycin) metronidazole tablet neomycin tinidazole XIFAXAN 200 MG (rifaximin)*	AEMCOLO (rifamycin) tablet** DIFICID (fidaxomicin)* FLAGYL (metronidazole) LIKMEZ (metronidazole)*** metronidazole capsule paromomycin VANCOCIN (vancomycin) vancomycin VOWST (fecal microbiota spores) capsules* XIFAXAN 550 MG (rifaximin)*	*Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. **Aemcolo may be authorized after a trial of Xifaxan 200mg tablets. ***Likmez may be authorized for those who are unable to ingest solid dosage forms of metronidazole due to documented oral motor difficulties or dysphagia.
ANTIBIOTICS, INHALED		
CLASS PA CRITERIA: Non-preferred agents require a twenty-eight (28) day trial of a preferred agent and documentation of therapeutic failure before they will be approved, unless one (1) of the exceptions on the PA form is present.		
KITABIS PAK (tobramycin) tobramycin 300 mg/5 ml	BETHKIS (tobramycin) CAYSTON (aztreonam) TOBI (tobramycin) TOBI PODHALER (tobramycin) tobramycin 300 mg/4 ml	
ANTIBIOTICS, TOPICAL		
CLASS PA CRITERIA: Non-preferred agents require ten (10) day trials of at least one preferred agent, including the generic formulation of the requested non-preferred agent, before they will be approved, unless one (1) of the exceptions on the PA form is present.		
bacitracin (Rx, OTC) gentamicin sulfate mupirocin ointment	CENTANY (mupirocin) CORTISPORIN (bacitracin/neomycin/polymyxin/HC) mupirocin cream neomycin/polymyxin/pramoxine XEPI CREAM (ozenoxacin)	
ANTIBIOTICS, VAGINAL		
CLASS PA CRITERIA: Non-preferred agents require trials of each chemically unique preferred agent at the manufacturer's recommended duration, before they will be approved, unless one (1) of the exceptions on the PA form is present.		
CLEOCIN OVULE (clindamycin) CLINDESSE (clindamycin)	CLEOCIN CREAM (clindamycin) clindamycin cream	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
metronidazole gel NUVESSA (metronidazole) SOLOSEC (secnidazole)	METROGEL (metronidazole) VANDAZOLE (metronidazole) XACIATO (clindamycin) GEL	
ANTICOAGULANTS		
CLASS PA CRITERIA: Non-preferred agents require a trial of each preferred agent in the same sub-class, unless one (1) of the exceptions on the PA form is present.		
INJECTABLE[CL/PA]		
enoxaparin	ARIXTRA (fondaparinux) fondaparinux FRAGMIN (dalteparin) LOVENOX (enoxaparin)	
ORAL		
ELIQUIS (apixaban) PRADAXA (dabigatran) warfarin XARELTO TABLETS (rivaroxaban)	dabigatran PRADAXA (dabigatran etexilate) oral pellets SAVAYSA (edoxaban) XARELTO SUSPENSION (rivaroxaban)	
ANTICONVULSANTS		
CLASS PA CRITERIA: For a diagnosis of seizure disorder, non-preferred agents require a fourteen (14) day trial of a preferred agent in the same sub-class before they will be approved, unless one (1) of the exceptions on the PA form is present; patients currently on established therapies shall be grandfathered. For all other diagnoses, non-preferred agents require a thirty (30) day trial of a preferred agent in the same sub-class before they will be approved, unless one (1) of the exceptions on the PA form is present. In situations where AB-rated generic equivalent products are available, “Brand Medically Necessary” must be hand-written by the prescriber on the prescription for the brand name product to be reimbursed.		
ADJUVANTS		
BRIVIACT (brivaracetam) carbamazepine carbamazepine ER CARBATROL (carbamazepine) DEPAKOTE SPRINKLE (divalproex) divalproex divalproex ER divalproex sprinkle EPITOL (carbamazepine) lacosamide tablets, solution LAMICTAL (lamotrigine) LAMICTAL CHEWABLE (lamotrigine) LAMICTAL XR (lamotrigine) lamotrigine lamotrigine ODT levetiracetam IR	APTIOM (eslicarbazepine) BANZEL (rufinamide) carbamazepine oral suspension DEPAKOTE (divalproex) DEPAKOTE DR (divalproex DEPAKOTE ER (divalproex) DIACOMIT CAPSULE/POWDER PACK (stripentol)** ELEPSIA XR (levetiracetam) EPRONTIA SOLUTION (topiramate)**** EQUETRO (carbamazepine) felbamate FELBATOL (felbamate) FINTEPLA (fenfluramine) SOLUTION***** FYCOMPA (perampanel) KEPPRA (levetiracetam)	*Topiramate ER will be authorized after a thirty (30) day trial of topiramate IR. **Diacomit may only be approved as adjunctive therapy for diagnosis of Dravet Syndrome when prescribed by, or in consultation with, a neurologist AND requires a thirty (30) day trial of valproate and clobazam unless one (1) of the exceptions on the PA form is present. Diacomit must be used concurrently with clobazam. *** Trokendi XR are only approvable on appeal. ****Eprontia requires medical reasoning beyond convenience or enhanced compliance as to why the medical need cannot be met by using the preferred Topamax (topiramate) sprinkle

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
levetiracetam ER levetiracetam IR suspension oxcarbazepine tablets QUDEXY XR (topiramate ER) TEGRETOL SUSPENSION (carbamazepine) TEGRETOL XR (carbamazepine) topiramate IR tablet topiramate ER* topiramate IR sprinkle caps topiramate ER sprinkle caps (generic Qudexy) TRILEPTAL SUSPENSION (oxcarbazepine) valproic acid zonisamide	KEPPRA SOLUTION (levetiracetam) KEPPRA XR (levetiracetam) LAMICTAL ODT (lamotrigine) lamotrigine dose pack lamotrigine ER methsuximide MOTPOLY XR (lacosamide)******* oxcarbazepine suspension OXTELLAR XR (oxcarbazepine) rufinamide oral suspension, tablets SABRIL (vigabatrin) SPRITAM (levetiracetam) TEGRETOL TABLETS (carbamazepine) tiagabine TOPAMAX SPRINKLE CAPS (topiramate) TOPAMAX TABLETS (topiramate) TRILEPTAL TABLETS (oxcarbazepine) TROKENDI XR (topiramate)*** vigabatrin tablet/powder pack VIMPAT (lacosamide) tablets, solution XCOPRI (cenobamate) ZONISADE (zonisamide) suspension******	capsules. *****Full PA criteria for Fintepla may be found on the PA Criteria page by clicking the hyperlink. ******Zonisade may only be authorized for those who are unable to ingest solid dosage forms due to documented oral-motor difficulties or dysphagia AND have had a (14) fourteen day trial with a preferred agent available in a non-solid dosage form resulting in an inadequate treatment response. *******Motpoly XR capsules may be authorized after a medical reason beyond convenience or enhanced compliance, as to why the clinical need cannot be met by using a preferred lacosamide agent, is provided.
BARBITURATES[AP]		
phenobarbital primidone	MYSOLINE (primidone)	
BENZODIAZEPINES[AP]		
clonazepam DIASTAT (diazepam rectal) diazepam rectal gel diazepam tablets NAYZILAM NASAL SPRAY (midazolam) VALTOCO NASAL SPRAY (diazepam)	clobazam* clonazepam ODT DIASTAT ACUDIAL (diazepam) KLONOPIN (clonazepam) ONFI (clobazam)* ONFI SUSPENSION (clobazam)* SYMPAZAN (clobazam film)*	*Onfi shall be authorized as adjunctive therapy for treatment of Lennox-Gastaut Syndrome and Dravet Syndrome without further restrictions. All other indications require an appeal to the Medical Director. NOTE: generic clobazam is preferred over brand ONFI.
CANNABINOIDS		
EPIDIOLEX SOLUTION (cannabidiol)*[AP]		*Epidiolex may be authorized after 14 (fourteen) day trials of two of the following agents within the past 12 months: clobazam, levetiracetam, valproate, lamotrigine, topiramate, rufinamide or felbamate.
HYDANTOINS[AP]		
DILANTIN CAPSULES, SUSPENSION, CHEW TABS (phenytoin sodium extended) PEGANONE (ethotoin)	PHENYTEK (phenytoin)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
phenytoin capsules, chewable tablets, suspension		
	SUCCINIMIDES	
CELONTIN (methsuximide) ethosuximide capsules ethosuximide syrup	ZARONTIN (ethosuximide) capsules ZARONTIN (ethosuximide) syrup	
ANTIDEPRESSANTS, OTHER		
CLASS PA CRITERIA: See below for individual sub-class criteria.		
	MAOIs[AP]	
	MARPLAN (isocarboxazid) NARDIL (phenelzine) phenelzine tranylcypromine	Patients stabilized on MAOI agents will be grandfathered.
	SNRIS[AP]	
duloxetine capulses venlafaxine ER capsules	CYMBALTA (duloxetine) desvenlafaxine ER desvenlafaxine fumarate ER EFFEXOR XR (venlafaxine) FETZIMA (levomilnacipran) PRISTIQ (desvenlafaxine) venlafaxine ER tablets venlafaxine IR	Non-preferred agents require separate thirty (30) day trials of a preferred agent in this sub-class **AND** an SSRI before they will be approved, unless one (1) of the exceptions on the PA form is present.
	SECOND GENERATION NON-SSRI, OTHER[AP]	
bupropion IR bupropion SR bupropion XL mirtazapine trazodone	APLENZIN (bupropion hbr) AUVELITY (dextromethorphan HBr/bupropion)* EMSAM (selegiline) FORFIVO XL (bupropion) nefazodone REMERON (mirtazapine) TRINTELLIX (vortioxetine) VIIBRYD (vilazodone HCl) vilazodone WELLBUTRIN SR (bupropion) WELLBUTRIN XL (bupropion)	Non-preferred agents require separate thirty (30) day trials of a preferred agent in this sub-class **AND** an SSRI before they will be approved, unless one (1) of the exceptions on the PA form is present. *Auvelity may be approved after the following has been met: 3. Documentation is provided giving medical reasoning beyond convenience as to why the clinical need cannot be met with using a combination of the preferred individual components; **AND** 4. A trial of 30 days resulting in an inadequate clinical response, with <u>each</u> of the following: • ONE dopamine/norepinephrine reuptake inhibitor (DNRI); **AND** • ONE selective norepinephrine reuptake inhibitor (SNRI); **AND** • ONE Tricyclic antidepressant (TCA); **AND**

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
		• TWO selective serotonin reuptake inhibitors (SSRIs)*;* **AND** • vilazodone (Viibryd); **AND** • vortioxetine (Trintellix)
	SELECTED TCAs	
imipramine HCl	imipramine pamoate	Non-preferred agents require a twelve (12) week trial of imipramine HCl before they will be approved, unless one (1) of the exceptions on the PA form is present.
ANTIDEPRESSANTS, SSRIs[AP]		
CLASS PA CRITERIA: Non-preferred agents require thirty (30) day trials of at least two (2) preferred agents before they will be approved, 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.		
citalopram escitalopram tablets fluoxetine capsules, solution fluvoxamine paroxetine sertraline	BRISDELLE (paroxetine) CELEXA (citalopram) citalopram capsules escitalopram solution fluoxetine tablets fluoxetine DR capsules fluvoxamine ER LEXAPRO (escitalopram) paroxetine 7.5 mg capsules paroxetine ER paroxetine suspension PAXIL (paroxetine) PAXIL CR (paroxetine) PEXEVA (paroxetine) PROZAC (fluoxetine) SARAFEM (fluoxetine) sertraline capsules ZOLOFT (sertraline)	
ANTIEMETICS[AP]		
CLASS PA CRITERIA: See below for sub-class criteria.		
	5HT3 RECEPTOR BLOCKERS	
granisetron tablets ondansetron ODT, solution, tablets	ondansetron vials SANCUSO (granisetron) SUSTOL (granisetron) ZOFRAN (ondansetron) ZUPLENZ (ondansetron)	Non-preferred agents require a three (3) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.
	CANNABINOIDS	
	dronabinol*	*Dronabinol will only be authorized for:

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	MARINOL (dronabinol)*	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)	Non-preferred agents require a three (3) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.
	COMBINATIONS	
DICLEGIS (doxylamine/pyridoxine)	AKYNZEO (netupitant/palonosetron) BONJESTA (doxylamine/pyridoxine) doxylamine/pyridoxine (generic Diclegis)	Non-preferred agents may only be approved after a trial and failure of a preferred agent unless one (1) of the exceptions on the PA form is present.
ANTIFUNGALS, ORAL		
CLASS PA CRITERIA: Non-preferred agents will only be authorized if one (1) of the exceptions on the PA form is present.		
Clotrimazole fluconazole* griseofulvin*** nystatin terbinafine CL/PA	ANCOBON (flucytosine) CRESEMBA (isovuconazonium) CL/PA** BREXAFEMME (ibrexafungerp) DIFLUCAN (fluconazole) flucytosine itraconazole ketoconazole**** MYCELEX (clotrimazole) NOXAFIL (posaconazole) ORAVIG (miconazole) posaconazole tablet SPORANOX (itraconazole) TOLSURA (itraconazole) VFEND (voriconazole) VIVJOA (oteseconazole) voriconazole suspension voriconazole tablets	*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. ****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 ratio (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

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
		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[AP]		
CLASS PA CRITERIA: Non-preferred agents require fourteen (14) day trials of two (2) preferred agents before they will be approved, 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 (i.e. ketoconazole shampoo) is required.		
ANTIFUNGALS		
econazole ketoconazole cream, shampoo miconazole (OTC) nystatin	CICLODAN (ciclopirox) ciclopirox ERTACZO (sertaconazole) EXELDERM (sulconazole) EXTINA (ketoconazole) GYNAZOLE 1 CREAM (butoconazole) JUBLIA (efinaconazole)* KERYDIN (tavaborole) ketoconazole foam KETODAN (ketoconazole) LOPROX (ciclopirox) luliconazole cream LUZU (luliconazole) miconazole/petrolatum/zinc oxide naftifine cream NAFTIN GEL (naftifine) oxiconazole cream OXISTAT (oxiconazole)** sulconazole nitrate solution, cream tavaborole 5% topical solution VUSION (miconazole/petrolatum/zinc oxide)	*Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. **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.
ANTIFUNGAL/STEROID COMBINATIONS		
clotrimazole/betamethasone cream	clotrimazole/betamethasone lotion nystatin/triamcinolone	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ANTIHEMOPHILIA FACTOR AGENTS[CL/PA]		
CLASS PA CRITERIA: All agents will require prior-authorization, and non-preferred agents require medical reasoning explaining why the need cannot be met using a preferred product. All currently established regimens shall be grandfathered with documentation of adherence to therapy.		
FACTOR VIII		
AFSTYLA ALPHANATE HEMOFIL M HUMATE-P JIVI KOATE KOGENATE FS KOVALTRY NOVOEIGHT NUWIQ WILATE XYNTHA XYNTHA SOLOFUSE	ADVATE ADYNOVATE ALTUVIIIO ELOCTATE ESPEROCT RECOMBINATE VONVENDI	
BYPASSING AGENTS		
	FEIBA NOVOSEVEN SEVENFACT	
FACTOR IX		
ALPHANINE SD ALPROLIX BENEFIX IXINITY MONONINE PROFILNINE RIXUBIS	IDELVION REBINYN	
FACTOR IXa/IX		
HEMLIBRA (emicizumab-kxwh)		
ANTIHYPERTENSIVES, SYMPATHOLYTICS		
CLASS PA CRITERIA: Non-preferred agents require thirty (30) day trials of each preferred unique chemical entity in the corresponding formulation before they will be approved, unless one (1) of the exceptions on the PA form is present.		
clonidine patch clonidine tablets		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ANTIHYPERURICEMICS		
CLASS PA CRITERIA: Non-preferred agents require a thirty (30) day trial of one (1) of the preferred agents for the prevention of gouty arthritis attacks (colchicine/probenecid, probenecid, or allopurinol) before they will be approved, unless one (1) of the exceptions on the PA form is present.		
ANTIMITOTICS		
colchicine tablets	colchicine capsules COLCRYS (colchicine) tablets MITIGARE (colchicine) GLOPERBA (colchicine)*	In the case of acute gouty attacks, a ten (10) day supply (twenty (20) units) of the preferred agent(s) in this subclass will be authorized per ninety (90) days. *Gloperba may only be authorized for those who are unable to ingest solid dosage forms due to documented oral-motor difficulties or dysphagia.
ANTIMITOTIC-URICOSURIC COMBINATION		
colchicine/probenecid		
URICOSURIC		
probenecid		
XANTHINE OXIDASE INHIBITORS		
allopurinol febuxostat tablets	ULORIC (febuxostat) ZYLOPRIM (allopurinol)	
ANTIMIGRAINE AGENTS, PROPHYLAXIS[CL/PA]		
CLASS PA CRITERIA: All agents require a prior authorization. Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. Non-preferred agents require a 90-day trial of all preferred agents.		
AIMOVIG (erenumab) AJOVY (fremanezumab) EMGALITY (galcanezumab) auto-injector, 120 mg syringes	EMGALITY (galcanezumab)* 300 mg syringes NURTEC ODT (rimegepant)** QULIPTA (atogepant)	*Emgality 300 mg/3 mL requires review by the Medical Director and is available only on appeal. **Nurtec ODT for a diagnosis of **Migraine prophylaxis**: Maximum Quantity limit of 16 tablets per 32 days.
ANTIMIGRAINE AGENTS, ACUTE[AP]		
CLASS PA CRITERIA: Non-preferred agents require three (3) day trials of each preferred unique chemical entity as well as a three (3) day trial using the same route of administration as the requested agent (if available), before they will be approved, unless one (1) of the exceptions on the PA form is present.		
TRIPTANS		
IMITREX NASAL SPRAY (sumatriptan) naratriptan rizatriptan ODT rizatriptan tablet sumatriptan injection vials, pens sumatriptan nasal spray sumatriptan tablets zolmitriptan tablets	almotriptan AMERGE (naratriptan) eletriptan FROVA (frovatriptan) frovatriptan MAXALT (rizatriptan) MAXALT MLT (rizatriptan) ONZETRA XSAIL (sumatriptan)*	***In addition to the Class Criteria**: Onzetra Xsail and Tosymra require three (3) day trials of each preferred oral, nasal and injectable forms of sumatriptan.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
zolmitriptan ODT	RELPAX (eletriptan) sumatriptan cartridges TOSYMRA NASAL SPRAY (sumatriptan)* ZEMBRACE SYMTOUCH (sumatriptan) zolmitriptan nasal spray ZOMIG (zolmitriptan) ZOMIG ZMT (zolmitriptan)	
	TRIPTAN COMBINATIONS	
	sumatriptan/naproxen sodium TREXIMET (sumatriptan/naproxen sodium)	
	OTHER	
NURTEC ODT (rimegepant)*	CAMBIA (diclofenac) D.H.E 45 AMPULE (dihydroergotamine)** dihydroergotamine injection, nasal spray** MIGERGOT RECTAL SUPPOSITORY (ergotamine/caffeine)** MIGRANAL SPRAY (dihydroergotamine)** REYVOW (lasmiditan)** TRUDHESA SPRAY (dihydroergotamine)** UBRELVY (ubrogepant)*** ZAVZPRET (zavegepant) nasal spray****	*Nurtec ODT For a diagnosis of **Migraine treatment**: requires three (3) day trials of two (2) preferred chemically distinct triptans before it may be approved, unless one (1) of the exceptions on the PA form is present. Maximum Quantity limit of 8 tablets per 30 days. **All non-preferred Ergot alkaloid agents require three (3) day trials of (2) preferred triptans as well as a three (3) day trial of a preferred triptan using the same route of administration as the requested agent (if available), before they will be approved, unless one (1) of the exceptions on the PA form is present. **Note: Ergot derivatives should not be used with or within 24 hours of triptans.** ****Additional Ergot Alkaloid criteria:** **Nasal spray:** dihydroergotamine nasal spray and Trudhesa spray may only be authorized after a trial and failure of Migranal spray. **Rectal suppository:** Migerot rectal suppository may only be authorized after a trial and failure of a preferred triptan nasal spray. **Injection:** dihydroergotamine injection and D.H.E 45 ampule may only be approved for cluster headaches. ***Ubrelvy and Reyvow require three (3) day trials of two (2) preferred chemically distinct triptans as well as a three (3) day trial of Nurtec ODT before they may be approved, unless one (1) of the exceptions on the PA form is present.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
		Zavzpret may be authorized after a trial and failure of a preferred CGRP agent used for acute treatment **AND** a trial and failure of two (2) chemically distinct preferred triptans, including sumatriptan nasal spray (unless contraindicated).
ANTIPARASITICS, TOPICAL[AP]		
CLASS PA CRITERIA: Non-preferred agents require trials of each preferred agent (which are age and weight appropriate) before they will be approved, unless one (1) of the exceptions on the PA form is present.		
NATROBA (spinosad) permethrin 5% cream pyrethrins-piperonyl butoxide OTC	ELIMITE CREAM (permethrin) EURAX (crotamiton) ivermectin 0.5% lotion LICE EGG REMOVER OTC (benzalkonium chloride) lindane malathion OVIDE (malathion) SKLICE (ivermectin) spinosad VANALICE (piperonyl/pyrethin)	
ANTIPARKINSON'S AGENTS		
CLASS PA CRITERIA: Patients starting therapy on drugs in this class must show a documented allergy to all preferred agents in the corresponding sub-class, before a non-preferred agent will be authorized.		
	ANTICHOLINERGICS	
benztropine trihexyphenidyl		
	COMT INHIBITORS	
entacapone	COMTAN (entacapone) ONGENTYS (opicapone) TASMAR (tolcapone) tolcapone	COMT Inhibitor agents will only be approved as add-on therapy to a levodopa-containing regimen for treatment of documented motor complications.
	DOPAMINE AGONISTS	
APOKYN (apomorphine) PEN bromocriptine pramipexole ropinirole	apomorphine pen, cartridge KYNMOBI (apomorphine) FILM MIRAPEX ER (pramipexole)* NEUPRO (rotigotine) pramipexole ER ropinirole ER	*Mirapex ER will be authorized for a diagnosis of Parkinsonism without a trial of preferred agents.
	OTHER ANTIPARKINSON'S AGENTS	
amantadine*[AP] carbidopa/levodopa	AZILECT (rasagiline) carbidopa	*Amantadine will not be authorized for the treatment or prophylaxis of influenza.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
levodopa/carbidopa/entacapone selegiline	GOCOVRI ER (amantadine) INBRIJA (levodopa) levodopa/carbidopa ODT LODOSYN (carbidopa) NOURIANZ (istradefylline) OSMOLEX ER (amantadine) PARLODEL (bromocriptine) rasagiline RYTARY (levodopa/carbidopa) SINEMET (levodopa/carbidopa) STALEVO (levodopa/carbidopa/entacapone) XADAGO (safinamide) ZELAPAR (selegiline)	
ANTIPSORIATICS, TOPICAL		
CLASS PA CRITERIA: Non-preferred agents require a thirty (30) day trial of a preferred agent. Documentation describing the reason for failure of the preferred agent must be provided. The required trial may be overridden when documented evidence is provided that the use of these preferred agent(s) would be medically contraindicated.		
calcipotriene solution ENSTILAR (calcipotriene/betamethasone) TACLONEX (calcipotriene/ betamethasone)	calcipotriene cream calcipotriene ointment calcipotriene/betamethasone ointment, suspension calcitriol SORILUX (calcipotriene) tazarotene cream VTAMA (tapinarof) ZORYVE (roflumilast) cream	
ANTIPSYCHOTICS, ATYPICAL		
CLASS 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. Non-preferred agents require thirty (30) day trials of two (2) preferred Atypical Antipsychotics approved or medically accepted for the member's diagnosis or indication, including the generic formulation of the requested agent (if available), before they will be approved unless one (1) of the exceptions on the PA form is present. When determining requests for non-preferred products, any trial utilizing a preferred agent whose dose or duration was limited due to adverse effects or clear lack of efficacy will be considered complete only if the agent was being taken within the FDA-approved therapeutic range. * Patients shall be grandfathered onto their existing therapy, provided the requested agent is being used according to the manufacturer label. Continuation of therapy for an off-label indication or non-standard dosage may be granted a thirty (30) day prior-authorization while the Medical Director reviews the request. *According to manufacturer dosing recommendations		
SINGLE INGREDIENT		
ABILIFY ASIMTUFII (aripiprazole) CL/PA ABILIFY MAINTENA (aripiprazole)CL/PA aripiprazole tablets	ABILIFY MYCITE (aripiprazole) ABILIFY TABLETS (aripiprazole) ADASUVE (loxapine)	**The following criteria exceptions apply to the specified products:**

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ARISTADA (aripiprazole)CL/PA ARISTADA INITIO (aripiprazole)CL/PA asenapine sublingual tablets clozapine INVEGA HAFYERA (paliperidone)*CL/PA INVEGA SUSTENNA (paliperidone)CL/PA INVEGA TRINZA (paliperidone)** CL/PA lurasidone olanzapine olanzapine ODT paliperidone ER PERSERIS (risperidone)CL/PA quetiapine** AP for the 25 mg Tablet Only quetiapine ER RISPERDAL CONSTA (risperidone)CL/PA risperidone solution, tablet, ODT VRAYLAR (capriprazine)***** ziprasidone	aripiprazole ODT aripiprazole solution CAPLYTA (lumateperone) clozapine ODT CLOZARIL (clozapine) FANAPT (iloperidone) GEODON (ziprasidone) GEODON IM (ziprasidone) INVEGA ER (paliperidone) LATUDA (lurasidone) LYBALVI (olanzapine and samidorphan)*** NUPLAZID (pimavanserin) **** olanzapine IMCL/PA REXULTI (brexipiprazole) RISPERDAL (risperidone) RYKINDO (risperidone)***** SAPHRIS (asenapine) SECUADO (asenapine) SEROQUEL (quetiapine) SEROQUEL XR (quetiapine) UZEDY (risperidone) VERSACLOZ (clozapine) ZYPREXA (olanzapine) ZYPREXA IM (olanzapine)CL/PA ZYPREXA RELPREVV (olanzapine)	*Invega Hafyera may only be authorized after four months' treatment with Invega Sustenna or at least a one three-month cycle with Invega Trinza. **Invega Trinza will be authorized after four months' treatment with Invega Sustenna **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.** ***Patient must have had a positive response with olanzapine and experienced clinically significant weight gain (documentation must be provided) which necessitated disruption of treatment. Patient must also have had an intolerance, inadequate treatment response or contraindication to 2 preferred antipsychotics, which have a lower potential of weight gain, prior to Lybalvi approval***. *Prior to initiating Lybalvi, there should be at least a 7-day opioid-free interval from the last use of short-acting opioids, and at least a 14-day opioid-free interval from the last use of long-acting opioids to avoid precipitation of opioid withdrawal.*** ****Nuplazid may only be authorized for the treatment of Parkinson Disease Induced Psychosis after documented treatment failure with quetiapine. ***** Vraylar may be authorized for the indication of major depressive disorder only after a 30-day trial and failure of 2 two preferred antidepressants. For all other indications a 30 day trial and failure of one preferred antipsychotic is required. *****Rykindo may be authorized after fulfilling class criteria. One of the trial requirements **MUST** be met with Risperdal Consta.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	ATYPICAL ANTIPSYCHOTIC/SSRI COMBINATIONS	
	olanzapine/fluoxetine	
ANTIRETROVIRALS[AP]		
CLASS 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.		
	SINGLE TABLET REGIMENS	
BIKTARVY (bictegravir/emtricitabine/ tenofovir alafenamide) COMPLERA(emtricitabine/rilpivirine/tenofovir) DELSTRIGO (doravirine/lamivudine/ tenofovir df) DOVATO (dolutegravir/lamivudine) efavirenz/emtricitabine/tenofovir GENVOYA (elvitegravir/cobicistat/ emtricitabine/tenofovir) ODEFSEY (emtricitabine/rilpivirine/tenofovir) TRIUMEQ (abacavir/lamivudine/ dolutegravir)	ATRIPLA (efavirenz/emtricitabine/tenofovir) efavirenz/lamivudine/tenofovir JULUCA (dolutegravir/rilpivirine) SYMFI (efavirenz/lamivudine/tenofovir) SYMFI LO (efavirenz/lamivudine/tenofovir) STRIBILD (elvitegravir/cobicistat/ emtricitabine/tenofovir)* SYMTUZA (darunavir/cobicistat/ emtricitabine/tenofovir alafenamide) TRIUMEQ PD (abacavir/lamivudine/ dolutegravir)	*Stribild requires medical reasoning beyond convenience or enhanced compliance as to why the medical need cannot be met with the the preferred agent Genvoya.
	INTEGRASE STRAND TRANSFER INHIBITORS	
ISENTRESS (raltegravir potassium) TIVICAY (dolutegravir sodium) TIVICAY PD (dolutegravir sodium)	ISENTRESS HD (raltegravir potassium)	
	NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTI)	
abacavir sulfate tablet EMTRIVA (emtricitabine) EPIVIR SOLUTION (lamivudine) lamivudine tenofovir disoproxil fumarate VIREAD ORAL POWDER (tenofovir disoproxil fumarate) ZIAGEN SOLUTION (abacavir sulfate) zidovudine	abacavir sulfate solution didanosine DR capsule emtricitabine capsule EPIVIR TABLET (lamivudine) RETROVIR (zidovudine) stavudine VIDEX EC (didanosine) VIDEX SOLUTION (didanosine) VIREAD TABLETS (tenofovir disoproxil fumarate) ZIAGEN TABLET (abacavir sulfate)	
	NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITOR (NNRTI)	
efavirenz	EDURANT (rilpivirine) etravirine INTELENCE (etravirine) nevirapine nevirapine ER PIFELTRO (doravirine) SUSTIVA (efavirenz) VIRAMUNE ER 24H (nevirapine)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	VIRAMUNE SUSPENSION (nevirapine)	
PHARMACOENHANCER – CYTOCHROME P450 INHIBITOR		
TYBOST (cobicistat)		
PROTEASE INHIBITORS (PEPTIDIC)		
atazanavir EVOTAZ (atazanavir/cobicistat) REYATAZ POWDER PACK (atazanavir) ritonavir tablet	fosamprenavir LEXIVA (fosamprenavir) NORVIR (ritonavir) REYATAZ CAPSULE (atazanavir) VIRACEPT (nelfinavir mesylate)	Norvir powder pack may be authorized for those who are unable to ingest solid dosage forms due to documented oral motor difficulties or dysphagia.
PROTEASE INHIBITORS (NON-PEPTIDIC)		
PREZCOBIX (darunavir/cobicistat) PREZISTA (darunavir ethanolate)	APTIVUS (tipranavir) darunavir ethanolate	
ENTRY INHIBITORS – CCR5 CO-RECEPTOR ANTAGONISTS		
	maraviroc SELZENTRY (maraviroc)	
ENTRY INHIBITORS – FUSION INHIBITORS		
	FUZEON (enfuvirtide)*	Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.
COMBINATION PRODUCTS – NRTIs		
abacavir/lamivudine lamivudine/zidovudine	abacavir/lamivudine/zidovudine CIMDUO (lamivudine/tenofovir) COMBIVIR (lamivudine/zidovudine) EPZICOM (abacavir/lamivudine) TEMIXYS (lamivudine/tenofovir) TRIZIVIR (abacavir/lamivudine/zidovudine)	
COMBINATION PRODUCTS – NUCLEOSIDE & NUCLEOTIDE ANALOG RTIs		
DESCOVY (emtricitabine/tenofovir) emtricitabine/tenofovir	TRUVADA (emtricitabine/tenofovir)	
COMBINATION PRODUCTS – PROTEASE INHIBITORS		
lopinavir/ritonavir	KALETRA (lopinavir/ritonavir)	
PRODUCTS FOR PRE-EXPOSURE PROPHYLAXIS (PrEP)		
APRETUDE (cabotegravir) DESCOVY (emtricitabine/tenofovir) emtricitabine/tenofovir	TRUVADA (emtricitabine/tenofovir)	
ANTIVIRALS, ORAL		
CLASS PA CRITERIA: Non-preferred agents require five (5) day trials of each preferred agent in the same sub-class before they will be approved, unless one (1) of the exceptions on the PA form is present.		
ANTI HERPES		
acyclovir valacyclovir	famciclovir SITAVIG (acyclovir)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	VALTREX (valacyclovir) ZOVIRAX (acyclovir)	
	ANTI-INFLUENZA	
oseltamivir	FLUMADINE (rimantadine) RELENZA (zanamivir) rimantadine TAMIFLU (oseltamivir) XOFLUZA (baloxavir)	**In addition to the Class Criteria**: The anti-influenza agents will be authorized only for a diagnosis of influenza.
ANTIVIRALS, TOPICAL[AP]		
CLASS PA CRITERIA: Non-preferred agents require a five (5) day trial of the preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
acyclovir ointment ZOVIRAX CREAM (acyclovir)	acyclovir cream DENAVIR (penciclovir) docosanol cream ZOVIRAX OINTMENT (acyclovir)	
BETA BLOCKERS[AP]		
CLASS PA CRITERIA: Non-preferred agents require fourteen (14) day trials of three (3) chemically distinct preferred agents, including the generic formulation of the requested non-preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
	BETA BLOCKERS	
acebutolol atenolol betaxolol bisoprolol BYSTOLIC (nebivolol) HEMANGEOL (propranolol)* metoprolol metoprolol ER nadolol pindolol propranolol propranolol ER SORINE (sotalol) sotalol timolol	BETAPACE (sotalol) CORGARD (nadolol) INDERAL LA (propranolol) INDERAL XL (propranolol) INNOPRAN XL (propranolol) KAPSPARGO SPRINKLE (metoprolol) LOPRESSOR (metoprolol) nebivolol TENORMIN (atenolol) TOPROL XL (metoprolol)	*Hemangeol will be authorized for the treatment of proliferating infantile hemangioma requiring systemic therapy.
	BETA BLOCKER/DIURETIC COMBINATION DRUGS	
atenolol/chlorthalidone bisoprolol/HCTZ metoprolol/HCTZ propranolol/HCTZ	nadolol/bendroflumethiazide TENORETIC (atenolol/chlorthalidone) ZIAC (bisoprolol/HCTZ)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	BETA- AND ALPHA-BLOCKERS	
carvedilol labetalol	carvedilol ER capsule COREG (carvedilol) COREG CR (carvedilol)	
BLADDER RELAXANT PREPARATIONS[AP]		
CLASS PA CRITERIA: Non-preferred agents require thirty (30) day trials of each chemically distinct preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present		
DETROL LA (tolterodine) GELNIQUE (oxybutynin) MYRBETRIQ TABLET (mirabegron) oxybutynin IR oxybutynin ER OXYTROL (oxybutynin) solifenacin TOVIAZ (fesoterodine)	darifenacin ER tablet DETROL (tolterodine) DITROPAN XL (oxybutynin) ENABLEX (darifenacin) fesoterodine ER flavoxate GEMTESA (vibegron) MYRBETRIQ SUSPENSION (mirabegron) tolterodine tolterodine ER trospium trospium ER VESICARE (solifenacin) VESICARE LS (solifenacin)	
BONE RESORPTION SUPPRESSION AND RELATED AGENTS		
CLASS PA CRITERIA: See below for class criteria.		
	BISPHOSPHONATES	
alendronate tablets ibandronate	ACTONEL (risedronate) alendronate solution ATELVIA (risedronate) BINOSTO (alendronate) BONIVA (ibandronate) FOSAMAX TABLETS (alendronate) FOSAMAX PLUS D (alendronate/vitamin D) risedronate	Non-preferred agents require thirty (30) day trials of **each** preferred Bisphosphonate agent before they will be approved, unless one (1) of the exceptions on the PA form is present.
	OTHER BONE RESORPTION SUPPRESSION AND RELATED AGENTS	
	calcitonin EVISTA (raloxifene)* FORTEO (teriparatide) MIACALCIN (calcitonin) raloxifene* teriparatide TYMLOS (abaloparatide)	Non-preferred agents require a thirty (30) day trial of a preferred Bisphosphonate agent before they will be approved, unless one (1) of the exceptions on the PA form is present. *Raloxifene will be authorized for postmenopausal women with osteoporosis who are at high risk for invasive breast cancer.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
BPH TREATMENTS		
CLASS PA CRITERIA: See below for individual sub-class criteria.		
	5-ALPHA-REDUCTASE (5AR) INHIBITORS AND PDE-5 AGENTS	
finasteride	AVODART (dutasteride) CIALIS 5 mg (tadalafil) Dutasteride ENTADFI (finasteride/tadalafil) capsules* PROSCAR (finasteride) tadalafil	Non-preferred 5-ALPHA-REDUCTASE (5AR) agents require a thirty (30) day trial of finasteride before they will be approved, unless one (1) of the exceptions on the PA form is present. Non-preferred PDE-5 agents require thirty (30) day trials of finasteride AND a preferred alpha blocker before they will be approved, unless one (1) of the exceptions on the PA form is present. *Documentation of medical reasoning beyond convnience must be provided as to why the clinical need cannot be met with finasteride used in combination with tadalafil.
	ALPHA BLOCKERS	
alfuzosin doxazosin tamsulosin terazosin	CARDURA (doxazosin) CARDURA XL (doxazosin) FLOMAX (tamsulosin) RAPAFLO (silodosin) silodosin	Non-preferred alpha blockers require thirty (30) day trials of at least two (2) preferred agents in this subclass, including the generic formulation of the requested non-preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.
	5-ALPHA-REDUCTASE (5AR) INHIBITORS/ALPHA BLOCKER COMBINATION	
	dutasteride/tamsulosin JALYN (dutasteride/tamsulosin)	**Substitute for Class Criteria**: Concurrent thirty (30) day trials of dutasteride and tamsulosin are required before the non-preferred agent will be authorized.
BRONCHODILATORS, BETA AGONIST[AP]		
CLASS PA CRITERIA: Non-preferred agents require thirty (30) day trials of each chemically distinct preferred agent in their corresponding sub-class unless one (1) of the exceptions on the PA form is present.		
	INHALATION SOLUTION	
albuterol	arformoterol BROVANA (arformoterol) formoterol levalbuterol metaproterenol PERFOROMIST (formoterol) XOPENEX (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.
	INHALERS, LONG-ACTING	
SEREVENT (salmeterol)	STRIVERDI RESPIMAT (olodaterol)	
	INHALERS, SHORT-ACTING	
albuterol HFA	PROAIR DIGIHALER (albuterol)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
PROAIR HFA (albuterol) PROAIR RESPICLICK (albuterol) PROVENTIL HFA (albuterol) VENTOLIN HFA (albuterol)	XOPENEX HFA (levalbuterol)	
	ORAL	
albuterol syrup	albuterol ER albuterol IR metaproterenol terbutaline	
CALCIUM CHANNEL BLOCKERS[AP]		
CLASS PA CRITERIA: Non-preferred agents require fourteen (14) day trials of each preferred agent within the corresponding sub-class before they will be approved, unless one (1) of the exceptions on the PA form is present.		
	LONG-ACTING	
amlodipine diltiazem ER/CD felodipine ER nifedipine ER verapamil ER	CALAN SR (verapamil) CARDIZEM CD, LA (diltiazem) DILT-XR diltiazem LA KATERZIA SUSPENSION (amlodipine)* levamlodipine maleate MATZIM LA (diltiazem) nisoldipine NORLIQVA (amlodipine)* NORVASC (amlodipine) PROCARDIA XL (nifedipine) SULAR (nisoldipine) TIAZAC (diltiazem) verapamil ER PM VERELAN/VERELAN PM (verapamil)	*Katerzia and Norliqva may be authorized for children who are 6-10 years of age who are unable to ingest solid dosage forms. Therapy may be authorized for older patients with clinical documentation indicating oral-motor difficulties or dysphagia. In addition, Norliqva may only be authorized for patients who have a documented allergy or are unable to tolerate Katerzia.
	SHORT-ACTING	
diltiazem verapamil	CARDIZEM (diltiazem) isradipine nicardipine nifedipine nimodipine NYMALIZE SOLUTION (nimodipine) PROCARDIA (nifedipine)	
CEPHALOSPORINS AND RELATED ANTIBIOTICS		
CLASS PA CRITERIA: Non-preferred agents require a five (5) day trial of a preferred agent within the corresponding sub-class before they will be approved, unless one (1) of the exceptions on the PA form is present.		
	BETA LACTAMS AND BETA LACTAM/BETA-LACTAMASE INHIBITOR COMBINATIONS	
amoxicillin/clavulanate IR	amoxicillin/clavulanate ER AUGMENTIN (amoxicillin/clavulanate)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	CEPHALOSPORINS	
cefaclor capsule cefadroxil tablet cefdinir cefuroxime tablet cephalexin capsule, suspension	cefaclor suspension cefaclor ER tablet cefadroxil capsule cefadroxil suspension cefixime cefpodoxime cefprozil cefuroxime suspension cephalexin tablet KEFLEX (cephalexin) SUPRAX (cefixime)	
COPD AGENTS		
CLASS PA CRITERIA: Non-preferred agents require a sixty (60) day trial of one preferred agent from the corresponding sub-class before they will be approved, unless one (1) of the exceptions on the PA form is present.		
	ANTICHOLINERGIC[AP]	
ATROVENT HFA (ipratropium) INCRUSE ELLIPTA (umeclidinium) ipratropium nebulizer solution SPIRIVA (tiotropium) SPIRIVA RESPIMAT (tiotropium)	LONHALA MAGNAIR (glycopyrrolate) TUDORZA (aclidinium) YUPELRI SOLUTION (revefenacin)	
	ANTICHOLINERGIC-BETA AGONIST COMBINATIONS[AP]	
albuterol/ipratropium nebulizer solution ANORO ELLIPTA (umeclidinium/vilanterol) COMBIVENT RESPIMAT (albuterol/ipratropium) STIOLTO RESPIMAT (tiotropium/olodaterol)	BEVESPI (glycopyrrolate/formoterol) DUAKLIR PRESSAIR (aclidinium/formoterol)*	*In addition to the Class PA criteria, Duaklir Pressair requires sixty (60) day trials of each long acting preferred agent, as well as a 60-day trial of Stiolto Respimat.
	ANTICHOLINERGIC-BETA AGONIST-GLUCOCORTICOID COMBINATIONS	
	BREZTRI AEROSPHERE (budesonide/glycopyrrolate/formoterol)** TRELEGY ELLIPTA (fluticasone/umeclidinium/vilanterol)*	* Trelegy Ellipta may be prior authorized for patients currently established on the individual components for at least 30 days. **Breztri may be prior authorized for patients currently established on the individual components for at least 30 days.
	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**

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
		5. No concurrent use with strong cytochrome P450 inducers (rifampicin, phenobarbital, carbamazepine or phenytoin)
CROHNS DISEASE ORAL STEROIDS		
	ORAL	
budesonide ER capsule (generic Entocort EC)	ENTOCORT EC (budesonide)* ORTIKOS (budesonide)*	*Please see the following PDL classes for PDL status of additional agents used for induction and remission (Cytokine and CAM Antagonists/ Immunosuppressives, Oral/ Ulcerative Colitis Agents) *Entocort EC and Ortikos may only be authorized if the patient has a documented allergy or intolerance to the generic budesonide 3mg 24-hour capsules.
CYTOKINE & CAM ANTAGONISTSCL/PA		
CLASS PA CRITERIA: Non-preferred agents require ninety (90) day trials of all preferred agents which are indicated for the diagnosis, unless one (1) of the exceptions on the PA form is present. *Patients stabilized for at least 6-months on their existing non-preferred regimen shall be grandfathered (provided the current therapy is for a labeled indication AND a more cost-effective biosimilar product is not available). In cases where a biosimilar exists but is also non-preferred, the PA vendor shall advise the provider which product is the most cost-effective agent. All off-label requests require review by the Medical Director.* **Full PA criteria may be found on the** PA Criteria **page by clicking the hyperlink.**		
	ANTI-TNFs	
AVSOLA (infliximab) ENBREL (etanercept) HUMIRA (adalimumab) infliximab SIMPONI subcutaneous (golimumab)	ABRILADA (adalimumab-afzb) adalimumab-fkjp AMJEVITA (adalimumab-atto) CIMZIA (certolizumab pegol) CYLTEZO (adalimumab-adbm) HADLIMA (adalimumab-bwwd) HULIO (adalimumab-fkjp) HYRIMOZ (adalimumab-adaz) IDACIO (adalimumab-aacf) INFLECTRA (infliximab) REMICADE (infliximab) RENFLEXIS (infliximab) SIMPONI ARIA (golimumab) YUFLYMA (adalimumab-aacf) YUSIMRY (adalimumab-aqvh)	
	OTHERS	
ACTEMRA subcutaneous (tocilizumab) KINERET (anakinra) ORENCIA CLICKJET/VIAL (abatacept) OTEZLA (apremilast) TALTZ (ixekizumab)* XELJANZ (tofacitinib)	ACTEMRA ACTPEN (tocilizumab) BIMZELX (bimekizumab-bkzx) COSENTYX (secukinumab) ENTYVIO (vedolizumab) ILARIS (canakinumab) ILUMYA (tildrakizumab)	*Taltz will be authorized for treatment of plaque psoriasis, psoriatic arthritis, and ankylosing spondylitis only after inadequate response to a ninety (90) day trial of one preferred ANTI-TNF agent.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	KEVZARA (sarilumab) OLUMIANT (baricitinib) OMVOH (mirikizumab-mrkz) ORENCIA SYRINGE (abatacept) RINVOQ ER (upadacitinib) SILIQ (brodalumab) SKYRIZI (risankizumab) SOTYKTU (deucravacitinib) STELARA subcutaneous (ustekinumab) TREMFYA (guselkumab) VELSIPITY (estrasimod) XELJANZ XR (tofacitinib)	
DIABETES AGENTS, BIGUANIDES		
CLASS PA CRITERIA: Non-preferred agents require a ninety (90) day trial of a preferred agent of similar duration before they will be approved, unless one (1) of the exceptions on the PA form is present.		
metformin metformin ER (generic Glucophage XR)	FORTAMET (metformin ER) GLUCOPHAGE XR (metformin ER) GLUMETZA (metformin ER)* metformin solution (generic Riomet) metformin ER (generic Glumetza & Fortamet) RIOMET (metformin)	*Glumetza will be approved only after a 30-day trial of Fortamet.
DIABETES AGENTS, DPP-4 INHIBITORS		
CLASS PA CRITERIA: Non-preferred agents are available only on appeal. **NOTE:** DPP-4 inhibitors will NOT be approved in combination with a GLP-1 agonist.		
JANUMET (sitagliptin/metformin) JANUMET XR (sitagliptin/metformin) JANUVIA (sitagliptin) JENTADUETO (linagliptin/metformin) TRADJENTA (linagliptin)	alogliptin alogliptin/metformin alogliptin/pioglitazone JENTADUETO XR (linagliptin/metformin) KAZANO (alogliptin/metformin) KOMBIGLYZE XR (saxagliptin/metformin) NESINA (alogliptin) ONGLYZA (saxagliptin) OSENI (alogliptin/pioglitazone)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
DIABETES AGENTS, GLP-1 AGONISTS[CL/PA]		
Preferred agents may be authorized with a diagnosis of Diabetes Mellitus Type II. **CLASS PA CRITERIA:** Non-preferred agents will only be approved (in 6-month intervals) if ALL of the following criteria has been met: 1) Diagnosis of Diabetes Mellitus Type II. 2) Current A1C must be submitted. Agents in this class will not be approved for patients with a starting A1C of less than (<) 7%. 3) Documentation demonstrating 90 days of compliance <u>on all current diabetic therapies</u> is provided. 4) Documentation demonstrating treatment failure with all unique preferred agents in the same class. Re-authorizations will require documentation of <u>continued</u> compliance on all diabetic therapies and A1C levels must reach goal, (either an A1C of ≤8%, or demonstrated continued improvement). **NOTE: GLP-1 agents will NOT be approved in combination with a DPP-4 inhibitor.**		
OZEMPIC (semaglutide) TRULICITY (dulaglutide) VICTOZA (liraglutide)	ADLYXIN (lixisenatide) BYDUREON BCISE (exenatide) BYETTA (exenatide) MOUNJARO (tirzepatide) RYBELSUS (semaglutide)	
DIABETES AGENTS, INSULIN AND RELATED AGENTS		
CLASS PA CRITERIA: Non-preferred agents require a ninety (90) day trial of a pharmacokinetically similar agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
APIDRA (insulin glulisine) HUMALOG (insulin lispro) HUMALOG JR KWIKPEN (insulin lispro) HUMALOG KWIKPEN U-100 (insulin lispro) HUMALOG MIX PENS (insulin lispro/lispro protamine) HUMALOG MIX VIALS (insulin lispro/lispro protamine) HUMULIN 70/30 (insulin) HUMULIN R U-500 VIAL (insulin) HUMULIN R U-500 KWIKPEN (insulin) insulin aspart flexpen, penfill, vial insulin aspart/aspart protamine pens, vials insulin glargine (labeler 00955 only) insulin lispro kwikpen U-100, vial LANTUS (insulin glargine) LEVEMIR (insulin detemir) NOVOLOG (insulin aspart) NOVOLOG MIX (insulin aspart/aspart	ADMELOG (insulin lispro) AFREZZA (insulin)[CL/PA] BASAGLAR (insulin glargine) FIASP (insulin aspart) HUMALOG KWIKPEN U-200 (insulin lispro) HUMULIN PENS (insulin) HUMULIN R VIAL (insulin) HUMULIN N VIAL (insulin) insulin glargine insulin lispro junior kwikpen insulin lispro protamine mix LYUMJEV (insulin lispro) NOVOLIN (insulin) REZVOGLAR (insulin glargine-aglr) SEMGLEE (insulin glargine) SOLIQUA (insulin glargine/lixisenatide)* TRESIBA (insulin degludec)** TRESIBA FLEXTOUCH (insulin degludec)** XULTOPHY (insulin degludec/liraglutide)*	* Non-preferred 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, and require medical reasoning beyond convenience or enhanced compliance as to why the clinical need cannot be met with a combination of preferred single-ingredient agents. **Patients stabilized on Tresiba may be grandfathered <u>at the request of the prescriber,</u> if the prescriber considers the preferred products to be clinically inappropriate. **<u>Tresiba U-100 may be approved only for:</u> Patients who have demonstrated at least a 6-month history of compliance on a preferred long-acting insulin and who continue to have regular incidents of hypoglycemia. **<u>Tresiba U-200 may be approved only for:</u> Patients who require once-daily doses of at least 60 units of long-acting

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
protamine) NOVOLIN N (insulin) TOUJEO SOLOSTAR (insulin glargine) TOUJEO MAX SOLOSTAR (insulin glargine)		insulin and have demonstrated at least a 6-month history of compliance on preferred long-acting insulin and who continue to have regular incidents of hypoglycemia.
DIABETES AGENTS, MEGLITINIDES		
CLASS PA CRITERIA: Non-preferred agents are available only on appeal.		
MEGLITINIDES		
nateglinide repaglinide	PRANDIN (repaglinide) STARLIX (nateglinide)	
MEGLITINIDE COMBINATIONS		
	repaglinide/metformin	
DIABETES AGENTS, MISCELLANEOUS AGENTS		
CLASS 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 diabetic agent.		
colesevelam	SYMLIN (pramlintide)* WELCHOL (colesevelam)[AP]	*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.
DIABETES AGENTS, SGLT2 INHIBITORS		
CLASS PA CRITERIA: Non-preferred agents will only be approved (in 6-month intervals) if ALL of the following criteria has been met: 1) Current A1C must be submitted. Agents in this class will not be approved for patients with a starting A1C of less than (<) 7%. 2) Documentation demonstrating 90 days of compliance <u>on all current diabetic therapies</u> is provided. 3) Documentation demonstrating treatment failure with all unique preferred agents in the same class. Re-authorizations will require documentation of <u>continued</u> compliance on all diabetic therapies and A1C levels must reach goal, (either an A1C of ≤8%, or demonstrated continued improvement).		
SGLT2 INHIBITORS		
FARXIGA (dapagliflozin) JARDIANCE (empagliflozin)	INVOKANA (canagliflozin) STEGLATRO (ertugliflozin)	
SGLT2 COMBINATIONS		
SYNJARDY (empagliflozin/metformin) XIGDUO XR (dapagliflozin/metformin)	GLYXAMBI (empagliflozin/linagliptin) INVOKAMET (canagliflozin/metformin) INVOKAMET XR (canagliflozin/metformin) QTERN (dapagliflozin/saxagliptin) SEGLUROMET (ertugliflozin/metformin STEGLUJAN (ertugliflozin/sitagliptin) SYNJARDY XR (empagliflozin/metformin) TRIJARDY XR (empagliflozin/linagliptin/metformin)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
DIABETES AGENTS, TZD		
CLASS PA CRITERIA: Non-preferred agents are available only on appeal.		
	THIAZOLIDINEDIONES	
pioglitazone	ACTOS (pioglitazone) AVANDIA (rosiglitazone)	
	TZD COMBINATIONS	
	ACTOPLUS MET (pioglitazone/ metformin) 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.
DRY EYE PRODUCTS[CL/PA]		
CLASS PA CRITERIA: All agents require a prior authorization. Non-preferred agents require a 60-day trial of the preferred agent(s)		
RESTASIS (cyclosporine)	CEQUA (cyclosporine) cyclosporine droperette EYSUVIS (loteprednol) RESTASIS MULTIDOSE (cyclosporine)* TYRVAYA (varenicline) XIIDRA (lifitegrast)	***Restasis Multidose** is approvable only on appeal and requires medical reasoning as to why the clinical need cannot be met with the preferred product (Restasis). **All agents must meet the following prior-authorization criteria:** 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
EPINEPHRINE, SELF-INJECTED		
CLASS PA CRITERIA: A non-preferred agent may be authorized with documentation showing the patient's inability to follow the instructions, or the patient's failure to understand the training for the preferred agent(s).		
epinephrine (labeler 49502 only)	AUVI-Q (epinepherine) epinephrine (all labelers except 49502) EPIPEN (epinephrine) EPIPEN JR (epinephrine) SYMJEPI (epinephrine)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ERYTHROPOIESIS STIMULATING PROTEINS[CL/PA]		
CLASS PA CRITERIA: Non-preferred agents require a thirty (30) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
EPOGEN (rHuEPO) MIRCERA (methoxy PEG-epoetin) RETACRIT (epoetin alfa)	ARANESP (darbepoetin) PROCRIT (rHuEPO)	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** 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.
FLUOROQUINOLONES, ORAL[AP]		
CLASS PA CRITERIA: Non-preferred agents require a five (5) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
CIPRO SUSPENSION (ciprofloxacin) ciprofloxacin levofloxacin tablet	BAXDELA (delafloxacin) CIPRO TABLETS (ciprofloxacin) ciprofloxacin suspension levofloxacin solution moxifloxacin ofloxacin	
GLUCOCORTICOIDS, INHALED[AP]		
CLASS PA CRITERIA: Non-preferred agents require thirty (30) day trials of each chemically unique preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
GLUCOCORTICOIDS		
ARNUITY ELLIPTA (fluticasone) ASMANEX TWISTHALER (mometasone) budesonide nebulizer 0.5 mg/2 ml & 0.25 mg/2 ml solution FLOVENT DISKUS (fluticasone) FLOVENT HFA (fluticasone)	ALVESCO (ciclesonide) ARMONAIR DIGIHALER (fluticasone) ASMANEX HFA (mometasone) budesonide nebulizer 1 mg/2ml solution fluticasone HFA	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
PULMICORT FLEXHALER (budesonide)	PULMICORT NEBULIZER SOLUTION (budesonide) QVAR REDIHALER (beclomethasone)	
GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS		
ADVAIR DISKUS (fluticasone/salmeterol) ADVAIR HFA (fluticasone/salmeterol) DULERA (mometasone/formoterol) SYMBICORT (budesonide/formoterol)	AIRDUO DIGIHALER (fluticasone/salmeterol) AIRDUO RESPICLICK (fluticasone/salmeterol) AIRSUPRA (albuterol/budesonide) BREO ELLIPTA (fluticasone/vilanterol) budesonide/formoterol fluticasone/salmeterol fluticasone/vilanterol WIXELA (fluticasone/salmeterol)	
GUANYLATE CYCLASE STIMULATORS[CL/PA]		
	ADEMPAS (riociguat)* VERQUVO (vericiguat)**	*Adempas requires a thirty (30) day trial of a preferred agent from any other PAH Class before it may be approved, unless one (1) of the exceptions on the PA form is present. **Full PA criteria for Verquvo may be found on the PA Criteria page by clicking the hyperlink.
GROWTH HORMONES AND ACHONDROPLASIA AGENTS[CL/PA]		
CLASS PA CRITERIA: Non-preferred agents require three (3) month trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
GENOTROPIN (somatropin) NORDITROPIN (somatropin)	HUMATROPE (somatropin) INCRELEX (mecasermin) NGENLA (somatrogon-ghla) NUTROPIN AQ (somatropin) OMNITROPE (somatropin) SAIZEN (somatropin) SEROSTIM (somatropin) SKYTROFA (lonapegsomatropin) SOGROYA (somapacitan-beco) VOXZOGO (vosoritide)** ZOMACTON (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. *Full PA criteria for Voxzogo may be found on the PA Criteria page by clicking the hyperlink.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
***H. PYLORI* TREATMENT**		
CLASS PA CRITERIA: Non-preferred agents require a trial of the combination of individual preferred components of the requested non-preferred agent and must be used at the recommended dosages, frequencies, and duration of the non-preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
Please use individual components: preferred PPI (omeprazole or pantoprazole) amoxicillin tetracycline metronidazole clarithromycin bismuth PYLERA (bismuth/metronidazole/tetracycline)	HELIDAC (bismuth/metronidazole/tetracycline) lansoprazole/amoxicillin/clarithromycin OMECLAMOX-PAK (omeprazole/amoxicillin/clarithromycin) TALICIA (omeprazole/amoxicillin/rifabutin)	
HEART FAILURE		
This is not an all-inclusive list of agents available for the treatment of heart failure. Please see beta blockers and SGLT-2 agents.)		
ENTRESTO (sacubitril/valsartan)*	INPEFA (sotagliflozin)** VERQUVO (vericiguat)***	*Entresto may be authorized only for patients ≥ 1 year of age diagnosed with chronic heart-failure. **Inpefa may be authorized for an FDA approved indication **AND** clinical reasoning must be provided as to why the medical need cannot be met with a preferred SGLT2 agent. ***Full PA criteria for Verquvo may be found on the PA Criteria page by clicking the hyperlink.
HEPATITIS B TREATMENTS		
CLASS PA CRITERIA: Non-preferred agents require ninety (90) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
BARACLUDE SOLUTION (entecavir) * entecavir lamivudine HBV	adefovir BARACLUDE TABLET (entecavir) EPIVIR HBV (lamivudine) HEPSERA (adefovir) VEMLIDY (tenofovir alafenamide fumarate)	*Baraclude solution will be authorized only for patients with documentation of dysphagia.
HEPATITIS C TREATMENTS[CL/PA]		
CLASS PA CRITERIA: For patients starting therapy in this class, preferred regimens may be found on the PA Criteria page. Requests for non-preferred regimens require medical reasoning why a preferred regimen cannot be used.		
MAVYRET (pibrentasvir/glecaprevir)* ribavirin sofosbuvir/velpatasvir (labeler 72626)*	EPCLUSA (sofosbuvir/velpatasvir)* HARVONI (ledipasvir/sofosbuvir)* ledipasvir/sofosbuvir* PEGASYS (pegylated interferon) PEG-INTRON (pegylated interferon) RIBASPHERE RIBAPAK (ribavirin) RIBASPHERE 400 mg, 600 mg (ribavirin)	*Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	SOVALDI (sofosbuvir)* VIEKIRA XR (dasabuvir/ombitasvir/ paritaprevir/ritonavir)* VOSEVI (sofosbuvir/velpatasvir/voxilaprevir) ZEPATIER (elbasvir/grazoprevir)	
HYPERPARATHYROID AGENTS[AP]		
CLASS PA CRITERIA: Non-preferred agents require thirty (30) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
cinacalcet paricalcitol capsule	doxercalciferol HECTOROL (doxercalciferol) paricalcitol injection RAYALDEE (calcifediol) SENSIPAR (cinacalcet) ZEMPLAR (paricalcitol)	
HYPOGLYCEMIA TREATMENTS		
CLASS PA CRITERIA: Non-preferred agents require clinical reasonining beyond convenience why the preferred glucagon products cannot be used.		
BAQSIMI SPRAY (glucagon) glucagon vial glucagon emergency kit ZEGALOGUE (dasiglucagon)	GLUCAGEN HYPOKIT (glucagon) GVOKE (glucagon)	
IMMUNOMODULATORS, ATOPIC DERMATITIS		
CLASS PA CRITERIA: Non-preferred agents require 30-day trial of a medium to high potency topical corticosteroid **AND all** preferred agents in this class unless one (1) of the exceptions on the PA form is present. Requirement for topical corticosteroids may be excluded with involvement of sensitive areas such as the face and skin folds.		
ADBRY (tralokinumab)* DUPIXENT (dupilumab)* ELIDEL (pimecrolimus) PROTOPIC (tacrolimus) tacrolimus ointment	CIBINQO (abrocitinib)* EUCRISA (crisaborole)[AP]** OPZELURA CREAM (ruxolitinib)* pimecrolimus cream SOTYKTU (deucravacitinib)	*Full PA criteria may be found on the PA Criteria page by clicking the hyperlink **Eucrisa requires a 30-day trial of Elidel **OR** a medium to high potency corticosteroid unless contraindicated.
IMMUNOMODULATORS, GENITAL WARTS & ACTINIC KERATOSIS AGENTS		
CLASS PA CRITERIA: Non-preferred agents require thirty (30) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
CONDYLOX GEL (podofilox) EFUDEX (fluorouracil) imiquimod cream	ALDARA (imiquimod) CARAC (fluorouracil) diclofenac 3% gel fluorouracil 0.5% cream fluorouracil 5% cream imiquimod pump podofilox TOLAK (fluorouracil 4% cream) VEREGEN (sinecatechins)	*Zyclara will be authorized for a diagnosis of actinic keratosis.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	ZYCLARA CREAM, PUMP (imiquimod)*	
IMMUNOSUPPRESSIVES, ORAL		
CLASS PA CRITERIA: Non-preferred agents require a fourteen (14) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
azathioprine cyclosporine cyclosporine, modified mycophenolate mofetil sirolimus tacrolimus capsule	ASTAGRAF XL (tacrolimus) AZASAN (azathioprine) CELLCEPT (mycophenolate mofetil) ENVARSUS XR (tacrolimus) everolimus tablet IMURAN (azathioprine) LUPKYNIS (voclosporin)* mycophenolic acid mycophenolic mofetil suspension MYFORTIC (mycophenolic acid) NEORAL (cyclosporine, modified) PROGRAF (tacrolimus) RAPAMUNE (sirolimus) REZUROCK (belumosudil)** SANDIMMUNE (cyclosporine) ZORTRESS (everolimus)	*Lupkynis requires a ninety (90) day trial of Benlysta prior to approval. Full PA criteria for Lupkynis may be found on the PA Criteria page by clicking the hyperlink. **Rezurock may be authorized after a trial of two systemic treatments for chronic graft-versus-host disease. Examples of systemic therapy may include methylprednisolone, Imbruvica® (ibrutinib capsules and tablets), cyclosporine, tacrolimus, sirolimus, mycophenolate mofetil and imatinib.
INTRANASAL RHINITIS AGENTS[AP]		
CLASS PA CRITERIA: See below for individual sub-class criteria.		
	ANTICHOLINERGICS	
ipratropium	ATROVENT (ipratropium)	Non-preferred agents require thirty (30) day trials of one (1) preferred nasal anti-cholinergic agent, **AND** one (1) preferred antihistamine **AND** one (1) preferred intranasal corticosteroid agent before they will be approved, unless one (1) of the exceptions on the PA form is present.
	ANTIHISTAMINES	
azelastine olopatadine	PATANASE (olopatadine)	
	COMBINATIONS	
	azelastine/fluticasone DYMISTA (azelastine / fluticasone) RYALTRIS (olopatadine HCl/mometasone)*	Dymista requires a concurrent thirty (30) day trial of each preferred component before it will be approved, unless one (1) of the exceptions on the PA form is present. *Ryaltris requires a thirty (30) day trial of each individual component before it may be approved.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	CORTICOSTEROIDS	
fluticasone propionate OMNARIS (ciclesonide) QNASL HFA (beclomethasone) ZETONNA (ciclesonide)	BECONASE AQ (beclomethasone) flunisolide mometasone NASONEX (mometasone)	Non-preferred agents require thirty (30) day trials of each preferred agent in this sub-class before they will be approved, unless one (1) of the exceptions on the PA form is present
IRRITABLE BOWEL SYNDROME/SHORT BOWEL SYNDROME/SELECTED GI AGENTS		
CLASS PA CRITERIA: All agents are approvable only for patients age eighteen (18) and older. **See below for additional sub-class criteria.**		
	CONSTIPATION	
LINZESS 145 and 290 mcg (linaclotide) lubiprostone capsule (labeler 00254 only) MOVANTIK (naloxegol) TRULANCE (plecanatide)	AMITIZA (lubiprostone) IBSRELA (tenapanor) LINZESS 72 mcg (linaclotide) lubiprostone capsule MOTEGRITY (prucalopride) RELISTOR INJECTION (methylnaltrexone) RELISTOR TABLET (methylnaltrexone) SYMPROIC (naldemedine)	No agent shall be approved to treat opioid induced constipation (OIC) without evidence of at least 90-days of opioid use preceding the request. Continuation of coverage shall be granted with evidence of continuous and concurrent opioid use. **Agents may be authorized only for their FDA-approved labeled indication. The following agent-specific criteria shall also apply, unless one (1) of the exceptions on the PA form is present:** **Ibsrela** requires thirty (30) day trials of each preferred agent for IBS-C, however for males, a trial of lubiprostone is not required. **Linzess 72mcg** may only be approved for a diagnosis of chronic idiopathic constipation (CIC) AND for those who cannot tolerate the 145mcg dose. Linzess may also be approvable for a diagnosis of functional constipation for pediatric patients 6 to 17 years of age. **Motegrity** requires a 30-day trial of both lubiprostone and Linzess. **Relistor** and **Symproic** are indicated for OIC and require thirty (30) day trials of both Movantik and lubiprostone.
	DIARRHEA	
	alosetron LOTRONEX (alosetron) MYTESI (crofelemer) VIBERZI (eluxadoline)	Full PA criteria may be found on the PA Criteria page by clicking the hyperlink
LAXATIVES AND CATHARTICS		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
CLASS PA CRITERIA: Non-preferred agents require thirty (30) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present		
CLENPIQ (sodium picosulfate, magnesium oxide, citric acid) COLYTE GOLYTELY MOVIPREP NULYTELY OSMOPREP peg 3350 SUPREP	peg 3350-sod sulf-NaCL-KCL-asb powder SUFLAVE (peg 350-sod sulf, chl-pot-mag) SUTAB (magnesium sulfate, potassium sulfate, sodium sulfate)	
LEUKOTRIENE MODIFIERS		
CLASS PA CRITERIA: Non-preferred agents require thirty (30) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
montelukast zafirlukast	ACCOLATE (zafirlukast) SINGULAIR (montelukast) zileuton ZYFLO (zileuton)	
LIPOTROPICS, OTHER (Non-statins)		
CLASS PA CRITERIA: Non-preferred agents require a twelve (12) week trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
BILE ACID SEQUESTRANTS[AP]		
cholestyramine colesevelam colestipol tablets	COLESTID (colestipol) colestipol granules 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		
ezetimibe	ZETIA (ezetimibe)	
FATTY ACIDS[CL/PA]		
omega-3 acid ethyl esters VASCEPA (icosapent ethyl)*	icosapent ethyl capsules LOVAZA (omega-3-acid ethyl esters)	[CL]All agents in this subclass require a prior authorization and an initial triglyceride level ≥ 500 mg/dL. *Additionally, Vascepa may be approved if the following criteria is met: 1. The patient has an initial triglyceride level of ≥ 150 mg/dL prior to start of therapy; AND 2. The patient has established cardiovascular disease or diabetes; AND 3. The patient is concomitantly receiving a statin.
FIBRIC ACID DERIVATIVES[AP]		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
fenofibrate 54 and 160 mg fenofibrate micronized 67mg, 134mg & 200mg fenofibrate nanocrystallized 48 mg, 145 mg gemfibrozil	ANTARA (fenofibrate) fenofibrate 40 mg tablet fenofibrate 150 mg capsules fenofibrate 43, 50, 120 and 130 mg fenofibrate micronized 30 and 90 mg fenofibric acid FENOGLIDE (fenofibrate) FIBRICOR (fenofibric acid) LIPOFEN (fenofibrate) LOPID (gemfibrozil) TRICOR (fenofibrate nanocrystallized) TRILIPIX (fenofibric acid)	
	MTP INHIBITORS	
	JUXTAPID (lomitapide)*	*Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.
	PCSK-9 INHIBITORS	
PRALUENT (alirocumab)* REPATHA (evolocumab)*	LEQVIO (inclisiran)*	*Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.
LIPOTROPICS, STATINS[AP]		
CLASS PA CRITERIA: See below for individual sub-class criteria.		
	STATINS	
atorvastatin lovastatin pravastatin rosuvastatin simvastatin**	ALTOPREV (lovastatin) ATORVALIQ (atorvastatin)*** CRESTOR (rosuvastatin) EZALLOR SPRINKLE (rosuvastatin)* fluvastatin fluvastatin ER LESCOL XL (fluvastatin) LIPITOR (atorvastatin) LIVALO (pitavastatin) PRAVACHOL (pravastatin) ZOCOR (simvastatin)** ZYPITAMAG (pitavastatin)	Non-preferred agents require twelve (12) week trials of two (2) preferred agents, including the generic formulation of the requested non-preferred agent, before they will be approved, unless one (1) of the exceptions on the PA form is present. *Ezallor SPRINKLE will only be authorized for those who are unable to ingest solid dosage forms due to documented oral-motor difficulties or dysphagia. **Zocor/simvastatin 80mg tablets will require a clinical PA. ***Atorvaliq may be authorized for children who are 6-10 years of age who are unable to ingest solid dosage forms. Therapy may be authorized for older patients with clinical documentation indicating oral-motor difficulties or dysphagia.
	STATIN COMBINATIONS	
	amlodipine/atorvastatin CADUET (atorvastatin/amlodipine) ezetimibe/simvastatin* VYTORIN (simvastatin/ezetimibe)*	Non-preferred agents require thirty (30) day concurrent trials of the corresponding preferred single agents before they will be approved, unless one (1) of the exceptions on the PA form is present.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
		*Vytorin will be authorized only after an insufficient response to a twelve (12) week trial of the maximum tolerable dose of atorvastatin or rosuvastatin, unless one (1) of the exceptions on the PA form is present. Vytorin 80/10mg tablets will require a clinical PA.
MABS, ANTI-IL/IgE		
CLASS PA CRITERIA: Non-preferred agents require ninety (90) day trials of all preferred agents which are indicated for the diagnosis. **Full PA Criteria may be found on the PA Criteria page by clicking the hyperlink.**		
DUPIXENT (dupilumab) FASENRA (benralizumab) NUCALA AUTO INJECTOR/SYRINGE (mepolizumab) XOLAIR VIAL (omalizumab)	NUCALA VIAL (mepolizumab) TEZSPIRE (tezepelumab-ekko) XOLAIR SYRINGES (omalizumab)	
MACROLIDES		
CLASS PA CRITERIA: Non-preferred agents require a five (5) day trial of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
MACROLIDES		
azithromycin tablet, suspension, packet	clarithromycin tablets clarithromycin ER clarithromycin suspension E.E.S. (erythromycin ethylsuccinate) ERYPED (erythromycin ethylsuccinate) ERY-TAB (erythromycin) ERYTHROCIN (erythromycin stearate) erythromycin tablet/capsule DR erythromycin tablet erythromycin estolate ZITHROMAX (azithromycin)	
MULTIPLE SCLEROSIS AGENTS[CL/PA]		
CLASS PA CRITERIA: All agents require a prior authorization and documented diagnosis of multiple sclerosis. Preferred oral agents require a ninety (90) day trial of any preferred injectable agent. Non-preferred agents require ninety (90) day trials of two (2) chemically unique preferred agents (in the same sub-class) before they will be approved, unless one (1) of the exceptions on the PA form is present.		
INTERFERONS[AP]		
AVONEX (interferon beta-1a) AVONEX PEN (interferon beta-1a) BETASERON (interferon beta-1b) REBIF (interferon beta-1a) REBIF REBIDOSE (interferon beta-1a)	EXTAVIA KIT (interferon beta-1b) EXTAVIA VIAL (interferon beta-1b) PLEGRIDY (peginterferon beta-1a)	
NON-INTERFERONS		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
COPAXONE 20 mg (glatiramer) dalfampridine ER** dimethyl fumerate*** fingolimod KESIMPTA INJECTION (ofatumumab)**** teriflunomide*	AMPYRA (dalfampridine)** AUBAGIO (teriflunomide)* BAFIERTAM CAPSULES (monomethyl fumarate) COPAXONE 40 mg (glatiramer)***** GILENYA (fingolimod) glatiramer GLATOPA (glatiramer) MAVENCLAD (cladribine) MAYZENT (siponimod)****** PONVORY (ponesimod) TASCENSO ODT TABLETS (fingolimod lauryl sulfate) TECFIDERA (dimethyl fumarate)*** VUMERITY (diroximel) ZEPOSIA (ozanimod)	**In addition to class PA criteria, the following conditions and criteria may also apply:** *Aubagio (teriflunomide) requires the following additional criteria to be 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 between eighteen (18) up to sixty-five (65) years of age **and** 6. Negative tuberculin skin test before initiation of therapy **Dalfampridine ER and Ampyra require the following additional criteria to be met: 1. Diagnosis of multiple sclerosis **and** 2. No history of seizures **and** 3. No evidence of moderate or severe renal impairment. 4. Initial authorization will be issued for thirty (30) days, with a limit of two (2) tablets per day. If the patient shows improvement, additional quantities may be authorized. ***Dimethyl fumerate and Tecfidera require the following additional criteria to be met: 1. Diagnosis of relapsing multiple sclerosis **and** 2. Complete blood count (CBC) within six (6) months of initiation of therapy and six (6) months after initiation **and** 3. Complete blood count (CBC) annually during therapy. ****Kesimpta may be approved with documentation of treatment failure/inadequate treatment response after a 90-day trial of at least one preferred MS agent. Documentation of a negative Hepatits B test must be provided. *****Copaxone 40mg will only be authorized for documented injection site issues.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
		******Mayzent may be authorized with no additional requirement beyond the diagnosis for patients with documented secondary progressive MS.
NEUROPATHIC PAIN		
CLASS PA CRITERIA: Non-preferred agents require a thirty (30) day trial of a preferred agent in the corresponding dosage form (oral or topical) before they will be approved, unless one (1) of the exceptions on the PA form is present.		
capsaicin OTC duloxetine gabapentin lidocaine patch 5% LYRICA CAPSULE/SOLUTION (pregabalin) pregabalin capsule	CYMBALTA (duloxetine) DRIZALMA SPRINKLE (duloxetine)* GRALISE (gabapentin)** HORIZANT (gabapentin)*** lidocaine patch 4% LIDODERM (lidocaine) LYRICA CR (pregabalin)**** NEURONTIN (gabapentin) pregabalin ER tablet (generic Lyrica CR) pregabalin solution SAVELLA (milnacipran)**** ZTLIDO PATCH (lidocaine)	*Drizalma SPRINKLE will only be authorized for those who are unable to ingest solid dosage forms due to documented oral-motor difficulties or dysphagia. **Gralise will be authorized only 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. 90-day 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. ****Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. ****Lyrica CR requires medical reasoning beyond convenience as to why the need cannot be met using preferred pregabalin capsules. ****Savella will be authorized for a diagnosis of fibromyalgia only after a 90-day trial of one preferred agent
NSAIDS[AP]		
CLASS PA CRITERIA: See below for sub-class PA criteria.		
	NON-SELECTIVE	
diclofenac (IR, SR) diclofenac potassium tablets flurbiprofen ibuprofen tablet, capsule, suspension, chewable (Rx and OTC) indomethacin ketoprofen	DAYPRO (oxaprozin) diclofenac potassium capsules diflunisal DUEXIS (famotidine/ibuprofen) EC-naproxen DR tablet ELYXYB (celecoxib) etodolac IR	Non-preferred agents require thirty (30) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ketorolac meloxicam tablet nabumetone naproxen sodium capsule, tablet naproxen sodium DS tablet piroxicam sulindac	etodolac SR famotidine/ibuprofen FELDENE (piroxicam) fenoprofen INDOCIN SUSPENSION (indomethacin) INDOCIN SUPPOSITORIES (indomethacin) indomethacin ER ketoprofen ER ketorolac spray LOFENA (diclofenac) meclofenamate mefenamic acid meloxicam submicronized capsule (generic Vivlodex) meloxicam suspension MOBIC TABLET (meloxicam) NALFON (fenoprofen) NAPRELAN (naproxen) naproxen suspension naproxen CR oxaprozin RELAFEN DS (nabumetone) SPRIX (ketorolac) TIVORBEX (indomethacin) tolmetin VIVLODEX (meloxicam) VOLTAREN (diclofenac) ZIPSOR (diclofenac potassium) ZORVOLEX (diclofenac)	
NSAID/GI PROTECTANT COMBINATIONS		
	ARTHROTEC (diclofenac/misoprostol) diclofenac/misoprostol ibuprofen/famotidine naproxen/esomeprazole VIMOVO (naproxen/esomeprazole)	Non-preferred agents are only available on appeal and require medical reasoning beyond convenience as to why the need cannot be met with the combination of preferred single agents.
COX-II SELECTIVE		
celecoxib	CELEBREX (celecoxib)	1.
TOPICAL		
diclofenac gel (RX)** FLECTOR PATCH (diclofenac)*	diclofenac patch diclofenac solution LICART PATCH (diclofenac) PENNSAID (diclofenac)	*Flector patches are limited to two per day. **diclofenac gel will be limited to 100 grams per month.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
		Non-preferred agents require a thirty (30) day trial of the preferred Topical agent and thirty (30) day trials of each preferred oral NSAID before they will be approved, unless one(1) of the exceptions on the PA form is present.
OPHTHALMIC ANTIBIOTICS[AP]		
CLASS PA CRITERIA: Non-preferred agents require three (3) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
bacitracin/polymyxin ointment ciprofloxacin* erythromycin gentamicin moxifloxacin* neomycin/bacitracin/polymyxin ofloxacin* polymyxin/trimethoprim tobramycin TOBREX OINT (tobramycin)	AZASITE (azithromycin) bacitracin BESIVANCE (besifloxacin)* BLEPH-10 (sulfacetamide) CILOXAN (ciprofloxacin) gatifloxacin neomycin/polymyxin/gramicidin OCUFLOX (ofloxacin) POLYTRIM (polymyxin/trimethoprim) sulfacetamide drops sulfacetamide ointment TOBREX (tobramycin) VIGAMOX (moxifloxacin) XDEMVY (lotilaner)** ZYMAXID (gatifloxacin)	*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. **Xdemvy may be authorized for the treatment of demodex blepharitis without further restrictions.
OPHTHALMIC ANTIBIOTIC/STEROID COMBINATIONS[AP]		
CLASS PA CRITERIA: Non-preferred agents require three (3) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
BLEPHAMIDE (prednisolone/sulfacetamide) MAXITROL ointment/suspension (neomycin/polymyxin/ dexamethasone) neomycin/bacitracin/polymyxin/hydrocortisone neomycin/polymyxin/dexamethasone PRED-G SUSPENSION (prednisolone/gentamicin) sulfacetamide/prednisolone TOBRADEX OINTMENT (tobramycin/ dexamethasone) TOBRADEX SUSPENSION (tobramycin/ dexamethasone) TOBRADEX ST (tobramycin/ dexamethasone) tobramycin/dexamethasone suspension ZYLET (loteprednol/tobramycin)	BLEPHAMIDE S.O.P. (prednisolone/sulfacetamide) neomycin/polymyxin/hydrocortisone PRED-G OINTMENT (prednisolone/gentamicin)	
OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS[AP]		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
CLASS PA CRITERIA: Non-preferred agents require thirty (30) day trials of three (3) preferred chemically unique agents before they will be approved, unless one (1) of the exceptions on the PA form is present.		
ALAWAY (ketotifen) ALREX (loteprednol) azelastine BEPREVE (bepotastine) cromolyn ketotifen ZADITOR OTC (ketotifen)	ALOCRIL (nedocromil) ALOMIDE (lodoxamide) bepotastine epinastine LUMIFY (brimonidine) olopatadine 0.1% olopatadine 0.2% PATADAY ONCE AND TWICE DAILY (olopatadine) ZERVIATE (cetirizine)	
OPHTHALMICS, ANTI-INFLAMMATORIES		
CLASS PA CRITERIA: Non-preferred agents require five (5) day trials of at least two (2) preferred agents before they will be approved, unless one (1) of the exceptions on the PA form is present. Trials must include at least one agent with the same mechanism of action as the requested non-preferred agent.		
Dexamethasone diclofenac DUREZOL (difluprednate) FLAREX (fluorometholone) FML (fluorometholone) FML FORTE (fluorometholone) FML S.O.P. (fluorometholone) ketorolac LOTEMAX GEL, OINTMENT, SUSPENSION (loteprednol) MAXIDEX (dexamethasone) NEVANAC (nepafenac) PRED FORTE (prednisolone) PRED MILD (prednisolone) prednisolone acetate prednisolone sodium phosphate	ACULAR (ketorolac) ACULAR LS (ketorolac) ACUVAIL (ketorolac tromethamine) bromfenac BROMSITE (bromfenac) difluprednate fluorometholone flurbiprofen ILEVRO (nepafenac) INVELTYS (loteprednol) LOTEMAX SM (loteprednol etabonate) loteprednol drops, gel OMNIPRED (prednisolone) OZURDEX (dexamethasone) PROLENSA (bromfenac) RETISERT (fluocinolone) TRIESENCE (triamcinolone)	
OPHTHALMICS, GLAUCOMA AGENTS		
CLASS PA CRITERIA: Non-preferred agents will only be authorized if there is an allergy to all preferred agents in the corresponding sub-class.		
COMBINATION AGENTS		
COMBIGAN (brimonidine/timolol) dorzolamide/timolol SIMBRINZA (brinzolamide/brimonidine)	brimonidine-timolol COSOPT PF (dorzolamide/timolol)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	BETA BLOCKERS	
BETOPTIC S (betaxolol) carteolol levobunolol timolol drops	betaxolol ISTALOL (timolol) timolol gel TIMOPTIC (timolol)	
	CARBONIC ANHYDRASE INHIBITORS	
AZOPT (brinzolamide) dorzolamide	brinzolamide TRUSOPT (dorzolamide)	
	PARASYMPATHOMIMETICS	
pilocarpine		
	PROSTAGLANDIN ANALOGS	
latanoprost TRAVATAN-Z (travoprost)	bimatoprost IYUZEH (latanoprost) LUMIGAN (bimatoprost) tafluprost travoprost VYZULTA (latanoprostene)* XALATAN (latanoprost) XELPROS (latanoprost) ZIOPTAN (tafluprost)	*Vyzulta – prior authorization requires failure on a 3-month trial of at least one preferred prostaglandin eye drop used in combination with an agent from another subclass.
	RHO-KINASE INHIBITORS	
RHOPRESSA (netarsudil) ROCKLATAN (netarsudil/latanoprost)		
	SYMPATHOMIMETICS	
ALPHAGAN P Solution (brimonidine) brimonidine 0.2%	apraclonidine brimonidine 0.15% IOPIDINE (apraclonidine)	
OPIATE DEPENDENCE TREATMENTS		
CLASS PA CRITERIA: Bunavail and Zubsolv may only be approved with a documented intolerance or allergy to Suboxone strips AND buprenorphine/naloxone tablets. *WV Medicaid's buprenorphine coverage policy may be viewed by clicking on the following hyperlink: Buprenorphine Coverage Policy and Related Forms		
BRIXADI (buprenorphine)CL/PA buprenorphine/naloxone tablets* KLOXXADO SPRAY (naloxone) naloxone vial/syringe/cartridge naloxone nasal spray (OTC) NARCAN NASAL SPRAY (naloxone) OPVEE (nalmefene) SUBLOCADE (buprenorphine soln)CL/PA* SUBOXONE FILM (buprenorphine/naloxone)* VIVITROL (naltrexone)	BUNAVAIL (buprenorphine/naloxone)* buprenorphine tablets* buprenorphine/naloxone film* LUCEMYRA (lofexidine)** naloxone nasal spray (RX) ZIMHI (naloxone hydrochloride) ZUBSOLV (buprenorphine/naloxone)*	** Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ORAL AND TOPICAL CONTRACEPTIVES		
CLASS PA CRITERIA: Non-preferred agents require a trial with three (3) preferred contraceptive products including a trial with a preferred product with the same route of administration as the requested non-preferred agent, before they will be approved, unless one (1) of the exceptions on the PA form is present.		
AFIRMELLE ALTAVERA AMETHYST APRI AUBRA AUBRA EQ AUROVELA AVIANE AYUNA AZURETTE BALZIVA BEYAZ BLISOVI FE CAMILA CAMRESE 3MO CHATEAL CHATEAL EQ CYRED CYRED EQ DEBLITANE desogestrel-ethinyl estradiol desogestrel-ethinyl estradiol/ethinyl estradiol DOLISHALE drospirenone-ethinyl estradiol ENSKYCE ERRIN ESTARYLLA FALMINA HAILEY FE HEATHER HER STYLE INCASSIA ISIBLOOM JENCYCLA JOLESSA 3MO	ALYACEN AMETHIA 3MO ARANELLE ASHLYNA 3MO AUROVELA 24 FE AUROVELA FE BALCOLTRA BLISOVI 24 FE BRIELLYN CAMRESE LO 3MO CHARLOTTE 24 FE CHEW TAB CRYSELLE CURAE DASETTA DAYSEE 3MO drospirenone-ethy estra-levomef ECONTRA EZ ECONTRA ONE-STEP ELINEST ELLA ENPRESSE ethynodiol-ethinyl estradiol FAYOSIM 3MO FINZALA GEMMILY HAILEY HAILEY 24 FE ICLEVIA 3MO INTROVALE 3MO JAIMIESS 3MO JASMIEL JOYEAUX JUNEL JUNEL FE 24 KAITLIB FE	*Phexxi may be approvable when it is prescribed for the prevention of pregnancy; **AND** reasoning is provided as to why the clinical need cannot be met with a preferred agent. Phexxi will not be approved for use by patients who are also using hormonal contraceptive vaginal rings.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
JULEBER	KALLIGA	
JUNEL FE	KELNOR 1-35	
KARIVA	KELNOR 1-50	
KURVELO	LARIN	
LESSINA	LARIN 24 FE	
LEVONEST	LARIN FE	
levonorgestrel	LAYOLIS FE CHEW TAB	
levonorgestrel-ethinyl estradiol	LEENA	
levonorgestrel-ethinyl estradiol (generic Loseasonique) 3MO	levonorgestrel-ethinyl estradiol (generic Jolessa) 3 MO	
levonorgestrel-ethinyl estradiol-ferrous bisglycinate	LEVORA-28	
LILLOW	LOESTRIN	
LO LOESTRIN FE	LOESTRIN FE	
LUTERA	LOJAIMIESS 3MO	
LYLEQ	LORYNA	
LYZA	LOSEASONIQUE 3MO	
MARLISSA	LOW-OGESTREL	
MIBELAS 24 FE	LO-ZUMANDIMINE	
MICROGESTIN FE	MERZEE	
MILI	MICROGESTIN	
MONO-LINYAH	MICROGESTIN 24 FE	
MY CHOICE	MINASTRIN 24 FE CHEW TAB	
MY WAY	MIRCETTE	
NATAZIA	NECON	
NEW DAY	NEXTSTELLIS	
NIKKI	norethindrone-e.estradiol-iron cap	
NORA-BE	norethindrone-e.estradiol-iron chew tab	
norethindrone	NORTREL	
norethindrone-e.estradiol-iron tab	OPTION 2	
norethindrone-ethinyl estradiol	PHEXXI VAGINAL GEL*	
norgestimate-ethinyl estradiol	PHILITH	
NORLYDA	PIMTREA	
NYLIA	QUARTETTE	
NYMYO	RECLIPSEN	
OCELLA	RIVELSA 3MO	
OPCICON ONE-STEP	SAFYRAL	
PORTIA	SEASONIQUE 3MO	
	SETLAKIN 3MO	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
SHAROBEL	SIMPESSE 3MO	
SIMLIYA	SLYND	
SPRINTEC	SYEDA	
SRONYX	TARINA 24 FE	
TARINA FE	TAYSOFY	
TARINA FE 1-20 EQ	TILIA FE	
TAYTULLA	TRI-LEGEST FE	
TRI-ESTARYLLA	TRIVORA-28	
TRI FEMYNOR	TURQOZ	
TRI-LINYAH	TYBLUME CHEW TAB	
TRI-LO-ESTARYLLA	TYDEMY	
TRI-LO-MARZIA	VELIVET	
TRI-LO-MILI	VESTURA	
TRI-LO-SPRINTEC	VYFEMLA	
TRI-MILI	WERA	
TRI-NYMYO	WYMZYA FE CHEW TAB	
TRI-SPRINTEC	ZAFEMY PATCH	
TRI-VYLIBRA		
TRI-VYLIBRA LO		
TULANA		
TWIRLA PATCH		
VIENVA		
VIORELE		
VOLNEA		
VYLIBRA		
XULANE PATCH		
YASMIN 28		
YAZ		
ZOVIA 1-35		
ZOVIA 1-35E		
ZUMANDIMINE		
OTIC ANTIBIOTICS[AP]		
CLASS PA CRITERIA: Non-preferred agents require five (5) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
CIPRO HC (ciprofloxacin/hydrocortisone) ciprofloxacin/dexamethasone	ciprofloxacin ciprofloxacin/fluocinolone	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
CORTISPORIN-TC (colistin/hydrocortisone/ neomycin) neomycin/polymyxin/HC solution/suspension ofloxacin	OTOVEL (ciprofloxacin/fluocinolone)	
PAH AGENTS – ENDOTHELIN RECEPTOR ANTAGONISTS[CL/PA]		
CLASS PA CRITERIA: Non-preferred agents require a thirty (30) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
LETAIRIS (ambrisentan) TRACLEER TABLET (bosentan)	ambrisentan bosentan OPSUMIT (macitentan) TRACLEER SUSP (bosentan)	
PAH AGENTS – PDE5s[CL/PA]		
CLASS PA CRITERIA: Non-preferred agents require a thirty (30) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. - Patients stabilized on non-preferred agents will be grandfathered.		
sildenafil tablets	ADCIRCA (tadalafil) LIQREV (sildenafil)* REVATIO IV (sildenafil) REVATIO SUSPENSION (sildenafil) REVATIO TABLETS (sildenafil) sildenafil suspension (generic Revatio)** TADLIQ SUSPENSION (tadalafil)***	*Liqrev may be authorized for those who are unable to ingest solid dosage forms due to documented oral-motor difficulties or dysphagia AND documentation is provided as to why the clinical need cannot be met with either Revatio or sildenafil suspension. **sildenafil suspension may be authorized for those who are unable to ingest solid dosage forms due to documented oral-motor difficulties or dysphagia AND documentation is provided as to why the clinical need cannot be met with Revatio. ***Tadliq may be authorized for those who are unable to ingest solid dosage forms due to documented oral-motor difficulties or dysphagia AND after a thirty (30) day trial of Revatio resulting in an inadequate treatment response.
PAH AGENTS – PROSTACYCLINS[CL/PA]		
CLASS PA CRITERIA: Non-preferred agents require a thirty (30) day trial of a preferred agent, including the preferred generic form of the non-preferred agent (if available), before they will be approved, unless one (1) of the exceptions on the PA form is present.		
epoprostenol (generic Flolan) epoprostenol (generic Veletri) VENTAVIS (iloprost)*	FLOLAN (epoprostenol) ORENITRAM ER (treprostinil) REMODULIN (treprostinil sodium) TYVASO (treprostinil) TYVASO DPI (treprostinil) UPTRAVI (selexipag) VELETRI (epoprostenol)	*Ventavis will only be authorized for the treatment of pulmonary artery hypertension (WHO Group 1) in patients with NYHA Class III or IV symptoms.
PANCREATIC ENZYMES[AP]		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
CLASS PA CRITERIA: Non-preferred agents require a thirty (30) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. - For members with cystic fibrosis, a trial of a preferred agent will not be required.		
CREON ZENPEP	PANCREAZE PERTZYE VIOKACE	
PHOSPHATE BINDERS[AP]		
CLASS PA CRITERIA: Non-preferred agents require a thirty (30) day trial of at least two (2) preferred agents before they will be approved, unless one (1) of the exceptions on the PA form is present.		
calcium acetate capsules CALPHRON (calcium acetate) MAGNEBIND RX (calcium carbonate, folic acid, magnesium carbonate) PHOSLYRA (calcium acetate) sevelamer carbonate	AURYXIA (ferric citrate) calcium acetate tablets FOSRENOL (lanthanum) lanthanum chewable RENAGEL (sevelamer) RENVELA (sevelamer carbonate) sevelamer carbonate powder packet sevelamer hcl VELPHORO (sucroferric oxyhydroxide)	
PITUITARY SUPPRESSIVE AGENTS, LHRH[CL/PA]		
CLASS PA CRITERIA: Unless otherwise noted, non-preferred agents are available only on appeal.		
FENSOLVI SYRINGE (leuprolide acetate) LUPANETA (leuprolide) LUPRON DEPOT KIT (leuprolide) LUPRON DEPOT-PED KIT (leuprolide) MYFEMBREE (relugolix, estradiol, norethindrone)* SYNAREL (nafarelin) TRELSTAR (triptorelin) TRIPTODUR (triptorelin)	leuprolide ORIAHNN (elagolix-estradiol-norethindrone)* ORILISSA (elagolix)* SUPPRELIN LA KIT (histrelin)	*Full PA criteria for Myfembree, Orilissa and Oriahnn may be found on the PA Criteria page by clicking the hyperlink. In addition, Orilissa and Oriahnn may only be approved if there is a documented side effect, allergy, or treatment failure with Myfembree. Use of GnRH receptor antagonists will be limited to 24 months.
PLATELET AGGREGATION INHIBITORS		
CLASS PA CRITERIA: Non-preferred agents require a thirty (30) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
BRILINTA (ticagrelor) clopidogrel dipyridamole prasugrel	clopidogrel kit dipyridamole/aspirin EFFIENT (prasugrel) PLAVIX (clopidogrel) ZONTIVITY (vorapaxar)	
PROGESTATIONAL AGENTS		
CLASS PA CRITERIA: Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.		
	hydroxyprogesterone caproate	
PROGESTINS FOR CACHEXIA		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
CLASS PA CRITERIA: Non-preferred agents require a thirty (30) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
megestrol		
PROTON PUMP INHIBITORS[AP]		
CLASS PA CRITERIA: Non-preferred agents require sixty (60) day trials of both omeprazole (Rx) and pantoprazole at the maximum recommended dose*, inclusive of a concurrent thirty (30) day trial at the maximum dose of an H_2 antagonist before they will be approved, unless one (1) of the exceptions on the PA form is present.		
omeprazole (Rx) pantoprazole tablets PROTONIX GRANULES (pantoprazole)**	ACIPHEX (rabeprazole) ACIPHEX SPRINKLE (rabeprazole) DEXILANT (dexlansoprazole) dexlansoprazole DR capsule esomeprazole magnesium KONVOMEP (omeprazole/sodium bicarbonate) lansoprazole Rx NEXIUM (esomeprazole) NEXIUM PACKETS (esomeprazole)** omeprazole/sodium bicarbonate (Rx) pantoprazole granules packet PREVACID CAPSULES (lansoprazole) PREVACID SOLUTABS (lansoprazole)** PRILOSEC Rx (omeprazole) PROTONIX DR TABLETS (pantoprazole) rabeprazole ZEGERID Rx (omeprazole/sodium bicarbonate)	*Maximum recommended doses of the PPIs and H2-receptor antagonists may be located at the BMS Pharmacy PA criteria page titled "Max PPI and H2RA" by clicking on the hyperlink. **Prior authorization is required for members nine (9) years of age or older for these agents.
SEDATIVE HYPNOTICS[AP]		
CLASS PA CRITERIA: Non-preferred agents require thirty (30) day trials of all preferred agents in **BOTH** sub-classes before they will be approved, unless one (1) of the exceptions on the PA form is present. All agents except melatonin will be limited to fifteen (15) tablets in a thirty (30) day period. NOTE: WV Medicaid covers melatonin up to a maximum dose of 9 mg/day without a PA. Melatonin labeler code 51645 is preferred if available, however all NDCs are payable.		
BENZODIAZEPINES		
temazepam 15, 30 mg	estazolam flurazepam HALCION (triazolam) RESTORIL (temazepam) temazepam 7.5, 22.5 mg triazolam	
OTHERS		
BELSOMRA (suvorexant)* melatonin ROZEREM (ramelteon) zolpidem 5, 10 mg	AMBIEN (zolpidem) AMBIEN CR (zolpidem) DAYVIGO (lemborexant) doxepin 3mg and 6mg	For treatment naïve female patients, zolpidem and zolpidem ER maximum dosages will be limited to 5 mg and 6.25 mg respectively per day.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	EDLUAR (zolpidem) eszopiclone HETLIOZ (tasimelteon)CL* LUNESTA (eszopiclone) QUVIVIQ (daridorexant) ramelteon SILENOR (doxepin) zaleplon zolpidem ER 6.25, 12.5 mg	*Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. *Belsomra may be approved after a trial of zolpidem or temazepam, unless one of the exceptions on the PA form is present.
SKELETAL MUSCLE RELAXANTSAP		
CLASS PA CRITERIA: See below for individual sub-class criteria.		
ACUTE MUSCULOSKELETAL RELAXANT AGENTS		
chlorzoxazone (generic PARAFON FORTE) cyclobenzaprine IR 5, 10 mg methocarbamol	AMRIX (cyclobenzaprine) carisoprodol* carisoprodol/ASA* carisoprodol/ASA/codeine* chlorzoxazone (generic LORZONE) cyclobenzaprine ER cyclobenzaprine IR 7.5 mg FEXMID (cyclobenzaprine) LORZONE (chlorzoxazone) metaxalone orphenadrine orphenadrine ER ROBAXIN (methocarbamol) SKELAXIN (metaxalone) SOMA (carisoprodol)	Non-preferred agents require thirty (30) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present, with the exception of carisoprodol. *Carisoprodol requires thirty (30) day trials of each of the preferred acute musculoskeletal relaxants and Skelaxin before it will be approved.
MUSCULOSKELETAL RELAXANT AGENTS USED FOR SPASTICITY		
baclofen tizanidine tablets	baclofen solution* DANTRIUM (dantrolene) dantrolene FLEQSUVY (baclofen)* LYVISPAH GRANULE PACKET (baclofen)* tizanidine capsules ZANAFLEX (tizanidine)	Non-preferred agents require thirty (30) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. *Oral baclofen solution, Fleqsuvy (baclofen suspension) and Lyvispah granules may only be authorized for those who are unable to ingest solid dosage forms due to documented oral-motor difficulties or dysphagia. In addition, Fleqsuvy and Lyvispah may only be authorized if there is a documented intolerance to oral baclofen solution.
STEROIDS, TOPICAL		
CLASS PA CRITERIA: Non-preferred agents require five (5) day trials of one (1) form of **EACH** preferred unique active ingredient in the corresponding potency group before they will be approved, unless one (1) of the exceptions on the PA form is present.		
VERY HIGH & HIGH POTENCY		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
betamethasone dipropionate cream betamethasone valerate cream betamethasone valerate lotion betamethasone valerate oint clobetasol emollient clobetasol propionate cream, gel, ointment, solution clobetasol propionate shampoo fluocinonide gel triamcinolone acetonide cream, ointment triamcinolone acetonide lotion	amcinonide APEXICON E (diflorasone diacetate) betamethasone dipropionate gel, lotion, ointment BRYHALI LOTION (halobetasol) clobetasol lotion clobetasol propionate foam, spray CLODAN KIT (clobetasol propionate) CLODAN SHAMPOO (clobetasol propionate) desoximetasone cream, gel, ointment, spray diflorasone diacetate DIPROLENE (betamethasone dipropionate/propylene glycol) fluocinonide cream fluocinonide ointment fluocinonide solution fluocinonide/emollient halcinonide cream halobetasol propionate HALOG (halcinonide) IMPEKLO LOTION (clobetasol propionate) KENALOG (triamcinolone acetonide) LEXETTE FOAM (halobetasol) OLUX (clobetasol propionate) OLUX-E (clobetasol propionate/emollient) PSORCON (diflorasone diacetate) TEMOVATE (clobetasol propionate) TOPICORT CREAM, GEL, OINTMENT (desoximetasone) TOPICORT SPRAY (desoximetasone) TOVET FOAM (clobetasol) ULTRAVATE (halobetasol propionate) ULTRAVATE PAC cream VANOS (fluocinonide)	
MEDIUM POTENCY		
fluticasone propionate cream, ointment mometasone furoate triamcinolone acetonide 0.025% and 0.1% cream	BESER LOTION (fluticasone) betamethasone valerate foam clocortolone cream CLODERM (clocortolone pivalate) CORDRAN (flurandrenolide) CUTIVATE (fluticasone propionate) fluocinolone acetonide cream, ointment, solution flurandrenolide lotion, ointment, cream fluticasone propionate lotion hydrocortisone butyrate cream	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	hydrocortisone butyrate ointment, solution hydrocortisone valerate LOCOID (hydrocortisone butyrate) LOCOID LIPOCREAM (hydrocortisone butyrate/emollient) LUXIQ (betamethasone valerate) PANDEL (hydrocortisone probutate) prednicarbate	
	LOW POTENCY	
DERMA-SMOOTHE FS (fluocinolone acetonide) hydrocortisone acetate (Rx, OTC) hydrocortisone cream (Rx, OTC) hydrocortisone lotion hydrocortisone ointment (Rx, OTC) hydrocortisone solution OTC hydrocortisone-aloe cream OTC hydrocortisone-aloe ointment OTC	alclometasone dipropionate AQUA GLYCOLIC HC (hydrocortisone) DESONATE (desonide) desonide cream, ointment desonide lotion fluocinolone oil hydrocortisone/mineral oil/petrolatum hydrocortisone acetate/urea hydrocortisone/aloe gel SCALPICIN OTC (hydrocortisone) SYNALAR (fluocinolone) TEXACORT (hydrocortisone)	
STIMULANTS AND RELATED AGENTS		
CLASS 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 preferred agent in the same subclass and with a similar duration of effect and mechanism of action, unless one (1) of the exceptions on the PA form is present. **NOTE**: Children under the age of 18 may continue their existing therapy at the discretion of the prescriber.		
	AMPHETAMINES	
ADDERALL XR (amphetamine salt combination) amphetamine salt combination ER amphetamine salt combination IR dextroamphetamine ER dextroamphetamine IR DYANAVEL XR SUSP (amphetamine) PROCENTRA solution (dextroamphetamine)	ADDERALL (amphetamine salt combination) ADZENYS XR ODT (amphetamine) ADZENYS ER SUSP (amphetamine) amphetamine tablets DESOXYN (methamphetamine) DEXEDRINE ER (dextroamphetamine) dextroamphetamine solution DYANAVEL XR TABLETS (amphetamine) EVEKEO (amphetamine) EVEKEO ODT (amphetamine) lisdexamfetamine methamphetamine MYDAYIS (dextroamphetamine/amphetamine salt)* VYVANSE CHEWABLE (lisdexamfetamine) VYVANSE CAPSULE (lisdexamfetamine)	**In addition to the Class Criteria**: Thirty (30) day trials of at least three (3) antidepressants are required before amphetamines will be authorized for depression. *Mydayis requires a 30-day trial of at least one long-acting preferred agent in this subclass and a trial of Adderall XR.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	XELSTRYM (dextroamphetamine) patches ZENZEDI (dextroamphetamine)	
	NON-AMPHETAMINE	
atomoxetine* clonidine IR clonidine ER CONCERTA (methylphenidate) dexmethylphenidate IR dexmethylphenidate XR guanfacine ER guanfacine IR methylphenidate IR methylphenidate CD capsules methylphenidate ER 24 tablet (generic CONCERTA) methylphenidate ER tablet (generic RITALIN SR) methylphenidate ER CD capsules methylphenidate solution QUILLICHEW ER (methylphenidate) QUILLIVANT XR (methylphenidate) RITALIN LA (methylphenidate)	ADHANSIA XR (methylphenidate) APTENSIO XR (methylphenidate) AZSTARYS (dexmethylphenidate/serdexmethylphenidate) COTEMPLA XR ODT (methylphenidate) DAYTRANA (methylphenidate) FOCALIN IR (dexmethylphenidate) FOCALIN XR (dexmethylphenidate) INTUNIV (guanfacine extended-release) JORNAY PM (methylphenidate) METHYLIN SOLUTION (methylphenidate) methylphenidate chewable tablets methylphenidate ER capsule methylphenidate ER 72 mg tablet methylphenidate ER LA capsule methylphenidate LA capsule methylphenidate patches QELBREE (viloxazine)** RITALIN (methylphenidate) STRATTERA (atomoxetine)*	*Strattera (atomoxetine) is limited to a maximum of 100 mg per day. **Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.
	NARCOLEPTIC AGENTS	
armodafinil* modafinil* NUVIGIL (armodafinil)* PROVIGIL (modafinil)* SUNOSI (solriamfetol)*	sodium oxybate** WAKIX (pitolisant)*** XYREM (sodium oxybate)** XYWAV (calcium, magnesium, potassium, and sodium oxybate)**	*Full PA criteria for narcoleptic agents may be found on the PA Criteria page by clicking the hyperlink. **Full PA criteria for Xyrem/Xywav may be found on the PA Criteria page by clicking the hyperlink. ***Wakix is approvable only with documentation of treatment failure after 30-day trials of armodafinil, modafinil and Sunosi.
TETRACYCLINES		
CLASS PA CRITERIA: Non-preferred agents require ten (10) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
doxycycline hyclate capsules doxycycline hyclate 100 mg tablets doxycycline monohydrate 50, 100 mg capsules minocycline capsules	demeclocycline** DORYX (doxycycline hyclate) doxycycline hyclate 50, 75, 150 mg tablets doxycycline hyclate tablet DR 75, 100, 150, 200 mg doxycycline hyclate tablet DR 50 mg doxycycline monohydrate 40, 75, 150 mg capsule doxycycline monohydrate tablet doxycycline monohydrate suspension MINOCIN (minocycline) minocycline ER capsules minocycline tablets MINOLIRA ER (minocycline) MORGIDOX KIT (doxycycline) NUZYRA (omadacycline)* SOLODYN (minocycline) tetracycline VIBRAMYCIN CAPSULES, SUSPENSION, SYRUP (doxycycline) XIMINO (minocycline)	***Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. **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.
ULCERATIVE COLITIS AGENTS[AP]		
CLASS PA CRITERIA: Non-preferred agents require thirty (30) day trials of each preferred dosage form or chemical entity before the corresponding non-preferred agent of that dosage form or chemical entity will be approved, unless one (1) of the exceptions on the PA form is present.		
ORAL		
APRISO (mesalamine) ASACOL HD (mesalamine) balsalazide PENTASA (mesalamine) 250 mg PENTASA (mesalamine) 500 mg sulfasalazine	AZULFIDINE (sulfasalazine) budesonide ER tablet COLAZAL (balsalazide) DELZICOL (mesalamine) DIPENTUM (olsalazine) LIALDA (mesalamine) mesalamine UCERIS (budesonide) ZEPOSIA (ozanimod)	
RECTAL		
mesalamine	DELZICOL DR (mesalamine) mesalamine kit ROWASA (mesalamine) SF ROWASA (mesalamine) UCERIS (budesonide)	
VAGINAL RING CONTRACEPTIVES		
CLASS 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.		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
NUVARING (etonogestrel/ethinyl estradiol)	ANNOVERA (segesterone/ethinyl estradiol) ELURYNG (etonogestrel/ethinyl estradiol) etonogestrel/ethinyl estradiol vaginal rings	
VASODILATORS, CORONARY		
CLASS PA CRITERIA: Non-preferred agents require thirty (30) day trials of each preferred dosage form before they will be approved, unless one (1) of the exceptions on the PA form is present.		
	SUBLINGUAL NITROGLYCERIN	
nitroglycerin spray (generic NITROLINGUAL) nitroglycerin sublingual NITROSTAT SUBLINGUAL (nitroglycerin)	GONITRO SPRAY POWDER (nitroglycerin) nitroglycerin spray (generic NITROMIST) NITROLINGUAL SPRAY (nitroglycerin) NITROMIST (nitroglycerin)	
	TOPICAL NITROGLYCERIN	
MINITRAN (nitroglycerin) patches NITRO-BID ointment nitroglycerin patches	NITRO-DUR (nitroglycerin) patches	
VMAT INHIBITORS		
CLASS PA CRITERIA: All agents require a prior authorization. Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.		
AUSTEDO TABLET (deutetrabenazine) AUSTEDO XR (deutetrabenazine) INGREZZA CAPSULE (valbenazine) tetrabenazine tablet	xenazine tablet	

MISCELLANEOUS COVERED AGENTS
This category contains covered agents which either did not easily fit into a single PDL category or had criteria that was too lengthy to cite within the PDL itself. Full criteria for the agents listed below may be found by following this hyperlink: (https://dhhr.wv.gov/bms/BMS%20Pharmacy/Pages/PA-Criteria.aspx). Please note that some agents may be available only by billing the appropriate HCPCS code noted in the criteria.
Adbry Afinitor Albenza and Emverm Amondys 45 Antifungal Agents Atypical Antipsychotic Agents for Children up to age 18 Belbuca Benlysta Botox Cabenuva

Camzyos
Carbaglu
CGRP Receptor Antagonists (antmigraine agents, prophylaxis)
Cibinqo
Continuous Glucose Monitors
Corlanor
Cresemba
Cuvposa
Cytokine & CAM Antagonists
Diclegis
Dificid
Dojolvi
Droxidopa
Duavee
Dupixent
Emflaza
Enspryng
Esbriet
Evrysdi
ExJade
Exondys 51
Fasenra
Ferriprox
Fuzeon
Gattex
Growth Hormone for Adults
Growth Hormone for Children
Hepatitis C PA Criteria
Hereditary Angioedema Agents (prophylaxis)
Hereditary Angioedema Agents (treatment)
Hetlioz
Home Infusion Drugs and Supplies
Horizant
HP Acthar
HyQvia
Increlex
Ingrezza
Jublia
Juxtapid
Kalydeco
Kerendia
Ketoconazole
Korlym
Kuvan
Kymriah
Kynamro

Leqvio
Lucemyra
Lutathera
Lupkynis
Luxturna
Max PPI an H2RA
Mozobil
Myalept
Myfembree
Mytesi
Narcoleptic Agents
Natpara
Nexletol and Nexlizet
Non-Sedating Antihistamines
Nucala
Nuzyra
OFEV
Oforta
Omnipod
Opzelura
Orilissa
Oralair
Oriahnn
Orkambi
Osphena
Oxlumo
Palforzia
Palynziq
PCSK9 Inhibitor
Qelbree
Rectiv
Restasis
Riluzole
Risperdal Consta
Sirturo
Spinraza
Spravato
Sprycel
Suboxone Policy
Symdeko
Synagis
Testosterone
Tezspire
Thalomid
Tobacco Cessation Policy
Trikafta

V-Go
Viberzi and Lotronex
Verquvo
Vowst
Voxzogo
Vyondys 53
Xanax XR
Xenazine
Xhance
Xifaxan
Xolair
Xyrem and Xywav
Yescarta
Zolgensma
Zulresso
Zurampic
Zyvox