- 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 over-the-counter (OTC) products may be found at the BMS Website by clicking the hyperlink.
- Prior authorization (PA) 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 cannot 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 restrictions 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:**
    - Clinical (CL) – Requires clinical PA. For detailed clinical criteria, please go to the PA criteria page by clicking the hyperlink.
    - Non-Reviewed (NR) – Denotes a new drug which has not yet been reviewed by the Pharmaceutical and Therapuetics (P&T) Committee. **These agents are available only on appeal to the BMS Medical Director.**
    - Automatic PA (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
ANTIHEMOPHILIA AGENTS			X
ANTIPSYCHOTICS, ATYPICAL AND COMBINATION			X
DIABETES AGENTS, DPP-4 INHIBITORS			X
EPINEPHRINE, SELF-ADMINISTERED			X
HYPOPARATHYROID AGENTS			X
HYPOGLYCEMIA AGENTS	X		
IMMUNOMODULATORS, ATOPIC DERMATITIS			X
SKELETAL MUSCLE RELAXANTS			X
STIMULANTS AND RELATED AGENTS- NON-AMPHETAMINE			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 subclass will be listed below. NOTE**: Non-preferred agents in the Rosacea subclass are available only on appeal and require at least a thirty (30) day trial of all preferred agents in that subclass.		
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 foam, gel 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 and OTC, 10% cream OTC, gel Rx and 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		
BENZAMYCIN PAK (benzoyl peroxide/ erythromycin) benzoyl peroxide/clindamycin gel (generic DUAC only) clindamycin phosphate.benzoyl peroxide (generic ACANYA) ONEXTON (clindamycin phosphate/benzoyl peroxide) sulfacetamide sodium/sulfur suspension ZIANA (clindamycin/tretinoin)*	ACANYA (clindamycin phosphate/benzoyl peroxide) adapalene-benzoyl peroxide* AVAR/-E/LS (sulfur/sulfacetamide) benzoyl peroxide/clindamycin gel (all generics other than DUAC) benzoyl peroxide/erythromycin benzoyl peroxide/urea CABTREO (clindamycin/adapalene/benzoyl peroxide) 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 cleanser, wash 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 FOAM (minocycline)	**Subclass criteria**: Non-preferred agents are available only on appeal and require evidence of thirty (30) day trials of all chemically unique preferred agents in the subclass.

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 subclass 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 mg and 10 mg donepezil ODT EXELON PATCHES (rivastigmine) galantamine tablets galantamine ER capsules RAZADYNE ER (galantamine) rivastigmine capsules	ADLARITY PATCHES (donepezil) ARICEPT (donepezil) donepezil 23 mg* galantamine solution rivastigmine patches	*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 memantine ER	memantine solution NAMENDA (memantine) solution, titration pak NAMENDA XR (memantine)	
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 prior authorization for children under eighteen (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 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr, and 100 mcg/hr[CL/PA] morphine ER tablets tramadol ER tablets (generic ULTRAM ER)	ARYMO ER (morphine sulfate) BELBUCA (buprenorphine buccal film)* buprenorphine buccal film buprenorphine patches (all labelers including 00093) CONZIP ER (tramadol) fentanyl transdermal 37.6 mcg/hr, 62.5 mcg/hr, and 87.5 mcg/hr hydrocodone ER capsules and tablets hydromorphone ER HYSINGLA ER (hydrocodone) KADIAN (morphine) methadone**	*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.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	MORPHABOND ER (morphine sulfate) morphine ER capsules (generic AVINZA) morphine ER capsules (generic KADIAN) MS CONTIN (morphine) 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 eighteen (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, and 10/325 mg hydrocodone/APAP solution hydromorphone tablets meperidine oral solution morphine NUCYNTA (tapentadol) oxycodone capsules, solution, tablets 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 and 10/300 mg hydrocodone/ibuprofen hydromorphone liquid, suppositories levorphanol LORCET (hydrocodone/APAP) LORTAB (hydrocodone/APAP) LORTAB SOLUTION (hydrocodone/acetaminophen) meperidine tablets morphine rectal suppository NORCO (hydrocodone/APAP) oxycodone concentrate oxycodone/ibuprofen	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**
	oxymorphone pentazocine/naloxone PERCOCET (oxycodone/APAP) QDOLO SOLUTION (tramadol) 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 PUMP (testosterone) CL/PA* TESTIM (testosterone) testosterone cypionate vial CL/PA* testosterone enanthate vial CL/PA* testosterone gel 1.62%	ANDROGEL PACKETS (testosterone) ANDROID (methyltestosterone) AVEED (testosterone undecanoate) FORTESTA (testosterone) JATENZO (testosterone undecanoate) METHITEST (methyltestosterone) methyltestosterone capsules 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, TOPICAL AP		
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 MODULATORS AP		
CLASS PA CRITERIA: Non-preferred agents require fourteen (14) day trials of each preferred agent in the same subclass, 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	ACCUPRIL (quinapril) ALTACE (ramipril) enalapril solution EPANED (enalapril)*	*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

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
lisinopril quinapril ramipril trandolapril	LOTENSIN (benazepril) moexipril perindopril PRINIVIL (lisinopril) QBRELIS SOLUTION (lisinopril)** VASOTEC (enalapril) ZESTRIL (lisinopril)	documented oral-motor difficulties or dysphagia. **Qbrelis solution may be authorized for children six (6) to ten (10) years of age who are unable to tolerate a solid dosage form. Qbrelis may also be authorized for older patients with clinical documentation indicating oral-motor difficulties or dysphagia.
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)	
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,

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
		at the maximum tolerable dose, before it will be authorized unless one (1) of the exceptions on the PA form is present.
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.		
metronidazole tablets neomycin tinidazole VANCOCIN (vancomycin) vancomycin capsules XIFAXAN 200 mg (rifaximin)*	AEMCOLO TABLETS (rifamycin)** DIFICID (fidaxomicin)* FIRVANQ SOLUTION (vancomycin)**** FLAGYL (metronidazole) LIKMEZ (metronidazole)*** metronidazole capsules paromomycin vancomycin solution**** VOWST CAPSULES (fecal microbiota spores)* 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 200 mg 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. ****Vancomycin solution and Firvanq solution may be authorized for children up to age nine (9) who are unable to ingest solid dosage forms of vancomycin. Therapy may be authorized for older patients with clinical documentation indicating 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		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
CLASS PA CRITERIA: Non-preferred agents require ten (10) day trials of at least one (1) 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) CLEOCIN CREAM (clindamycin) metronidazole gel	clindamycin cream CLINDESSE (clindamycin) METROGEL (metronidazole) NUVESSA (metronidazole) SOLOSEC (secnidazole) VANDAZOLE (metronidazole) XACIATO GEL (clindamycin)	
ANTICOAGULANTS		
CLASS PA CRITERIA: Non-preferred agents require a trial of each preferred agent in the same subclass, 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 ORAL PELLETS (dabigatran etexilate) 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 subclass 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 subclass 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		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
BRIVIACT (brivaracetam) carbamazepine carbamazepine ER CARBATROL (carbamazepine) DEPAKOTE SPRINKLE CAPSULES (divalproex) divalproex divalproex ER divalproex sprinkle capsules EPITOL (carbamazepine) lacosamide solution, tablets LAMICTAL (lamotrigine) LAMICTAL CHEWABLE (lamotrigine) LAMICTAL XR (lamotrigine) lamotrigine lamotrigine ODT levetiracetam IR levetiracetam ER levetiracetam IR suspension oxcarbazepine tablets QUDEXY XR (topiramate ER) TEGRETOL SUSPENSION (carbamazepine) TEGRETOL XR (carbamazepine) topiramate IR tablets topiramate ER* topiramate IR sprinkle capsules topiramate ER sprinkle capsules (generic QUDEXY) TRILEPTAL SUSPENSION (oxcarbazepine) valproic acid zonisamide	APTIOM (eslicarbazepine) BANZEL (rufinamide) carbamazepine oral suspension DEPAKOTE (divalproex) DEPAKOTE DR (divalproex DEPAKOTE ER (divalproex) DIACOMIT CAPSULES/POWDER PACK (stiripentol)** ELEPSIA XR (levetiracetam) EPRONTIA SOLUTION (topiramate)**** EQUETRO (carbamazepine) felbamate FELBATOL (felbamate) FINTEPLA SOLUTION (fenfluramine)***** FYCOMPA (perampanel) KEPPRA (levetiracetam) 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 CAPSULES (topiramate) TOPAMAX TABLETS (topiramate) TRILEPTAL TABLETS (oxcarbazepine) TROKENDI XR (topiramate)*** vigabatrin tablet/powder pack VIGAFYDE (vigabatrin solution) VIMPAT SOLUTION, TABLETS (lacosamide) XCOPRI (cenobamate) ZONISADE SOLUTION (zonisamide)******	*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 is available only 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 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 fourteen (14) 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]		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
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) LIBERVANT BUCCAL FILM (diazepam)** 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. **Libervant requires review by the Medical Director and is available only on appeal.
CANNABINOIDS		
EPIDIOLEX SOLUTION (cannabidiol)[AP]*		*Epidiolex may be authorized after fourteen (14) day trials of two (2) of the following agents within the past twelve (12) months: clobazam, levetiracetam, valproate, lamotrigine, topiramate, rufinamide or felbamate.
HYDANTOINS[AP]		
DILANTIN CAPSULES, CHEWABLE TABLETS, SUSPENSION (phenytoin sodium extended) PEGANONE (ethotoin) phenytoin capsules, chewable tablets, suspension	PHENYTEK (phenytoin)	
SUCCINIMIDES		
CELONTIN (methsuximide) ethosuximide capsules ethosuximide syrup	ZARONTIN CAPSULES (ethosuximide) ZARONTIN SYRUP (ethosuximide)	
ANTIDEPRESSANTS, OTHER		
CLASS PA CRITERIA: See below for individual subclass criteria.		
MAOIs[AP]		
	MARPLAN (isocarboxazid) NARDIL (phenelzine) phenelzine tranylcypromine	Patients stabilized on MAOI agents will be grandfathered.
SNRIS[AP]		
desvenlafaxine succinate ER (generic Pristiq) duloxetine capsules venlafaxine ER capsules venlafaxine IR tablets	CYMBALTA (duloxetine) desvenlafaxine fumarate ER EFFEXOR XR (venlafaxine) FETZIMA (levomilnacipran) PRISTIQ (desvenlafaxine) venlafaxine ER tablets	Non-preferred agents require separate thirty (30) day trials of a preferred agent in this subclass **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]		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
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 subclass **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: 1. The diagnosis is Major depressive disorder; **AND** 2. 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** 3. A trial of sixty (60) days resulting in an inadequate clinical response, with two (2) distinct classes used to treat major depressive disorder, with one (1) of the trials being Buproprion.
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	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	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	ZOLOFT (sertraline)	
ANTIEMETICS[AP]		
CLASS PA CRITERIA: See below for subclass 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* MARINOL (dronabinol)*	*Dronabinol will only be authorized for: 1. The treatment of anorexia associated with weight loss in patients with AIDS or cancer and unresponsive to megestrol; **OR** 2. The prophylaxis of chemotherapy induced nausea and vomiting unresponsive to three (3) day trials of ondansetron or promethazine for patients from eighteen (18) up to sixty-five (65) years of age.
	SUBSTANCE P ANTAGONISTS	
aprepitant EMEND 125 mg capsules EMEND SUSPENSION (aprepitant)	EMEND (arprepitant) 80 mg capsules, dosepak 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	
doxylamine/pyridoxine (generic Diclegis)	AKYNZEO (netupitant/palonosetron) BONJESTA (doxylamine/pyridoxine) DICLEGIS (doxylamine/pyridoxine)	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 (isavuconazonium)[CL/PA**] BREXAFEMME (ibrexafungerp) DIFLUCAN (fluconazole) flucytosine itraconazole ketoconazole**** MYCELEX (clotrimazole) NOXAFIL (posaconazole) ORAVIG (miconazole) posaconazole 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:

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	SPORANOX (itraconazole) TOLSURA (itraconazole) VFEND (voriconazole) VIVJOA (oteseconazole) voriconazole suspension voriconazole tablets	1. Diagnosis of one (1) 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 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	*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.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	NAFTIN GEL (naftifine) oxiconazole cream OXISTAT (oxiconazole)** sulconazole nitrate cream, solution tavaborole 5% topical solution VUSION (miconazole/petrolatum/zinc oxide)	
ANTIFUNGAL/STEROID COMBINATIONS		
clotrimazole/betamethasone cream	clotrimazole/betamethasone lotion nystatin/triamcinolone	
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		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ALPHANINE SD ALPROLIX BENEFIX IXINITY MONONINE PROFILNINE RIXUBIS	IDELVION REBINYN	
FACTOR IXa/IX		
HEMLIBRA (emicizumab-kxwh)		
NON-FACTOR REPLACEMENT		
	HYMPAVZI (marstacimab-hcnq)	
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		
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 TABLETS (colchicine) 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)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
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 niney (90) day trial of all preferred agents.		
AIMOVIG (erenumab) AJOVY (fremanezumab) EMGALITY AUTO-INJECTOR, 120 mg SYRINGES (galcanezumab)	EMGALITY 300 mg SYRINGES (galcanezumab)* 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 sixteen (16) tablets per thirty-two (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 pens, vials sumatriptan nasal spray sumatriptan tablets zolmitriptan tablets zolmitriptan ODT	almotriptan AMERGE (naratriptan) Eletriptan FROVA (frovatriptan) frovatriptan MAXALT (rizatriptan) MAXALT MLT (rizatriptan) ONZETRA XSAIL (sumatriptan)* RELPAX (eletriptan) sumatriptan cartridges TOSYMRA NASAL SPRAY (sumatriptan)* ZEMBRACE SYMTOUCH (sumatriptan) zolmitriptan nasal spray ZOMIG (zolmitriptan) ZOMIG ZMT (zolmitriptan)	***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.
	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** ELYXYB (celecoxib) MIGERGOT RECTAL SUPPOSITORY (ergotamine/caffeine)** MIGRANAL SPRAY (dihydroergotamine)** REYVOW (lasmiditan)*** TRUDHESA SPRAY (dihydroergotamine)**	*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 eight (8) tablets per thirty (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

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	UBRELVY (ubrogepant)*** ZAVZPRET NASAL SPRAY (zavegepant)****	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 twenty-four (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. ****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)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	spinosad VANALICE (piperonyl/pyrethrum)	
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 subclass 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 PEN (apomorphine) bromocriptine pramipexole ropinirole	apomorphine pen, cartridge KYNMOBI FILM (apomorphine) 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 levodopa/carbidopa/entacapone selegiline	AZILECT (rasagiline) Carbidopa CREXONT (carbidopa/levodopa) 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)	*Amantadine will not be authorized for the treatment or prophylaxis of influenza.
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.		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
calcipotriene solution ENSTILAR (calcipotriene/betamethasone) TACLONEX (calcipotriene/ betamethasone)	calcipotriene cream calcipotriene ointment calcipotriene/betamethasone ointment, suspension calcitriol SORILUX (calcipotriene) tazarotene cream VTAMA (tapinarof) ZORYVE CREAM 0.3%, foam(roflumilast)	
ANTIPSYCHOTICS, ATYPICAL AND COMBINATION		
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 six (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 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 quetiapineAP for the 25 mg Tablet Only*** quetiapine ER RYKINDO (risperidone) risperidone ODT, solution, tablets	ABILIFY MYCITE (aripiprazole) ABILIFY TABLETS (aripiprazole) ADASUVE (loxapine) aripiprazole ODT aripiprazole solution CAPLYTA (lumateperone) clozapine ODT CLOZARIL (clozapine) COBENFY (xanomeline/trospium) ERZOFRI (paliperidone) FANAPT (iloperidone) GEODON (ziprasidone) GEODON IM (ziprasidone) INVEGA ER (paliperidone) LATUDA (lurasidone) LYBALVI (olanzapine/samidorphan)**** NUPLAZID (pimavanserin)***** olanzapine IMCL/PA olanzapine/fluoxetine	**The following criteria exceptions apply to the specified products:** *Invega Hafyera may only be authorized after four (4) months treatment with Invega Sustenna or at least a one (1) three (3) month cycle with Invega Trinza. **Invega Trinza will be authorized after four (4) 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

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
VRAYLAR (cariprazine)****** ziprasidone	REXULTI (brexpiprazole) RISPERDAL (risperidone) RISPERDAL CONSTA (risperidone)CL/PA SAPHRIS (asenapine) SECUADO (asenapine) SEROQUEL (quetiapine) SEROQUEL XR (quetiapine) UZEDY (risperidone) VERSACLOZ (clozapine) ZYPREXA (olanzapine) ZYPREXA IM (olanzapine)CL/PA ZYPREXA RELPREVV (olanzapine)	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 two (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 seven (7) day opioid-free interval from the last use of short-acting opioids, and at least a fourteen (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 thirty (30) day trial and failure of two (2) preferred antidepressants. For all other indications a thirty (30) day trial and failure of one (1) preferred antipsychotic is required.
ANTIRETROVIRALSAP		
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 (1) 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 disoproxil fumarate) 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 preferred agent Genvoya.
INTEGRASE STRAND TRANSFER INHIBITORS		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ISENTRESS (raltegravir potassium) TIVICAY (dolutegravir sodium) TIVICAY PD (dolutegravir sodium)	ISENTRESS HD (raltegravir potassium)	
NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTI)		
abacavir sulfate tablets 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 capsules emtricitabine capsules EPIVIR TABLETS (lamivudine) RETROVIR (zidovudine) stavudine VIDEX EC (didanosine) VIDEX SOLUTION (didanosine) VIREAD TABLETS (tenofovir disoproxil fumarate) ZIAGEN TABLETS (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) VIRAMUNE SUSPENSION (nevirapine)	
PHARMACOENHANCER – CYTOCHROME P450 INHIBITOR		
TYBOST (cobicistat)		
PROTEASE INHIBITORS (PEPTIDIC)		
atazanavir EVOTAZ (atazanavir/cobicistat) REYATAZ POWDER PACK (atazanavir) ritonavir tablets	fosamprenavir LEXIVA (fosamprenavir) NORVIR (ritonavir) REYATAZ CAPSULES (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)		
darunavir PREZCOBIX (darunavir/cobicistat)	APTIVUS (tipranavir) PREZISTA (darunavir)	
ENTRY INHIBITORS – CCR5 CO-RECEPTOR ANTAGONISTS		
	maraviroc SELZENTRY (maraviroc)	
ENTRY INHIBITORS – FUSION INHIBITORS		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	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 subclass before they will be approved, unless one (1) of the exceptions on the PA form is present.		
	ANTI HERPES	
acyclovir valacyclovir	famciclovir SITAVIG (acyclovir) 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) DENAVIR (penciclovir)	acyclovir cream docosanol cream penciclovir cream ZOVIRAX OINTMENT (acyclovir)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
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 HEMANGEOL (propranolol)* metoprolol metoprolol ER nadolol nebivolol pindolol propranolol propranolol ER SORINE (sotalol) sotalol timolol	BETAPACE (sotalol) BYSTOLIC (nebivolol) CORGARD (nadolol) INDERAL LA (propranolol) INDERAL XL (propranolol) INNOPRAN XL (propranolol) KAPSPARGO SPRINKLE (metoprolol) LOPRESSOR (metoprolol) 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)	
BETA- AND ALPHA-BLOCKERS		
carvedilol labetalol	carvedilol ER capsules 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) fesoterodine ER GELNIQUE (oxybutynin) MYRBETRIQ TABLETS (mirabegron) oxybutynin IR oxybutynin ER OXYTROL (oxybutynin)	darifenacin ER tablets DETROL (tolterodine) DITROPAN XL (oxybutynin) ENABLEX (darifenacin) flavoxate GEMTESA (vibegron) mirabegron ER	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
solifenacin	MYRBETRIQ SUSPENSION (mirabegron) tolterodine tolterodine ER TOVIAZ (fesoterodine) 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.
BPH TREATMENTS		
CLASS PA CRITERIA: See below for individual subclass criteria.		
5-ALPHA-REDUCTASE (5AR) INHIBITORS AND PDE-5 AGENTS		
finasteride	AVODART (dutasteride) CIALIS 5 mg (tadalafil) Dutasteride ENTADFI CAPSULES (finasteride/tadalafil)* 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.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
		*Documentation of medical reasoning beyond convenience 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 subclass 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 HFA (albuterol) PROAIR RESPICLICK (albuterol) PROVENTIL HFA (albuterol) VENTOLIN HFA (albuterol)	PROAIR DIGIHALER (albuterol) XOPENEX HFA (levalbuterol)	*Airsupra can be found in Glucocorticoids, Inhaled section of PDL.
	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 subclass before they will be approved, unless one (1) of the exceptions on the PA form is present.		
	LONG-ACTING	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
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 six (6) to ten (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 subclass 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)	
CEPHALOSPORINS		
cefaclor capsules cefadroxil tablets cefdinir cefuroxime tablets cephalexin capsules, suspension	cefaclor suspension cefaclor ER tablets cefadroxil capsules cefadroxil suspension cefixime cefpodoxime cefprozil cefuroxime suspension cephalexin tablets KEFLEX (cephalexin) SUPRAX (cefixime)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
COPD AGENTS		
CLASS PA CRITERIA: Non-preferred agents require a sixty (60) day trial of one preferred agent from the corresponding subclass 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 sixty (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 thirty (30) days. **Breztri may be prior authorized for patients currently established on the individual components for at least thirty (30) days.
PHOSPHODIESTERASE INHIBITORS		
	DALIRESP (roflumilast) OHTUVAYRE (ensifentrine)* roflumilast	*Ohtuvayre is being used for the maintenance treatment of patients with moderate to severe COPD **AND** the patient has had a documented side effect, allergy, treatment failure, or a contraindication to maximally tolerated dual therapy with at least one (1) inhaled long-acting anticholinergic (LAMA) AND at least one (1) inhaled long-acting beta-agonist (LABA) OR maximally tolerated triple therapy with at least one (1) inhaled LAMA + LABA AND at least one (1) inhaled corticosteroid (when blood eosinophils ⩾300 cells/microL).
CROHNS DISEASE ORAL STEROIDS		
ORAL		
budesonide ER capsules (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

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
		generic budesonide 3 mg twenty-four (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 six (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-axxq) ENBREL (etanercept) HUMIRA (adalimumab) infliximab SIMPONI SUBCUTANEOUS (golimumab)	ABRILADA (adalimumab-afzb)adalimumab-aacf adalimumab-aaty adalimumab-adbm adalimumab-adaz 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-dyyb) REMICADE (infliximab) RENFLEXIS (infliximab-abda) SIMLANDI (adalimumab-ryvk) SIMPONI ARIA (golimumab) YUFLYMA (adalimumab-aaty) YUSIMRY (adalimumab-aqvh) ZYMFENTRA (infliximab-dyyb)	
OTHERS		
KINERET (anakinra) ORENCIA CLICKJECT, VIAL (abatacept) OTEZLA (apremilast) TALTZ (ixekizumab)* TYENNE (tocilizumab-aazg) XELJANZ (tofacitinib)	ACTEMRA ACTPEN (tocilizumab) ACTEMRA SUBCUTANEOUS (tocilizumab) BIMZELX (bimekizumab-bkzx) COSENTYX (secukinumab) ENTYVIO (vedolizumab) ILARIS (canakinumab) ILUMYA (tildrakizumab) KEVZARA (sarilumab) OLUMIANT (baricitinib) OMVOH (mirikizumab-mrkz) ORENCIA SYRINGE (abatacept)	*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 (1) preferred Anti-TNF agent.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	RINVOQ ER (upadacitinib) SILIQ (brodalumab) SKYRIZI (risankizumab-rzaa) SOTYKTU (deucravacitinib) STELARA SUBCUTANEOUS (ustekinumab) TOFIDENCE (tocilizumab-bavi) TREMFYA (guselkumab) VELSIPITY (etrasimod) 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 and FORTAMET) RIOMET (metformin)	*Glumetza will be approved only after a thirty (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) sitagliptin sitagliptin/metformin ZITUVIO (sitagliptin) ZITUVIMET (sitagliptin/metformin) ZITUVIMET XR (sitagliptin/metformin)	
DIABETES AGENTS, GLP-1 AGONISTS[CL/PA]		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Preferred agents may be authorized with a diagnosis of Diabetes Mellitus Type II. **CLASS PA CRITERIA:** Non-preferred agents will only be approved (in six (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 ninety (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 less than or equal to (≤) 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) liraglutide 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 VIALS (insulin) HUMULIN R U-500 KWIKPEN (insulin) insulin aspart flexpen, penfill, vials insulin aspart/aspart protamine pens, vials insulin glargine (labeler 00955 only) insulin lispro kwikpen U-100, vials LANTUS (insulin glargine) NOVOLOG (insulin aspart) NOVOLOG MIX (insulin aspart/aspart protamine) NOVOLIN N (insulin) TOUJEO SOLOSTAR (insulin glargine)	ADMELOG (insulin lispro) AFREZZA (insulin)CL/PA BASAGLAR (insulin glargine) FIASP (insulin aspart) HUMALOG U-200 KWIKPEN (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 six (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 sixty (60) units of long-acting insulin and have demonstrated at least a six (6) month

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
TOUJEO MAX SOLOSTAR (insulin glargine)		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 Diabetes Mellitus Type II 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 six (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 ninety (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 less than or equal to (≤) 8%, or demonstrated continued improvement). **<u>For all other FDA approved indications:</u>** A thirty (30) day trial and failure of each preferred SGLT2 is required.		
SGLT2 INHIBITORS		
FARXIGA (dapagliflozin) JARDIANCE (empagliflozin)	dapagliflozin INVOKANA (canagliflozin) STEGLATRO (ertugliflozin)	
SGLT2 COMBINATIONS		
SYNJARDY (empagliflozin/metformin) XIGDUO XR (dapagliflozin/metformin)	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)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	TRIJARDY XR (empagliflozin/linagliptin/metformin)	
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 sixty (60) day trial of the preferred agent(s).		
RESTASIS (cyclosporine) XIIDRA (lifitegrast)	CEQUA (cyclosporine) cyclosporine dropperette RESTASIS MULTIDOSE (cyclosporine) TYRVAYA (varenicline) VEVYE (cyclosporine)	**All agents must meet the following PA 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-ADMINISTERED		
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) EPIPEN (epinephrine) EPIPEN JR (epinephrine)	AUVI-Q (epinephrine) epinephrine (all labelers except 49502) NEFFY NASAL SPRAY (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) RETACRIT (epoetin alpha)	ARANESP (darbepoetin) MIRCERA (methoxy PEG-epoetin) 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 (Laboratory values must be dated within six (6) weeks of request); **AND** 2. Transferrin saturation greater than or equal to (≥) 20%, ferritin levels greater than or equal to (≥) 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 less than or equal to (≤) 500 mU/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 tablets	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)	ALVESCO (ciclesonide) ARMONAIR DIGIHALER (fluticasone) ASMANEX HFA (mometasone)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
budesonide nebulizer 0.5 mg/2 ml and 0.25 mg/2 ml solution PULMICORT FLEXHALER (budesonide)	budesonide nebulizer 1 mg/2 ml solution fluticasone HFA 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)	
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.
***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.		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Please use individual components: preferred PPI (omeprazole or pantoprazole) amoxicillin tetracycline capsules metronidazole clarithromycin bismuth PYLERA (bismuth/metronidazole/tetracycline)	HELIDAC (bismuth/metronidazole/tetracycline) lansoprazole/amoxicillin/clarithromycin OMECLAMOX-PAK (omeprazole/amoxicillin/clarithromycin) TALICIA (omeprazole/amoxicillin/rifabutin) tetracycline tablets VOQUEZNA DUAL PAK (vonoprazan/amoxicillin) VOQUEZNA TRIPLE PAK (vonoprazan/amoxicillin/clarithromycin)	
HEART FAILURE TREATMENTS		
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)*	ENTRESTO SPRINKLE CAPSULES (sacubitril/valsartan)** INPEFA (sotagliflozin)*** VERQUVO (vericiguat)****	*Entresto may be authorized only for patients greater than or equal to (≥) one (1) year of age diagnosed with chronic heart failure. **Entresto sprinkle capsules may be authorized for children one (1) years of age up to age nine (9) who are unable to ingest solid dosage forms. Therapy may be authorized for older patients with clinical documentation indicating oral-motor difficulties or dysphagia. ***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 TABLETS (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	EPCLUSA (sofosbuvir/velpatasvir)* HARVONI (ledipasvir/sofosbuvir)*	*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**
sofosbuvir/velpatasvir (labeler 72626)*	ledipasvir/sofosbuvir* PEGASYS (pegylated interferon) PEG-INTRON (pegylated interferon) RIBASPHERE RIBAPAK (ribavirin) RIBASPHERE 400 mg and 600 mg (ribavirin) 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 capsules	doxercalciferol HECTOROL (doxercalciferol) paricalcitol injection RAYALDEE (calcifediol) SENSIPAR (cinacalcet) ZEMPLAR (paricalcitol)	
HYPERPHOSPHATEMIA AGENTS[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) XPHOZAH (tenapanor)	
HYPOGLYCEMIA TREATMENTS		
CLASS PA CRITERIA: Non-preferred agents require clinical reasoning beyond convenience why the preferred glucagon products cannot be used.		
BAQSIMI SPRAY (glucagon) glucagon vial glucagon emergency kit GVOKE (glucagon) ZEGALOGUE (dasiglucagon)	GLUCAGEN HYPOKIT (glucagon)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
HYPOPARATHYROID AGENTS		
	YORVIPATH (palopegteriparatide)	
IMMUNOMODULATORS, ATOPIC DERMATITIS		
CLASS PA CRITERIA: Non-preferred agents require a thirty (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) tacrolimus ointment	CIBINQO (abrocitinib)* EBGLYSS (lebrikizumab) EUCRISA (crisaborole)[AP]** OPZELURA CREAM (ruxolitinib)* pimecrolimus cream ZORYVE CREAM 0.15% (roflumilast)	*Full PA criteria may be found on the PA Criteria page by clicking the hyperlink **Eucrisa requires a thirty (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 CREAM, PUMP (imiquimod)*	*Zyclara will be authorized for a diagnosis of actinic keratosis.
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 capsules	ASTAGRAF XL (tacrolimus) AZASAN (azathioprine) CELLCEPT (mycophenolate mofetil) ENVARSUS XR (tacrolimus) everolimus tablets IMURAN (azathioprine) LUPKYNIS (voclosporin)* mycophenolic acid	*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 (2) systemic treatments for chronic graft-versus-host disease. Examples of systemic therapy may include methylprednisolone, Imbruvica

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	mycophenolic mofetil suspension MYFORTIC (mycophenolic acid) MYHIBBIN (mycophenolate mofetil suspension)*** NEORAL (cyclosporine, modified) PROGRAF (tacrolimus) RAPAMUNE (sirolimus) REZUROCK (belumosudil)** SANDIMMUNE (cyclosporine) ZORTRESS (everolimus)	(ibrutinib capsules and tablets), cyclosporine, tacrolimus, sirolimus, mycophenolate mofetil and imatinib. ***Myhibbin 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 mycophenolate suspension.
INTRANASAL RHINITIS AGENTS[AP]		
CLASS PA CRITERIA: See below for individual subclass 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.
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 subclass 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 eighteen (18) years of age and older. **See below for additional subclass criteria.**		
CONSTIPATION		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
LINZESS 145 mcg and 290 mcg (linaclotide) lubiprostone capsules MOVANTIK (naloxegol) TRULANCE (plecanatide)	AMITIZA (lubiprostone) IBSRELA (tenapanor) LINZESS 72 mcg (linaclotide) MOTEGRITY (prucalopride) RELISTOR INJECTION (methylnaltrexone) RELISTOR TABLETS (methylnaltrexone) SYMPROIC (naldemedine)	No agent shall be approved to treat opioid induced constipation (OIC) without evidence of at least ninety (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 72 mcg** may only be approved for a diagnosis of chronic idiopathic constipation (CIC) AND for those who cannot tolerate the 145 mcg dose. Linzess may also be approvable for a diagnosis of functional constipation for pediatric patients six (6) to seventeen (17) years of age. **Motegrity** requires a thirty (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		
CLASS PA CRITERIA: Non-preferred agents require 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-sod sulf-NaCL-KCL-asb powder SUFLAVE (peg 350-sod sulf, chl-pot-mag) SUPREP SUTAB (magnesium sulfate/potassium sulfate/ sodium sulfate)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
peg 3350 sod sulfate-pot sulf-mag sulf (generic SUPREP)		
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.		
BEMPEDOIC ACIDS		
	NEXLIZET (bempedoic acid/ezetimibe) NEXLETOL (bempedoic acid)	NEXLIZET AND NEXLETOL may be approved if the following criteria is met: 1. Patient must meet all age and indication restrictions imposed by the current FDA approved label; **AND** 2. Documentation must be submitted indicating that the patient failed to reach an LDL less than (<) 70 mg/dL after an eight (8) week trial of either atorvastatin 40 mg - 80 mg + ezetimibe **OR** rosuvastatin 20 mg - 40 mg + ezetimibe. **NOTE**: If the patient failed to tolerate the first statin, then they must be trialed on the second statin for eight (8) weeks or until intolerance occurs.
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 Diabetes Mellitus Type II 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		
omega-3 acid ethyl esters	icosapent ethyl capsules LOVAZA (omega-3-acid ethyl esters)	Icosapent ethyl capsules may be approved if the following criteria are met (A or B):

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
		A) The patient has a triglyceride level of at least 500 mg/dL and has previously completed at least a twelve (12) week trial on omega-3 acid ethyl esters; **OR** B) The patient has an initial triglyceride level of at least 150 mg/dL; **AND** The patient has either established cardiovascular disease or diabetes; **AND** The patient will be concurrently receiving a statin
FIBRIC ACID DERIVATIVES[AP]		
fenofibrate 54 mg and 160 mg fenofibrate micronized 67 mg, 134 mg and 200 mg fenofibrate nanocrystallized 48 mg and 145 mg gemfibrozil	ANTARA (fenofibrate) fenofibrate 40 mg tablets fenofibrate 150 mg capsules fenofibrate 43 mg, 50 mg, 120 mg and 130 mg fenofibrate micronized 30 mg 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 subclass 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)	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 80 mg tablets will require a clinical PA.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	ZOCOR (simvastatin)** ZYPITAMAG (pitavastatin)	***Atorvaliq may be authorized for children who are six (6) to ten (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. *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 80/10 mg 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 AUTOINJECTOR, 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 packet, suspension, tablets clarithromycin tablets	clarithromycin ER clarithromycin suspension E.E.S. (erythromycin ethylsuccinate) ERYPED (erythromycin ethylsuccinate) ERY-TAB (erythromycin) ERYTHROCIN (erythromycin stearate) erythromycin tablets/capsules DR erythromycin tablets erythromycin estolate ZITHROMAX (azithromycin)	
MULTIPLE SCLEROSIS AGENTS CL/PA		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
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 subclass) 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		
COPAXONE 20 mg (glatiramer) dalfampridine ER** dimethyl fumarate*** 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 fumarate) ZEPOSIA (ozanimod)	**In addition to the 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 six (6) months before initiation of therapy and ALT levels at least monthly for six (6) months after initiation of therapy; **AND** 3. Complete blood 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.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
		***Dimethyl fumarate 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 ninety (90) day trial of at least one (1) preferred MS agent. Documentation of a negative Hepatitis B test must be provided. *****Copaxone 40 mg will only be authorized for documented injection site issues. ******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 OTCduloxetine gabapentin lidocaine patch 5% LYRICA CAPSULES, SOLUTION (pregabalin) pregabalin capsules	CYMBALTA (duloxetine) DRIZALMA SPRINKLE (duloxetine)* gabapentin ER (generic Gralise) GRALISE (gabapentin)** HORIZANT (gabapentin)*** lidocaine patch 4% LIDODERM (lidocaine) LYRICA CR (pregabalin)**** NEURONTIN (gabapentin) pregabalin ER tablets (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 postherpetic neuralgia; **AND** 2. Trial of a tricyclic antidepressant for at least thirty (30) days; **AND** 3. Ninety (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.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
		****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 niney (90) day trial of one (1) preferred agent.
NSAIDS[AP]		
CLASS PA CRITERIA: See below for subclass PA criteria.		
	NON-SELECTIVE	
diclofenac (IR, SR) flurbiprofen ibuprofen capsules, suspension, tablets chewable (Rx and OTC) indomethacin ketoprofen ketorolac meloxicam tablets nabumetone naproxen sodium capsules, tablets naproxen sodium DS tablets piroxicam sulindac	DAYPRO (oxaprozin) diclofenac potassium capsules, tablets diflunisal DUEXIS (famotidine/ibuprofen) EC-naproxen DR tablets etodolac IR 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 capsules (generic VIVLODEX) meloxicam suspension MOBIC TABLETS (meloxicam) NALFON (fenoprofen) NAPRELAN (naproxen) naproxen suspension naproxen CR oxaprozin RELAFEN DS (nabumetone) SPRIX (ketorolac) TIVORBEX (indomethacin) tolmetin VIVLODEX (meloxicam) VOLTAREN (diclofenac)	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**
	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)	
	TOPICAL	
diclofenac gel (RX)*	diclofenac patch diclofenac solution LICART PATCH (diclofenac) PENNSAID (diclofenac)	*Diclofenac gel will be limited to 100 grams per month. 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 OINTMENT (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)	BLEPHAMIDE S.O.P. (prednisolone/sulfacetamide)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
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)	neomycin/polymyxin/hydrocortisone PRED-G OINTMENT (prednisolone/gentamicin)	
OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS[AP]		
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 EYSUVIS (loteprednol) ketotifen ZADITOR OTC (ketotifen)	ALOCRIL (nedocromil) ALOMIDE (lodoxamide) bepotastine epinastine loteprednol 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 (1) 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)	ACULAR (ketorolac) ACULAR LS (ketorolac) ACUVAIL (ketorolac tromethamine) bromfenac BROMSITE (bromfenac) difluprednate fluorometholone flurbiprofen ILEVRO (nepafenac) INVELTYS (loteprednol) LOTEMAX SM (loteprednol etabonate)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
NEVANAC (nepafenac) PRED FORTE (prednisolone) PRED MILD (prednisolone) prednisolone acetate prednisolone sodium phosphate	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 subclass.		
COMBINATION AGENTS		
COMBIGAN (brimonidine/timolol) dorzolamide/timolol SIMBRINZA (brinzolamide/brimonidine)	brimonidine-timolol COSOPT PF (dorzolamide/timolol)	
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 three (3) month trial of at least one (1) 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%	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	IOPIDINE (apraclonidine)	
OPIATE DEPENDENCE TREATMENTS		
CLASS PA CRITERIA: Bunavail and Zubsolv may only be approved with a documented intolerance or allergy to Suboxone films 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) REXTOVY NASAL SPRAY (naloxone) SUBLOCADE (buprenorphine solution)CL/PA* SUBOXONE FILM (buprenorphine/naloxone)* VIVITROL (naltrexone)	BUNAVAIL (buprenorphine/naloxone)* buprenorphine tablets* buprenorphine/naloxone film* lofexidine 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.
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 3 MONTH CHATEAL CHATEAL EQ CYRED	ALYACEN AMETHIA 3 MONTH ARANELLE ASHLYNA 3 MONTH AUROVELA 24 FE AUROVELA FE BALCOLTRA BLISOVI 24 FE BRIELLYN CAMRESE LO 3 MONTH CHARLOTTE 24 FE CHEWABLE TABLETS CRYSELLE CURAE DASETTA DAYSEE 3 MONTH drospirenone-ethinyl estradiol-levomefolate ECONTRA EZ ECONTRA ONE-STEP	*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**
CYRED EQ	ELINEST	
DEBLITANE	ELLA	
desogestrel-ethinyl estradiol	ENPRESSE	
desogestrel-ethinyl estradiol/ethinyl estradiol	ethynodiol-ethinyl estradiol	
DOLISHALE	FAYOSIM 3 MONTH	
drospirenone-ethinyl estradiol	FINZALA	
ENSKYCE	GEMMILY	
ERRIN	HAILEY	
ESTARYLLA	HAILEY 24 FE	
FALMINA	ICLEVIA 3 MONTH	
HAILEY FE	INTROVALE 3 MONTH	
HEATHER	JAIMIESS 3 MONTH	
HER STYLE	JASMIEL	
INCASSIA	JOYEAUX	
ISIBLOOM	JUNEL	
JENCYCLA	JUNEL FE 24	
JOLESSA 3 MONTH	KAITLIB FE	
JULEBER	KALLIGA	
JUNEL FE	KELNOR 1-35	
KARIVA	KELNOR 1-50	
KURVELO	LARIN	
LARIN FE	LARIN 24 FE	
LESSINA	LAYOLIS FE CHEWABLE TABLETS	
LEVONEST	LEENA	
levonorgestrel	levonorgestrel-ethinyl estradiol (generic JOLESSA) 3 MONTH	
levonorgestrel-ethinyl estradiol	LEVORA-28	
levonorgestrel-ethinyl estradiol (generic LOSEASONIQUE) 3 MONTH	LOESTRIN	
levonorgestrel-ethinyl estradiol-ferrous bisglycinate	LOESTRIN FE	
LILLOW	LOJAIMIESS 3 MONTH	
LO LOESTRIN FE	LOSEASONIQUE 3 MONTH	
LORYNA	LOW-OGESTREL	
LUTERA	LO-ZUMANDIMINE	
LYLEQ	MERZEE	
LYZA	MICROGESTIN	
MARLISSA	MICROGESTIN 24 FE	
	MINASTRIN 24 FE CHEWABLE TABLETS	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
MIBELAS 24 FE	MIRCETTE	
MICROGESTIN FE	NECON	
MILI	NEXTSTELLIS	
MONO-LINYAH	norethindrone-ethinyl estradiol-iron capsules	
MY CHOICE	norethindrone-ethinyl estradiol-iron chewable tablets	
MY WAY	NORTREL	
NATAZIA	OPTION 2	
NEW DAY	PHEXXI VAGINAL GEL*	
NIKKI	PHILITH	
NORA-BE	PIMTREA	
norethindrone	QUARTETTE	
norethindrone-ethinyl estradiol-iron tablets	RECLIPSEN	
norethindrone-ethinyl estradiol	RIVELSA 3 MONTH	
norgestimate-ethinyl estradiol	SAFYRAL	
NORLYDA	SEASONIQUE 3 MONTH	
NYLIA	SETLAKIN 3 MONTH	
NYMYO	SIMPESSE 3 MONTH	
OCELLA	SLYND	
OPCICON ONE-STEP	SYEDA	
PORTIA	TARINA 24 FE	
SHAROBEL	TAYSOFY	
SIMLIYA	TILIA FE	
SPRINTEC	TRI-LEGEST FE	
SRONYX	TRIVORA-28	
TARINA FE	TURQOZ	
TARINA FE 1-20 EQ	TYBLUME CHEWABLE TABLETS	
TAYTULLA	TYDEMY	
TRI-ESTARYLLA	VELIVET	
TRI FEMYNOR	VESTURA	
TRI-LINYAH	VYFEMLA	
TRI-LO-ESTARYLLA	WERA	
TRI-LO-MARZIA	WYMZYA FE CHEWABLE TABLETS	
TRI-LO-MILI	XULANE PATCH	
TRI-LO-SPRINTEC		
TRI-MILI		
TRI-NYMYO		
TRI-SPRINTEC		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
TRI-VYLIBRA TRI-VYLIBRA LO TULANA TWIRLA PATCH VIENVA VIORELE VOLNEA VYLIBRA YASMIN-28 YAZ ZAFEMY PATCH 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 CORTISPORIN-TC (colistin/hydrocortisone/ neomycin) neomycin/polymyxin/HC solution, suspension ofloxacin	ciprofloxacin ciprofloxacin/fluocinolone OTOVEL (ciprofloxacin/fluocinolone)	
PAH AGENTS[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.		
ACTIVIN SIGNALING INHIBITOR		
	WINREVAIR (sotatercept-csrk)	
COMBINATIONS		
	OPSYNVI (macitentan/tadalafil)*	*Opsynvi requires review by the Medical Director and is available only on appeal.
ENDOTHELIN RECEPTOR ANTAGONISTS		
bosentan LETAIRIS (ambrisentan)	ambrisentan OPSUMIT (macitentan) TRACLEER SUSPENSION (bosentan) TRACLEER TABLETS (bosentan)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
GUANYLATE CYCLASE INHIBITORS		
	ADEMPAS (riociguat)*	*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.
PAH AGENTS – PDE5s		
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		
epoprostenol (generic FLOLAN) epoprostenol (generic VELETRI) VENTAVIS (iloprost)*	FLOLAN (epoprostenol) ORENITRAM ER (treprostinil) REMODULIN (treprostinil sodium) treprostinil (generic REMODULIN) 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]		
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 PERTZYE ZENPEP	PANCREAZE VIOKACE	
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)	leuprolide ORIAHNN (elagolix/estradiol/norethindrone)*	*Full PA criteria for Myfembree, Orilissa and Oriahnn may be found on the PA Criteria page by clicking the hyperlink. In

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
LUPRON DEPOT KIT (leuprolide) LUPRON DEPOT-PED KIT (leuprolide) MYFEMBREE (relugolix/estradiol/ norethindrone)* ORILISSA (elagolix)* SYNAREL (nafarelin) TRELSTAR (triptorelin) TRIPTODUR (triptorelin)	SUPPRELIN LA KIT (histrelin)	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 twenty-four (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)	
POTASSIUM REMOVING AGENTS		
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.		
LOKELMA (sodium zirconium cyclosilicate)	KIONEX (sodium polystyrene sulfonate) SPS (sodium polystyrene sulfonate) VELTASSA (patiromer calcium sorbitex)	
PROGESTINS FOR CACHEXIA		
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 capsules esomeprazole magnesium KONVOMEP (omeprazole/sodium bicarbonate) lansoprazole Rx NEXIUM (esomeprazole) NEXIUM PACKETS (esomeprazole)	*Maximum recommended doses of the PPIs and H_2-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. ***VOQUEZNA (vonoprazan) is NOT a PROTON PUMP INHIBITOR but will remain on the PDL in this class due to

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	omeprazole/sodium bicarbonate (Rx) pantoprazole granule packets PREVACID CAPSULES (lansoprazole) PREVACID SOLUTABS (lansoprazole)** PRILOSEC Rx (omeprazole) PROTONIX DR TABLETS (pantoprazole) Rabeprazole VOQUEZNA (vonoprazan)*** ZEGERID Rx (omeprazole/sodium bicarbonate)	similar indications.
SEDATIVE HYPNOTICS[AP]		
CLASS PA CRITERIA: Non-preferred agents require thirty (30) day trials of all preferred agents in **BOTH subclasses** 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 mg and 30 mg	estazolam flurazepam HALCION (triazolam) RESTORIL (temazepam) temazepam 7.5 mg and 22.5 mg triazolam	
OTHERS		
BELSOMRA (suvorexant)** melatonin ROZEREM (ramelteon) zolpidem 5 mg and 10 mg	AMBIEN (zolpidem) AMBIEN CR (zolpidem) DAYVIGO (lemborexant) doxepin 3 mg and 6 mg EDLUAR (zolpidem) eszopiclone HETLIOZ (tasimelteon)[CL]* LUNESTA (eszopiclone) QUVIVIQ (daridorexant) ramelteon SILENOR (doxepin) tasimelteon zaleplon zolpidem ER 6.25 mg and 12.5 mg	For treatment naïve female patients, zolpidem and zolpidem ER maximum dosages will be limited to 5 mg and 6.25 mg respectively per day. *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 (1) of the exceptions on the PA form is present.
SKELETAL MUSCLE RELAXANTS[AP]		
CLASS PA CRITERIA: See below for individual subclass criteria.		
ACUTE MUSCULOSKELETAL RELAXANT AGENTS		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
chlorzoxazone (generic PARAFON FORTE) cyclobenzaprine IR 5 mg and 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) TANLOR (methocarbamol)	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*, suspension DANTRIUM (dantrolene) dantrolene FLEQSUVY (baclofen)* LYVISPAH GRANULE PACKETS (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		
betamethasone dipropionate cream betamethasone valerate cream betamethasone valerate lotion betamethasone valerate ointment 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	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	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 emulsion) 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 cream, lotion, ointment fluticasone propionate lotion hydrocortisone butyrate cream hydrocortisone butyrate ointment, solution hydrocortisone valerate LOCOID (hydrocortisone butyrate) LOCOID LIPOCREAM (hydrocortisone butyrate/emollient) LUXIQ (betamethasone valerate) PANDEL (hydrocortisone probutate) prednicarbate	
LOW POTENCY		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
fluocinolone oil 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) DERMA-SMOOTHE FS (fluocinolone acetonide) DESONATE (desonide) desonide cream, ointment desonide lotion 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 prior authorization is required for adults eighteen (18) years of age or older. Non-preferred agents require a thirty (30) day trial of at least one (1) 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 eighteen (18) years of age 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 SUSPENSION (amphetamine) PROCENTRA SOLUTION (dextroamphetamine)	ADDERALL (amphetamine salt combination) ADZENYS XR ODT (amphetamine) ADZENYS ER SUSPENSION (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 CAPSULES (lisdexamfetamine) XELSTRYM PATCHES (dextroamphetamine) ZENZEDI (dextroamphetamine)	**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 thirty (30) day trial of at least one (1) long-acting preferred agent in this subclass and a trial of Adderall XR.
NON-AMPHETAMINE		
atomoxetine* clonidine IR clonidine ER CONCERTA (methylphenidate) dexmethylphenidate IR dexmethylphenidate XR	ADHANSIA XR (methylphenidate) APTENSIO XR (methylphenidate) AZSTARYS (dexmethylphenidate/serdexmethylphenidate) COTEMPLA XR ODT (methylphenidate) DAYTRANA (methylphenidate)	*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.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
guanfacine ER guanfacine IR methylphenidate IR methylphenidate CD capsules methylphenidate ER 24 tablets (generic CONCERTA) methylphenidate ER tablets (generic RITALIN SR) methylphenidate ER CD capsules methylphenidate solution QUILLICHEW ER (methylphenidate) QUILLIVANT XR (methylphenidate) RITALIN LA (methylphenidate)	FOCALIN IR (dexmethylphenidate) FOCALIN XR (dexmethylphenidate) INTUNIV (guanfacine ER) JORNAY PM (methylphenidate) METHYLIN SOLUTION (methylphenidate) methylphenidate chewable tablets methylphenidate ER capsules methylphenidate ER 72 mg tablets methylphenidate ER LA capsules methylphenidate LA capsules methylphenidate patches ONYDA XR (clonidine) QELBREE (viloxazine)** RELEXXII (methylphenidate ER) RITALIN (methylphenidate) STRATTERA (atomoxetine)*	
NARCOLEPTIC AGENTS		
armodafinil* modafinil* NUVIGIL (armodafinil)* PROVIGIL (modafinil)*	sodium oxybate** SUNOSI (solriamfetol)* WAKIX (pitolisant)*** XYREM (sodium oxybate)** XYWAV (calcium/magnesium/potassium/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 thirty (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.		
doxycycline hyclate capsules doxycycline hyclate 100 mg tablets doxycycline monohydrate 50 mg and 100 mg capsules minocycline capsules tetracycline capsules	demeclocycline** DORYX (doxycycline hyclate) doxycycline hyclate 50 mg, 75 mg and 150 mg tablets doxycycline hyclate DR 75 mg, 100 mg, 150 mg and 200 mg tablets doxycycline hyclate DR 50 mg tablets	*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.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	doxycycline monohydrate 40 mg, 75 mg and 150 mg capsules doxycycline monohydrate tablets doxycycline monohydrate suspension MINOCIN (minocycline) minocycline ER capsules minocycline tablets MINOLIRA ER (minocycline) MORGIDOX KIT (doxycycline) NUZYRA (omadacycline)* SOLODYN (minocycline) tetracycline tablets VIBRAMYCIN CAPSULES, SUSPENSION, SYRUP (doxycycline) XIMINO (minocycline)	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 250 mg (mesalamine) PENTASA 500 mg (mesalamine) sulfasalazine	AZULFIDINE (sulfasalazine) budesonide ER tablets 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.		
NUVARING (etonogestrel/ethinyl estradiol)	ANNOVERA (segesterone/ethinyl estradiol) ELURYNG (etonogestrel/ethinyl estradiol) etonogestrel/ethinyl estradiol vaginal rings	
VASODILATORS, CORONARY		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
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 PATCHES (nitroglycerin) NITRO-BID OINTMENT nitroglycerin patches	NITRO-DUR PATCHES (nitroglycerin)	
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 TABLETS (deutetrabenazine) AUSTEDO XR (deutetrabenazine) INGREZZA CAPSULES (valbenazine) INGREZZA SPRINKLE CAPSULES (valbenazine) tetrabenazine tablets	XENAZINE TABLETS	

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 eighteen (18) years of age
Belbuca
Benlysta
Botox
Cabenuva

Camzyos
Carbaglu
CGRP Receptor Antagonists (antimigraine 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

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