- Prior authorization for a non-preferred agent in any category will be given only if there has been a trial of the preferred brand/generic equivalent or preferred formulation of the active ingredient, at a therapeutic dose, that resulted in a partial response with a documented intolerance.
- Prior authorization of a non-preferred isomer, pro-drug, or metabolite will be considered with a trial of a preferred parent drug of the same chemical entity, at a therapeutic dose, that resulted in a partial response with documented intolerance or a previous trial and therapy failure, at a therapeutic dose, with a preferred drug of a different chemical entity indicated to treat the submitted diagnosis. (The required trial may be overridden when documented evidence is provided that the use of these preferred agent(s) would be medically contraindicated.)
- Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC drugs are not covered unless specified.
- PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
- The use of pharmaceutical samples will not be considered when evaluating the members' medical condition or prior prescription history for drugs that require prior authorization.
- Prior Authorization Criteria that applies among multiple sub-categories will be listed directly under the main category's name. PA Criteria specific to a sub-category will be listed in the sub-category.
- Quantity limits may apply. Refer to the Limits List at the BMS Website by clicking the hyperlink.
- Acronyms
- CL - Requires clinical PA. For detailed clinical criteria, please refer to the BMS Website by clicking the hyperlink.
    - NR - New drug has not been reviewed by P & T Committee
    - AP - Non-preferred and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA criteria column.

CLASSES CHANGING	Status Changes	PA Criteria Changes	New Drugs
ALZHEIMER'S AGENTS	XXXX		
ANTIFUNGALS, ORAL			XXXX
ANTIPSYCHOTICS, ATYPICAL			XXXX
BPH TREATMENTS			XXXX
HYPOGLYCEMICS, MEGLITINIDES	XXXX		XXXX
IMMUNOMODULATORS, GENITAL WARTS & ACTINIC KERATOSIS AGENTS	XXXX		XXXX
IRRITABLE BOWEL SYNDROME/SHORT BOWEWL SYNDROME/SELECTED GI AGENTS			XXXX
LIPOTROPICS, OTHER (NON-STATINS)/FIBRIC ACID DERIVATIVES	XXXX		XXXX
LIPOTROPICS, OTHER (NON-STATINS)/PCSK-9 INHIBITORS			XXXX
MACROLIDES/KETOLIDES	XXXX		
NSAIDS	XXXX		XXXX
OPIATE DEPENDENCE TREATMENTS			XXXX

THERAPEUTIC DRUG CLASS		
ALZHEIMER'S AGENTS[AP]		
CATEGORY PA CRITERIA: A thirty (30) day trial of a preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. Prior authorization is required for members up to forty-five (45) years of age if there is no diagnosis of Alzheimer's disease		
CHOLINESTERASE INHIBITORS		
donepezil 5 and 10 mg	ARICEPT (donepezil) donepezil 23 mg* EXELON CAPSULE (rivastigmine) EXELON PATCH (rivastigmine) galantamine galantamine ER RAZADYNE (galantamine) RAZADYNE ER (galantamine) rivastigmine	*Donepezil 23 mg tablets will be authorized if the following criteria are met: 1. There is a diagnosis of moderate-to-severe Alzheimer's Disease **and** 2. There has been a trial of donepezil 10 mg daily for at least three (3) months and donepezil 20 mg daily for an additional one (1) month.
NMDA RECEPTOR ANTAGONIST		
memantine	NAMENDA XR (memantine) NAMENDA (memantine)	*Namenda XR requires ninety (90) days of compliant therapy with Namenda.
CHOLINESTERASE INHIBITOR/NMDA RECEPTOR ANTAGONIST COMBINATIONS		
	NAMZARIC (donepezil/memantine)	
ANTIFUNGALS, ORAL		
CATEGORY PA CRITERIA: Non-preferred agents will be authorized only if one (1) of the exceptions on the PA form is present.		
clotrimazole fluconazole* nystatin terbinafine [CL]	ANCOBON (flucytosine) CRESEMBA (isovuconazonium)[CL]** DIFLUCAN (fluconazole) flucytosine GRIFULVIN V TABLET (griseofulvin) griseofulvin GRIS-PEG (griseofulvin) itraconazole ketoconazole*** LAMISIL (terbinafine) MYCELEX (clotrimazole) MYCOSTATIN Tablets (nystatin) NIZORAL (ketoconazole) NOXAFIL (posaconazole) ONMEL (itraconazole) ORAVIG (miconazole) SPORANOX (itraconazole) VFEND (voriconazole) voriconazole suspension voriconazole tablets	*PA is required when limits are exceeded. PA is not required for griseofulvin suspension for children up to eighteen (18) years of age for the treatment of tinea capitis. ** Full prior-authorization criteria may be found at the BMS Pharmacy PA criteria page for (Cresemba Hyperlink) ***Ketoconazole will be authorized if the following criteria are met: 1. Diagnosis of one of the following fungal infections: blastomycosis, coccidioidomycosis, histoplasmosis, chromomycosis, or paracoccidioidomycosis **and** 2. Documented failure or intolerance of all other diagnosis-appropriate antifungal therapies, i.e. itraconazole, fluconazole, flucytosine, etc **and** 3. Baseline assessment of the liver status including alanine aminotransferase (ALT), aspartate aminotransferase (AST), total bilirubin, alkaline phosphatase, prothrombin time, and international normalized ration (INR) before starting treatment **and**

THERAPEUTIC DRUG CLASS		
		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.

ANTIPSYCHOTICS, ATYPICAL

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

All antipsychotic agents require prior authorization for children up to six (6) years of age.

Non-preferred agents will be authorized if the following criteria have been met:
1. A fourteen (14) day trial of a preferred generic agent **and**
2. Two (2) fourteen (14) day trials of additional preferred products unless one (1) of the exceptions on the PA form is present.

Upon discharge, a hospitalized patient stabilized on a non-preferred agent may receive authorization to continue this drug for labeled indications and at FDA recommended dosages.

SINGLE INGREDIENT		
ABILIFY (aripiprazole)* AP ABILIFY MAINTENA (aripiprazole)** CL clozapine clozapine ODT INVEGA SUSTENNA (paliperidone)** CL INVEGA TRINZA (paliperidone)*** CL LATUDA (lurasidone)**** AP olanzapine olanzapine ODT quetiapine***** AP for the 25 mg Tablet Only RISPERDAL CONSTA (risperidone) ** CL risperidone ziprasidone	ADASUVE (loxapine) aripiprazole CLOZARIL (clozapine) FANAPT (iloperidone) FAZACLO (clozapine) GEODON (ziprasidone) GEODON IM (ziprasidone) INVEGA (paliperidone) olanzapine IM** paliperidone ER REXULTI (brexipiprazole) RISPERDAL (risperidone) SAPHRIS (asenapine) SEROQUEL (quetiapine) SEROQUEL XR (quetiapine) VERSACLOZ (clozapine) ZYPREXA (olanzapine) ZYPREXA IM (olanzapine)** ZYPREXA RELPREVV (olanzapine)	*Abilify will be prior authorized via electronic PA for MDD if the following criteria are met: 1. The patient is eighteen (18) years of age or older **and** 2. Diagnosis of Major Depressive Disorder (MDD) **and** 3. Prescribed as adjunctive therapy with buproprion, an SSRI agent or an SNRI agent **and** 4. The daily dose does not exceed 15 mg **All injectable antipsychotic products require clinical prior authorization and will be approved on a case-by-case basis. ***Invega Trinza will be authorized after four months' treatment with Invega Sustenna ****Latuda will be authorized for patients only after a trial of one other preferred drug *****Quetiapine 25 mg will be authorized: 1. For a diagnosis of schizophrenia **or**

THERAPEUTIC DRUG CLASS		
		2. For a diagnosis of bipolar disorder **or** 3. When prescribed concurrently with other strengths of Seroquel in order to achieve therapeutic treatment levels. *****Quetiapine 25 mg will not be authorized for use as a sedative hypnotic.
ATYPICAL ANTIPSYCHOTIC/SSRI COMBINATIONS		
	olanzapine/fluoxetine SYMBYAX (olanzapine/fluoxetine)	
BPH TREATMENTS		
CATEGORY PA CRITERIA: Thirty (30) day trials each of at least two (2) chemically distinct preferred agents, including the generic formulation of the requested non-preferred agent, are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.		
5-ALPHA-REDUCTASE (5AR) INHIBITORS		
finasteride	AVODART (dutasteride) CIALIS 5 mg (tadalafil) PROSCAR (finasteride)	
ALPHA BLOCKERS		
alfuzosin doxazosin tamsulosin terazosin	CARDURA (doxazosin) CARDURA XL (doxazosin) FLOMAX (tamsulosin) HYTRIN (terazosin) RAPAFLO (silodosin) UROXATRAL (alfuzosin)	
5-ALPHA-REDUCTASE (5AR) INHIBITORS/ALPHA BLOCKER COMBINATION		
	dutasteride/tamsulosin JALYN (dutasteride/tamsulosin)	**Substitute for Category Criteria**: Concurrent thirty (30) day trials of dutasteride and tamsulosin are required before the non-preferred agent will be authorized.
CYTOKINE & CAM ANTAGONISTS[CL]		
CATEGORY PA CRITERIA: Non-preferred agents require ninety (90) day trials of both Humira and Enbrel unless one (1) of the exceptions on the PA form is present. For all FDA-approved indications, an additional ninety (90) day trial of Cosentyx will also be required.		
ANTI-TNFs		
ENBREL (etanercept) * HUMIRA (adalimumab) *	CIMZIA (certolizumab pegol) SIMPONI (golimumab)	*Additional criteria for this category may be found at the BMS Website, by clicking the hyperlink.
OTHERS		
COSENTYX (secukinumab)*	ACTEMRA syringe (tocilizumab) KINERET (anakinra) ORENCIA syringe (abatacept) OTEZLA (apremilast) STELARA syringe (ustekinumab)	*Cosentyx will be authorized for treatment of plaque psoriasis, psoriatic arthritis and ankylosing spondylitis only after inadequate response to a ninety (90) day trial of Humira.

THERAPEUTIC DRUG CLASS		
	XELJANZ (tofacitinib)	
HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS		
CATEGORY PA CRITERIA: All agents (preferred and non-preferred) require a previous history of a thirty (30) day trial of metformin. A ninety (90) day trial of each chemically distinct preferred agent will be required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present All agents will be approved in six (6) month intervals. For re-authorizations, documentation that A1C levels have decreased by at least 1% or are maintained at ≤8% is required. A1C levels submitted must be for the most recent thirty (30) day period.		
INJECTABLE		
BYDUREON (exenatide)* BYETTA (exenatide)[AP] VICTOZA (liraglutide)	SYMLIN (pramlintide) ** TANZEUM (albiglutide)[AP] TRULICITY (dulaglutide)	**In addition to the Category Criteria**: A thirty (30) day trial of one (1) preferred agent with a chemical entity distinct from the requested non-preferred agent will be required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. **Symlin will be authorized with a history of bolus insulin utilization in the past ninety (90) days with no gaps in insulin therapy greater than thirty (30) days.
ORAL[AP]		
JENTADUETO (linagliptin/metformin) [AP] TRADJENTA (linagliptin) [AP]	JANUMET (sitagliptin/metformin)[AP] JANUMET XR (sitagliptin/metformin) [AP] JANUVIA (sitagliptin) [AP] KAZANO (alogliptin/metformin) KOMBIGLYZE XR (saxagliptin/metformin) * NESINA (alogliptin) ONGLYZA (saxagliptin) OSENI (alogliptin/pioglitazone)	**In addition to the Category Criteria**: A ninety (90) day trial of the corresponding (single drug vs. combination drug) preferred agent is required before a non-preferred agent will be approved. *Kombiglyze XR will be authorized after thirty (30) day trials of the preferred combination agents.
HYPOGLYCEMICS, INSULIN AND RELATED AGENTS		
CATEGORY PA CRITERIA: A ninety (90) day trial of a pharmacokinetically similar preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. Humulin pens and Humalog Mix pens will be authorized only for patients who cannot utilize vials due to impaired vision or dexterity.		
HUMALOG (insulin lispro) HUMALOG MIX VIALS (insulin lispro/lispro protamine) HUMULIN VIALS (insulin)	AFREZZA (insulin)[CL] APIDRA (insulin glulisine)[AP]* HUMALOG PEN/KWIKPEN (insulin lispro) HUMALOG MIX PENS (insulin lispro/lispro	*Apidra will be authorized if the following criteria are met: 1. Patient is four (4) years of age or older; **and** 2. Patient is currently on a regimen including a longer acting or basal insulin, **and**

THERAPEUTIC DRUG CLASS		
LANTUS (insulin glargine) LEVEMIR (insulin detemir) NOVOLOG (insulin aspart) NOVOLOG MIX (insulin aspart/aspart protamine)	protamine) HUMULIN PENS (insulin) NOVOLIN (insulin) TOUJEO SOLOSTAR (insulin glargine)**	3. Patient has had a trial of a similar preferred agent, Novolog or Humalog, with documentation that the desired results were not achieved. **Toujeo Solostar will be authorized only after 6 months of compliance on preferred long-acting insulin. Toujeo will **only** be approved for once daily doses of at least 60 units.
HYPOGLYCEMICS, MEGLITINIDES		
CATEGORY PA CRITERIA: All agents (preferred and non-preferred) require a previous history of a thirty (30) day trial of metformin. A ninety (90) day trial of each chemically distinct preferred agent will be required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. All agents will be approved in six (6) month intervals. For re-authorizations, documentation that A1C levels have decreased by at least 1% or are maintained at ≤8% is required. A1C levels submitted must be for the most recent thirty (30) day period.		
MEGLITINIDES		
nateglinide repaglinide	PRANDIN (repaglinide) repaglinide/metformin STARLIX (nateglinide)	
MEGLITINIDE COMBINATIONS		
	PRANDIMET (repaglinide/metformin)	
HYPOGLYCEMICS, TZD[AP]		
CATEGORY PA CRITERIA: All agents (preferred and non-preferred) require a previous history of a thirty (30) day trial of metformin. A ninety (90) day trial of each chemically distinct preferred agent will be required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. All agents will be approved in six (6) month intervals. For re-authorizations, documentation that A1C levels have decreased by at least 1% or are maintained at ≤8% is required. A1C levels submitted must be for the most recent thirty (30) day period.		
THIAZOLIDINEDIONES		
Pioglitazone	ACTOS (pioglitazone) AVANDIA (rosiglitazone)	
TZD COMBINATIONS		
	ACTOPLUS MET (pioglitazone/ metformin) ACTOPLUS MET XR (pioglitazone/ metformin) AVANDAMET (rosiglitazone/metformin) AVANDARYL (rosiglitazone/glimepiride) DUETACT (pioglitazone/glimepiride) pioglitazone/glimepiride pioglitazone/ metformin	Patients are required to use the components of Actoplus Met and Duetact separately. Exceptions will be handled on a case-by-case basis.

THERAPEUTIC DRUG CLASS		
IMMUNOMODULATORS, GENITAL WARTS & ACTINIC KERATOSIS AGENTS		
CATEGORY PA CRITERIA: A thirty (30) day trial of both preferred agents is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.		
CONDYLOX GEL (podofilox) EFUDEX (fluorouracil) imiquimod	ALDARA (imiquimod) CARAC (fluorouracil) CONDYLOX SOLUTION (podofilox) diclofenac 3% gel fluorouracil 5% cream podofilox SOLARAZE (diclofenac) VEREGEN (sinecatechins) ZYCLARA (imiquimod)*	*Zyclara will be authorized for a diagnosis of actinic keratosis.
IRRITABLE BOWEL SYNDROME/SHORT BOWEL SYNDROME/SELECTED GI AGENTS		
CATEGORY PA CRITERIA: Thirty (30) day trial of the preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.		
AMITIZA (lubiprostone)[CL]* LINZESS (linaclotide) [CL]**	FULYZAQ (crofelemer) LOTRONEX (alosetron) MOVANTIK (naloxegol)[CL]*** RELISTOR (methylnaltrexone)	* Full prior-authorization criteria may be found at the BMS Pharmacy PA criteria page for Amitiza ** Full prior-authorization criteria may be found at the BMS Pharmacy PA criteria page for Linzess *** Full prior-authorization criteria may be found at the BMS Pharmacy PA criteria page for Movantik
LIPOTROPICS, OTHER (Non-statins)[AP]		
CATEGORY PA CRITERIA: A twelve (12) week trial of one (1) of the preferred agents is required before a non-preferred agent in the corresponding category will be authorized.		
BILE ACID SEQUESTRANTS		
cholestyramine colestipol tablets	COLESTID (colestipol) colestipol granules KYNAMRO[CL]** (mipomersen) QUESTRAN (cholestyramine) WELCHOL (colesevelam)*	* Welchol will be authorized for add-on therapy for type 2 diabetes when there is a previous history of a thirty (30) day trial of an oral agent (metformin, sulfonylurea or thiazolidinedione (TZD)). See HYPOGLYCEMICS, MISCELLANEOUS. ** Kynamro requires a 24-week trial of Repatha.
CHOLESTEROL ABSORPTION INHIBITORS		
ZETIA (ezetimibe) [AP]		Zetia will be authorized with prior use of a HMG-CoA reductase inhibitor within the previous six (6) months.
FATTY ACIDS		

THERAPEUTIC DRUG CLASS		
	LOVAZA (omega-3-acid ethyl esters) omega-3 acid ethyl esters VASCEPA (icosapent ethyl)	These agents shall only be authorized when the patient has an initial triglyceride level ≥ 500 mg/dL and has had inadequate response or intolerance to trials of BOTH a nicotinic acid and a fibrate, unless otherwise contraindicated.
FIBRIC ACID DERIVATIVES		
fenofibrate 40 mg fenofibrate 54, 150 and 160 mg fenofibrate micronized 67mg, 134mg & 200mg gemfibrozil TRICOR (fenofibrate nanocrystallized)	ANTARA (fenofibrate) FENOGLIDE (fenofibrate) FIBRICOR (fenofibric acid) fenofibrate 43, 50, 120 and 130 mg fenofibrate nanocrystallized 48 mg, 145 mg fenofibric acid LIPOFEN (fenofibrate) LOFIBRA (fenofibrate) LOPID (gemfibrozil) TRIGLIDE (fenofibrate) TRILIPIX (fenofibric acid)	
MTP INHIBITORS		
	Juxtapid (lomitapide)*	* Juxtapid will be authorized only after a 24-week trial of Repatha. Full prior-authorization criteria may be found at the BMS Pharmacy PA criteria page for Juxtapid
NIACIN		
niacin NIACOR (niacin) NIASPAN (niacin)	niacin ER	
PCSK-9 INHIBITORS		
	PRALUENT (alirocumab)* REPATHA (evolocumab)**	* Full prior-authorization criteria may be found at the BMS Pharmacy PA criteria page for Praluent ** Full prior-authorization criteria may be found at the BMS Pharmacy PA criteria page for (REPATHA LINK)
MACROLIDES/KETOLIDES		
CATEGORY PA CRITERIA: See below for individual sub-class criteria.		
KETOLIDES		
	KETEK (telithromycin)	Requests for telithromycin will be authorized if there is documentation of the use of any antibiotic within the past twenty-eight (28) days.
MACROLIDES		

THERAPEUTIC DRUG CLASS		
azithromycin clarithromycin suspension erythromycin base	BIAXIN (clarithromycin) clarithromycin tablets clarithromycin ER E.E.S. (erythromycin ethylsuccinate) E-MYCIN (erythromycin) ERYC (erythromycin) ERYPED (erythromycin ethylsuccinate) ERY-TAB (erythromycin) ERYTHROCIN (erythromycin stearate) erythromycin estolate PCE (erythromycin) ZITHROMAX (azithromycin) ZMAX (azithromycin)	Five (5) day trials each of the preferred agents are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.
NSAIDS[AP]		
CATEGORY PA CRITERIA: Thirty (30) day trials of each of the preferred agents are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.		
NON-SELECTIVE		
diclofenac (IR, SR) flurbiprofen ibuprofen (Rx and OTC) INDOCIN SUSPENSION (indomethacin) indomethacin ketoprofen ketorolac nabumetone naproxen (Rx and OTC) piroxicam sulindac	ANAPROX (naproxen) ANSAID (flurbiprofen) CATAFLAM (diclofenac) CLINORIL (sulindac) DAYPRO (oxaprozin) diflunisal DUEXIS (famotidine/ibuprofen) etodolac IR etodolac SR FELDENE (piroxicam) fenoprofen INDOCIN SUPPOSITORIES (indomethacin) indomethacin ER ketoprofen ER meclofenamate mefenamic acid MOTRIN (ibuprofen) NALFON (fenoprofen) NAPRELAN (naproxen) NAPROSYN (naproxen) oxaprozin PONSTEL (meclofenamate) SPRIX (ketorolac) TIVORBEX (indomethacin) tolmetin VOLTAREN (diclofenac)	

THERAPEUTIC DRUG CLASS		
	ZIPSOR (diclofenac potassium) ZORVOLEX (diclofenac)	
NSAID/GI PROTECTANT COMBINATIONS		
	ARTHROTEC (diclofenac/misoprostol) diclofenac/misoprostol VIMOVO (naproxen/esomeprazole)	
COX-II SELECTIVE		
meloxicam	CELEBREX (celecoxib) celecoxib MOBIC (meloxicam)	COX-II Inhibitor agents will be authorized if the following criteria are met: Patient has a history or risk of a serious GI complication **or** Agent is requested for treatment of a chronic condition **and** 1. Patient is seventy (70) years of age or older, **or** 2. Patient is currently on anticoagulation therapy**.**
TOPICAL		
VOLTAREN GEL (diclofenac)*[AP]	diclofenac solution FLECTOR PATCH (diclofenac)** PENNSAID (diclofenac)	**In addition to the Category Criteria**: Thirty (30) day trials of each of the preferred oral NSAIDS are required before a topical NSAID gel or solution will be authorized unless one (1) of the exceptions on the PA form is present. *Voltaren Gel will be authorized if the following criteria are met: 1. Thirty (30) day trials of two (2) of the preferred oral NSAIDs, **or**. 2. The patient is on anticoagulant therapy **or** 3. The patient has had a GI bleed or ulcer diagnosed in the last two (2) years. Prior authorizations will be limited to 100 grams per month. **Flector patches will be authorized for a diagnosis of acute strain, sprain or injury after a five (5) day trial of one (1) of the preferred oral NSAIDs and for a maximum duration of fourteen (14) days unless one (1) of the exceptions on the PA form is present.
OPIATE DEPENDENCE TREATMENTS		
CATEGORY PA CRITERIA: Buprenorphine/naloxone tablets, Bunavail and Zubsolv will only be approved with a documented intolerance of or allergy to Suboxone strips. See below for further criteria.		
SUBOXONE FILM (buprenorphine/naloxone)[CL] VIVITROL (naltrexone) [CL] naloxone	EVZIO (naloxone) buprenorphine/naloxone tablets BUNAVAIL (buprenorphine/naloxone) ZUBSOLV (buprenorphine/naloxone)	Suboxone PA criteria is available at the BMS Website, by clicking the hyperlink. Vivitrol PA criteria is available at the BMS Website, by clicking

THERAPEUTIC DRUG CLASS		
NARCAN NASAL SPRAY (naloxone)		the hyperlink. Evzio PA criteria is available at the BMS Website, by clicking the hyperlink.