- 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 on the BMS Website by clicking the hyperlink.
- Acronyms
  - CL - Requires clinical PA. For detailed clinical criteria, please go to the PA criteria page 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
ANALGESICS, NARCOTIC LONG ACTING			XXXX
ANDROGENIC AGENTS			XXXX
ANGIOTENSIN MODULATORS, ACE INHIBITORS			XXXX
ANGIOTENSIN MODULATORS, ARB COMBINATIONS			XXXX
ANTICONVULSANTS	XXXX		XXXX
ANTIHYPERURICEMICS, ANTIMIOTICS	XXXX		
ANTIMIGRAINE AGENTS, TRIPTANS	XXXX		
ANTIPSYCHOTICS, ATYPICAL	XXXX		XXXX
COLONY STIMULATING FACTORS	XXXX		
COPD AGENTS, ANTICHOLINERGIC-BETA AGONIST COMB.			XXXX
CYTOKINE & CAM ANTAGONISTS, OTHERS			XXXX
GLUCOCORTICOIDS, INHALED, GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS	XXXX		
HEPATITIS C TREATMENTS	XXXX		XXXX
HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS			XXXX
LIPOTROPICS, OTHER (NON-STATINS), FIBRIC ACID DERIVATIVES	XXXX		
MULTIPLE SCLEROSIS AGENTS, NON-INTERFERONS			XXXX
OPHTHALMIC ANTIBIOTICS	XXXX		
OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS	XXXX		
OPHTHALMICS, ANTI-INFLAMMATORIES-IMMUNOMODULATORS			XXXX
OPHTHALMICS, ANTI-INFLAMMATORIES	XXXX		
OPHTHALMICS, GLAUCOMA AGENTS – BETA BLOCKERS	XXXX		
OTIC ANTIBIOTICS			XXXX
STEROIDS, TOPICAL – VERY HIGH & HIGH POTENCY			XXXX

STIMULANTS AND RELATED AGENTS, AMPHETAMINES	**XXXX**		**XXXX**
STIMULANTS AND RELATED AGENTS, NON-AMPHETAMINE	**XXXX**		
ULCERATIVE COLITIS AGENTS, RECTAL	**XXXX**		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ACNE AGENTS, TOPICAL[AP]		
CATEGORY PA CRITERIA: Thirty (30) day trials each of one (1) preferred retinoid and two (2) unique chemical entities in two (2) other subclasses, including the generic version of the requested non-preferred product, are required before the non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. In cases of pregnancy, a trial of retinoids will *not* be required. For Members eighteen (18) years of age or older, a trial of retinoids will *not* be required. Acne kits are non-preferred. Specific Criteria for sub-categories will be listed below.		
ANTI-INFECTIVE		
clindamycin gel, lotion, medicated swab, solution erythromycin gel, solution	ACZONE (dapsone) AKNE-MYCIN (erythromycin) AZELEX (azelaic acid) CLEOCIN-T (clindamycin) CLINDACIN PAC (clindamycin) CLINDAGEL (clindamycin) clindamycin foam erythromycin medicated swab EVOCLIN (clindamycin) FABIOR (tazarotene) KLARON (sulfacetamide) OVACE/PLUS (sulfacetamide) sodium sulfacetamide 10% cleansing gel sulfacetamide cleanser sulfacetamide cleanser ER sulfacetamide shampoo sulfacetamide suspension	
RETINOIDS		
RETIN-A (tretinoin) TAZORAC (tazarotene)	adapalene ATRALIN (tretinoin) AVITA (tretinoin) DIFFERIN (adapalene) RETIN-A MICRO (tretinoin) tretinoin cream, gel tretinoin gel micro	**In addition to the Category Criteria**: PA required for members eighteen (18) years of age or older for Retinoids sub-class.
KERATOLYTICS		
benzoyl peroxide cleanser Rx & OTC, 10% cream OTC, gel Rx & OTC, lotion OTC, wash OTC	BENZEFOAM ULTRA (benzoyl peroxide) BENZEPRO (benzoyl peroxide) benzoyl peroxide cloths, medicated pads, microspheres cleanser BP 10-1 (benzoyl peroxide) BP WASH 7% LIQUID	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	DELOS (benzoyl peroxide) DESQUAM-X (benzoyl peroxide) LAVOCLEN (benzoyl peroxide) PACNEX/HP/LP (benzoyl peroxide) PANOXYL-4, -8 OTC (benzoyl peroxide) PERSA-GEL OTC (benzoyl peroxide) SASTID (sulfur) SULPHO-LAC (sulfur)	
	COMBINATION AGENTS	
erythromycin/benzoyl peroxide	ACANYA (clindamycin phosphate/benzoyl peroxide) AVAR/-E/LS (sulfur/sulfacetamide) BENZACLIN GEL (benzoyl peroxide/ clindamycin) BENZAMYCIN PAK (benzoyl peroxide/ erythromycin) benzoyl peroxide/clindamycin gel benzoyl peroxide/urea CERISA (sulfacetamide sodium/sulfur) CLARIFOAM EF (sulfacetamide/sulfur) CLENIA (sulfacetamide sodium/sulfur) DUAC (benzoyl peroxide/clindamycin) EPIDUO (adapalene/benzoyl peroxide)* INOVA 4/1, 5/2 (benzoyl peroxide/salicylic acid) NEUAC (clindamycin phosphate/benzoyl peroxide) NUOX (benzoyl peroxide/sulfur) ONEXTON (clindamycin phosphate/benzoyl peroxide) PRASCION (sulfacetamide sodium/sulfur) SE 10-5 SS (sulfacetamide/sulfur) SSS 10-4 (sulfacetamide /sulfur) SSS 10-5 foam (sulfacetamide /sulfur) sulfacetamide sodium/sulfur cloths, lotion, pads, suspension sulfacetamide/sulfur wash/cleanser sulfacetamide/sulfur wash kit sulfacetamide sodium/sulfur/ urea SUMADAN/XLT (sulfacetamide/sulfur) SUMAXIN/TS (sulfacetamide sodium/sulfur) VELTIN (clindamycin/tretinoin)* ZIANA (clindamycin/tretinoin)*	**In addition to the Category PA**: Thirty (30) day trials of combinations of the corresponding preferred single agents available are required before non-preferred combination agents will be authorized. *PA required for combination agents with Retinoid products for members eighteen (18) years of age or older.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
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 (memantine) NAMENDA XR (memantine)	*****Namenda XR requires ninety (90) days of compliant therapy with Namenda.
	CHOLINESTERASE INHIBITOR/NMDA RECEPTOR ANTAGONIST COMBINATIONS	
	NAMZARIC (donepezil/memantine)	
ANALGESICS, NARCOTIC LONG ACTING (Non-parenteral)[AP]		
CATEGORY PA CRITERIA: Six (6) day trials of two (2) chemically distinct preferred agents are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PDL form is present. In addition, a six (6) day trial of the generic form of the requested non-preferred agent, if available, is required before the non-preferred agent will be authorized. If no generic form is available for the requested non-preferred brand agent, then another generic non-preferred agent must be trialed instead.		
BUTRANS (buprenorphine) EMBEDA (morphine/naltrexone) fentanyl transdermal 12, 25, 50, 75, 100 mcg/hr morphine ER tablets	BELBUCA (buprenorphine buccal film) CONZIP ER (tramadol) DOLOPHINE (methadone) DURAGESIC (fentanyl) EXALGO ER (hydromorphone) fentanyl transdermal 37.5, 62.5, 87.5 mcg/hr hydromorphone ER HYSINGLA ER (hydrocodone) KADIAN (morphine) methadone* morphine ER capsules (generic for Avinza) morphine ER capsules (generic for Kadian) MS CONTIN (morphine) NUCYNTA ER (tapentadol) OPANA ER (oxymorphone) oxycodone ER*	*****Methadone, oxycodone ER and oxymorphone ER will be authorized without a trial of the preferred agents if a diagnosis of cancer is submitted. **Tramadol ER requires a manual review and may be authorized for 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**
	OXYCONTIN (oxycodone) oxymorphone ER* tramadol ER** ULTRAM ER (tramadol) XTAMPZA ER (oxycodone) XARTEMIS XR (oxycodone/ acetaminophen) ZOHYDRO ER (hydrocodone)	
ANALGESICS, NARCOTIC SHORT ACTING (Non-parenteral)[AP]		
CATEGORY PA CRITERIA: Six (6) day trials each of at least four (4) chemically distinct preferred agents (based on narcotic ingredient only), including the generic formulation of the requested non-preferred agent, are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.		
APAP/codeine butalbital/APAP/caffeine/codeine codeine hydrocodone/APAP 2.5/325 mg, 5/325 mg, 7.5/325 mg,10/325 mg hydrocodone/APAP solution hydrocodone/ibuprofen hydromorphone tablets morphine oxycodone tablets, concentrate, solution oxycodone/APAP oxycodone/ASA pentazocine/naloxone ROXICET SOLUTION (oxycodone/ acetaminophen) tramadol tramadol/APAP	ABSTRAL (fentanyl) ACTIQ (fentanyl) butalbital/ASA/caffeine/codeine butorphanol CAPITAL W/CODEINE (APAP/codeine) DEMEROL (meperidine) dihydrocodeine/ APAP/caffeine DILAUDID (hydromorphone) fentanyl FENTORA (fentanyl) FIORICET W/ CODEINE (butalbital/APAP/caffeine/codeine) FIORINAL W/ CODEINE (butalbital/ASA/caffeine/codeine) hydrocodone/APAP 5/300 mg, 7.5/300 mg, 10/300 mg hydromorphone liquid, suppositories IBUDONE (hydrocodone/ibuprofen) LAZANDA (fentanyl) levorphanol LORCET (hydrocodone/APAP) LORTAB (hydrocodone/APAP) meperidine NORCO (hydrocodone/APAP) NUCYNTA (tapentadol) ONSOLIS (fentanyl) OPANA (oxymorphone) OXECTA (oxycodone) oxycodone capsules oxycodone/ibuprofen oxymorphone	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 for the purpose of maximizing the use of longer acting medications to prevent unnecessary breakthrough pain in chronic pain therapy. Immediate-release tramadol is limited to 240 tablets per thirty (30) days.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	PERCOCET (oxycodone/APAP) PRIMLEV (oxycodone/APAP) REPREXAIN (hydrocodone/ibuprofen) ROXICODONE (oxycodone) RYBIX ODT (tramadol) SUBSYS (fentanyl) SYNALGOS-DC (dihydrocodeine/ASA/ caffeine) TYLENOL W/CODEINE (APAP/codeine) ULTRACET (tramadol/APAP) ULTRAM (tramadol) VEDROCET (hydrocodone/APAP) VICODIN VICOPROFEN (hydrocodone/ibuprofen) XODOL (hydrocodone/acetaminophen) XYLON (hydrocodone/ibuprofen) ZAMICET (hydrocodone/APAP)	
ANDROGENIC AGENTS		
CATEGORY PA CRITERIA: A non-preferred agent will only be authorized if one (1) of the exceptions on the PA form is present.		
ANDRODERM (testosterone) ANDROGEL (testosterone) METHITEST (methyltestosterone)	ANDROID (methyltestosterone) AXIRON (testosterone) FORTESTA (testosterone) methyltestosterone capsule NATESTO (testosterone) TESTIM (testosterone) TESTRED (methyltestosterone) testosterone gel VOGELXO (testosterone)	
ANESTHETICS, TOPICAL[AP]		
CATEGORY PA CRITERIA: Ten (10) day trials of each of the preferred topical anesthetics are required before a non-preferred topical anesthetic will be authorized unless one (1) of the exceptions on the PA form is present		
lidocaine lidocaine/prilocaine xylocaine	EMLA (lidocaine/prilocaine) LIDAMANTLE (lidocaine) LIDAMANTLE HC (lidocaine/hydrocortisone) lidocaine/hydrocortisone SYNERA (lidocaine/tetracaine)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ANGIOTENSIN MODULATORS[AP]		
CATEGORY PA CRITERIA: Fourteen (14) day trials of each of the preferred agents in the corresponding group, with the exception of the Direct Renin Inhibitors, are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.		
ACE INHIBITORS		
benazepril captopril enalapril fosinopril lisinopril quinapril ramipril	ACCUPRIL (quinapril) ACEON (perindopril) ALTACE (ramipril) EPANED (enalapril)* LOTENSIN (benazepril) MAVIK (trandolapril) moexipril perindopril PRINIVIL (lisinopril) QBRELIS SOLUTION (lisinopril) trandolapril UNIVASC (moexipril) VASOTEC (enalapril) ZESTRIL (lisinopril)	*Epaned will be authorized with a diagnosis of hypertension, symptomatic heart failure or asymptomatic left ventricular dysfunction provided that the patient is less than seven (7) years of age **OR** is unable to ingest a solid dosage form due to documented oral-motor difficulties or dysphagia.
ACE INHIBITOR COMBINATION DRUGS		
benazepril/amlodipine benazepril/HCTZ captopril/HCTZ enalapril/HCTZ fosinopril/HCTZ lisinopril/HCTZ quinapril/HCTZ	ACCURETIC (quinapril/HCTZ) CAPOZIDE (captopril/HCTZ) LOTENSIN HCT (benazepril/HCTZ) LOTREL (benazepril/amlodipine) moexipril/HCTZ PRESTALIA (perindopril/amlodipine) PRINZIDE (lisinopril/HCTZ) TARKA (trandolapril/verapamil) trandolapril/verapamil VASERETIC (enalapril/HCTZ) ZESTORETIC (lisinopril/HCTZ)	
ANGIOTENSIN II RECEPTOR BLOCKERS (ARBs)		
BENICAR (olmesartan) irbesartan losartan MICARDIS (telmisartan) valsartan	ATACAND (candesartan) AVAPRO (irbesartan) candesartan COZAAR (losartan) DIOVAN (valsartan) EDARBI (azilsartan) eprosartan telmisartan TEVETEN (eprosartan)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	ARB COMBINATIONS	
AZOR (olmesartan/amlodipine) BENICAR-HCT (olmesartan/HCTZ) EXFORGE HCT (valsartan/amlodipine/HCTZ) irbesartan/HCTZ losartan/HCTZ MICARDIS-HCT (telmisartan/HCTZ) TRIBENZOR (olmesartan/amlodipine/HCTZ) valsartan/amlodipine valsartan/HCTZ	ATACAND-HCT (candesartan/HCTZ) AVALIDE (irbesartan/HCTZ) BYVALSON (nebivolol/valsartan) candesartan/HCTZ DIOVAN-HCT (valsartan/HCTZ) EDARBYCLOR (azilsartan/chlorthalidone) ENTRESTO (valsartan/sucubitril)* EXFORGE (valsartan/amlodipine) HYZAAR (losartan/HCTZ) telmisartan/amlodipine telmisartan HCTZ TEVETEN-HCT (eprosartan/HCTZ) TWYNSTA (telmisartan/amlodipine) valsartan/amlodipine/HCTZ	*Entresto will only be authorized for patients diagnosed with heart-failure NYHA classification 2-4 with an EF < 40%. No preferred drug trial is required to receive authorization
	DIRECT RENIN INHIBITORS	
	AMTURNIDE (aliskiren/amlodipine/HCTZ) TEKAMLO (aliskiren/amlodipine) TEKTURNA (aliskiren) TEKTURNA HCT (aliskiren/HCTZ) VALTURNA (aliskiren/valsartan)	**Substitute for Category Criteria**: A thirty (30) day trial of one (1) preferred ACE, ARB, or combination agent, at the maximum tolerable dose, is required before Tekturna will be authorized unless one (1) of the exceptions on the PA form is present. Amturnide, Tekamlo, Tekturna HCT or Valturna will be authorized if the criteria for Tekturna are met and the patient also needs the other agents in the combination.
ANTIANGINAL & ANTI-ISCHEMIC		
CATEGORY PA CRITERIA: Ranexa will 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.		
	RANEXA (ranolazine)[AP]	
ANTIBIOTICS, GI		
CATEGORY PA CRITERIA: A fourteen (14) day trial of a preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.		
metronidazole tablet neomycin TINDAMAX (tinidazole)	ALINIA (nitazoxanide) DIFICID (fidaxomicin)* FLAGYL (metronidazole) FLAGYL ER (metronidazole ER) metronidazole capsule paromomycin	*Dificid will be authorized if the following criteria are met: 1. There is a diagnosis of severe *C. difficile* infection; **and** 2. There is no response to prior treatment with vancomycin for ten (10) to fourteen (14) days.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	tinidazole VANCOCIN (vancomycin) vancomycin** XIFAXAN (rifaximin)***	**Vancomycin will be authorized for treatment of mild to moderate *C. difficile* infections after a fourteen (14) day trial of metronidazole. Severe *C. difficile* infections do not require a trial of metronidazole for authorization. ***Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.
ANTIBIOTICS, INHALED		
CATEGORY PA CRITERIA: A twenty-eight (28) day trial of the preferred agent and documentation of therapeutic failure is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.		
BETHKIS (tobramycin) KITABIS PAK (tobramycin)	CAYSTON (aztreonam) TOBI (tobramycin) TOBI PODHALER Tobramycin	
ANTIBIOTICS, TOPICAL		
CATEGORY PA CRITERIA: Ten (10) day trials of at least one (1) preferred agent, including the generic formulation of a requested non-preferred agent, are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.		
bacitracin (Rx, OTC) gentamicin sulfate mupirocin ointment	ALTABAX (retapamulin) BACTROBAN (mupirocin) CENTANY (mupirocin) CORTISPORIN (bacitracin/neomycin/polymyxin/HC) mupirocin cream neomycin/polymyxin/pramoxine	
ANTIBIOTICS, VAGINAL		
CATEGORY PA CRITERIA: A trial, the duration of the manufacturer's recommendation, of each preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.		
clindamycin cream METROGEL (metronidazole)	AVC (sulfanilamide) CLEOCIN CREAM (clindamycin) CLEOCIN OVULE (clindamycin) CLINDESSE (clindamycin) metronidazole NUVESSA (metronidazole) VANDAZOLE (metronidazole)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ANTICOAGULANTS		
CATEGORY PA CRITERIA: Trials of each preferred agent will be required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.		
	INJECTABLE[CL]	
enoxaparin	ARIXTRA (fondaparinux) fondaparinux FRAGMIN (dalteparin) LOVENOX (enoxaparin)	
	ORAL	
COUMADIN (warfarin) ELIQUIS (apixaban)[AP]* PRADAXA (dabigatran)[AP]** warfarin XARELTO (rivaroxaban)[AP]***	SAVAYSA (edoxaban)	*Eliquis will be authorized for the following indications: 1. Non-valvular atrial fibrillation **or** 2. Deep vein thombrosis (DVT) and pulmonary embolism (PE) **or** 3. DVT prophylaxis if treatment is limited to thirty-five (35) days for hip replacement surgeries or twelve (12) days for knee replacement surgeries. **Pradaxa will be authorized for the following indications: 1. Non-valvular atrial fibrillation **or** 2. To reduce the risk of recurrent DVT and PE in patients who have previously been treated **or** 3. Treatment of acute DVT and PE in patients who have been treated with a parenteral anticoagulant for five (5) to (10) days**.** ***Xarelto will be authorized for the following indications:: 1. Non-valvular atrial fibrillation **or** 2. DVT, and PE, and reduction in risk of recurrence of DVT and PE **or** 3. DVT prophylaxis if treatment is limited to thirty-five (35) days for hip replacement surgeries or twelve (12) days for knee replacement surgeries.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ANTICONVULSANTS		
CATEGORY PA CRITERIA: A fourteen (14) day trial of one (1) of the preferred agents in the corresponding group is required for treatment naïve patients with a diagnosis of a seizure disorder before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. A thirty (30) day trial of one (1) of the preferred agents in the corresponding group is required for patients with a diagnosis other than seizure disorders unless one (1) of the exceptions on the PA form is present. Non-preferred anticonvulsants will be authorized for patients on established therapies with a diagnosis of seizure disorders with no trials of preferred agents required. In situations where AB-rated generic equivalent products are available, "Brand Medically Necessary" must be hand-written by the prescriber on the prescription in order for the brand name product to be reimbursed.		
ADJUVANTS		
carbamazepine carbamazepine ER carbamazepine XR DEPAKOTE SPRINKLE (divalproex) divalproex divalproex ER EPITOL (carbamazepine) GABITRIL (tiagabine) lamotrigine levetiracetam IR levetiracetam ER oxcarbazepine suspension and tablets topiramate IR topiramate ER* valproic acid VIMPAT(lacosamide)[AP]** zonisamide	APTIOM (eslicarbazepine) BANZEL(rufinamide) BRIVIACT (brivaracetam) CARBATROL (carbamazepine) DEPAKENE (valproic acid) DEPAKOTE (divalproex) DEPAKOTE ER (divalproex) divalproex sprinkle EQUETRO (carbamazepine) FANATREX SUSPENSION (gabapentin) felbamate FELBATOL (felbamate)*** FYCOMPA (perampanel) KEPPRA (levetiracetam) KEPPRA XR (levetiracetam) LAMICTAL (lamotrigine) LAMICTAL CHEWABLE (lamotrigine) LAMICTAL ODT (lamotrigine) LAMICTAL XR (lamotrigine) lamotrigine dose pack lamotrigine ER ONFI (clobazam) **** ONFI SUSPENSION (clobazam) **** OXTELLAR XR (oxcarbazepine) POTIGA (ezogabine) QUDEXY XR (topiramate ER) SABRIL (vigabatrin) SPRITAM (levetiracetam) STAVZOR (valproic acid) TEGRETOL (carbamazepine) TEGRETOL XR (carbamazepine)	*Topiramate ER will be authorized after a thirty (30) day trial of topiramate IR. **Vimpat will be approved as monotherapy or adjunctive therapy for members seventeen (17) years of age or older with a diagnosis of partial-onset seizure disorder. ***Patients stabilized on Felbatol will be grandfathered ****Onfi will be authorized if the following criteria are met: 1. Adjunctive therapy for Lennox-Gastaut **or** 2. Generalized tonic, atonic or myoclonic seizures **and** 3. Previous failure of at least two (2) non-benzodiazepine anticonvulsants and previous failure of clonazepam. (For continuation, prescriber must include information regarding improved response/effectiveness with this medication)

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	tiagabine TOPAMAX (topiramate) TRILEPTAL SUSPENSION and TABLETS (oxcarbazepine) TROKENDI XR (topiramate) ZONEGRAN (zonisamide)	
	BARBITURATES[AP]	
phenobarbital primidone	MYSOLINE (primidone)	
	BENZODIAZEPINES[AP]	
clonazepam DIASTAT (diazepam rectal) diazepam tablets	clonazepam ODT diazepam rectal gel KLONOPIN (clonazepam) VALIUM TABLETS (diazepam)	
	HYDANTOINS[AP]	
DILANTIN (phenytoin sodium, extended) PEGANONE (ethotoin) phenytoin capsules, chewable tablets, suspension	DILANTIN INFATABS (phenytoin) PHENYTEK (phenytoin)	
	SUCCINIMIDES	
CELONTIN (methsuximide) ethosuximide syrup ZARONTIN (ethosuximide) capsules	ethosuximide capsules ZARONTIN (ethosuximide) syrup	
ANTIDEPRESSANTS, OTHER		
CATEGORY PA CRITERIA: See below for individual sub-class criteria.		
	MAOIs[AP]	
	MARPLAN (isocarboxazid) NARDIL (phenelzine) PARNATE (tranylcypromine) phenelzine tranylcypromine	Patients stabilized on MAOI agents will be grandfathered.
	SNRIS[AP]	
duloxetine capulses venlafaxine ER capsules	CYMBALTA (duloxetine) desvenlafaxine ER desvenlafaxine fumarate ER	A thirty (30) day trial each of a preferred agent and an SSRI is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	EFFEXOR XR (venlafaxine) FETZIMA (levomilnacipran) KHEDEZLA (desvenlafaxine) PRISTIQ (desvenlafaxine) venlafaxine IR VENLAFAXINE ER TABLETS (venlafaxine)	
SECOND GENERATION NON-SSRI, OTHER[AP]		
bupropion IR bupropion SR bupropion XL mirtazapine trazodone	APLENZIN (bupropion hbr) EMSAM (selegiline) FORFIVO XL (bupropion) nefazodone OLEPTRO ER (trazodone) REMERON (mirtazapine) TRINTELLIX (vortioxetine) VIIBRYD (vilazodone hcl) WELLBUTRIN (bupropion) WELLBUTRIN SR (bupropion) WELLBUTRIN XL (bupropion)	A thirty (30) day trial each of a preferred agent and an SSRI is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.
SELECTED TCAs		
imipramine hcl	imipramine pamoate TOFRANIL (imipramine hcl) TOFRANIL PM (imipramine pamoate)	A twelve (12) week trial of imipramine hcl is required before a non-preferred TCA will be authorized unless one (1) of the exceptions on the PA form is present.
ANTIDEPRESSANTS, SSRIs[AP]		
CATEGORY PA CRITERIA: Thirty (30) day trials each of two (2) 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. Upon hospital discharge, patients admitted with a primary mental health diagnosis who have been stabilized on a non-preferred SSRI will receive an authorization to continue that drug		
citalopram escitalopram tablets fluoxetine capsules, solution fluvoxamine paroxetine sertraline	BRISDELLE (paroxetine) CELEXA (citalopram) escitalopram solution fluoxetine tablets fluvoxamine ER LEXAPRO (escitalopram) LUVOX CR (fluvoxamine) paroxetine ER PAXIL (paroxetine) PAXIL CR (paroxetine) PEXEVA (paroxetine) PROZAC (fluoxetine) SARAFEM (fluoxetine) ZOLOFT (sertraline)	.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ANTIEMETICS[AP]		
CATEGORY PA CRITERIA: A three (3) 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. PA is required for ondansetron when limits are exceeded.		
	5HT3 RECEPTOR BLOCKERS	
ondansetron ODT, solution, tablets	ANZEMET (dolasetron) granisetron GRANISOL (granisetron) ondansetron vials SANCUSO (granisetron) ZOFRAN (ondansetron) ZUPLENZ (ondansetron)	
	CANNABINOIDS	
	CESAMET (nabilone)* dronabinol MARINOL (dronabinol)**	*Cesamet will be authorized only for the treatment of nausea and vomiting associated with cancer chemotherapy for patients who have failed to respond adequately to three (3) day trials of conventional treatments such as promethazine or ondansetron and are eighteen (18) years of age or older. **Marinol (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	
EMEND (aprepitant)	VARUBI (rolapitant)	
	COMBINATIONS	
	AKYNZEO (netupitant/ palonosetron	
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****	*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

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	LAMISIL (terbinafine) MYCELEX (clotrimazole) MYCOSTATIN Tablets (nystatin) NIZORAL (ketoconazole) NOXAFIL (posaconazole) ONMEL (itraconazole) ORAVIG (miconazole) SPORANOX (itraconazole) VFEND (voriconazole) voriconazole suspension voriconazole tablets	met: 1. Diagnosis of one of the following fungal infections: blastomycosis, coccidioidomycosis, histoplasmosis, chromomycosis, or paracoccidioidomycosis **and** 2. Documented failure or intolerance of all other diagnosis-appropriate antifungal therapies, i.e. itraconazole, fluconazole, flucytosine, etc **and** 3. Baseline assessment of the liver status including alanine aminotransferase (ALT), aspartate aminotransferase (AST), total bilirubin, alkaline phosphatase, prothrombin time, and international normalized ration (INR) before starting treatment **and** 4. Weekly monitoring of serum ALT for the duration of treatment (If ALT values increase to a level above the upper limit of normal or 30% above baseline, or if the patient develops symptoms of abnormal liver function, treatment should be interrupted and a full set of liver tests be obtained. Liver tests should be repeated to ensure normalization of values.) **and** 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]		
CATEGORY PA CRITERIA: Fourteen (14) day trials of two (2) of the preferred agents are required before a non-preferred agents will be authorized unless one (1) of the exceptions on the PA form is present. If a non-preferred shampoo is requested, a fourteen (14) day trial of one (1) preferred product (ketoconazole shampoo) is required.		
ANTIFUNGALS		
econazole ketoconazole cream, shampoo MENTAX (butenafine) miconazole (OTC) nystatin	CICLODAN (ciclopirox) ciclopirox ERTACZO (sertaconazole) EXELDERM (sulconazole) EXTINA (ketoconazole) JUBLIA (efinaconazole) ketoconazole foam KERYDIN (tavaborole) KETODAN (ketoconazole) LOPROX (ciclopirox) LUZU (luliconazole) MYCOSTATIN (nystatin) NAFTIN CREAM (naftifine) NAFTIN GEL (naftifine)	*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**
	NIZORAL (ketoconazole) OXISTAT (oxiconazole)* PEDIPIROX-4 (ciclopirox) PENLAC (ciclopirox) VUSION (miconazole/petrolatum/zinc oxide) XOLEGEL (ketoconazole)	
	ANTIFUNGAL/STEROID COMBINATIONS	
clotrimazole/betamethasone nystatin/triamcinolone	KETOCON PLUS (ketoconazole/hydrocortisone) LOTRISONE (clotrimazole/betamethasone)	
ANTIHYPERTENSIVES, SYMPATHOLYTICS		
CATEGORY PA CRITERIA: A thirty (30) day trial of each preferred unique chemical entity in the corresponding formulation is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.		
CATAPRES-TTS (clonidine) clonidine tablets	CATAPRES TABLETS (clonidine) clonidine patch NEXICLON XR (clonidine)	
ANTIHYPERURICEMICS		
CATEGORY PA CRITERIA: A thirty (30) day trial of one (1) of the preferred agents for the prevention of gouty arthritis attacks (colchicine/probenecid, probenecid, or allopurinol) is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.		
	ANTIMITOTICS	
MITIGARE (colchicines)	colchicine capsules* colchicine tablets COLCRYS (colchicine)	*In the case of acute gouty attacks, a ten (10) day supply (twenty (20) capsules) of colchicine will be authorized per ninety (90) days.
	ANTIMITOTIC-URICOSURIC COMBINATION	
colchicine/probenecid		
	URICOSURIC	
Probenecid		
	XANTHINE OXIDASE INHIBITORS	
allopurinol	ULORIC (febuxostat) ZYLOPRIM (allopurinol)	
ANTIMIGRAINE AGENTS, OTHER[AP]		
CATEGORY PA CRITERIA: Three (3) day trials of each unique chemical entity of the preferred Antimigraine Triptan agents are required before Cambia will be authorized unless (1) of the exceptions on the PA form is present.		
	CAMBIA (diclofenac)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ANTIMIGRAINE AGENTS, TRIPTANS[AP]		
CATEGORY PA CRITERIA: Three (3) day trials of each unique chemical entity 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. Quantity limits apply for this drug class.		
TRIPTANS		
naratriptan rizatriptan rizatriptan ODT sumatriptan nasal spray/injection* sumatriptan tablets	almotriptan AMERGE (naratriptan) AXERT (almotriptan) FROVA (frovatriptan) IMITREX INJECTION (sumatriptan)[CL] IMITREX NASAL SPRAY (sumatriptan) IMITREX tablets (sumatriptan) MAXALT (rizatriptan) MAXALT MLT (rizatriptan) RELPAX (eletriptan) SUMAVEL (sumatriptan) ZECUITY PATCH (sumatriptan) ZEMBRACE SYMTOUCH (sumatriptan) zolmitriptan zolmitriptan ODT ZOMIG (zolmitriptan) ZOMIG ZMT (zolmitriptan)	**In addition to the Category Criteria**: Three (3) day trials of each preferred agent will be required before Imitrex injection is authorized. *AP does not apply to nasal spray or injectable sumatriptan.
TRIPTAN COMBINATIONS		
	TREXIMET (sumatriptan/naproxen sodium)	
ANTIPARASITICS, TOPICAL[AP]		
CATEGORY PA CRITERIA: Trials of each of the preferred agents (which are age and weight appropriate) are required before non-preferred agents will be authorized unless one (1) of the exceptions on the PA form is present.		
NATROBA (spinosad) permethrin 5% cream permethrin 1% lotion (OTC) pyrethrins-piperonyl butoxide OTC SKLICE (ivermectin)	EURAX (crotamiton) LICE EGG REMOVER OTC (benzalkonium chloride) lindane malathion OVIDE (malathion) spinosad	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ANTIPARKINSON'S AGENTS		
CATEGORY PA CRITERIA: Patients starting therapy on drugs in this class must show a documented allergy to all of the preferred agents in the corresponding class, before a non-preferred agent will be authorized.		
	ANTICHOLINERGICS	
benztropine trihexyphenidyl	COGENTIN (benztropine)	
	COMT INHIBITORS	
	COMTAN (entacapone) entacapone TASMAR (tolcapone)	
	DOPAMINE AGONISTS	
pramipexole ropinirole	MIRAPEX (pramipexole) MIRAPEX ER (pramipexole) NEUPRO (rotigotine) pramipexole ER REQUIP (ropinirole) REQUIP XL (ropinirole) ropinirole ER	Mirapex, Mirapex ER, Requip, and Requip XL will be authorized for a diagnosis of Parkinsonism with no trials of preferred agents required.
	OTHER ANTIPARKINSON'S AGENTS	
amantadine[AP] bromocriptine carbidopa/levodopa levodopa/carbidopa/entacapone selegiline	AZILECT (rasagiline) carbidopa ELDEPRYL (selegiline) levodopa/carbidopa ODT LODOSYN (carbidopa) PARCOPA (levodopa/carbidopa) PARLODEL (bromocriptine) RYTARY (levodopa/carbidopa) SINEMET (levodopa/carbidopa) STALEVO (levodopa/carbidopa/entacapone) ZELAPAR (selegiline)	Amantadine will be authorized only for a diagnosis of Parkinsonism.
ANTIPSORIATICS, TOPICAL		
CATEGORY PA CRITERIA: Thirty (30) day trials of two (2) preferred unique chemical entities are required before non-preferred agents will be authorized unless one (1) of the exceptions on the PA form is present.		
calcipotriene ointment calcipotriene/betamethasone ointment TAZORAC (tazarotene)	calcipotriene cream calcipotriene solution CALCITRENE (calcipotriene) calcitriol DOVONEX (calcipotriene)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	ENSTILAR (calcipotriene/betamethasone) TACLONEX (calcipotriene/ betamethasone) SORILUX (calcipotriene) VECTICAL (calcitriol)	

ANTIPSYCHOTICS, ATYPICAL

CATEGORY PA CRITERIA: All antipsychotic agents require prior authorization for children up to eighteen (18) years of age. All PA requests for antipsychotics for children 6 years of age and younger will be reviewed by Medicaid's consultant psychiatrist.

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

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.

In the event there are not three preferred drugs with FDA-approved labels for the patient's age range or diagnosis, the drug may still receive approval at the discretion of RDTP or by BMS on appeal.

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. Requests for off-label use will be given at least a 30 day prior-authorization so that BMS may properly review the requested therapy.

SINGLE INGREDIENT		
ABILIFY MAINTENA (aripiprazole)* CL ABILIFY DISCMELT & ORAL SOLUTION (aripiprazole) aripiprazole tablets ARISTADA (aripiprazole)***** clozapine 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	ABILIFY TABLETS (aripiprazole) ADASUVE (loxapine) aripiprazole discmelt & oral solution clozapine ODT CLOZARIL (clozapine) FANAPT (iloperidone) FAZACLO (clozapine) GEODON (ziprasidone) GEODON IM (ziprasidone) INVEGA (paliperidone) NUPLAZID (pimavanserin) olanzapine IM* paliperidone ER REXULTI (brexipiprazole) RISPERDAL (risperidone) SAPHRIS (asenapine) SEROQUEL (quetiapine) SEROQUEL XR (quetiapine)	*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** 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.**

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	VERSACLOZ (clozapine) VRAYLAR (capriprazine) ZYPREXA (olanzapine) ZYPREXA IM (olanzapine)* ZYPREXA RELPREVV (olanzapine)	*****Aristada is only approvable on appeal and requires that tolerability has been previously established with oral aripiprazole for at least 2 weeks AND that there is a clinically compelling reason why Abilify Maintena cannot be used.
	ATYPICAL ANTIPSYCHOTIC/SSRI COMBINATIONS	
	olanzapine/fluoxetine SYMBYAX (olanzapine/fluoxetine)	
ANTIRETROVIRALS		
CATEGORY PA CRITERIA: Non-preferred drugs require medical reasoning beyond convenience or enhanced compliance as to why the clinical need cannot be met with a preferred agent or combination of preferred agents. NOTE: Regimens consisting of preferred agents will result in no more than one additional unit per day over equivalent regimens composed of non-preferred agents. Patients already on a non-preferred regimen shall be grandfathered.		
	INTEGRASE STRAND TRANSFER INHIBITORS	
ISENTRESS (raltegravir potassium) TIVICAY (dolutegravir sodium) VITEKTA (elvitegravir)		
	NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTI)	
abacavir sulfate didanosine DR capsule EMTRIVA (emtricitabine) EPIVIR SOLUTION (butransine) lamivudine stavudine VIDEX SOLUTION (didanosine) VIREAD (tenofovir disoproxil fumarate) ZIAGEN SOLUTION (abacavir sulfate) Zidovudine	EPIVIR TABLET (butransine) RETROVIR (zidovudine) VIDEX EC (didanosine) ZERIT (stavudine) ZIAGEN TABLET (abacavir sulfate)	
	NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITOR (NNRTI)	
EDURANT (rilpivirine) SUSTIVA (efavirenz)	INTELENCE (etravirine) nevirapine nevirapine ER RESCRIPTOR (delavirdine mesylate) VIRAMUNE ER 24H (nevirapine) VIRAMUNE SUSPENSION (nevirapine)	
	PHARMACOENHANCER – CYTOCHROME P450 INHIBITOR	
TYBOST (cobicistat)		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	PROTEASE INHIBITORS (PEPTIDIC)	
EVOTAZ (atazanavir/cobicistat) NORVIR (ritonavir) REYATAZ (atazanavir)	CRIXIVAN (indinavir) INVIRASE (saquinavir mesylate) LEXIVA (fosamprenavir) VIRACEPT (nelfinavir mesylate)	
	PROTEASE INHIBITORS (NON-PEPTIDIC)	
PREZISTA (darunavir ethanolate)	APTIVUS (tipranavir) PREZCOBIX (darunavir/cobicistat)	
	ENTRY INHIBITORS – CCR5 CO-RECEPTOR ANTAGONISTS	
	SELZENTRY (maraviroc)	
	ENTRY INHIBITORS – FUSION INHIBITORS	
	FUZEON (enfuvirtide)	
	COMBINATION PRODUCTS - NRTIs	
EPZICOM (abacavir/lamivudine) lamivudine/zidovudine	abacavir/lamivudine/zidovudine COMBIVIR (lamivudine/zidovudine) TRIZIVIR (abacavir/lamivudine/zidovudine)	
	COMBINATION PRODUCTS – NUCLEOSIDE & NUCLEOTIDE ANALOG RTIs	
DESCOVY (emtricitabine/tenofovir) TRUVADA (emtricitabine/tenofovir)		
	COMBINATION PRODUCTS – NUCLEOSIDE & NUCLEOTIDE ANALOGS & INTEGRASE INHIBITORS	
GENVOYA (elvitegravir/cobicistat/emtricitabine/tenofovir)	STRIBILD (elvitegravir/cobicistat/emtricitabine/tenofovir)* TRIUMEQ (abacavir/lamivudine/ dolutegravir)**	* Stribild requires medical reasoning beyond convenience or enhanced compliance as to why the medical need cannot be met with the the preferred agent Genvoya. ** Triumeq requires medical reasoning beyond convenience or enhanced compliance as to why the medical need cannot be met with the preferred agents Epzicom and Tivicay.
	COMBINATION PRODUCTS – NUCLEOSIDE & NUCLEOTIDE ANALOGS & NON-NUCLEOSIDE RTIs	
ATRIPLA (efavirenz/emtricitabine/tenofovir)	COMPLERA (emtricitabine/rilpivirine/tenofovir)* ODEFSEY (emtricitabine/rilpivirine/tenofovir)	* Complera requires medical reasoning beyond convenience or enhanced compliance as to why the medical need cannot be met with the preferred agents Truvada and Edurant.
	COMBINATION PRODUCTS – PROTEASE INHIBITORS	
KALETRA (lopinavir/ritonavir)		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ANTIVIRALS, ORAL		
CATEGORY PA CRITERIA: 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.		
	ANTI HERPES	
acyclovir valacyclovir	famciclovir FAMVIR (famciclovir) SITAVIG (acyclovir) VALTREX ZOVIRAX (acyclovir)	
	ANTI-INFLUENZA	
RELENZA (zanamivir) TAMIFLU (oseltamivir)	FLUMADINE (rimantadine) rimantadine	**In addition to the Category Criteria**: The anti-influenza agents will be authorized only for a diagnosis of influenza.
ANTIVIRALS, TOPICAL[AP]		
CATEGORY PA CRITERIA: A five (5) day trial of the preferred agent will be required before a non-preferred agent will be approved unless one (1) of the exceptions on the PA form is present.		
ZOVIRAX CREAM (acyclovir)	ABREVA (docosanol) acyclovir ointment DENAVIR (penciclovir) ZOVIRAX OINTMENT (acyclovir)	
BETA BLOCKERS[AP]		
CATEGORY PA CRITERIA: Fourteen (14) day trials each of three (3) chemically distinct preferred agents, including the generic formulation of a requested non-preferred agent, are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.		
	BETA BLOCKERS	
acebutolol atenolol betaxolol bisoprolol metoprolol metoprolol ER nadolol pindolol propranolol sotalol timolol	BETAPACE (sotalol) BYSTOLIC (nebivolol) CORGARD (nadolol) HEMANGEOL (propranolol)* INDERAL LA (propranolol) INDERAL XL (propranolol) INNOPRAN XL (propranolol) KERLONE (betaxolol) LEVATOL (penbutolol) LOPRESSOR (metoprolol) propranolol ER** SECTRAL (acebutolol) TENORMIN (atenolol) TOPROL XL (metoprolol) ZEBETA (bisoprolol)	*Hemangeol will be authorized for the treatment of proliferating infantile hemangioma requiring systemic therapy. **Propranolol ER shall be authorized for patients with a diagnosis of migraines. Existing users will be grandfathered for use in migraine prophylaxis.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	BETA BLOCKER/DIURETIC COMBINATION DRUGS	
atenolol/chlorthalidone bisoprolol/HCTZ metoprolol/HCTZ nadolol/bendroflumethiazide propranolol/HCTZ	CORZIDE (nadolol/bendroflumethiazide) DUTOPROL (metoprolol ER/HCTZ ER) LOPRESSOR HCT (metoprolol/HCTZ) TENORETIC (atenolol/chlorthalidone) ZIAC (bisoprolol/HCTZ)	
	BETA- AND ALPHA-BLOCKERS	
carvedilol labetalol	COREG (carvedilol) COREG CR (carvedilol) TRANDATE (labetalol)	
BLADDER RELAXANT PREPARATIONS[AP]		
CATEGORY PA CRITERIA: A thirty (30) day trial of each chemically distinct preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.		
oxybutynin IR oxybutynin ER VESICARE (solifenacin)	DETROL (tolterodine) DETROL LA (tolterodine) DITROPAN XL (oxybutynin) ENABLEX (darifenacin) flavoxate GELNIQUE (oxybutynin) MYRBETRIQ (mirabegron) OXYTROL (oxybutynin) SANCTURA (trospium) SANCTURA XR (trospium) tolterodine tolterodine ER TOVIAZ (fesoterodine) trospium trospium ER	
BONE RESORPTION SUPPRESSION AND RELATED AGENTS		
CATEGORY PA CRITERIA: A 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.		
	BISPHOSPHONATES	
alendronate tablets	ACTONEL (risedronate) ACTONEL WITH CALCIUM (risedronate/ calcium) alendronate solution	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	ATELVIA (risedronate) BINOSTO (alendronate) BONIVA (ibandronate) DIDRONEL (etidronate) etidronate FOSAMAX TABLETS (alendronate) FOSAMAX PLUS D (alendronate/vitamin D) ibandronate risedronate	
OTHER BONE RESORPTION SUPPRESSION AND RELATED AGENTS		
calcitonin	EVISTA (raloxifene)* FORTEO (teriparatide) FORTICAL (calcitonin) MIACALCIN (calcitonin) Raloxifene	*Evista will be authorized for postmenopausal women with osteoporosis or at high risk for invasive breast cancer.
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) dutasteride 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.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
BRONCHODILATORS, BETA AGONIST[AP]		
CATEGORY PA CRITERIA: Thirty (30) day trials each of the chemically distinct preferred agents in their corresponding groups are required before a non-preferred agent in that group will be authorized unless one (1) of the exceptions on the PA form is present.		
	INHALATION SOLUTION	
ACCUNEB (albuterol)* albuterol	BROVANA (arformoterol) levalbuterol metaproterenol PERFOROMIST (formoterol) XOPENEX (levalbuterol)	*No PA is required for Accuneb for children up to five (5) years of age.
	INHALERS, LONG-ACTING	
FORADIL (formoterol) SEREVENT (salmeterol)	ARCAPTA (indacaterol maleate) STRIVERDI RESPIMAT (olodaterol)	
	INHALERS, SHORT-ACTING	
PROAIR HFA (albuterol) PROVENTIL HFA (albuterol)	MAXAIR (pirbuterol) PROAIR RESPICLICK (albuterol) VENTOLIN HFA (albuterol) XOPENEX HFA (levalbuterol)	Xopenex Inhalation Solution will be authorized for twelve (12) months for a diagnosis of asthma or COPD for patients on concurrent asthma controller therapy (either oral or inhaled) with documentation of failure on a trial of albuterol or documented intolerance of albuterol, or for concurrent diagnosis of heart disease.
	ORAL	
albuterol IR, ER terbutaline	metaproterenol VOSPIRE ER (albuterol)	
CALCIUM CHANNEL BLOCKERS[AP]		
CATEGORY PA CRITERIA: A fourteen (14) day trial of each preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.		
	LONG-ACTING	
amlodipine diltiazem ER felodipine ER nifedipine ER verapamil ER	ADALAT CC (nifedipine) CALAN SR (verapamil) CARDENE SR (nicardipine) CARDIZEM CD, LA (diltiazem) COVERA-HS (verapamil) diltiazem LA DYNACIRC CR (isradipine) ISOPTIN SR (verapamil) MATZIM LA (diltiazem) nisoldipine NORVASC (amlodipine) PLENDIL (felodipine) PROCARDIA XL (nifedipine)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	SULAR (nisoldipine) TIAZAC (diltiazem) verapamil ER PM VERELAN/VERELAN PM (verapamil)	
	SHORT-ACTING	
diltiazem verapamil	CALAN (verapamil) CARDIZEM (diltiazem) isradipine nicardipine nifedipine nimodipine NIMOTOP (nimodipine) NYMALIZE SOLUTION (nimodipine) PROCARDIA (nifedipine)	
CEPHALOSPORINS AND RELATED ANTIBIOTICS[AP]		
CATEGORY PA CRITERIA: A five (5) 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.		
	BETA LACTAMS AND BETA LACTAM/BETA-LACTAMASE INHIBITOR COMBINATIONS	
amoxicillin/clavulanate IR	amoxicillin/clavulanate ER AUGMENTIN (amoxicillin/clavulanate) AUGMENTIN XR (amoxicillin/clavulanate) MOXATAG (amoxicillin)	
	CEPHALOSPORINS	
cefaclor capsule cefadroxil capsule, tablet cefdinir cefuroxime tablet cephalexin capsule, suspension	CEDAX (ceftibuten) cefaclor suspension cefaclor ER tablet cefadroxil suspension cefditoren cefpodoxime cefprozil ceftibuten capsule, suspension CEFTIN (cefuroxime) cefuroxime suspension cephalexin tablet KEFLEX (cephalexin) OMNICEF (cefdinir) RANICLOR (cefaclor) SPECTRACEF (cefditoren) SUPRAX (cefixime)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
COLONY STIMULATING FACTORS		
CATEGORY PA CRITERIA: A thirty (30) day trial of one (1) of the preferred agents is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present		
GRANIX (tbo-filgrastim) LEUKINE (sargramostim) NEUPOGEN (filgrastim)	NEULASTA (pegfilgrastim) ZARXIO (filgrastim)	.
COPD AGENTS		
CATEGORY PA CRITERIA: A thirty (30) day trial of a preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.		
ANTICHOLINERGIC[AP]		
ATROVENT HFA (ipratropium) ipratropium SPIRIVA (tiotropium)	INCRUSE ELLIPTA (umeclidinium) SPIRIVA RESPIMAT (tiotropium) TUDORZA (aclidinium)	**Substitute for Category Criteria**: A thirty (30) day trial of tiotropium is required before a non-preferred agent will be authorized.
ANTICHOLINERGIC-BETA AGONIST COMBINATIONS[AP]		
albuterol/ipratropium COMBIVENT RESPIMAT (albuterol/ipratropium)	ANORO ELLIPTA (umeclidinium/vilanterol)* BEVESPI (glycopyrrolate/formoterol) DUONEB (albuterol/ipratropium) STIOLTO RESPIMAT (tiotropium/olodaterol)*	*Anoro Ellipta and Stiolto Respimat will be authorized if the following criteria are met: 1) Patient must be eighteen (18) years of age or older; **AND** 2) Patient must have had a diagnosis of COPD; **AND** 3) Patient must have had a thirty (30) day trial of a LABA; **AND** 4) Patient must have had a **concurrent thirty (**30) day trial with a long-acting anticholinergic. Prior-authorization will be denied for patients with a sole diagnosis of asthma.
PDE4 INHIBITOR		
	DALIRESP (roflumilast)*	*Daliresp will be authorized if the following criteria are met: 1. Patient is forty (40) years of age or older **and** 2. Diagnosis of severe chronic obstructive pulmonary disease (COPD) associated with chronic bronchitis and multiple exacerbations requiring systemic glucocorticoids in the preceding six (6) months **and** **3.** Concurrent therapy with an inhaled corticosteroid and

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
		long-acting bronchodilator and evidence of compliance **and** **4.** No evidence of moderate to severe liver impairment (Child-Pugh Class B or C) **and** 5. No concurrent use with strong cytochrome P450 inducers (rifampicin, phenobarbital, carbamazepine or phenytoin)
CYTOKINE & CAM ANTAGONISTS[CL]		
CATEGORY PA CRITERIA: Non-preferred agents require ninety (90) day trials of both Humira and Enbrel unless one (1) of the exceptions on the PA form is present. For 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)	* Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.
OTHERS		
COSENTYX (secukinumab)*	ACTEMRA syringe (tocilizumab) KINERET (anakinra) ORENCIA syringe (abatacept) OTEZLA (apremilast) STELARA syringe (ustekinumab) TALTZ (ixekizumab) XELJANZ (tofacitinib) XELJANZ XR (tofacitinib)	*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.
EPINEPHRINE, SELF-INJECTED		
CATEGORY PA CRITERIA: A non-preferred agent will be authorized upon documentation showing the patient's inability to follow the instructions, or the patient's failure to understand the training for both preferred agents.		
epinephrine EPIPEN (epinephrine) EPIPEN JR (epinephrine)	ADRENACLICK (epinephrine) AUVI-Q (epinephrine)	
ERYTHROPOIESIS STIMULATING PROTEINS[CL]		
CATEGORY PA CRITERIA: A 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.		
PROCRIT (rHuEPO)	ARANESP (darbepoetin) EPOGEN (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

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
		reviewed. (Lab oratory values must be dated within six (6) weeks of request.) **and** 2. Transferrin saturation ≥ 20%, ferritin levels ≥100 mg/ml, or on concurrent therapeutic iron therapy. (Laboratory values must be dated within three (3) weeks of request. For re-authorization, transferrin saturation or ferritin levels are not required if the patient has been responsive to the erythropoietin agent **and** 3. For HIV-infected patients, endogenous serum erythropoietin level must be ≤ 500mU/ml to initiate therapy **and** 4. No evidence of untreated GI bleeding, hemolysis, or Vitamin B-12, iron or folate deficiency.
FLUOROQUINOLONES (Oral)[AP]		
CATEGORY PA CRITERIA: A five (5) 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.		
CIPRO SUSPENSION (ciprofloxacin) ciprofloxacin levofloxacin tablet	AVELOX (moxifloxacin) CIPRO TABLETS (ciprofloxacin) CIPRO XR (ciprofloxacin) ciprofloxacin ER ciprofloxacin suspension FACTIVE (gemifloxacin) LEVAQUIN (levofloxacin) levofloxacin solution moxifloxacin NOROXIN (norfloxacin) Ofloxacin	
GLUCOCORTICOIDS, INHALED[AP]		
CATEGORY PA CRITERIA: Thirty (30) day trials of each of the preferred agents are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. A prior authorization will be required for children nine (9) years of age or older, and for individuals unable to use an MDI.		
GLUCOCORTICOIDS		
ASMANEX TWISTHALER (mometasone) FLOVENT HFA (fluticasone) FLOVENT DISKUS (fluticasone) PULMICORT RESPULES (budesonide)* QVAR (beclomethasone)	AEROSPAN (flunisolide)** ALVESCO (ciclesonide) ARNUITY ELLIPTA (fluticasone) ASMANEX HFA (mometasone) budesonide PULMICORT FLEXHALER (budesonide)	* Pulmicort Respules are preferred for children up to nine (9) years of age. * Brand Pulmicort Respules are preferred over the generic formulation. * Pulmicort Respules may be prior authorized in children and adults nine (9) years of age and older for severe nasal polyps.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
		**Aerospan will be authorized for children ages 6 through 11 years old without a trial of a preferred agent.
GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS		
ADVAIR DISKUS (fluticasone/salmeterol) ADVAIR HFA (fluticasone/salmeterol) BREO ELLIPTA (fluticasone/vilanerol) DULERA (mometasone/formoterol) SYMBICORT(budesonide/formoterol)		**Substitute for Category Criteria**: For a diagnosis of COPD, thirty (30) day trials of each of the preferred agents in this category indicated for COPD are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.
GROWTH HORMONE[CL]		
CATEGORY PA CRITERIA: A trial of each preferred agents is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.		
GENOTROPIN (somatropin) NORDITROPIN (somatropin) NUTROPIN AQ (somatropin)	HUMATROPE (somatropin) INCRELEX (mecasermin) OMNITROPE (somatropin) SAIZEN (somatropin) SEROSTIM (somatropin) TEV-TROPIN (somatropin) ZORBTIVE (somatropin)	Patients already on a non-preferred agent will receive authorization to continue therapy on that agent for the duration of the existing PA.
***H. PYLORI* TREATMENT**		
CATEGORY PA CRITERIA: A trial of the preferred agent or individual preferred components of the non-preferred agent (with omeprazole or pantoprazole) at the recommended dosages, frequencies and duration is required before the brand name combination packages will be authorized unless one (1) of the exceptions on the PA form is present.		
Please use individual components: preferred PPI (omeprazole or pantoprazole) amoxicillin tetracycline metronidazole clarithromycin bismuth	HELIDAC (bismuth/metronidazole/tetracycline) lansoprazole/amoxicillin/clarithromycin OMECLAMOX-PAK (omeprazole/amoxicillin/clarithromycin) PREVPAC (lansoprazole/amoxicillin/clarithromycin) PYLERA (bismuth/metronidazole/tetracycline)	
HEPATITIS B TREATMENTS		
CATEGORY PA CRITERIA: A 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.		
BARACLUDE (entecavir) EPIVIR HBV (lamivudine) TYZEKA (telbivudine)	adefovir entecavir HEPSERA (adefovir) lamivudine HBV	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
HEPATITIS C TREATMENTS[CL]		
CATEGORY PA CRITERIA: For patients starting therapy in this class, a trial of the preferred agent of a dosage form is required before a non-preferred agent of that dosage form will be authorized.		
EPCLUSA (SOFOSBUVIR/VELPATASVIR) HARVONI (ledipasvir/sofosbuvir)* PEGASYS (pegylated interferon) PEG-INTRON (pegylated interferon) ribavirin SOVALDI (sofosbuvir)* TECHNIVIE (ombitasvir/paritaprevir/ritonavir)* ZEPATIER (elbasvir/grazoprevir)	COPEGUS (ribavirin) DAKLINZA (daclatasvir)* MODERIBA 400 mg, 600 mg MODERIBA DOSE PACK OLYSIO (simeprevir)* REBETOL (ribavirin) RIBASPHERE RIBAPAK (ribavirin) RIBASPHERE 400 mg, 600 mg (ribavirin) VIEKIRA PAK (dasabuvir/ombitasvir/ paritaprevir/ritonavir)* VIEKIRA XR (dasabuvir/ombitasvir/ paritaprevir/ritonavir)*	* Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.
HYPERPARATHYROID AGENTS[AP]		
CATEGORY PA CRITERIA: A thirty (30) day trial of a preferred agent will be required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.		
HECTOROL (doxercalciferol) paricalcitol capsule	doxercalciferol paricalcitol injection SENSIPAR (cinacalcet) ZEMPLAR (paricalcitol)	
HYPOGLYCEMICS, BIGUANIDES		
CATEGORY PA CRITERIA: A ninety (90) day trial of one (1) preferred agent will be required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.		
metformin metformin ER	FORTAMET (metformin ER) GLUCOPHAGE (metformin) GLUCOPHAGE XR (metformin ER) GLUMETZA (metformin ER) RIOMET (metformin)	Glumetza will be approved only after a 30-day trial of Fortamet.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
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 in its respective class is 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)[AP] BYETTA (exenatide)[AP] VICTOZA (liraglutide)[AP]	SYMLIN (pramlintide)* TANZEUM (albiglutide) TRULICITY (dulaglutide)	*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		
JANUMET (sitagliptin/metformin) [AP] JANUVIA (sitagliptin)[AP] JENTADUETO (linagliptin/metformin) [AP] TRADJENTA (linagliptin) [AP]	JANUMET XR (sitagliptin/metformin) JENTADUETO XR (linagliptin/metformin) 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.
HYPOGLYCEMICS, INSULIN AND RELATED AGENTS		
CATEGORY PA CRITERIA: A ninety (90) day trial of a pharmacokinetically similar 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) LANTUS (insulin glargine) LEVEMIR (insulin detemir) NOVOLOG (insulin aspart) NOVOLOG MIX (insulin aspart/aspart protamine)	AFREZZA (insulin)[CL] APIDRA (insulin glulisine)[AP]* HUMALOG PEN/KWIKPEN (insulin lispro) HUMALOG MIX PENS (insulin lispro/lispro protamine) HUMULIN PENS (insulin) NOVOLIN (insulin) TOUJEO SOLOSTAR (insulin glargine)** TRESIBA (insulin degludec)**	*Apidra will be authorized if the following criteria are met: 1. Patient is four (4) years of age or older; **and** 2. Patient is currently on a regimen including a longer acting or basal insulin, **and** 3. Patient has had a trial of a similar preferred agent, Novolog or Humalog, with documentation that the desired results were not achieved. **Tresiba U-100 will be authorized only for patients with a 6-month history of compliance on preferred long-acting insulin. Tresiba U-200 and Toujeo Solostar will **only** be approved for patients with a 6-month history of compliance on preferred long-acting insulin who require once-daily doses of at least 60 units of insulin.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
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) STARLIX (nateglinide)	
MEGLITINIDE COMBINATIONS		
	PRANDIMET (repaglinide/metformin) repaglinide/metformin	
HYPOGLYCEMICS, BILE ACID SEQUESTRANTS		
CATEGORY PA CRITERIA: Welchol will be authorized for add-on therapy for type 2 diabetes when there is a previous history of a thirty (30) day trial of an oral agent (sulfonylurea, thiazolidinedione (TZD) or metformin).		
WELCHOL (colesevelam)[AP]		
HYPOGLYCEMICS, SGLT2 INHIBITORS		
CATEGORY PA CRITERIA: All agents will be approved in six (6) month intervals if the following criteria are met: **Initial starts** require a diagnosis of Type 2 Diabetes and an A1C taken within the last 60 days reflecting the patient's current and stabilized regimen. Current A1C must be less than or equal to (≤) 10.5%. No agent in this category shall be approved except as add on therapy to a regimen consisting of metformin (unless contraindicated) and at least one other oral agent prescribed at the maximum tolerable doses for at least 60 days. **Re-authorizations** require <u>continued</u> maintenance on a regimen consisting of metformin and at least one other oral agent at the maximum tolerable doses. Documentation must be submitted that the A1C has decreased by at least 1% or is maintained at ≤8%.		
SGLT2 INHIBITORS		
	FARXIGA (dapagliflozin) INVOKANA (canagliflozin) JARDIANCE (empagliflozin)	
SGLT2 COMBINATIONS		
	GLYXAMBI (empagliflozin/linagliptin) INVOKAMET (canagliflozin/metformin) SYNJARDY (empagliflozin/metformin) XIGDUO XR (dapagliflozin/metformin)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
HYPOGLYCEMICS, TZD		
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[AP]	ACTOS (pioglitazone) AVANDIA (rosiglitazone)	
TZD COMBINATIONS		
	ACTOPLUS MET (pioglitazone/ metformin) ACTOPLUS MET XR (pioglitazone/ metformin) AVANDAMET (rosiglitazone/metformin) AVANDARYL (rosiglitazone/glimepiride) DUETACT (pioglitazone/glimepiride) pioglitazone/glimepiride pioglitazone/ metformin	Patients are required to use the components of Actoplus Met and Duetact separately. Exceptions will be handled on a case-by-case basis.
IMMUNE GLOBULINS, IV[CL]		
CATEGORY PA CRITERIA: Immune globulin agents will be authorized according to FDA approved indications.		
BIVIGAM (human immunoglobulin gamma) CARIMUNE NF (human immunoglobulin gamma) FLEBOGAMMA DIF (human immunoglobulin gamma) GAMMAGARD LIQUID (human immunoglobulin gamma) GAMMAGARD S-D (human immunoglobulin gamma) GAMMAKED (human immunoglobulin gamma) GAMMAPLEX (human immunoglobulin gamma) GAMUNEX-C (human immunoglobulin gamma) OCTAGAM (human immunoglobulin gamma) PRIVIGEN (human immunoglobulin gamma)		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
IMMUNE GLOBULINS, OTHER[CL]		
CATEGORY PA CRITERIA: Immune globulin agents will be authorized according to FDA approved indications. A trial of a preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.		
CYTOGAM (human cytomegalovirus immune globulin) GAMASTAN S-D VIAL (human immunoglobulin gamma) HEPAGAM B (hepatitis b immune globulin (human)) HIZENTRA (human immunoglobulin gamma) VARIZIG (varicella zoster immune globulin (human))	HYQVIA (human immune globulin G and hyaluronidase)	
IMMUNOMODULATORS, ATOPIC DERMATITIS[AP]		
CATEGORY PA CRITERIA: A thirty (30) day trial of a preferred medium or high potency topical corticosteroid is required before coverage of Elidel will be considered; additionally, a thirty (30) day trial of Elidel is required before a non-preferred agent will be considered, unless one (1) of the exceptions on the PA form is present.		
ELIDEL (pimecrolimus)[AP]	PROTOPIC (tacrolimus) tacrolimus ointment	A thirty (30) day trial of a preferred medium or high potency topical corticosteroid is required before coverage of Elidel will be considered; additionally, a thirty (30) day trial of Elidel is required before Protopic will be considered, unless one (1) of the exceptions on the PA form is present.
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 0.5% cream fluorouracil 5% cream podofilox SOLARAZE (diclofenac) TOLAK (fluorouracil 4% cream) VEREGEN (sinecatechins) ZYCLARA (imiquimod)*	*Zyclara will be authorized for a diagnosis of actinic keratosis.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
IMMUNOSUPPRESSIVES, ORAL		
CATEGORY PA CRITERIA: A fourteen (14) day trial of a preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.		
azathioprine cyclosporine cyclosporine, modified mycophenolate mofetil RAPAMUNE (sirolimus) sirolimus tacrolimus capsule	ASTAGRAF XL (tacrolimus) AZASAN (azathioprine) CELLCEPT (mycophenolate mofetil) ENVARSUS XR (tacrolimus) IMURAN (azathioprine) mycophenolic acid mycophenolic mofetil suspension MYFORTIC (mycophenolic acid) PROGRAF (tacrolimus) NEORAL (cyclosporine, modified) SANDIMMUNE (cyclosporine) ZORTRESS (everolimus)	
INTRANASAL RHINITIS AGENTS[AP]		
CATEGORY PA CRITERIA: See below for individual sub-class criteria.		
	ANTICHOLINERGICS	
Ipratropium	ATROVENT(ipratropium)	Thirty (30) day trials each of one (1) of the nasal anti-cholinergic, one (1) of the antihistamine, and one (1) of the corticosteroid preferred agents are required before a non-preferred anti-cholinergic will be authorized unless one (1) of the exceptions on the PA form is present.
	ANTIHISTAMINES	
ASTEPRO (azelastine) PATANASE (olopatadine)	azelastine	Thirty (30) day trials of each preferred intranasal antihistamines and a thirty (30) day trial of one (1) of the preferred intranasal corticosteroids are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.
	COMBINATIONS	
	DYMISTA (azelastine / fluticasone)	A concurrent thirty (30) day trial of each of the preferred components is required before Dymista will be authorized unless one (1) of the exceptions on the PA form is present.
	CORTICOSTEROIDS	
fluticasone propionate QNASL HFA (beclomethasone)	BECONASE AQ (beclomethasone) budesonide FLONASE (fluticasone propionate) flunisolide NASACORT AQ (triamcinolone)	Thirty (30) day trials of each preferred agent in the corticosteroid group are required before a non-preferred corticosteroid agent will be authorized unless one (1) of the exceptions on the PA form is present.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	NASONEX (mometasone) OMNARIS (ciclesonide) RHINOCORT AQUA (budesonide) triamcinolone VERAMYST (fluticasone furoate) ZETONNA (ciclesonide)	
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]*	alosetron FULYZAQ (crofelemer)* LOTRONEX (alosetron) MOVANTIK (naloxegol)* RELISTOR (methylnaltrexone)* VIBERZI (eluxadoline)	* Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.
LAXATIVES AND CATHARTICS		
CATEGORY PA CRITERIA: Thirty (30) 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.		
COLYTE GOLYTELY NULYTELY peg 3350	HALFLYTELY-BISACODYL KIT MOVIPREP OSMOPREP PREPOPIK SUPREP	
LEUKOTRIENE MODIFIERS		
CATEGORY PA CRITERIA: Thirty (30) 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.		
ACCOLATE (zafirlukast) montelukast	SINGULAIR (montelukast) zafirlukast ZYFLO (zileuton)	
LIPOTROPICS, OTHER (Non-statins)		
CATEGORY PA CRITERIA: A twelve (12) week trial of one (1) of the preferred agents is required before a non-preferred agent in the corresponding category will be authorized.		
BILE ACID SEQUESTRANTS[AP]		
cholestyramine colestipol tablets	COLESTID (colestipol) colestipol granules KYNAMRO (mipomersen) [CL]*	*Kynamro requires a 24-week trial of Repatha. **Welchol will be authorized for add-on therapy for type 2

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	QUESTRAN (cholestyramine) WELCHOL (colesevelam)**	diabetes when there is a previous history of a thirty (30) day trial of an oral agent (metformin, sulfonylurea or thiazolidinedione (TZD)). See HYPOGLYCEMICS, MISCELLANEOUS.
CHOLESTEROL ABSORPTION INHIBITORS		
ZETIA (ezetimibe) [AP]		Zetia will be authorized with prior use of a HMG-CoA reductase inhibitor within the previous six (6) months.
FATTY ACIDS[AP]		
	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[AP]		
fenofibrate 40 mg fenofibrate 54, 150 and 160 mg fenofibrate micronized 67mg, 134mg & 200mg fenofibrate nanocrystallized 48 mg, 145 mg gemfibrozil	ANTARA (fenofibrate) FENOGLIDE (fenofibrate) FIBRICOR (fenofibric acid) fenofibrate 43, 50, 120 and 130 mg fenofibric acid LIPOFEN (fenofibrate) LOFIBRA (fenofibrate) LOPID (gemfibrozil) TRICOR (fenofibrate nanocrystallized) TRIGLIDE (fenofibrate) TRILIPIX (fenofibric acid)	
MTP INHIBITORS		
	JUXTAPID (lomitapide)*	* Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.
NIACIN		
niacin NIACOR (niacin) NIASPAN (niacin)	niacin ER	
PCSK-9 INHIBITORS		
	PRALUENT (alirocumab)* REPATHA (evolocumab)*	* 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**
LIPOTROPICS, STATINS[AP]		
CATEGORY PA CRITERIA: See below for individual sub-class criteria.		
	STATINS	
atorvastatin CRESTOR (rosuvastatin) lovastatin pravastatin simvastatin[CL]*	ALTOPREV (lovastatin) fluvastatin fluvastatin ER LESCOL (fluvastatin) LESCOL XL (fluvastatin) LIPITOR (atorvastatin) LIVALO (pitavastatin) MEVACOR (lovastatin) PRAVACHOL (pravastatin) ZOCOR (simvastatin)*	Twelve (12) week trials each of two (2) of the preferred statins, including the generic formulation of a requested non-preferred agent, are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. *Zocor/simvastatin 80mg tablets will require a clinical PA
	STATIN COMBINATIONS	
	ADVICOR (lovastatin/niacin) amlodipine/atorvastatin CADUET (atorvastatin/amlodipine) LIPTRUZET (atorvastatin/ezetimibe) SIMCOR (simvastatin/niacin ER) VYTORIN (simvastatin/ezetimibe)*	Thirty (30) day concurrent trials of the appropriate single agents are required before a non-preferred Statin combination will be authorized. *Vytorin will be authorized only after an insufficient response to the maximum tolerable dose of atorvastatin or rosuvastatin after twelve (12) weeks, unless one (1) of the exceptions on the PA form is present. Vytorin 80/10mg tablets will require a clinical PA
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	
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)	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.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	erythromycin estolate PCE (erythromycin) ZITHROMAX (azithromycin) ZMAX (azithromycin)	
MULTIPLE SCLEROSIS AGENTS		
CATEGORY PA CRITERIA: A diagnosis of multiple sclerosis and a thirty (30) day trial of a preferred agent in the corresponding class (interferon or non-interferon) will be required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.		
INTERFERONS[AP]		
AVONEX (interferon beta-1a)[AP] AVONEX PEN (interferon beta-1a)[AP] BETASERON (interferon beta-1b)[AP]	EXTAVIA KIT (interferon beta-1b) EXTAVIA VIAL (interferon beta-1b) PLEGRIDY (peginterferon beta-1a) REBIF (interferon beta-1a) REBIF REBIDOSE (interferon beta-1a)	
NON-INTERFERONS		
COPAXONE 20 mg (glatiramer)[AP] GILENYA (fingolimod) [AP*]	AMPYRA (dalfampridine)[CL**] AUBAGIO (teriflunomide)[CL***] COPAXONE 40 mg (glatiramer)[CL****] GLATOPA (glatiramer) TECFIDERA (dimethyl fumarate)[CL*****] ZINBRYTA (daclizumab)	**In addition to category PA criteria, the following conditions and criteria also apply:** *Gilenya will be approved after a thirty (30) day trial of a preferred injectable agent. **Ampyra will be authorized if the following criteria are met: 1. Diagnosis of multiple sclerosis **and** 2. No history of seizures **and** 3. No evidence of moderate or severe renal impairment **and** 4. Initial prescription will be authorized for thirty (30) days only. ***Aubagio will be authorized if the following criteria are met: 1. Diagnosis of relapsing multiple sclerosis **and** 2. Measurement of transaminase and bilirubin levels within the (6) months before initiation of therapy and ALT levels at least monthly for six (6) months after initiation of therapy **and** 3. Complete blood cell count (CBC) within six (6) months before initiation of therapy **and** 4. Female patients must have a negative pregnancy test before initiation of therapy and be established on a reliable method of contraception if appropriate **and** 5. Patient is from eighteen (18) up to sixty-five (65) years of

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
		age **and** 6. Negative tuberculin skin test before initiation of therapy ****Copaxone 40mg will only be authorized for documented injection site issues. *****Tecfidera will be authorized if the following criteria are met: 1. Diagnosis of relapsing multiple sclerosis **and** 2. A thirty (30) day trial of a preferred agent in the corresponding class **and** 3. Complete blood count (CBC) within six (6) months of initiation of therapy and six (6) months after initiation **and** 4. Complete blood count (CBC) annually during therapy.
NEUROPATHIC PAIN		
CATEGORY PA CRITERIA: A trial of a preferred agent in the corresponding dosage form (oral or topical) will be required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.		
capsaicin OTC duloxetine gabapentin capsules, solution LIDODERM (lidocaine)[AP]*	CYMBALTA (duloxetine) gabapentin tablets GRALISE (gabapentin)** HORIZANT (gabapentin) IRENKA (duloxetine) lidocaine patch LYRICA CAPSULE (pregabalin)*** LYRICA SOLUTION (pregabalin)*** NEURONTIN (gabapentin) QUTENZA (capsaicin) SAVELLA (milnacipran)**** ZOSTRIX OTC (capsaicin)	*Lidoderm patches will be authorized for a diagnosis of post-herpetic neuralgia. **Gralise will be authorized if the following criteria are met: 1. Diagnosis of post herpetic neuralgia **and** 2. Trial of a tricyclic antidepressant for a least thirty (30) days **and** 3. Trial of gabapentin immediate release formulation (positive response without adequate duration) **and** 4. Request is for once daily dosing with 1800 mg maximum daily dosage. ***Lyrica will be authorized if the following criteria are met: 1. Diagnosis of seizure disorders or neuropathic pain associated with a spinal cord injury **or** 2. Diagnosis of fibromyalgia, postherpetic neuralgia, or diabetic neuropathy AND a history of a trial of duloxetine at the generally accepted maximum therapeutic dose of 60 mg/day OR gabapentin at a therapeutic dose range between 900 mg and 2,400 mg per day for thirty (30) days within the previous twenty-four (24) month period or an intolerance due to a potential adverse drug-drug interaction, drug-disease interaction, or intolerable side effect (In cases of renal impairment, doses may be

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
		adjusted based on the degree of impairment.) ****Savella will be authorized for a diagnosis of fibromyalgia or a previous thirty (30) day trial of a drug that infers fibromyalgia: duloxetine, gabapentin, amitriptyline or nortriptyline.
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 meloxicam tablet MOBIC SUSPENSION (meloxicam) 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 meloxicam suspension MOBIC TABLET (meloxicam) MOTRIN (ibuprofen) NALFON (fenoprofen) NAPRELAN (naproxen) NAPROSYN (naproxen) naproxen CR oxaprozin PONSTEL (meclofenamate) SPRIX (ketorolac) TIVORBEX (indomethacin) Tolmetin VIVLODEX (meloxicam) VOLTAREN (diclofenac) ZIPSOR (diclofenac potassium) ZORVOLEX (diclofenac)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	NSAID/GI PROTECTANT COMBINATIONS	
	ARTHROTEC (diclofenac/misoprostol) diclofenac/misoprostol VIMOVO (naproxen/esomeprazole)	
	COX-II SELECTIVE	
	CELEBREX (celecoxib) celecoxib	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 gel 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.
OPHTHALMIC ANTIBIOTICS[AP]		
CATEGORY PA CRITERIA: Three (3) day trials of each of the preferred agents are required before non-preferred agents will be authorized unless one (1) of the exceptions on the PA form is present.		
bacitracin/polymyxin ointment BESIVANCE (besifloxacin) ciprofloxacin* erythromycin gentamicin MOXEZA (moxifloxacin)*	AZASITE (azithromycin) bacitracin BLEPH-10 (sulfacetamide) CILOXAN (ciprofloxacin) GARAMYCIN (gentamicin) gatifloxacin	The American Academy of Ophthalmology guidelines on treating bacterial conjunctivitis recommend as first line treatment options: erythromycin ointment, sulfacetamide drops, or polymyxin/trimethoprim drops. *A prior authorization is required for the fluoroquinolone agents

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ofloxacin* polymyxin/trimethoprim tobramycin VIGAMOX (moxifloxacin)*	ILOTYCIN (erythromycin) levofloxacin NATACYN (natamycin) neomycin/bacitracin/polymyxin neomycin/polymyxin/gramicidin NEOSPORIN (neomycin/polymyxin/gramicidin) OCUFLOX (ofloxacin) POLYTRIM (polymyxin/trimethoprim) sulfacetamide drops sulfacetamide ointment TOBREX (tobramycin) ZYMAR (gatifloxacin) ZYMAXID (gatifloxacin)	for patients up to twenty-one (21) years of age unless there has been a trial of a first line treatment option within the past ten (10) days.
OPHTHALMIC ANTIBIOTIC/STEROID COMBINATIONS[AP]		
CATEGORY PA CRITERIA: Three (3) day trials of each of the preferred agents are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.		
BLEPHAMIDE (prednisolone/sulfacetamide) neomycin/polymyxin/dexamethasone sulfacetamide/prednisolone TOBRADEX OINTMENT (tobramycin/ dexamethasone) TOBRADEX ST (tobramycin/ dexamethasone) TOBRADEX SUSPENSION (tobramycin/ dexamethasone)	BLEPHAMIDE S.O.P. (prednisolone/ sulfacetamide) MAXITROL ointment (neomycin/polymyxin/ dexamethasone) MAXITROL suspension (neomycin/polymyxin/ dexamethasone) neomycin/bacitracin/polymyxin/ hydrocortisone neomycin/polymyxin/hydrocortisone PRED-G (prednisolone/gentamicin) tobramycin/dexamethasone suspension ZYLET (loteprednol/tobramycin)	
OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS[AP]		
CATEGORY PA CRITERIA: Thirty (30) day trials of each of three (3) of the preferred agents are required before a non-preferred agent will be authorized, unless one (1) of the exceptions on the PA form is present.		
ALAWAY (ketotifen) cromolyn ketotifen PAZEO (olopatadine) ZADITOR OTC (ketotifen) ZYRTEC ITCHY EYE (ketotifen)	ALAMAST (pemirolast) ALOCRIL (nedocromil) ALOMIDE (lodoxamide) ALREX (loteprednol) azelastine BEPREVE (bepotastine) CROLOM (cromolyn) ELESTAT (epinastine) EMADINE (emedastine)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	epinastine LASTACAFT (alcaftadine) OPTICROM (cromolyn) OPTIVAR (azelastine) PATADAY (olopatadine) PATANOL (olopatadine)	
OPHTHALMICS, ANTI-INFLAMMATORIES- IMMUNOMODULATORS		
CATEGORY PA CRITERIA: See below for individual sub-class criteria.		
	RESTASIS (cyclosporine) XIIDRA (lifitegrast)	Restasis will be authorized if the following criteria are met: 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
OPHTHALMIC ANTI-INFLAMMATORIES[AP]		
CATEGORY PA CRITERIA: Five (5) day trials of each of the preferred agents are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.		
dexamethasone diclofenac DUREZOL (difluprednate) fluorometholone flurbiprofen ketorolac prednisolone acetate prednisolone sodium phosphate	ACULAR (ketorolac) ACULAR LS (ketorolac) ACUVAIL (ketorolac tromethamine) BROMDAY (bromfenac) bromfenac FLAREX (fluorometholone) FML (fluorometholone) FML FORTE (fluorometholone) FML S.O.P. (fluorometholone) ILEVRO (nepafenac) LOTEMAX DROPS, OINTMENT (loteprednol) LOTEMAX GEL (loteprednol) MAXIDEX (dexamethasone) NEVANAC (nepafenac) OMNIPRED (prednisolone)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	OZURDEX (dexamethasone) PRED FORTE (prednisolone) PRED MILD (prednisolone) PROLENSA (bromfenac) RETISERT (fluocinolone) TRIESENCE (triamcinolone) VEXOL (rimexolone) XIBROM (bromfenac)	
OPHTHALMICS, GLAUCOMA AGENTS		
CATEGORY PA CRITERIA: A non-preferred agent will only be authorized if there is an allergy to the preferred agents.		
COMBINATION AGENTS		
COMBIGAN (brimonidine/timolol) dorzolamide/timolol SIMBRINZA (brinzolamide/brimonidine)	COSOPT (dorzolamide/timolol) COSOPT PF (dorzolamide/timolol)	
BETA BLOCKERS		
BETOPTIC S (betaxolol) carteolol levobunolol metipranolol timolol drops	BETAGAN (levobunolol) betaxolol BETIMOL (timolol) ISTALOL (timolol) OPTIPRANOLOL (metipranolol) timolol gel TIMOPTIC (timolol)	
CARBONIC ANHYDRASE INHIBITORS		
AZOPT (brinzolamide) dorzolamide	TRUSOPT (dorzolamide)	
PARASYMPATHOMIMETICS		
PHOSPHOLINE IODIDE (echothiophate iodide)	pilocarpine	
PROSTAGLANDIN ANALOGS		
latanoprost TRAVATAN-Z (travoprost)	bimatoprost LUMIGAN (bimatoprost) RESCULA (unoprostone) travoprost XALATAN (latanoprost) ZIOPTAN (tafluprost)	
SYMPATHOMIMETICS		
brimonidine 0.2%	ALPHAGAN P 0.1% Solution (brimonidine) ALPHAGAN P 0.15% Solution (brimonidine) apraclonidine brimonidine 0.15% IOPIDINE (apraclonidine)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
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.		
naloxone NARCAN NASAL SPRAY (naloxone) SUBOXONE FILM (buprenorphine/naloxone)[CL]* VIVITROL (naltrexone) [CL]*	buprenorphine tablets buprenorphine/naloxone tablets BUNAVAIL (buprenorphine/naloxone) EVZIO (naloxone)* PROBUPHINE IMPLANT (buprenorphine)[NR] ZUBSOLV (buprenorphine/naloxone)	* Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.
OTIC ANTIBIOTICS[AP]		
CATEGORY PA CRITERIA: Five (5) day trials of each of the preferred agents are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.		
CIPRO HC (ciprofloxacin/hydrocortisone) CIPRODEX (ciprofloxacin/dexamethasone) ciprofloxacin COLY-MYCIN S (colistin/hydrocortisone/ neomycin/thonzonium bromide) neomycin/polymyxin/HC solution/suspension	CORTISPORIN-TC (colistin/hydrocortisone/ neomycin) ofloxacin OTOVEL (ciprofloxacin/fluocinolone)	
PAH AGENTS – ENDOTHELIN RECEPTOR ANTAGONISTS[CL]		
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.		
LETAIRIS (ambrisentan) TRACLEER (bosentan)	OPSUMIT (macitentan)	Letairis and Tracleer will be authorized for a diagnosis of pulmonary arterial hypertension (PAH).
PAH AGENTS – GUANYLATE CYCLASE STIMULATOR[CL]		
CATEGORY PA CRITERIA: A thirty (30) day trial of a preferred PAH agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.		
	ADEMPAS (riociguat)	
PAH AGENTS – PDE5s[CL]		
CATEGORY PA CRITERIA: A 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. Patients stabilized on non-preferred agents will be grandfathered.		
sildenafil	ADCIRCA (tadalafil) REVATIO IV (sildenafil) REVATIO SUSPENSION (sildenafil) REVATIO TABLETS (sildenafil)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
PAH AGENTS – PROSTACYCLINS[CL]		
CATEGORY PA CRITERIA: A thirty (30) day trial of a preferred agent, including the preferred generic form of the non-preferred agent, is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.		
epoprostenol VENTAVIS (iloprost)*	FLOLAN (epoprostenol) ORENITRAM ER (treprostinil) REMODULIN (treprostinil sodium) TYVASO (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]		
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. Non-preferred agents will be authorized for members with cystic fibrosis.		
CREON ZENPEP	PANCREAZE PERTZYE ULTRESA VIOKACE	
PHOSPHATE BINDERS[AP]		
CATEGORY PA CRITERIA: Thirty (30) day trials of at least two (2) preferred agents are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.		
calcium acetate MAGNEBIND RX (calcium carbonate, folic acid, magnesium carbonate) PHOSLYRA (calcium acetate) RENAGEL (sevelamer)	AURYXIA (ferric citrate) ELIPHOS (calcium acetate) FOSRENOL (lanthanum) PHOSLO (calcium acetate) RENVELA (sevelamer carbonate) sevelamer carbonate VELPHORO (sucroferric oxyhydroxide)	
PLATELET AGGREGATION INHIBITORS		
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.		
AGGRENOX (dipyridamole/ASA) BRILINTA (ticagrelor) clopidogrel EFFIENT (prasugrel)	dipyridamole dipyridamole/aspirin DURLAZA ER (aspirin) PERSANTINE (dipyridamole) PLAVIX (clopidogrel) TICLID (ticlopidine) ticlopidine ZONTIVITY (vorapaxar)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
PROGESTINS FOR CACHEXIA		
CATEGORY PA CRITERIA: A 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.		
megestrol	MEGACE (megestrol) MEGACE ES (megestrol)	
PROTON PUMP INHIBITORS[AP]		
CATEGORY PA CRITERIA: Sixty (60) day trials of each of 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 are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present		
omeprazole (Rx) pantoprazole PREVACID SOLUTABS (lansoprazole)**	ACIPHEX (rabeprazole) ACIPHEX SPRINKLE (rabeprazole) DEXILANT (dexlansoprazole) esomeprazole strontium lansoprazole Rx NEXIUM (esomeprazole) omeprazole/sodium bicarbonate (Rx) PREVACID CAPSULES (lansoprazole) PRILOSEC Rx (omeprazole) PROTONIX (pantoprazole) rabeprazole ZEGERID Rx (omeprazole/sodium bicarbonate)	* Maximum recommended doses of the PPIs and H2-receptor antagonists may be located at the BMS Pharmacy PA criteria page titled "Max PPI and H2RA" by clicking on the hyperlink. **Prior authorization is required for Prevacid Solutabs for members nine (9) years of age or older.
SEDATIVE HYPNOTICS[AP]		
CATEGORY PA CRITERIA: Thirty (30) day trials of the preferred agents in both categories are required before any non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. All agents in this class will be limited to fifteen (15) tablets in a thirty (30) day period.		
BENZODIAZEPINES		
temazepam 15, 30 mg	DALMANE (flurazepam) DORAL (quazepam) estazolam flurazepam HALCION (triazolam) quazepam RESTORIL (temazepam) temazepam 7.5, 22.5 mg triazolam	
OTHERS		
zolpidem 5, 10 mg	AMBIEN (zolpidem) AMBIEN CR (zolpidem) BELSOMRA (suvorexant)	Strengths of zolpidem that are non-preferred (6.25 and 12.5 mg) must be created by combining or splitting the preferred doses (5 and 10 mg) of zolpidem, if appropriate.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	chloral hydrate EDLUAR (zolpidem) eszopiclone INTERMEZZO (zolpidem) LUNESTA (eszopiclone) ROZEREM (ramelteon) SILENOR (doxepin) SOMNOTE (chloral hydrate) SONATA (zaleplon) zaleplon zolpidem ER 6.25, 12.5 mg ZOLPIMIST (zolpidem)	For treatment naïve female patients, zolpidem and zolpidem ER maximum dosages will be limited to 5 mg and 6.25 mg respectively per day.
SKELETAL MUSCLE RELAXANTS[AP]		
CATEGORY PA CRITERIA: See below for individual sub-class criteria.		
ACUTE MUSCULOSKELETAL RELAXANT AGENTS		
chlorzoxazone cyclobenzaprine IR 5, 10 mg methocarbamol	AMRIX (cyclobenzaprine) carisoprodol carisoprodol/ASA carisoprodol/ASA/codeine cyclobenzaprine ER cyclobenzaprine IR 7.5 mg FEXMID (cyclobenzaprine) FLEXERIL (cyclobenzaprine) LORZONE (chlorzoxazone) metaxalone orphenadrine orphenadrine/ASA/caffeine orphenadrine ER PARAFON FORTE (chlorzoxazone) ROBAXIN (methocarbamol) SKELAXIN (metaxalone) SOMA (carisoprodol)	Thirty (30) day trials of each of the preferred acute musculoskeletal relaxants are required before a non-preferred acute musculoskeletal agent will be authorized, with the exception of carisoprodol. Thirty (30) day trials of each of the preferred acute musculoskeletal relaxants and Skelaxin are required before carisoprodol will be authorized.
MUSCULOSKELETAL RELAXANT AGENTS USED FOR SPASTICITY		
baclofen tizanidine tablets	DANTRIUM (dantrolene) dantrolene tizanidine capsules ZANAFLEX (tizanidine)	Thirty (30) day trials of both preferred skeletal muscle relaxants associated with the treatment of spasticity are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
STEROIDS, TOPICAL		
CATEGORY PA CRITERIA: Five (5) day trials of one (1) form of each preferred unique active ingredient in the corresponding potency group are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.		
	VERY HIGH & HIGH POTENCY	
betamethasone dipropionate cream betamethasone valerate cream clobetasol propionate cream/gel/ointment/solution clobetasol emollient fluocinonide cream, gel, solution fluocinonide/emollient halobetasol propionate triamcinolone acetonide cream, ointment	amcinonide APEXICON (diflorasone diacetate) APEXICON E (diflorasone diacetate) betamethasone dipropionate gel, lotion, ointment betamethasone valerate lotion, ointment, clobetasol lotion, shampoo clobetasol propionate foam CLOBEX (clobetasol propionate) CLODAN (clobetasol propionate) CORMAX (clobetasol propionate) desoximetasone cream/gel/ointment diflorasone diacetate DIPROLENE (betamethasone dipropionate/propylene glycol) DIPROLENE AF (betamethasone dipropionate/propylene glycol) DIPROSONE (betamethasone dipropionate) fluocinonide ointment halcinonide HALAC (halobetasol propionate) HALOG (halcinonide) HALONATE (halobetasol propionate) KENALOG (triamcinolone acetonide) LIDEX (fluocinonide) LIDEX-E (fluocinonide) OLUX (clobetasol propionate) OLUX-E (clobetasol propionate/emollient) PSORCON (diflorasone diacetate) SERNIVO SPRAY (betamethasone dipropionate) TEMOVATE (clobetasol propionate) TEMOVATE-E (clobetasol propionate/emollient) TOPICORT CREAM, GEL, OINTMENT (desoximetasone) TOPICORT SPRAY (desoximetasone) triamcinolone acetonide lotion	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	ULTRAVATE (halobetasol propionate) ULTRAVATE PAC cream ULTRAVATE X (halobetasol propionate / lactic acid) VANOS (fluocinonide)	
	MEDIUM POTENCY	
fluticasone propionate cream, ointment hydrocortisone butyrate ointment, solution hydrocortisone valerate mometasone furoate triamcinolone acetonide 0.025% and 0.1% cream	ARISTOCORT (triamcinolone) BETA-VAL (betamethasone valerate) betamethasone valerate foam CLODERM (clocortolone pivalate) clocortolone cream CORDRAN/CORDRAN SP (flurandrenolide) CUTIVATE (fluticasone propionate) DERMATOP (prednicarbate) ELOCON (mometasone furoate) fluocinolone acetonide cream, ointment, solution fluticasone propionate lotion hydrocortisone butyrate cream LOCOID (hydrocortisone butyrate) LOCOID LIPOCREAM (hydrocortisone butyrate/emollient) LUXIQ (betamethasone valerate) MOMEXIN (mometasone) PANDEL (hydrocortisone probutate) prednicarbate TOPICORT LP (desoximetasone) TRIDERM (triamcinolone acetonide) WESTCORT (hydrocortisone valerate)	
	LOW POTENCY	
desonide cream, ointment hydrocortisone acetate (Rx, OTC) hydrocortisone cream (Rx, OTC) hydrocortisone lotion OTC hydrocortisone ointment (Rx, OTC) hydrocortisone solution OTC hydrocortisone-aloe cream OTC hydrocortisone-aloe ointment OTC	ACLOVATE (alclometasone dipropionate) alclometasone dipropionate AQUA GLYCOLIC HC (hydrocortisone) CAPEX (fluocinolone acetonide) DERMA-SMOOTHE FS (fluocinolone acetonide) DESONATE (desonide) desonide lotion DESOWEN (desonide) fluocinolone oil hydrocortisone/mineral oil/petrolatum hydrocortisone acetate/urea hydrocortisone lotion	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	hydrocortisone/aloe gel LOKARA (desonide) PEDIADERM HC (hydrocortisone) PEDIADERM TA (hydrocortisone) SCALPICIN OTC (hydrocortisone) SYNALAR (fluocinolone) TEXACORT (hydrocortisone) VERDESO (desonide)	
STIMULANTS AND RELATED AGENTS		
CATEGORY PA CRITERIA: A PA is required for adults eighteen (18) years of age or older. A thirty (30) day trial of one of the preferred agents in each group (amphetamines and non-amphetamines) is required before a non-preferred agent will be authorized. In addition, a thirty (30) day trial of a long-acting preferred agent in each class is required before a non-preferred long-acting stimulant will be authorized. Patients stabilized on non-preferred agents will be grandfathered.		
AMPHETAMINES		
ADZENYS XR ODT (dextroamphetamine/amphetamine) amphetamine salt combination IR dextroamphetamine ER dextroamphetamine IR PROCENTRA solution (dextroamphetamine) VYVANSE (lisdexamfetamine)	ADDERALL (amphetamine salt combination) ADDERALL XR* (amphetamine salt combination) amphetamine salt combination ER DESOXYN (methamphetamine) DEXEDRINE ER (dextroamphetamine) DEXEDRINE IR (dextroamphetamine) dextroamphetamine solution DYANAVEL XR (dextroamphetamine/amphetamine) EVEKEO (amphetamine) methamphetamine ZENZEDI (dextroamphetamine)	**In addition to the Category Criteria**: Thirty (30) day trials of at least three (3) antidepressants are required before amphetamines will be authorized for depression. *Adderall XR is preferred over its generic equivalents.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	NON-AMPHETAMINE	
clonidine IR DAYTRANA (methylphenidate) dexmethylphenidate IR FOCALIN XR (dexmethylphenidate) guanfacine ER** guanfacine IR METADATE CD (methylphenidate) METHYLIN SOLUTION (methylphenidate) methylphenidate IR QUILLICHEW ER (methylphenidate) QUILLIVANT XR (methylphenidate) STRATTERA (atomoxetine)*	APTENSIO XR (methylphenidate) armodafinil clonidine ER CONCERTA (methylphenidate) dexmethylphenidate XR FOCALIN IR (dexmethylphenidate) INTUNIV (guanfacine extended-release) KAPVAY (clonidine extended-release)** METHYLIN CHEWABLE TABLETS (methylphenidate) methylphenidate chewable tablets, solution methylphenidate CD methylphenidate ER (generic CONCERTA) methylphenidate ER methylphenidate LA modafinil*** NUVIGIL (armodafinil) *** PROVIGIL (modafinil) *** RITALIN (methylphenidate) RITALIN LA (methylphenidate)	*Strattera does not required a PA for adults eighteen (18) years of age or older. Strattera will not be authorized for concurrent administration with amphetamines or methylphenidates, except for thirty (30) days or less for tapering purposes. Strattera is limited to a maximum of 100 mg per day. **Guanfacine ER and Kapvay/clonidine ER will be authorized if the following criteria are met: 1. Fourteen (14) day trials of at least one (1) preferred product from the amphetamine and non-amphetamine class **and** 2. A fourteen (14) day trial of clonidine IR (for Kapvay) and guanfacine IR (for guanfacine ER) unless one (1) of the exceptions on the PA form is present**.** In cases of a diagnosis of Tourette's syndrome, tics, autism or disorders included in the autism spectrum, only a fourteen (14) day trial of clonidine (for Kapvay) will be required for approval. ***Provigil is preferred over its generic equivalent and Nuvigil. These drugs will only be authorized for patients sixteen (16) years of age or older with a diagnosis of narcolepsy.
TETRACYCLINES		
CATEGORY PA CRITERIA: A ten (10) day trial of each of the preferred agents is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.		
doxycycline hyclate capsules, tablets doxycycline monohydrate 50, 100 mg capsules minocycline capsules tetracycline	ADOXA (doxycycline monohydrate) demeclocycline* DORYX (doxycycline hyclate) doxycycline hyclate tablet DR doxycycline monohydrate 40, 75, 150 mg capsule doxycycline monohydrate tablet doxycycline monohydrate suspension DYNACIN (minocycline) MINOCIN (minocycline) minocycline ER capsules minocycline tablets MONODOX (doxycycline monohydrate) MORGIDOX KIT (doxycycline)	*Demeclocycline will be authorized for conditions caused by susceptible strains of organisms designated in the product information supplied by the manufacturer. A C&S report must accompany this request. Demeclocycline will also be authorized for SIADH.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	ORACEA (doxycycline monohydrate) SOLODYN (minocycline) VIBRAMYCIN CAPSULES, SUSPENSION, SYRUP (doxycycline)	
ULCERATIVE COLITIS AGENTS[AP]		
CATEGORY PA CRITERIA: Thirty (30) day trials of each of the preferred dosage form or chemical entity must be tried before the corresponding non-preferred agent of that dosage form or chemical entity will be authorized unless one (1) of the exceptions on the PA form is present.		
ORAL		
APRISO (mesalamine) balsalazide DELZICOL (mesalamine) PENTASA (mesalamine) 250 mg sulfasalazine	ASACOL HD (mesalamine) AZULFIDINE (sulfasalazine) COLAZAL (balsalazide) DIPENTUM (olsalazine) GIAZO (balsalazide) LIALDA (mesalamine) PENTASA (mesalamine) 500 mg UCERIS (budesonide)	
RECTAL		
CANASA (mesalamine)	DELZICOL DR (mesalamine) mesalamine mesalamine kit ROWASA (mesalamine) SF ROWASA (mesalamine) UCERIS (budesonide)	
VASODILATORS, CORONARY		
CATEGORY PA CRITERIA: A thirty (30) day trial of each preferred dosage form will be required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.		
SUBLINGUAL NITROGLYCERIN		
nitroglycerin sublingual NITROLINGUAL SPRAY (nitroglycerin) NITROSTAT SUBLINGUAL (nitroglycerin)	nitroglycerin spray NITROMIST (nitroglycerin)	