- Prior authorization for a non-preferred agent in any class 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.
- Quantity limits may apply. Refer to the Limits List on the BMS Website by clicking the hyperlink.
- Unless otherwise indicated, non-preferred combination products require medical reasoning beyond convenience or enhanced compliance as to why the clinical need cannot be met with a preferred agent or combination of preferred single-ingredient agents.
- Acronyms
  - CL - Requires clinical PA. For detailed clinical criteria, please go to the PA criteria page by clicking the hyperlink.
  - NR – Denotes a new drug which has not yet been reviewed by the P & T Committee. **These agents are available only on appeal to the BMS Medical Director.**
  - AP - Non-preferred and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA criteria column.

| CLASSES CHANGING | Status Changes | PA Criteria Changes | New Drugs |
|---|---|---|---|
| ACNE, RETINOIDS | | | XXXX |
| ANTICONVULSANTS, BENZODIAZEPINES | | | XXXX |
| ANTIMIGRAINE, TRIPTANS | | XXXX | XXXX |
| ANTIPARKINSON'S AGENTS | | | XXXX |
| BRONCHODILATORS, BETA AGONISTS | | | XXXX |
| CALCIUM CHANNEL BLOCKERS | | XXXX | XXXX |
| COPD AGENTS, ANTICHOLINERGIC-BETA AGONIST COMBINATIONS | | XXXX | XXXX |
| CYTOKINE & CAM ANTAGONISTS | | | XXXX |
| HYPOGLYCEMICS, GLP-1 AGONISTS | XXXX | XXXX | XXXX |
| HYPOGLYCEMICS, SGLT2 INHIBITORS | | XXXX | |
| LIPOTROPICS, STATINS | | XXXX | XXXX |
| MABS, ANTI-IL/IgE | | XXXX | XXXX |
| NEUROPATHIC PAIN AGENTS | | XXXX | XXXX |
| NSAIDs | | | XXXX |
| STEROIDS, TOPICAL - MEDIUM POTENCY | | | XXXX |
| STEROIDS, TOPICAL - HIGH/VERY HIGH POTENCY | | | XXXX |
| STIMULANTS & RELATED AGENTS – AMPHETAMINES | | | XXXX |
| STIMULANTS & RELATED AGENTS – NON-AMPHETAMINES | | | XXXX |
| STIMULANTS – NARCOLEPTIC AGENTS | | XXXX | XXXX |
| TETRACYCLINES | | | XXXX |
| | | | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **ACNE AGENTS, TOPICAL[AP]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a thirty (30) day trial of one (1) preferred retinoid and two (2) unique chemical entities in two (2) other subclasses, including the generic version of the requested non-preferred product, before they will be approved, unless one (1) of the exceptions on the PA form is present.<br><br>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.<br>Acne kits are non-preferred.<br><br>**Specific Criteria for sub-class will be listed below.** NOTE: Non-preferred agents in the Rosacea sub-class are available only on appeal and require at least a 30-day trial of all preferred agents in that sub-class. | | |
| **ANTI-INFECTIVE** | | |
| clindamycin gel, lotion, medicated swab, solution<br>ERYGEL (erythromycin)<br>erythromycin gel, solution | ACZONE (dapsone)<br>AKNE-MYCIN (erythromycin)<br>AZELEX (azelaic acid)<br>CLEOCIN-T (clindamycin)<br>CLINDACIN PAC (clindamycin)<br>CLINDAGEL (clindamycin)<br>clindamycin foam<br>erythromycin medicated swab<br>EVOCLIN (clindamycin)<br>FABIOR (tazarotene)<br>KLARON (sulfacetamide)<br>OVACE/PLUS (sulfacetamide)<br>sodium sulfacetamide 10% cleansing gel<br>sulfacetamide cleanser<br>sulfacetamide cleanser ER<br>sulfacetamide shampoo<br>sulfacetamide suspension | |
| **RETINOIDS** | | |
| TAZORAC (tazarotene)<br>tretinoin cream, gel | adapalene<br>AKLIEF CREAM (trifarotene)<br>ALTRENO LOTION (tretinoin)<br>ATRALIN (tretinoin)<br>AVITA (tretinoin)<br>DIFFERIN (adapalene)<br>PLIXDA SOLUTION (adapalene)<br>RETIN-A (tretinoin)<br>RETIN-A MICRO (tretinoin)<br>tazarotene cream<br>tretinoin gel micro | **In addition to the Class Criteria**: PA required for members eighteen (18) years of age or older. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | **KERATOLYTICS** | |
| benzoyl peroxide cleanser Rx & OTC, 10% cream OTC, gel Rx & OTC, lotion OTC, wash OTC<br>PANOXYL-4 OTC (benzoyl peroxide) | BENZEFOAM ULTRA (benzoyl peroxide)<br>BP 10-1 (benzoyl peroxide)<br>PANOXYL-8 OTC (benzoyl peroxide)<br>SULPHO-LAC (sulfur) | |
| | **COMBINATION AGENTS** | |
| benzoyl peroxide/clindamycin gel (generic DUAC only)<br>EPIDUO (adapalene/benzoyl peroxide)*<br>EPIDUO FORTE (adapalene/benzoyl peroxide)*<br>erythromycin/benzoyl peroxide | ACANYA (clindamycin phosphate/benzoyl peroxide)<br>AVAR/-E/LS (sulfur/sulfacetamide)<br>BENZACLIN GEL (benzoyl peroxide/ clindamycin)<br>BENZAMYCIN PAK (benzoyl peroxide/ erythromycin)<br>benzoyl peroxide/clindamycin gel (all generics other than DUAC)<br>benzoyl peroxide/urea<br>CERISA (sulfacetamide sodium/sulfur)<br>CLARIFOAM EF (sulfacetamide/sulfur)<br>CLENIA (sulfacetamide sodium/sulfur)<br>DUAC (benzoyl peroxide/clindamycin)<br>NEUAC (clindamycin phosphate/benzoyl peroxide)<br>ONEXTON (clindamycin phosphate/benzoyl peroxide)<br>PRASCION (sulfacetamide sodium/sulfur)<br>SE 10-5 SS (sulfacetamide/sulfur)<br>SSS 10-4 (sulfacetamide /sulfur)<br>SSS 10-5 foam (sulfacetamide /sulfur)<br>sulfacetamide sodium/sulfur cloths, lotion, pads, suspension<br>sulfacetamide/sulfur wash/cleanser<br>sulfacetamide/sulfur wash kit<br>sulfacetamide sodium/sulfur/ urea<br>SUMADAN/XLT (sulfacetamide/sulfur)<br>SUMAXIN/TS (sulfacetamide sodium/sulfur)<br>VELTIN (clindamycin/tretinoin)*<br>ZIANA (clindamycin/tretinoin)* | **In addition to the Class Criteria:** Non-preferred combination agents require thirty (30) day trials of the corresponding preferred single agents before they will be approved.<br><br>*PA required for combination agents with Retinoid products for members eighteen (18) years of age or older. |
| | **ROSACEA AGENTS** | |
| FINACEA GEL (azelaic acid)<br>MIRVASO GEL (brimonidine)<br>metronidazole cream | FINACEA FOAM (azelaic acid)<br>METROCREAM (metronidazole)<br>METROGEL GEL (metronidazole) | **Subclass criteria**: Non-preferred agents are available only on appeal and require evidence of 30-day trials of all chemically-unique preferred agents in the sub-class. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| metronidazole gel 0.75% (NDCs 00115-1474-46, 00168-0275-45, 51672-4116-06, 66993-0962-45 only) | METROLOTION (metronidazole)<br>metronidazole lotion<br>metronidazole gel (all other NDCs)<br>NORITATE CREAM (metronidazole)<br>RHOFADE (oxymetazoline)<br>ROSADAN (metronidazole)<br>SOOLANTRA CREAM (ivermectin) | |
| **ALZHEIMER'S AGENTS[AP]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a thirty (30) day trial of a preferred agent in the same sub-class before they will be approved, unless one (1) of the exceptions on the PA form is present.<br><br>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<br>donepezil ODT | ARICEPT (donepezil)<br>donepezil 23 mg*<br>EXELON CAPSULE (rivastigmine)<br>EXELON PATCH (rivastigmine)<br>galantamine<br>galantamine ER<br>RAZADYNE (galantamine)<br>RAZADYNE ER (galantamine)<br>rivastigmine | *Donepezil 23 mg tablets will be authorized if the following criteria are met:<br>1. There is a diagnosis of moderate-to-severe Alzheimer's Disease **and**<br>2. There has been a trial of donepezil 10 mg daily for at least three (3) months and donepezil 20 mg daily for an additional one (1) month. |
| **NMDA RECEPTOR ANTAGONIST** | | |
| memantine | memantine ER<br>memantine solution<br>NAMENDA (memantine)<br>NAMENDA XR (memantine)* | *****Namenda XR requires ninety (90) days of compliant therapy with Namenda. |
| **CHOLINESTERASE INHIBITOR/NMDA RECEPTOR ANTAGONIST COMBINATIONS** | | |
| | NAMZARIC (donepezil/memantine) | Combination agents require thirty (30) day trials of each corresponding preferred single agent. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **ANALGESICS, NARCOTIC LONG ACTING (Non-parenteral)[AP]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require six (6) day trials of two (2) chemically distinct preferred agents **AND** a six (6) day trial of the generic form of the requested non-preferred agent (if available) before they will be approved, unless one (1) of the exceptions on the PA form is present. If no generic form is available for the requested non-preferred brand agent, then another generic non-preferred agent must be trialed instead. **NOTE: All long-acting opioid agents require a prior authorization for children under 18 years of age.** Requests must be for an FDA approved age and indication and specify previous opioid and non-opioid therapies attempted. | | |
| BUTRANS (buprenorphine)<br>fentanyl transdermal 12, 25, 50, 75, 100 mcg/hr<br>morphine ER tablets | ARYMO ER (morphine sulfate)<br>BELBUCA (buprenorphine buccal film)*<br>buprenorphine patch (all labelers including 00093)<br>CONZIP ER (tramadol)<br>DOLOPHINE (methadone)<br>DURAGESIC (fentanyl)<br>EMBEDA (morphine/naltrexone)<br>EXALGO ER (hydromorphone)<br>fentanyl transdermal 37.5, 62.5, 87.5 mcg/hr<br>hydromorphone ER<br>HYSINGLA ER (hydrocodone)<br>KADIAN (morphine)<br>LAZANDA SPRAY (fentanyl)<br>methadone**<br>MORPHABOND ER (morphine sulfate)<br>morphine ER capsules (generic for Avinza)<br>morphine ER capsules (generic for Kadian)<br>MS CONTIN (morphine)<br>NUCYNTA ER (tapentadol)<br>OPANA ER (oxymorphone)<br>oxycodone ER**<br>OXYCONTIN (oxycodone)<br>oxymorphone ER**<br>tramadol ER***<br>ULTRAM ER (tramadol)<br>XARTEMIS XR (oxycodone/ acetaminophen)<br>XTAMPZA ER (oxycodone)<br>ZOHYDRO ER (hydrocodone) | *Belbuca prior authorization requires manual review. Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.<br><br>**Methadone, oxycodone ER and oxymorphone ER will be authorized without a trial of the preferred agents if a diagnosis of cancer is submitted.<br><br>***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** |
| **ANALGESICS, NARCOTIC SHORT ACTING (Non-parenteral)[AP]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require six (6) day trials of at least four (4) chemically distinct preferred agents (based on the narcotic ingredient only), including the generic formulation of the requested non-preferred agent, before they will be approved, unless one (1) of the exceptions on the PA form is present. **NOTE: All tramadol and codeine products require a prior authorization for children under 18 years of age.** Requests must be for an FDA approved age and indication and specify non-opioid therapies attempted. | | |
| APAP/codeine<br>butalbital/APAP/caffeine/codeine<br>codeine<br>hydrocodone/APAP 2.5/325 mg, 5/325 mg, 7.5/325 mg,10/325 mg<br>hydrocodone/APAP solution<br>hydrocodone/ibuprofen<br>hydromorphone tablets<br>LORTAB SOLUTION (hydrocodone/acetaminophen)<br>morphine<br>oxycodone tablets, concentrate, solution<br>oxycodone/APAP<br>oxycodone/ASA<br>pentazocine/naloxone<br>tramadol<br>tramadol/APAP | ABSTRAL (fentanyl)<br>ACTIQ (fentanyl)<br>butalbital/ASA/caffeine/codeine<br>butorphanol<br>CAPITAL W/CODEINE (APAP/codeine)<br>DEMEROL (meperidine)<br>dihydrocodeine/ APAP/caffeine<br>DILAUDID (hydromorphone)<br>fentanyl<br>FENTORA (fentanyl)<br>FIORICET W/ CODEINE (butalbital/APAP/caffeine/codeine)<br>FIORINAL W/ CODEINE (butalbital/ASA/caffeine/codeine)<br>hydrocodone/APAP 5/300 mg, 7.5/300 mg, 10/300 mg<br>hydromorphone liquid, suppositories<br>IBUDONE (hydrocodone/ibuprofen)<br>LAZANDA (fentanyl)<br>levorphanol<br>LORCET (hydrocodone/APAP)<br>LORTAB (hydrocodone/APAP)<br>meperidine<br>NORCO (hydrocodone/APAP)<br>NUCYNTA (tapentadol)<br>ONSOLIS (fentanyl)<br>OPANA (oxymorphone)<br>OXECTA (oxycodone)<br>oxycodone capsules<br>oxycodone/ibuprofen<br>oxymorphone<br>PERCOCET (oxycodone/APAP)<br>PRIMLEV (oxycodone/APAP)<br>REPREXAIN (hydrocodone/ibuprofen)<br>ROXICODONE (oxycodone) | 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.<br><br>**Limits:** Unless the patient has escalating cancer pain or another diagnosis supporting increased quantities of short-acting opioids, all short acting solid forms of the narcotic analgesics are limited to 120 tablets per thirty (30) days. Longer-acting medications should be maximized to prevent unnecessary breakthrough pain in chronic pain therapy.<br><br>Immediate-release tramadol is limited to 240 tablets per thirty (30) days. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | ROXYBOND (oxycodone)<br>RYBIX ODT (tramadol)<br>SUBSYS (fentanyl)<br>SYNALGOS-DC (dihydrocodeine/ASA/ caffeine)<br>TYLENOL W/CODEINE (APAP/codeine)<br>ULTRACET (tramadol/APAP)<br>ULTRAM (tramadol)<br>VERDROCET (hydrocodone/APAP)<br>VICODIN (hydrocodone/APAP)<br>VICOPROFEN (hydrocodone/ibuprofen)<br>XODOL (hydrocodone/acetaminophen)<br>XYLON (hydrocodone/ibuprofen)<br>ZAMICET (hydrocodone/APAP) | |
| **ANDROGENIC AGENTS** | | |
| **CLASS PA CRITERIA:** A non-preferred agent will only be authorized if one (1) of the exceptions on the PA form is present. | | |
| ANDRODERM (testosterone)<br>ANDROGEL (testosterone)<br>METHITEST (methyltestosterone)<br>testosterone cypionate vial[CL]<br>testosterone enanthate vial[CL] | ANDROID (methyltestosterone)<br>AVEED VIAL (testosterone undecanoate)<br>AXIRON (testosterone)<br>FORTESTA (testosterone)<br>methyltestosterone capsule<br>NATESTO (testosterone)<br>STRIANT BUCCAL (testosterone)<br>TESTIM (testosterone)<br>TESTRED (methyltestosterone)<br>testosterone gel<br>VOGELXO (testosterone)<br>XYOSTED (testosterone enanthate) | |
| **ANESTHETICS, TOPICAL[AP]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require ten (10) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| lidocaine<br>lidocaine/prilocaine<br>xylocaine | LIDAMANTLE (lidocaine)<br>LIDAMANTLE HC (lidocaine/hydrocortisone)<br>lidocaine/hydrocortisone<br>LIDOTRAL CREAM (lidocaine)<br>LIDOZION LOTION (lidocaine)<br>SYNERA (lidocaine/tetracaine)<br>VOPAC MDS (ketoprofen/lidocaine) | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **ANGIOTENSIN MODULATORS**[AP] | | |
| **CLASS PA CRITERIA:** Non-preferred agents require fourteen (14) day trials of each preferred agent in the same sub-class, with the exception of the Direct Renin Inhibitors, before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| | **ACE INHIBITORS** | |
| benazepril<br>captopril<br>enalapril<br>fosinopril<br>lisinopril<br>quinapril<br>ramipril | ACCUPRIL (quinapril)<br>ACEON (perindopril)<br>ALTACE (ramipril)<br>EPANED (enalapril)*<br>LOTENSIN (benazepril)<br>MAVIK (trandolapril)<br>moexipril<br>perindopril<br>PRINIVIL (lisinopril)<br>QBRELIS SOLUTION (lisinopril)**<br>trandolapril<br>UNIVASC (moexipril)<br>VASOTEC (enalapril)<br>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.<br><br>**Qbrelis solution may be authorized for children ages 6-10 who are unable to tolerate a solid dosage form. Qbrelis may also be authorized for older patients with clinical documentation indicating oral-motor difficulties or dysphagia. |
| | **ACE INHIBITOR COMBINATION DRUGS** | |
| benazepril/amlodipine<br>benazepril/HCTZ<br>captopril/HCTZ<br>enalapril/HCTZ<br>fosinopril/HCTZ<br>lisinopril/HCTZ<br>quinapril/HCTZ | ACCURETIC (quinapril/HCTZ)<br>CAPOZIDE (captopril/HCTZ)<br>LOTENSIN HCT (benazepril/HCTZ)<br>LOTREL (benazepril/amlodipine)<br>moexipril/HCTZ<br>PRESTALIA (perindopril/amlodipine)<br>PRINZIDE (lisinopril/HCTZ)<br>TARKA (trandolapril/verapamil)<br>trandolapril/verapamil<br>VASERETIC (enalapril/HCTZ)<br>ZESTORETIC (lisinopril/HCTZ) | |
| | **ANGIOTENSIN II RECEPTOR BLOCKERS (ARBs)** | |
| irbesartan<br>losartan<br>valsartan<br>olmesartan | ATACAND (candesartan)<br>AVAPRO (irbesartan)<br>BENICAR (olmesartan)<br>candesartan<br>COZAAR (losartan)<br>DIOVAN (valsartan)<br>EDARBI (azilsartan) | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | eprosartan<br>MICARDIS (telmisartan)<br>telmisartan | |
| | **ARB COMBINATIONS** | |
| ENTRESTO (valsartan/sacubitril)[AP]*<br>irbesartan/HCTZ<br>losartan/HCTZ<br>olmesartan/amlodipine<br>olmesartan/HCTZ<br>TRIBENZOR (olmesartan/amlodipine/HCTZ)<br>TWYNSTA (telmisartan/amlodipine)<br>valsartan/amlodipine<br>valsartan/amlodipine/HCTZ<br>valsartan/HCTZ | ATACAND-HCT (candesartan/HCTZ)<br>AVALIDE (irbesartan/HCTZ)<br>AZOR (olmesartan/amlodipine)<br>BENICAR-HCT (olmesartan/HCTZ)<br>BYVALSON (nebivolol/valsartan)<br>candesartan/HCTZ<br>DIOVAN-HCT (valsartan/HCTZ)<br>EDARBYCLOR (azilsartan/chlorthalidone)<br>EXFORGE (valsartan/amlodipine)<br>EXFORGE HCT (valsartan/amlodipine/HCTZ)<br>HYZAAR (losartan/HCTZ)<br>MICARDIS-HCT (telmisartan/HCTZ)<br>olmesartan/amlodipine/HCTZ<br>telmisartan/amlodipine<br>telmisartan HCTZ | *Entresto will only be authorized for patients 18 years of age or older who are diagnosed with chronic heart-failure. |
| | **DIRECT RENIN INHIBITORS** | |
| | AMTURNIDE (aliskiren/amlodipine/HCTZ)<br>TEKAMLO (aliskiren/amlodipine)<br>TEKTURNA (aliskiren)<br>TEKTURNA HCT (aliskiren/HCTZ)<br>VALTURNA (aliskiren/valsartan) | **Substitute for Class Criteria**: Tekturna requires a thirty (30) day trial of one (1) preferred ACE, ARB, or combination agent, at the maximum tolerable dose, before it will be authorized unless one (1) of the exceptions on the PA form is present.<br><br>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** | | |
| **CLASS PA CRITERIA:** Agents in this class may only be authorized for patients with angina who are also taking a calcium channel blocker, a beta blocker, or a nitrite as single agents or a combination agent containing one (1) of these ingredients. | | |
| ranolazine[AP] | RANEXA | |
| **ANTIBIOTICS, GI & RELATED AGENTS** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a fourteen (14) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| FIRVANQ (vancomycin)<br>metronidazole tablet<br>neomycin<br>tinidazole | DIFICID (fidaxomicin)*<br>FLAGYL (metronidazole)<br>FLAGYL ER (metronidazole ER)<br>metronidazole capsule | *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** |
| | paromomycin<br>TINDAMAX (tinidazole)<br>VANCOCIN (vancomycin)<br>vancomycin<br>XIFAXAN (rifaximin)* | |
| **ANTIBIOTICS, INHALED** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a twenty-eight (28) day trial of a preferred agent and documentation of therapeutic failure before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| BETHKIS (tobramycin)<br>KITABIS PAK (tobramycin) | CAYSTON (aztreonam)<br>TOBI (tobramycin)<br>TOBI PODHALER (tobramycin)<br>tobramycin | |
| **ANTIBIOTICS, TOPICAL** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require ten (10) day trials of at least one preferred agent, including the generic formulation of the requested non-preferred agent, before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| bacitracin (Rx, OTC)<br>gentamicin sulfate<br>mupirocin ointment | BACTROBAN (mupirocin)<br>CENTANY (mupirocin)<br>CORTISPORIN (bacitracin/neomycin/polymyxin/HC)<br>mupirocin cream<br>neomycin/polymyxin/pramoxine | |
| **ANTIBIOTICS, VAGINAL** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require trials of each chemically unique preferred agent at the manufacturer's recommended duration, before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| CLEOCIN OVULE (clindamycin)<br>CLINDESSE (clindamycin)<br>metronidazole | AVC (sulfanilamide)<br>CLEOCIN CREAM (clindamycin)<br>clindamycin cream<br>METROGEL (metronidazole)<br>NUVESSA (metronidazole)<br>SOLOSEC (secnidazole)<br>VANDAZOLE (metronidazole) | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **ANTICOAGULANTS** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a trial of each preferred agent in the same sub-class, unless one (1) of the exceptions on the PA form is present. | | |
| **INJECTABLE[CL]** | | |
| enoxaparin | ARIXTRA (fondaparinux)<br>fondaparinux<br>FRAGMIN (dalteparin)<br>LOVENOX (enoxaparin) | |
| **ORAL** | | |
| COUMADIN (warfarin)<br>ELIQUIS (apixaban)<br>PRADAXA (dabigatran)<br>warfarin<br>XARELTO (rivaroxaban) | SAVAYSA (edoxaban) | |
| **ANTICONVULSANTS** | | |
| **CLASS PA CRITERIA:** For a diagnosis of seizure disorder, non-preferred agents require a fourteen (14) day trial of a preferred agent in the same sub-class before they will be approved, unless one (1) of the exceptions on the PA form is present; patients currently on established therapies shall be grandfathered.<br><br>For all other diagnoses, non-preferred agents require a thirty (30) day trial of a preferred agent in the same sub-class before they will be approved, unless one (1) of the exceptions on the PA form is present.<br><br>In situations where AB-rated generic equivalent products are available, “Brand Medically Necessary” must be hand-written by the prescriber on the prescription for the brand name product to be reimbursed. | | |
| **ADJUVANTS** | | |
| carbamazepine<br>carbamazepine ER<br>carbamazepine XR<br>divalproex<br>divalproex ER<br>divalproex sprinkle<br>EPITOL (carbamazepine)<br>GABITRIL (tiagabine)<br>lamotrigine<br>levetiracetam IR<br>levetiracetam ER<br>levetiracetam IR suspension<br>oxcarbazepine suspension and tablets | APTIOM (eslicarbazepine)<br>BANZEL (rufinamide)<br>BRIVIACT (brivaracetam)<br>carbamazepine oral suspension<br>carbamazepine XR<br>CARBATROL (carbamazepine)<br>DEPAKENE (valproic acid)<br>DEPAKOTE (divalproex)<br>DEPAKOTE ER (divalproex)<br>DEPAKOTE SPRINKLE (divalproex)<br>EQUETRO (carbamazepine)<br>FANATREX SUSPENSION (gabapentin)<br>felbamate | *Topiramate ER will be authorized after a thirty (30) day trial of topiramate IR.<br><br>**Qudexy XR and Trokendi XR are only approvable on appeal. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| TEGRETOL SUSPENSION (carbamazepine)<br>topiramate IR<br>topiramate ER*<br>valproic acid<br>VIMPAT (lacosamide)<br>zonisamide | FELBATOL (felbamate)<br>FYCOMPA (perampanel)<br>KEPPRA (levetiracetam)<br>KEPPRA SOLUTION (levetiracetam)<br>KEPPRA XR (levetiracetam)<br>LAMICTAL (lamotrigine)<br>LAMICTAL CHEWABLE (lamotrigine)<br>LAMICTAL ODT (lamotrigine)<br>LAMICTAL XR (lamotrigine)<br>lamotrigine dose pack<br>lamotrigine ER<br>OXTELLAR XR (oxcarbazepine)<br>POTIGA (ezogabine)<br>QUDEXY XR (topiramate ER)**<br>SABRIL (vigabatrin)<br>SPRITAM (levetiracetam)<br>STAVZOR (valproic acid)<br>TEGRETOL TABLETS (carbamazepine)<br>TEGRETOL XR (carbamazepine)<br>tiagabine<br>TOPAMAX (topiramate)<br>TRILEPTAL SUSPENSION and TABLETS (oxcarbazepine)<br>TROKENDI XR (topiramate)**<br>ZONEGRAN (zonisamide) | |
| **BARBITURATES[AP]** | | |
| phenobarbital<br>primidone | MYSOLINE (primidone) | |
| **BENZODIAZEPINES[AP]** | | |
| clonazepam<br>diazepam rectal gel<br>diazepam tablets<br>NAYZILAM NASAL SPRAY (midazolam)<br>VALTOCO NASAL SPRAY (diazepam) | clobazam*<br>clonazepam ODT<br>DIASTAT (diazepam rectal)<br>KLONOPIN (clonazepam)<br>ONFI (clobazam)*<br>ONFI SUSPENSION (clobazam)*<br>SYMPAZAN (clobazam film)* | *Onfi shall be authorized as adjunctive therapy for treatment of Lennox-Gastaut Syndrome without further restrictions. Off-label use requires an appeal to the Medical Director.<br>NOTE: generic clobazam is preferred over brand ONFI. |
| **CANNABINOIDS** | | |
| | EPIDIOLEX SOLUTION (cannabidiol)* | * 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** |
| | **HYDANTOINS[AP]** | |
| DILANTIN (phenytoin sodium, extended)<br>PEGANONE (ethotoin)<br>phenytoin capsules, chewable tablets, suspension | DILANTIN INFATABS (phenytoin)<br>PHENYTEK (phenytoin) | |
| | **SUCCINIMIDES** | |
| CELONTIN (methsuximide)<br>ethosuximide capsules<br>ethosuximide syrup | ZARONTIN (ethosuximide) capsules<br>ZARONTIN (ethosuximide) syrup | |
| **ANTIDEPRESSANTS, OTHER** | | |
| **CLASS PA CRITERIA:** See below for individual sub-class criteria. | | |
| | **MAOIs[AP]** | |
| | MARPLAN (isocarboxazid)<br>NARDIL (phenelzine)<br>PARNATE (tranylcypromine)<br>phenelzine<br>tranylcypromine | Patients stabilized on MAOI agents will be grandfathered. |
| | **SNRIS[AP]** | |
| duloxetine capulses<br>venlafaxine ER capsules | CYMBALTA (duloxetine)<br>desvenlafaxine ER<br>desvenlafaxine fumarate ER<br>EFFEXOR XR (venlafaxine)<br>FETZIMA (levomilnacipran)<br>KHEDEZLA (desvenlafaxine)<br>PRISTIQ (desvenlafaxine)<br>venlafaxine IR<br>VENLAFAXINE ER TABLETS (venlafaxine) | Non-preferred agents require separate thirty (30) day trials of a preferred agent in this sub-class **AND** an SSRI before they will be approved, unless one (1) of the exceptions on the PA form is present. |
| | **SECOND GENERATION NON-SSRI, OTHER[AP]** | |
| bupropion IR<br>bupropion SR<br>bupropion XL<br>mirtazapine<br>trazodone | APLENZIN (bupropion hbr)<br>EMSAM (selegiline)<br>FORFIVO XL (bupropion)<br>nefazodone<br>OLEPTRO ER (trazodone)<br>REMERON (mirtazapine)<br>TRINTELLIX (vortioxetine)<br>VIIBRYD (vilazodone HCl)<br>WELLBUTRIN (bupropion) | Non-preferred agents require separate thirty (30) day trials of a preferred agent in this sub-class **AND** an SSRI before they will be approved, unless one (1) of the exceptions on the PA form is present. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | WELLBUTRIN SR (bupropion)<br>WELLBUTRIN XL (bupropion) | |
| | **SELECTED TCAs** | |
| imipramine HCl | imipramine pamoate<br>TOFRANIL (imipramine HCl)<br>TOFRANIL PM (imipramine pamoate) | Non-preferred agents require a twelve (12) week trial of imipramine HCl before they will be approved, unless one (1) of the exceptions on the PA form is present. |
| **ANTIDEPRESSANTS, SSRIs[AP]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require thirty (30) day trials of at least two (2) preferred agents before they will be approved, unless one (1) of the exceptions on the PA form is present.<br><br>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<br>escitalopram tablets<br>fluoxetine capsules, solution<br>fluvoxamine<br>paroxetine<br>sertraline | BRISDELLE (paroxetine)<br>CELEXA (citalopram)<br>escitalopram solution<br>fluoxetine tablets<br>fluvoxamine ER<br>LEXAPRO (escitalopram)<br>LUVOX CR (fluvoxamine)<br>paroxetine 7.5 mg capsules<br>paroxetine ER<br>PAXIL (paroxetine)<br>PAXIL CR (paroxetine)<br>PEXEVA (paroxetine)<br>PROZAC (fluoxetine)<br>SARAFEM (fluoxetine)<br>ZOLOFT (sertraline) | |
| **ANTIEMETICS[AP]** | | |
| **CLASS PA CRITERIA:** See below for sub-class criteria. | | |
| | **5HT3 RECEPTOR BLOCKERS** | |
| granisetron<br>ondansetron ODT, solution, tablets | ANZEMET (dolasetron)<br>GRANISOL (granisetron)<br>ondansetron vials<br>SANCUSO (granisetron)<br>SUSTOL (granisetron)<br>ZOFRAN (ondansetron)<br>ZUPLENZ (ondansetron) | Non-preferred agents require a three (3) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | **CANNABINOIDS** | |
| | CESAMET (nabilone)*<br>dronabinol**<br>MARINOL (dronabinol)**<br>SYNDROS SOLUTION (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.<br><br>**Dronabinol will only be authorized for:<br>1. The treatment of anorexia associated with weight loss in patients with AIDS or cancer and unresponsive to megestrol **or**<br>2. The prophylaxis of chemotherapy induced nausea and vomiting unresponsive to three (3) day trials of ondansetron or promethazine for patients from eighteen (18) up to sixty-five (65) years of age. |
| | **SUBSTANCE P ANTAGONISTS** | |
| EMEND (aprepitant) | aprepitant<br>VARUBI (rolapitant) | Non-preferred agents require a three (3) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. |
| | **COMBINATIONS** | |
| | AKYNZEO (netupitant/palonosetron)<br>BONJESTA (doxylamine/pyridoxine)<br>DICLEGIS (doxylamine/pyridoxine) | Non-preferred agents will only be approved on appeal. |
| **ANTIFUNGALS, ORAL** | | |
| **CLASS PA CRITERIA:** Non-preferred agents will only be authorized if one (1) of the exceptions on the PA form is present. | | |
| clotrimazole<br>fluconazole*<br>nystatin<br>terbinafine[CL] | ANCOBON (flucytosine)<br>CRESEMBA (isovuconazonium)[CL]**<br>DIFLUCAN (fluconazole)<br>flucytosine<br>griseofulvin***<br>GRIS-PEG (griseofulvin)<br>itraconazole<br>ketoconazole****<br>LAMISIL (terbinafine)<br>MYCELEX (clotrimazole)<br>NIZORAL (ketoconazole)<br>NOXAFIL (posaconazole)<br>ONMEL (itraconazole)<br>ORAVIG (miconazole) | *PA is required when limits are exceeded.<br><br>**Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.<br><br>***PA is not required for griseofulvin suspension for children up to eighteen (18) years of age for the treatment of tinea capitis.<br><br>****Ketoconazole will be authorized if the following criteria are met:<br>1. Diagnosis of one of the following fungal infections: blastomycosis, coccidioidomycosis, histoplasmosis, chromomycosis, or paracoccidioidomycosis **and** |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | SPORANOX (itraconazole)<br>TOLSURA (itraconazole)<br>VFEND (voriconazole)<br>voriconazole suspension<br>voriconazole tablets | 2. Documented failure or intolerance of all other diagnosis-appropriate antifungal therapies, i.e. itraconazole, fluconazole, flucytosine, etc **and**<br>3. Baseline assessment of the liver status including alanine aminotransferase (ALT), aspartate aminotransferase (AST), total bilirubin, alkaline phosphatase, prothrombin time, and international normalized ratio (INR) before starting treatment **and**<br>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**<br>5. Assessment of all concomitant medications for potential adverse drug interactions with ketoconazole.<br>**Ketoconazole will not be authorized for treatment for fungal infections of the skin and nails.** |
| **ANTIFUNGALS, TOPICAL[AP]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require fourteen (14) day trials of two (2) preferred agents before they will be approved, unless one (1) of the exceptions on the PA form is present. If a non-preferred shampoo is requested, a fourteen (14) day trial of one (1) preferred product (i.e. ketoconazole shampoo) is required. | | |
| **ANTIFUNGALS** | | |
| econazole<br>ketoconazole cream, shampoo<br>MENTAX (butenafine)<br>miconazole (OTC)<br>nystatin | CICLODAN (ciclopirox)<br>ciclopirox<br>ERTACZO (sertaconazole)<br>EXELDERM (sulconazole)<br>EXTINA (ketoconazole)<br>GYNAZOLE 1 CREAM (butoconazole)<br>JUBLIA (efinaconazole)<br>ketoconazole foam<br>KERYDIN (tavaborole)<br>KETODAN (ketoconazole)<br>LOPROX (ciclopirox)<br>LUZU (luliconazole)<br>MYCOSTATIN (nystatin)<br>NAFTIN CREAM (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** |
| | NAFTIN GEL (naftifine)<br>NIZORAL (ketoconazole)<br>OXISTAT (oxiconazole)*<br>PEDIPIROX-4 (ciclopirox)<br>PENLAC (ciclopirox)<br>VUSION (miconazole/petrolatum/zinc oxide) | |
| **ANTIFUNGAL/STEROID COMBINATIONS** | | |
| clotrimazole/betamethasone cream | clotrimazole/betamethasone lotion<br>KETOCON PLUS (ketoconazole/hydrocortisone)<br>LOTRISONE (clotrimazole/betamethasone)<br>nystatin/triamcinolone | |
| **ANTIHEMOPHILIA FACTOR AGENTS[CL]** | | |
| **CLASS PA CRITERIA:** All agents will require prior-authorization, and non-preferred agents require medical reasoning explaining why the need cannot be met using a preferred product.<br><br>All currently established regimens shall be grandfathered with documentation of adherence to therapy. | | |
| **FACTOR VIII** | | |
| ADVATE<br>AFSTYLA<br>ALPHANATE<br>HELIXATE FS<br>HEMOFIL M<br>HUMATE-P<br>KOATE<br>KOATE-DVI<br>KOGENATE FS<br>MONOCLATE-P<br>NOVOEIGHT<br>NUWIQ<br>WILATE<br>XYNTHA<br>XYNTHA SOLOFUSE | ADYNOVATE<br>ELOCTATE<br>JIVI<br>KOVALTRY<br>RECOMBINATE<br>VONVENDI | |
| **FACTOR IX** | | |
| ALPHANINE SD<br>ALPROLIX<br>BEBULIN<br>BENEFIX<br>IXINITY<br>MONONINE | IDELVION<br>REBINYN | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| PROFILNINE<br>RIXUBIS | | |
| **FACTOR IXa/IX** | | |
| | HEMLIBRA (emicizumab-kxwh)* | *Hemlibra shall be approved without further restriction for patients with Hemophilia A with documented presence of Factor VIII inhibitors. |
| **ANTIHYPERTENSIVES, SYMPATHOLYTICS** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require thirty (30) day trials of each preferred unique chemical entity in the corresponding formulation before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| CATAPRES-TTS (clonidine)<br>clonidine tablets | CATAPRES TABLETS (clonidine)<br>clonidine patch<br>NEXICLON XR (clonidine) | |
| **ANTIHYPERURICEMICS** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a thirty (30) day trial of one (1) of the preferred agents for the prevention of gouty arthritis attacks (colchicine/probenecid, probenecid, or allopurinol) before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| **ANTIMITOTICS** | | |
| colchicine capsules | colchicine tablets<br>COLCRYS (colchicine)<br>MITIGARE (colchicine) | In the case of acute gouty attacks, a ten (10) day supply (twenty (20) capsules) of the preferred agent(s) in this subclass will be authorized per ninety (90) days. |
| **ANTIMITOTIC-URICOSURIC COMBINATION** | | |
| colchicine/probenecid | | |
| **URICOSURIC** | | |
| probenecid | ZURAMPIC (lesinurad)* | *Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. |
| **XANTHINE OXIDASE INHIBITORS** | | |
| allopurinol | ULORIC (febuxostat)<br>ZYLOPRIM (allopurinol) | |
| **URICOSURIC – XANTHINE OXIDASE INHIBITORS** | | |
| | DUZALLO (allopurinol/lesinurad) | Non-preferred agents will only be approved on appeal. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **ANTIMIGRAINE AGENTS, CGRP INHIBITORS**[CL] | | |
| **CLASS PA CRITERIA: All agents require a prior authorization.** Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. Non-preferred agents require a 90-day trial of all preferred agents. | | |
| AIMOVIG (erenumab)<br>EMGALITY (galcanezumab) 120mg/mL | AJOVY (fremanezumab)<br>EMGALITY (galcanezumab) 300mg/3 mL* | *Emgality 300 mg/3 mL requires review by the Medical Director and is available only on appeal. |
| **ANTIMIGRAINE AGENTS, OTHER**[AP] | | |
| **CLASS PA CRITERIA:** Non-preferred agents require three (3) day trials of each unique chemical entity of the preferred Antimigraine Triptan Agents before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| | CAMBIA (diclofenac) | |
| **ANTIMIGRAINE AGENTS, TRIPTANS**[AP] | | |
| **CLASS PA CRITERIA:** Non-preferred agents require three (3) day trials of each preferred unique chemical entity as well as a three (3) day trial using the same route of administration as the requested agent (if available), before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| | **TRIPTANS** | |
| naratriptan<br>rizatriptan ODT<br>rizatriptan tablet<br>sumatriptan injection[CL]<br>sumatriptan nasal spray<br>sumatriptan tablets | almotriptan<br>AMERGE (naratriptan)<br>AXERT (almotriptan)<br>eletriptan<br>FROVA (frovatriptan)<br>frovatriptan<br>IMITREX INJECTION (sumatriptan)[CL]<br>IMITREX NASAL SPRAY (sumatriptan)<br>IMITREX tablets (sumatriptan)<br>MAXALT MLT (rizatriptan)<br>MAXALT (rizatriptan)<br>ONZETRA XSAIL (sumatriptan)*<br>RELPAX (eletriptan)<br>SUMAVEL (sumatriptan)<br>TOSYMRA NASAL SPRAY (sumatriptan)*<br>ZECUITY PATCH (sumatriptan)<br>ZEMBRACE SYMTOUCH (sumatriptan)<br>zolmitriptan<br>zolmitriptan ODT<br>ZOMIG (zolmitriptan)<br>ZOMIG ZMT (zolmitriptan) | ***In addition to the Class Criteria**: Onzetra Xsail and Tosymra require three (3) day trials of each preferred oral, nasal and injectable forms of sumatriptan. |
| | **TRIPTAN COMBINATIONS** | |
| | TREXIMET (sumatriptan/naproxen sodium) | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **ANTIPARASITICS, TOPICAL[AP]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require trials of each preferred agent (which are age and weight appropriate) before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| NATROBA (spinosad)<br>permethrin 5% cream<br>pyrethrins-piperonyl butoxide OTC | ELIMITE CREAM (permethrin)<br>EURAX (crotamiton)<br>LICE EGG REMOVER OTC (benzalkonium chloride)<br>lindane<br>malathion<br>OVIDE (malathion)<br>SKLICE (ivermectin)<br>spinosad<br>VANALICE (piperonyl/pyrethin) | |
| **ANTIPARKINSON'S AGENTS** | | |
| **CLASS PA CRITERIA:** Patients starting therapy on drugs in this class must show a documented allergy to all preferred agents in the corresponding sub-class, before a non-preferred agent will be authorized. | | |
| **ANTICHOLINERGICS** | | |
| benztropine<br>trihexyphenidyl | | |
| **COMT INHIBITORS** | | |
| entacapone | COMTAN (entacapone)<br>TASMAR (tolcapone) | COMT Inhibitor agents will only be approved as add-on therapy to a levodopa-containing regimen for treatment of documented motor complications. |
| **DOPAMINE AGONISTS** | | |
| pramipexole<br>ropinirole | MIRAPEX (pramipexole)<br>MIRAPEX ER (pramipexole)*<br>NEUPRO (rotigotine)<br>pramipexole ER<br>REQUIP (ropinirole)<br>REQUIP XL (ropinirole)*<br>ropinirole ER | *Mirapex ER and Requip XL will be authorized for a diagnosis of Parkinsonism without a trial of preferred agents. |
| **OTHER ANTIPARKINSON'S AGENTS** | | |
| amantadine*[AP]<br>APOKYN (apomorphine)<br>bromocriptine | AZILECT (rasagiline)<br>carbidopa<br>ELDEPRYL (selegiline) | *Amantadine will not be authorized for the treatment or prophylaxis of influenza. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| carbidopa/levodopa<br>levodopa/carbidopa/entacapone<br>selegiline | GOCOVRI ER (amantadine)<br>INBRIJA (levodopa)<br>levodopa/carbidopa ODT<br>LODOSYN (carbidopa)<br>NOURIANZ (istradefylline)<br>OSMOLEX ER (amantadine)<br>PARCOPA (levodopa/carbidopa)<br>PARLODEL (bromocriptine)<br>rasagiline<br>RYTARY (levodopa/carbidopa)<br>SINEMET (levodopa/carbidopa)<br>STALEVO (levodopa/carbidopa/entacapone)<br>XADAGO (safinamide)<br>ZELAPAR (selegiline) | |
| **ANTIPSORIATICS, TOPICAL** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require thirty (30) day trials of two (2) preferred unique chemical entities before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| TACLONEX OINT (calcipotriene/ betamethasone)<br>TAZORAC (tazarotene)<br>VECTICAL (calcitriol) | calcipotriene cream<br>calcipotriene ointment<br>calcipotriene solution<br>calcipotriene/betamethasone ointment<br>CALCITRENE (calcipotriene)<br>calcitriol<br>DOVONEX (calcipotriene)<br>ENSTILAR (calcipotriene/betamethasone)<br>SORILUX (calcipotriene)<br>tazarotene cream (tazarotene) | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **ANTIPSYCHOTICS, ATYPICAL** | | |
| **CLASS PA CRITERIA: All antipsychotic agents require prior authorization for children up to eighteen (18) years of age. All PA requests for antipsychotics for children 6 years of age and younger will be reviewed by Medicaid's consultant psychiatrist.**<br><br>Non-preferred agents require thirty (30) day trials of two (2) preferred agents, including the generic formulation of the requested agent (if available), before they will be approved unless one (1) of the exceptions on the PA form is present. All trials must be at the maximum recommended dose for the diagnosis provided before they would be considered a failure unless an adverse reaction is documented necessitating a change in therapy.<br><br>Patients shall be grandfathered onto their existing therapy, provided the requested agent is being used according to the manufacturer label. Continuation of therapy for an off-label indication or non-standard dosage may be granted a thirty (30) day prior-authorization while the Medical Director reviews the request. | | |
| **SINGLE INGREDIENT** | | |
| ABILIFY MAINTENA (aripiprazole)[CL]<br>aripiprazole tablets<br>ARISTADA (aripiprazole)[CL]<br>ARISTADA INITIO (aripiprazole)[CL]<br>clozapine<br>INVEGA SUSTENNA (paliperidone)[CL]<br>INVEGA TRINZA (paliperidone)* [CL]<br>olanzapine<br>olanzapine ODT<br>PERSERIS (risperidone)[CL]<br>quetiapine ER<br>quetiapine** AP for the 25 mg Tablet Only<br>RISPERDAL CONSTA (risperidone)[CL]<br>risperidone ODT<br>risperidone solution, tablet<br>ziprasidone<br>ZYPREXA RELPREVV (olanzapine) | ABILIFY MYCITE (aripiprazole)<br>ABILIFY TABLETS (aripiprazole)<br>ADASUVE (loxapine)<br>aripiprazole solution<br>clozapine ODT<br>CLOZARIL (clozapine)<br>FANAPT (iloperidone)<br>FAZACLO (clozapine)<br>GEODON (ziprasidone)<br>GEODON IM (ziprasidone)<br>INVEGA ER (paliperidone)<br>LATUDA (lurasidone)***<br>NUPLAZID (pimavanserin) ****<br>olanzapine IM[CL]<br>paliperidone ER<br>REXULTI (brexipiprazole)<br>RISPERDAL (risperidone)<br>SAPHRIS (asenapine)<br>SEROQUEL (quetiapine)<br>SEROQUEL XR (quetiapine)<br>VERSACLOZ (clozapine)<br>VRAYLAR (capriprazine)*****<br>VRAYLAR DOSE PAK (capriprazine)*****<br>ZYPREXA (olanzapine)<br>ZYPREXA IM (olanzapine)[CL] | **The following criteria exceptions apply to the specified products:**<br>*Invega Trinza will be authorized after four months' treatment with Invega Sustenna<br><br>**Quetiapine 25 mg will be authorized:<br>1. For a diagnosis of schizophrenia **or**<br>2. For a diagnosis of bipolar disorder **or**<br>3. When prescribed concurrently with other strengths of Seroquel in order to achieve therapeutic treatment levels.<br>**Quetiapine 25 mg will not be authorized for use as a sedative hypnotic.**<br><br>*** LATUDA will be be authorized for the indication of Bipolar Depression with documentation of the diagnosis. All other indications require class criteria to be followed.<br><br>****Nuplazid may only be authorized for the treatment of Parkinson Disease Induced Psychosis after documented treatment failure with quetiapine.<br><br>***** VRAYLAR may be authorized for the indication of Bipolar Depression only after failure of a 30-day trial of Latuda and a 30-day trial of either quetiapine OR a combination of olanzapine + fluoxetine. All other indications require class |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | | criteria to be followed. |
| **ATYPICAL ANTIPSYCHOTIC/SSRI COMBINATIONS** | | |
| | olanzapine/fluoxetine<br>SYMBYAX (olanzapine/fluoxetine) | |
| **ANTIRETROVIRALS[AP]** | | |
| **CLASS PA CRITERIA:** Non-preferred drugs require medical reasoning beyond convenience or enhanced compliance as to why the clinical need cannot be met with a preferred agent or combination of preferred agents. NOTE: Regimens consisting of preferred agents will result in no more than one additional unit per day over equivalent regimens composed of non-preferred agents. Patients already on a non-preferred regimen shall be grandfathered. | | |
| **SINGLE TABLET REGIMENS** | | |
| BIKTARVY (bictegravir/emtricitabine/tenofovir alafenamide)<br>COMPLERA (emtricitabine/rilpivirine/tenofovir)<br>DELSTRIGO(doravirine/lamivudine/tenofovir df)<br>GENVOYA (elvitegravir/cobicistat/emtricitabine/tenofovir)<br>ODEFSEY (emtricitabine/rilpivirine/tenofovir)<br>SYMFI (efavirenz/lamivudine/tenofovir)<br>SYMFI LO (efavirenz/lamivudine/tenofovir | ATRIPLA (efavirenz/emtricitabine/tenofovir)<br>DOVATO (dolutegravir/lamivudine)<br>JULUCA (dolutegravir/rilpivirine)<br>SYMTUZA (darunavir/cobicistat/emtricitabine/tenofovir alafenamide)<br>STRIBILD (elvitegravir/cobicistat/emtricitabine/tenofovir)*<br>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.<br><br>**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. |
| **INTEGRASE STRAND TRANSFER INHIBITORS** | | |
| ISENTRESS (raltegravir potassium)<br>TIVICAY (dolutegravir sodium)<br>VITEKTA (elvitegravir) | ISENTRESS HD (raltegravir potassium) | |
| **NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTI)** | | |
| abacavir sulfate tablet<br>EMTRIVA (emtricitabine)<br>EPIVIR SOLUTION (lamivudine)<br>lamivudine<br>tenofovir disoproxil fumarate<br>VIREA ORAL POWDER (tenofovir disoproxil fumarate)<br>ZIAGEN SOLUTION (abacavir sulfate)<br>zidovudine | abacavir sulfate solution<br>didanosine DR capsule<br>EPIVIR TABLET (lamivudine)<br>RETROVIR (zidovudine)<br>stavudine<br>VIDEX EC (didanosine)<br>VIDEX SOLUTION (didanosine)<br>VIREAD TABLETS (tenofovir disoproxil fumarate)<br>ZERIT (stavudine)<br>ZIAGEN TABLET (abacavir sulfate) | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITOR (NNRTI)** | | |
| SUSTIVA (efavirenz) | EDURANT (rilpivirine)<br>efavirenz<br>INTELENCE (etravirine)<br>nevirapine<br>nevirapine ER<br>PIFELTRO (doravirine)<br>RESCRIPTOR (delavirdine mesylate)<br>VIRAMUNE ER 24H (nevirapine)<br>VIRAMUNE SUSPENSION (nevirapine) | |
| **PHARMACOENHANCER – CYTOCHROME P450 INHIBITOR** | | |
| TYBOST (cobicistat) | | |
| **PROTEASE INHIBITORS (PEPTIDIC)** | | |
| atazanavir<br>EVOTAZ (atazanavir/cobicistat)<br>NORVIR (ritonavir)<br>REYATAZ POWDER PACK (atazanavir) | CRIXIVAN (indinavir)<br>fosamprenavir<br>INVIRASE (saquinavir mesylate)<br>LEXIVA (fosamprenavir)<br>REYATAZ CAPSULE (atazanavir)<br>VIRACEPT (nelfinavir mesylate) | |
| **PROTEASE INHIBITORS (NON-PEPTIDIC)** | | |
| PREZCOBIX (darunavir/cobicistat)<br>PREZISTA (darunavir ethanolate) | APTIVUS (tipranavir) | |
| **ENTRY INHIBITORS – CCR5 CO-RECEPTOR ANTAGONISTS** | | |
| | SELZENTRY (maraviroc) | |
| **ENTRY INHIBITORS – FUSION INHIBITORS** | | |
| | FUZEON (enfuvirtide) | |
| **COMBINATION PRODUCTS - NRTIs** | | |
| abacavir/lamivudine<br>CIMDUO (lamivudine/tenofovir)<br>lamivudine/zidovudine | abacavir/lamivudine/zidovudine<br>COMBIVIR (lamivudine/zidovudine)<br>EPZICOM (abacavir/lamivudine)<br>TRIZIVIR (abacavir/lamivudine/zidovudine) | |
| **COMBINATION PRODUCTS – NUCLEOSIDE & NUCLEOTIDE ANALOG RTIs** | | |
| DESCOVY (emtricitabine/tenofovir) | TRUVADA (emtricitabine/tenofovir)* | *Truvada shall be treated as preferred when prescribed for PrEP in members assigned female at birth. Truvada may also be approved over Descovy where guidelines clearly indicate superiority over Descovy (documentation may be required to support the request for PA). |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | **COMBINATION PRODUCTS – PROTEASE INHIBITORS** | |
| KALETRA (lopinavir/ritonavir) | lopinavir/ritonavir | |
| **ANTIVIRALS, ORAL** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require five (5) day trials of each preferred agent in the same sub-class before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| | **ANTI HERPES** | |
| acyclovir<br>valacyclovir | famciclovir<br>FAMVIR (famciclovir)<br>SITAVIG (acyclovir)<br>VALTREX (valacyclovir)<br>ZOVIRAX (acyclovir) | |
| | **ANTI-INFLUENZA** | |
| oseltamivir<br>RELENZA (zanamivir)<br>TAMIFLU (oseltamivir) | FLUMADINE (rimantadine)<br>rimantadine<br>XOFLUZA (baloxavir) | **In addition to the Class Criteria**: The anti-influenza agents will be authorized only for a diagnosis of influenza. |
| **ANTIVIRALS, TOPICAL**[AP] | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a five (5) day trial of the preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| ABREVA (docosanol)<br>ZOVIRAX CREAM (acyclovir)<br>ZOVIRAX OINTMENT (acyclovir) | acyclovir ointment<br>DENAVIR (penciclovir) | |
| **BETA BLOCKERS**[AP] | | |
| **CLASS PA CRITERIA:** Non-preferred agents require fourteen (14) day trials of three (3) chemically distinct preferred agents, including the generic formulation of the requested non-preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| | **BETA BLOCKERS** | |
| acebutolol<br>atenolol<br>betaxolol<br>bisoprolol<br>CORGARD (nadolol)<br>metoprolol<br>metoprolol ER<br>pindolol<br>propranolol<br>SORINE (sotalol)<br>sotalol | BETAPACE (sotalol)<br>BYSTOLIC (nebivolol)<br>HEMANGEOL (propranolol)*<br>INDERAL LA (propranolol)<br>INDERAL XL (propranolol)<br>INNOPRAN XL (propranolol)<br>KAPSPARGO SPRINKLE (metoprolol)<br>KERLONE (betaxolol)<br>LEVATOL (penbutolol)<br>LOPRESSOR (metoprolol)<br>nadolol | *Hemangeol will be authorized for the treatment of proliferating infantile hemangioma requiring systemic therapy.<br><br>**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** |
| timolol | propranolol ER**<br>SECTRAL (acebutolol)<br>TENORMIN (atenolol)<br>TOPROL XL (metoprolol)<br>ZEBETA (bisoprolol) | |
| | **BETA BLOCKER/DIURETIC COMBINATION DRUGS** | |
| atenolol/chlorthalidone<br>bisoprolol/HCTZ<br>metoprolol/HCTZ<br>propranolol/HCTZ | CORZIDE (nadolol/bendroflumethiazide)<br>DUTOPROL (metoprolol ER/HCTZ ER)<br>LOPRESSOR HCT (metoprolol/HCTZ)<br>metoprolol/HCTZ ER<br>nadolol/bendroflumethiazide<br>TENORETIC (atenolol/chlorthalidone)<br>ZIAC (bisoprolol/HCTZ) | |
| | **BETA- AND ALPHA-BLOCKERS** | |
| carvedilol<br>labetalol | COREG (carvedilol)<br>COREG CR (carvedilol)<br>TRANDATE (labetalol) | |
| **BLADDER RELAXANT PREPARATIONS[AP]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require thirty (30) day trials of each chemically distinct preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present | | |
| GELNIQUE (oxybutynin)<br>oxybutynin IR<br>oxybutynin ER<br>solifenacin<br>TOVIAZ (fesoterodine) | DETROL (tolterodine)<br>DETROL LA (tolterodine)<br>DITROPAN XL (oxybutynin)<br>ENABLEX (darifenacin)<br>flavoxate<br>MYRBETRIQ (mirabegron)<br>OXYTROL (oxybutynin)<br>SANCTURA (trospium)<br>SANCTURA XR (trospium)<br>tolterodine<br>tolterodine ER<br>trospium<br>trospium ER<br>VESICARE (solifenacin) | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **BONE RESORPTION SUPPRESSION AND RELATED AGENTS** | | |
| **CLASS PA CRITERIA:** See below for class criteria. | | |
| **BISPHOSPHONATES** | | |
| alendronate tablets<br>ibandronate | ACTONEL (risedronate)<br>ACTONEL WITH CALCIUM (risedronate/ calcium)<br>alendronate solution<br>ATELVIA (risedronate)<br>BINOSTO (alendronate)<br>BONIVA (ibandronate)<br>DIDRONEL (etidronate)<br>etidronate<br>FOSAMAX TABLETS (alendronate)<br>FOSAMAX PLUS D (alendronate/vitamin D)<br>risedronate | Non-preferred agents require thirty (30) day trials of **each** preferred Bisphosphonate agent before they will be approved, unless one (1) of the exceptions on the PA form is present. |
| **OTHER BONE RESORPTION SUPPRESSION AND RELATED AGENTS** | | |
| | calcitonin<br>EVISTA (raloxifene)*<br>FORTEO (teriparatide)<br>FORTICAL (calcitonin)<br>MIACALCIN (calcitonin)<br>raloxifene*<br>TYMLOS (abaloparatide) | Non-preferred agents require a thirty (30) day trial of a preferred Bisphosphonate agent before they will be approved, unless one (1) of the exceptions on the PA form is present.<br><br>*Raloxifene will be authorized for postmenopausal women with osteoporosis or at high risk for invasive breast cancer. |
| **BPH TREATMENTS** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require thirty (30) day trials of at least two (2) chemically distinct preferred agents, including the generic formulation of the requested non-preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| **5-ALPHA-REDUCTASE (5AR) INHIBITORS AND PDE-5 AGENTS** | | |
| finasteride | AVODART (dutasteride)<br>CIALIS 5 mg (tadalafil)<br>dutasteride<br>PROSCAR (finasteride) | |
| **ALPHA BLOCKERS** | | |
| alfuzosin<br>doxazosin<br>tamsulosin<br>terazosin | CARDURA (doxazosin)<br>CARDURA XL (doxazosin)<br>FLOMAX (tamsulosin)<br>HYTRIN (terazosin)<br>RAPAFLO (silodosin)<br>silodosin<br>UROXATRAL (alfuzosin) | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **5-ALPHA-REDUCTASE (5AR) INHIBITORS/ALPHA BLOCKER COMBINATION** | | |
| | dutasteride/tamsulosin<br>JALYN (dutasteride/tamsulosin) | **Substitute for Class Criteria**: Concurrent thirty (30) day trials of dutasteride and tamsulosin are required before the non-preferred agent will be authorized. |
| **BRONCHODILATORS, BETA AGONIST[AP]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require thirty (30) day trials of each chemically distinct preferred agent in their corresponding sub-class unless one (1) of the exceptions on the PA form is present. | | |
| **INHALATION SOLUTION** | | |
| albuterol | BROVANA (arformoterol)<br>levalbuterol<br>metaproterenol<br>PERFOROMIST (formoterol)<br>XOPENEX (levalbuterol)* | *Xopenex Inhalation Solution will be authorized for twelve (12) months for a diagnosis of asthma or COPD for patients on concurrent asthma controller therapy (either oral or inhaled) with documentation of failure on a trial of albuterol or documented intolerance of albuterol, or for concurrent diagnosis of heart disease. |
| **INHALERS, LONG-ACTING** | | |
| FORADIL (formoterol)<br>SEREVENT (salmeterol) | ARCAPTA (indacaterol maleate)<br>STRIVERDI RESPIMAT (olodaterol) | |
| **INHALERS, SHORT-ACTING** | | |
| PROAIR HFA (albuterol)<br>PROAIR RESPICLICK (albuterol)<br>PROVENTIL HFA (albuterol) | MAXAIR (pirbuterol)<br>PROAIR DIGIHALER (albuterol)<br>VENTOLIN HFA (albuterol)<br>XOPENEX HFA (levalbuterol) | |
| **ORAL** | | |
| | albuterol ER<br>albuterol IR<br>metaproterenol<br>VOSPIRE ER (albuterol)<br>terbutaline | |
| **CALCIUM CHANNEL BLOCKERS[AP]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require fourteen (14) day trials of each preferred agent within the corresponding sub-class before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| **LONG-ACTING** | | |
| amlodipine<br>diltiazem ER<br>felodipine ER<br>nifedipine ER<br>verapamil ER | ADALAT CC (nifedipine)<br>CALAN SR (verapamil)<br>CARDENE SR (nicardipine)<br>CARDIZEM CD, LA (diltiazem)<br>COVERA-HS (verapamil) | *Katerzia will be authorized for children who are 6-10 years of age who are unable to ingest solid dosage forms. Katerzia may also be authorized for older patients with clinical documentation indicating oral-motor |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | diltiazem LA<br>KATERZIA SUSPENSION (amlodipine)*<br>MATZIM LA (diltiazem)<br>nisoldipine<br>NORVASC (amlodipine)<br>PLENDIL (felodipine)<br>PROCARDIA XL (nifedipine)<br>SULAR (nisoldipine)<br>TIAZAC (diltiazem)<br>verapamil ER PM<br>VERELAN/VERELAN PM (verapamil) | difficulties or dysphagia. |
| **SHORT-ACTING** | | |
| diltiazem<br>verapamil | CALAN (verapamil)<br>CARDIZEM (diltiazem)<br>isradipine<br>nicardipine<br>nifedipine<br>nimodipine<br>NIMOTOP (nimodipine)<br>NYMALIZE SOLUTION (nimodipine)<br>PROCARDIA (nifedipine) | |
| **CEPHALOSPORINS AND RELATED ANTIBIOTICS** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a five (5) day trial of a preferred agent within the corresponding sub-class before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| **BETA LACTAMS AND BETA LACTAM/BETA-LACTAMASE INHIBITOR COMBINATIONS** | | |
| amoxicillin/clavulanate IR | amoxicillin/clavulanate ER<br>AUGMENTIN (amoxicillin/clavulanate)<br>AUGMENTIN XR (amoxicillin/clavulanate)<br>MOXATAG (amoxicillin) | |
| **CEPHALOSPORINS** | | |
| cefaclor capsule<br>cefadroxil capsule, tablet<br>cefdinir<br>cefuroxime tablet<br>cephalexin capsule, suspension | CEDAX (ceftibuten)<br>cefaclor suspension<br>cefaclor ER tablet<br>cefadroxil suspension<br>cefpodoxime<br>cefprozil<br>ceftibuten capsule, suspension | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | CEFTIN (cefuroxime)<br>cefuroxime suspension<br>cephalexin tablet<br>DAXABIA (cephalexin)<br>KEFLEX (cephalexin)<br>OMNICEF (cefdinir)<br>RANICLOR (cefaclor)<br>SUPRAX (cefixime) | |
| **COPD AGENTS** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a sixty (60) day trial of one preferred agent from the corresponding sub-class before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| **ANTICHOLINERGIC[AP]** | | |
| ATROVENT HFA (ipratropium)<br>ipratropium nebulizer solution<br>SPIRIVA (tiotropium)<br>SPIRIVA RESPIMAT (tiotropium)<br>TUDORZA (aclidinium) | INCRUSE ELLIPTA (umeclidinium)<br>LONHALA MAGNAIR (glycopyrrolate)<br>SEEBRI NEOHALER (glycopyrrolate)<br>YUPELRI SOLUTION (revefenacin) | |
| **ANTICHOLINERGIC-BETA AGONIST COMBINATIONS[AP]** | | |
| ANORO ELLIPTA (umeclidinium/vilanterol)<br>albuterol/ipratropium nebulizer solution<br>BEVESPI (glycopyrrolate/formoterol)<br>COMBIVENT RESPIMAT (albuterol/ipratropium)<br>UTIBRON (indacaterol/glycopyrrolate) | DUAKLIR PRESSAIR (aclidinium/formoterol)*<br>DUONEB (albuterol/ipratropium)<br>STIOLTO RESPIMAT (tiotropium/olodaterol)** | *In addition to the Class PA criteria, Duaklir Pressair requires sixty (60) day trials of each long acting preferred agent, as well as a 60-day trial of Stiolto Respimat.<br><br>**In addition to the Class PA criteria, Stiolto Respimat requires a sixty (60) day trial of a long acting preferred agent. |
| **ANTICHOLINERGIC-BETA AGONIST-GLUCOCORTICOID COMBINATIONS** | | |
| | TRELEGY ELLIPTA (fluticasone/umeclidinium/vilanterol)* | * Trelegy Ellipta may be prior authorized for patients currently established on the individual components for at least 30 days. |
| **PDE4 INHIBITOR** | | |
| | DALIRESP (roflumilast)* | *Daliresp will be authorized if the following criteria are met:<br>1. Patient is forty (40) years of age or older **and**<br>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**<br>3. Concurrent therapy with an inhaled corticosteroid and long-acting bronchodilator and evidence of |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | | compliance **and**<br>4. No evidence of moderate to severe liver impairment (Child-Pugh Class B or C) **and**<br>5. No concurrent use with strong cytochrome P450 inducers (rifampicin, phenobarbital, carbamazepine or phenytoin) |
| **CYTOKINE & CAM ANTAGONISTS**[CL] | | |
| **CLASS 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. *Patients stabilized for at least 6-months on their existing non-preferred regimen shall be grandfathered (provided the current therapy is for a labeled indicaton). All off-label requests require review by the Medical Director.* | | |
| **ANTI-TNFs** | | |
| ENBREL (etanercept)*<br>HUMIRA (adalimumab)* | CIMZIA (certolizumab pegol)<br>REMICADE (infliximab)<br>RENFLEXIS (infliximab)<br>SIMPONI subcutaneous (golimumab) | *Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. |
| **OTHERS** | | |
| COSENTYX (secukinumab)* | ACTEMRA subcutaneous (tocilizumab)<br>ENTYVIO (vedolizumab)<br>ILARIS (canakinumab)<br>ILUMYA (tildrakizumab)<br>KEVZARA (sarilumab)<br>KINERET (anakinra)<br>OLUMIANT (baricitinib)<br>ORENCIA subcutaneous (abatacept)<br>OTEZLA (apremilast)<br>RINVOQ ER (upadacitinib)<br>SILIQ (brodalumab)<br>SKYRIZI (risankizumab)<br>STELARA subcutaneous (ustekinumab)<br>TALTZ (ixekizumab)<br>TREMFYA (guselkumab)<br>XELJANZ (tofacitinib)<br>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 one preferred agent. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **EPINEPHRINE, SELF-INJECTED** | | |
| **CLASS PA CRITERIA:** A non-preferred agent may be authorized with documentation showing the patient's inability to follow the instructions, or the patient's failure to understand the training for the preferred agent(s). | | |
| epinephrine (labeler 49502 only) | ADRENACLICK (epinephrine)<br>epinephrine (all labelers except 49502)<br>EPIPEN (epinephrine)<br>EPIPEN JR (epinephrine)<br>SYMJEPI (epinephrine) | |
| **ERYTHROPOIESIS STIMULATING PROTEINS**[CL] | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a thirty (30) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| EPOGEN (rHuEPO)<br>RETACRIT (epoetin alfa) | ARANESP (darbepoetin)<br>MIRCERA (methoxy PEG-epoetin)<br>PROCRIT (rHuEPO) | Erythropoiesis agents will be authorized if the following criteria are met:<br>1. Hemoglobin or Hematocrit less than 10/30 respectively. For renewal, hemoglobin or hematocrit levels greater than 12/36 will require dosage reduction or discontinuation. Exceptions will be considered on an individual basis after medical documentation is reviewed. (Lab oratory values must be dated within six (6) weeks of request.) **and**<br>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**<br>3. For HIV-infected patients, endogenous serum erythropoietin level must be ≤ 500mU/ml to initiate therapy **and**<br>4. No evidence of untreated GI bleeding, hemolysis, or Vitamin B-12, iron or folate deficiency. |
| **FLUOROQUINOLONES (Oral)**[AP] | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a five (5) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| CIPRO SUSPENSION (ciprofloxacin)<br>ciprofloxacin | AVELOX (moxifloxacin)<br>BAXDELA (delafloxacin) | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| levofloxacin tablet | CIPRO TABLETS (ciprofloxacin)<br>CIPRO XR (ciprofloxacin)<br>ciprofloxacin ER<br>ciprofloxacin suspension<br>LEVAQUIN (levofloxacin)<br>levofloxacin solution<br>moxifloxacin<br>NOROXIN (norfloxacin)<br>ofloxacin | |
| **GLUCOCORTICOIDS, INHALED[AP]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require thirty (30) day trials of each chemically unique preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| | **GLUCOCORTICOIDS** | |
| ASMANEX TWISTHALER (mometasone)<br>FLOVENT DISKUS (fluticasone)<br>FLOVENT HFA (fluticasone)<br>PULMICORT FLEXHALER (budesonide)<br>PULMICORT NEBULIZER 0.5 mg/2 ml & 0.25 mg/2 ml SOLUTION (budesonide)<br>PULMICORT RESPULES (budesonide)*<br>QVAR REDIHALER (beclomethasone) | AEROSPAN (flunisolide)**<br>ALVESCO (ciclesonide)<br>ARMONAIR RESPICLICK (fluticasone)<br>ARNUITY ELLIPTA (fluticasone)<br>ASMANEX HFA (mometasone)<br>budesonide nebulizer<br>PULMICORT NEBULIZER 1 mg/2 ml SOLUTION (budesonide) | *Pulmicort Respules are only preferred for children up to nine (9) years of age. For patients nine (9) and older, prior authorization is required and will be approved only for a diagnosis of severe nasal polyps.<br><br>**Aerospan will be authorized for children ages 6 through 11 years old without a trial of a preferred agent. |
| | **GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS** | |
| ADVAIR HFA (fluticasone/salmeterol)<br>DULERA (mometasone/formoterol)<br>fluticasone/salmeterol<br>SYMBICORT(budesonide/formoterol) | ADVAIR DISKUS (fluticasone/salmeterol)<br>AIRDUO RESPICLICK (fluticasone/salmeterol)<br>BREO ELLIPTA (fluticasone/vilanterol)<br>WIXELA (fluticasone/salmeterol) | |
| **GROWTH HORMONE[CL]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require three (3) month trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| GENOTROPIN (somatropin)<br>NORDITROPIN (somatropin) | HUMATROPE (somatropin)<br>INCRELEX (mecasermin)<br>NUTROPIN AQ (somatropin)<br>OMNITROPE (somatropin)<br>SAIZEN (somatropin)<br>SEROSTIM (somatropin)<br>ZOMACTON (somatropin)<br>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. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| ***H. PYLORI* TREATMENT** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a trial of the combination of individual preferred components of the requested non-preferred agent and must be used at the recommended dosages, frequencies and duration of the non-preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| Please use individual components:<br>preferred PPI (omeprazole or pantoprazole)<br>amoxicillin<br>tetracycline<br>metronidazole<br>clarithromycin<br>bismuth<br>PYLERA (bismuth/metronidazole/tetracycline) | HELIDAC (bismuth/metronidazole/tetracycline)<br>lansoprazole/amoxicillin/clarithromycin<br>OMECLAMOX-PAK (omeprazole/amoxicillin/clarithromycin)<br>PREVPAC (lansoprazole/amoxicillin/clarithromycin) | |
| **HEPATITIS B TREATMENTS** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require ninety (90) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| BARACLUDE SOLUTION (entecavir) *<br>entecavir<br>lamivudine HBV | adefovir<br>BARACLUDE TABLET (entecavir)<br>EPIVIR HBV (lamivudine)<br>HEPSERA (adefovir)<br>VEMLIDY (tenofovir alafenamide fumarate) | *Baraclude solution will be authorized only for patients with documentation of dysphagia. |
| **HEPATITIS C TREATMENTS[CL]** | | |
| **CLASS PA CRITERIA:** For patients starting therapy in this class, preferred regimens may be found on the PA Criteria page. Requests for non-preferred regimens require medical reasoning why a preferred regimen cannot be used. | | |
| EPCLUSA (sofosbuvir/velpatasvir)*<br>MAVYRET (pibrentasvir/glecaprevir)*<br>ribavirin<br>ZEPATIER (elbasvir/grazoprevir)* | COPEGUS (ribavirin)<br>DAKLINZA (daclatasvir)*<br>HARVONI (ledipasvir/sofosbuvir)*<br>ledipasvir/sofosbuvir*<br>MODERIBA 400 mg, 600 mg<br>MODERIBA DOSE PACK<br>PEGASYS (pegylated interferon)<br>PEG-INTRON (pegylated interferon)<br>OLYSIO (simeprevir)*<br>REBETOL (ribavirin)<br>RIBASPHERE RIBAPAK (ribavirin)<br>RIBASPHERE 400 mg, 600 mg (ribavirin)<br>sofosbuvir/velpatasvir*<br>SOVALDI (sofosbuvir)* | *Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | TECHNIVIE (ombitasvir/paritaprevir/ritonavir)*<br>VIEKIRA PAK (dasabuvir/ombitasvir/ paritaprevir/ritonavir)*<br>VIEKIRA XR (dasabuvir/ombitasvir/ paritaprevir/ritonavir)*<br>VOSEVI (sofosbuvir/velpatasvir/voxilaprevir) | |
| **HYPERPARATHYROID AGENTS[AP]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require thirty (30) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| paricalcitol capsule | cinacalcet<br>doxercalciferol<br>HECTOROL (doxercalciferol)<br>paricalcitol injection<br>RAYALDEE (calcifediol)<br>SENSIPAR (cinacalcet)<br>ZEMPLAR (paricalcitol) | |
| **HYPOGLYCEMICS, BIGUANIDES** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a ninety (90) day trial of a preferred agent of similar duration before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| metformin<br>metformin ER (generic Glucophage XR) | FORTAMET (metformin ER)<br>GLUCOPHAGE (metformin)<br>GLUCOPHAGE XR (metformin ER)<br>GLUMETZA (metformin ER)*<br>metformin ER (generic Glumetza & Fortamet)<br>RIOMET (metformin) | *Glumetza will be approved only after a 30-day trial of Fortamet. |
| **HYPOGLYCEMICS, DPP-4 INHIBITORS** | | |
| **CLASS PA CRITERIA: Non-preferred agents are available only on appeal.**<br><br>**NOTE: DPP-4 inhibitors will NOT be approved in combination with a GLP-1 agonist.** | | |
| JANUMET (sitagliptin/metformin)<br>JANUMET XR (sitagliptin/metformin)<br>JANUVIA (sitagliptin)<br>JENTADUETO (linagliptin/metformin) | alogliptin<br>alogliptin/metformin<br>alogliptin/pioglitazone<br>JENTADUETO XR (linagliptin/metformin) | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| TRADJENTA (linagliptin) | KAZANO (alogliptin/metformin)<br>KOMBIGLYZE XR (saxagliptin/metformin)<br>NESINA (alogliptin)<br>ONGLYZA (saxagliptin)<br>OSENI (alogliptin/pioglitazone) | |
| **HYPOGLYCEMICS, GLP-1 AGONISTS[CL]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents will only be approved (in 6-month intervals) if ALL of the following criteria has been met:<br><br>1) Current A1C must be submitted. Agents in this class will not be approved for patients with a starting A1C of less than (<) 7%.<br>2) Documentation demonstrating 90 days of compliance on all current diabetic therapies is provided.<br>3) Documentation demonstrating treatment failure with all unique preferred agents in the same class.<br><br>Re-authorizations will require documentation of continued compliance on all diabetic therapies and A1C levels must reach goal, (either an A1C of ≤8%, or demonstrated continued improvement).<br><br>**NOTE: GLP-1 agents will NOT be approved in combination with a DPP-4 inhibitor.** | | |
| OZEMPIC (semaglutide)<br>TRULICITY (dulaglutide)<br>VICTOZA (liraglutide) | ADLYXIN (lixisenatide)<br>BYDUREON (exenatide)<br>BYETTA (exenatide)<br>BYDUREON BCISE (exenatide)<br>RYBELSUS (semaglutide)<br>TANZEUM (albiglutide) | |
| **HYPOGLYCEMICS, INSULIN AND RELATED AGENTS** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a ninety (90) day trial of a pharmacokinetically similar agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| APIDRA (insulin gluisine)[AP]*<br>FIASP (insulin aspart)<br>HUMALOG (insulin lispro)<br>HUMALOG JR KWIKPEN (insulin lispro)<br>HUMALOG KWIKPEN U-100 (insulin lispro)<br>HUMALOG MIX PENS (insulin lispro/lispro protamine)<br>HUMALOG MIX VIALS (insulin lispro/lispro protamine)<br>HUMULIN N VIAL (insulin) | ADMELOG (insulin lispro)<br>AFREZZA (insulin)[CL]<br>BASAGLAR (insulin glargine)<br>HUMULIN PENS (insulin)<br>HUMULIN R VIAL (insulin)<br>HUMULIN 70/30 (insulin)<br>NOVOLIN (insulin)<br>SOLIQUA (insulin glargine/lixisenatide)**<br>TOUJEO SOLOSTAR (insulin glargine)***<br>XULTOPHY (insulin degludec/liraglutide)** | *Apidra will be authorized if the following criteria are met:<br>1. Patient is four (4) years of age or older; **and**<br>2. Patient is currently on a regimen including a longer acting or basal insulin, **and**<br>3. Patient has had a trial of a similar preferred agent, Novolog or Humalog, with documentation that the desired results were not achieved..<br><br>** Non-preferred insulin combination products require that the patient must already be established on the individual agents at |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| HUMULIN R U-500 VIAL (insulin)<br>HUMULIN R U-500 KWIKPEN (insulin)<br>LANTUS (insulin glargine)<br>LEVEMIR (insulin detemir)<br>NOVOLOG (insulin aspart)<br>NOVOLOG MIX (insulin aspart/aspart protamine)<br>TRESIBA (insulin degludec)<br>TRESIBA FLEXTOUCH (insulin degludec) | | doses not exceeding the maximum dose achievable with the combination product, and require medical reasoning beyond convenience or enhanced compliance as to why the clinical need cannot be met with a combination of preferred single-ingredient agents.<br><br>***Toujeo Solostar and Toujeo Max Solostar may be approved only for:<br>1.) Patients who require once-daily doses of at least 60 units of long-acting insulin and have demonstrated at least a 6-month history of compliance on preferred long-acting insulin and who continue to have regular incidents of hypoglycemia.<br>**OR**<br>2.) Patients who currently require over 200 units per day of long-acting insulin. |
| **HYPOGLYCEMICS, MEGLITINIDES** | | |
| **CLASS PA CRITERIA: Non-preferred agents are available only on appeal.** | | |
| **MEGLITINIDES** | | |
| nateglinide<br>repaglinide | PRANDIN (repaglinide)<br>STARLIX (nateglinide) | |
| **MEGLITINIDE COMBINATIONS** | | |
| | PRANDIMET (repaglinide/metformin)<br>repaglinide/metformin | |
| **HYPOGLYCEMICS, MISCELLANEOUS AGENTS** | | |
| **CLASS PA CRITERIA:** Welchol will be authorized for add-on therapy for type 2 diabetes when there is a previous history of a thirty (30) day trial of an oral diabetic agent. | | |
| WELCHOL (colesevelam)[AP] | SYMLIN (pramlintide)* | *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. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **HYPOGLYCEMICS, SGLT2 INHIBITORS[CL]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents will only be approved (in 6-month intervals) if ALL of the following criteria has been met:<br><br>1) Current A1C must be submitted. Agents in this class will not be approved for patients with a starting A1C of less than (<) 7%.<br>2) Documentation demonstrating 90 days of compliance on all current diabetic therapies is provided.<br>3) Documentation demonstrating treatment failure with all unique preferred agents in the same class.<br><br>Re-authorizations will require documentation of continued compliance on all diabetic therapies and A1C levels must reach goal, (either an A1C of ≤8%, or demonstrated continued improvement). | | |
| **SGLT2 INHIBITORS** | | |
| FARXIGA (dapagliflozin)<br>INVOKANA (canagliflozin)<br>JARDIANCE (empagliflozin) | STEGLATRO (ertugliflozin) | |
| **SGLT2 COMBINATIONS** | | |
| INVOKAMET (canagliflozin/metformin)<br>SYNJARDY (empagliflozin/metformin) | GLYXAMBI (empagliflozin/linagliptin)<br>INVOKAMET XR (canagliflozin/metformin)<br>SEGLUROMET (ertugliflozin/metformin<br>STEGLUJAN (ertugliflozin/sitagliptin)<br>SYNJARDY XR (empagliflozin/metformin)<br>QTERN (dapagliflozin/saxagliptin)<br>XIGDUO XR (dapagliflozin/metformin) | |
| **HYPOGLYCEMICS, TZD** | | |
| **CLASS PA CRITERIA: Non-preferred agents are available only on appeal.** | | |
| **THIAZOLIDINEDIONES** | | |
| pioglitazone | ACTOS (pioglitazone)<br>AVANDIA (rosiglitazone) | |
| **TZD COMBINATIONS** | | |
| | ACTOPLUS MET (pioglitazone/ metformin)<br>ACTOPLUS MET XR (pioglitazone/ metformin)<br>AVANDARYL (rosiglitazone/glimepiride)<br>DUETACT (pioglitazone/glimepiride)<br>pioglitazone/glimepiride<br>pioglitazone/ metformin | Patients are required to use the components of Actoplus Met and Duetact separately. Exceptions will be handled on a case-by-case basis. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **IMMUNOMODULATORS, ATOPIC DERMATITIS** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require 30-day trial of a medium to high potency topical corticosteroid **AND all** preferred agents in this class unless one (1) of the exceptions on the PA form is present. Requirement for topical corticosteroids may be excluded with involvement of sensitive areas such as the face and skin folds. | | |
| ELIDEL (pimecrolimus)<br>PROTOPIC (tacrolimus)<br>EUCRISA (crisaborole)[AP]* | DUPIXENT (dupilumab)**<br>tacrolimus ointment | *Eucrisa requires a 30-day trial of Elidel **OR** a medium to high potency corticosteroid unless contraindicated.<br><br>**Full PA criteria for Dupixent may be found on the PA Criteria page by clicking the hyperlink |
| **IMMUNOMODULATORS, GENITAL WARTS & ACTINIC KERATOSIS AGENTS** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require thirty (30) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| CONDYLOX GEL (podofilox)<br>EFUDEX (fluorouracil)<br>imiquimod | ALDARA (imiquimod)<br>CARAC (fluorouracil)<br>diclofenac 3% gel<br>fluorouracil 0.5% cream<br>fluorouracil 5% cream<br>podofilox<br>SOLARAZE (diclofenac)<br>TOLAK (fluorouracil 4% cream)<br>VEREGEN (sinecatechins)<br>ZYCLARA (imiquimod)* | *Zyclara will be authorized for a diagnosis of actinic keratosis. |
| **IMMUNOSUPPRESSIVES, ORAL** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a fourteen (14) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| azathioprine<br>cyclosporine<br>cyclosporine, modified<br>mycophenolate mofetil<br>sirolimus<br>tacrolimus capsule | ASTAGRAF XL (tacrolimus)<br>AZASAN (azathioprine)<br>CELLCEPT (mycophenolate mofetil)<br>ENVARSUS XR (tacrolimus)<br>IMURAN (azathioprine)<br>mycophenolic acid<br>mycophenolic mofetil suspension<br>MYFORTIC (mycophenolic acid)<br>NEORAL (cyclosporine, modified)<br>PROGRAF (tacrolimus) | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | RAPAMUNE (sirolimus)<br>SANDIMMUNE (cyclosporine)<br>ZORTRESS (everolimus) | |
| **INTRANASAL RHINITIS AGENTS[AP]** | | |
| **CLASS PA CRITERIA:** See below for individual sub-class criteria. | | |
| **ANTICHOLINERGICS** | | |
| ipratropium | ATROVENT (ipratropium) | Non-preferred agents require thirty (30) day trials of one (1) preferred nasal anti-cholinergic agent, **AND** one (1) preferred antihistamine **AND** one (1) preferred intranasal corticosteroid agent before they will be approved, unless one (1) of the exceptions on the PA form is present. |
| **ANTIHISTAMINES** | | |
| azelastine | ASTEPRO (azelastine)<br>olopatadine<br>PATANASE (olopatadine) | Non-preferred agents require thirty (30) day trials of one (1) preferred antihistamine **AND** one (1) preferred intranasal corticosteroid before they will be approved, unless one (1) of the exceptions on the PA form is present. |
| **COMBINATIONS** | | |
| | DYMISTA (azelastine / fluticasone) | Dymista requires a concurrent thirty (30) day trial of each preferred component before it will be approved, unless one (1) of the exceptions on the PA form is present. |
| **CORTICOSTEROIDS** | | |
| fluticasone propionate<br>OMNARIS (ciclesonide)<br>QNASL HFA (beclomethasone)<br>ZETONNA (ciclesonide) | BECONASE AQ (beclomethasone)<br>budesonide<br>flunisolide<br>mometasone<br>NASACORT AQ (triamcinolone)<br>NASONEX (mometasone)<br>triamcinolone<br>VERAMYST (fluticasone furoate) | Non-preferred agents require thirty (30) day trials of each preferred agent in this sub-class before they will be approved, unless one (1) of the exceptions on the PA form is present |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **IRRITABLE BOWEL SYNDROME/SHORT BOWEL SYNDROME/SELECTED GI AGENTS [CL]** | | |
| **CLASS PA CRITERIA:** All agents are approvable only for patients age eighteen (18) and older. **See below for additional sub-class criteria.** | | |
| **CONSTIPATION** | | |
| AMITIZA (lubiprostone)<br>LINZESS (linaclotide)<br>MOVANTIK (naloxegol) | MOTEGRITY (prucalopride)<br>RELISTOR INJECTION (methylnaltrexone)<br>RELISTOR TABLET (methylnaltrexone)<br>SYMPROIC (naldemedine)<br>TRULANCE (plecanatide) | All agents in this subclass require documentation of the current diagnosis and evidence that the patient has failed to find relief with dietary modification and a fourteen (14) day trial of an osmotic laxative.<br><br>No agent shall be approved to treat opioid induced constipation (OIC) without evidence of at least 90-days of opioid use preceding the request. Continuation of coverage shall be granted with evidence of continuous and concurrent opioid use.<br><br>**Agents may be authorized only for their FDA-approved labeled indication. The following agent-specific criteria shall also apply:**<br><br>**Motegrity** requires a 30-day trial of both Amitiza and Linzess.<br>**Relistor** and **Symproic** are indicated for OIC and require thirty (30) day trials of both Movantik and Amitiza.<br>**Trulance** requires thirty (30) day trials of both Amitiza and Linzess, however for the indication of IBS-C in males, a trial of Amitiza is not required. |
| **DIARRHEA** | | |
| | alosetron<br>MYTESI (crofelemer)<br>LOTRONEX (alosetron)<br>VIBERZI (eluxadoline) | Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. |
| **LAXATIVES AND CATHARTICS** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require thirty (30) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present | | |
| COLYTE<br>GOLYTELY | HALFLYTELY-BISACODYL KIT<br>MOVIPREP | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| NULYTELY<br>peg 3350 | OSMOPREP<br>PREPOPIK<br>SUPREP | |
| **LEUKOTRIENE MODIFIERS** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require thirty (30) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| montelukast<br>zafirlukast | ACCOLATE (zafirlukast)<br>SINGULAIR (montelukast)<br>zileuton<br>ZYFLO (zileuton) | |
| **LIPOTROPICS, OTHER (Non-statins)** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a twelve (12) week trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| **BILE ACID SEQUESTRANTS[AP]** | | |
| cholestyramine<br>colestipol tablets | COLESTID (colestipol)<br>colestipol granules<br>KYNAMRO (mipomersen)*<br>QUESTRAN (cholestyramine)<br>WELCHOL (colesevelam)** | *Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.<br><br>**Welchol will be authorized for add-on therapy for type 2 diabetes when there is a previous history of a thirty (30) day trial of an oral agent (metformin, sulfonylurea or thiazolidinedione (TZD)). See HYPOGLYCEMICS, MISCELLANEOUS. |
| **CHOLESTEROL ABSORPTION INHIBITORS** | | |
| ezetimibe | ZETIA (ezetimibe) | |
| **FATTY ACIDS[CL]** | | |
| omega-3 acid ethyl esters<br>VASCEPA (icosapent ethyl) | LOVAZA (omega-3-acid ethyl esters) | [CL]All agents in this subclass require a prior authorization and an initial triglyceride level ≥ 500 mg/dL.<br>Additionally, Vascepa may be approved if the following criteria is met:<br>1. The patient has an initial triglyceride level of ≥ 150 mg/dL prior to start of therapy; AND<br>2. The patient has established cardiovascular disease or diabetes; AND<br>3. The patient is concomitantly receiving a statin. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | **FIBRIC ACID DERIVATIVES[AP]** | |
| fenofibrate 54 and 160 mg<br>fenofibrate micronized 67mg, 134mg & 200mg<br>fenofibrate nanocrystallized 48 mg, 145 mg<br>gemfibrozil | ANTARA (fenofibrate)<br>FENOGLIDE (fenofibrate)<br>FIBRICOR (fenofibric acid)<br>fenofibrate 40 mg tablet<br>fenofibrate 150 mg capsules<br>fenofibrate 43, 50, 120 and 130 mg<br>fenofibric acid<br>LIPOFEN (fenofibrate)<br>LOFIBRA (fenofibrate)<br>LOPID (gemfibrozil)<br>TRICOR (fenofibrate nanocrystallized)<br>TRIGLIDE (fenofibrate)<br>TRILIPIX (fenofibric acid) | |
| | **MTP INHIBITORS** | |
| | JUXTAPID (lomitapide)* | *Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. |
| | **NIACIN** | |
| niacin<br>niacin ER (OTC)<br>NIACOR (niacin)<br>NIASPAN (niacin) | niacin ER (Rx) | |
| | **PCSK-9 INHIBITORS** | |
| | PRALUENT (alirocumab)*<br>REPATHA (evolocumab)* | *Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. |
| **LIPOTROPICS, STATINS[AP]** | | |
| **CLASS PA CRITERIA:** See below for individual sub-class criteria. | | |
| | **STATINS** | |
| atorvastatin<br>lovastatin<br>pravastatin<br>rosuvastatin<br>simvastatin* | ALTOPREV (lovastatin)<br>CRESTOR (rosuvastatin)<br>EZALLOR (rosuvastatin)[NR]<br>EZALLOR SPRINKLE (rosuvastatin)*<br>fluvastatin<br>fluvastatin ER<br>LESCOL (fluvastatin)<br>LESCOL XL (fluvastatin)<br>LIPITOR (atorvastatin)<br>LIVALO (pitavastatin) | Non-preferred agents require twelve (12) week trials of two (2) preferred agents, including the generic formulation of the requested non-preferred agent, before they will be approved, unless one (1) of the exceptions on the PA form is present.<br><br>*Ezallor SPRINKLE will only be authorized for those who are unable to ingest solid dosage forms due to documented oral-motor difficulties or dysphagia.<br><br>**Zocor/simvastatin 80mg tablets will require a clinical PA. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | MEVACOR (lovastatin)<br>PRAVACHOL (pravastatin)<br>ZOCOR (simvastatin)**<br>ZYPITAMAG (pitavastatin) | |
| | **STATIN COMBINATIONS** | |
| | ADVICOR (lovastatin/niacin)<br>amlodipine/atorvastatin<br>CADUET (atorvastatin/amlodipine)<br>ezetimibe/simvastatin<br>LIPTRUZET (atorvastatin/ezetimibe)<br>SIMCOR (simvastatin/niacin ER)<br>VYTORIN (simvastatin/ezetimibe)* | Non-preferred agents require thirty (30) day concurrent trials of the corresponding preferred single agents before they will be approved, unless one (1) of the exceptions on the PA form is present.<br><br>*Vytorin will be authorized only after an insufficient response to a twelve (12) week trial of the maximum tolerable dose of atorvastatin or rosuvastatin, unless one (1) of the exceptions on the PA form is present.<br><br>Vytorin 80/10mg tablets will require a clinical PA. |
| **MABS, ANTI-IL/IgE** | | |
| **CLASS PA CRITERIA: Full PA Criteria may be found on the PA Criteria page by clicking the hyperlink.** | | |
| | DUPIXENT (dupilumab)<br>FASENRA (benralizumab)<br>FASENRA PEN (benralizumab)<br>NUCALA SYRINGE/VIAL (mepolizumab)<br>NUCALA AUTO INJECTOR (mepolizumab)<br>XOLAIR (omalizumab) | |
| **MACROLIDES** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a five (5) day trial of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| | **MACROLIDES** | |
| azithromycin<br>erythromycin base | BIAXIN (clarithromycin)<br>clarithromycin tablets<br>clarithromycin ER<br>clarithromycin suspension<br>E.E.S. (erythromycin ethylsuccinate)<br>E-MYCIN (erythromycin)<br>ERYC (erythromycin)<br>ERYPED (erythromycin ethylsuccinate)<br>ERY-TAB (erythromycin)<br>ERYTHROCIN (erythromycin stearate)<br>erythromycin estolate | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | PCE (erythromycin)<br>ZITHROMAX (azithromycin)<br>ZMAX (azithromycin) | |
| **MULTIPLE SCLEROSIS AGENTS[CL]** | | |
| **CLASS PA CRITERIA: All agents require a prior authorization and documented diagnosis of multiple sclerosis.** Preferred oral agents require a ninety (90) day trial of any preferred injectable agent. Non-preferred agents require ninety (90) day trials of each chemically unique preferred agent (in the same sub-class) before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| **INTERFERONS[AP]** | | |
| AVONEX (interferon beta-1a)<br>AVONEX PEN (interferon beta-1a)<br>BETASERON (interferon beta-1b)<br>REBIF (interferon beta-1a)<br>REBIF REBIDOSE (interferon beta-1a) | EXTAVIA KIT (interferon beta-1b)<br>EXTAVIA VIAL (interferon beta-1b)<br>PLEGRIDY (peginterferon beta-1a) | |
| **NON-INTERFERONS** | | |
| AMPYRA (dalfampridine)*<br>AUBAGIO (teriflunomide)**<br>COPAXONE 20 mg (glatiramer)<br>GILENYA (fingolimod) | COPAXONE 40 mg (glatiramer)***<br>glatiramer<br>GLATOPA (glatiramer)<br>MAYZENT (siponimod)****<br>MAVENCLAD (cladribine)<br>TECFIDERA (dimethyl fumarate)*****<br>ZINBRYTA (daclizumab) | **In addition to class PA criteria, the following conditions and criteria may also apply:**<br><br>*Ampyra requires the following additional criteria to be met:<br>1. Diagnosis of multiple sclerosis **and**<br>2. No history of seizures **and**<br>3. No evidence of moderate or severe renal impairment.<br><br>**Aubagio requires the following additional criteria to be met:<br>1. Diagnosis of relapsing multiple sclerosis **and**<br>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**<br>3. Complete blood cell count (CBC) within six (6) months before initiation of therapy **and**<br>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**<br>5. Patient is between eighteen (18) up to sixty-five (65) years of age **and**<br>6. Negative tuberculin skin test before initiation of therapy<br><br>***Copaxone 40mg will only be authorized for documented injection site issues. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | | ****Mayzent may be authorized with no additional requirement beyond the diagnosis for patients with documented secondary progressive MS.<br><br>*****Tecfidera requires the following additional criteria to be met:<br>1. Diagnosis of relapsing multiple sclerosis **and**<br>2. Complete blood count (CBC) within six (6) months of initiation of therapy and six (6) months after initiation **and**<br>3. Complete blood count (CBC) annually during therapy. |
| **NEUROPATHIC PAIN** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a thirty (30) day trial of a preferred agent in the corresponding dosage form (oral or topical) before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| capsaicin OTC<br>duloxetine<br>gabapentin<br>lidocaine patch<br>pregabalin capsule | CYMBALTA (duloxetine)<br>DRIZALMA SPRINKLE (duloxetine)*<br>GRALISE (gabapentin)**<br>HORIZANT (gabapentin)<br>IRENKA (duloxetine)<br>LIDODERM (lidocaine)<br>LYRICA CR (pregabalin)***<br>LYRICA SOLUTION (pregabalin)***<br>NEURONTIN (gabapentin)$^{AP}$<br>QUTENZA (capsaicin)<br>SAVELLA (milnacipran)****<br>ZTLIDO PATCH (lidocaine)<br>LYRICA CAPSULE (pregabalin) | *Drizalma SPRINKLE will only be authorized for those who are unable to ingest solid dosage forms due to documented oral-motor difficulties or dysphagia.<br><br>**Gralise will be authorized only if the following criteria are met:<br>1. Diagnosis of post herpetic neuralgia **and**<br>2. Trial of a tricyclic antidepressant for a least thirty (30) days **and**<br>3. 90-day trial of gabapentin immediate release formulation (positive response without adequate duration) **and**<br>4. Request is for once daily dosing with 1800 mg maximum daily dosage.<br><br>***Lyrica CR and Lyrica Solution require medical reasoning beyond convenience as to why the need cannot be met using preferred pregabalin capsules.<br><br>****Savella will be authorized for a diagnosis of fibromyalgia only after a 90-day trial of one preferred agent |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **NSAIDS[AP]** | | |
| **CLASS PA CRITERIA:** See below for sub-class PA criteria. | | |
| **NON-SELECTIVE** | | |
| diclofenac (IR, SR)<br>flurbiprofen<br>ibuprofen (Rx and OTC)<br>INDOCIN SUSPENSION (indomethacin)<br>indomethacin<br>ketoprofen<br>ketorolac<br>meloxicam tablet<br>nabumetone<br>naproxen sodium tablet<br>naproxen sodium DS tablet<br>naproxen suspension<br>EC-naproxen DR tablet<br>piroxicam<br>sulindac | CATAFLAM (diclofenac)<br>CLINORIL (sulindac)<br>DAYPRO (oxaprozin)<br>diflunisal<br>DUEXIS (famotidine/ibuprofen)<br>etodolac IR<br>etodolac SR<br>FELDENE (piroxicam)<br>fenoprofen<br>INDOCIN SUPPOSITORIES (indomethacin)<br>indomethacin ER<br>ketoprofen ER<br>meclofenamate<br>mefenamic acid<br>meloxicam suspension<br>MOBIC TABLET (meloxicam)<br>NALFON (fenoprofen)<br>NAPRELAN (naproxen)<br>NAPROSYN (naproxen)<br>naproxen CR<br>oxaprozin<br>PONSTEL (meclofenamate)<br>RELAFEN DS (nabumetone)<br>SPRIX (ketorolac)<br>TIVORBEX (indomethacin)<br>tolmetin<br>VIVLODEX (meloxicam)<br>VOLTAREN (diclofenac)<br>ZIPSOR (diclofenac potassium)<br>ZORVOLEX (diclofenac) | Non-preferred agents require thirty (30) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | **NSAID/GI PROTECTANT COMBINATIONS** | |
| | ARTHROTEC (diclofenac/misoprostol)<br>diclofenac/misoprostol<br>VIMOVO (naproxen/esomeprazole) | Non-preferred agents are only available on appeal and require medical reasoning beyond convenience as to why the need cannot be met with the combination of preferred single agents. |
| | **COX-II SELECTIVE** | |
| | CELEBREX (celecoxib)<br>celecoxib | COX-II Selective agents require thirty (30) day trials of each preferred Non-Selective Oral NSAID, **UNLESS** the following criteria are met:<br><br>Patient has a history or risk of a serious GI complication; **OR**<br>Agent is requested for treatment of a chronic condition **and**<br>1. Patient is seventy (70) years of age or older, **or**<br>2. Patient is currently on anticoagulation therapy**.** |
| | **TOPICAL** | |
| FLECTOR PATCH (diclofenac)*<br>VOLTAREN GEL (diclofenac)** | diclofenac gel<br>diclofenac solution<br>PENNSAID (diclofenac) | *Flector patches are limited to two per day.<br><br>**Voltaren Gel will be limited to 100 grams per month.<br><br>Non-preferred agents require a thirty (30) day trial of the preferred Topical agent and thirty (30) day trials of each preferred oral NSAID before they will be approved, unless one(1) of the exceptions on the PA form is present. |
| **OPHTHALMIC ANTIBIOTICS**[AP] | | |
| **CLASS PA CRITERIA:** Non-preferred agents require three (3) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| bacitracin/polymyxin ointment<br>ciprofloxacin*<br>erythromycin<br>gentamicin<br>levofloxacin*<br>MOXEZA (moxifloxacin)<br>neomycin/bacitracin/polymyxin<br>ofloxacin*<br>polymyxin/trimethoprim<br>tobramycin<br>TOBREX OINT (tobramycin) | AZASITE (azithromycin)<br>bacitracin<br>BLEPH-10 (sulfacetamide)<br>BESIVANCE (besifloxacin)*<br>CILOXAN (ciprofloxacin)<br>GARAMYCIN (gentamicin)<br>gatifloxacin<br>ILOTYCIN (erythromycin)<br>moxifloxacin**<br>NATACYN (natamycin)<br>neomycin/polymyxin/gramicidin<br>NEOSPORIN (neomycin/polymyxin/gramicidin) | *Prior authorization of any fluoroquinolone agent requires three (3) day trials of all other preferred agents unless definitive laboratory cultures exist indicating the need to use a fluoroquinolone. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | OCUFLOX (ofloxacin)<br>POLYTRIM (polymyxin/trimethoprim)<br>sulfacetamide drops<br>sulfacetamide ointment<br>TOBREX (tobramycin)<br>VIGAMOX (moxifloxacin)**<br>ZYMAR (gatifloxacin)<br>ZYMAXID (gatifloxacin) | |
| **OPHTHALMIC ANTIBIOTIC/STEROID COMBINATIONS[AP]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require three (3) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| neomycin/polymyxin/dexamethasone<br>sulfacetamide/prednisolone<br>TOBRADEX OINTMENT (tobramycin/ dexamethasone)<br>TOBRADEX SUSPENSION (tobramycin/ dexamethasone)<br>ZYLET (loteprednol/tobramycin) | BLEPHAMIDE (prednisolone/sulfacetamide)<br>BLEPHAMIDE S.O.P. (prednisolone/ sulfacetamide)<br>MAXITROL ointment (neomycin/polymyxin/ dexamethasone)<br>MAXITROL suspension (neomycin/polymyxin/ dexamethasone)<br>neomycin/bacitracin/polymyxin/ hydrocortisone<br>neomycin/polymyxin/hydrocortisone<br>PRED-G (prednisolone/gentamicin)<br>TOBRADEX ST (tobramycin/ dexamethasone)<br>tobramycin/dexamethasone suspension | |
| **OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS[AP]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require thirty (30) day trials of three (3) preferred chemically unique agents before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| ALAWAY (ketotifen)<br>ALREX (loteprednol)<br>BEPREVE (bepotastine)<br>cromolyn<br>ketotifen<br>LASTACAFT (alcaftadine)<br>olopatadine 0.1% (Generic PATANOL labeler 61314 only)<br>ZADITOR OTC (ketotifen) | ALAMAST (pemirolast)<br>ALOCRIL (nedocromil)<br>ALOMIDE (lodoxamide)<br>azelastine<br>CROLOM (cromolyn)<br>ELESTAT (epinastine)<br>EMADINE (emedastine)<br>epinastine<br>olopatadine 0.1% (all formulations except Generic PATANOL labeler 61314)<br>olopatadine 0.2% (all labelers)<br>OPTICROM (cromolyn) | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | OPTIVAR (azelastine)<br>PATADAY (olopatadine)<br>PATANOL (olopatadine)<br>PAZEO (olopatadine) | |
| **OPHTHALMICS, ANTI-INFLAMMATORIES- IMMUNOMODULATORS[CL]** | | |
| **CLASS PA CRITERIA: All agents require a prior authorization.** Non-preferred agents require a 60-day trial of the preferred agent(s). | | |
| RESTASIS (cyclosporine) | CEQUA (cyclosporine)<br>RESTASIS MULTIDOSE (cyclosporine)*<br>XIIDRA (lifitegrast)* | ***Restasis Multidose** is approvable only on appeal and requires medical reasoning as to why the clinical need cannot be met with the preferred product (Restasis).<br><br>**All agents must meet the following prior-authorization criteria:**<br>1.) Patient must be sixteen (16) years of age or greater; **AND**<br>2.) Prior Authorization must be requested by an ophthalmologist or optometrist; **AND**<br>3.) Clinically diagnosed tear deficiency due to ocular inflammation in patients with keratoconjunctivitis sicca or dry eye syndrome (also known as dry eye); **AND**<br>4.) Patient must have a functioning lacrimal gland; **AND**<br>5.) Patient using artificial tears at least four (4) times a day over the last thirty (30) days; **AND**<br>Patient must not have an active ocular infection |
| **OPHTHALMICS, ANTI-INFLAMMATORIES** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require five (5) day trials of at least two (2) preferred agents before they will be approved, unless one (1) of the exceptions on the PA form is present. Trials must include at least one agent with the same mechanism of action as the requested non-preferred agent. | | |
| dexamethasone<br>diclofenac<br>DUREZOL (difluprednate)<br>fluorometholone<br>FML FORTE (fluorometholone)<br>FML S.O.P. (fluorometholone)<br>ketorolac<br>LOTEMAX DROPS, OINTMENT (loteprednol)<br>MAXIDEX (dexamethasone)<br>NEVANAC (nepafenac)<br>PRED MILD (prednisolone) | ACULAR (ketorolac)<br>ACULAR LS (ketorolac)<br>ACUVAIL (ketorolac tromethamine)<br>BROMDAY (bromfenac)<br>bromfenac<br>BROMSITE (bromfenac)<br>FLAREX (fluorometholone)<br>flurbiprofen<br>FML (fluorometholone)<br>ILEVRO (nepafenac)<br>INVELTYS (loteprednol) | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| prednisolone acetate<br>prednisolone sodium phosphate | LOTEMAX GEL (loteprednol)<br>OMNIPRED (prednisolone)<br>OZURDEX (dexamethasone)<br>PRED FORTE (prednisolone)<br>PROLENSA (bromfenac)<br>RETISERT (fluocinolone)<br>TRIESENCE (triamcinolone)<br>VEXOL (rimexolone)<br>XIBROM (bromfenac) | |
| **OPHTHALMICS, GLAUCOMA AGENTS** | | |
| **CLASS PA CRITERIA:** Non-preferred agents will only be authorized if there is an allergy to all preferred agents in the corresponding sub-class. | | |
| **COMBINATION AGENTS** | | |
| COMBIGAN (brimonidine/timolol)<br>dorzolamide/timolol<br>SIMBRINZA (brinzolamide/brimonidine) | COSOPT (dorzolamide/timolol)<br>COSOPT PF (dorzolamide/timolol) | |
| **BETA BLOCKERS** | | |
| BETOPTIC S (betaxolol)<br>carteolol<br>levobunolol<br>timolol drops | BETAGAN (levobunolol)<br>betaxolol<br>ISTALOL (timolol)<br>OPTIPRANOLOL (metipranolol)<br>timolol gel<br>TIMOPTIC (timolol) | |
| **CARBONIC ANHYDRASE INHIBITORS** | | |
| AZOPT (brinzolamide)<br>orzolamide | TRUSOPT (dorzolamide) | |
| **PARASYMPATHOMIMETICS** | | |
| PHOSPHOLINE IODIDE (echothiophate iodide) | pilocarpine | |
| **PROSTAGLANDIN ANALOGS** | | |
| latanoprost<br>TRAVATAN-Z (travoprost) | bimatoprost<br>LUMIGAN (bimatoprost)<br>travoprost<br>VYZULTA (latanoprostene)*<br>XALATAN (latanoprost)<br>XELPROS (latanoprost)<br>ZIOPTAN (tafluprost) | *Vyzulta – prior authorization requires failure on a 3-month trial of at least one preferred prostaglandin eye drop used in combination with an agent from another subclass. |
| **RHO-KINASE INHIBITORS** | | |
| RHOPRESSA (netarsudil)<br>ROCKLATAN (netarsudil/latanoprost) | | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | **SYMPATHOMIMETICS** | |
| brimonidine 0.2% | ALPHAGAN P 0.1% Solution (brimonidine)<br>ALPHAGAN P 0.15% Solution (brimonidine)<br>apraclonidine<br>brimonidine 0.15%<br>IOPIDINE (apraclonidine) | |
| **OPIATE DEPENDENCE TREATMENTS** | | |
| **CLASS PA CRITERIA:** Buprenorphine/naloxone tablets, Bunavail and Zubsolv will only be approved with a documented intolerance of or allergy to Suboxone strips.<br><br>WV Medicaid's buprenorphine coverage policy may be viewed by clicking on the following hyperlink: Buprenorphine Coverage Policy and Related Forms | | |
| naloxone<br>NARCAN NASAL SPRAY (naloxone)<br>SUBOXONE FILM (buprenorphine/naloxone)*<br>VIVITROL (naltrexone) | BUNAVAIL (buprenorphine/naloxone)<br>buprenorphine tablets<br>buprenorphine/naloxone tablets<br>buprenorphine/naloxone film<br>LUCEMYRA (lofexidine)<br>SUBLOCADE (buprenorphine soln)**<br>ZUBSOLV (buprenorphine/naloxone) | * Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.<br>**Sublocade is approvable only on appeal and requires medical reasoning as to why the clinical need cannot be met with a preferred product.<br><br>VIVITROL no longer requires a PA. |
| **OTIC ANTIBIOTICS[AP]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require five (5) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| CIPRO HC (ciprofloxacin/hydrocortisone)<br>CIPRODEX (ciprofloxacin/dexamethasone)<br>COLY-MYCIN S (colistin/hydrocortisone/ neomycin/thonzonium bromide)<br>ofloxacin | ciprofloxacin<br>CORTISPORIN-TC (colistin/hydrocortisone/ neomycin)<br>neomycin/polymyxin/HC solution/suspension<br>OTOVEL ( ciprofloxacin/fluocinolone) | |
| **PAH AGENTS – ENDOTHELIN RECEPTOR ANTAGONISTS[CL]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a thirty (30) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| LETAIRIS (ambrisentan)<br>TRACLEER TABLET (bosentan) | ambrisentan<br>bosentan<br>OPSUMIT (macitentan)<br>TRACLEER SUSP (bosentan) | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **PAH AGENTS – GUANYLATE CYCLASE STIMULATOR[CL]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a thirty (30) day trial of a preferred agent from any other PAH Class before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| | ADEMPAS (riociguat) | |
| **PAH AGENTS – PDE5s[CL]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a thirty (30) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.<br>Patients stabilized on non-preferred agents will be grandfathered. | | |
| sildenafil | ADCIRCA (tadalafil)<br>REVATIO IV (sildenafil)<br>REVATIO SUSPENSION (sildenafil)<br>REVATIO TABLETS (sildenafil) | |
| **PAH AGENTS – PROSTACYCLINS[CL]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a thirty (30) day trial of a preferred agent, including the preferred generic form of the non-preferred agent (if available), before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| epoprostenol<br>VENTAVIS (iloprost)* | FLOLAN (epoprostenol)<br>ORENITRAM ER (treprostinil)<br>REMODULIN (treprostinil sodium)<br>TYVASO (treprostinil)<br>UPTRAVI (selexipag)<br>VELETRI (epoprostenol) | *Ventavis will only be authorized for the treatment of pulmonary artery hypertension (WHO Group 1) in patients with NYHA Class III or IV symptoms. |
| **PANCREATIC ENZYMES[AP]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a thirty (30) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.<br>For members with cystic fibrosis, a trial of a preferred agent will not be required. | | |
| CREON<br>ZENPEP | PANCREAZE<br>PERTZYE<br>ULTRESA<br>VIOKACE | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **PHOSPHATE BINDERS[AP]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a thirty (30) day trial of at least two (2) preferred agents before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| calcium acetate<br>CALPHRON (calcium acetate)<br>MAGNEBIND RX (calcium carbonate, folic acid, magnesium carbonate)<br>PHOSLYRA (calcium acetate)<br>sevelamer carbonate | AURYXIA (ferric citrate)<br>ELIPHOS (calcium acetate)<br>FOSRENOL (lanthanum)<br>lanthanum chewable<br>PHOSLO (calcium acetate)<br>RENAGEL (sevelamer)<br>RENVELA (sevelamer carbonate)<br>VELPHORO (sucroferric oxyhydroxide) | |
| **PITUITARY SUPPRESSIVE AGENTS, LHRH[CL]** | | |
| **CLASS PA CRITERIA:** Unless otherwise noted, non-preferred agents are available only on appeal. | | |
| LUPANETA (leuprolide)<br>LUPRON DEPOT KIT (leuprolide)<br>LUPRON DEPOT-PED KIT (leuprolide)<br>SYNAREL (nafarelin)<br>TRELSTAR (triptorelin)<br>TRIPTODUR (triptorelin)<br>VANTAS (histrelin)<br>ZOLADEX (goserelin) | leuprolide<br>ORILISSA (elagolix)*<br>SUPPRELIN LA KIT (histrelin) | * Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. |
| **PLATELET AGGREGATION INHIBITORS** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a thirty (30) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| AGGRENOX (dipyridamole/ASA)<br>BRILINTA (ticagrelor)<br>clopidogrel<br>dipyridamole<br>prasugrel | clopidogrel kit<br>dipyridamole/aspirin<br>EFFIENT (prasugrel)<br>PERSANTINE (dipyridamole)<br>PLAVIX (clopidogrel)<br>TICLID (ticlopidine)<br>ticlopidine<br>ZONTIVITY (vorapaxar) | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **PROGESTATIONAL AGENTS** | | |
| **CLASS PA CRITERIA:** Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. | | |
| MAKENA (hydroxyprogesterone caproate) AUTO INJECTOR<br>MAKENA (hydroxyprogesterone caproate) VIAL | hydroxyprogesterone caproate | |
| **PROGESTINS FOR CACHEXIA** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a thirty (30) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| megestrol | MEGACE ES (megestrol) | |
| **PROTON PUMP INHIBITORS[AP]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require sixty (60) day trials of both omeprazole (Rx) and pantoprazole at the maximum recommended dose*, inclusive of a concurrent thirty (30) day trial at the maximum dose of an $H_2$ antagonist before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| omeprazole (Rx)<br>pantoprazole<br><br>NEXIUM PACKETS (esomeprazole)**<br>PROTONIX GRANULES (pantoprazole)** | ACIPHEX (rabeprazole)<br>ACIPHEX SPRINKLE (rabeprazole)<br>DEXILANT (dexlansoprazole)<br>esomeprazole magnesium<br>esomeprazole strontium<br>lansoprazole Rx<br>NEXIUM (esomeprazole)<br>omeprazole/sodium bicarbonate (Rx)<br>PREVACID CAPSULES (lansoprazole)<br>PREVACID SOLUTABS (lansoprazole)**<br>PRILOSEC Rx (omeprazole)<br>PROTONIX DR TABLETS (pantoprazole)<br>rabeprazole<br>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.<br><br>**Prior authorization is required for members nine (9) years of age or older for these agents. |

| THERAPEUTIC DRUG CLASS | | |
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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **SEDATIVE HYPNOTICS[AP]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require thirty (30) day trials of all preferred agents in **BOTH** sub-classes before they will be approved, unless one (1) of the exceptions on the PA form is present. All agents except melatonin will be limited to fifteen (15) tablets in a thirty (30) day period. NOTE: WV Medicaid covers melatonin up to a maximum dose of 9 mg/day without a PA. Melatonin labeler code 51645 is preferred if available, however all NDCs are payable. | | |
| **BENZODIAZEPINES** | | |
| temazepam 15, 30 mg | DALMANE (flurazepam)<br>estazolam<br>flurazepam<br>HALCION (triazolam)<br>RESTORIL (temazepam)<br>temazepam 7.5, 22.5 mg<br>triazolam | |
| **OTHERS** | | |
| melatonin<br>zolpidem 5, 10 mg | AMBIEN (zolpidem)<br>AMBIEN CR (zolpidem)<br>BELSOMRA (suvorexant)<br>chloral hydrate<br>EDLUAR (zolpidem)<br>eszopiclone<br>HETLIOZ (tasimelteon)[CL]*<br>INTERMEZZO (zolpidem)<br>LUNESTA (eszopiclone)<br>ramelteon<br>ROZEREM (ramelteon)<br>SILENOR (doxepin)<br>SOMNOTE (chloral hydrate)<br>SONATA (zaleplon)<br>zaleplon<br>zolpidem ER 6.25, 12.5 mg<br>ZOLPIMIST (zolpidem) | Strengths of zolpidem that are non-preferred (6.25 and 12.5 mg) must be created by combining or splitting the preferred doses (5 and 10 mg) of zolpidem, if appropriate.<br><br>For treatment naïve female patients, zolpidem and zolpidem ER maximum dosages will be limited to 5 mg and 6.25 mg respectively per day.<br><br>*Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. |
| **SKELETAL MUSCLE RELAXANTS[AP]** | | |
| **CLASS PA CRITERIA:** See below for individual sub-class criteria. | | |
| **ACUTE MUSCULOSKELETAL RELAXANT AGENTS** | | |
| Chlorzoxazone (generic PARAFON FORTE)<br>cyclobenzaprine IR 5, 10 mg<br>methocarbamol | AMRIX (cyclobenzaprine)<br>carisoprodol*<br>carisoprodol/ASA*<br>carisoprodol/ASA/codeine* | Non-preferred agents require thirty (30) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present, with the exception of carisoprodol. |

| THERAPEUTIC DRUG CLASS | | |
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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | chlorzoxazone (generic LORZONE)<br>cyclobenzaprine ER<br>cyclobenzaprine IR 7.5 mg<br>FEXMID (cyclobenzaprine)<br>FLEXERIL (cyclobenzaprine)<br>LORZONE (chlorzoxazone)<br>metaxalone<br>orphenadrine<br>orphenadrine/ASA/caffeine<br>orphenadrine ER<br>PARAFON FORTE (chlorzoxazone)<br>ROBAXIN (methocarbamol)<br>SKELAXIN (metaxalone)<br>SOMA (carisoprodol) | *Carisoprodol requires thirty (30) day trials of each of the preferred acute musculoskeletal relaxants and Skelaxin before it will be approved. |
| **MUSCULOSKELETAL RELAXANT AGENTS USED FOR SPASTICITY** | | |
| baclofen<br>tizanidine tablets | DANTRIUM (dantrolene)<br>dantrolene<br>tizanidine capsules<br>ZANAFLEX (tizanidine) | Non-preferred agents require thirty (30) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. |
| **STEROIDS, TOPICAL** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require five (5) day trials of one (1) form of **EACH** preferred unique active ingredient in the corresponding potency group before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| **VERY HIGH & HIGH POTENCY** | | |
| betamethasone dipropionate cream<br>betamethasone valerate cream<br>betamethasone valerate lotion<br>betamethasone valerate oint<br>clobetasol propionate cream/gel/ointment/solution<br>clobetasol emollient<br>clobetasol propionate shampoo<br>fluocinonide gel<br>triamcinolone acetonide cream, ointment<br>triamcinolone acetonide lotion | amcinonide<br>APEXICON (diflorasone diacetate)<br>APEXICON E (diflorasone diacetate)<br>betamethasone dipropionate gel, lotion, ointment<br>BRYHALI LOTION (halobetasol)<br>clobetasol lotion<br>clobetasol propionate foam<br>CLOBEX (clobetasol propionate)<br>CLODAN KIT (clobetasol propionate)<br>CLODAN SHAMPOO (clobetasol propionate)<br>CORMAX (clobetasol propionate)<br>desoximetasone cream/gel/ointment<br>diflorasone diacetate<br>DIPROLENE (betamethasone dipropionate/propylene glycol)<br>DIPROLENE AF (betamethasone | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | dipropionate/propylene glycol)<br>DIPROSONE (betamethasone dipropionate)<br>fluocinonide cream<br>fluocinonide ointment<br>fluocinonide solution<br>fluocinonide/emollient<br>halcinonide<br>HALAC (halobetasol propionate)<br>halobetasol propionate<br>HALOG (halcinonide)<br>HALONATE (halobetasol propionate)<br>KENALOG (triamcinolone acetonide)<br>LEXETTE FOAM (halobetasol)<br>LIDEX (fluocinonide)<br>LIDEX-E (fluocinonide)<br>OLUX (clobetasol propionate)<br>OLUX-E (clobetasol propionate/emollient)<br>PSORCON (diflorasone diacetate)<br>SERNIVO SPRAY (betamethasone dipropionate)<br>TEMOVATE (clobetasol propionate)<br>TEMOVATE-E (clobetasol propionate/emollient)<br>TOPICORT CREAM, GEL, OINTMENT (desoximetasone)<br>TOPICORT SPRAY (desoximetasone)<br>TOVET FOAM (clobetasol)<br>ULTRAVATE (halobetasol propionate)<br>ULTRAVATE PAC cream<br>ULTRAVATE X (halobetasol propionate / lactic acid)<br>VANOS (fluocinonide) | |
| **MEDIUM POTENCY** | | |
| fluticasone propionate cream, ointment<br>mometasone furoate<br>triamcinolone acetonide 0.025% and 0.1% cream | ARISTOCORT (triamcinolone)<br>BESER LOTION (fluticasone)<br>BETA-VAL (betamethasone valerate)<br>betamethasone valerate foam<br>CLODERM (clocortolone pivalate)<br>clocortolone cream<br>CORDRAN/CORDRAN SP (flurandrenolide)<br>CUTIVATE (fluticasone propionate) | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | DERMATOP (prednicarbate)<br>ELOCON (mometasone furoate)<br>fluocinolone acetonide cream, ointment, solution<br>fluticasone propionate lotion<br>hydrocortisone butyrate cream<br>hydrocortisone butyrate ointment, solution<br>hydrocortisone valerate<br>LOCOID (hydrocortisone butyrate)<br>LOCOID LIPOCREAM (hydrocortisone butyrate/emollient)<br>LUXIQ (betamethasone valerate)<br>MOMEXIN (mometasone)<br>PANDEL (hydrocortisone probutate)<br>prednicarbate<br>TOPICORT LP (desoximetasone)<br>TRIDERM (triamcinolone acetonide)<br>WESTCORT (hydrocortisone valerate) | |
| **LOW POTENCY** | | |
| hydrocortisone acetate (Rx, OTC)<br>hydrocortisone cream (Rx, OTC)<br>hydrocortisone lotion OTC<br>hydrocortisone ointment (Rx, OTC)<br>hydrocortisone solution OTC<br>hydrocortisone-aloe cream OTC<br>hydrocortisone-aloe ointment OTC | ACLOVATE (alclometasone dipropionate)<br>alclometasone dipropionate<br>AQUA GLYCOLIC HC (hydrocortisone)<br>CAPEX (fluocinolone acetonide)<br>DERMA-SMOOTHE FS (fluocinolone acetonide)<br>DESONATE (desonide)<br>desonide cream, ointment<br>desonide lotion<br>DESOWEN (desonide)<br>fluocinolone oil<br>hydrocortisone/mineral oil/petrolatum<br>hydrocortisone acetate/urea<br>hydrocortisone lotion<br>hydrocortisone/aloe gel<br>LOKARA (desonide)<br>PEDIADERM HC (hydrocortisone)<br>PEDIADERM TA (hydrocortisone)<br>SCALPICIN OTC (hydrocortisone)<br>SYNALAR (fluocinolone)<br>TEXACORT (hydrocortisone) | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **STIMULANTS AND RELATED AGENTS** | | |
| **CLASS PA CRITERIA:** A PA is required for adults eighteen (18) years of age or older.<br><br>Non-preferred agents require a thirty (30) day trial of at least one preferred agent in the same subclass and with a similar duration of effect and mechanism of action, unless one (1) of the exceptions on the PA form is present. **NOTE**: Non-preferred agents will NOT be "grandfathered" for adults. Children under the age of 18 may continue their current therapy until the end of the school year after which they will be required to switch to a preferred agent. | | |
| **AMPHETAMINES** | | |
| amphetamine salt combination ER<br>amphetamine salt combination IR<br>dextroamphetamine ER<br>dextroamphetamine IR<br>VYVANSE CHEWABLE (lisdexamfetamine)<br>VYVANSE CAPSULE (lisdexamfetamine) | ADDERALL (amphetamine salt combination)<br>ADDERALL XR (amphetamine salt combination)<br>ADZENYS XR ODT (amphetamine)<br>ADZENYS ER SUSP (amphetamine)<br>DESOXYN (methamphetamine)<br>DEXEDRINE ER (dextroamphetamine)<br>DEXEDRINE IR (dextroamphetamine)<br>dextroamphetamine solution<br>DYANAVEL XR SUSP (amphetamine)<br>EVEKEO (amphetamine)<br>EVEKEO ODT (amphetamine)<br>methamphetamine<br>MYDAYIS (dextroamphetamine/amphetamine salt)*<br>PROCENTRA solution (dextroamphetamine)<br>ZENZEDI (dextroamphetamine) | **In addition to the Class Criteria**: Thirty (30) day trials of at least three (3) antidepressants are required before amphetamines will be authorized for depression.<br><br>*Mydayis requires a 30-day trial of at least one long-acting preferred agent in this subclass and a trial of Adderall XR. |
| **NON-AMPHETAMINE** | | |
| APTENSIO XR (methylphenidate)<br>atomoxetine<br>clonidine IR<br>dexmethylphenidate IR<br>FOCALIN XR (dexmethylphenidate)<br>guanfacine ER<br>guanfacine IR<br>methylphenidate IR<br>METHYLIN SOLUTION (methylphenidate)<br>QUILLICHEW ER (methylphenidate)<br>QUILLIVANT XR (methylphenidate) | ADHANSIA XR (methylphenidate)<br>clonidine ER<br>CONCERTA (methylphenidate)<br>COTEMPLA XR ODT (methylphenidate)<br>DAYTRANA (methylphenidate)<br>dexmethylphenidate XR<br>FOCALIN IR (dexmethylphenidate)<br>INTUNIV (guanfacine extended-release)<br>JORNAY PM (methylphenidate)<br>KAPVAY (clonidine extended-release)<br>methylphenidate CD<br>methylphenidate chewable tablets, solution<br>methylphenidate ER<br>methylphenidate ER (generic CONCERTA)<br>methylphenidate LA<br>RITALIN (methylphenidate) | * Strattera is limited to a maximum of 100 mg per day. |

| THERAPEUTIC DRUG CLASS | | |
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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | RITALIN LA (methylphenidate)<br>STRATTERA (atomoxetine)* | |
| | **NARCOLEPTIC AGENTS** | |
| armodafinil[CL]<br>modafinil[CL] | NUVIGIL (armodafinil)<br>PROVIGIL (modafinil)<br>SUNOSI (solriamfetol)*<br>WAKIX (pitolisant)** | * Sunosi is approvable only with documentation of treatment failure after 30-day trials of both armodafinil and modafinil.<br><br>**Wakix is approvable only with documentation of treatment failure after 30-day trials of armodafinil, modafinil and Sunosi. |
| **TETRACYCLINES** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require ten (10) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| doxycycline hyclate capsules<br>doxycycline hyclate 100 mg tablets<br>doxycycline monohydrate 50, 100 mg capsules<br>minocycline capsules | ADOXA (doxycycline monohydrate)<br>demeclocycline*<br>DORYX (doxycycline hyclate)<br>doxycycline hyclate 75, 150 mg tablets<br>doxycycline hyclate tablet DR 75, 100, 150, 200 mg<br>doxycycline hyclate tablet DR 50 mg<br>doxycycline monohydrate 40, 75, 150 mg capsule<br>doxycycline monohydrate tablet<br>doxycycline monohydrate suspension<br>DYNACIN (minocycline)<br>MINOCIN (minocycline)<br>minocycline ER capsules<br>minocycline tablets<br>MINOLIRA ER (minocycline)<br>MORGIDOX KIT (doxycycline)<br>ORACEA (doxycycline monohydrate)<br>SOLODYN (minocycline)<br>tetracycline<br>VIBRAMYCIN CAPSULES, SUSPENSION, SYRUP (doxycycline)<br>XIMINO (minocycline) | *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.<br>Demeclocycline will also be authorized for SIADH. |

| THERAPEUTIC DRUG CLASS | | |
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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **ULCERATIVE COLITIS AGENTS[AP]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require thirty (30) day trials of each preferred dosage form or chemical entity before the corresponding non-preferred agent of that dosage form or chemical entity will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| **ORAL** | | |
| APRISO (mesalamine)<br>ASACOL HD (mesalamine)<br>balsalazide<br>PENTASA (mesalamine) 250 mg<br>PENTASA (mesalamine) 500 mg<br>sulfasalazine | AZULFIDINE (sulfasalazine)<br>COLAZAL (balsalazide)<br>DELZICOL (mesalamine)<br>DIPENTUM (olsalazine)<br>GIAZO (balsalazide)<br>LIALDA (mesalamine)<br>mesalamine<br>UCERIS (budesonide) | |
| **RECTAL** | | |
| CANASA (mesalamine)<br>mesalamine | DELZICOL DR (mesalamine)<br>mesalamine kit<br>ROWASA (mesalamine)<br>SF ROWASA (mesalamine)<br>UCERIS (budesonide) | |
| **VASODILATORS, CORONARY** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require thirty (30) day trials of each preferred dosage form before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| **SUBLINGUAL NITROGLYCERIN** | | |
| nitroglycerin spray (generic NITROLINGUAL)<br>nitroglycerin sublingual<br>NITROSTAT SUBLINGUAL (nitroglycerin) | GONITRO SPRAY POWDER (nitroglycerin)<br>nitroglycerin spray (generic NITROMIST)<br>NITROLINGUAL SPRAY (nitroglycerin)<br>NITROMIST (nitroglycerin) | |