- 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
ANDROGENIC AGENTS			XXXX
ANTICONVULSANTS, BENZODIAZEPINES			XXXX
ANTIFUNGALS, ORAL			XXXX
ANTIPSYCHOTICS, ATYPICAL			XXXX
BPH TREATMENTS			XXXX
COPD AGENTS			XXXX
EPINEPHRINE, SELF-INJECTED			XXXX
OPHTHALMICS, ANTI-INFLAMMATORY			XXXX
OPHTHALMICS, ANTI-INFLAMMATORY-IMMUNOMODULATORS			XXXX
OPHTHALMICS, PROSTAGLANDIN ANALOGS			XXXX
STEROIDS, TOPICAL			XXXX
STIMULANTS AND RELATED AGENTS		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. In cases of pregnancy, a trial of retinoids will *not* be required. For members eighteen (18) years of age or older, a trial of retinoids will *not* be required. Acne kits are non-preferred. **Specific Criteria for sub-class will be listed below.** NOTE: Non-preferred agents in the Rosacea sub-class are available only on appeal and require at least a 30-day trial of all preferred agents in that sub-class.		
ANTI-INFECTIVE		
clindamycin gel, lotion, medicated swab, solution ERYGEL (erythromycin) erythromycin gel, solution	ACZONE (dapsone) AKNE-MYCIN (erythromycin) AZELEX (azelaic acid) CLEOCIN-T (clindamycin) CLINDACIN PAC (clindamycin) CLINDAGEL (clindamycin) clindamycin foam erythromycin medicated swab EVOCLIN (clindamycin) FABIOR (tazarotene) KLARON (sulfacetamide) OVACE/PLUS (sulfacetamide) sodium sulfacetamide 10% cleansing gel sulfacetamide cleanser sulfacetamide cleanser ER sulfacetamide shampoo sulfacetamide suspension	
RETINOIDS		
TAZORAC (tazarotene) tretinoin cream, gel	adapalene ALTRENO LOTION (tretinoin) ATRALIN (tretinoin) AVITA (tretinoin) DIFFERIN (adapalene) PLIXDA SOLUTION (adapalene) RETIN-A (tretinoin) RETIN-A MICRO (tretinoin) tazarotene cream 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 PANOXYL-4 OTC (benzoyl peroxide)	BENZEFOAM ULTRA (benzoyl peroxide) BP 10-1 (benzoyl peroxide) PANOXYL-8 OTC (benzoyl peroxide) SULPHO-LAC (sulfur)	
	COMBINATION AGENTS	
benzoyl peroxide/clindamycin gel (generic DUAC only) EPIDUO (adapalene/benzoyl peroxide)* EPIDUO FORTE (adapalene/benzoyl peroxide)* erythromycin/benzoyl peroxide	ACANYA (clindamycin phosphate/benzoyl peroxide) AVAR/-E/LS (sulfur/sulfacetamide) BENZACLIN GEL (benzoyl peroxide/ clindamycin) BENZAMYCIN PAK (benzoyl peroxide/ erythromycin) benzoyl peroxide/clindamycin gel (all generics other than DUAC) benzoyl peroxide/urea CERISA (sulfacetamide sodium/sulfur) CLARIFOAM EF (sulfacetamide/sulfur) CLENIA (sulfacetamide sodium/sulfur) DUAC (benzoyl peroxide/clindamycin) NEUAC (clindamycin phosphate/benzoyl peroxide) ONEXTON (clindamycin phosphate/benzoyl peroxide) PRASCION (sulfacetamide sodium/sulfur) SE 10-5 SS (sulfacetamide/sulfur) SSS 10-4 (sulfacetamide /sulfur) SSS 10-5 foam (sulfacetamide /sulfur) sulfacetamide sodium/sulfur cloths, lotion, pads, suspension sulfacetamide/sulfur wash/cleanser sulfacetamide/sulfur wash kit sulfacetamide sodium/sulfur/ urea SUMADAN/XLT (sulfacetamide/sulfur) SUMAXIN/TS (sulfacetamide sodium/sulfur) VELTIN (clindamycin/tretinoin)* ZIANA (clindamycin/tretinoin)*	**In addition to the Class Criteria:** Non-preferred combination agents require thirty (30) day trials of the corresponding preferred single agents before they will be approved. *PA required for combination agents with Retinoid products for members eighteen (18) years of age or older.
	ROSACEA AGENTS	
FINACEA GEL (azelaic acid) MIRVASO GEL (brimonidine) metronidazole cream	FINACEA FOAM (azelaic acid) METROCREAM (metronidazole) 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, 00713-0637-37, 51672-4116-06, 66993-0962-45 only)	METROLOTION (metronidazole) metronidazole lotion metronidazole gel (all other NDCs) NORITATE CREAM (metronidazole) RHOFADE (oxymetazoline) ROSADAN (metronidazole) 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. Prior authorization is required for members up to forty-five (45) years of age if there is no diagnosis of Alzheimer's disease.		
CHOLINESTERASE INHIBITORS		
donepezil 5 and 10 mg	ARICEPT (donepezil) donepezil 23 mg* EXELON CAPSULE (rivastigmine) EXELON PATCH (rivastigmine) galantamine galantamine ER RAZADYNE (galantamine) RAZADYNE ER (galantamine) rivastigmine	*Donepezil 23 mg tablets will be authorized if the following criteria are met: 1. There is a diagnosis of moderate-to-severe Alzheimer's Disease **and** 2. There has been a trial of donepezil 10 mg daily for at least three (3) months and donepezil 20 mg daily for an additional one (1) month.
NMDA RECEPTOR ANTAGONIST		
memantine	memantine ER memantine solution NAMENDA (memantine) NAMENDA XR (memantine)*	*****Namenda XR requires ninety (90) days of compliant therapy with Namenda.
CHOLINESTERASE INHIBITOR/NMDA RECEPTOR ANTAGONIST COMBINATIONS		
	NAMZARIC (donepezil/memantine)	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.		
buprenorphine patch (labeler 00093 only) BUTRANS (buprenorphine) EMBEDA (morphine/naltrexone) fentanyl transdermal 12, 25, 50, 75, 100 mcg/hr morphine ER tablets	ARYMO ER (morphine sulfate) BELBUCA (buprenorphine buccal film)* buprenorphine patch (all labelers excl 00093) CONZIP ER (tramadol) DOLOPHINE (methadone) DURAGESIC (fentanyl) EXALGO ER (hydromorphone) fentanyl transdermal 37.5, 62.5, 87.5 mcg/hr hydromorphone ER HYSINGLA ER (hydrocodone) KADIAN (morphine) LAZANDA SPRAY (fentanyl) methadone** MORPHABOND ER (morphine sulfate) morphine ER capsules (generic for Avinza) morphine ER capsules (generic for Kadian) MS CONTIN (morphine) NUCYNTA ER (tapentadol) OPANA ER (oxymorphone) oxycodone ER** OXYCONTIN (oxycodone) oxymorphone ER** tramadol ER*** ULTRAM ER (tramadol) XARTEMIS XR (oxycodone/ acetaminophen) XTAMPZA ER (oxycodone) ZOHYDRO ER (hydrocodone)	*Belbuca prior authorization requires manual review. Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. **Methadone, oxycodone ER and oxymorphone ER will be authorized without a trial of the preferred agents if a diagnosis of cancer is submitted. ***Tramadol ER requires a manual review and may be authorized for ninety (90) days with submission of a detailed treatment plan including anticipated duration of treatment and scheduled follow-ups with the prescriber.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ANALGESICS, NARCOTIC SHORT ACTING (Non-parenteral)[AP]		
CLASS PA CRITERIA: Non-preferred agents require six (6) day trials of at least four (4) chemically distinct preferred agents (based on the narcotic ingredient only), including the generic formulation of the requested non-preferred agent, before they will be approved, unless one (1) of the exceptions on the PA form is present. **NOTE: All tramadol and codeine products require a prior authorization for children under 18 years of age.** Requests must be for an FDA approved age and indication and specify non-opioid therapies attempted.		
APAP/codeine butalbital/APAP/caffeine/codeine codeine hydrocodone/APAP 2.5/325 mg, 5/325 mg, 7.5/325 mg,10/325 mg hydrocodone/APAP solution hydrocodone/ibuprofen hydromorphone tablets LORTAB SOLUTION (hydrocodone/acetaminophen) morphine oxycodone tablets, concentrate, solution oxycodone/APAP oxycodone/ASA pentazocine/naloxone tramadol tramadol/APAP	ABSTRAL (fentanyl) ACTIQ (fentanyl) butalbital/ASA/caffeine/codeine butorphanol CAPITAL W/CODEINE (APAP/codeine) DEMEROL (meperidine) dihydrocodeine/ APAP/caffeine DILAUDID (hydromorphone) fentanyl FENTORA (fentanyl) FIORICET W/ CODEINE (butalbital/APAP/caffeine/codeine) FIORINAL W/ CODEINE (butalbital/ASA/caffeine/codeine) hydrocodone/APAP 5/300 mg, 7.5/300 mg, 10/300 mg hydromorphone liquid, suppositories IBUDONE (hydrocodone/ibuprofen) LAZANDA (fentanyl) levorphanol LORCET (hydrocodone/APAP) LORTAB (hydrocodone/APAP) meperidine NORCO (hydrocodone/APAP) NUCYNTA (tapentadol) ONSOLIS (fentanyl) OPANA (oxymorphone) OXECTA (oxycodone) oxycodone capsules oxycodone/ibuprofen oxymorphone PERCOCET (oxycodone/APAP) PRIMLEV (oxycodone/APAP) REPREXAIN (hydrocodone/ibuprofen) 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. **Limits:** Unless the patient has escalating cancer pain or another diagnosis supporting increased quantities of short-acting opioids, all short acting solid forms of the narcotic analgesics are limited to 120 tablets per thirty (30) days. Longer-acting medications should be maximized to prevent unnecessary breakthrough pain in chronic pain therapy. Immediate-release tramadol is limited to 240 tablets per thirty (30) days.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	ROXYBOND (oxycodone) RYBIX ODT (tramadol) SUBSYS (fentanyl) SYNALGOS-DC (dihydrocodeine/ASA/ caffeine) TYLENOL W/CODEINE (APAP/codeine) ULTRACET (tramadol/APAP) ULTRAM (tramadol) VERDROCET (hydrocodone/APAP) VICODIN (hydrocodone/APAP) VICOPROFEN (hydrocodone/ibuprofen) XODOL (hydrocodone/acetaminophen) XYLON (hydrocodone/ibuprofen) 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) ANDROGEL (testosterone) METHITEST (methyltestosterone) testosterone cypionate vial[CL] testosterone enanthate vial[CL]	ANDROID (methyltestosterone) AVEED VIAL (testosterone undecanoate) AXIRON (testosterone) FORTESTA (testosterone) methyltestosterone capsule NATESTO (testosterone) STRIANT BUCCAL (testosterone) TESTIM (testosterone) TESTRED (methyltestosterone) testosterone gel VOGELXO (testosterone) XYOSTED (testosterone enanthate)[NR]	
ANESTHETICS, TOPICAL[AP]		
CLASS PA CRITERIA: Non-preferred agents require ten (10) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
lidocaine lidocaine/prilocaine xylocaine	LIDAMANTLE (lidocaine) LIDAMANTLE HC (lidocaine/hydrocortisone) lidocaine/hydrocortisone LIDOTRAL CREAM (lidocaine) LIDOZION LOTION (lidocaine) SYNERA (lidocaine/tetracaine) 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 captopril enalapril fosinopril lisinopril quinapril ramipril	ACCUPRIL (quinapril) ACEON (perindopril) ALTACE (ramipril) EPANED (enalapril)* LOTENSIN (benazepril) MAVIK (trandolapril) moexipril perindopril PRINIVIL (lisinopril) QBRELIS SOLUTION (lisinopril)** trandolapril UNIVASC (moexipril) VASOTEC (enalapril) ZESTRIL (lisinopril)	*Epaned will be authorized with a diagnosis of hypertension, symptomatic heart failure or asymptomatic left ventricular dysfunction provided that the patient is less than seven (7) years of age **OR** is unable to ingest a solid dosage form due to documented oral-motor difficulties or dysphagia. **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 benazepril/HCTZ captopril/HCTZ enalapril/HCTZ fosinopril/HCTZ lisinopril/HCTZ quinapril/HCTZ	ACCURETIC (quinapril/HCTZ) CAPOZIDE (captopril/HCTZ) LOTENSIN HCT (benazepril/HCTZ) LOTREL (benazepril/amlodipine) moexipril/HCTZ PRESTALIA (perindopril/amlodipine) PRINZIDE (lisinopril/HCTZ) TARKA (trandolapril/verapamil) trandolapril/verapamil VASERETIC (enalapril/HCTZ) ZESTORETIC (lisinopril/HCTZ)	
	ANGIOTENSIN II RECEPTOR BLOCKERS (ARBs)	
irbesartan losartan valsartan olmesartan	ATACAND (candesartan) AVAPRO (irbesartan) BENICAR (olmesartan) candesartan COZAAR (losartan) DIOVAN (valsartan)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	EDARBI (azilsartan) eprosartan MICARDIS (telmisartan) telmisartan	
	ARB COMBINATIONS	
ENTRESTO (valsartan/sacubitril)[AP]* irbesartan/HCTZ losartan/HCTZ olmesartan/amlodipine olmesartan/HCTZ valsartan/amlodipine valsartan/HCTZ	ATACAND-HCT (candesartan/HCTZ) AVALIDE (irbesartan/HCTZ) AZOR (olmesartan/amlodipine) BENICAR-HCT (olmesartan/HCTZ) BYVALSON (nebivolol/valsartan) candesartan/HCTZ DIOVAN-HCT (valsartan/HCTZ) EDARBYCLOR (azilsartan/chlorthalidone) EXFORGE (valsartan/amlodipine) EXFORGE HCT (valsartan/amlodipine/HCTZ) HYZAAR (losartan/HCTZ) MICARDIS-HCT (telmisartan/HCTZ) olmesartan/amlodipine/HCTZ telmisartan/amlodipine telmisartan HCTZ TRIBENZOR (olmesartan/amlodipine/HCTZ) TWYNSTA (telmisartan/amlodipine) valsartan/amlodipine/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) TEKAMLO (aliskiren/amlodipine) TEKTURNA (aliskiren) TEKTURNA HCT (aliskiren/HCTZ) 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. 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: Ranexa will be authorized for patients with angina who are also taking a calcium channel blocker, a beta blocker, or a nitrite as single agents or a combination agent containing one (1) of these ingredients.		
RANEXA (ranolazine)[AP]		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ANTIBIOTICS, GI & RELATED AGENTS		
CLASS PA CRITERIA: Non-preferred agents require a fourteen (14) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
FIRVANQ (vancomycin) metronidazole tablet neomycin tinidazole	DIFICID (fidaxomicin)* FLAGYL (metronidazole) FLAGYL ER (metronidazole ER) metronidazole capsule paromomycin TINDAMAX (tinidazole) VANCOCIN (vancomycin) vancomycin XIFAXAN (rifaximin)*	*Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.
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) KITABIS PAK (tobramycin)	CAYSTON (aztreonam) TOBI (tobramycin) TOBI PODHALER (tobramycin) 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) gentamicin sulfate mupirocin ointment	BACTROBAN (mupirocin) CENTANY (mupirocin) CORTISPORIN (bacitracin/neomycin/polymyxin/HC) mupirocin cream 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.		
clindamycin cream CLINDESSE (clindamycin) metronidazole	AVC (sulfanilamide) CLEOCIN CREAM (clindamycin) CLEOCIN OVULE (clindamycin) METROGEL (metronidazole) NUVESSA (metronidazole) SOLOSEC (secnidazole) 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) fondaparinux FRAGMIN (dalteparin) LOVENOX (enoxaparin)	
ORAL		
COUMADIN (warfarin) ELIQUIS (apixaban) PRADAXA (dabigatran) warfarin 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. For all other diagnoses, non-preferred agents require a thirty (30) day trial of a preferred agent in the same sub-class before they will be approved, unless one (1) of the exceptions on the PA form is present. In situations where AB-rated generic equivalent products are available, “Brand Medically Necessary” must be hand-written by the prescriber on the prescription for the brand name product to be reimbursed.		
ADJUVANTS		
carbamazepine carbamazepine ER carbamazepine XR divalproex divalproex ER divalproex sprinkle EPITOL (carbamazepine) GABITRIL (tiagabine) lamotrigine levetiracetam IR levetiracetam ER oxcarbazepine suspension and tablets	APTIOM (eslicarbazepine) BANZEL (rufinamide) BRIVIACT (brivaracetam) CARBATROL (carbamazepine) DEPAKENE (valproic acid) DEPAKOTE (divalproex) DEPAKOTE ER (divalproex) DEPAKOTE SPRINKLE (divalproex) EQUETRO (carbamazepine) FANATREX SUSPENSION (gabapentin) felbamate FELBATOL (felbamate)	*Topiramate ER will be authorized after a thirty (30) day trial of topiramate IR. **Qudexy XR and Trokendi XR are only approvable on appeal.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
topiramate IR topiramate ER* valproic acid VIMPAT (lacosamide) zonisamide	FYCOMPA (perampanel) KEPPRA (levetiracetam) KEPPRA XR (levetiracetam) LAMICTAL (lamotrigine) LAMICTAL CHEWABLE (lamotrigine) LAMICTAL ODT (lamotrigine) LAMICTAL XR (lamotrigine) lamotrigine dose pack lamotrigine ER OXTELLAR XR (oxcarbazepine) POTIGA (ezogabine) QUDEXY XR (topiramate ER)** SABRIL (vigabatrin) SPRITAM (levetiracetam) STAVZOR (valproic acid) TEGRETOL (carbamazepine) TEGRETOL XR (carbamazepine) tiagabine TOPAMAX (topiramate) TRILEPTAL SUSPENSION and TABLETS (oxcarbazepine) TROKENDI XR (topiramate)** ZONEGRAN (zonisamide)	
BARBITURATES[AP]		
phenobarbital primidone	MYSOLINE (primidone)	
BENZODIAZEPINES[AP]		
clonazepam diazepam rectal gel diazepam tablets	clobazam* clonazepam ODT DIASTAT (diazepam rectal) KLONOPIN (clonazepam) ONFI (clobazam)* ONFI SUSPENSION (clobazam)* SYMPAZAN (clobazam film)*[NR]	*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. 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) PEGANONE (ethotoin) phenytoin capsules, chewable tablets, suspension	DILANTIN INFATABS (phenytoin) PHENYTEK (phenytoin)	
	SUCCINIMIDES	
CELONTIN (methsuximide) ethosuximide capsules ethosuximide syrup	ZARONTIN (ethosuximide) capsules ZARONTIN (ethosuximide) syrup	
ANTIDEPRESSANTS, OTHER		
CLASS PA CRITERIA: See below for individual sub-class criteria.		
	MAOIs[AP]	
	MARPLAN (isocarboxazid) NARDIL (phenelzine) PARNATE (tranylcypromine) phenelzine tranylcypromine	Patients stabilized on MAOI agents will be grandfathered.
	SNRIS[AP]	
duloxetine capulses venlafaxine ER capsules	CYMBALTA (duloxetine) desvenlafaxine ER desvenlafaxine fumarate ER EFFEXOR XR (venlafaxine) FETZIMA (levomilnacipran) KHEDEZLA (desvenlafaxine) PRISTIQ (desvenlafaxine) venlafaxine IR 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 bupropion SR bupropion XL mirtazapine trazodone	APLENZIN (bupropion hbr) EMSAM (selegiline) FORFIVO XL (bupropion) nefazodone OLEPTRO ER (trazodone) REMERON (mirtazapine) TRINTELLIX (vortioxetine) VIIBRYD (vilazodone HCl)	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 (bupropion) WELLBUTRIN SR (bupropion) WELLBUTRIN XL (bupropion)	
	SELECTED TCAs	
imipramine HCl	imipramine pamoate TOFRANIL (imipramine HCl) 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. Upon hospital discharge, patients admitted with a primary mental health diagnosis who have been stabilized on a non-preferred SSRI will receive an authorization to continue that drug.		
citalopram escitalopram tablets fluoxetine capsules, solution fluvoxamine paroxetine sertraline	BRISDELLE (paroxetine) CELEXA (citalopram) escitalopram solution fluoxetine tablets fluvoxamine ER LEXAPRO (escitalopram) LUVOX CR (fluvoxamine) paroxetine 7.5 mg capsules paroxetine ER PAXIL (paroxetine) PAXIL CR (paroxetine) PEXEVA (paroxetine) PROZAC (fluoxetine) SARAFEM (fluoxetine) ZOLOFT (sertraline)	
ANTIEMETICS[AP]		
CLASS PA CRITERIA: See below for sub-class criteria.		
	5HT3 RECEPTOR BLOCKERS	
granisetron ondansetron ODT, solution, tablets	ANZEMET (dolasetron) GRANISOL (granisetron) ondansetron vials SANCUSO (granisetron) SUSTOL (granisetron)	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**
	ZOFRAN (ondansetron) ZUPLENZ (ondansetron)	
	CANNABINOIDS	
	CESAMET (nabilone)* dronabinol** MARINOL (dronabinol)** 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. **Dronabinol will only be authorized for: 1. The treatment of anorexia associated with weight loss in patients with AIDS or cancer and unresponsive to megestrol **or** 2. The prophylaxis of chemotherapy induced nausea and vomiting unresponsive to three (3) day trials of ondansetron or promethazine for patients from eighteen (18) up to sixty-five (65) years of age.
	SUBSTANCE P ANTAGONISTS	
EMEND (aprepitant)	aprepitant VARUBI (rolapitant)	Non-preferred agents require a three (3) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.
	COMBINATIONS	
	AKYNZEO (netupitant/palonosetron) BONJESTA (doxylamine/pyridoxine) 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 fluconazole* nystatin terbinafine[CL]	ANCOBON (flucytosine) CRESEMBA (isovuconazonium)[CL]** DIFLUCAN (fluconazole) flucytosine griseofulvin*** GRIS-PEG (griseofulvin) itraconazole ketoconazole**** LAMISIL (terbinafine) MYCELEX (clotrimazole) NIZORAL (ketoconazole) NOXAFIL (posaconazole)	*PA is required when limits are exceeded. **Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. ***PA is not required for griseofulvin suspension for children up to eighteen (18) years of age for the treatment of tinea capitis. ****Ketoconazole will be authorized if the following criteria are met: 1. Diagnosis of one of the following fungal infections: blastomycosis, coccidioidomycosis, histoplasmosis,

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	ONMEL (itraconazole) ORAVIG (miconazole) SPORANOX (itraconazole) TOLSURA (itraconazole)[NR] VFEND (voriconazole) voriconazole suspension voriconazole tablets	chromomycosis, or paracoccidioidomycosis **and** 2. Documented failure or intolerance of all other diagnosis-appropriate antifungal therapies, i.e. itraconazole, fluconazole, flucytosine, etc **and** 3. Baseline assessment of the liver status including alanine aminotransferase (ALT), aspartate aminotransferase (AST), total bilirubin, alkaline phosphatase, prothrombin time, and international normalized ratio (INR) before starting treatment **and** 4. Weekly monitoring of serum ALT for the duration of treatment (If ALT values increase to a level above the upper limit of normal or 30% above baseline, or if the patient develops symptoms of abnormal liver function, treatment should be interrupted and a full set of liver tests be obtained. Liver tests should be repeated to ensure normalization of values.) **and** 5. Assessment of all concomitant medications for potential adverse drug interactions with ketoconazole. **Ketoconazole will not be authorized for treatment for fungal infections of the skin and nails.**
ANTIFUNGALS, TOPICAL[AP]		
CLASS PA CRITERIA: Non-preferred agents require fourteen (14) day trials of two (2) preferred agents before they will be approved, unless one (1) of the exceptions on the PA form is present. If a non-preferred shampoo is requested, a fourteen (14) day trial of one (1) preferred product (i.e. ketoconazole shampoo) is required.		
ANTIFUNGALS		
econazole ketoconazole cream, shampoo MENTAX (butenafine) miconazole (OTC) nystatin	CICLODAN (ciclopirox) ciclopirox ERTACZO (sertaconazole) EXELDERM (sulconazole) EXTINA (ketoconazole) JUBLIA (efinaconazole) ketoconazole foam KERYDIN (tavaborole) KETODAN (ketoconazole) LOPROX (ciclopirox) LUZU (luliconazole) MYCOSTATIN (nystatin) NAFTIN CREAM (naftifine)	*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) NIZORAL (ketoconazole) OXISTAT (oxiconazole)* PEDIPIROX-4 (ciclopirox) PENLAC (ciclopirox) VUSION (miconazole/petrolatum/zinc oxide)	
ANTIFUNGAL/STEROID COMBINATIONS		
clotrimazole/betamethasone cream	clotrimazole/betamethasone lotion KETOCON PLUS (ketoconazole/hydrocortisone) LOTRISONE (clotrimazole/betamethasone) nysatin/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. All currently established regimens shall be grandfathered with documentation of adherence to therapy.		
FACTOR VIII		
ALPHANATE HEMOFIL M HUMATE-P KOATE KOATE-DVI MONOCLATE-P NOVOEIGHT WILATE XYNTHA XYNTHA SOLOFUSE	ADVATE ADYNOVATE ELOCTATE JIVI KOGENATE FS KOVALTRY NUWIQ RECOMBINATE VONVENDI	
FACTOR IX		
ALPHANINE SD BEBULIN BENEFIX IXINITY MONONINE PROFILNINE RIXUBIS	ALPROLIX IDELVION REBINYN	
FACTOR IXa/IX		
HEMLIBRA (emicizumab-kxwh)		

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
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) clonidine tablets	CATAPRES TABLETS (clonidine) clonidine patch 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 COLCRYS (colchicine) 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) ZYLOPRIM (allopurinol)	
URICOSURIC – XANTHINE OXIDASE INHIBITORS		
	DUZALLO (allopurinol/lesinurad)	Non-preferred agents will only be approved on appeal.
ANTIMIGRAINE AGENTS, CGRP INHIBITORS[AP]		
CLASS PA CRITERIA:		
	AIMOVIG (erenumab) AJOVY (fremanezumab) EMGALITY (galcanezumab)	
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)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ANTIMIGRAINE AGENTS, TRIPTANS[AP]		
CLASS PA CRITERIA: Non-preferred agents require three (3) day trials of each preferred unique chemical entity before they will be approved, unless one (1) of the exceptions on the PA form is present.		
	TRIPTANS	
naratriptan rizatriptan ODT rizatriptan tablet sumatriptan injection[CL] sumatriptan nasal spray sumatriptan tablets	almotriptan AMERGE (naratriptan) AXERT (almotriptan) eletriptan FROVA (frovatriptan) frovatriptan IMITREX INJECTION (sumatriptan)[CL] IMITREX NASAL SPRAY (sumatriptan) IMITREX tablets (sumatriptan) MAXALT MLT (rizatriptan) MAXALT (rizatriptan) ONZETRA XSAIL (sumatriptan)* RELPAX (eletriptan) SUMAVEL (sumatriptan) ZECUITY PATCH (sumatriptan) ZEMBRACE SYMTOUCH (sumatriptan) zolmitriptan zolmitriptan ODT ZOMIG (zolmitriptan) ZOMIG ZMT (zolmitriptan)	***In addition to the Class Criteria**: Onzetra Xsail requires three (3) day trials of each preferred oral, nasal and injectable forms of sumatriptan.
	TRIPTAN COMBINATIONS	
	TREXIMET (sumatriptan/naproxen sodium)	
ANTIPARASITICS, TOPICAL[AP]		
CLASS PA CRITERIA: Non-preferred agents require trials of each preferred agent (which are age and weight appropriate) before they will be approved, unless one (1) of the exceptions on the PA form is present.		
NATROBA (spinosad) permethrin 5% cream pyrethrins-piperonyl butoxide OTC SKLICE (ivermectin)	EURAX (crotamiton) LICE EGG REMOVER OTC (benzalkonium chloride) lindane malathion OVIDE (malathion) spinosad	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ANTIPARKINSON'S AGENTS		
CLASS PA CRITERIA: Patients starting therapy on drugs in this class must show a documented allergy to all preferred agents in the corresponding sub-class, before a non-preferred agent will be authorized.		
ANTICHOLINERGICS		
benztropine trihexyphenidyl		
COMT INHIBITORS		
entacapone	COMTAN (entacapone) 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 ropinirole	MIRAPEX (pramipexole) MIRAPEX ER (pramipexole)* NEUPRO (rotigotine) pramipexole ER REQUIP (ropinirole) REQUIP XL (ropinirole)* 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 bromocriptine carbidopa/levodopa levodopa/carbidopa/entacapone selegiline	AZILECT (rasagiline) carbidopa ELDEPRYL (selegiline) GOCOVRI ER (amantadine) levodopa/carbidopa ODT LODOSYN (carbidopa) OSMOLEX ER (amantadine) PARCOPA (levodopa/carbidopa) PARLODEL (bromocriptine) rasagiline RYTARY (levodopa/carbidopa) SINEMET (levodopa/carbidopa) STALEVO (levodopa/carbidopa/entacapone) XADAGO (safinamide) ZELAPAR (selegiline)	*Amantadine will not be authorized for the treatment or prophylaxis of influenza.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
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) TAZORAC (tazarotene) VECTICAL (calcitriol)	calcipotriene cream calcipotriene ointment calcipotriene solution calcipotriene/betamethasone ointment CALCITRENE (calcipotriene) calcitriol DOVONEX (calcipotriene) ENSTILAR (calcipotriene/betamethasone) SORILUX (calcipotriene) tazarotene cream (tazarotene)	
ANTIPSYCHOTICS, ATYPICAL		
CLASS PA CRITERIA: All antipsychotic agents require prior authorization for children up to eighteen (18) years of age. All PA requests for antipsychotics for children 6 years of age and younger will be reviewed by Medicaid's consultant psychiatrist. Non-preferred agents require thirty (30) day trials of two (2) preferred 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. Upon discharge, a hospitalized patient stabilized on a non-preferred agent may receive authorization to continue this drug for labeled indications and at FDA recommended dosages. For off-label indications or dosages, a thirty (30) day prior-authorization shall be granted pending BMS review.		
SINGLE INGREDIENT		
ABILIFY MAINTENA (aripiprazole)[CL] aripiprazole tablets ARISTADA (aripiprazole)[CL] clozapine INVEGA SUSTENNA (paliperidone)[CL] INVEGA TRINZA (paliperidone)* [CL] olanzapine olanzapine ODT quetiapine** AP for the 25 mg Tablet Only quetiapine ER RISPERDAL CONSTA (risperidone)[CL] risperidone ziprasidone	ABILIFY MYCITE (aripiprazole)[NR] ABILIFY TABLETS (aripiprazole) ADASUVE (loxapine) clozapine ODT CLOZARIL (clozapine) FANAPT (iloperidone) FAZACLO (clozapine) GEODON (ziprasidone) GEODON IM (ziprasidone) INVEGA ER (paliperidone) LATUDA (lurasidone)*** NUPLAZID (pimavanserin) **** olanzapine IM[CL]	**In addition to class criteria:** *Invega Trinza will be authorized after four months' treatment with Invega Sustenna **Quetiapine 25 mg will be authorized: 1. For a diagnosis of schizophrenia **or** 2. For a diagnosis of bipolar disorder **or** 3. When prescribed concurrently with other strengths of Seroquel in order to achieve therapeutic treatment levels. **Quetiapine 25 mg will not be authorized for use as a sedative hypnotic.**

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	paliperidone ER PERSERIS (risperidone)[CL] REXULTI (brexipiprazole) RISPERDAL (risperidone) SAPHRIS (asenapine) SEROQUEL (quetiapine) SEROQUEL XR (quetiapine) VERSACLOZ (clozapine) VRAYLAR (capriprazine)*** VRAYLAR DOSE PAK (capriprazine)*** ZYPREXA (olanzapine) ZYPREXA IM (olanzapine)[CL] ZYPREXA RELPREVV (olanzapine)	***For the indication of bipolar depression only, prior authorization of LATUDA or VRAYLAR requires failure of a 30-day trial of either quetiapine OR a combination of olanzapine + fluoxetine. 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. All other indications follow class criteria. Patients already stabilized on Latuda or Vraylar shall be grandfathered. ****Nuplazid will only be authorized for the treatment of Parkinson Disease Induced Psychosis after documented treatment failure with quetiapine.
ATYPICAL ANTIPSYCHOTIC/SSRI COMBINATIONS		
	olanzapine/fluoxetine 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) GENVOYA (elvitegravir/cobicistat/emtricitabine/tenofovir) ODEFSEY (emtricitabine/rilpivirine/tenofovir) SYMFI (efavirenz/lamivudine/tenofovir) SYMFI LO (efavirenz/lamivudine/tenofovir	ATRIPLA (efavirenz/emtricitabine/tenofovir) COMPLERA (emtricitabine/rilpivirine/tenofovir)* DELSTRIGO(doravirine/lamivudine/tenofovir df) JULUCA (dolutegravir/rilpivirine) SYMTUZA (darunavir/cobicistat/emtricitabine/tenofovir alafenamide) STRIBILD (elvitegravir/cobicistat/emtricitabine/tenofovir)** TRIUMEQ (abacavir/lamivudine/ dolutegravir)***	*Complera requires medical reasoning beyond convenience or enhanced compliance as to why the medical need cannot be met with the preferred agents Truvada and Edurant. **Stribild requires medical reasoning beyond convenience or enhanced compliance as to why the medical need cannot be met with the the preferred agent Genvoya. ***Triumeq requires medical reasoning beyond convenience or enhanced compliance as to why the medical need cannot be met with the preferred agents Epzicom and Tivicay.
INTEGRASE STRAND TRANSFER INHIBITORS		
ISENTRESS (raltegravir potassium) TIVICAY (dolutegravir sodium) VITEKTA (elvitegravir)	ISENTRESS HD (raltegravir potassium)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTI)		
abacavir sulfate tablet EMTRIVA (emtricitabine) EPIVIR SOLUTION (lamivudine) lamivudine tenofovir disoproxil fumarate VIREA ORAL POWDER (tenofovir disoproxil fumarate) ZIAGEN SOLUTION (abacavir sulfate) zidovudine	abacavir sulfate solution didanosine DR capsule EPIVIR TABLET (lamivudine) RETROVIR (zidovudine) stavudine VIDEX EC (didanosine) VIDEX SOLUTION (didanosine) VIREAD TABLETS (tenofovir disoproxil fumarate) ZERIT (stavudine) ZIAGEN TABLET (abacavir sulfate)	
NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITOR (NNRTI)		
EDURANT (rilpivirine) SUSTIVA (efavirenz)	efavirenz INTELENCE (etravirine) nevirapine nevirapine ER PIFELTRO (doravirine) RESCRIPTOR (delavirdine mesylate) VIRAMUNE ER 24H (nevirapine) VIRAMUNE SUSPENSION (nevirapine)	
PHARMACOENHANCER – CYTOCHROME P450 INHIBITOR		
TYBOST (cobicistat)		
PROTEASE INHIBITORS (PEPTIDIC)		
atazanavir EVOTAZ (atazanavir/cobicistat) NORVIR (ritonavir) REYATAZ POWDER PACK (atazanavir)	CRIXIVAN (indinavir) INVIRASE (saquinavir mesylate) fosamprenavir LEXIVA (fosamprenavir) REYATAZ CAPSULE (atazanavir) VIRACEPT (nelfinavir mesylate)	
PROTEASE INHIBITORS (NON-PEPTIDIC)		
PREZCOBIX (darunavir/cobicistat) PREZISTA (darunavir ethanolate)	APTIVUS (tipranavir)	
ENTRY INHIBITORS – CCR5 CO-RECEPTOR ANTAGONISTS		
	SELZENTRY (maraviroc)	
ENTRY INHIBITORS – FUSION INHIBITORS		
	FUZEON (enfuvirtide)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	COMBINATION PRODUCTS - NRTIs	
abacavir/lamivudine CIMDUO (lamivudine/tenofovir) lamivudine/zidovudine	abacavir/lamivudine/zidovudine COMBIVIR (lamivudine/zidovudine) EPZICOM (abacavir/lamivudine) TRIZIVIR (abacavir/lamivudine/zidovudine)	
	COMBINATION PRODUCTS – NUCLEOSIDE & NUCLEOTIDE ANALOG RTIs	
DESCOVY (emtricitabine/tenofovir) TRUVADA (emtricitabine/tenofovir)		
	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 valacyclovir	famciclovir FAMVIR (famciclovir) SITAVIG (acyclovir) VALTREX (valacyclovir) ZOVIRAX (acyclovir)	
	ANTI-INFLUENZA	
oseltamivir RELENZA (zanamivir) TAMIFLU (oseltamivir)	FLUMADINE (rimantadine) rimantadine 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) ZOVIRAX CREAM (acyclovir) ZOVIRAX OINTMENT (acyclovir)	acyclovir ointment 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 atenolol	BETAPACE (sotalol) BYSTOLIC (nebivolol)	*Hemangeol will be authorized for the treatment of proliferating infantile hemangioma requiring systemic therapy.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
betaxolol bisoprolol CORGARD (nadolol) metoprolol metoprolol ER pindolol propranolol SORINE (sotalol) sotalol timolol	HEMANGEOL (propranolol)* INDERAL LA (propranolol) INDERAL XL (propranolol) INNOPRAN XL (propranolol) KAPSPARGO SPRINKLE (metoprolol) KERLONE (betaxolol) LEVATOL (penbutolol) LOPRESSOR (metoprolol) nadolol propranolol ER** SECTRAL (acebutolol) TENORMIN (atenolol) TOPROL XL (metoprolol) ZEBETA (bisoprolol)	**Propranolol ER shall be authorized for patients with a diagnosis of migraines. Existing users will be grandfathered for use in migraine prophylaxis.
BETA BLOCKER/DIURETIC COMBINATION DRUGS		
atenolol/chlorthalidone bisoprolol/HCTZ metoprolol/HCTZ propranolol/HCTZ	CORZIDE (nadolol/bendroflumethiazide) DUTOPROL (metoprolol ER/HCTZ ER) LOPRESSOR HCT (metoprolol/HCTZ) metoprolol/HCTZ ER nadolol/bendroflumethiazide TENORETIC (atenolol/chlorthalidone) ZIAC (bisoprolol/HCTZ)	
BETA- AND ALPHA-BLOCKERS		
carvedilol labetalol	COREG (carvedilol) COREG CR (carvedilol) 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		
oxybutynin IR oxybutynin ER TOVIAZ (fesoterodine)	DETROL (tolterodine) DETROL LA (tolterodine) DITROPAN XL (oxybutynin) ENABLEX (darifenacin) flavoxate GELNIQUE (oxybutynin) MYRBETRIQ (mirabegron) OXYTROL (oxybutynin) SANCTURA (trospium)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	SANCTURA XR (trospium) tolterodine tolterodine ER trospium trospium ER VESICARE (solifenacin)	
BONE RESORPTION SUPPRESSION AND RELATED AGENTS		
CLASS PA CRITERIA: See below for class criteria.		
BISPHOSPHONATES		
alendronate tablets ibandronate	ACTONEL (risedronate) ACTONEL WITH CALCIUM (risedronate/ calcium) alendronate solution ATELVIA (risedronate) BINOSTO (alendronate) BONIVA (ibandronate) DIDRONEL (etidronate) etidronate FOSAMAX TABLETS (alendronate) FOSAMAX PLUS D (alendronate/vitamin D) risedronate	Non-preferred agents require thirty (30) day trials of **each** preferred Bisphosphonate agent before they will be approved, unless one (1) of the exceptions on the PA form is present.
OTHER BONE RESORPTION SUPPRESSION AND RELATED AGENTS		
	calcitonin EVISTA (raloxifene)* FORTEO (teriparatide) FORTICAL (calcitonin) MIACALCIN (calcitonin) raloxifene* TYMLOS (abaloparatide)	Non-preferred agents require a thirty (30) day trial of a preferred Bisphosphonate agent before they will be approved, unless one (1) of the exceptions on the PA form is present. *Raloxifene will be authorized for postmenopausal women with osteoporosis 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) CIALIS 5 mg (tadalafil) dutasteride PROSCAR (finasteride)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	ALPHA BLOCKERS	
alfuzosin doxazosin tamsulosin terazosin	CARDURA (doxazosin) CARDURA XL (doxazosin) FLOMAX (tamsulosin) HYTRIN (terazosin) RAPAFLO (silodosin) Silodosin[NR] UROXATRAL (alfuzosin)	
	5-ALPHA-REDUCTASE (5AR) INHIBITORS/ALPHA BLOCKER COMBINATION	
	dutasteride/tamsulosin JALYN (dutasteride/tamsulosin)	**Substitute for Class Criteria**: Concurrent thirty (30) day trials of dutasteride and tamsulosin are required before the non-preferred agent will be authorized.
BRONCHODILATORS, BETA AGONIST[AP]		
CLASS PA CRITERIA: Non-preferred agents require thirty (30) day trials of each chemically distinct preferred agent in their corresponding sub-class unless one (1) of the exceptions on the PA form is present.		
	INHALATION SOLUTION	
albuterol	BROVANA (arformoterol) levalbuterol metaproterenol PERFOROMIST (formoterol) XOPENEX (levalbuterol)*	*Xopenex Inhalation Solution will be authorized for twelve (12) months for a diagnosis of asthma or COPD for patients on concurrent asthma controller therapy (either oral or inhaled) with documentation of failure on a trial of albuterol or documented intolerance of albuterol, or for concurrent diagnosis of heart disease.
	INHALERS, LONG-ACTING	
FORADIL (formoterol) SEREVENT (salmeterol)	ARCAPTA (indacaterol maleate) STRIVERDI RESPIMAT (olodaterol)	
	INHALERS, SHORT-ACTING	
PROAIR HFA (albuterol) PROAIR RESPICLICK (albuterol) PROVENTIL HFA (albuterol)	MAXAIR (pirbuterol) VENTOLIN HFA (albuterol) XOPENEX HFA (levalbuterol)	
	ORAL	
	albuterol ER albuterol IR metaproterenol VOSPIRE ER (albuterol) terbutaline	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
CALCIUM CHANNEL BLOCKERS[AP]		
CLASS PA CRITERIA: Non-preferred agents require fourteen (14) day trials of each preferred agent within the corresponding sub-class before they will be approved, unless one (1) of the exceptions on the PA form is present.		
LONG-ACTING		
amlodipine diltiazem ER felodipine ER nifedipine ER verapamil ER	ADALAT CC (nifedipine) CALAN SR (verapamil) CARDENE SR (nicardipine) CARDIZEM CD, LA (diltiazem) COVERA-HS (verapamil) diltiazem LA MATZIM LA (diltiazem) nisoldipine NORVASC (amlodipine) PLENDIL (felodipine) PROCARDIA XL (nifedipine) SULAR (nisoldipine) TIAZAC (diltiazem) verapamil ER PM VERELAN/VERELAN PM (verapamil)	
SHORT-ACTING		
diltiazem verapamil	CALAN (verapamil) CARDIZEM (diltiazem) isradipine nicardipine nifedipine nimodipine NIMOTOP (nimodipine) NYMALIZE SOLUTION (nimodipine) PROCARDIA (nifedipine)	
CEPHALOSPORINS AND RELATED ANTIBIOTICS[AP]		
CLASS PA CRITERIA: Non-preferred agents require a five (5) day trial of a preferred agent within the corresponding sub-class before they will be approved, unless one (1) of the exceptions on the PA form is present.		
BETA LACTAMS AND BETA LACTAM/BETA-LACTAMASE INHIBITOR COMBINATIONS		
amoxicillin/clavulanate IR	amoxicillin/clavulanate ER AUGMENTIN (amoxicillin/clavulanate) AUGMENTIN XR (amoxicillin/clavulanate) MOXATAG (amoxicillin)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	CEPHALOSPORINS	
cefaclor capsule cefadroxil capsule, tablet cefdinir cefuroxime tablet cephalexin capsule, suspension	CEDAX (ceftibuten) cefaclor suspension cefaclor ER tablet cefadroxil suspension cefpodoxime cefprozil ceftibuten capsule, suspension CEFTIN (cefuroxime) cefuroxime suspension cephalexin tablet DAXABIA (cephalexin) KEFLEX (cephalexin) OMNICEF (cefdinir) RANICLOR (cefaclor) 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]	
ipratropium nebulizer solution SPIRIVA (tiotropium) TUDORZA (aclidinium)	ATROVENT HFA (ipratropium) INCRUSE ELLIPTA (umeclidinium) LONHALA MAGNAIR (glycopyrrolate) SEEBRI NEOHALER (glycopyrrolate) SPIRIVA RESPIMAT (tiotropium) YUPELRI SOLUTION (revefenacin)[NR]	
	ANTICHOLINERGIC-BETA AGONIST COMBINATIONS[AP]	
ANORO ELLIPTA (umeclidinium/vilanterol) albuterol/ipratropium nebulizer solution BEVESPI (glycopyrrolate/formoterol) UTIBRON (indacaterol/glycopyrrolate)	COMBIVENT RESPIMAT (albuterol/ipratropium) DUONEB (albuterol/ipratropium) STIOLTO RESPIMAT (tiotropium/olodaterol)*	*In addition to the Class PA criteria, Stiolto Respimat requires a sixty (60) day trial of Anoro Ellipta.
	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.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	PDE4 INHIBITOR	
	DALIRESP (roflumilast)*	*Daliresp will be authorized if the following criteria are met: 1. Patient is forty (40) years of age or older **and** 2. Diagnosis of severe chronic obstructive pulmonary disease (COPD) associated with chronic bronchitis and multiple exacerbations requiring systemic glucocorticoids in the preceding six (6) months **and** 3. Concurrent therapy with an inhaled corticosteroid and long-acting bronchodilator and evidence of compliance **and** 4. No evidence of moderate to severe liver impairment (Child-Pugh Class B or C) **and** 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.		
	ANTI-TNFs	
ENBREL (etanercept)* HUMIRA (adalimumab)*	CIMZIA (certolizumab pegol) REMICADE (infliximab) RENFLEXIS (infliximab) SIMPONI subcutaneous (golimumab)	*Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.
	OTHERS	
COSENTYX (secukinumab)*	ACTEMRA subcutaneous (tocilizumab) ENTYVIO (vedolizumab) ILARIS (canakinumab) ILUMYA (tildrakizumab) KEVZARA (sarilumab) KINERET (anakinra) OLUMIANT (baricitinib) ORENCIA subcutaneous (abatacept) OTEZLA (apremilast) SILIQ (brodalumab) STELARA subcutaneous (ustekinumab) TALTZ (ixekizumab)	*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**
	TREMFYA (guselkumab) XELJANZ (tofacitinib) XELJANZ XR (tofacitinib)	
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) epinephrine (all labelers except 49502) EPIPEN (epinephrine) EPIPEN JR (epinephrine) SYMJEPI (epinephrine)NR	
ERYTHROPOIESIS STIMULATING PROTEINSCL		
CLASS PA CRITERIA: Non-preferred agents require a thirty (30) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
EPOGEN (rHuEPO) RETACRIT (epoetin alfa)	ARANESP (darbepoetin) MIRCERA (methoxy PEG-epoetin) PROCRIT (rHuEPO)	Erythropoiesis agents will be authorized if the following criteria are met: 1. Hemoglobin or Hematocrit less than 10/30 respectively. For renewal, hemoglobin or hematocrit levels greater than 12/36 will require dosage reduction or discontinuation. Exceptions will be considered on an individual basis after medical documentation is reviewed. (Lab oratory values must be dated within six (6) weeks of request.) **and** 2. Transferrin saturation ≥ 20%, ferritin levels ≥100 mg/ml, or on concurrent therapeutic iron therapy. (Laboratory values must be dated within three (3) weeks of request. For re-authorization, transferrin saturation or ferritin levels are not required if the patient has been responsive to the erythropoietin agent **and** 3. For HIV-infected patients, endogenous serum erythropoietin level must be ≤ 500mU/ml to initiate therapy **and** 4. No evidence of untreated GI bleeding, hemolysis, or Vitamin B-12, iron or folate deficiency.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
FLUOROQUINOLONES (Oral)[AP]		
CLASS PA CRITERIA: Non-preferred agents require a five (5) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
CIPRO SUSPENSION (ciprofloxacin) ciprofloxacin levofloxacin tablet	AVELOX (moxifloxacin) BAXDELA (delafloxacin) CIPRO TABLETS (ciprofloxacin) CIPRO XR (ciprofloxacin) ciprofloxacin ER ciprofloxacin suspension LEVAQUIN (levofloxacin) levofloxacin solution moxifloxacin NOROXIN (norfloxacin) 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) FLOVENT DISKUS (fluticasone) FLOVENT HFA (fluticasone) PULMICORT FLEXHALER (budesonide) PULMICORT RESPULES (budesonide)* QVAR REDIHALER (beclomethasone)	AEROSPAN (flunisolide)** ALVESCO (ciclesonide) ARMONAIR RESPICLICK (fluticasone) ARNUITY ELLIPTA (fluticasone) ASMANEX HFA (mometasone) 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. **Aerospan will be authorized for children ages 6 through 11 years old without a trial of a preferred agent.
GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS		
ADVAIR DISKUS (fluticasone/salmeterol) ADVAIR HFA (fluticasone/salmeterol) DULERA (mometasone/formoterol) SYMBICORT(budesonide/formoterol)	AIRDUO RESPICLICK (fluticasone/salmeterol) BREO ELLIPTA (fluticasone/vilanterol) 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) NORDITROPIN (somatropin)	HUMATROPE (somatropin) INCRELEX (mecasermin) NUTROPIN AQ (somatropin) OMNITROPE (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**
	SAIZEN (somatropin) SEROSTIM (somatropin) ZOMACTON (somatropin) ZORBTIVE (somatropin)	
***H. PYLORI* TREATMENT**		
CLASS PA CRITERIA: Non-preferred agents require a trial of the combination of individual preferred components of the requested non-preferred agent and must be used at the recommended dosages, frequencies and duration of the non-preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
Please use individual components: preferred PPI (omeprazole or pantoprazole) amoxicillin tetracycline metronidazole clarithromycin bismuth PYLERA (bismuth/metronidazole/tetracycline)	HELIDAC (bismuth/metronidazole/tetracycline) lansoprazole/amoxicillin/clarithromycin OMECLAMOX-PAK (omeprazole/amoxicillin/clarithromycin) 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) entecavir lamivudine HBV	adefovir BARACLUDE TABLET (entecavir) EPIVIR HBV (lamivudine) HEPSERA (adefovir) VEMLIDY (tenofovir alafenamide fumarate)	
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)* HARVONI (ledipasvir/sofosbuvir)* MAVYRET (pibrentasvir/glecaprevir)* ribavirin ZEPATIER (elbasvir/grazoprevir)*	COPEGUS (ribavirin) DAKLINZA (daclatasvir)* ledipasvir/sofosbuvir* MODERIBA 400 mg, 600 mg MODERIBA DOSE PACK PEGASYS (pegylated interferon) PEG-INTRON (pegylated interferon) OLYSIO (simeprevir)* REBETOL (ribavirin)	*Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	RIBASPHERE RIBAPAK (ribavirin) RIBASPHERE 400 mg, 600 mg (ribavirin) sofosbuvir/velpatasvir* SOVALDI (sofosbuvir)* TECHNIVIE (ombitasvir/paritaprevir/ritonavir)* VIEKIRA PAK (dasabuvir/ombitasvir/ paritaprevir/ritonavir)* VIEKIRA XR (dasabuvir/ombitasvir/ paritaprevir/ritonavir)* 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	doxercalciferol HECTOROL (doxercalciferol) paricalcitol injection RAYALDEE (calcifediol) SENSIPAR (cinacalcet) 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 metformin ER (generic Glucophage XR)	FORTAMET (metformin ER) GLUCOPHAGE (metformin) GLUCOPHAGE XR (metformin ER) GLUMETZA (metformin ER)* metformin ER (generic Glumetza & Fortamet) 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. **NOTE: DPP-4 inhibitors will NOT be approved in combination with a GLP-1 agonist.**		
JANUMET (sitagliptin/metformin) JANUMET XR (sitagliptin/metformin) JANUVIA (sitagliptin)	alogliptin alogliptin/metformin alogliptin/pioglitazone	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
JENTADUETO (linagliptin/metformin) TRADJENTA (linagliptin)	JENTADUETO XR (linagliptin/metformin) KAZANO (alogliptin/metformin) KOMBIGLYZE XR (saxagliptin/metformin) NESINA (alogliptin) ONGLYZA (saxagliptin) OSENI (alogliptin/pioglitazone)	
HYPOGLYCEMICS, GLP-1 AGONISTS[CL]		
CLASS PA CRITERIA: Agents in this class will not be approved for patients with a starting A1C < 7%. Non-preferred agents are available only on appeal. Preferred agents in this class shall be approved in six (6) month intervals if the following criteria are met: • Initial starts require a diagnosis of Type 2 Diabetes and an A1C taken within the last 30 days reflecting the patient's current and stabilized regimen. • No agent in this class shall be approved except as add on therapy to a regimen consisting of at least one (1) other agent prescribed at the maximum tolerable dose for at least 90 days. • Re-authorizations require continued maintenance on a regimen consisting of at least one (1) other agent at the maximum tolerable dose AND an A1C of ≤8%. **NOTE: GLP-1 agents will NOT be approved in combination with a DPP-4 inhibitor.**		
BYDUREON (exenatide) BYETTA (exenatide) OZEMPIC (semaglutide) VICTOZA (liraglutide)	ADLYXIN (lixisenatide) BYDUREON BCISE (exenatide) TANZEUM (albiglutide) TRULICITY (dulaglutide)	
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. Humulin pens and Humalog Mix pens will be authorized only for patients who cannot utilize vials due to impaired vision or dexterity.		
FIASP (insulin aspart) HUMALOG (insulin lispro) HUMALOG MIX VIALS (insulin lispro/lispro protamine) HUMULIN VIALS (insulin) LANTUS (insulin glargine) LEVEMIR (insulin detemir) NOVOLOG (insulin aspart) NOVOLOG MIX (insulin aspart/aspart protamine) TRESIBA (insulin degludec)	ADMELOG (insulin lispro) AFREZZA (insulin)[CL] APIDRA (insulin glulisine)[AP]* BASAGLAR (insulin glargine) HUMALOG JR KWIKPEN (insulin lispro) HUMALOG PEN/KWIKPEN (insulin lispro) HUMALOG MIX PENS (insulin lispro/lispro protamine) HUMULIN PENS (insulin) NOVOLIN (insulin) SOLIQUA (insulin glargine/lixisenatide)** TOUJEO SOLOSTAR (insulin glargine)**	*Apidra will be authorized if the following criteria are met: 1. Patient is four (4) years of age or older; **and** 2. Patient is currently on a regimen including a longer acting or basal insulin, **and** 3. Patient has had a trial of a similar preferred agent, Novolog or Humalog, with documentation that the desired results were not achieved. ** Non-preferred insulin combination products require that the patient must already be established on the individual agents at doses not exceeding the maximum dose achievable with the

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	XULTOPHY (insulin degludec/liraglutide)**	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.
HYPOGLYCEMICS, MEGLITINIDES		
CLASS PA CRITERIA: Non-preferred agents are available only on appeal.		
MEGLITINIDES		
nateglinide repaglinide	PRANDIN (repaglinide) STARLIX (nateglinide)	
MEGLITINIDE COMBINATIONS		
	PRANDIMET (repaglinide/metformin) 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.
HYPOGLYCEMICS, SGLT2 INHIBITORS[CL]		
CLASS PA CRITERIA: Agents in this class will not be approved for patients with a starting A1C < 7%. Non-preferred agents are available only on appeal. Preferred agents in this class shall be approved in six (6) month intervals if the following criteria are met. • Initial starts require a diagnosis of Type 2 Diabetes and an A1C taken within the last 30 days reflecting the patient's current and stabilized regimen. • No agent in this class shall be approved except as add on therapy to a regimen consisting of at least one (1) other agent prescribed at the maximum tolerable dose for at least 90 days. • Re-authorizations require continued maintenance on a regimen consisting of at least one (1) other agent at the maximum tolerable dose AND an A1C of ≤8%.		
SGLT2 INHIBITORS		
FARXIGA (dapagliflozin) INVOKANA (canagliflozin) JARDIANCE (empagliflozin)	STEGLATRO (ertugliflozin)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	SGLT2 COMBINATIONS	
	GLYXAMBI (empagliflozin/linagliptin) INVOKAMET (canagliflozin/metformin) INVOKAMET XR (canagliflozin/metformin) SEGLUROMET (ertugliflozin/metformin STEGLUJAN (ertugliflozin/sitagliptin) SYNJARDY (empagliflozin/metformin) SYNJARDY XR (empagliflozin/metformin) QTERN (dapagliflozin/saxagliptin) XIGDUO XR (dapagliflozin/metformin)	
HYPOGLYCEMICS, TZD		
CLASS PA CRITERIA: Non-preferred agents are available only on appeal.		
	THIAZOLIDINEDIONES	
pioglitazone	ACTOS (pioglitazone) AVANDIA (rosiglitazone)	
	TZD COMBINATIONS	
	ACTOPLUS MET (pioglitazone/ metformin) ACTOPLUS MET XR (pioglitazone/ metformin) AVANDARYL (rosiglitazone/glimepiride) DUETACT (pioglitazone/glimepiride) pioglitazone/glimepiride pioglitazone/ metformin	Patients are required to use the components of Actoplus Met and Duetact separately. Exceptions will be handled on a case-by-case basis.
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) EUCRISA (crisaborole)^{AP}*	DUPIXENT (dupilumab)** PROTOPIC (tacrolimus)*** tacrolimus ointment	*Eucrisa requires a 30-day trial of Elidel **OR** a medium to high potency corticosteroid unless contraindicated. **Full PA criteria for Dupixent may be found on the PA Criteria page by clicking the hyperlink ***Protopic brand is preferred over its generic equiviliant.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
IMMUNOMODULATORS, GENITAL WARTS & ACTINIC KERATOSIS AGENTS		
CLASS PA CRITERIA: Non-preferred agents require thirty (30) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
CONDYLOX GEL (podofilox) EFUDEX (fluorouracil) imiquimod	ALDARA (imiquimod) CARAC (fluorouracil) diclofenac 3% gel fluorouracil 0.5% cream fluorouracil 5% cream podofilox SOLARAZE (diclofenac) TOLAK (fluorouracil 4% cream) VEREGEN (sinecatechins) ZYCLARA (imiquimod)*	*Zyclara will be authorized for a diagnosis of actinic keratosis.
IMMUNOSUPPRESSIVES, ORAL		
CLASS PA CRITERIA: Non-preferred agents require a fourteen (14) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
azathioprine cyclosporine cyclosporine, modified mycophenolate mofetil sirolimus tacrolimus capsule	ASTAGRAF XL (tacrolimus) AZASAN (azathioprine) CELLCEPT (mycophenolate mofetil) ENVARSUS XR (tacrolimus) IMURAN (azathioprine) mycophenolic acid mycophenolic mofetil suspension MYFORTIC (mycophenolic acid) NEORAL (cyclosporine, modified) PROGRAF (tacrolimus) RAPAMUNE (sirolimus) SANDIMMUNE (cyclosporine) 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

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
		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) olopatadine 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 OMNARIS (ciclesonide) QNASL HFA (beclomethasone) ZETONNA (ciclesonide)	BECONASE AQ (beclomethasone) budesonide flunisolide mometasone NASACORT AQ (triamcinolone) NASONEX (mometasone) triamcinolone 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
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)* MOVANTIK (naloxegol)**	LINZESS (linaclotide)*** RELISTOR INJECTION (methylnaltrexone)**** RELISTOR TABLET (methylnaltrexone)**** SYMPROIC (naldemedine)**** TRULANCE (plecanatide)*****	All agents 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. In addition: * Amitiza is indicated for CIC, IBS-C (females only) and OIC. Approval for the diagnosis of OIC requires a concurrent and continuous 90-day history of opioid claims on record. ** Movantik will be approved per the FDA-approved label for OIC with a concurrent and continuous 90-day history of opioid claims on record. *** Linzess is indicated for CIC and IBS-C and requires a

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
		thirty (30) day trial of Amitiza. . For the indication of IBS-C in males, a trial of Amitiza is not required. **** Relistor and Symproic are indicated for OIC and require thirty (30) day trials of both Movantik and Amitiza. ***** Trulance is indicated for CIC and requires a thirty (30) day trial of Amitiza. For the indication of IBS-C in males, a trial of Amitiza is not required.
	DIARRHEA	
	alosetron MYTESI (crofelemer) LOTRONEX (alosetron) 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 GOLYTELY NULYTELY peg 3350	HALFLYTELY-BISACODYL KIT MOVIPREP OSMOPREP PREPOPIK SUPREP	
LEUKOTRIENE MODIFIERS		
CLASS PA CRITERIA: Non-preferred agents require thirty (30) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
montelukast zafirlukast	ACCOLATE (zafirlukast) SINGULAIR (montelukast) zileuton ZYFLO (zileuton)	
LIPOTROPICS, OTHER (Non-statins)		
CLASS PA CRITERIA: Non-preferred agents require a twelve (12) week trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
	BILE ACID SEQUESTRANTS[AP]	
cholestyramine colestipol tablets	COLESTID (colestipol) colestipol granules KYNAMRO (mipomersen)*	*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**
	QUESTRAN (cholestyramine) WELCHOL (colesevelam)**	**Welchol will be authorized for add-on therapy for type 2 diabetes when there is a previous history of a thirty (30) day trial of an oral agent (metformin, sulfonylurea or thiazolidinedione (TZD)). See HYPOGLYCEMICS, MISCELLANEOUS.
CHOLESTEROL ABSORPTION INHIBITORS		
ZETIA (ezetimibe)* AP	ezetimibe	*Zetia will be authorized with prior use of a HMG-CoA reductase inhibitor within the previous six (6) months.
FATTY ACIDS CL		
LOVAZA (omega-3-acid ethyl esters) omega-3 acid ethyl esters	VASCEPA (icosapent ethyl)	These agents are recommended when the patient has an initial triglyceride level ≥ 500 mg/dL.
FIBRIC ACID DERIVATIVES AP		
fenofibrate 54 and 160 mg fenofibrate micronized 67mg, 134mg & 200mg fenofibrate nanocrystallized 48 mg, 145 mg gemfibrozil	ANTARA (fenofibrate) FENOGLIDE (fenofibrate) FIBRICOR (fenofibric acid) fenofibrate 40 mg tablet fenofibrate 150 mg capsules fenofibrate 43, 50, 120 and 130 mg fenofibric acid LIPOFEN (fenofibrate) LOFIBRA (fenofibrate) LOPID (gemfibrozil) TRICOR (fenofibrate nanocrystallized) TRIGLIDE (fenofibrate) TRILIPIX (fenofibric acid)	
MTP INHIBITORS		
	JUXTAPID (lomitapide)*	*Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.
NIACIN		
niacin niacin ER (OTC) NIACOR (niacin) NIASPAN (niacin)	niacin ER (Rx)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	PCSK-9 INHIBITORS	
	PRALUENT (alirocumab)* 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 lovastatin pravastatin rosuvastatin simvastatin*	ALTOPREV (lovastatin) CRESTOR (rosuvastatin) fluvastatin fluvastatin ER LESCOL (fluvastatin) LESCOL XL (fluvastatin) LIPITOR (atorvastatin) LIVALO (pitavastatin) MEVACOR (lovastatin) PRAVACHOL (pravastatin) ZOCOR (simvastatin)* ZYPITAMAG (pitavastatin)	Non-preferred agents require twelve (12) week trials of two (2) preferred agents, including the generic formulation of the requested non-preferred agent, before they will be approved, unless one (1) of the exceptions on the PA form is present. *Zocor/simvastatin 80mg tablets will require a clinical PA.
	STATIN COMBINATIONS	
	ADVICOR (lovastatin/niacin) amlodipine/atorvastatin CADUET (atorvastatin/amlodipine) ezetimibe/simvastatin LIPTRUZET (atorvastatin/ezetimibe) SIMCOR (simvastatin/niacin ER) VYTORIN (simvastatin/ezetimibe)*	Non-preferred agents require thirty (30) day concurrent trials of the corresponding preferred single agents before they will be approved, unless one (1) of the exceptions on the PA form is present. *Vytorin will be authorized only after an insufficient response to a twelve (12) week trial of the maximum tolerable dose of atorvastatin or rosuvastatin, unless one (1) of the exceptions on the PA form is present. Vytorin 80/10mg tablets will require a clinical PA.
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 erythromycin base	BIAXIN (clarithromycin) clarithromycin tablets clarithromycin ER	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	clarithromycin suspension E.E.S. (erythromycin ethylsuccinate) E-MYCIN (erythromycin) ERYC (erythromycin) ERYPED (erythromycin ethylsuccinate) ERY-TAB (erythromycin) ERYTHROCIN (erythromycin stearate) erythromycin estolate PCE (erythromycin) ZITHROMAX (azithromycin) ZMAX (azithromycin)	
MULTIPLE SCLEROSIS AGENTS[CL]		
CLASS PA CRITERIA: Non-preferred agents require a diagnosis of multiple sclerosis and thirty (30) 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) AVONEX PEN (interferon beta-1a) BETASERON (interferon beta-1b)	EXTAVIA KIT (interferon beta-1b) EXTAVIA VIAL (interferon beta-1b) PLEGRIDY (peginterferon beta-1a) REBIF (interferon beta-1a) REBIF REBIDOSE (interferon beta-1a)	
	NON-INTERFERONS	
COPAXONE 20 mg (glatiramer) GILENYA (fingolimod) *	AMPYRA (dalfampridine)** AUBAGIO (teriflunomide)*** COPAXONE 40 mg (glatiramer)**** glatiramer GLATOPA (glatiramer) TECFIDERA (dimethyl fumarate)***** ZINBRYTA (daclizumab)	**In addition to class PA criteria, the following conditions and criteria also apply:** *Gilenya will be approved after a thirty (30) day trial of a preferred injectable agent. **Ampyra will be authorized if the following criteria are met: 1. Diagnosis of multiple sclerosis **and** 2. No history of seizures **and** 3. No evidence of moderate or severe renal impairment **and** 4. Initial prescription will be authorized for thirty (30) days only. ***Aubagio will be authorized if the following criteria are met: 1. Diagnosis of relapsing multiple sclerosis **and**

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
		2. Measurement of transaminase and bilirubin levels within the (6) months before initiation of therapy and ALT levels at least monthly for six (6) months after initiation of therapy **and** 3. Complete blood cell count (CBC) within six (6) months before initiation of therapy **and** 4. Female patients must have a negative pregnancy test before initiation of therapy and be established on a reliable method of contraception if appropriate **and** 5. Patient is from eighteen (18) up to sixty-five (65) years of age **and** 6. Negative tuberculin skin test before initiation of therapy ****Copaxone 40mg will only be authorized for documented injection site issues. *****Tecfidera will be authorized if the following criteria are met: 1. Diagnosis of relapsing multiple sclerosis **and** 2. Complete blood count (CBC) within six (6) months of initiation of therapy and six (6) months after initiation **and** 3. Complete blood count (CBC) annually during therapy.
NEUROPATHIC PAIN		
CLASS PA CRITERIA: Non-preferred agents require a thirty (30) day trial of a preferred agent in the corresponding dosage form (oral or topical) before they will be approved, unless one (1) of the exceptions on the PA form is present.		
capsaicin OTC duloxetine gabapentin lidocaine patch LYRICA CAPSULE (pregabalin)	CYMBALTA (duloxetine) GRALISE (gabapentin)* HORIZANT (gabapentin) IRENKA (duloxetine) LIDODERM (lidocaine) LYRICA CR (pregabalin)** LYRICA SOLUTION (pregabalin)** NEURONTIN (gabapentin)^{AP} QUTENZA (capsaicin) SAVELLA (milnacipran)***	*Gralise will be authorized only if the following criteria are met: 1. Diagnosis of post herpetic neuralgia **and** 2. Trial of a tricyclic antidepressant for a least thirty (30) days **and** 3. 90-day trial of gabapentin immediate release formulation (positive response without adequate duration) **and** 4. Request is for once daily dosing with 1800 mg maximum daily dosage.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	ZTLIDO PATCH (lidocaine)	**Lyrica CR and Lyrica Solution require medical reasoning beyond convenience as to why the need cannot be met using preferred Lyrica capsules. ***Savella will be authorized for a diagnosis of fibromyalgia only after a 90-day trial of one preferred agent
NSAIDS[AP]		
CLASS PA CRITERIA: See below for sub-class PA criteria.		
	NON-SELECTIVE	
diclofenac (IR, SR) flurbiprofen ibuprofen (Rx and OTC) INDOCIN SUSPENSION (indomethacin) indomethacin ketoprofen ketorolac meloxicam tablet nabumetone naproxen (Rx and OTC) piroxicam sulindac	CATAFLAM (diclofenac) CLINORIL (sulindac) DAYPRO (oxaprozin) diflunisal DUEXIS (famotidine/ibuprofen) etodolac IR etodolac SR FELDENE (piroxicam) fenoprofen INDOCIN SUPPOSITORIES (indomethacin) indomethacin ER ketoprofen ER meclofenamate mefenamic acid meloxicam suspension MOBIC TABLET (meloxicam) NALFON (fenoprofen) NAPRELAN (naproxen) NAPROSYN (naproxen) naproxen CR oxaprozin PONSTEL (meclofenamate) SPRIX (ketorolac) TIVORBEX (indomethacin)	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**
	tolmetin VIVLODEX (meloxicam) VOLTAREN (diclofenac) ZIPSOR (diclofenac potassium) ZORVOLEX (diclofenac)	
	NSAID/GI PROTECTANT COMBINATIONS	
	ARTHROTEC (diclofenac/misoprostol) diclofenac/misoprostol 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) celecoxib	COX-II Selective agents require thirty (30) day trials of each preferred Non-Selective Oral NSAID, **UNLESS** the following criteria are met: Patient has a history or risk of a serious GI complication; **OR** Agent is requested for treatment of a chronic condition **and** 1. Patient is seventy (70) years of age or older, **or** 2. Patient is currently on anticoagulation therapy**.** 3.
	TOPICAL	
FLECTOR PATCH (diclofenac)* VOLTAREN GEL (diclofenac)**	diclofenac gel diclofenac solution PENNSAID (diclofenac)	*Flector patches are limited to two per day. **Voltaren Gel will be limited to 100 grams per month. Non-preferred agents require a thirty (30) day trial of the preferred Topical agent and thirty (30) day trials of each preferred oral NSAID before they will be approved, unless one(1) of the exceptions on the PA form is present.
OPHTHALMIC ANTIBIOTICS[AP]		
CLASS PA CRITERIA: Non-preferred agents require three (3) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
bacitracin/polymyxin ointment ciprofloxacin* erythromycin gentamicin levofloxacin* MOXEZA (moxifloxacin)	AZASITE (azithromycin) bacitracin BLEPH-10 (sulfacetamide) BESIVANCE (besifloxacin)* CILOXAN (ciprofloxacin) GARAMYCIN (gentamicin)	*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**
neomycin/bacitracin/polymyxin ofloxacin* polymyxin/trimethoprim tobramycin TOBREX OINT (tobramycin)	gatifloxacin ILOTYCIN (erythromycin) moxifloxacin** NATACYN (natamycin) neomycin/polymyxin/gramicidin NEOSPORIN (neomycin/polymyxin/gramicidin) OCUFLOX (ofloxacin) POLYTRIM (polymyxin/trimethoprim) sulfacetamide drops sulfacetamide ointment TOBREX (tobramycin) VIGAMOX (moxifloxacin)** ZYMAR (gatifloxacin) 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.		
BLEPHAMIDE (prednisolone/sulfacetamide) neomycin/polymyxin/dexamethasone sulfacetamide/prednisolone TOBRADEX OINTMENT (tobramycin/ dexamethasone) TOBRADEX SUSPENSION (tobramycin/ dexamethasone)	BLEPHAMIDE S.O.P. (prednisolone/ sulfacetamide) MAXITROL ointment (neomycin/polymyxin/ dexamethasone) MAXITROL suspension (neomycin/polymyxin/ dexamethasone) neomycin/bacitracin/polymyxin/ hydrocortisone neomycin/polymyxin/hydrocortisone PRED-G (prednisolone/gentamicin) TOBRADEX ST (tobramycin/ dexamethasone) tobramycin/dexamethasone suspension ZYLET (loteprednol/tobramycin	
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) cromolyn ketotifen olopatadine 0.1% (Generic PATANOL labeler	ALAMAST (pemirolast) ALOCRIL (nedocromil) ALOMIDE (lodoxamide) ALREX (loteprednol)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
61314 only) ZADITOR OTC (ketotifen)	azelastine BEPREVE (bepotastine) CROLOM (cromolyn) ELESTAT (epinastine) EMADINE (emedastine) epinastine LASTACAFT (alcaftadine) olopatadine 0.1% (all formulations except Generic PATANOL labeler 61314) olopatadine 0.2% (all labelers) OPTICROM (cromolyn) OPTIVAR (azelastine) PATADAY (olopatadine) PATANOL (olopatadine) PAZEO (olopatadine)	
OPHTHALMICS, ANTI-INFLAMMATORIES- IMMUNOMODULATORS		
CLASS PA CRITERIA: See below for individual sub-class criteria.		
	CEQUA (cyclosporine)[NR] RESTASIS (cyclosporine) XIIDRA (lifitegrast)	The following prior authorization criteria apply to both Restasis and Xiidra: 1.) Patient must be sixteen (16) years of age or greater; **AND** 2.) Prior Authorization must be requested by an ophthalmologist or optometrist; **AND** 3.) Clinically diagnosed tear deficiency due to ocular inflammation in patients with keratoconjunctivitis sicca or dry eye syndrome (also known as dry eye); **AND** 4.) Patient must have a functioning lacrimal gland; **AND** 5.) Patient using artificial tears at least four (4) times a day over the last thirty (30) days; **AND** 6.) Patient must not have an active ocular infection
OPHTHALMICS, ANTI-INFLAMMATORIES		
CLASS PA CRITERIA: Non-preferred agents require five (5) day trials of at least two (2) preferred agents before they will be approved, unless one (1) of the exceptions on the PA form is present. Trials must include at least one agent with the same mechanism of action as the requested non-preferred agent.		
dexamethasone diclofenac DUREZOL (difluprednate) fluorometholone	ACULAR (ketorolac) ACULAR LS (ketorolac) ACUVAIL (ketorolac tromethamine) BROMDAY (bromfenac)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
flurbiprofen ILEVRO (nepafenac) ketorolac prednisolone acetate prednisolone sodium phosphate	bromfenac BROMSITE (bromfenac) FLAREX (fluorometholone) FML (fluorometholone) FML FORTE (fluorometholone) FML S.O.P. (fluorometholone) INVELTYS (loteprednol)^{NR} LOTEMAX DROPS, OINTMENT (loteprednol) LOTEMAX GEL (loteprednol) MAXIDEX (dexamethasone) NEVANAC (nepafenac) OMNIPRED (prednisolone) OZURDEX (dexamethasone) PRED FORTE (prednisolone) PRED MILD (prednisolone) PROLENSA (bromfenac) RETISERT (fluocinolone) TRIESENCE (triamcinolone) VEXOL (rimexolone) 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) dorzolamide/timolol SIMBRINZA (brinzolamide/brimonidine)	COSOPT (dorzolamide/timolol) COSOPT PF (dorzolamide/timolol)	
BETA BLOCKERS		
BETOPTIC S (betaxolol) carteolol levobunolol timolol drops	BETAGAN (levobunolol) betaxolol ISTALOL (timolol) OPTIPRANOLOL (metipranolol) timolol gel TIMOPTIC (timolol)	
CARBONIC ANHYDRASE INHIBITORS		
AZOPT (brinzolamide) orzolamide	TRUSOPT (dorzolamide)	
PARASYMPATHOMIMETICS		
PHOSPHOLINE IODIDE (echothiophate iodide)	pilocarpine	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	PROSTAGLANDIN ANALOGS	
latanoprost TRAVATAN-Z (travoprost)	bimatoprost LUMIGAN (bimatoprost) travoprost VYZULTA (latanoprostene)* XALATAN (latanoprost) XELPROS (latanoprost)[NR] 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)	Prior authorization of any agent in this sub-class requires a trial of at least one (1) preferred agent from all other sub-classes.
	SYMPATHOMIMETICS	
brimonidine 0.2%	ALPHAGAN P 0.1% Solution (brimonidine) ALPHAGAN P 0.15% Solution (brimonidine) apraclonidine brimonidine 0.15% 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. WV Medicaid's buprenorphine coverage policy may be viewed by clicking on the following hyperlink: Buprenorphine Coverage Policy and Related Forms		
naloxone NARCAN NASAL SPRAY (naloxone) SUBOXONE FILM (buprenorphine/naloxone)* VIVITROL (naltrexone)	buprenorphine tablets buprenorphine/naloxone tablets BUNAVAIL (buprenorphine/naloxone) LUCEMYRA (lofexidine) SUBLOCADE (buprenorphine soln)** ZUBSOLV (buprenorphine/naloxone)	* Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. **Sublocade is approvable only on appeal and requires medical reasoning as to why the clinical need cannot be met with a preferred product. 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) CIPRODEX (ciprofloxacin/dexamethasone) COLY-MYCIN S (colistin/hydrocortisone/ neomycin/thonzonium bromide) ofloxacin	ciprofloxacin CORTISPORIN-TC (colistin/hydrocortisone/ neomycin) neomycin/polymyxin/HC solution/suspension OTOVEL (ciprofloxacin/fluocinolone)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
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) TRACLEER (bosentan)	OPSUMIT (macitentan)	
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. Patients stabilized on non-preferred agents will be grandfathered.		
sildenafil	ADCIRCA (tadalafil) REVATIO IV (sildenafil) REVATIO SUSPENSION (sildenafil) 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 VENTAVIS (iloprost)*	FLOLAN (epoprostenol) ORENITRAM ER (treprostinil) REMODULIN (treprostinil sodium) TYVASO (treprostinil) UPTRAVI (selexipag) VELETRI (epoprostenol)	*Ventavis will only be authorized for the treatment of pulmonary artery hypertension (WHO Group 1) in patients with NYHA Class III or IV symptoms.
PANCREATIC ENZYMES[AP]		
CLASS PA CRITERIA: Non-preferred agents require a thirty (30) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. For members with cystic fibrosis, a trial of a preferred agent will not be required.		
CREON ZENPEP	PANCREAZE PERTZYE ULTRESA 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 MAGNEBIND RX (calcium carbonate, folic acid, magnesium carbonate) PHOSLYRA (calcium acetate) RENAGEL (sevelamer)	AURYXIA (ferric citrate) ELIPHOS (calcium acetate) FOSRENOL (lanthanum) PHOSLO (calcium acetate) RENVELA (sevelamer carbonate) sevelamer carbonate VELPHORO (sucroferric oxyhydroxide)	
PITUITARY SUPPRESSIVE AGENTS, LHRH[CL]		
CLASS PA CRITERIA: Non-preferred agents **are available only on appeal.**		
LUPANETA (leuprolide) LUPRON DEPOT KIT (leuprolide) LUPRON DEPOT-PED KIT (leuprolide) ORILISSA(elagolix)* SYNAREL (nafarelin) TRELSTAR (triptorelin) TRIPTODUR (triptorelin) VANTAS (histrelin) ZOLADEX (goserelin)	leuprolide 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) BRILINTA (ticagrelor) clopidogrel prasugrel	clopidogrel kit dipyridamole dipyridamole/aspirin EFFIENT (prasugrel) PERSANTINE (dipyridamole) PLAVIX (clopidogrel) TICLID (ticlopidine) ticlopidine 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 MAKENA (hydroxyprogesterone caproate) VIAL		
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) pantoprazole NEXIUM PACKETS (esomeprazole)** PROTONIX GRANULES (pantoprazole)**	ACIPHEX (rabeprazole) ACIPHEX SPRINKLE (rabeprazole) DEXILANT (dexlansoprazole) esomeprazole magnesium esomeprazole strontium lansoprazole Rx NEXIUM (esomeprazole) omeprazole/sodium bicarbonate (Rx) PREVACID CAPSULES (lansoprazole) PREVACID SOLUTABS (lansoprazole)** PRILOSEC Rx (omeprazole) PROTONIX DR TABLETS (pantoprazole) rabeprazole ZEGERID Rx (omeprazole/sodium bicarbonate)	*Maximum recommended doses of the PPIs and H2-receptor antagonists may be located at the BMS Pharmacy PA criteria page titled "Max PPI and H2RA" by clicking on the hyperlink. **Prior authorization is required for members nine (9) years of age or older for these agents.
SEDATIVE HYPNOTICS[AP]		
CLASS PA CRITERIA: Non-preferred agents require thirty (30) day trials of all preferred agents in **BOTH** sub-classes before they will be approved, unless one (1) of the exceptions on the PA form is present. All agents except melatonin will be limited to fifteen (15) tablets in a thirty (30) day period. NOTE: WV Medicaid covers melatonin up to a maximum dose of 9 mg/day without a PA.		
BENZODIAZEPINES		
temazepam 15, 30 mg	DALMANE (flurazepam) estazolam flurazepam	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	HALCION (triazolam) RESTORIL (temazepam) temazepam 7.5, 22.5 mg triazolam	
	OTHERS	
Melatonin (labeler code 51645 only) zolpidem 5, 10 mg	AMBIEN (zolpidem) AMBIEN CR (zolpidem) BELSOMRA (suvorexant) chloral hydrate EDLUAR (zolpidem) eszopiclone HETLIOZ (tasimelteon)CL* INTERMEZZO (zolpidem) LUNESTA (eszopiclone) ROZEREM (ramelteon) SILENOR (doxepin) SOMNOTE (chloral hydrate) SONATA (zaleplon) zaleplon zolpidem ER 6.25, 12.5 mg 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. For treatment naïve female patients, zolpidem and zolpidem ER maximum dosages will be limited to 5 mg and 6.25 mg respectively per day. *Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.
SKELETAL MUSCLE RELAXANTSAP		
CLASS PA CRITERIA: See below for individual sub-class criteria.		
	ACUTE MUSCULOSKELETAL RELAXANT AGENTS	
Chlorzoxazone (generic PARAFON FORTE) cyclobenzaprine IR 5, 10 mg methocarbamol	AMRIX (cyclobenzaprine) carisoprodol* carisoprodol/ASA* carisoprodol/ASA/codeine* chlorzoxazone (generic LORZONE)NR cyclobenzaprine ER cyclobenzaprine IR 7.5 mg FEXMID (cyclobenzaprine) FLEXERIL (cyclobenzaprine) LORZONE (chlorzoxazone) metaxalone orphenadrine orphenadrine/ASA/caffeine orphenadrine ER	Non-preferred agents require thirty (30) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present, with the exception of carisoprodol. *Carisoprodol requires thirty (30) day trials of each of the preferred acute musculoskeletal relaxants and Skelaxin before it will be approved.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	PARAFON FORTE (chlorzoxazone) ROBAXIN (methocarbamol) SKELAXIN (metaxalone) SOMA (carisoprodol)	
MUSCULOSKELETAL RELAXANT AGENTS USED FOR SPASTICITY		
baclofen tizanidine tablets	DANTRIUM (dantrolene) dantrolene tizanidine capsules ZANAFLEX (tizanidine)	Non-preferred agents require thirty (30) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.
STEROIDS, TOPICAL		
CLASS PA CRITERIA: Non-preferred agents require five (5) day trials of one (1) form of **EACH** preferred unique active ingredient in the corresponding potency group before they will be approved, unless one (1) of the exceptions on the PA form is present.		
VERY HIGH & HIGH POTENCY		
betamethasone dipropionate cream betamethasone valerate cream betamethasone valerate lotion betamethasone valerate oint clobetasol propionate cream/gel/ointment/solution clobetasol emollient clobetasol propionate shampoo fluocinonide gel triamcinolone acetonide cream, ointment triamcinolone acetonide lotion	amcinonide APEXICON (diflorasone diacetate) APEXICON E (diflorasone diacetate) betamethasone dipropionate gel, lotion, ointment BRYHALI LOTION (halobetasol)^{NR} clobetasol lotion clobetasol propionate foam CLOBEX (clobetasol propionate) CLODAN KIT (clobetasol propionate) CLODAN SHAMPOO (clobetasol propionate) CORMAX (clobetasol propionate) desoximetasone cream/gel/ointment diflorasone diacetate DIPROLENE (betamethasone dipropionate/propylene glycol) DIPROLENE AF (betamethasone dipropionate/propylene glycol) DIPROSONE (betamethasone dipropionate) fluocinonide cream fluocinonide ointment fluocinonide solution fluocinonide/emollient halcinonide HALAC (halobetasol propionate) halobetasol propionate HALOG (halcinonide)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	HALONATE (halobetasol propionate) KENALOG (triamcinolone acetonide) LEXETTE FOAM (halobetasol)NR LIDEX (fluocinonide) LIDEX-E (fluocinonide) OLUX (clobetasol propionate) OLUX-E (clobetasol propionate/emollient) PSORCON (diflorasone diacetate) SERNIVO SPRAY (betamethasone dipropionate) TEMOVATE (clobetasol propionate) TEMOVATE-E (clobetasol propionate/emollient) TOPICORT CREAM, GEL, OINTMENT (desoximetasone) TOPICORT SPRAY (desoximetasone) ULTRAVATE (halobetasol propionate) ULTRAVATE PAC cream ULTRAVATE X (halobetasol propionate / lactic acid) VANOS (fluocinonide)	
	MEDIUM POTENCY	
fluticasone propionate cream, ointment mometasone furoate triamcinolone acetonide 0.025% and 0.1% cream	ARISTOCORT (triamcinolone) BETA-VAL (betamethasone valerate) betamethasone valerate foam CLODERM (clocortolone pivalate) clocortolone cream CORDRAN/CORDRAN SP (flurandrenolide) CUTIVATE (fluticasone propionate) DERMATOP (prednicarbate) ELOCON (mometasone furoate) fluocinolone acetonide cream, ointment, solution fluticasone propionate lotion hydrocortisone butyrate cream hydrocortisone butyrate ointment, solution hydrocortisone valerate LOCOID (hydrocortisone butyrate) LOCOID LIPOCREAM (hydrocortisone butyrate/emollient) LUXIQ (betamethasone valerate) MOMEXIN (mometasone)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	PANDEL (hydrocortisone probutate) prednicarbate TOPICORT LP (desoximetasone) TRIDERM (triamcinolone acetonide) WESTCORT (hydrocortisone valerate)	
	LOW POTENCY	
hydrocortisone acetate (Rx, OTC) hydrocortisone cream (Rx, OTC) hydrocortisone lotion OTC hydrocortisone ointment (Rx, OTC) hydrocortisone solution OTC hydrocortisone-aloe cream OTC hydrocortisone-aloe ointment OTC	ACLOVATE (alclometasone dipropionate) alclometasone dipropionate AQUA GLYCOLIC HC (hydrocortisone) CAPEX (fluocinolone acetonide) DERMA-SMOOTHE FS (fluocinolone acetonide) DESONATE (desonide) desonide cream, ointment desonide lotion DESOWEN (desonide) fluocinolone oil hydrocortisone/mineral oil/petrolatum hydrocortisone acetate/urea hydrocortisone lotion hydrocortisone/aloe gel LOKARA (desonide) PEDIADERM HC (hydrocortisone) PEDIADERM TA (hydrocortisone) SCALPICIN OTC (hydrocortisone) SYNALAR (fluocinolone) TEXACORT (hydrocortisone)	
STIMULANTS AND RELATED AGENTS		
CLASS PA CRITERIA: A PA is required for adults eighteen (18) years of age or older. Non-preferred agents require a thirty (30) day trial of at least one preferred agent in the same subclass and with a similar duration of effect and mechanism of action, unless one (1) of the exceptions on the PA form is present. **NOTE**: 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 IR dextroamphetamine ER dextroamphetamine IR PROCENTRA solution (dextroamphetamine) VYVANSE CHEWABLE (lisdexamfetamine) VYVANSE CAPSULE (lisdexamfetamine)	ADDERALL (amphetamine salt combination) ADDERALL XR* (amphetamine salt combination) ADZENYS XR ODT (amphetamine) ADZENYS ER SUSP (amphetamine) amphetamine salt combination ER DESOXYN (methamphetamine)	**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. *Adderall XR is preferred over its generic equivalents.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	DEXEDRINE ER (dextroamphetamine) DEXEDRINE IR (dextroamphetamine) dextroamphetamine solution DYANAVEL XR SUSP (amphetamine) EVEKEO (amphetamine) methamphetamine MYDAYIS (dextroamphetamine/amphetamine salt)** ZENZEDI (dextroamphetamine)	**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) armodafinil[CL] atomoxetine clonidine IR DAYTRANA (methylphenidate) dexmethylphenidate IR FOCALIN XR (dexmethylphenidate) guanfacine ER guanfacine IR METHYLIN SOLUTION (methylphenidate) methylphenidate IR modafinil[CL] QUILLICHEW ER (methylphenidate) QUILLIVANT XR (methylphenidate)	clonidine ER CONCERTA (methylphenidate) COTEMPLA XR ODT (methylphenidate) dexmethylphenidate XR FOCALIN IR (dexmethylphenidate) INTUNIV (guanfacine extended-release) KAPVAY (clonidine extended-release) methylphenidate CD methylphenidate chewable tablets, solution methylphenidate ER methylphenidate ER (generic CONCERTA) methylphenidate LA NUVIGIL (armodafinil) PROVIGIL (modafinil) RITALIN (methylphenidate) RITALIN LA (methylphenidate) STRATTERA (atomoxetine)*	*Strattera is limited to a maximum of 100 mg per day.
TETRACYCLINES		
CLASS PA CRITERIA: Non-preferred agents require ten (10) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
doxycycline hyclate capsules doxycycline hyclate 100 mg tablets doxycycline monohydrate 50, 100 mg capsules minocycline capsules	ADOXA (doxycycline monohydrate) demeclocycline* DORYX (doxycycline hyclate) doxycycline hyclate 75, 150 mg tablets doxycycline hyclate tablet DR 75, 100, 150, 200 mg doxycycline hyclate tablet DR 50 mg doxycycline monohydrate 40, 75, 150 mg capsule	*Demeclocycline will be authorized for conditions caused by susceptible strains of organisms designated in the product information supplied by the manufacturer. A C&S report must accompany this request. Demeclocycline will also be authorized for SIADH.

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
	doxycycline monohydrate tablet doxycycline monohydrate suspension DYNACIN (minocycline) MINOCIN (minocycline) minocycline ER capsules minocycline tablets MORGIDOX KIT (doxycycline) ORACEA (doxycycline monohydrate) SOLODYN (minocycline) tetracycline VIBRAMYCIN CAPSULES, SUSPENSION, SYRUP (doxycycline) XIMINO (minocycline)	
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) balsalazide sulfasalazine	ASACOL HD (mesalamine) AZULFIDINE (sulfasalazine) COLAZAL (balsalazide) DELZICOL (mesalamine) DIPENTUM (olsalazine) GIAZO (balsalazide) LIALDA (mesalamine) mesalamine PENTASA (mesalamine) 250 mg PENTASA (mesalamine) 500 mg UCERIS (budesonide)	
RECTAL		
CANASA (mesalamine) mesalamine	DELZICOL DR (mesalamine) mesalamine kit ROWASA (mesalamine) SF ROWASA (mesalamine) UCERIS (budesonide)	

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
VASODILATORS, CORONARY		
CLASS PA CRITERIA: Non-preferred agents require thirty (30) day trials of each preferred dosage form before they will be approved, unless one (1) of the exceptions on the PA form is present.		
SUBLINGUAL NITROGLYCERIN		
nitroglycerin spray (generic NITROLINGUAL) nitroglycerin sublingual NITROSTAT SUBLINGUAL (nitroglycerin)	GONITRO SPRAY POWDER (nitroglycerin) nitroglycerin spray (generic NITROMIST) NITROLINGUAL SPRAY (nitroglycerin) NITROMIST (nitroglycerin)	