- 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 |
|---|---|---|---|
| ALZHEIMER'S AGENTS | XXXX | | |
| ANALGESICS, NARCOTIC LONG ACTING (Non-parenteral) | XXXX | | |
| ANGIOTENSIN MODULATORS | XXXX | | |
| ANTIBIOTICS, VAGINAL | XXXX | | |
| ANTICONVULSANTS | XXXX | | |
| ANTIEMETICS | XXXX | | |
| ANTIHEMOPHILIA FACTOR AGENTS | XXXX | | |
| ANTIMIGRAINE AGENTS, CGRP INHIBITORS | XXXX | | |
| ANTIPARASITICS, TOPICAL | XXXX | | |
| ANTIPARKINSON'S AGENTS | XXXX | | |
| ANTIPSYCHOTICS, ATYPICAL | XXXX | | |
| ANTIRETROVIRALS | XXXX | | |
| BETA BLOCKERS | XXXX | | |
| BLADDER RELAXANT PREPARATIONS | XXXX | | |
| COPD AGENTS | XXXX | | |
| GLUCOCORTICOIDS, INHALED | XXXX | | XXXX |
| HEPATITIS C TREATMENTS | XXXX | | |
| HYPOGLYCEMICS, INSULIN AND RELATED AGENTS | XXXX | | |
| HYPOGLYCEMICS, SGLT2 INHIBITORS | XXXX | | |
| IMMUNOMODULATORS, ATOPIC DERMATITIS | XXXX | | |
| IRRITABLE BOWEL SYNDROME/SHORT BOWEL SYNDROME/SELECTED GI AGENTS | XXXX | | XXXX |
| LIPOTROPICS, OTHER (Non-statins) | XXXX | | |

| | | | |
|---|---|---|---|
| MULTIPLE SCLEROSIS AGENTS | XXXX | | |
| NSAIDS | XXXX | | |
| OPHTHALMIC ANTIBIOTIC/STEROID COMBINATIONS | XXXX | | |
| OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS | XXXX | | |
| OPHTHALMICS,ANTI-INFLAMMATORIES- IMMUNOMODULATORS | XXXX | | |
| OPHTHALMICS,ANTI-INFLAMMATORIES | XXXX | | |
| OPHTHALMICS, GLAUCOMA AGENTS | XXXX | | XXXX |
| OPIATE DEPENDENCE TREATMENTS | XXXX | | |
| PAH AGENTS – ENDOTHELIN RECEPTOR ANTAGONISTS | XXXX | | XXXX |
| PHOSPHATE BINDERS | XXXX | | XXXX |
| PITUITARY SUPPRESSIVE AGENTS, LHRH | XXXX | | |
| PLATELET AGGREGATION INHIBITORS | XXXX | | |
| STIMULANTS AND RELATED AGENTS | XXXX | | |
| ULCERATIVE COLITIS 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.<br><br>In cases of pregnancy, a trial of retinoids will *not* be required. For members eighteen (18) years of age or older, a trial of retinoids will *not* be required.<br>Acne kits are non-preferred.<br><br>**Specific Criteria for sub-class will be listed below.** NOTE: Non-preferred agents in the Rosacea sub-class are available only on appeal and require at least a 30-day trial of all preferred agents in that sub-class. | | |
| **ANTI-INFECTIVE** | | |
| clindamycin gel, lotion, medicated swab, solution<br>ERYGEL (erythromycin)<br>erythromycin gel, solution | ACZONE (dapsone)<br>AKNE-MYCIN (erythromycin)<br>AZELEX (azelaic acid)<br>CLEOCIN-T (clindamycin)<br>CLINDACIN PAC (clindamycin)<br>CLINDAGEL (clindamycin)<br>clindamycin foam<br>erythromycin medicated swab<br>EVOCLIN (clindamycin)<br>FABIOR (tazarotene)<br>KLARON (sulfacetamide)<br>OVACE/PLUS (sulfacetamide)<br>sodium sulfacetamide 10% cleansing gel<br>sulfacetamide cleanser<br>sulfacetamide cleanser ER<br>sulfacetamide shampoo<br>sulfacetamide suspension | |
| **RETINOIDS** | | |
| TAZORAC (tazarotene)<br>tretinoin cream, gel | adapalene<br>ALTRENO LOTION (tretinoin)<br>ATRALIN (tretinoin)<br>AVITA (tretinoin)<br>DIFFERIN (adapalene)<br>PLIXDA SOLUTION (adapalene)<br>RETIN-A (tretinoin)<br>RETIN-A MICRO (tretinoin)<br>tazarotene cream<br>tretinoin gel micro | **In addition to the Class Criteria**: PA required for members eighteen (18) years of age or older. |

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

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| metronidazole gel 0.75% (NDCs 00115-1474-46, 00168-0275-45, 00713-0637-37, 51672-4116-06, 66993-0962-45 only) | METROLOTION (metronidazole)<br>metronidazole lotion<br>metronidazole gel (all other NDCs)<br>NORITATE CREAM (metronidazole)<br>RHOFADE (oxymetazoline)<br>ROSADAN (metronidazole)<br>SOOLANTRA CREAM (ivermectin) | |
| **ALZHEIMER'S AGENTS**[AP] | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a thirty (30) day trial of a preferred agent in the same sub-class before they will be approved, unless one (1) of the exceptions on the PA form is present.<br><br>Prior authorization is required for members up to forty-five (45) years of age if there is no diagnosis of Alzheimer's disease. | | |
| **CHOLINESTERASE INHIBITORS** | | |
| donepezil 5 and 10 mg | ARICEPT (donepezil)<br>donepezil 23 mg*<br>donepezil ODT<br>EXELON CAPSULE (rivastigmine)<br>EXELON PATCH (rivastigmine)<br>galantamine<br>galantamine ER<br>RAZADYNE (galantamine)<br>RAZADYNE ER (galantamine)<br>rivastigmine | *Donepezil 23 mg tablets will be authorized if the following criteria are met:<br>1. There is a diagnosis of moderate-to-severe Alzheimer's Disease **and**<br>2. There has been a trial of donepezil 10 mg daily for at least three (3) months and donepezil 20 mg daily for an additional one (1) month. |
| **NMDA RECEPTOR ANTAGONIST** | | |
| memantine | memantine ER<br>memantine solution<br>NAMENDA (memantine)<br>NAMENDA XR (memantine)* | ***Namenda XR requires ninety (90) days of compliant therapy with Namenda. |
| **CHOLINESTERASE INHIBITOR/NMDA RECEPTOR ANTAGONIST COMBINATIONS** | | |
| | NAMZARIC (donepezil/memantine) | Combination agents require thirty (30) day trials of each corresponding preferred single agent. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **ANALGESICS, NARCOTIC LONG ACTING (Non-parenteral)[AP]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require six (6) day trials of two (2) chemically distinct preferred agents **AND** a six (6) day trial of the generic form of the requested non-preferred agent (if available) before they will be approved, unless one (1) of the exceptions on the PA form is present. If no generic form is available for the requested non-preferred brand agent, then another generic non-preferred agent must be trialed instead. **NOTE: All long-acting opioid agents require a prior authorization for children under 18 years of age.** Requests must be for an FDA approved age and indication and specify previous opioid and non-opioid therapies attempted. | | |
| BUTRANS (buprenorphine)<br>EMBEDA (morphine/naltrexone)<br>fentanyl transdermal 12, 25, 50, 75, 100 mcg/hr<br>morphine ER tablets<br>XTAMPZA ER (oxycodone) | ARYMO ER (morphine sulfate)<br>BELBUCA (buprenorphine buccal film)*<br>buprenorphine patch (all labelers including 00093)<br>CONZIP ER (tramadol)<br>DOLOPHINE (methadone)<br>DURAGESIC (fentanyl)<br>EXALGO ER (hydromorphone)<br>fentanyl transdermal 37.5, 62.5, 87.5 mcg/hr<br>hydromorphone ER<br>HYSINGLA ER (hydrocodone)<br>KADIAN (morphine)<br>LAZANDA SPRAY (fentanyl)<br>methadone**<br>MORPHABOND ER (morphine sulfate)<br>morphine ER capsules (generic for Avinza)<br>morphine ER capsules (generic for Kadian)<br>MS CONTIN (morphine)<br>NUCYNTA ER (tapentadol)<br>OPANA ER (oxymorphone)<br>oxycodone ER**<br>OXYCONTIN (oxycodone)<br>oxymorphone ER**<br>tramadol ER***<br>ULTRAM ER (tramadol)<br>XARTEMIS XR (oxycodone/ acetaminophen)<br>ZOHYDRO ER (hydrocodone) | *Belbuca prior authorization requires manual review. Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.<br><br>**Methadone, oxycodone ER and oxymorphone ER will be authorized without a trial of the preferred agents if a diagnosis of cancer is submitted.<br><br>***Tramadol ER requires a manual review and may be authorized for ninety (90) days with submission of a detailed treatment plan including anticipated duration of treatment and scheduled follow-ups with the prescriber. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **ANALGESICS, NARCOTIC SHORT ACTING (Non-parenteral)[AP]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require six (6) day trials of at least four (4) chemically distinct preferred agents (based on the narcotic ingredient only), including the generic formulation of the requested non-preferred agent, before they will be approved, unless one (1) of the exceptions on the PA form is present. **NOTE: All tramadol and codeine products require a prior authorization for children under 18 years of age.** Requests must be for an FDA approved age and indication and specify non-opioid therapies attempted. | | |
| APAP/codeine<br>butalbital/APAP/caffeine/codeine<br>codeine<br>hydrocodone/APAP 2.5/325 mg, 5/325 mg, 7.5/325 mg,10/325 mg<br>hydrocodone/APAP solution<br>hydrocodone/ibuprofen<br>hydromorphone tablets<br>LORTAB SOLUTION (hydrocodone/acetaminophen)<br>morphine<br>oxycodone tablets, concentrate, solution<br>oxycodone/APAP<br>oxycodone/ASA<br>pentazocine/naloxone<br>tramadol<br>tramadol/APAP | ABSTRAL (fentanyl)<br>ACTIQ (fentanyl)<br>butalbital/ASA/caffeine/codeine<br>butorphanol<br>CAPITAL W/CODEINE (APAP/codeine)<br>DEMEROL (meperidine)<br>dihydrocodeine/ APAP/caffeine<br>DILAUDID (hydromorphone)<br>fentanyl<br>FENTORA (fentanyl)<br>FIORICET W/ CODEINE (butalbital/APAP/caffeine/codeine)<br>FIORINAL W/ CODEINE (butalbital/ASA/caffeine/codeine)<br>hydrocodone/APAP 5/300 mg, 7.5/300 mg, 10/300 mg<br>hydromorphone liquid, suppositories<br>IBUDONE (hydrocodone/ibuprofen)<br>LAZANDA (fentanyl)<br>levorphanol<br>LORCET (hydrocodone/APAP)<br>LORTAB (hydrocodone/APAP)<br>meperidine<br>NORCO (hydrocodone/APAP)<br>NUCYNTA (tapentadol)<br>ONSOLIS (fentanyl)<br>OPANA (oxymorphone)<br>OXECTA (oxycodone)<br>oxycodone capsules<br>oxycodone/ibuprofen<br>oxymorphone<br>PERCOCET (oxycodone/APAP)<br>PRIMLEV (oxycodone/APAP)<br>REPREXAIN (hydrocodone/ibuprofen)<br>ROXICODONE (oxycodone) | Fentanyl buccal, nasal and sublingual products will only be authorized for a diagnosis of cancer and as an adjunct to a long-acting agent. These dosage forms will not be authorized for monotherapy.<br><br>**Limits:** Unless the patient has escalating cancer pain or another diagnosis supporting increased quantities of short-acting opioids, all short acting solid forms of the narcotic analgesics are limited to 120 tablets per thirty (30) days. Longer-acting medications should be maximized to prevent unnecessary breakthrough pain in chronic pain therapy.<br><br>Immediate-release tramadol is limited to 240 tablets per thirty (30) days. |

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

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **ANGIOTENSIN MODULATORS**[AP] | | |
| **CLASS PA CRITERIA:** Non-preferred agents require fourteen (14) day trials of each preferred agent in the same sub-class, with the exception of the Direct Renin Inhibitors, before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| | **ACE INHIBITORS** | |
| benazepril<br>captopril<br>enalapril<br>fosinopril<br>lisinopril<br>quinapril<br>ramipril | ACCUPRIL (quinapril)<br>ACEON (perindopril)<br>ALTACE (ramipril)<br>EPANED (enalapril)*<br>LOTENSIN (benazepril)<br>MAVIK (trandolapril)<br>moexipril<br>perindopril<br>PRINIVIL (lisinopril)<br>QBRELIS SOLUTION (lisinopril)**<br>trandolapril<br>UNIVASC (moexipril)<br>VASOTEC (enalapril)<br>ZESTRIL (lisinopril) | *Epaned will be authorized with a diagnosis of hypertension, symptomatic heart failure or asymptomatic left ventricular dysfunction provided that the patient is less than seven (7) years of age **OR** is unable to ingest a solid dosage form due to documented oral-motor difficulties or dysphagia.<br><br>**Qbrelis solution may be authorized for children ages 6-10 who are unable to tolerate a solid dosage form. Qbrelis may also be authorized for older patients with clinical documentation indicating oral-motor difficulties or dysphagia. |
| | **ACE INHIBITOR COMBINATION DRUGS** | |
| benazepril/amlodipine<br>benazepril/HCTZ<br>captopril/HCTZ<br>enalapril/HCTZ<br>fosinopril/HCTZ<br>lisinopril/HCTZ<br>quinapril/HCTZ | ACCURETIC (quinapril/HCTZ)<br>CAPOZIDE (captopril/HCTZ)<br>LOTENSIN HCT (benazepril/HCTZ)<br>LOTREL (benazepril/amlodipine)<br>moexipril/HCTZ<br>PRESTALIA (perindopril/amlodipine)<br>PRINZIDE (lisinopril/HCTZ)<br>TARKA (trandolapril/verapamil)<br>trandolapril/verapamil<br>VASERETIC (enalapril/HCTZ)<br>ZESTORETIC (lisinopril/HCTZ) | |
| | **ANGIOTENSIN II RECEPTOR BLOCKERS (ARBs)** | |
| irbesartan<br>losartan<br>valsartan<br>olmesartan | ATACAND (candesartan)<br>AVAPRO (irbesartan)<br>BENICAR (olmesartan)<br>candesartan<br>COZAAR (losartan)<br>DIOVAN (valsartan) | |

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

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

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| oxcarbazepine suspension and tablets<br>TEGRETOL (carbamazepine)<br>topiramate IR<br>topiramate ER*<br>valproic acid<br>VIMPAT (lacosamide)<br>zonisamide | FYCOMPA (perampanel)<br>KEPPRA (levetiracetam)<br>KEPPRA XR (levetiracetam)<br>LAMICTAL (lamotrigine)<br>LAMICTAL ODT (lamotrigine)<br>LAMICTAL XR (lamotrigine)<br>lamotrigine dose pack<br>lamotrigine ER<br>levetiracetam IR suspension<br>OXTELLAR XR (oxcarbazepine)<br>POTIGA (ezogabine)<br>QUDEXY XR (topiramate ER)**<br>SABRIL (vigabatrin)<br>SPRITAM (levetiracetam)<br>STAVZOR (valproic acid)<br>TEGRETOL XR (carbamazepine)<br>tiagabine<br>TOPAMAX (topiramate)<br>TRILEPTAL SUSPENSION and TABLETS (oxcarbazepine)<br>TROKENDI XR (topiramate)**<br>ZONEGRAN (zonisamide) | |
| **BARBITURATES[AP]** | | |
| phenobarbital<br>primidone | MYSOLINE (primidone) | |
| **BENZODIAZEPINES[AP]** | | |
| clonazepam<br>diazepam rectal gel<br>diazepam tablets | clobazam*<br>clonazepam ODT<br>DIASTAT (diazepam rectal)<br>KLONOPIN (clonazepam)<br>ONFI (clobazam)*<br>ONFI SUSPENSION (clobazam)*<br>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.<br>NOTE: generic clobazam is preferred over brand ONFI. |
| **CANNABINOIDS** | | |
| | EPIDIOLEX SOLUTION (cannabidiol)* | * Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. |
| **HYDANTOINS[AP]** | | |
| DILANTIN (phenytoin sodium, extended)<br>PEGANONE (ethotoin) | DILANTIN INFATABS (phenytoin)<br>PHENYTEK (phenytoin) | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| phenytoin capsules, chewable tablets, suspension | | |
| | **SUCCINIMIDES** | |
| CELONTIN (methsuximide)<br>ethosuximide capsules<br>ethosuximide syrup | ZARONTIN (ethosuximide) capsules<br>ZARONTIN (ethosuximide) syrup | |
| **ANTIDEPRESSANTS, OTHER** | | |
| **CLASS PA CRITERIA:** See below for individual sub-class criteria. | | |
| | **MAOIs[AP]** | |
| | MARPLAN (isocarboxazid)<br>NARDIL (phenelzine)<br>PARNATE (tranylcypromine)<br>phenelzine<br>tranylcypromine | Patients stabilized on MAOI agents will be grandfathered. |
| | **SNRIS[AP]** | |
| duloxetine capulses<br>venlafaxine ER capsules | CYMBALTA (duloxetine)<br>desvenlafaxine ER<br>desvenlafaxine fumarate ER<br>EFFEXOR XR (venlafaxine)<br>FETZIMA (levomilnacipran)<br>KHEDEZLA (desvenlafaxine)<br>PRISTIQ (desvenlafaxine)<br>venlafaxine IR<br>VENLAFAXINE ER TABLETS (venlafaxine) | Non-preferred agents require separate thirty (30) day trials of a preferred agent in this sub-class **AND** an SSRI before they will be approved, unless one (1) of the exceptions on the PA form is present. |
| | **SECOND GENERATION NON-SSRI, OTHER[AP]** | |
| bupropion IR<br>bupropion SR<br>bupropion XL<br>mirtazapine<br>trazodone | APLENZIN (bupropion hbr)<br>EMSAM (selegiline)<br>FORFIVO XL (bupropion)<br>nefazodone<br>OLEPTRO ER (trazodone)<br>REMERON (mirtazapine)<br>TRINTELLIX (vortioxetine)<br>VIIBRYD (vilazodone HCl)<br>WELLBUTRIN (bupropion)<br>WELLBUTRIN SR (bupropion)<br>WELLBUTRIN XL (bupropion) | Non-preferred agents require separate thirty (30) day trials of a preferred agent in this sub-class **AND** an SSRI before they will be approved, unless one (1) of the exceptions on the PA form is present. |

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

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

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

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| PROFILNINE<br>RIXUBIS | | |
| **FACTOR IXa/IX** | | |
| | HEMLIBRA (emicizumab-kxwh) | |
| **ANTIHYPERTENSIVES, SYMPATHOLYTICS** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require thirty (30) day trials of each preferred unique chemical entity in the corresponding formulation before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| CATAPRES-TTS (clonidine)<br>clonidine tablets | CATAPRES TABLETS (clonidine)<br>clonidine patch<br>NEXICLON XR (clonidine) | |
| **ANTIHYPERURICEMICS** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a thirty (30) day trial of one (1) of the preferred agents for the prevention of gouty arthritis attacks (colchicine/probenecid, probenecid, or allopurinol) before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| **ANTIMITOTICS** | | |
| colchicine capsules | colchicine tablets<br>COLCRYS (colchicine)<br>MITIGARE (colchicine) | In the case of acute gouty attacks, a ten (10) day supply (twenty (20) capsules) of the preferred agent(s) in this subclass will be authorized per ninety (90) days. |
| **ANTIMITOTIC-URICOSURIC COMBINATION** | | |
| colchicine/probenecid | | |
| **URICOSURIC** | | |
| probenecid | ZURAMPIC (lesinurad)* | *Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. |
| **XANTHINE OXIDASE INHIBITORS** | | |
| allopurinol | ULORIC (febuxostat)<br>ZYLOPRIM (allopurinol) | |
| **URICOSURIC – XANTHINE OXIDASE INHIBITORS** | | |
| | DUZALLO (allopurinol/lesinurad) | Non-preferred agents will only be approved on appeal. |
| **ANTIMIGRAINE AGENTS, CGRP INHIBITORS$^{AP}$** | | |
| **CLASS PA CRITERIA:** | | |
| EMGALITY (galcanezumab) | AIMOVIG (erenumab)<br>AJOVY (fremanezumab) | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **ANTIMIGRAINE AGENTS, OTHER**[AP] | | |
| **CLASS PA CRITERIA:** Non-preferred agents require three (3) day trials of each unique chemical entity of the preferred Antimigraine Triptan Agents before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| | CAMBIA (diclofenac) | |
| **ANTIMIGRAINE AGENTS, TRIPTANS**[AP] | | |
| **CLASS PA CRITERIA:** Non-preferred agents require three (3) day trials of each preferred unique chemical entity before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| | **TRIPTANS** | |
| naratriptan<br>rizatriptan ODT<br>rizatriptan tablet<br>sumatriptan injection[CL]<br>sumatriptan nasal spray<br>sumatriptan tablets | almotriptan<br>AMERGE (naratriptan)<br>AXERT (almotriptan)<br>eletriptan<br>FROVA (frovatriptan)<br>frovatriptan<br>IMITREX INJECTION (sumatriptan)[CL]<br>IMITREX NASAL SPRAY (sumatriptan)<br>IMITREX tablets (sumatriptan)<br>MAXALT MLT (rizatriptan)<br>MAXALT (rizatriptan)<br>ONZETRA XSAIL (sumatriptan)*<br>RELPAX (eletriptan)<br>SUMAVEL (sumatriptan)<br>ZECUITY PATCH (sumatriptan)<br>ZEMBRACE SYMTOUCH (sumatriptan)<br>zolmitriptan<br>zolmitriptan ODT<br>ZOMIG (zolmitriptan)<br>ZOMIG ZMT (zolmitriptan) | ***In addition to the Class Criteria**: Onzetra Xsail 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)<br>permethrin 5% cream | ELIMITE CREAM (permethrin)<br>EURAX (crotamiton) | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| pyrethrins-piperonyl butoxide OTC<br>SKLICE (ivermectin) | LICE EGG REMOVER OTC (benzalkonium chloride)<br>lindane<br>malathion<br>OVIDE (malathion)<br>Spinosad<br>VANALICE (piperonyl/pyrethin) | |
| **ANTIPARKINSON'S AGENTS** | | |
| **CLASS PA CRITERIA:** Patients starting therapy on drugs in this class must show a documented allergy to all preferred agents in the corresponding sub-class, before a non-preferred agent will be authorized. | | |
| **ANTICHOLINERGICS** | | |
| benztropine<br>trihexyphenidyl | | |
| **COMT INHIBITORS** | | |
| entacapone | COMTAN (entacapone)<br>TASMAR (tolcapone) | COMT Inhibitor agents will only be approved as add-on therapy to a levodopa-containing regimen for treatment of documented motor complications. |
| **DOPAMINE AGONISTS** | | |
| pramipexole<br>ropinirole | MIRAPEX (pramipexole)<br>MIRAPEX ER (pramipexole)*<br>NEUPRO (rotigotine)<br>pramipexole ER<br>REQUIP (ropinirole)<br>REQUIP XL (ropinirole)*<br>ropinirole ER | *Mirapex ER and Requip XL will be authorized for a diagnosis of Parkinsonism without a trial of preferred agents. |
| **OTHER ANTIPARKINSON'S AGENTS** | | |
| amantadine*AP<br>APOKYN (apomorphine)<br>bromocriptine<br>carbidopa/levodopa<br>INBRIJA (levodopa)<br>levodopa/carbidopa/entacapone<br>selegiline | AZILECT (rasagiline)<br>carbidopa<br>ELDEPRYL (selegiline)<br>GOCOVRI ER (amantadine)<br>levodopa/carbidopa ODT<br>LODOSYN (carbidopa)<br>OSMOLEX ER (amantadine)<br>PARCOPA (levodopa/carbidopa)<br>PARLODEL (bromocriptine)<br>rasagiline<br>RYTARY (levodopa/carbidopa) | *Amantadine will not be authorized for the treatment or prophylaxis of influenza. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | SINEMET (levodopa/carbidopa)<br>STALEVO (levodopa/carbidopa/entacapone)<br>XADAGO (safinamide)<br>ZELAPAR (selegiline) | |
| **ANTIPSORIATICS, TOPICAL** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require thirty (30) day trials of two (2) preferred unique chemical entities before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| TACLONEX OINT (calcipotriene/ betamethasone)<br>TAZORAC (tazarotene)<br>VECTICAL (calcitriol) | calcipotriene cream<br>calcipotriene ointment<br>calcipotriene solution<br>calcipotriene/betamethasone ointment<br>CALCITRENE (calcipotriene)<br>calcitriol<br>DOVONEX (calcipotriene)<br>ENSTILAR (calcipotriene/betamethasone)<br>SORILUX (calcipotriene)<br>tazarotene cream (tazarotene) | |
| **ANTIPSYCHOTICS, ATYPICAL** | | |
| **CLASS PA CRITERIA: All antipsychotic agents require prior authorization for children up to eighteen (18) years of age. All PA requests for antipsychotics for children 6 years of age and younger will be reviewed by Medicaid's consultant psychiatrist.**<br><br>Non-preferred agents require thirty (30) day trials of two (2) preferred agents, including the generic formulation of the requested agent (if available), before they will be approved unless one (1) of the exceptions on the PA form is present. All trials must be at the maximum recommended dose for the diagnosis provided before they would be considered a failure unless an adverse reaction is documented necessitating a change in therapy.<br><br>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** | | |
| aripiprazole tablets<br>ARISTADA (aripiprazole)[CL]<br>ARISTADA INITIO (aripiprazole)[CL]<br>clozapine<br>FANAPT (iloperidone)<br>INVEGA SUSTENNA (paliperidone)[CL]<br>INVEGA TRINZA (paliperidone)* [CL]<br>LATUDA (lurasidone)***<br>olanzapine<br>PERSERIS (risperidone)[CL] | ABILIFY MAINTENA (aripiprazole)[CL]<br>ABILIFY MYCITE (aripiprazole)[NR]<br>ABILIFY TABLETS (aripiprazole)<br>ADASUVE (loxapine)<br>aripiprazole solution<br>clozapine ODT<br>CLOZARIL (clozapine)<br>FAZACLO (clozapine)<br>GEODON (ziprasidone)<br>GEODON IM (ziprasidone) | **In addition to class criteria:**<br><br>*Invega Trinza will be authorized after four months' treatment with Invega Sustenna<br><br>**Quetiapine 25 mg will be authorized:<br>1. For a diagnosis of schizophrenia **or**<br>2. For a diagnosis of bipolar disorder **or**<br>3. When prescribed concurrently with other strengths of Seroquel in order to achieve therapeutic treatment |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| quetiapine** AP for the 25 mg Tablet Only<br>RISPERDAL CONSTA (risperidone)CL<br>risperidone solution, tablet<br>ziprasidone<br>ZYPREXA RELPREVV (olanzapine) | INVEGA ER (paliperidone)<br>NUPLAZID (pimavanserin) ****<br>olanzapine IMCL<br>olanzapine ODT<br>paliperidone ER<br>quetiapine ER<br>REXULTI (brexipiprazole)<br>RISPERDAL (risperidone)<br>risperidone ODT<br>SAPHRIS (asenapine)<br>SEROQUEL (quetiapine)<br>SEROQUEL XR (quetiapine)<br>VERSACLOZ (clozapine)<br>VRAYLAR (capriprazine)***<br>VRAYLAR DOSE PAK (capriprazine)***<br>ZYPREXA (olanzapine)<br>ZYPREXA IM (olanzapine)CL | levels.<br>**Quetiapine 25 mg will not be authorized for use as a sedative hypnotic.**<br><br>***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.<br>All other indications follow class criteria. Patients already stabilized on Latuda or Vraylar shall be grandfathered.<br>****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<br>SYMBYAX (olanzapine/fluoxetine) | |
| **ANTIRETROVIRALSAP** | | |
| **CLASS PA CRITERIA:** Non-preferred drugs require medical reasoning beyond convenience or enhanced compliance as to why the clinical need cannot be met with a preferred agent or combination of preferred agents. NOTE: Regimens consisting of preferred agents will result in no more than one additional unit per day over equivalent regimens composed of non-preferred agents. Patients already on a non-preferred regimen shall be grandfathered. | | |
| | **SINGLE TABLET REGIMENS** | |
| BIKTARVY (bictegravir/emtricitabine/tenofovir alafenamide)<br>COMPLERA (emtricitabine/rilpivirine/tenofovir)*<br>DELSTRIGO(doravirine/lamivudine/tenofovir df)<br>GENVOYA (elvitegravir/cobicistat/emtricitabine/tenofovir)<br>ODEFSEY (emtricitabine/rilpivirine/tenofovir)<br>SYMFI (efavirenz/lamivudine/tenofovir)<br>SYMFI LO (efavirenz/lamivudine/tenofovir | ATRIPLA (efavirenz/emtricitabine/tenofovir)<br>JULUCA (dolutegravir/rilpivirine)<br>SYMTUZA (darunavir/cobicistat/emtricitabine/tenofovir alafenamide)<br>STRIBILD (elvitegravir/cobicistat/emtricitabine/tenofovir)**<br>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.<br><br>**Stribild requires medical reasoning beyond convenience or enhanced compliance as to why the medical need cannot be met with the the preferred agent Genvoya.<br><br>***Triumeq requires medical reasoning beyond convenience or enhanced compliance as to why the medical need cannot be met with the preferred agents Epzicom and Tivicay. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **INTEGRASE STRAND TRANSFER INHIBITORS** | | |
| ISENTRESS (raltegravir potassium)<br>TIVICAY (dolutegravir sodium)<br>VITEKTA (elvitegravir) | ISENTRESS HD (raltegravir potassium) | |
| **NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTI)** | | |
| abacavir sulfate tablet<br>EMTRIVA (emtricitabine)<br>EPIVIR SOLUTION (lamivudine)<br>lamivudine<br>tenofovir disoproxil fumarate<br>VIREA ORAL POWDER (tenofovir disoproxil fumarate)<br>ZIAGEN SOLUTION (abacavir sulfate)<br>zidovudine | abacavir sulfate solution<br>didanosine DR capsule<br>EPIVIR TABLET (lamivudine)<br>RETROVIR (zidovudine)<br>stavudine<br>VIDEX EC (didanosine)<br>VIDEX SOLUTION (didanosine)<br>VIREAD TABLETS (tenofovir disoproxil fumarate)<br>ZERIT (stavudine)<br>ZIAGEN TABLET (abacavir sulfate) | |
| **NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITOR (NNRTI)** | | |
| SUSTIVA (efavirenz) | EDURANT (rilpivirine)<br>efavirenz<br>INTELENCE (etravirine)<br>nevirapine<br>nevirapine ER<br>PIFELTRO (doravirine)<br>RESCRIPTOR (delavirdine mesylate)<br>VIRAMUNE ER 24H (nevirapine)<br>VIRAMUNE SUSPENSION (nevirapine) | |
| **PHARMACOENHANCER – CYTOCHROME P450 INHIBITOR** | | |
| TYBOST (cobicistat) | | |
| **PROTEASE INHIBITORS (PEPTIDIC)** | | |
| atazanavir<br>EVOTAZ (atazanavir/cobicistat)<br>NORVIR (ritonavir)<br>REYATAZ POWDER PACK (atazanavir) | CRIXIVAN (indinavir)<br>fosamprenavir<br>INVIRASE (saquinavir mesylate)<br>LEXIVA (fosamprenavir)<br>REYATAZ CAPSULE (atazanavir)<br>VIRACEPT (nelfinavir mesylate) | |
| **PROTEASE INHIBITORS (NON-PEPTIDIC)** | | |
| PREZCOBIX (darunavir/cobicistat)<br>PREZISTA (darunavir ethanolate) | APTIVUS (tipranavir) | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | **ENTRY INHIBITORS – CCR5 CO-RECEPTOR ANTAGONISTS** | |
| | SELZENTRY (maraviroc) | |
| | **ENTRY INHIBITORS – FUSION INHIBITORS** | |
| | FUZEON (enfuvirtide) | |
| | **COMBINATION PRODUCTS - NRTIs** | |
| abacavir/lamivudine<br>CIMDUO (lamivudine/tenofovir)<br>lamivudine/zidovudine | abacavir/lamivudine/zidovudine<br>COMBIVIR (lamivudine/zidovudine)<br>EPZICOM (abacavir/lamivudine)<br>TRIZIVIR (abacavir/lamivudine/zidovudine) | |
| | **COMBINATION PRODUCTS – NUCLEOSIDE & NUCLEOTIDE ANALOG RTIs** | |
| DESCOVY (emtricitabine/tenofovir) | TRUVADA (emtricitabine/tenofovir) | |
| | **COMBINATION PRODUCTS – PROTEASE INHIBITORS** | |
| KALETRA (lopinavir/ritonavir) | lopinavir/ritonavir | |
| **ANTIVIRALS, ORAL** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require five (5) day trials of each preferred agent in the same sub-class before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| | **ANTI HERPES** | |
| acyclovir<br>valacyclovir | famciclovir<br>FAMVIR (famciclovir)<br>SITAVIG (acyclovir)<br>VALTREX (valacyclovir)<br>ZOVIRAX (acyclovir) | |
| | **ANTI-INFLUENZA** | |
| oseltamivir<br>RELENZA (zanamivir)<br>TAMIFLU (oseltamivir) | FLUMADINE (rimantadine)<br>rimantadine<br>XOFLUZA (baloxavir) | **In addition to the Class Criteria**: The anti-influenza agents will be authorized only for a diagnosis of influenza. |
| **ANTIVIRALS, TOPICAL[AP]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a five (5) day trial of the preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| ABREVA (docosanol)<br>ZOVIRAX CREAM (acyclovir)<br>ZOVIRAX OINTMENT (acyclovir) | acyclovir ointment<br>DENAVIR (penciclovir) | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **BETA BLOCKERS**[AP] | | |
| **CLASS PA CRITERIA:** Non-preferred agents require fourteen (14) day trials of three (3) chemically distinct preferred agents, including the generic formulation of the requested non-preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| **BETA BLOCKERS** | | |
| acebutolol<br>atenolol<br>betaxolol<br>bisoprolol<br>CORGARD (nadolol)<br>HEMANGEOL (propranolol)*<br>metoprolol<br>metoprolol ER<br>pindolol<br>propranolol<br>SORINE (sotalol)<br>sotalol<br>timolol | BETAPACE (sotalol)<br>BYSTOLIC (nebivolol)<br>INDERAL LA (propranolol)<br>INDERAL XL (propranolol)<br>INNOPRAN XL (propranolol)<br>KAPSPARGO SPRINKLE (metoprolol)<br>KERLONE (betaxolol)<br>LEVATOL (penbutolol)<br>LOPRESSOR (metoprolol)<br>nadolol<br>propranolol ER**<br>SECTRAL (acebutolol)<br>TENORMIN (atenolol)<br>TOPROL XL (metoprolol)<br>ZEBETA (bisoprolol) | *Hemangeol will be authorized for the treatment of proliferating infantile hemangioma requiring systemic therapy.<br><br>**Propranolol ER shall be authorized for patients with a diagnosis of migraines. Existing users will be grandfathered for use in migraine prophylaxis. |
| **BETA BLOCKER/DIURETIC COMBINATION DRUGS** | | |
| atenolol/chlorthalidone<br>bisoprolol/HCTZ<br>metoprolol/HCTZ<br>propranolol/HCTZ | CORZIDE (nadolol/bendroflumethiazide)<br>DUTOPROL (metoprolol ER/HCTZ ER)<br>LOPRESSOR HCT (metoprolol/HCTZ)<br>metoprolol/HCTZ ER<br>nadolol/bendroflumethiazide<br>TENORETIC (atenolol/chlorthalidone)<br>ZIAC (bisoprolol/HCTZ) | |
| **BETA- AND ALPHA-BLOCKERS** | | |
| carvedilol<br>labetalol | COREG (carvedilol)<br>COREG CR (carvedilol)<br>TRANDATE (labetalol) | |
| **BLADDER RELAXANT PREPARATIONS**[AP] | | |
| **CLASS PA CRITERIA:** Non-preferred agents require thirty (30) day trials of each chemically distinct preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present | | |
| GELNIQUE (oxybutynin)<br>oxybutynin IR<br>oxybutynin ER<br>TOVIAZ (fesoterodine) | DETROL (tolterodine)<br>DETROL LA (tolterodine)<br>DITROPAN XL (oxybutynin)<br>ENABLEX (darifenacin) | |

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

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **BPH TREATMENTS** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require thirty (30) day trials of at least two (2) chemically distinct preferred agents, including the generic formulation of the requested non-preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| **5-ALPHA-REDUCTASE (5AR) INHIBITORS AND PDE-5 AGENTS** | | |
| finasteride | AVODART (dutasteride)<br>CIALIS 5 mg (tadalafil)<br>dutasteride<br>PROSCAR (finasteride) | |
| **ALPHA BLOCKERS** | | |
| alfuzosin<br>doxazosin<br>tamsulosin<br>terazosin | CARDURA (doxazosin)<br>CARDURA XL (doxazosin)<br>FLOMAX (tamsulosin)<br>HYTRIN (terazosin)<br>RAPAFLO (silodosin)<br>Silodosin[NR]<br>UROXATRAL (alfuzosin) | |
| **5-ALPHA-REDUCTASE (5AR) INHIBITORS/ALPHA BLOCKER COMBINATION** | | |
| | dutasteride/tamsulosin<br>JALYN (dutasteride/tamsulosin) | **Substitute for Class Criteria**: Concurrent thirty (30) day trials of dutasteride and tamsulosin are required before the non-preferred agent will be authorized. |
| **BRONCHODILATORS, BETA AGONIST[AP]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require thirty (30) day trials of each chemically distinct preferred agent in their corresponding sub-class unless one (1) of the exceptions on the PA form is present. | | |
| **INHALATION SOLUTION** | | |
| albuterol | BROVANA (arformoterol)<br>levalbuterol<br>metaproterenol<br>PERFOROMIST (formoterol)<br>XOPENEX (levalbuterol)* | *Xopenex Inhalation Solution will be authorized for twelve (12) months for a diagnosis of asthma or COPD for patients on concurrent asthma controller therapy (either oral or inhaled) with documentation of failure on a trial of albuterol or documented intolerance of albuterol, or for concurrent diagnosis of heart disease. |
| **INHALERS, LONG-ACTING** | | |
| FORADIL (formoterol)<br>SEREVENT (salmeterol) | ARCAPTA (indacaterol maleate)<br>STRIVERDI RESPIMAT (olodaterol) | |
| **INHALERS, SHORT-ACTING** | | |
| PROAIR HFA (albuterol)<br>PROAIR RESPICLICK (albuterol)<br>PROVENTIL HFA (albuterol) | MAXAIR (pirbuterol)<br>VENTOLIN HFA (albuterol)<br>XOPENEX HFA (levalbuterol) | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | **ORAL** | |
| | albuterol ER<br>albuterol IR<br>metaproterenol<br>VOSPIRE ER (albuterol)<br>terbutaline | |
| **CALCIUM CHANNEL BLOCKERS**[AP] | | |
| **CLASS PA CRITERIA:** Non-preferred agents require fourteen (14) day trials of each preferred agent within the corresponding sub-class before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| | **LONG-ACTING** | |
| amlodipine<br>diltiazem ER<br>felodipine ER<br>nifedipine ER<br>verapamil ER | ADALAT CC (nifedipine)<br>CALAN SR (verapamil)<br>CARDENE SR (nicardipine)<br>CARDIZEM CD, LA (diltiazem)<br>COVERA-HS (verapamil)<br>diltiazem LA<br>MATZIM LA (diltiazem)<br>nisoldipine<br>NORVASC (amlodipine)<br>PLENDIL (felodipine)<br>PROCARDIA XL (nifedipine)<br>SULAR (nisoldipine)<br>TIAZAC (diltiazem)<br>verapamil ER PM<br>VERELAN/VERELAN PM (verapamil) | |
| | **SHORT-ACTING** | |
| diltiazem<br>verapamil | CALAN (verapamil)<br>CARDIZEM (diltiazem)<br>isradipine<br>nicardipine<br>nifedipine<br>nimodipine<br>NIMOTOP (nimodipine)<br>NYMALIZE SOLUTION (nimodipine)<br>PROCARDIA (nifedipine) | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **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<br>AUGMENTIN (amoxicillin/clavulanate)<br>AUGMENTIN XR (amoxicillin/clavulanate)<br>MOXATAG (amoxicillin) | |
| **CEPHALOSPORINS** | | |
| cefaclor capsule<br>cefadroxil capsule, tablet<br>cefdinir<br>cefuroxime tablet<br>cephalexin capsule, suspension | CEDAX (ceftibuten)<br>cefaclor suspension<br>cefaclor ER tablet<br>cefadroxil suspension<br>cefpodoxime<br>cefprozil<br>ceftibuten capsule, suspension<br>CEFTIN (cefuroxime)<br>cefuroxime suspension<br>cephalexin tablet<br>DAXABIA (cephalexin)<br>KEFLEX (cephalexin)<br>OMNICEF (cefdinir)<br>RANICLOR (cefaclor)<br>SUPRAX (cefixime) | |
| **COPD AGENTS** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a sixty (60) day trial of one preferred agent from the corresponding sub-class before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| **ANTICHOLINERGIC[AP]** | | |
| ATROVENT HFA (ipratropium)<br>ipratropium nebulizer solution<br>SPIRIVA (tiotropium)<br>SPIRIVA RESPIMAT (tiotropium)<br>TUDORZA (aclidinium) | INCRUSE ELLIPTA (umeclidinium)<br>LONHALA MAGNAIR (glycopyrrolate)<br>SEEBRI NEOHALER (glycopyrrolate)<br><br>YUPELRI SOLUTION (revefenacin)[NR] | |
| **ANTICHOLINERGIC-BETA AGONIST COMBINATIONS[AP]** | | |
| ANORO ELLIPTA (umeclidinium/vilanterol)<br>albuterol/ipratropium nebulizer solution<br>BEVESPI (glycopyrrolate/formoterol)<br>COMBIVENT RESPIMAT (albuterol/ipratropium) | DUONEB (albuterol/ipratropium) | *In addition to the Class PA criteria, Stiolto Respimat requires a sixty (60) day trial of Anoro Ellipta. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| STIOLTO RESPIMAT (tiotropium/olodaterol)*<br>UTIBRON (indacaterol/glycopyrrolate) | | |
| **ANTICHOLINERGIC-BETA AGONIST-GLUCOCORTICOID COMBINATIONS** | | |
| | TRELEGY ELLIPTA (fluticasone/umeclidinium/vilanterol)* | * Trelegy Ellipta may be prior authorized for patients currently established on the individual components for at least 30 days. |
| **PDE4 INHIBITOR** | | |
| | DALIRESP (roflumilast)* | *Daliresp will be authorized if the following criteria are met:<br>1. Patient is forty (40) years of age or older **and**<br>2. Diagnosis of severe chronic obstructive pulmonary disease (COPD) associated with chronic bronchitis and multiple exacerbations requiring systemic glucocorticoids in the preceding six (6) months **and**<br>3. Concurrent therapy with an inhaled corticosteroid and long-acting bronchodilator and evidence of compliance **and**<br>4. No evidence of moderate to severe liver impairment (Child-Pugh Class B or C) **and**<br>5. No concurrent use with strong cytochrome P450 inducers (rifampicin, phenobarbital, carbamazepine or phenytoin) |
| **CYTOKINE & CAM ANTAGONISTS**[CL] | | |
| **CLASS PA CRITERIA:** Non-preferred agents require ninety (90) day trials of both Humira and Enbrel unless one (1) of the exceptions on the PA form is present. For FDA-approved indications, an additional ninety (90) day trial of Cosentyx will also be required. | | |
| **ANTI-TNFs** | | |
| ENBREL (etanercept)*<br>HUMIRA (adalimumab)* | CIMZIA (certolizumab pegol)<br>REMICADE (infliximab)<br>RENFLEXIS (infliximab)<br>SIMPONI subcutaneous (golimumab) | *Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. |
| **OTHERS** | | |
| COSENTYX (secukinumab)* | ACTEMRA subcutaneous (tocilizumab)<br>ENTYVIO (vedolizumab)<br>ILARIS (canakinumab)<br>ILUMYA (tildrakizumab)<br>KEVZARA (sarilumab)<br>KINERET (anakinra) | *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** |
| | OLUMIANT (baricitinib)<br>ORENCIA subcutaneous (abatacept)<br>OTEZLA (apremilast)<br>SILIQ (brodalumab)<br>STELARA subcutaneous (ustekinumab)<br>TALTZ (ixekizumab)<br>TREMFYA (guselkumab)<br>XELJANZ (tofacitinib)<br>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)<br>epinephrine (all labelers except 49502)<br>EPIPEN (epinephrine)<br>EPIPEN JR (epinephrine)<br>SYMJEPI (epinephrine)[NR] | |
| **ERYTHROPOIESIS STIMULATING PROTEINS[CL]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a thirty (30) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| EPOGEN (rHuEPO)<br>RETACRIT (epoetin alfa) | ARANESP (darbepoetin)<br>MIRCERA (methoxy PEG-epoetin)<br>PROCRIT (rHuEPO) | Erythropoiesis agents will be authorized if the following criteria are met:<br>1. Hemoglobin or Hematocrit less than 10/30 respectively. For renewal, hemoglobin or hematocrit levels greater than 12/36 will require dosage reduction or discontinuation. Exceptions will be considered on an individual basis after medical documentation is reviewed. (Lab oratory values must be dated within six (6) weeks of request.) **and**<br>2. Transferrin saturation ≥ 20%, ferritin levels ≥100 mg/ml, or on concurrent therapeutic iron therapy. (Laboratory values must be dated within three (3) weeks of request. For re-authorization, transferrin saturation or ferritin levels are not required if the patient has been responsive to the erythropoietin agent **and** |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | | 3. For HIV-infected patients, endogenous serum erythropoietin level must be ≤ 500mU/ml to initiate therapy **and**<br>4. No evidence of untreated GI bleeding, hemolysis, or Vitamin B-12, iron or folate deficiency. |
| **FLUOROQUINOLONES (Oral)[AP]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a five (5) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| CIPRO SUSPENSION (ciprofloxacin)<br>ciprofloxacin<br>levofloxacin tablet | AVELOX (moxifloxacin)<br>BAXDELA (delafloxacin)<br>CIPRO TABLETS (ciprofloxacin)<br>CIPRO XR (ciprofloxacin)<br>ciprofloxacin ER<br>ciprofloxacin suspension<br>LEVAQUIN (levofloxacin)<br>levofloxacin solution<br>moxifloxacin<br>NOROXIN (norfloxacin)<br>ofloxacin | |
| **GLUCOCORTICOIDS, INHALED[AP]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require thirty (30) day trials of each chemically unique preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| **GLUCOCORTICOIDS** | | |
| ASMANEX TWISTHALER (mometasone)<br>budesonide nebulizer 0.25 mg/2ml<br>budesonide nebulizer 0.5 mg/2ml<br>FLOVENT DISKUS (fluticasone)<br>FLOVENT HFA (fluticasone)<br>PULMICORT FLEXHALER (budesonide)<br>PULMICORT RESPULES (budesonide)*<br>QVAR REDIHALER (beclomethasone) | AEROSPAN (flunisolide)**<br>ALVESCO (ciclesonide)<br>ARMONAIR RESPICLICK (fluticasone)<br>ARNUITY ELLIPTA (fluticasone)<br>ASMANEX HFA (mometasone)<br>budesonide nebulizer 1 mg/2ml | *Pulmicort Respules are only preferred for children up to nine (9) years of age. For patients nine (9) and older, prior authorization is required and will be approved only for a diagnosis of severe nasal polyps.<br><br>**Aerospan will be authorized for children ages 6 through 11 years old without a trial of a preferred agent. |
| **GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS** | | |
| ADVAIR HFA (fluticasone/salmeterol)<br>DULERA (mometasone/formoterol)<br>SYMBICORT(budesonide/formoterol) | ADVAIR DISKUS (fluticasone/salmeterol)<br>AIRDUO RESPICLICK (fluticasone/salmeterol)<br>BREO ELLIPTA (fluticasone/vilanterol)<br>fluticasone/salmeterol<br>WIXELA (fluticasone/salmeterol) | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **GROWTH HORMONE**[CL] | | |
| **CLASS PA CRITERIA:** Non-preferred agents require three (3) month trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| GENOTROPIN (somatropin)<br>NORDITROPIN (somatropin) | HUMATROPE (somatropin)<br>INCRELEX (mecasermin)<br>NUTROPIN AQ (somatropin)<br>OMNITROPE (somatropin)<br>SAIZEN (somatropin)<br>SEROSTIM (somatropin)<br>ZOMACTON (somatropin)<br>ZORBTIVE (somatropin) | Patients already on a non-preferred agent will receive authorization to continue therapy on that agent for the duration of the existing PA. |
| ***H. PYLORI* TREATMENT** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a trial of the combination of individual preferred components of the requested non-preferred agent and must be used at the recommended dosages, frequencies and duration of the non-preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| Please use individual components:<br>preferred PPI (omeprazole or pantoprazole)<br>amoxicillin<br>tetracycline<br>metronidazole<br>clarithromycin<br>bismuth<br>PYLERA (bismuth/metronidazole/tetracycline) | HELIDAC (bismuth/metronidazole/tetracycline)<br>lansoprazole/amoxicillin/clarithromycin<br>OMECLAMOX-PAK<br>(omeprazole/amoxicillin/clarithromycin)<br>PREVPAC<br>(lansoprazole/amoxicillin/clarithromycin) | |
| **HEPATITIS B TREATMENTS** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require ninety (90) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| BARACLUDE SOLUTION (entecavir)<br>entecavir<br>lamivudine HBV | adefovir<br>BARACLUDE TABLET (entecavir)<br>EPIVIR HBV (lamivudine)<br>HEPSERA (adefovir)<br>VEMLIDY (tenofovir alafenamide fumarate) | |
| **HEPATITIS C TREATMENTS**[CL] | | |
| **CLASS PA CRITERIA:** For patients starting therapy in this class, preferred regimens may be found on the PA Criteria page. Requests for non-preferred regimens require medical reasoning why a preferred regimen cannot be used. | | |
| EPCLUSA (sofosbuvir/velpatasvir)*<br>MAVYRET (pibrentasvir/glecaprevir)*<br>ribavirin | COPEGUS (ribavirin)<br>DAKLINZA (daclatasvir)*<br>HARVONI (ledipasvir/sofosbuvir)* | *Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | ledipasvir/sofosbuvir*<br>MODERIBA 400 mg, 600 mg<br>MODERIBA DOSE PACK<br>PEGASYS (pegylated interferon)<br>PEG-INTRON (pegylated interferon)<br>OLYSIO (simeprevir)*<br>REBETOL (ribavirin)<br>RIBASPHERE RIBAPAK (ribavirin)<br>RIBASPHERE 400 mg, 600 mg (ribavirin)<br>sofosbuvir/velpatasvir*<br>SOVALDI (sofosbuvir)*<br>TECHNIVIE (ombitasvir/paritaprevir/ritonavir)*<br>VIEKIRA PAK (dasabuvir/ombitasvir/ paritaprevir/ritonavir)*<br>VIEKIRA XR (dasabuvir/ombitasvir/ paritaprevir/ritonavir)*<br>VOSEVI (sofosbuvir/velpatasvir/voxilaprevir)<br>ZEPATIER (elbasvir/grazoprevir)* | |
| **HYPERPARATHYROID AGENTS[AP]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require thirty (30) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| paricalcitol capsule | doxercalciferol<br>HECTOROL (doxercalciferol)<br>paricalcitol injection<br>RAYALDEE (calcifediol)<br>SENSIPAR (cinacalcet)<br>ZEMPLAR (paricalcitol) | |
| **HYPOGLYCEMICS, BIGUANIDES** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a ninety (90) day trial of a preferred agent of similar duration before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| metformin<br>metformin ER (generic Glucophage XR) | FORTAMET (metformin ER)<br>GLUCOPHAGE (metformin)<br>GLUCOPHAGE XR (metformin ER)<br>GLUMETZA (metformin ER)*<br>metformin ER (generic Glumetza & Fortamet)<br>RIOMET (metformin) | *Glumetza will be approved only after a 30-day trial of Fortamet. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **HYPOGLYCEMICS, DPP-4 INHIBITORS** | | |
| **CLASS PA CRITERIA: Non-preferred agents are available only on appeal.**<br><br>**NOTE: DPP-4 inhibitors will NOT be approved in combination with a GLP-1 agonist.** | | |
| JANUMET (sitagliptin/metformin)<br>JANUMET XR (sitagliptin/metformin)<br>JANUVIA (sitagliptin)<br>JENTADUETO (linagliptin/metformin)<br>TRADJENTA (linagliptin) | alogliptin<br>alogliptin/metformin<br>alogliptin/pioglitazone<br>JENTADUETO XR (linagliptin/metformin)<br>KAZANO (alogliptin/metformin)<br>KOMBIGLYZE XR (saxagliptin/metformin)<br>NESINA (alogliptin)<br>ONGLYZA (saxagliptin)<br>OSENI (alogliptin/pioglitazone) | |
| **HYPOGLYCEMICS, GLP-1 AGONISTS[CL]** | | |
| **CLASS PA CRITERIA: 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:<br><br>• 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.<br>• 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.<br>• Re-authorizations require <u>continued</u> maintenance on a regimen consisting of at least one (1) other agent at the maximum tolerable dose AND an A1C of ≤8%.<br><br>**NOTE: GLP-1 agents will NOT be approved in combination with a DPP-4 inhibitor.** | | |
| BYDUREON (exenatide)<br>BYETTA (exenatide)<br>OZEMPIC (semaglutide)<br>VICTOZA (liraglutide) | ADLYXIN (lixisenatide)<br>BYDUREON BCISE (exenatide)<br>TANZEUM (albiglutide)<br>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.<br><br>Humulin pens and Humalog Mix pens will be authorized only for patients who cannot utilize vials due to impaired vision or dexterity. | | |
| APIDRA (insulin glulisine)[AP*]<br>HUMALOG (insulin lispro)<br>HUMALOG JR KWIKPEN (insulin lispro) | ADMELOG (insulin lispro)<br>AFREZZA (insulin)[CL]<br>BASAGLAR (insulin glargine) | *Apidra will be authorized if the following criteria are met:<br>1. Patient is four (4) years of age or older; **and**<br>2. Patient is currently on a regimen including a longer |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| HUMALOG KWIKPEN U-100 (insulin lispro)<br>HUMALOG MIX PENS (insulin lispro/lispro protamine)<br>HUMALOG MIX VIALS (insulin lispro/lispro protamine)<br>HUMULIN R U-500 VIAL (insulin)<br>HUMULIN R U-500 KWIKPEN (insulin)<br>LANTUS (insulin glargine)<br>LEVEMIR (insulin detemir)<br>NOVOLOG (insulin aspart)<br>NOVOLOG MIX (insulin aspart/aspart protamine)<br>TOUJEO SOLOSTAR (insulin glargine)<br>TRESIBA (insulin degludec)<br>TRESIBA FLEXTOUCH (insulin degludec) | FIASP (insulin aspart)<br>HUMULIN PENS (insulin)<br>HUMULIN N VIAL (insulin)<br>HUMULIN R VIAL (insulin)<br>NOVOLIN (insulin)<br>SOLIQUA (insulin glargine/lixisenatide)**<br>XULTOPHY (insulin degludec/liraglutide)** | acting or basal insulin, **and**<br>3. Patient has had a trial of a similar preferred agent, Novolog or Humalog, with documentation that the desired results were not achieved..<br><br>** Non-preferred insulin combination products require that the patient must already be established on the individual agents at doses not exceeding the maximum dose achievable with the combination product, and require medical reasoning beyond convenience or enhanced compliance as to why the clinical need cannot be met with a combination of preferred single-ingredient agents. |
| **HYPOGLYCEMICS, MEGLITINIDES** | | |
| **CLASS PA CRITERIA: Non-preferred agents are available only on appeal.** | | |
| **MEGLITINIDES** | | |
| nateglinide<br>repaglinide | PRANDIN (repaglinide)<br>STARLIX (nateglinide) | |
| **MEGLITINIDE COMBINATIONS** | | |
| | PRANDIMET (repaglinide/metformin)<br>repaglinide/metformin | |
| **HYPOGLYCEMICS, MISCELLANEOUS AGENTS** | | |
| **CLASS PA CRITERIA:** Welchol will be authorized for add-on therapy for type 2 diabetes when there is a previous history of a thirty (30) day trial of an oral diabetic agent. | | |
| WELCHOL (colesevelam)[AP] | SYMLIN (pramlintide)* | *Symlin will be authorized with a history of bolus insulin utilization in the past ninety (90) days with no gaps in insulin therapy greater than thirty (30) days. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **HYPOGLYCEMICS, SGLT2 INHIBITORS[CL]** | | |
| **CLASS PA CRITERIA: 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.<br>• 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.<br>• 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.<br>• 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** | | |
| JARDIANCE (empagliflozin) | FARXIGA (dapagliflozin)<br>INVOKANA (canagliflozin)<br>STEGLATRO (ertugliflozin) | |
| **SGLT2 COMBINATIONS** | | |
| SYNJARDY (empagliflozin/metformin) | GLYXAMBI (empagliflozin/linagliptin)<br>INVOKAMET (canagliflozin/metformin)<br>INVOKAMET XR (canagliflozin/metformin)<br>SEGLUROMET (ertugliflozin/metformin<br>STEGLUJAN (ertugliflozin/sitagliptin)<br>SYNJARDY XR (empagliflozin/metformin)<br>QTERN (dapagliflozin/saxagliptin)<br>XIGDUO XR (dapagliflozin/metformin) | |
| **HYPOGLYCEMICS, TZD** | | |
| **CLASS PA CRITERIA: Non-preferred agents are available only on appeal.** | | |
| **THIAZOLIDINEDIONES** | | |
| pioglitazone | ACTOS (pioglitazone)<br>AVANDIA (rosiglitazone) | |
| **TZD COMBINATIONS** | | |
| | ACTOPLUS MET (pioglitazone/ metformin)<br>ACTOPLUS MET XR (pioglitazone/ metformin)<br>AVANDARYL (rosiglitazone/glimepiride)<br>DUETACT (pioglitazone/glimepiride)<br>pioglitazone/glimepiride<br>pioglitazone/ metformin | Patients are required to use the components of Actoplus Met and Duetact separately. Exceptions will be handled on a case-by-case basis. |

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

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

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **IRRITABLE BOWEL SYNDROME/SHORT BOWEL SYNDROME/SELECTED GI AGENTS** CL | | |
| **CLASS PA CRITERIA:** All agents are approvable only for patients age eighteen (18) and older. See below for additional sub-class criteria. | | |
| **CONSTIPATION** | | |
| AMITIZA (lubiprostone)*<br>LINZESS (linaclotide)***<br>MOVANTIK (naloxegol)** | MOTEGRITY (prucalopride)<br>RELISTOR INJECTION (methylnaltrexone)****<br>RELISTOR TABLET (methylnaltrexone)****<br>SYMPROIC (naldemedine)****<br>TRULANCE (plecanatide)***** | All agents require documentation of the current diagnosis and evidence that the patient has failed to find relief with dietary modification and a fourteen (14) day trial of an osmotic laxative.<br><br>In addition:<br>* 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.<br>** Movantik will be approved per the FDA-approved label for OIC with a concurrent and continuous 90-day history of opioid claims on record.<br>*** Linzess is indicated for CIC and IBS-C and requires a thirty (30) day trial of Amitiza. . For the indication of IBS-C in males, a trial of Amitiza is not required.<br>**** Relistor and Symproic are indicated for OIC and require thirty (30) day trials of both Movantik and Amitiza.<br>***** 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<br>MYTESI (crofelemer)<br>LOTRONEX (alosetron)<br>VIBERZI (eluxadoline) | Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. |
| **LAXATIVES AND CATHARTICS** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require thirty (30) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present | | |
| COLYTE<br>GOLYTELY<br>NULYTELY<br>peg 3350 | HALFLYTELY-BISACODYL KIT<br>MOVIPREP<br>OSMOPREP<br>PREPOPIK<br>SUPREP | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **LEUKOTRIENE MODIFIERS** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require thirty (30) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| montelukast<br>zafirlukast | ACCOLATE (zafirlukast)<br>SINGULAIR (montelukast)<br>zileuton<br>ZYFLO (zileuton) | |
| **LIPOTROPICS, OTHER (Non-statins)** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a twelve (12) week trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| **BILE ACID SEQUESTRANTS[AP]** | | |
| cholestyramine<br>colestipol tablets | COLESTID (colestipol)<br>colestipol granules<br>KYNAMRO (mipomersen)*<br>QUESTRAN (cholestyramine)<br>WELCHOL (colesevelam)** | *Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.<br><br>**Welchol will be authorized for add-on therapy for type 2 diabetes when there is a previous history of a thirty (30) day trial of an oral agent (metformin, sulfonylurea or thiazolidinedione (TZD)). See HYPOGLYCEMICS, MISCELLANEOUS. |
| **CHOLESTEROL ABSORPTION INHIBITORS** | | |
| 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)<br>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<br>fenofibrate micronized 67mg, 134mg & 200mg<br>fenofibrate nanocrystallized 48 mg, 145 mg<br>gemfibrozil | ANTARA (fenofibrate)<br>FENOGLIDE (fenofibrate)<br>FIBRICOR (fenofibric acid)<br>fenofibrate 40 mg tablet<br>fenofibrate 150 mg capsules<br>fenofibrate 43, 50, 120 and 130 mg<br>fenofibric acid<br>LIPOFEN (fenofibrate)<br>LOFIBRA (fenofibrate)<br>LOPID (gemfibrozil) | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | TRICOR (fenofibrate nanocrystallized)<br>TRIGLIDE (fenofibrate)<br>TRILIPIX (fenofibric acid) | |
| | **MTP INHIBITORS** | |
| | JUXTAPID (lomitapide)* | *Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. |
| | **NIACIN** | |
| niacin<br>niacin ER (OTC)<br>NIACOR (niacin)<br>NIASPAN (niacin) | niacin ER (Rx) | |
| | **PCSK-9 INHIBITORS** | |
| PRALUENT (alirocumab)* | REPATHA (evolocumab)* | *Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. |
| **LIPOTROPICS, STATINS[AP]** | | |
| **CLASS PA CRITERIA:** See below for individual sub-class criteria. | | |
| | **STATINS** | |
| atorvastatin<br>lovastatin<br>pravastatin<br>rosuvastatin<br>simvastatin* | ALTOPREV (lovastatin)<br>CRESTOR (rosuvastatin)<br>fluvastatin<br>fluvastatin ER<br>LESCOL (fluvastatin)<br>LESCOL XL (fluvastatin)<br>LIPITOR (atorvastatin)<br>LIVALO (pitavastatin)<br>MEVACOR (lovastatin)<br>PRAVACHOL (pravastatin)<br>ZOCOR (simvastatin)*<br>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.<br><br>*Zocor/simvastatin 80mg tablets will require a clinical PA. |
| | **STATIN COMBINATIONS** | |
| | ADVICOR (lovastatin/niacin)<br>amlodipine/atorvastatin<br>CADUET (atorvastatin/amlodipine)<br>ezetimibe/simvastatin<br>LIPTRUZET (atorvastatin/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. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | SIMCOR (simvastatin/niacin ER)<br>VYTORIN (simvastatin/ezetimibe)* | *Vytorin will be authorized only after an insufficient response to a twelve (12) week trial of the maximum tolerable dose of atorvastatin or rosuvastatin, unless one (1) of the exceptions on the PA form is present.<br><br>Vytorin 80/10mg tablets will require a clinical PA. |
| **MACROLIDES** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a five (5) day trial of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| **MACROLIDES** | | |
| azithromycin<br>erythromycin base | BIAXIN (clarithromycin)<br>clarithromycin tablets<br>clarithromycin ER<br>clarithromycin suspension<br>E.E.S. (erythromycin ethylsuccinate)<br>E-MYCIN (erythromycin)<br>ERYC (erythromycin)<br>ERYPED (erythromycin ethylsuccinate)<br>ERY-TAB (erythromycin)<br>ERYTHROCIN (erythromycin stearate)<br>erythromycin estolate<br>PCE (erythromycin)<br>ZITHROMAX (azithromycin)<br>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)<br>AVONEX PEN (interferon beta-1a)<br>BETASERON (interferon beta-1b)<br>REBIF (interferon beta-1a)<br>REBIF REBIDOSE (interferon beta-1a) | EXTAVIA KIT (interferon beta-1b)<br>EXTAVIA VIAL (interferon beta-1b)<br>PLEGRIDY (peginterferon beta-1a) | |
| **NON-INTERFERONS** | | |
| AMPYRA (dalfampridine)**<br>COPAXONE 20 mg (glatiramer) | AUBAGIO (teriflunomide)***<br>COPAXONE 40 mg (glatiramer)**** | **In addition to class PA criteria, the following conditions and criteria also apply:** |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| GILENYA (fingolimod) * | glatiramer<br>GLATOPA (glatiramer)<br>TECFIDERA (dimethyl fumarate)*****<br>ZINBRYTA (daclizumab) | *Gilenya will be approved after a thirty (30) day trial of a preferred injectable agent.<br><br>**Ampyra will be authorized if the following criteria are met:<br>1. Diagnosis of multiple sclerosis **and**<br>2. No history of seizures **and**<br>3. No evidence of moderate or severe renal impairment **and**<br>4. Initial prescription will be authorized for thirty (30) days only.<br><br>***Aubagio will be authorized if the following criteria are met:<br>1. Diagnosis of relapsing multiple sclerosis **and**<br>2. Measurement of transaminase and bilirubin levels within the (6) months before initiation of therapy and ALT levels at least monthly for six (6) months after initiation of therapy **and**<br>3. Complete blood cell count (CBC) within six (6) months before initiation of therapy **and**<br>4. Female patients must have a negative pregnancy test before initiation of therapy and be established on a reliable method of contraception if appropriate **and**<br>5. Patient is from eighteen (18) up to sixty-five (65) years of age **and**<br>6. Negative tuberculin skin test before initiation of therapy<br><br>****Copaxone 40mg will only be authorized for documented injection site issues.<br><br>*****Tecfidera will be authorized if the following criteria are met:<br>1. Diagnosis of relapsing multiple sclerosis **and**<br>2. Complete blood count (CBC) within six (6) months of initiation of therapy and six (6) months after initiation **and**<br>3. Complete blood count (CBC) annually during therapy. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **NEUROPATHIC PAIN** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a thirty (30) day trial of a preferred agent in the corresponding dosage form (oral or topical) before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| capsaicin OTC<br>duloxetine<br>gabapentin<br>lidocaine patch<br>LYRICA CAPSULE (pregabalin) | CYMBALTA (duloxetine)<br>GRALISE (gabapentin)*<br>HORIZANT (gabapentin)<br>IRENKA (duloxetine)<br>LIDODERM (lidocaine)<br>LYRICA CR (pregabalin)**<br>LYRICA SOLUTION (pregabalin)**<br>NEURONTIN (gabapentin)[AP]<br>QUTENZA (capsaicin)<br>SAVELLA (milnacipran)***<br>ZTLIDO PATCH (lidocaine) | *Gralise will be authorized only if the following criteria are met:<br>1. Diagnosis of post herpetic neuralgia **and**<br>2. Trial of a tricyclic antidepressant for a least thirty (30) days **and**<br>3. 90-day trial of gabapentin immediate release formulation (positive response without adequate duration) **and**<br>4. Request is for once daily dosing with 1800 mg maximum daily dosage.<br><br>**Lyrica CR and Lyrica Solution require medical reasoning beyond convenience as to why the need cannot be met using preferred Lyrica capsules.<br><br>***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)<br>flurbiprofen<br>ibuprofen (Rx and OTC)<br>INDOCIN SUSPENSION (indomethacin)<br>indomethacin<br>ketoprofen<br>ketorolac<br>meloxicam tablet<br>nabumetone<br>naproxen sodium tablet<br>naproxen sodium DS tablet<br>piroxicam<br>sulindac | CATAFLAM (diclofenac)<br>CLINORIL (sulindac)<br>DAYPRO (oxaprozin)<br>diflunisal<br>DUEXIS (famotidine/ibuprofen)<br>etodolac IR<br>etodolac SR<br>FELDENE (piroxicam)<br>fenoprofen<br>INDOCIN SUPPOSITORIES (indomethacin)<br>indomethacin ER<br>ketoprofen ER<br>meclofenamate<br>mefenamic acid | 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** |
| | meloxicam suspension<br>MOBIC TABLET (meloxicam)<br>NALFON (fenoprofen)<br>NAPRELAN (naproxen)<br>NAPROSYN (naproxen)<br>naproxen CR<br>naproxen suspension<br>EC-naproxen DR tablet<br>oxaprozin<br>PONSTEL (meclofenamate)<br>SPRIX (ketorolac)<br>TIVORBEX (indomethacin)<br>tolmetin<br>VIVLODEX (meloxicam)<br>VOLTAREN (diclofenac)<br>ZIPSOR (diclofenac potassium)<br>ZORVOLEX (diclofenac) | |
| **NSAID/GI PROTECTANT COMBINATIONS** | | |
| | ARTHROTEC (diclofenac/misoprostol)<br>diclofenac/misoprostol<br>VIMOVO (naproxen/esomeprazole) | Non-preferred agents are only available on appeal and require medical reasoning beyond convenience as to why the need cannot be met with the combination of preferred single agents. |
| **COX-II SELECTIVE** | | |
| | CELEBREX (celecoxib)<br>celecoxib | COX-II Selective agents require thirty (30) day trials of each preferred Non-Selective Oral NSAID, **UNLESS** the following criteria are met:<br><br>Patient has a history or risk of a serious GI complication; **OR**<br>Agent is requested for treatment of a chronic condition **and**<br>1. Patient is seventy (70) years of age or older, **or**<br>2. Patient is currently on anticoagulation therapy**.**<br>3. |
| **TOPICAL** | | |
| FLECTOR PATCH (diclofenac)*<br>PENNSAID (diclofenac)<br>VOLTAREN GEL (diclofenac)** | diclofenac gel<br>diclofenac solution | *Flector patches are limited to two per day.<br><br>**Voltaren Gel will be limited to 100 grams per month.<br><br>Non-preferred agents require a thirty (30) day trial of the preferred Topical agent and thirty (30) day trials of each preferred oral NSAID before they will be approved, unless one(1) of the exceptions on the PA form is present. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **OPHTHALMIC ANTIBIOTICS[AP]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require three (3) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| bacitracin/polymyxin ointment<br>ciprofloxacin*<br>erythromycin<br>gentamicin<br>levofloxacin*<br>MOXEZA (moxifloxacin)<br>neomycin/bacitracin/polymyxin<br>ofloxacin*<br>polymyxin/trimethoprim<br>tobramycin<br>TOBREX OINT (tobramycin) | AZASITE (azithromycin)<br>bacitracin<br>BLEPH-10 (sulfacetamide)<br>BESIVANCE (besifloxacin)*<br>CILOXAN (ciprofloxacin)<br>GARAMYCIN (gentamicin)<br>gatifloxacin<br>ILOTYCIN (erythromycin)<br>moxifloxacin**<br>NATACYN (natamycin)<br>neomycin/polymyxin/gramicidin<br>NEOSPORIN (neomycin/polymyxin/gramicidin)<br>OCUFLOX (ofloxacin)<br>POLYTRIM (polymyxin/trimethoprim)<br>sulfacetamide drops<br>sulfacetamide ointment<br>TOBREX (tobramycin)<br>VIGAMOX (moxifloxacin)**<br>ZYMAR (gatifloxacin)<br>ZYMAXID (gatifloxacin) | *Prior authorization of any fluoroquinolone agent requires three (3) day trials of all other preferred agents unless definitive laboratory cultures exist indicating the need to use a fluoroquinolone. |
| **OPHTHALMIC ANTIBIOTIC/STEROID COMBINATIONS[AP]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require three (3) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| neomycin/polymyxin/dexamethasone<br>sulfacetamide/prednisolone<br>TOBRADEX OINTMENT (tobramycin/ dexamethasone)<br>TOBRADEX SUSPENSION (tobramycin/ dexamethasone)<br>ZYLET (loteprednol/tobramycin) | BLEPHAMIDE (prednisolone/sulfacetamide)<br>BLEPHAMIDE S.O.P. (prednisolone/ sulfacetamide)<br>MAXITROL ointment (neomycin/polymyxin/ dexamethasone)<br>MAXITROL suspension (neomycin/polymyxin/ dexamethasone)<br>neomycin/bacitracin/polymyxin/ hydrocortisone<br>neomycin/polymyxin/hydrocortisone<br>PRED-G (prednisolone/gentamicin)<br>TOBRADEX ST (tobramycin/ dexamethasone)<br>tobramycin/dexamethasone suspension | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS[AP]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require thirty (30) day trials of three (3) preferred chemically unique agents before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| ALAWAY (ketotifen)<br>ALREX (loteprednol)<br>azelastine<br>BEPREVE (bepotastine)<br>cromolyn<br>ketotifen<br>LASTACAFT (alcaftadine)<br>ZADITOR OTC (ketotifen) | ALAMAST (pemirolast)<br>ALOCRIL (nedocromil)<br>ALOMIDE (lodoxamide)<br>CROLOM (cromolyn)<br>ELESTAT (epinastine)<br>EMADINE (emedastine)<br>epinastine<br>olopatadine 0.1% (Generic PATANOL labeler 61314 only)<br>olopatadine 0.1% (all formulations except Generic PATANOL labeler 61314)<br>olopatadine 0.2% (all labelers)<br>OPTICROM (cromolyn)<br>OPTIVAR (azelastine)<br>PATADAY (olopatadine)<br>PATANOL (olopatadine)<br>PAZEO (olopatadine) | |
| **OPHTHALMICS, ANTI-INFLAMMATORIES- IMMUNOMODULATORS** | | |
| **CLASS PA CRITERIA:** See below for individual sub-class criteria. | | |
| RESTASIS (cyclosporine) | CEQUA (cyclosporine)[NR]<br>XIIDRA (lifitegrast) | The following prior authorization criteria apply to both Restasis and Xiidra:<br>1.) Patient must be sixteen (16) years of age or greater; **AND**<br>2.) Prior Authorization must be requested by an ophthalmologist or optometrist; **AND**<br>3.) Clinically diagnosed tear deficiency due to ocular inflammation in patients with keratoconjunctivitis sicca or dry eye syndrome (also known as dry eye); **AND**<br>4.) Patient must have a functioning lacrimal gland; **AND**<br>5.) Patient using artificial tears at least four (4) times a day over the last thirty (30) days; **AND**<br>6.) Patient must not have an active ocular infection |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **OPHTHALMICS, ANTI-INFLAMMATORIES** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require five (5) day trials of at least two (2) preferred agents before they will be approved, unless one (1) of the exceptions on the PA form is present. Trials must include at least one agent with the same mechanism of action as the requested non-preferred agent. | | |
| dexamethasone<br>diclofenac<br>DUREZOL (difluprednate)<br>FLAREX (fluorometholone)<br>fluorometholone<br>FML FORTE (fluorometholone)<br>FML S.O.P. (fluorometholone)<br>ketorolac<br>LOTEMAX DROPS, OINTMENT (loteprednol)<br>LOTEMAX GEL (loteprednol)<br>MAXIDEX (dexamethasone)<br>NEVANAC (nepafenac)<br>PRED MILD (prednisolone)<br>prednisolone acetate<br>prednisolone sodium phosphate | ACULAR (ketorolac)<br>ACULAR LS (ketorolac)<br>ACUVAIL (ketorolac tromethamine)<br>BROMDAY (bromfenac)<br>bromfenac<br>BROMSITE (bromfenac)<br>flurbiprofen<br>FML (fluorometholone)<br>ILEVRO (nepafenac)<br>INVELTYS (loteprednol)$^{NR}$<br>OMNIPRED (prednisolone)<br>OZURDEX (dexamethasone)<br>PRED FORTE (prednisolone)<br>PROLENSA (bromfenac)<br>RETISERT (fluocinolone)<br>TRIESENCE (triamcinolone)<br>VEXOL (rimexolone)<br>XIBROM (bromfenac) | |
| **OPHTHALMICS, GLAUCOMA AGENTS** | | |
| **CLASS PA CRITERIA:** Non-preferred agents will only be authorized if there is an allergy to all preferred agents in the corresponding sub-class. | | |
| **COMBINATION AGENTS** | | |
| COMBIGAN (brimonidine/timolol)<br>dorzolamide/timolol | COSOPT (dorzolamide/timolol)<br>COSOPT PF (dorzolamide/timolol)<br>SIMBRINZA (brinzolamide/brimonidine) | |
| **BETA BLOCKERS** | | |
| BETOPTIC S (betaxolol)<br>carteolol<br>levobunolol<br>timolol drops | BETAGAN (levobunolol)<br>betaxolol<br>ISTALOL (timolol)<br>OPTIPRANOLOL (metipranolol)<br>timolol gel<br>TIMOPTIC (timolol) | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **CARBONIC ANHYDRASE INHIBITORS** | | |
| AZOPT (brinzolamide)<br>orzolamide | TRUSOPT (dorzolamide) | |
| **PARASYMPATHOMIMETICS** | | |
| PHOSPHOLINE IODIDE (echothiophate iodide) | pilocarpine | |
| **PROSTAGLANDIN ANALOGS** | | |
| latanoprost<br>TRAVATAN-Z (travoprost) | bimatoprost<br>LUMIGAN (bimatoprost)<br>travoprost<br>VYZULTA (latanoprostene)*<br>XALATAN (latanoprost)<br>XELPROS (latanoprost)[NR]<br>ZIOPTAN (tafluprost) | *Vyzulta – prior authorization requires failure on a 3-month trial of at least one preferred prostaglandin eye drop used in combination with an agent from another subclass. |
| **RHO-KINASE INHIBITORS** | | |
| RHOPRESSA (netarsudil)<br>ROCKLATAN (netarsudil/latanoprost) | | 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** | | |
| ALPHAGAN P 0.1% Solution (brimonidine)<br>ALPHAGAN P 0.15% Solution (brimonidine)<br>brimonidine 0.2% | apraclonidine<br>brimonidine 0.15%<br>IOPIDINE (apraclonidine) | |
| **OPIATE DEPENDENCE TREATMENTS** | | |
| **CLASS PA CRITERIA:** Buprenorphine/naloxone tablets, Bunavail and Zubsolv will only be approved with a documented intolerance of or allergy to Suboxone strips.<br><br>WV Medicaid's buprenorphine coverage policy may be viewed by clicking on the following hyperlink: Buprenorphine Coverage Policy and Related Forms | | |
| buprenorphine tablets<br>buprenorphine/naloxone tablets<br>buprenorphine/naloxone film (labeler 00781 only)<br>naloxone<br>NARCAN NASAL SPRAY (naloxone)<br>SUBOXONE FILM (buprenorphine/naloxone)*<br>VIVITROL (naltrexone) | BUNAVAIL (buprenorphine/naloxone)<br>buprenorphine/naloxone film (all labelers except 00781)<br>LUCEMYRA (lofexidine)<br>SUBLOCADE (buprenorphine soln)**<br>ZUBSOLV (buprenorphine/naloxone) | * Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.<br>**Sublocade is approvable only on appeal and requires medical reasoning as to why the clinical need cannot be met with a preferred product.<br><br>VIVITROL no longer requires a PA. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **OTIC ANTIBIOTICS[AP]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require five (5) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| CIPRO HC (ciprofloxacin/hydrocortisone)<br>CIPRODEX (ciprofloxacin/dexamethasone)<br>COLY-MYCIN S (colistin/hydrocortisone/ neomycin/thonzonium bromide)<br>ofloxacin | ciprofloxacin<br>CORTISPORIN-TC (colistin/hydrocortisone/ neomycin)<br>neomycin/polymyxin/HC solution/suspension<br>OTOVEL ( ciprofloxacin/fluocinolone) | |
| **PAH AGENTS – ENDOTHELIN RECEPTOR ANTAGONISTS[CL]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a thirty (30) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| LETAIRIS (ambrisentan)<br>TRACLEER TABLET (bosentan) | ambrisentan<br>bosentan<br>OPSUMIT (macitentan)<br>TRACLEER SUSP (bosentan) | |
| **PAH AGENTS – GUANYLATE CYCLASE STIMULATOR[CL]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a thirty (30) day trial of a preferred agent from any other PAH Class before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| | ADEMPAS (riociguat) | |
| **PAH AGENTS – PDE5s[CL]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a thirty (30) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.<br>Patients stabilized on non-preferred agents will be grandfathered. | | |
| sildenafil | ADCIRCA (tadalafil)<br>REVATIO IV (sildenafil)<br>REVATIO SUSPENSION (sildenafil)<br>REVATIO TABLETS (sildenafil) | |
| **PAH AGENTS – PROSTACYCLINS[CL]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a thirty (30) day trial of a preferred agent, including the preferred generic form of the non-preferred agent (if available), before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| epoprostenol<br>VENTAVIS (iloprost)* | FLOLAN (epoprostenol)<br>ORENITRAM ER (treprostinil) | *Ventavis will only be authorized for the treatment of pulmonary artery hypertension (WHO Group 1) in patients with NYHA |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | REMODULIN (treprostinil sodium)<br>TYVASO (treprostinil)<br>UPTRAVI (selexipag)<br>VELETRI (epoprostenol) | Class III or IV symptoms. |
| **PANCREATIC ENZYMES[AP]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a thirty (30) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.<br>For members with cystic fibrosis, a trial of a preferred agent will not be required. | | |
| CREON<br>ZENPEP | PANCREAZE<br>PERTZYE<br>ULTRESA<br>VIOKACE | |
| **PHOSPHATE BINDERS[AP]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a thirty (30) day trial of at least two (2) preferred agents before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| calcium acetate<br>CALPHRON (calcium acetate)<br>MAGNEBIND RX (calcium carbonate, folic acid, magnesium carbonate)<br>PHOSLYRA (calcium acetate) | AURYXIA (ferric citrate)<br>ELIPHOS (calcium acetate)<br>FOSRENOL (lanthanum)<br>lanthanum chewable<br>PHOSLO (calcium acetate)<br>RENAGEL (sevelamer)<br>RENVELA (sevelamer carbonate)<br>sevelamer carbonate<br>VELPHORO (sucroferric oxyhydroxide) | |
| **PITUITARY SUPPRESSIVE AGENTS, LHRH[CL]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents **are available only on appeal.** | | |
| LUPANETA (leuprolide)<br>LUPRON DEPOT KIT (leuprolide)<br>LUPRON DEPOT-PED KIT (leuprolide)<br>SYNAREL (nafarelin)<br>TRELSTAR (triptorelin)<br>TRIPTODUR (triptorelin)<br>VANTAS (histrelin)<br>ZOLADEX (goserelin) | leuprolide<br>ORILISSA(elagolix)*<br>SUPPRELIN LA KIT (histrelin) | * Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **PLATELET AGGREGATION INHIBITORS** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a thirty (30) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| AGGRENOX (dipyridamole/ASA)<br>BRILINTA (ticagrelor)<br>clopidogrel<br>dipyridamole<br>prasugrel | clopidogrel kit<br>dipyridamole/aspirin<br>EFFIENT (prasugrel)<br>PERSANTINE (dipyridamole)<br>PLAVIX (clopidogrel)<br>TICLID (ticlopidine)<br>ticlopidine<br>ZONTIVITY (vorapaxar) | |
| **PROGESTATIONAL AGENTS** | | |
| **CLASS PA CRITERIA:** Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. | | |
| MAKENA (hydroxyprogesterone caproate) AUTO INJECTOR<br>MAKENA (hydroxyprogesterone caproate) VIAL | | |
| **PROGESTINS FOR CACHEXIA** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a thirty (30) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| megestrol | MEGACE ES (megestrol) | |
| **PROTON PUMP INHIBITORS[AP]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require sixty (60) day trials of both omeprazole (Rx) and pantoprazole at the maximum recommended dose*, inclusive of a concurrent thirty (30) day trial at the maximum dose of an $H_2$ antagonist before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| omeprazole (Rx)<br>pantoprazole<br><br>NEXIUM PACKETS (esomeprazole)**<br>PROTONIX GRANULES (pantoprazole)** | ACIPHEX (rabeprazole)<br>ACIPHEX SPRINKLE (rabeprazole)<br>DEXILANT (dexlansoprazole)<br>esomeprazole magnesium<br>esomeprazole strontium<br>lansoprazole Rx<br>NEXIUM (esomeprazole)<br>omeprazole/sodium bicarbonate (Rx)<br>PREVACID CAPSULES (lansoprazole) | *Maximum recommended doses of the PPIs and H2-receptor antagonists may be located at the BMS Pharmacy PA criteria page titled "Max PPI and H2RA" by clicking on the hyperlink.<br><br>**Prior authorization is required for members nine (9) years of age or older for these agents. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | PREVACID SOLUTABS (lansoprazole)**<br>PRILOSEC Rx (omeprazole)<br>PROTONIX DR TABLETS (pantoprazole)<br>rabeprazole<br>ZEGERID Rx (omeprazole/sodium bicarbonate) | |
| **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)<br>estazolam<br>flurazepam<br>HALCION (triazolam)<br>RESTORIL (temazepam)<br>temazepam 7.5, 22.5 mg<br>triazolam | |
| **OTHERS** | | |
| Melatonin (labeler code 51645 only)<br>zolpidem 5, 10 mg | AMBIEN (zolpidem)<br>AMBIEN CR (zolpidem)<br>BELSOMRA (suvorexant)<br>chloral hydrate<br>EDLUAR (zolpidem)<br>eszopiclone<br>HETLIOZ (tasimelteon)[CL]*<br>INTERMEZZO (zolpidem)<br>LUNESTA (eszopiclone)<br>ROZEREM (ramelteon)<br>SILENOR (doxepin)<br>SOMNOTE (chloral hydrate)<br>SONATA (zaleplon)<br>zaleplon<br>zolpidem ER 6.25, 12.5 mg<br>ZOLPIMIST (zolpidem) | Strengths of zolpidem that are non-preferred (6.25 and 12.5 mg) must be created by combining or splitting the preferred doses (5 and 10 mg) of zolpidem, if appropriate.<br><br>For treatment naïve female patients, zolpidem and zolpidem ER maximum dosages will be limited to 5 mg and 6.25 mg respectively per day.<br><br>*Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **SKELETAL MUSCLE RELAXANTS**[AP] | | |
| **CLASS PA CRITERIA:** See below for individual sub-class criteria. | | |
| **ACUTE MUSCULOSKELETAL RELAXANT AGENTS** | | |
| Chlorzoxazone (generic PARAFON FORTE)<br>cyclobenzaprine IR 5, 10 mg<br>methocarbamol | AMRIX (cyclobenzaprine)<br>carisoprodol*<br>carisoprodol/ASA*<br>carisoprodol/ASA/codeine*<br>chlorzoxazone (generic LORZONE)[NR]<br>cyclobenzaprine ER<br>cyclobenzaprine IR 7.5 mg<br>FEXMID (cyclobenzaprine)<br>FLEXERIL (cyclobenzaprine)<br>LORZONE (chlorzoxazone)<br>metaxalone<br>orphenadrine<br>orphenadrine/ASA/caffeine<br>orphenadrine ER<br>PARAFON FORTE (chlorzoxazone)<br>ROBAXIN (methocarbamol)<br>SKELAXIN (metaxalone)<br>SOMA (carisoprodol) | 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.<br><br>*Carisoprodol requires thirty (30) day trials of each of the preferred acute musculoskeletal relaxants and Skelaxin before it will be approved. |
| **MUSCULOSKELETAL RELAXANT AGENTS USED FOR SPASTICITY** | | |
| baclofen<br>tizanidine tablets | DANTRIUM (dantrolene)<br>dantrolene<br>tizanidine capsules<br>ZANAFLEX (tizanidine) | Non-preferred agents require thirty (30) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. |
| **STEROIDS, TOPICAL** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require five (5) day trials of one (1) form of **EACH** preferred unique active ingredient in the corresponding potency group before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| **VERY HIGH & HIGH POTENCY** | | |
| betamethasone dipropionate cream<br>betamethasone valerate cream<br>betamethasone valerate lotion<br>betamethasone valerate oint<br>clobetasol propionate<br>cream/gel/ointment/solution<br>clobetasol emollient | amcinonide<br>APEXICON (diflorasone diacetate)<br>APEXICON E (diflorasone diacetate)<br>betamethasone dipropionate gel, lotion, ointment<br>BRYHALI LOTION (halobetasol)[NR]<br>clobetasol lotion<br>clobetasol propionate foam | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| clobetasol propionate shampoo<br>fluocinonide gel<br>triamcinolone acetonide cream, ointment<br>triamcinolone acetonide lotion | CLOBEX (clobetasol propionate)<br>CLODAN KIT (clobetasol propionate)<br>CLODAN SHAMPOO (clobetasol propionate)<br>CORMAX (clobetasol propionate)<br>desoximetasone cream/gel/ointment<br>diflorasone diacetate<br>DIPROLENE (betamethasone dipropionate/propylene glycol)<br>DIPROLENE AF (betamethasone dipropionate/propylene glycol)<br>DIPROSONE (betamethasone dipropionate)<br>fluocinonide cream<br>fluocinonide ointment<br>fluocinonide solution<br>fluocinonide/emollient<br>halcinonide<br>HALAC (halobetasol propionate)<br>halobetasol propionate<br>HALOG (halcinonide)<br>HALONATE (halobetasol propionate)<br>KENALOG (triamcinolone acetonide)<br>LEXETTE FOAM (halobetasol)[NR]<br>LIDEX (fluocinonide)<br>LIDEX-E (fluocinonide)<br>OLUX (clobetasol propionate)<br>OLUX-E (clobetasol propionate/emollient)<br>PSORCON (diflorasone diacetate)<br>SERNIVO SPRAY (betamethasone dipropionate)<br>TEMOVATE (clobetasol propionate)<br>TEMOVATE-E (clobetasol propionate/emollient)<br>TOPICORT CREAM, GEL, OINTMENT (desoximetasone)<br>TOPICORT SPRAY (desoximetasone)<br>ULTRAVATE (halobetasol propionate)<br>ULTRAVATE PAC cream<br>ULTRAVATE X (halobetasol propionate / lactic acid)<br>VANOS (fluocinonide) | |

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

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

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| guanfacine IR<br>methylphenidate IR<br>modafinil[CL]<br>QUILLICHEW ER (methylphenidate)<br>QUILLIVANT XR (methylphenidate) | METHYLIN SOLUTION (methylphenidate)<br>methylphenidate CD<br>methylphenidate chewable tablets, solution<br>methylphenidate ER<br>methylphenidate ER (generic CONCERTA)<br>methylphenidate LA<br>NUVIGIL (armodafinil)<br>PROVIGIL (modafinil)<br>RITALIN (methylphenidate)<br>RITALIN LA (methylphenidate)<br>STRATTERA (atomoxetine)* | |
| **TETRACYCLINES** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require ten (10) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| doxycycline hyclate capsules<br>doxycycline hyclate 100 mg tablets<br>doxycycline monohydrate 50, 100 mg capsules<br>minocycline capsules | ADOXA (doxycycline monohydrate)<br>demeclocycline*<br>DORYX (doxycycline hyclate)<br>doxycycline hyclate 75, 150 mg tablets<br>doxycycline hyclate tablet DR 75, 100, 150, 200 mg<br>doxycycline hyclate tablet DR 50 mg<br>doxycycline monohydrate 40, 75, 150 mg capsule<br>doxycycline monohydrate tablet<br>doxycycline monohydrate suspension<br>DYNACIN (minocycline)<br>MINOCIN (minocycline)<br>minocycline ER capsules<br>minocycline tablets<br>MORGIDOX KIT (doxycycline)<br>ORACEA (doxycycline monohydrate)<br>SOLODYN (minocycline)<br>tetracycline<br>VIBRAMYCIN CAPSULES, SUSPENSION, SYRUP (doxycycline)<br>XIMINO (minocycline) | *Demeclocycline will be authorized for conditions caused by susceptible strains of organisms designated in the product information supplied by the manufacturer. A C&S report must accompany this request.<br>Demeclocycline will also be authorized for SIADH. |

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