- 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	X		
Analgesics, Narcotic Short Acting	X		
Androgenic Agents	X		
Antibiotics-GI Related Agents	X		X
Antibiotics, Vaginal	X		
Anticonvusants	X		
Antifungals, Oral			X
Antihemophilia Factor Agents	X		
Antipsychotics, Atypical	X		
Antiretrovirals	X		
Antivirals, Oral-Anti-Influenza	X		
Antivirals, Topical	X		
Beta Blockers	X		
Bladder Relaxant Preparations	X		
Bronchodilators, Beta-Agonist	X		
COPD Agents	X		
Cytokine and CAM Antagonists	X		
Erythropoiesis Stimulating Proteins	X		
Hepatitis C Treatments	X		
Hypoglycemics, Insulins	X		
Hypoglycemics, SGLT2	X		
Immunomodulators-Atopic Dermatitis	X		
Immunomodulators, Genital Warts and Actinic Keratosis	X		
Immunosuppressives, Oral			X
Laxatives, Cathartics	X		
Lipotropics, Other (Non-Statins)	X		

MABS-ANTI-IL, ANT-IGE	X		
Macrolides	X		
Neuropathic Pain	X		
Ophthalmics, Antibiotic/Steroid Combinations	X		
Ophthalmics for Allergic Conjunctivitis	X		
Ophthalmic Anti-inflammatories	X		
Ophthalmics, Glaucoma Agents	X		
Opiate Dependence Treatments	X		X
Otic Antibiotics	X		
Pituitary Suppressive Agents	X		
Skeletal Muscle Relaxants			X
Stimulants and Related Agents	X		X

THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ACNE AGENTS, TOPICAL[AP]		
CLASS PA CRITERIA: Non-preferred agents require a thirty (30) day trial of one (1) preferred retinoid and two (2) unique chemical entities in two (2) other subclasses, including the generic version of the requested non-preferred product, before they will be approved, unless one (1) of the exceptions on the PA form is present. In cases of pregnancy, a trial of retinoids will *not* be required. For members eighteen (18) years of age or older, a trial of retinoids will *not* be required. Acne kits are non-preferred. **Specific Criteria for sub-class will be listed below.** NOTE: Non-preferred agents in the Rosacea sub-class are available only on appeal and require at least a 30-day trial of all preferred agents in that sub-class.		
ANTI-INFECTIVE		
CLINDAGEL (clindamycin) clindamycin lotion, medicated swab, solution erythromycin gel, solution	AMZEEQ FOAM (minocycline) CLEOCIN-T (clindamycin) CLINDACIN ETZ kit, medicated swab (clindamycin) CLINDACIN P (clindamycin) CLINDACIN PAC (clindamycin) clindamycin gel, foam dapsone ERYGEL (erythromycin) erythromycin medicated swab EVOCLIN (clindamycin) FABIOR (tazarotene) KLARON (sulfacetamide) OVACE/PLUS (sulfacetamide) sodium sulfacetamide 10% cleansing gel sulfacetamide	
RETINOIDS		
DIFFERIN (adapalene) RETIN-A (tretinoin) RETIN-A MICRO (tretinoin)	adapalene AKLIEF CREAM (trifarotene) ALTRENO LOTION (tretinoin) ARAZLO (tazarotene) ATRALIN (tretinoin) AVITA (tretinoin) tazarotene cream tretinoin cream, gel tretinoin gel micro	**In addition to the Class Criteria**: PA required for members eighteen (18) years of age or older.
KERATOLYTICS		

benzoyl peroxide cleanser Rx & OTC, 10% cream OTC, gel Rx & OTC, lotion OTC, wash OTC PANOXYL-4 OTC (benzoyl peroxide)	BENZEFOAM benzoyl peroxide) BP 10-1 (benzoyl peroxide) BPO (benzoyl peroxide)	
COMBINATION AGENTS		
ACANYA (clindamycin phosphate/benzoyl peroxide) BENZAMYCIN PAK (benzoyl peroxide/ erythromycin) benzoyl peroxide/clindamycin gel (generic DUAC only) EPIDUO (adapalene/benzoyl peroxide)* EPIDUO FORTE (adapalene/benzoyl peroxide)* ONEXTON (clindamycin phosphate/benzoyl peroxide) sulfacetamide sodium/sulfur suspension ZIANA (clindamycin/tretinoin)*	adapalene-benzoyl peroxide* AVAR/-E/LS (sulfur/sulfacetamide) BENZACLIN GEL (benzoyl peroxide/ clindamycin) benzoyl peroxide/clindamycin gel (all generics other than DUAC) benzoyl peroxide/urea clindamycin phosphate/benzoyl peroxide (generic Acanya) clindamycin-tretinoin gel* erythromycin/benzoyl peroxide NEUAC (clindamycin phosphate/benzoyl peroxide) SSS 10-4 (sulfacetamide /sulfur) SSS 10-5 foam (sulfacetamide /sulfur) sulfacetamide sodium/sulfur cloths, lotion, pads sulfacetamide/sulfur wash/cleanser sulfacetamide/sulfur wash kit sulfacetamide sodium/sulfur/ urea SUMADAN/XLT (sulfacetamide/sulfur) SUMAXIN/TS (sulfacetamide sodium/sulfur)	**In addition to the Class Criteria:** Non-preferred combination agents require thirty (30) day trials of the corresponding preferred single agents before they will be approved. *PA required for combination agents with Retinoid products for members eighteen (18) years of age or older.
ROSACEA AGENTS		
FINACEA GEL (azelaic acid) MIRVASO GEL (brimonidine) metronidazole cream metronidazole gel 0.75% (NDCs 00115-1474-46, 00168-0275-45, 51672-4116-06, 66993-0962-45 only)	azelaic acid gel FINACEA FOAM (azelaic acid) ivermectin METROCREAM (metronidazole) METROGEL GEL (metronidazole) metronidazole lotion metronidazole gel (all other NDCs) NORITATE CREAM (metronidazole) RHOFADE (oxymetazoline) ROSADAN (metronidazole) SOOLANTRA CREAM (ivermectin) ZILXI (minocycline) foam	**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.

ALZHEIMER'S AGENTS[AP]

CLASS PA CRITERIA: Non-preferred agents require a thirty (30) day trial of a preferred agent in the same sub-class before they will be approved, unless one (1) of the exceptions on the PA form is present.

Prior authorization is required for members up to forty-five (45) years of age if there is no diagnosis of Alzheimer's disease.

CHOLINESTERASE INHIBITORS		
donepezil 5 and 10 mg donepezil ODT galantamine galantamine ER EXELON PATCH (rivastigmine) RAZADYNE ER (galantamine) rivastigmine	ARICEPT (donepezil) donepezil 23 mg*	*Donepezil 23 mg tablets will be authorized if the following criteria are met: 1. There is a diagnosis of moderate-to-severe Alzheimer's Disease **and** 2. There has been a trial of donepezil 10 mg daily for at least three (3) months and donepezil 20 mg daily for an additional one (1) month.
NMDA RECEPTOR ANTAGONIST		
memantine NAMENDA (memantine)	memantine ER memantine solution 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.
ANALGESICS, NARCOTIC LONG ACTING (Non-parenteral)[AP]		
CLASS PA CRITERIA: Non-preferred agents require six (6) day trials of three (3) 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) fentanyl transdermal 12, 25, 50, 75, 100 mcg/hr morphine ER tablets tramadol ER tablets (generic Ultram ER) XTAMPZA ER (oxycodone)	ARYMO ER (morphine sulfate) BELBUCA (buprenorphine buccal film)* buprenorphine patch (all labelers including 00093) CONZIP ER (tramadol) fentanyl transdermal 37.5, 62.5, 87.5 mcg/hr hydromorphone ER HYSINGLA ER (hydrocodone) hydrocodone ER capsule and tablet KADIAN (morphine) methadone** MORPHABOND ER (morphine sulfate) morphine ER capsules (generic for Avinza) morphine ER capsules (generic for Kadian) MS CONTIN (morphine) NUCYNTA ER (tapentadol)**** oxycodone ER OXYCONTIN (oxycodone) oxymorphone ER tramadol ER (generic Conzip ER)*** ULTRAM ER (tramadol) ZOHYDRO ER (hydrocodone)	*Belbuca prior authorization requires manual review. Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. **Methadone will be authorized without a trial of the preferred agents if a diagnosis of cancer is submitted. ***Tramadol ER (generic Conzip) 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. ****Nucynta requires six (6) day trials of three (3) chemically distinct preferred agents

ANALGESICS, NARCOTIC SHORT ACTING (Non-parenteral)[AP]

CLASS PA CRITERIA: Non-preferred agents require six (6) day trials of at least four (4) chemically distinct preferred agents (based on the narcotic ingredient only), including the generic formulation of the requested non-preferred agent, before they will be approved, unless one (1) of the exceptions on the PA form is present.
NOTE: All tramadol and codeine products require a prior authorization for children under 18 years of age. Requests must be for an FDA approved age and indication and specify non-opioid therapies attempted.

APAP/codeine butalbital/APAP/caffeine/codeine codeine hydrocodone/APAP 2.5/325 mg, 5/325 mg, 7.5/325 mg,10/325 mg hydrocodone/APAP solution hydromorphone tablets LORTAB SOLUTION (hydrocodone/acetaminophen) meperidine oral solution morphine NUCYNTA (tapentadol) oxycodone capsule, tablets, solution oxycodone/APAP oxycodone/ASA tramadol tramadol/APAP	ABSTRAL (fentanyl) ACTIQ (fentanyl) butalbital/APAP/caffeine/codeine 50-300-30 mg butalbital/ASA/caffeine/codeine butorphanol DEMEROL (meperidine) dihydrocodeine/ APAP/caffeine DILAUDID (hydromorphone) fentanyl FENTORA (fentanyl) FIORICET W/ CODEINE (butalbital/APAP/caffeine/codeine) FIORINAL W/ CODEINE (butalbital/ASA/caffeine/codeine) hydrocodone/APAP 5/300 mg, 7.5/300 mg, 10/300 mg hydrocodone/ibuprofen hydromorphone liquid, suppositories levorphanol LORCET (hydrocodone/APAP) LORTAB (hydrocodone/APAP)morphine rectal suppository meperidine tabletNORCO (hydrocodone/APAP) oxycodone concentrate oxycodone/ibuprofen oxymorphone pentazocine/naloxone PERCOCET (oxycodone/APAP) QDOLO SOLUTION (tramadol) ROXICODONE (oxycodone)ULTRACET (tramadol/APAP) VICOPROFEN (hydrocodone/ibuprofen)	Fentanyl buccal, nasal and sublingual products will only be authorized for a diagnosis of cancer and as an adjunct to a long-acting agent. These dosage forms will not be authorized for monotherapy. **Limits:** Unless the patient has escalating cancer pain or another diagnosis supporting increased quantities of short-acting opioids, all short acting solid forms of the narcotic analgesics are limited to 120 tablets per thirty (30) days. Longer-acting medications should be maximized to prevent unnecessary breakthrough pain in chronic pain therapy. Immediate-release tramadol is limited to 240 tablets per thirty (30) days.

ANDROGENIC AGENTS

CLASS PA CRITERIA: A non-preferred agent will only be authorized if one (1) of the exceptions on the PA form is present.

ANDRODERM (testosterone) ANDROGEL (testosterone) pump METHITEST (methyltestosterone) testosterone cypionate vial[CL] testosterone enanthate vial[CL]	ANDROGEL (testosterone) packet ANDROID (methyltestosterone) FORTESTA (testosterone) JATENZO (testosterone undecanoate) methyltestosterone capsule NATESTO (testosterone) TESTIM (testosterone)	

	TESTRED (methyltestosterone) testosterone gel VOGELXO (testosterone) XYOSTED (testosterone enanthate)	
ANESTHETICS, TOPICAL[AP]		
CLASS PA CRITERIA: Non-preferred agents require ten (10) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
lidocaine lidocaine/prilocaine xylocaine	lidocaine/hydrocortisone LIDOTRAL CREAM (lidocaine) LIDOZION LOTION (lidocaine) SYNERA (lidocaine/tetracaine)	
ANGIOTENSIN MODULATORS[AP]		
CLASS PA CRITERIA: Non-preferred agents require fourteen (14) day trials of each preferred agent in the same sub-class, with the exception of the Direct Renin Inhibitors, before they will be approved, unless one (1) of the exceptions on the PA form is present.		
ACE INHIBITORS		
benazepril captopril enalapril fosinopril lisinopril quinapril ramipril	ACCUPRIL (quinapril) ALTACE (ramipril) EPANED (enalapril)* LOTENSIN (benazepril) moexipril perindopril PRINIVIL (lisinopril) QBRELIS SOLUTION (lisinopril)** trandolapril VASOTEC (enalapril) ZESTRIL (lisinopril)	*Epaned will be authorized with a diagnosis of hypertension, symptomatic heart failure or asymptomatic left ventricular dysfunction provided that the patient is less than seven (7) years of age **OR** is unable to ingest a solid dosage form due to documented oral-motor difficulties or dysphagia. **Qbrelis solution may be authorized for children ages 6-10 who are unable to tolerate a solid dosage form. Qbrelis may also be authorized for older patients with clinical documentation indicating oral-motor difficulties or dysphagia.
ACE INHIBITOR COMBINATION DRUGS		
benazepril/amlodipine benazepril/HCTZ captopril/HCTZ enalapril/HCTZ fosinopril/HCTZ lisinopril/HCTZ quinapril/HCTZ	ACCURETIC (quinapril/HCTZ) LOTENSIN HCT (benazepril/HCTZ) LOTREL (benazepril/amlodipine) TARKA (trandolapril/verapamil) trandolapril/verapamil VASERETIC (enalapril/HCTZ) ZESTORETIC (lisinopril/HCTZ)	
ANGIOTENSIN II RECEPTOR BLOCKERS (ARBs)		
irbesartan losartan valsartan olmesartan	ATACAND (candesartan) AVAPRO (irbesartan) BENICAR (olmesartan) candesartan COZAAR (losartan) DIOVAN (valsartan) EDARBI (azilsartan) MICARDIS (telmisartan) telmisartan	
ARB COMBINATIONS		

ENTRESTO (valsartan/sacubitril)[AP]* irbesartan/HCTZ losartan/HCTZ olmesartan/amlodipine olmesartan/HCTZ TRIBENZOR (olmesartan/amlodipine/HCTZ) valsartan/amlodipine valsartan/amlodipine/HCTZ valsartan/HCTZ	ATACAND-HCT (candesartan/HCTZ) AVALIDE (irbesartan/HCTZ) AZOR (olmesartan/amlodipine) BENICAR-HCT (olmesartan/HCTZ) candesartan/HCTZ DIOVAN-HCT (valsartan/HCTZ) EDARBYCLOR (azilsartan/chlorthalidone) EXFORGE (valsartan/amlodipine) EXFORGE HCT (valsartan/amlodipine/HCTZ) HYZAAR (losartan/HCTZ) MICARDIS-HCT (telmisartan/HCTZ) olmesartan/amlodipine/HCTZ telmisartan/amlodipine telmisartan HCTZ	*Entresto will only be authorized for patients 18 years of age or older who are diagnosed with chronic heart-failure.
DIRECT RENIN INHIBITORS		
	aliskiren TEKTURNA (aliskiren) TEKTURNA HCT (aliskiren/HCTZ)	**Substitute for Class Criteria**: Tekturna requires a thirty (30) day trial of one (1) preferred ACE, ARB, or combination agent, at the maximum tolerable dose, before it will be authorized unless one (1) of the exceptions on the PA form is present. Amturnide, Tekamlo, Tekturna HCT or Valturna will be authorized if the criteria for Tekturna are met and the patient also needs the other agents in the combination.
ANTIANGINAL & ANTI-ISCHEMIC		
CLASS PA CRITERIA: Agents in this class may only be authorized for patients with angina who are also taking a calcium channel blocker, a beta blocker, or a nitrite as single agents or a combination agent containing one (1) of these ingredients.		
ranolazine[AP]	RANEXA	
ANTIBIOTICS, GI & RELATED AGENTS		
CLASS PA CRITERIA: Non-preferred agents require a fourteen (14) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
FIRVANQ (vancomycin) metronidazole tablet neomycin tinidazole XIFAXAN 200 MG (rifaximin)*	AEMCOLO (rifamycin) tablet DIFICID (fidaxomicin)* FLAGYL (metronidazole) metronidazole capsule paromomycin VANCOCIN (vancomycin) vancomycin XIFAXAN 550 MG (rifaximin)*	*Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.
ANTIBIOTICS, INHALED		
CLASS PA CRITERIA: Non-preferred agents require a twenty-eight (28) day trial of a preferred agent and documentation of therapeutic failure before they will be approved, unless one (1) of the exceptions on the PA form is present.		
BETHKIS (tobramycin) KITABIS PAK (tobramycin)	ARIKAYCE (amikacin liposomal) CAYSTON (aztreonam) TOBI (tobramycin) TOBI PODHALER (tobramycin)	

	tobramycin	
ANTIBIOTICS, TOPICAL		
CLASS PA CRITERIA: Non-preferred agents require ten (10) day trials of at least one preferred agent, including the generic formulation of the requested non-preferred agent, before they will be approved, unless one (1) of the exceptions on the PA form is present.		
bacitracin (Rx, OTC) gentamicin sulfate mupirocin ointment	CENTANY (mupirocin) CORTISPORIN (bacitracin/neomycin/polymyxin/HC) mupirocin cream neomycin/polymyxin/pramoxine XEPI CREAM (ozenoxacin)	
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) CLINDESSE (clindamycin) metronidazole gel NUVESSA (metronidazole) SOLOSEC (secnidazole) VANDAZOLE (metronidazole)	CLEOCIN CREAM (clindamycin) clindamycin cream METROGEL (metronidazole)	
ANTICOAGULANTS		
CLASS PA CRITERIA: Non-preferred agents require a trial of each preferred agent in the same sub-class, unless one (1) of the exceptions on the PA form is present.		
	INJECTABLE[CL]	
enoxaparin	ARIXTRA (fondaparinux) fondaparinux FRAGMIN (dalteparin) LOVENOX (enoxaparin)	
	ORAL	
ELIQUIS (apixaban) PRADAXA (dabigatran) warfarin XARELTO (rivaroxaban)	SAVAYSA (edoxaban)	
ANTICONVULSANTS		

CLASS PA CRITERIA: For a diagnosis of seizure disorder, non-preferred agents require a fourteen (14) day trial of a preferred agent in the same sub-class before they will be approved, unless one (1) of the exceptions on the PA form is present; patients currently on established therapies shall be grandfathered.

For all other diagnoses, non-preferred agents require a thirty (30) day trial of a preferred agent in the same sub-class before they will be approved, unless one (1) of the exceptions on the PA form is present.

In situations where AB-rated generic equivalent products are available, "Brand Medically Necessary" must be hand-written by the prescriber on the prescription for the brand name product to be reimbursed.

ADJUVANTS		
carbamazepine carbamazepine ER CARBATROL (carbamazepine) DEPAKOTE SPRINKLE (divalproex) divalproex divalproex ER divalproex sprinkle EPITOL (carbamazepine) EQUETRO (carbamazepine) GABITRIL (tiagabine) LAMICTAL (lamotrigine) LAMICTAL CHEWABLE (lamotrigine) LAMICTAL ODT (lamotrigine) LAMICTAL XR (lamotrigine) lamotrigine levetiracetam IR levetiracetam ER levetiracetam IR suspension oxcarbazepine tablets QUDEXY XR (topiramate ER)*** TEGRETOL SUSPENSION (carbamazepine) TEGRETOL XR (carbamazepine) TOPAMAX SPRINKLE CAPS (topiramate) TRILEPTAL SUSPENSION (oxcarbazepine) topiramate IR tablet topiramate ER* valproic acid VIMPAT (lacosamide) zonisamide	APTIOM (eslicarbazepine) BANZEL (rufinamide) BRIVIACT (brivaracetam) carbamazepine oral suspension DEPAKOTE (divalproex) DEPAKOTE ER (divalproex) DIACOMIT CAPSULE/POWDER PACK (stripentol)** ELEPSIA XR (levetiracetam) felbamate FELBATOL (felbamate) FINTEPLA (fenfluramine) SOLUTION**** FYCOMPA (perampanel) KEPPRA (levetiracetam) KEPPRA SOLUTION (levetiracetam) KEPPRA XR (levetiracetam) lamotrigine dose pack lamotrigine ER lamotrigine ODT oxcarbazepine suspension OXTELLAR XR (oxcarbazepine) rufinamide oral suspension, tablets SABRIL (vigabatrin) SPRITAM (levetiracetam) TEGRETOL TABLETS (carbamazepine) tiagabine TOPAMAX TABLETS (topiramate) topiramate IR sprinkle caps topiramate ER sprinkle caps (generic Qudexy) TRILEPTAL TABLETS (oxcarbazepine) TROKENDI XR (topiramate)*** vigabatrin tablet/powder pack XCOPRI (cenobamate)	*Topiramate ER will be authorized after a thirty (30) day trial of topiramate IR. **Diacomit may only be approved as adjunctive therapy for diagnosis of Dravet Syndrome when prescribed by, or in consultation with, a neurologist AND requires a thirty (30) day trial of valproate and clobazam unless one (1) of the exceptions on the PA form is present. Diacomit must be used concurrently with clobazam. *** Trokendi XR are only approvable on appeal. ****Full PA criteria for Fintepla may be found on the PA Criteria page by clicking the hyperlink.
BARBITURATES[AP]		
phenobarbital primidone	MYSOLINE (primidone)	

BENZODIAZEPINES[AP]		
clonazepam DIASTAT (diazepam rectal) diazepam rectal gel diazepam tablets NAYZILAM NASAL SPRAY (midazolam) VALTOCO NASAL SPRAY (diazepam)	clobazam* clonazepam ODT KLONOPIN (clonazepam) ONFI (clobazam)* ONFI SUSPENSION (clobazam)* SYMPAZAN (clobazam film)*	*Onfi shall be authorized as adjunctive therapy for treatment of Lennox-Gastaut Syndrome and Dravet Syndrome without further restrictions. All other indications require an appeal to the Medical Director. NOTE: generic clobazam is preferred over brand ONFI.
CANNABINOIDS		
EPIDIOLEX SOLUTION (cannabidiol)*		* Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.
HYDANTOINS[AP]		
DILANTIN CAPSULES, SUSPENSION, CHEW TABS (phenytoin sodium, extended) PEGANONE (ethotoin) phenytoin capsules, chewable tablets, suspension	PHENYTEK (phenytoin)	
SUCCINIMIDES		
CELONTIN (methsuximide) ethosuximide capsules ethosuximide syrup	ZARONTIN (ethosuximide) capsules ZARONTIN (ethosuximide) syrup	
ANTIDEPRESSANTS, OTHER		
CLASS PA CRITERIA: See below for individual sub-class criteria.		
MAOIs[AP]		
	MARPLAN (isocarboxazid) NARDIL (phenelzine) phenelzine tranylcypromine	Patients stabilized on MAOI agents will be grandfathered.
SNRIS[AP]		
duloxetine capulses venlafaxine ER capsules	CYMBALTA (duloxetine) desvenlafaxine ER desvenlafaxine fumarate ER EFFEXOR XR (venlafaxine) FETZIMA (levomilnacipran) PRISTIQ (desvenlafaxine) venlafaxine IR venlafaxine ER tablets (venlafaxine)	Non-preferred agents require separate thirty (30) day trials of a preferred agent in this sub-class **AND** an SSRI before they will be approved, unless one (1) of the exceptions on the PA form is present.
SECOND GENERATION NON-SSRI, OTHER[AP]		
bupropion IR bupropion SR bupropion XL mirtazapine	APLENZIN (bupropion hbr) EMSAM (selegiline) FORFIVO XL (bupropion) nefazodone	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.

trazodone	REMERON (mirtazapine) TRINTELLIX (vortioxetine) VIIBRYD (vilazodone HCl) WELLBUTRIN SR (bupropion) WELLBUTRIN XL (bupropion)	
	SELECTED TCAs	
imipramine HCl	imipramine pamoate	Non-preferred agents require a twelve (12) week trial of imipramine HCl before they will be approved, unless one (1) of the exceptions on the PA form is present.
ANTIDEPRESSANTS, SSRIs[AP]		
CLASS PA CRITERIA: Non-preferred agents require thirty (30) day trials of at least two (2) preferred agents before they will be approved, unless one (1) of the exceptions on the PA form is present. Upon hospital discharge, patients admitted with a primary mental health diagnosis who have been stabilized on a non-preferred SSRI will receive an authorization to continue that drug.		
citalopram escitalopram tablets fluoxetine capsules, solution fluvoxamine paroxetine sertraline	BRISDELLE (paroxetine) CELEXA (citalopram) escitalopram solution fluoxetine tablets fluvoxamine ER LEXAPRO (escitalopram) paroxetine 7.5 mg capsules paroxetine ER PAXIL (paroxetine) PAXIL CR (paroxetine) PEXEVA (paroxetine) PROZAC (fluoxetine) SARAFEM (fluoxetine) ZOLOFT (sertraline)	
ANTIEMETICS[AP]		
CLASS PA CRITERIA: See below for sub-class criteria.		
	5HT3 RECEPTOR BLOCKERS	
granisetron ondansetron ODT, solution, tablets	ondansetron vials SANCUSO (granisetron) SUSTOL (granisetron) ZOFRAN (ondansetron) 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.
	CANNABINOIDS	
	dronabinol* MARINOL (dronabinol)*	*Dronabinol will only be authorized for: 1. The treatment of anorexia associated with weight loss in patients with AIDS or cancer and unresponsive to megestrol **or**

		2. The prophylaxis of chemotherapy induced nausea and vomiting unresponsive to three (3) day trials of ondansetron or promethazine for patients from eighteen (18) up to sixty-five (65) years of age.
	SUBSTANCE P ANTAGONISTS	
EMEND (aprepitant)	aprepitant VARUBI (rolapitant)	Non-preferred agents require a three (3) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.
	COMBINATIONS	
	AKYNZEO (netupitant/palonosetron) BONJESTA (doxylamine/pyridoxine) DICLEGIS (doxylamine/pyridoxine) doxylamine/pyridoxine (generic Diclegis)	Non-preferred agents will only be approved on appeal.
ANTIFUNGALS, ORAL		
CLASS PA CRITERIA: Non-preferred agents will only be authorized if one (1) of the exceptions on the PA form is present.		
clotrimazole fluconazole* nystatin terbinafine[CL]	ANCOBON (flucytosine)CRESEMBA (isovuconazonium)[CL]** BREXAFEMME (ibrexafungerp) DIFLUCAN (fluconazole) flucytosine griseofulvin*** itraconazole ketoconazole**** MYCELEX (clotrimazole) NOXAFIL (posaconazole) ORAVIG (miconazole) posaconazole tablet SPORANOX (itraconazole) TOLSURA (itraconazole) VFEND (voriconazole) voriconazole suspension voriconazole tablets	*PA is required when limits are exceeded. **Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. ***PA is not required for griseofulvin suspension for children up to eighteen (18) years of age for the treatment of tinea capitis. ****Ketoconazole will be authorized if the following criteria are met: 1. Diagnosis of one of the following fungal infections: blastomycosis, coccidioidomycosis, histoplasmosis, chromomycosis, or paracoccidioidomycosis **and** 2. Documented failure or intolerance of all other diagnosis-appropriate antifungal therapies, i.e. itraconazole, fluconazole, flucytosine, etc **and** 3. Baseline assessment of the liver status including alanine aminotransferase (ALT), aspartate aminotransferase (AST), total bilirubin, alkaline phosphatase, prothrombin time, and international normalized ratio (INR) before starting treatment **and** 4. Weekly monitoring of serum ALT for the duration of treatment (If ALT values increase to a level above the upper limit of normal or 30% above baseline, or if the patient develops symptoms of abnormal liver function, treatment should be interrupted and a full set of liver tests

		be obtained. Liver tests should be repeated to ensure normalization of values.) **and** 5. Assessment of all concomitant medications for potential adverse drug interactions with ketoconazole. **Ketoconazole will not be authorized for treatment for fungal infections of the skin and nails.**
ANTIFUNGALS, TOPICAL[AP]		
CLASS PA CRITERIA: Non-preferred agents require fourteen (14) day trials of two (2) preferred agents before they will be approved, unless one (1) of the exceptions on the PA form is present. If a non-preferred shampoo is requested, a fourteen (14) day trial of one (1) preferred product (i.e. ketoconazole shampoo) is required.		
ANTIFUNGALS		
econazole ketoconazole cream, shampoo MENTAX (butenafine) miconazole (OTC) nystatin	CICLODAN (ciclopirox) ciclopirox ERTACZO (sertaconazole) EXELDERM (sulconazole) EXTINA (ketoconazole) GYNAZOLE 1 CREAM (butoconazole) JUBLIA (efinaconazole) ketoconazole foam KERYDIN (tavaborole) KETODAN (ketoconazole) LOPROX (ciclopirox) LUZU (luliconazole) miconazole/petrolatum/zinc oxide NAFTIN GEL (naftifine) OXISTAT (oxiconazole)* tavaborole 5% topical solution VUSION (miconazole/petrolatum/zinc oxide)	*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.
ANTIFUNGAL/STEROID COMBINATIONS		
clotrimazole/betamethasone cream	clotrimazole/betamethasone lotion 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. All currently established regimens shall be grandfathered with documentation of adherence to therapy.		
FACTOR VIII		
ADVATE AFSTYLA ALPHANATE HEMOFIL M HUMATE-P KOATE KOGENATE FS	ADYNOVATE ELOCTATE ESPEROCT JIVI VONVENDI	

KOVALTRY NOVOEIGHT NUWIQ RECOMBINATE WILATE XYNTHA XYNTHA SOLOFUSE		
BYPASSING AGENTS		
	FEIBA NOVOSEVEN SEVENFAC	
FACTOR IX		
ALPHANINE SD ALPROLIX BENEFIX IDELVION IXINITY MONONINE PROFILNINE RIXUBIS	REBINYN	
FACTOR IXa/IX		
HEMLIBRA (emicizumab-kxwh)*		*Hemlibra shall be approved without further restriction for patients with Hemophilia A with documented presence of Factor VIII inhibitors.
ANTIHYPERTENSIVES, SYMPATHOLYTICS		
CLASS PA CRITERIA: Non-preferred agents require thirty (30) day trials of each preferred unique chemical entity in the corresponding formulation before they will be approved, unless one (1) of the exceptions on the PA form is present.		
CATAPRES-TTS (clonidine) clonidine patch clonidine tablets	CATAPRES TABLETS (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		
COLCRYS (colchicine) tablets	colchicine capsules colchicine tablets MITIGARE (colchicine) GLOPERBA (colchicine)*	In the case of acute gouty attacks, a ten (10) day supply (twenty (20) units) of the preferred agent(s) in this subclass will be authorized per ninety (90) days. *Gloperba may only be authorized for those who are unable to ingest solid dosage forms due to documented oral-motor difficulties or dysphagia.
ANTIMITOTIC-URICOSURIC COMBINATION		

colchicine/probenecid		
URICOSURIC		
probenecid		
XANTHINE OXIDASE INHIBITORS		
allopurinol	febuxostat tablets ULORIC (febuxostat) ZYLOPRIM (allopurinol)	
ANTIMIGRAINE AGENTS, PROPHYLAXIS[CL]		
CLASS PA CRITERIA: All agents require a prior authorization. Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. Non-preferred agents require a 90-day trial of all preferred agents.		
AIMOVIG (erenumab) AJOVY (fremanezumab)	EMGALITY (galcanezumab)* NNURTEC ODT (Rimegepant)	*Emgality 300 mg/3 mL requires review by the Medical Director and is available only on appeal.
ANTIMIGRAINE AGENTS, ACUTE[AP]		
CLASS PA CRITERIA: Non-preferred agents require three (3) day trials of each preferred unique chemical entity as well as a three (3) day trial using the same route of administration as the requested agent (if available), before they will be approved, unless one (1) of the exceptions on the PA form is present.		
TRIPTANS		
IMITREX NASAL SPRAY (sumatriptan) naratriptan rizatriptan ODT rizatriptan tablet sumatriptan injection[CL] sumatriptan nasal spray sumatriptan tablets zolmitriptan zolmitriptan ODT	almotriptan AMERGE (naratriptan) eletriptan FROVA (frovatriptan) frovatriptan IMITREX tablets (sumatriptan) MAXALT MLT (rizatriptan) MAXALT (rizatriptan) ONZETRA XSAIL (sumatriptan)* RELPAX (eletriptan) TOSYMRA NASAL SPRAY (sumatriptan)* ZEMBRACE SYMTOUCH (sumatriptan) ZOMIG (zolmitriptan) ZOMIG ZMT (zolmitriptan)	***In addition to the Class Criteria**: Onzetra Xsail and Tosymra require three (3) day trials of each preferred oral, nasal and injectable forms of sumatriptan.
TRIPTAN COMBINATIONS		
	TREXIMET (sumatriptan/naproxen sodium)	
OTHER		
NURTEC ODT (rimegepant)*	CAMBIA (diclofenac) UBRELVY (ubrogepant)** REYVOW (lasmiditan)**	*Nurtec ODT For a diagnosis of **Migraine treatment**: requires three (3) day trials of two (2) preferred chemically distinct triptans before it may be approved, unless one (1) of the exceptions on the PA form is present. Maximum Quantity limit of 8 tablets per 30 days. *Nurtec ODT For a diagnosis of **Migraine prophylaxis**:

		In addition to the Class Criteria for CGRP PA Criteria, a 90-day trial of each preferred agent for antimigraine prophylaxis is required, unless one (1) of the exceptions on the PA form is present. Maximum Quantity limit of 16 tablets per 32 days. **Ubrelvy and Reyvow require three (3) day trials of two (2) preferred chemically distinct triptans as well as a three (3) day trial of Nurtec ODT before they may be approved, unless one (1) of the exceptions on the PA form is present.
ANTIPARASITICS, TOPICAL[AP]		
CLASS PA CRITERIA: Non-preferred agents require trials of each preferred agent (which are age and weight appropriate) before they will be approved, unless one (1) of the exceptions on the PA form is present.		
NATROBA (spinosad) permethrin 5% cream pyrethrins-piperonyl butoxide OTC	ELIMITE CREAM (permethrin) EURAX (crotamiton) ivermectin 0.5% lotion LICE EGG REMOVER OTC (benzalkonium chloride) lindane malathion OVIDE (malathion) SKLICE (ivermectin) spinosad 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 trihexyphenidyl		
COMT INHIBITORS		
entacapone	COMTAN (entacapone) ONGENTYS (opicapone) TASMAR (tolcapone) 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		
APOKYN (apomorphine) PEN bromocriptine pramipexole ropinirole	KYNMOBI (apomorphine) FILM MIRAPEX ER (pramipexole)* NEUPRO (rotigotine) pramipexole ER ropinirole ER	*Mirapex ER will be authorized for a diagnosis of Parkinsonism without a trial of preferred agents.
OTHER ANTIPARKINSON'S AGENTS		
amantadine*[AP] carbidopa/levodopa levodopa/carbidopa/entacapone	AZILECT (rasagiline) carbidopa GOCOVRI ER (amantadine)	*Amantadine will not be authorized for the treatment or prophylaxis of influenza.

selegiline	INBRIJA (levodopa) levodopa/carbidopa ODT LODOSYN (carbidopa) NOURIANZ (istradefylline) OSMOLEX ER (amantadine) PARLODEL (bromocriptine) rasagiline RYTARY (levodopa/carbidopa) SINEMET (levodopa/carbidopa) STALEVO (levodopa/carbidopa/entacapone) XADAGO (safinamide) 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 (calcipotriene/ betamethasone) VECTICAL (calcitriol)	calcipotriene cream calcipotriene ointment calcipotriene solution calcipotriene/betamethasone ointment, suspension calcitriol DOVONEX (calcipotriene) ENSTILAR (calcipotriene/betamethasone) SORILUX (calcipotriene) tazarotene cream	

ANTIPSYCHOTICS, ATYPICAL

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

Non-preferred agents require thirty (30) day trials of two (2) preferred agents, including the generic formulation of the requested agent (if available), before they will be approved unless one (1) of the exceptions on the PA form is present. All trials must be at the maximum recommended dose for the diagnosis provided before they would be considered a failure unless an adverse reaction is documented necessitating a change in therapy.

Patients shall be grandfathered onto their existing therapy, provided the requested agent is being used according to the manufacturer label. Continuation of therapy for an off-label indication or non-standard dosage may be granted a thirty (30) day prior-authorization while the Medical Director reviews the request.

SINGLE INGREDIENT		
ABILIFY MAINTENA (aripiprazole)[CL] aripiprazole tablets ARISTADA (aripiprazole)[CL] ARISTADA INITIO (aripiprazole)[CL] clozapine INVEGA ER (paliperidone) INVEGA SUSTENNA (paliperidone)[CL] INVEGA TRINZA (paliperidone)* [CL] LATUDA (lurasidone)*** olanzapine olanzapine ODT PERSERIS (risperidone)[CL] quetiapine ER quetiapine** AP for the 25 mg Tablet Only RISPERDAL CONSTA (risperidone)[CL] risperidone solution, tablet, ODT SAPHRIS (asenapine) ziprasidone	ABILIFY MYCITE (aripiprazole) ABILIFY TABLETS (aripiprazole) ADASUVE (loxapine) aripiprazole solution asenapine sublingual tablets CAPLYTA (lumateperone) clozapine ODT CLOZARIL (clozapine) FANAPT (iloperidone) GEODON (ziprasidone) GEODON IM (ziprasidone) LYBALVI (olanzapine and samidorphan)[NR] NUPLAZID (pimavanserin) **** olanzapine IM[CL] paliperidone ER REXULTI (brexipiprazole) RISPERDAL (risperidone) SECUADO (asenapine) SEROQUEL (quetiapine) SEROQUEL XR (quetiapine) VERSACLOZ (clozapine) VRAYLAR (cariprazine)***** VRAYLAR DOSE PAK (cariprazine)***** ZYPREXA (olanzapine) ZYPREXA IM (olanzapine)[CL] ZYPREXA RELPREVV (olanzapine)	**The following criteria exceptions apply to the specified products:** *Invega Trinza will be authorized after four months' treatment with Invega Sustenna **Quetiapine 25 mg will be authorized: 1. For a diagnosis of schizophrenia **or** 2. For a diagnosis of bipolar disorder **or** 3. When prescribed concurrently with other strengths of Seroquel in order to achieve therapeutic treatment levels. **Quetiapine 25 mg will not be authorized for use as a sedative hypnotic.** *** Latuda will be be authorized for the indication of Bipolar Depression with documentation of the diagnosis. All other indications require class criteria to be followed. ****Nuplazid may only be authorized for the treatment of Parkinson Disease Induced Psychosis after documented treatment failure with quetiapine. ***** Vraylar may be authorized for the indication of Bipolar Depression only after failure of a 30-day trial of Latuda and a 30-day trial of either quetiapine OR a combination of olanzapine + fluoxetine. All other indications require class criteria to be followed.
ATYPICAL ANTIPSYCHOTIC/SSRI COMBINATIONS		
	olanzapine/fluoxetine	

ANTIRETROVIRALS[AP]

CLASS PA CRITERIA: Non-preferred drugs require medical reasoning beyond convenience or enhanced compliance as to why the clinical need cannot be met with a preferred agent or combination of preferred agents. NOTE: Regimens consisting of preferred agents will result in no more than one additional unit per day over equivalent regimens composed of non-preferred agents. Patients already on a non-preferred regimen shall be grandfathered.

SINGLE TABLET REGIMENS		
BIKTARVY (bictegravir/emtricitabine/ tenofovir alafenamide) COMPLERA (emtricitabine/rilpivirine/tenofovir) DELSTRIGO (doravirine/lamivudine/ tenofovir df) efavirenz/emtricitabine/tenofovir GENVOYA (elvitegravir/cobicistat/ emtricitabine/tenofovir)	ATRIPLA (efavirenz/emtricitabine/tenofovir) CABENUVA (cabotegravir/rilpivirine) DOVATO (dolutegravir/lamivudine) JULUCA (dolutegravir/rilpivirine) SYMTUZA (darunavir/cobicistat/ emtricitabine/tenofovir alafenamide) STRIBILD (elvitegravir/cobicistat/ emtricitabine/tenofovir)*	*Stribild requires medical reasoning beyond convenience or enhanced compliance as to why the medical need cannot be met with the the preferred agent Genvoya. **Triumeq requires medical reasoning beyond convenience or enhanced compliance as to why the medical need cannot be met with the preferred agents Epzicom and Tivicay.

ODEFSEY (emtricitabine/rilpivirine/tenofovir) SYMFI (efavirenz/lamivudine/tenofovir) SYMFI LO (efavirenz/lamivudine/tenofovir)	TRIUMEQ (abacavir/lamivudine/ dolutegravir)**	
INTEGRASE STRAND TRANSFER INHIBITORS		
ISENTRESS (raltegravir potassium) TIVICAY (dolutegravir sodium) TIVICAY PD (dolutegravir sodium)	ISENTRESS HD (raltegravir potassium)	
NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTI)		
abacavir sulfate tablet EMTRIVA (emtricitabine) EPIVIR SOLUTION (lamivudine) lamivudine tenofovir disoproxil fumarate VIREAD ORAL POWDER (tenofovir disoproxil fumarate) ZIAGEN SOLUTION (abacavir sulfate) zidovudine	abacavir sulfate solution didanosine DR capsule emtricitabine capsule EPIVIR TABLET (lamivudine) RETROVIR (zidovudine) stavudine VIDEX EC (didanosine) VIDEX SOLUTION (didanosine) VIREAD TABLETS (tenofovir disoproxil fumarate) ZIAGEN TABLET (abacavir sulfate)	
NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITOR (NNRTI)		
efavirenz	EDURANT (rilpivirine) etravirine INTELENCE (etravirine) nevirapine nevirapine ER PIFELTRO (doravirine) SUSTIVA (efavirenz) VIRAMUNE ER 24H (nevirapine) VIRAMUNE SUSPENSION (nevirapine)	
PHARMACOENHANCER – CYTOCHROME P450 INHIBITOR		
TYBOST (cobicistat)		
PROTEASE INHIBITORS (PEPTIDIC)		
atazanavir EVOTAZ (atazanavir/cobicistat) NORVIR (ritonavir) REYATAZ POWDER PACK (atazanavir)	fosamprenavir LEXIVA (fosamprenavir) REYATAZ CAPSULE (atazanavir) ritonavir tablet VIRACEPT (nelfinavir mesylate)	
PROTEASE INHIBITORS (NON-PEPTIDIC)		
PREZCOBIX (darunavir/cobicistat) PREZISTA (darunavir ethanolate)	APTIVUS (tipranavir)	
ENTRY INHIBITORS – CCR5 CO-RECEPTOR ANTAGONISTS		
	SELZENTRY (maraviroc)	
ENTRY INHIBITORS – FUSION INHIBITORS		
	FUZEON (enfuvirtide)	
COMBINATION PRODUCTS – NRTIs		
abacavir/lamivudine	abacavir/lamivudine/zidovudine	

CIMDUO (lamivudine/tenofovir) lamivudine/zidovudine	COMBIVIR (lamivudine/zidovudine) EPZICOM (abacavir/lamivudine) TEMIXYS (lamivudine/tenofovir) TRIZIVIR (abacavir/lamivudine/zidovudine)	
COMBINATION PRODUCTS – NUCLEOSIDE & NUCLEOTIDE ANALOG RTIs		
DESCOVY (emtricitabine/tenofovir) emtricitabine/tenofovir	TRUVADA (emtricitabine/tenofovir)*	*Truvada shall be treated as preferred when prescribed for PrEP in members assigned female at birth. Truvada may also be approved over Descovy where guidelines clearly indicate superiority over Descovy (documentation may be required to support the request for PA).
COMBINATION PRODUCTS – PROTEASE INHIBITORS		
lopinavir/ritonavir	KALETRA (lopinavir/ritonavir)	
GP 120 DIRECTED ATTACHMENT INHIBITORS		
RUKOBIA (fostemsavir tromethamine) TABLETS		
ANTIVIRALS, ORAL		
CLASS PA CRITERIA: Non-preferred agents require five (5) day trials of each preferred agent in the same sub-class before they will be approved, unless one (1) of the exceptions on the PA form is present.		
ANTI HERPES		
acyclovir valacyclovir	famciclovir SITAVIG (acyclovir) VALTREX (valacyclovir) ZOVIRAX (acyclovir)	
ANTI-INFLUENZA		
oseltamivir	FLUMADINE (rimantadine) RELENZA (zanamivir) rimantadine TAMIFLU (oseltamivir) 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.		
acyclovir ointment ZOVIRAX CREAM (acyclovir)	docosanol cream DENAVIR (penciclovir) ZOVIRAX OINTMENT (acyclovir)	
BETA BLOCKERS[AP]		
CLASS PA CRITERIA: Non-preferred agents require fourteen (14) day trials of three (3) chemically distinct preferred agents, including the generic formulation of the requested non-preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
BETA BLOCKERS		
acebutolol atenolol betaxolol	BETAPACE (sotalol) CORGARD (nadolol) INDERAL LA (propranolol)	*Hemangeol will be authorized for the treatment of proliferating infantile hemangioma requiring systemic therapy.

bisoprolol BYSTOLIC (nebivolol) HEMANGEOL (propranolol)* metoprolol metoprolol ER nadolol pindolol propranolol propranolol ER** SORINE (sotalol) sotalol timolol	INDERAL XL (propranolol) INNOPRAN XL (propranolol) KAPSPARGO SPRINKLE (metoprolol) LOPRESSOR (metoprolol) TENORMIN (atenolol) TOPROL XL (metoprolol)	**Propranolol ER shall be authorized for patients with a diagnosis of migraines. Existing users will be grandfathered for use in migraine prophylaxis.
BETA BLOCKER/DIURETIC COMBINATION DRUGS		
atenolol/chlorthalidone bisoprolol/HCTZ metoprolol/HCTZ propranolol/HCTZ	nadolol/bendroflumethiazide TENORETIC (atenolol/chlorthalidone) ZIAC (bisoprolol/HCTZ)	
BETA- AND ALPHA-BLOCKERS		
carvedilol labetalol	carvedilol ER capsule COREG (carvedilol) COREG CR (carvedilol)	
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		
DETROL LA (tolterodine) GELNIQUE (oxybutynin) MYRBETRIQ (mirabegron) oxybutynin IR oxybutynin ER OXYTROL (oxybutynin) solifenacin TOVIAZ (fesoterodine)	darifenacin ER tablet DETROL (tolterodine) DITROPAN XL (oxybutynin) ENABLEX (darifenacin) flavoxate GEMTESA (vibegron) tolterodine tolterodine ER trospium trospium ER VESICARE (solifenacin) VESICARE LS (solifenacin)	***In addition to class criteria**, a 30-day trial of Myrbetriq (mirabegron) is required prior to Gemtesa approval, unless one (1) of the exceptions on the PA form is present.
BONE RESORPTION SUPPRESSION AND RELATED AGENTS		
CLASS PA CRITERIA: See below for class criteria.		
BISPHOSPHONATES		

alendronate tablets ibandronate	ACTONEL (risedronate) alendronate solution ATELVIA (risedronate) BINOSTO (alendronate) BONIVA (ibandronate) FOSAMAX TABLETS (alendronate) FOSAMAX PLUS D (alendronate/vitamin D) Risedronate	Non-preferred agents require thirty (30) day trials of **each** preferred Bisphosphonate agent before they will be approved, unless one (1) of the exceptions on the PA form is present.
OTHER BONE RESORPTION SUPPRESSION AND RELATED AGENTS		
	calcitonin EVISTA (raloxifene)* FORTEO (teriparatide) MIACALCIN (calcitonin) raloxifene* teriparatide TYMLOS (abaloparatide)	Non-preferred agents require a thirty (30) day trial of a preferred Bisphosphonate agent before they will be approved, unless one (1) of the exceptions on the PA form is present. *Raloxifene will be authorized for postmenopausal women with osteoporosis who are at high risk for invasive breast cancer.
BPH TREATMENTS		
CLASS PA CRITERIA: Non-preferred agents require thirty (30) day trials of at least two (2) chemically distinct preferred agents, including the generic formulation of the requested non-preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
5-ALPHA-REDUCTASE (5AR) INHIBITORS AND PDE-5 AGENTS		
finasteride	AVODART (dutasteride) CIALIS 5 mg (tadalafil) dutasteride PROSCAR (finasteride)	
ALPHA BLOCKERS		
alfuzosin doxazosin tamsulosin terazosin	CARDURA (doxazosin) CARDURA XL (doxazosin) FLOMAX (tamsulosin) RAPAFLO (silodosin) silodosin	
5-ALPHA-REDUCTASE (5AR) INHIBITORS/ALPHA BLOCKER COMBINATION		
	dutasteride/tamsulosin JALYN (dutasteride/tamsulosin)	**Substitute for Class Criteria**: Concurrent thirty (30) day trials of dutasteride and tamsulosin are required before the non-preferred agent will be authorized.
BRONCHODILATORS, BETA AGONIST[AP]		
CLASS PA CRITERIA: Non-preferred agents require thirty (30) day trials of each chemically distinct preferred agent in their corresponding sub-class unless one (1) of the exceptions on the PA form is present.		
INHALATION SOLUTION		
albuterol	arformoterol BROVANA (arformoterol) formoterol 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

	metaproterenol PERFOROMIST (formoterol) XOPENEX (levalbuterol)*	documented intolerance of albuterol, or for concurrent diagnosis of heart disease.
	INHALERS, LONG-ACTING	
SEREVENT (salmeterol)	STRIVERDI RESPIMAT (olodaterol)	
	INHALERS, SHORT-ACTING	
PROAIR HFA (albuterol) VENTOLIN HFA (albuterol)	albuterol HFA PROAIR DIGIHALER (albuterol) PROAIR RESPICLICK (albuterol) PROVENTIL HFA (albuterol) XOPENEX HFA (levalbuterol)	
	ORAL	
	albuterol ER albuterol IR metaproterenol 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 diltiazem ER felodipine ER nifedipine ER verapamil ER	ADALAT CC (nifedipine) CALAN SR (verapamil) CARDIZEM CD, LA (diltiazem) diltiazem LA KATERZIA SUSPENSION (amlodipine)* MATZIM LA (diltiazem) nisoldipine NORVASC (amlodipine) PROCARDIA XL (nifedipine) SULAR (nisoldipine) TIAZAC (diltiazem) verapamil ER PM VERELAN/VERELAN PM (verapamil)	*Katerzia will be authorized for children who are 6-10 years of age who are unable to ingest solid dosage forms. Katerzia may also be authorized for older patients with clinical documentation indicating oral-motor difficulties or dysphagia.
	SHORT-ACTING	
diltiazem verapamil	CARDIZEM (diltiazem) isradipine nicardipine nifedipine nimodipine NYMALIZE SOLUTION (nimodipine) PROCARDIA (nifedipine)	

CEPHALOSPORINS AND RELATED ANTIBIOTICS

CLASS PA CRITERIA: Non-preferred agents require a five (5) day trial of a preferred agent within the corresponding sub-class before they will be approved, unless one (1) of the exceptions on the PA form is present.

BETA LACTAMS AND BETA LACTAM/BETA-LACTAMASE INHIBITOR COMBINATIONS		
amoxicillin/clavulanate IR	amoxicillin/clavulanate ER AUGMENTIN (amoxicillin/clavulanate)	
CEPHALOSPORINS		
cefaclor capsule cefadroxil capsule, tablet cefdinir cefuroxime tablet cephalexin capsule, suspension	cefaclor suspension cefaclor ER tablet cefadroxil suspension cefixime cefpodoxime cefprozil cefuroxime suspension cephalexin tablet KEFLEX (cephalexin) 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) INCRUSE ELLIPTA (umeclidinium) ipratropium nebulizer solution SPIRIVA (tiotropium) SPIRIVA RESPIMAT (tiotropium)	LONHALA MAGNAIR (glycopyrrolate) SPIRIVA RESPIMAT (tiotropium) TUDORZA (aclidinium) YUPELRI SOLUTION (revefenacin)	
ANTICHOLINERGIC-BETA AGONIST COMBINATIONS[AP]		
ANORO ELLIPTA (umeclidinium/vilanterol) albuterol/ipratropium nebulizer solution COMBIVENT RESPIMAT (albuterol/ipratropium) STIOLTO RESPIMAT (tiotropium/olodaterol)**	BEVESPI (glycopyrrolate/formoterol) DUAKLIR PRESSAIR (aclidinium/formoterol)*	*In addition to the Class PA criteria, Duaklir Pressair requires sixty (60) day trials of each long acting preferred agent, as well as a 60-day trial of Stiolto Respimat. **In addition to the Class PA criteria, Stiolto Respimat requires a sixty (60) day trial of a long acting preferred agent.
ANTICHOLINERGIC-BETA AGONIST-GLUCOCORTICOID COMBINATIONS		
	TRELEGY ELLIPTA (fluticasone/umeclidinium/vilanterol)* BREZTRI AEROSPHERE (budesonide/glycopyrrolate/formoterol)**	* Trelegy Ellipta may be prior authorized for patients currently established on the individual components for at least 30 days. **Breztri 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: 1. Patient is forty (40) years of age or older **and** 2. Diagnosis of severe chronic obstructive pulmonary disease (COPD) associated with chronic bronchitis and multiple exacerbations requiring systemic glucocorticoids in the preceding six (6) months **and** 3. Concurrent therapy with an inhaled corticosteroid and long-acting bronchodilator and evidence of compliance **and** 4. No evidence of moderate to severe liver impairment (Child-Pugh Class B or C) **and** 5. No concurrent use with strong cytochrome P450 inducers (rifampicin, phenobarbital, carbamazepine or phenytoin)
CROHNS DISEASE ORAL STEROIDS		
ORAL		
budesonide ER capsule (generic Entocort EC)	ENTOCORT EC (budesonide)* ORTIKOS (budesonide)*	*Please see the following PDL classes for PDL status of additional agents used for induction and remission (Cytokine and CAM Antagonists/ Immunosuppressives, Oral/ Ulcerative Colitis Agents) *Entocort EC and Ortikos may only be authorized if the patient has a documented allergy or intolerance to the generic budesonide 3mg 24-hour capsules.
CYTOKINE & CAM ANTAGONISTS[CL]		
CLASS PA CRITERIA: Non-preferred agents require ninety (90) day trials of all preferred agents which are indicated for the diagnosis, unless one (1) of the exceptions on the PA form is present. *Patients stabilized for at least 6-months on their existing non-preferred regimen shall be grandfathered (provided the current therapy is for a labeled indication). All off-label requests require review by the Medical Director..* Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.		
ANTI-TNFs		
ENBREL (etanercept)* HUMIRA (adalimumab)* SIMPONI subcutaneous (golimumab)	AVSOLA (infliximab)* CIMZIA (certolizumab pegol) INFLECTRA (infliximab)* REMICADE (infliximab)* RENFLEXIS (infliximab*) SIMPONI ARIA (golimumab)	*For all requests, the most cost-effective alternative will be approved. Should the provider request a different infliximab product, documentation of contraindication or allergy to the required agent must be provided. As of 10/1/2021, Avsola is the most cost-effective alternative.
OTHERS		
ACTEMRA subcutaneous (tocilizumab) KINERET (anakinra) OTEZLA (apremilast) ORENCIA CLICKJET/VIAL (abatacept) TALTZ (ixekizumab)* XELJANZ (tofacitinib)**	ACTEMRA ACTPEN (tocilizumab) COSENTYX (secukinumab) ENTYVIO (vedolizumab) ILARIS (canakinumab) ILUMYA (tildrakizumab) KEVZARA (sarilumab) OLUMIANT (baricitinib)	*Taltz 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. **Xeljanz will only be preferred for the treatment of rheumatoid arthritis and ulcerative colitis. For all other indications it is non

	ORENCIA SYRINGE (abatacept) RINVOQ ER (upadacitinib) SILIQ (brodalumab) SKYRIZI (risankizumab) STELARA subcutaneous (ustekinumab) TREMFYA (guselkumab) XELJANZ XR (tofacitinib)	preferred. Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.
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)	epinephrine (all labelers except 49502) EPIPEN (epinephrine) EPIPEN JR (epinephrine) SYMJEPI (epinephrine)	
ERYTHROPOIESIS STIMULATING PROTEINS[CL]		
CLASS PA CRITERIA: Non-preferred agents require a thirty (30) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
EPOGEN (rHuEPO) MIRCERA (methoxy PEG-epoetin) RETACRIT (epoetin alfa)	ARANESP (darbepoetin) PROCRIT (rHuEPO)	Erythropoiesis agents will be authorized if the following criteria are met: 1. Hemoglobin or Hematocrit less than 10/30 respectively. For renewal, hemoglobin or hematocrit levels greater than 12/36 will require dosage reduction or discontinuation. Exceptions will be considered on an individual basis after medical documentation is reviewed. (Lab oratory values must be dated within six (6) weeks of request.) **and** 2. Transferrin saturation ≥ 20%, ferritin levels ≥100 mg/ml, or on concurrent therapeutic iron therapy. (Laboratory values must be dated within three (3) weeks of request. For re-authorization, transferrin saturation or ferritin levels are not required if the patient has been responsive to the erythropoietin agent **and** 3. For HIV-infected patients, endogenous serum erythropoietin level must be ≤ 500mU/ml to initiate therapy **and** 4. No evidence of untreated GI bleeding, hemolysis, or Vitamin B-12, iron or folate deficiency.

FLUOROQUINOLONES (Oral)[AP]		
CLASS PA CRITERIA: Non-preferred agents require a five (5) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
CIPRO SUSPENSION (ciprofloxacin) ciprofloxacin levofloxacin tablet	BAXDELA (delafloxacin) CIPRO TABLETS (ciprofloxacin) ciprofloxacin suspension levofloxacin solution moxifloxacin 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) budesonide nebulizer 0.5 mg/2 ml & 0.25 mg/2 ml solution* FLOVENT DISKUS (fluticasone) FLOVENT HFA (fluticasone) PULMICORT FLEXHALER (budesonide)	ARMONAIR DIGIHALER (fluticasone) ALVESCO (ciclesonide) ARNUITY ELLIPTA (fluticasone) ASMANEX HFA (mometasone) budesonide nebulizer 1 mg/2ml solution PULMICORT NEBULIZER SOLUTION (budesonide) QVAR REDIHALER (beclomethasone)	*Budesonide 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.
GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS		
ADVAIR DISKUS (fluticasone/salmeterol) ADVAIR HFA (fluticasone/salmeterol) DULERA (mometasone/formoterol) SYMBICORT(budesonide/formoterol)	AIRDUO DIGIHALER (fluticasone/salmeterol) AIRDUO RESPICLICK (fluticasone/salmeterol) budesonide/formoterol BREO ELLIPTA (fluticasone/vilanterol) fluticasone/salmeterol WIXELA (fluticasone/salmeterol)	
GUANYLATE CYCLASE STIMULATORS[CL]		
	ADEMPAS (riociguat)* VERQUVO (vericiguat)**	*Adempas requires a thirty (30) day trial of a preferred agent from any other PAH Class before it may be approved, unless one (1) of the exceptions on the PA form is present. **Full PA criteria for Verquvo may be found on the PA Criteria page by clicking the hyperlink.
GROWTH HORMONE[CL]		

CLASS PA CRITERIA: Non-preferred agents require three (3) month trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
GENOTROPIN (somatropin) NORDITROPIN (somatropin)	INCRELEX (mecasermin) NUTROPIN AQ (somatropin) OMNITROPE (somatropin) SAIZEN (somatropin) SEROSTIM (somatropin) ZOMACTON (somatropin) ZORBTIVE (somatropin)	Patients already on a non-preferred agent will receive authorization to continue therapy on that agent for the duration of the existing PA.
***H. PYLORI* TREATMENT**		
CLASS PA CRITERIA: Non-preferred agents require a trial of the combination of individual preferred components of the requested non-preferred agent and must be used at the recommended dosages, frequencies and duration of the non-preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
Please use individual components: preferred PPI (omeprazole or pantoprazole) amoxicillin tetracycline metronidazole clarithromycin bismuth PYLERA (bismuth/metronidazole/tetracycline)	HELIDAC (bismuth/metronidazole/tetracycline) lansoprazole/amoxicillin/clarithromycin OMECLAMOX-PAK (omeprazole/amoxicillin/clarithromycin) TALICIA (omeprazole/amoxicillin/rifabutin)	
HEPATITIS B TREATMENTS		
CLASS PA CRITERIA: Non-preferred agents require ninety (90) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
BARACLUDE SOLUTION (entecavir) * entecavir lamivudine HBV	adefovir BARACLUDE TABLET (entecavir) EPIVIR HBV (lamivudine) HEPSERA (adefovir) VEMLIDY (tenofovir alafenamide fumarate)	*Baraclude solution will be authorized only for patients with documentation of dysphagia.
HEPATITIS C TREATMENTS[CL]		
CLASS PA CRITERIA: For patients starting therapy in this class, preferred regimens may be found on the PA Criteria page. Requests for non-preferred regimens require medical reasoning why a preferred regimen cannot be used.		
MAVYRET (pibrentasvir/glecaprevir)* ribavirin sofosbuvir/velpatasvir (labeler 72626)*	EPCLUSA (sofosbuvir/velpatasvir)* HARVONI (ledipasvir/sofosbuvir)* ledipasvir/sofosbuvir* PEGASYS (pegylated interferon) PEG-INTRON (pegylated interferon) RIBASPHERE RIBAPAK (ribavirin) RIBASPHERE 400 mg, 600 mg (ribavirin) SOVALDI (sofosbuvir)*	*Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.

	VIEKIRA XR (dasabuvir/ombitasvir/ paritaprevir/ritonavir)* VOSEVI (sofosbuvir/velpatasvir/voxilaprevir) 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	cinacalcet doxercalciferol HECTOROL (doxercalciferol) paricalcitol injection RAYALDEE (calcifediol) SENSIPAR (cinacalcet) ZEMPLAR (paricalcitol)	
HYPOGLYCEMIA TREATMENTS		
CLASS PA CRITERIA:		
BAQSIMI SPRAY (glucagon) GLUCAGEN VIAL (glucagon) glucagon emergency kit (labeler 00002) ZEGALOGUE (dasiglucagon)	glucagon emergency kit GVOKE (glucagon)	
HYPOGLYCEMICS, BIGUANIDES		
CLASS PA CRITERIA: Non-preferred agents require a ninety (90) day trial of a preferred agent of similar duration before they will be approved, unless one (1) of the exceptions on the PA form is present.		
metformin metformin ER (generic Glucophage XR)	FORTAMET (metformin ER) GLUCOPHAGE XR (metformin ER) GLUMETZA (metformin ER)* metformin solution (generic Riomet) metformin ER (generic Glumetza & Fortamet) RIOMET (metformin)	*Glumetza will be approved only after a 30-day trial of Fortamet.
HYPOGLYCEMICS, DPP-4 INHIBITORS		
CLASS PA CRITERIA: Non-preferred agents are available only on appeal. **NOTE: DPP-4 inhibitors will NOT be approved in combination with a GLP-1 agonist.**		
JANUMET (sitagliptin/metformin) JANUMET XR (sitagliptin/metformin) JANUVIA (sitagliptin) JENTADUETO (linagliptin/metformin) TRADJENTA (linagliptin)	alogliptin alogliptin/metformin alogliptin/pioglitazone JENTADUETO XR (linagliptin/metformin) KAZANO (alogliptin/metformin) KOMBIGLYZE XR (saxagliptin/metformin) NESINA (alogliptin) ONGLYZA (saxagliptin)	

	OSENI (alogliptin/pioglitazone)	

HYPOGLYCEMICS, GLP-1 AGONISTS[CL]

CLASS PA CRITERIA: Non-preferred agents will only be approved (in 6-month intervals) if ALL of the following criteria has been met:

1) Current A1C must be submitted. Agents in this class will not be approved for patients with a starting A1C of less than (<) 7%.
2) Documentation demonstrating 90 days of compliance on all current diabetic therapies is provided.
3) Documentation demonstrating treatment failure with all unique preferred agents in the same class.

Re-authorizations will require documentation of continued compliance on all diabetic therapies and A1C levels must reach goal, (either an A1C of ≤8%, or demonstrated continued improvement).

NOTE: GLP-1 agents will NOT be approved in combination with a DPP-4 inhibitor.

OZEMPIC (semaglutide) TRULICITY (dulaglutide) VICTOZA (liraglutide)	ADLYXIN (lixisenatide) BYETTA (exenatide) BYDUREON BCISE (exenatide) RYBELSUS (semaglutide)	

HYPOGLYCEMICS, INSULIN AND RELATED AGENTS

CLASS PA CRITERIA: Non-preferred agents require a ninety (90) day trial of a pharmacokinetically similar agent before they will be approved, unless one (1) of the exceptions on the PA form is present.

APIDRA (insulin gluisine)[AP]* HUMALOG (insulin lispro) HUMALOG JR KWIKPEN (insulin lispro) HUMALOG KWIKPEN U-100 (insulin lispro) HUMALOG MIX PENS (insulin lispro/lispro protamine) HUMALOG MIX VIALS (insulin lispro/lispro protamine) HUMULIN 70/30 (insulin) HUMULIN R U-500 VIAL (insulin) HUMULIN R U-500 KWIKPEN (insulin) LANTUS (insulin glargine) LEVEMIR (insulin detemir) NOVOLOG (insulin aspart) NOVOLOG MIX (insulin aspart/aspart protamine) TOUJEO SOLOSTAR (insulin glargine) TOUJEO MAX SOLOSTAR (insulin glargine	ADMELOG (insulin lispro) AFREZZA (insulin)[CL] BASAGLAR (insulin glargine) FIASP (insulin aspart) HUMALOG KWIKPEN U-200 (insulin lispro) HUMULIN PENS (insulin) HUMULIN R VIAL (insulin) insulin aspart insulin aspart/aspart protamine insulin lispro HUMULIN N VIAL (insulin) LYUMJEV (insulin lispro) NOVOLIN (insulin) SEMGLEE (insulin glargine) SOLIQUA (insulin glargine/lixisenatide)** TRESIBA (insulin degludec)*** TRESIBA FLEXTOUCH (insulin degludec)*** XULTOPHY (insulin degludec/liraglutide)**	*Apidra will be authorized if the following criteria are met: 1. Patient is four (4) years of age or older; **and** 2. Patient is currently on a regimen including a longer acting or basal insulin, **and** 3. Patient has had a trial of a similar preferred agent, Novolog or Humalog, with documentation that the desired results were not achieved.. ** Non-preferred insulin combination products require that the patient must already be established on the individual agents at doses not exceeding the maximum dose achievable with the 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. ***Patients stabilized on Tresiba may be grandfathered at the request of the prescriber, if the prescriber considers the preferred products to be clinically inappropriate.

		***Tresiba U-100 may be approved only for: Patients who have demonstrated at least a 6-month history of compliance on a preferred long-acting insulin and who continue to have regular incidents of hypoglycemia. ***Tresiba U-200 may be approved only for: Patients who require once-daily doses of at least 60 units of long-acting insulin and have demonstrated at least a 6-month history of compliance on preferred long-acting insulin and who continue to have regular incidents of hypoglycemia.
HYPOGLYCEMICS, MEGLITINIDES		
CLASS PA CRITERIA: Non-preferred agents are available only on appeal.		
MEGLITINIDES		
nateglinide repaglinide	PRANDIN (repaglinide) STARLIX (nateglinide)	
MEGLITINIDE COMBINATIONS		
	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]	colesevelam SYMLIN (pramlintide)*	*Symlin will be authorized with a history of bolus insulin utilization in the past ninety (90) days with no gaps in insulin therapy greater than thirty (30) days.
HYPOGLYCEMICS, SGLT2 INHIBITORS		
CLASS PA CRITERIA: Non-preferred agents will only be approved (in 6-month intervals) if ALL of the following criteria has been met: 1) Current A1C must be submitted. Agents in this class will not be approved for patients with a starting A1C of less than (<) 7%. 2) Documentation demonstrating 90 days of compliance on all current diabetic therapies is provided. 3) Documentation demonstrating treatment failure with all unique preferred agents in the same class. Re-authorizations will require documentation of continued compliance on all diabetic therapies and A1C levels must reach goal, (either an A1C of ≤8%, or demonstrated continued improvement). *Preferred SGLT2 inhibitors and combinations may be approved for a diagnosis of Heart Failure with Reduced Ejection Fraction (HFrEF) with or without Type II		

DM, Chronic Kidney Disease (CKD) with or without Type II DM, or Atherosclerotic Cardiovascular Disease (ASCVD) with Type II DM without further restrictions.		
SGLT2 INHIBITORS		
FARXIGA (dapagliflozin)* INVOKANA (canagliflozin)* JARDIANCE (empagliflozin)*	STEGLATRO (ertugliflozin)	
SGLT2 COMBINATIONS		
INVOKAMET (canagliflozin/metformin)* SYNJARDY (empagliflozin/metformin)* XIGDUO XR (dapagliflozin/metformin)*	GLYXAMBI (empagliflozin/linagliptin) INVOKAMET XR (canagliflozin/metformin) SEGLUROMET (ertugliflozin/metformin STEGLUJAN (ertugliflozin/sitagliptin) SYNJARDY XR (empagliflozin/metformin) TRIJARDY XR (empagliflozin/linagliptin/metformin) QTERN (dapagliflozin/saxagliptin)	
HYPOGLYCEMICS, TZD		
CLASS PA CRITERIA: Non-preferred agents are available only on appeal.		
THIAZOLIDINEDIONES		
pioglitazone	ACTOS (pioglitazone) AVANDIA (rosiglitazone)	
TZD COMBINATIONS		
	ACTOPLUS MET (pioglitazone/ metformin) DUETACT (pioglitazone/glimepiride) pioglitazone/glimepiride pioglitazone/ metformin	Patients are required to use the components of Actoplus Met and Duetact separately. Exceptions will be handled on a case-by-case basis.
IMMUNOMODULATORS, ATOPIC DERMATITIS		
CLASS PA CRITERIA: Non-preferred agents require 30-day trial of a medium to high potency topical corticosteroid **AND all** preferred agents in this class unless one (1) of the exceptions on the PA form is present. Requirement for topical corticosteroids may be excluded with involvement of sensitive areas such as the face and skin folds.		
DUPIXENT (dupilumab)* ELIDEL (pimecrolimus) PROTOPIC (tacrolimus)	EUCRISA (crisaborole)[AP]** pimecrolimus cream tacrolimus ointment	*Full PA criteria for Dupixent may be found on the PA Criteria page by clicking the hyperlink **Eucrisa requires a 30-day trial of Elidel **OR** a medium to high potency corticosteroid unless contraindicated.
IMMUNOMODULATORS, GENITAL WARTS & ACTINIC KERATOSIS AGENTS		
CLASS PA CRITERIA: Non-preferred agents require thirty (30) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
CONDYLOX GEL (podofilox) EFUDEX (fluorouracil) imiquimod cream ZYCLARA PUMP (imiquimod)*	ALDARA (imiquimod) CARAC (fluorouracil) diclofenac 3% gel fluorouracil 0.5% cream	*Zyclara will be authorized for a diagnosis of actinic keratosis.

	fluorouracil 5% cream imiquimod pump podofilox TOLAK (fluorouracil 4% cream) VEREGEN (sinecatechins) ZYCLARA CREAM (imiquimod)*	
IMMUNOSUPPRESSIVES, ORAL		
CLASS PA CRITERIA: Non-preferred agents require a fourteen (14) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
azathioprine cyclosporine cyclosporine, modified mycophenolate mofetil sirolimus tacrolimus capsule	ASTAGRAF XL (tacrolimus) AZASAN (azathioprine) CELLCEPT (mycophenolate mofetil) ENVARSUS XR (tacrolimus) IMURAN (azathioprine) LUPKYNIS (voclosporin)* mycophenolic acid mycophenolic mofetil suspension MYFORTIC (mycophenolic acid) NEORAL (cyclosporine, modified) PROGRAF (tacrolimus) RAPAMUNE (sirolimus) REZUROCK (belumosudil) SANDIMMUNE (cyclosporine) ZORTRESS (everolimus)	*Lupkynis requires a ninety (90) day trial of Benlysta prior to approval. Full PA criteria for Lupkynis may be found on the PA Criteria page by clicking the hyperlink.
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	olopatadine PATANASE (olopatadine)	Non-preferred agents require thirty (30) day trials of one (1) preferred antihistamine **AND** one (1) preferred intranasal corticosteroid before they will be approved, unless one (1) of the exceptions on the PA form is present.
COMBINATIONS		
	azelastine/fluticasone DYMISTA (azelastine / fluticasone)	Dymista requires a concurrent thirty (30) day trial of each preferred component before it will be approved, unless one (1) of the exceptions on the PA form is present.

CORTICOSTEROIDS		
fluticasone propionate OMNARIS (ciclesonide) QNASL HFA (beclomethasone) ZETONNA (ciclesonide)	BECONASE AQ (beclomethasone) flunisolide mometasone NASONEX (mometasone)	Non-preferred agents require thirty (30) day trials of each preferred agent in this sub-class before they will be approved, unless one (1) of the exceptions on the PA form is present
IRRITABLE BOWEL SYNDROME/SHORT BOWEL SYNDROME/SELECTED GI AGENTS CL		
CLASS PA CRITERIA: All agents are approvable only for patients age eighteen (18) and older. **See below for additional sub-class criteria.**		
CONSTIPATION		
AMITIZA (lubiprostone) MOVANTIK (naloxegol) LINZESS 145 and 290 mcg (linaclotide)	LINZESS 72 mcg (linaclotide) lubiprostone capsule MOTEGRITY (prucalopride) RELISTOR INJECTION (methylnaltrexone) RELISTOR TABLET (methylnaltrexone) SYMPROIC (naldemedine) TRULANCE (plecanatide) ZELNORM (tegaserod maleate)	All agents in this subclass require documentation of the current diagnosis and evidence that the patient has failed to find relief with dietary modification and a fourteen (14) day trial of an osmotic laxative. No agent shall be approved to treat opioid induced constipation (OIC) without evidence of at least 90-days of opioid use preceding the request. Continuation of coverage shall be granted with evidence of continuous and concurrent opioid use. **Agents may be authorized only for their FDA-approved labeled indication. The following agent-specific criteria shall also apply, unless one (1) of the exceptions on the PA form is present:** **Motegrity** requires a 30-day trial of both Amitiza and Linzess. **Relistor** and **Symproic** are indicated for OIC and require thirty (30) day trials of both Movantik and Amitiza. **Trulance** requires thirty (30) day trials of both Amitiza and Linzess, however for the indication of IBS-C in males, a trial of Amitiza is not required. **Linzess 72mcg** may only be approved for a diagnosis of chronic idiopathic constipation (CIC) AND for those who cannot tolerate the 145mcg dose. **Zelnorm** is indicated for females < 65 years of age diagnosed with irritable bowel syndrome with constipation (IBS-C) AND requires thirty (30) day trials of Amitiza and Linzess. **Lubiprostone** may only be authorized with a documented allergy or intolerance to Amitiza.
DIARRHEA		

	Alosetron MYTESI (crofelemer) LOTRONEX (alosetron) VIBERZI (eluxadoline)	Full PA criteria may be found on the PA Criteria page by clicking the hyperlink
LAXATIVES AND CATHARTICS		
CLASS PA CRITERIA: Non-preferred agents require thirty (30) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present		
CLENPIQ (sodium picosulfate, magnesium oxide, citric acid) COLYTE GOLYTELY MOVIPREP NULYTELY peg 3350 SUPREP	OSMOPREP peg 3350-sod sulf-NaCL-KCL-asb powder SUTAB (magnesium sulfate, potassium sulfate, sodium sulfate)	
LEUKOTRIENE MODIFIERS		
CLASS PA CRITERIA: Non-preferred agents require thirty (30) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
montelukast zafirlukast	ACCOLATE (zafirlukast) SINGULAIR (montelukast) zileuton ZYFLO (zileuton)	
LIPOTROPICS, OTHER (Non-statins)		
CLASS PA CRITERIA: Non-preferred agents require a twelve (12) week trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
BILE ACID SEQUESTRANTS[AP]		
cholestyramine colestipol tablets	COLESTID (colestipol) colesevelam colestipol granules QUESTRAN (cholestyramine) WELCHOL (colesevelam)*	*Welchol will be authorized for add-on therapy for type 2 diabetes when there is a previous history of a thirty (30) day trial of an oral agent (metformin, sulfonylurea or thiazolidinedione (TZD)). See HYPOGLYCEMICS, MISCELLANEOUS.
CHOLESTEROL ABSORPTION INHIBITORS		
ezetimibe	ZETIA (ezetimibe)	
FATTY ACIDS[CL]		
omega-3 acid ethyl esters VASCEPA (icosapent ethyl)*	icosapent ethyl capsules LOVAZA (omega-3-acid ethyl esters)	[CL]All agents in this subclass require a prior authorization and an initial triglyceride level ≥ 500 mg/dL. *Additionally, Vascepa may be approved if the following criteria is met:

		1. The patient has an initial triglyceride level of ≥ 150 mg/dL prior to start of therapy; AND 2. The patient has established cardiovascular disease or diabetes; AND 3. The patient is concomitantly receiving a statin.
FIBRIC ACID DERIVATIVES[AP]		
fenofibrate 54 and 160 mg fenofibrate micronized 67mg, 134mg & 200mg fenofibrate nanocrystallized 48 mg, 145 mg gemfibrozil	ANTARA (fenofibrate) FENOGLIDE (fenofibrate) FIBRICOR (fenofibric acid) fenofibrate 40 mg tablet fenofibrate 150 mg capsules fenofibrate 43, 50, 120 and 130 mg fenofibric acid LIPOFEN (fenofibrate) LOPID (gemfibrozil) TRICOR (fenofibrate nanocrystallized) TRILIPIX (fenofibric acid)	
MTP INHIBITORS		
	JUXTAPID (lomitapide)*	*Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.
NIACIN		
niacin niacin ER (OTC) NIASPAN (niacin)	niacin ER (Rx)	
PCSK-9 INHIBITORS/BEMPEDOIC ACID[CL]		
PRALUENT (alirocumab)* REPATHA (evolocumab)*	NEXLETOL (bempedoic acid)* NEXLIZET (bempedoic acid/ezetimibe)*	*Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.
LIPOTROPICS, STATINS[AP]		
CLASS PA CRITERIA: See below for individual sub-class criteria.		
STATINS		
atorvastatin lovastatin pravastatin rosuvastatin simvastatin*	ALTOPREV (lovastatin) CRESTOR (rosuvastatin) EZALLOR (rosuvastatin)[NR] EZALLOR SPRINKLE (rosuvastatin)* fluvastatin fluvastatin ER LESCOL XL (fluvastatin) LIPITOR (atorvastatin) LIVALO (pitavastatin) PRAVACHOL (pravastatin) ZOCOR (simvastatin)** ZYPITAMAG (pitavastatin)	Non-preferred agents require twelve (12) week trials of two (2) preferred agents, including the generic formulation of the requested non-preferred agent, before they will be approved, unless one (1) of the exceptions on the PA form is present. *Ezallor SPRINKLE will only be authorized for those who are unable to ingest solid dosage forms due to documented oral-motor difficulties or dysphagia. **Zocor/simvastatin 80mg tablets will require a clinical PA.

STATIN COMBINATIONS		
	amlodipine/atorvastatin CADUET (atorvastatin/amlodipine) ezetimibe/simvastatin VYTORIN (simvastatin/ezetimibe)*	Non-preferred agents require thirty (30) day concurrent trials of the corresponding preferred single agents before they will be approved, unless one (1) of the exceptions on the PA form is present. *Vytorin will be authorized only after an insufficient response to a twelve (12) week trial of the maximum tolerable dose of atorvastatin or rosuvastatin, unless one (1) of the exceptions on the PA form is present. Vytorin 80/10mg tablets will require a clinical PA.

MABS, ANTI-IL/IgE

CLASS PA CRITERIA: For FDA-approved indications, non-preferred agents require a ninety (90) day trial of Xolair. **Full PA Criteria may be found on the PA Criteria page by clicking the hyperlink.**

DUPIXENT (dupilumab) FASENRA (benralizumab XOLAIR (omalizumab)	NUCALA SYRINGE/VIAL (mepolizumab) NUCALA AUTO INJECTOR (mepolizumab)	

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 tablet, suspension, packet	clarithromycin tablets clarithromycin ER clarithromycin suspension E.E.S. (erythromycin ethylsuccinate) ERYPED (erythromycin ethylsuccinate) ERY-TAB (erythromycin) ERYTHROCIN (erythromycin stearate) erythromycin tablet/capsule DR erythromycin tablet erythromycin estolate ZITHROMAX (azithromycin)	

MULTIPLE SCLEROSIS AGENTS[CL]

CLASS PA CRITERIA: All agents require a prior authorization and documented diagnosis of multiple sclerosis. Preferred oral agents require a ninety (90) day trial of any preferred injectable agent. Non-preferred agents require ninety (90) day trials of two (2) chemically unique preferred agents (in the same sub-class) before they will be approved, unless one (1) of the exceptions on the PA form is present.

INTERFERONS[AP]		
AVONEX (interferon beta-1a) AVONEX PEN (interferon beta-1a) BETASERON (interferon beta-1b) REBIF (interferon beta-1a)	EXTAVIA KIT (interferon beta-1b) EXTAVIA VIAL (interferon beta-1b) PLEGRIDY (peginterferon beta-1a)	

REBIF REBIDOSE (interferon beta-1a)		
NON-INTERFERONS		
AUBAGIO (teriflunomide)* dalfampridine ER** COPAXONE 20 mg (glatiramer) GILENYA (fingolimod) TECFIDERA (dimethyl fumarate)***	AMPYRA (dalfampridine)** BAFIERTAM CAPSULES (monomethyl fumarate) COPAXONE 40 mg (glatiramer)**** dimethyl fumerate*** glatiramer GLATOPA (glatiramer) KESIMPTA INJECTION (ofatumumab) MAYZENT (siponimod)***** MAVENCLAD (cladribine) PONVORY (ponesimod) VUMERITY (diroximel) ZEPOSIA (ozanimod)	**In addition to class PA criteria, the following conditions and criteria may also apply:** *Aubagio requires the following additional criteria to be met: 1. Diagnosis of relapsing multiple sclerosis **and** 2. Measurement of transaminase and bilirubin levels within the (6) months before initiation of therapy and ALT levels at least monthly for six (6) months after initiation of therapy **and** 3. Complete blood cell count (CBC) within six (6) months before initiation of therapy **and** 4. Female patients must have a negative pregnancy test before initiation of therapy and be established on a reliable method of contraception if appropriate **and** 5. Patient is between eighteen (18) up to sixty-five (65) years of age **and** 6. Negative tuberculin skin test before initiation of therapy **Dalfampridine ER and Ampyra require the following additional criteria to be met: 1. Diagnosis of multiple sclerosis **and** 2. No history of seizures **and** 3. No evidence of moderate or severe renal impairment. ***Dimethyl fumerate and Tecfidera require the following additional criteria to be met: 1. Diagnosis of relapsing multiple sclerosis **and** 2. Complete blood count (CBC) within six (6) months of initiation of therapy and six (6) months after initiation **and** 3. Complete blood count (CBC) annually during therapy. ****Copaxone 40mg will only be authorized for documented injection site issues. *****Mayzent may be authorized with no additional requirement beyond the diagnosis for patients with documented secondary progressive MS.
NEUROPATHIC PAIN		

CLASS PA CRITERIA: Non-preferred agents require a thirty (30) day trial of a preferred agent in the corresponding dosage form (oral or topical) before they will be approved, unless one (1) of the exceptions on the PA form is present.		
capsaicin OTC duloxetine gabapentin lidocaine patch 5% LYRICA (pregabalin) NEURONTIN (gabapentin) pregabalin capsule	CYMBALTA (duloxetine) DRIZALMA SPRINKLE (duloxetine)* GRALISE (gabapentin)** HORIZANT (gabapentin) lidocaine patch 4% LIDODERM (lidocaine) LYRICA CAPSULE (pregabalin) LYRICA CR (pregabalin)*** LYRICA SOLUTION (pregabalin)*** pregabalin ER tablet (generic Lyrica CR) QUTENZA (capsaicin) SAVELLA (milnacipran)**** ZTLIDO PATCH (lidocaine)	*Drizalma SPRINKLE will only be authorized for those who are unable to ingest solid dosage forms due to documented oral-motor difficulties or dysphagia. **Gralise will be authorized only if the following criteria are met: 1. Diagnosis of post herpetic neuralgia **and** 2. Trial of a tricyclic antidepressant for a least thirty (30) days **and** 3. 90-day trial of gabapentin immediate release formulation (positive response without adequate duration) **and** 4. Request is for once daily dosing with 1800 mg maximum daily dosage. ****Savella will be authorized for a diagnosis of fibromyalgia only after a 90-day trial of one preferred agent
NSAIDS[AP]		
CLASS PA CRITERIA: See below for sub-class PA criteria.		
NON-SELECTIVE		
diclofenac (IR, SR) flurbiprofen ibuprofen (Rx and OTC) INDOCIN SUSPENSION (indomethacin) indomethacin ketoprofen ketorolac meloxicam tablet nabumetone naproxen sodium tablet naproxen sodium DS tablet naproxen suspension EC-naproxen DR tablet piroxicam sulindac	DAYPRO (oxaprozin) diflunisal DUEXIS (famotidine/ibuprofen) etodolac IR etodolac SR FELDENE (piroxicam) fenoprofen INDOCIN SUPPOSITORIES (indomethacin) indomethacin ER ketoprofen ER meclofenamate mefenamic acid meloxicam submicronized capsule (generic Vivlodex) meloxicam suspension MOBIC TABLET (meloxicam) NALFON (fenoprofen) NAPRELAN (naproxen) naproxen CR oxaprozin RELAFEN DS (nabumetone) SPRIX (ketorolac)	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.

	TIVORBEX (indomethacin) tolmetin VIVLODEX (meloxicam) VOLTAREN (diclofenac) ZIPSOR (diclofenac potassium) ZORVOLEX (diclofenac)	
NSAID/GI PROTECTANT COMBINATIONS		
	ARTHROTEC (diclofenac/misoprostol) diclofenac/misoprostol naproxen/esomeprazole VIMOVO (naproxen/esomeprazole)	Non-preferred agents are only available on appeal and require medical reasoning beyond convenience as to why the need cannot be met with the combination of preferred single agents.
COX-II SELECTIVE		
	CELEBREX (celecoxib) celecoxib	COX-II Selective agents require thirty (30) day trials of each preferred Non-Selective Oral NSAID, **UNLESS** the following criteria are met: Patient has a history or risk of a serious GI complication; **OR** Agent is requested for treatment of a chronic condition **and** 1. Patient is seventy (70) years of age or older, **or** 2. Patient is currently on anticoagulation therapy**.**
TOPICAL		
FLECTOR PATCH (diclofenac)* diclofenac gel (RX)**	diclofenac patch diclofenac solution LICART PATCH (diclofenac) PENNSAID (diclofenac)	*Flector patches are limited to two per day. **diclofenac gel will be limited to 100 grams per month. Non-preferred agents require a thirty (30) day trial of the preferred Topical agent and thirty (30) day trials of each preferred oral NSAID before they will be approved, unless one(1) of the exceptions on the PA form is present.
OPHTHALMIC ANTIBIOTICS[AP]		
CLASS PA CRITERIA: Non-preferred agents require three (3) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
bacitracin/polymyxin ointment ciprofloxacin* erythromycin gentamicin levofloxacin* MOXEZA (moxifloxacin) neomycin/bacitracin/polymyxin ofloxacin* polymyxin/trimethoprim tobramycin TOBREX OINT (tobramycin)	AZASITE (azithromycin) bacitracin BLEPH-10 (sulfacetamide) BESIVANCE (besifloxacin)* CILOXAN (ciprofloxacin) gatifloxacin moxifloxacin** NATACYN (natamycin) neomycin/polymyxin/gramicidin OCUFLOX (ofloxacin) POLYTRIM (polymyxin/trimethoprim) sulfacetamide drops	*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.

	sulfacetamide ointment TOBREX (tobramycin) VIGAMOX (moxifloxacin) ZYMAXID (gatifloxacin)	

OPHTHALMIC ANTIBIOTIC/STEROID COMBINATIONS[AP]

CLASS PA CRITERIA: Non-preferred agents require three (3) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.

BLEPHAMIDE (prednisolone/sulfacetamide) MAXITROL ointment (neomycin/polymyxin/ dexamethasone) MAXITROL suspension (neomycin/polymyxin/ dexamethasone) neomycin/polymyxin/dexamethasone neomycin/bacitracin/polymyxin/ hydrocortisone PRED-G SUSPENSION (prednisolone/gentamicin) sulfacetamide/prednisolone TOBRADEX OINTMENT (tobramycin/ dexamethasone) TOBRADEX SUSPENSION (tobramycin/ dexamethasone) TOBRADEX ST (tobramycin/ dexamethasone) ZYLET (loteprednol/tobramycin)	BLEPHAMIDE S.O.P. (prednisolone/sulfacetamide) neomycin/polymyxin/hydrocortisone PRED-G OINTMENT (prednisolone/gentamicin) tobramycin/dexamethasone suspension	

OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS[AP]

CLASS PA CRITERIA: Non-preferred agents require thirty (30) day trials of three (3) preferred chemically unique agents before they will be approved, unless one (1) of the exceptions on the PA form is present.

ALAWAY (ketotifen) ALOCRIL (nedocromil) ALREX (loteprednol) azelastine BEPREVE (bepotastine) cromolyn ketotifen LASTACAFT (alcaftadine) ZADITOR OTC (ketotifen)	ALOMIDE (lodoxamide) bepotastine epinastine LUMIFY (brimonidine) olopatadine 0.1% olopatadine 0.2% PATADAY ONCE AND TWICE DAILY (olopatadine) ZERVIATE (cetirizine)	

OPHTHALMICS, ANTI-INFLAMMATORIES- IMMUNOMODULATORS[CL]

CLASS PA CRITERIA: All agents require a prior authorization. Non-preferred agents require a 60-day trial of the preferred agent(s).

RESTASIS (cyclosporine)	CEQUA (cyclosporine) EYSUVIS (loteprednol) RESTASIS MULTIDOSE (cyclosporine)* XIIDRA (lifitegrast)	***Restasis Multidose** is approvable only on appeal and requires medical reasoning as to why the clinical need cannot be met with the preferred product (Restasis). **All agents must meet the following prior-authorization criteria:** 1.) Patient must be sixteen (16) years of age or greater; **AND** 2.) Prior Authorization must be requested by an ophthalmologist or optometrist; **AND** 3.) Clinically diagnosed tear deficiency due to ocular inflammation in patients with keratoconjunctivitis sicca or dry eye syndrome (also known as dry eye); **AND** 4.) Patient must have a functioning lacrimal gland; **AND** 5.) Patient using artificial tears at least four (4) times a day over the last thirty (30) days; **AND** Patient must not have an active ocular infection

OPHTHALMICS, ANTI-INFLAMMATORIES

CLASS PA CRITERIA: Non-preferred agents require five (5) day trials of at least two (2) preferred agents before they will be approved, unless one (1) of the exceptions on the PA form is present. Trials must include at least one agent with the same mechanism of action as the requested non-preferred agent.

dexamethasone diclofenac DUREZOL (difluprednate) FLAREX (fluorometholone) FML (fluorometholone) FML FORTE (fluorometholone) FML S.O.P. (fluorometholone) ketorolac LOTEMAX GEL, OINTMENT, SUSPENSION (loteprednol) MAXIDEX (dexamethasone) NEVANAC (nepafenac) PRED FORTE (prednisolone) PRED MILD (prednisolone) prednisolone acetate prednisolone sodium phosphate	ACULAR (ketorolac) ACULAR LS (ketorolac) ACUVAIL (ketorolac tromethamine) bromfenac BROMSITE (bromfenac) fluorometholone flurbiprofen ILEVRO (nepafenac) INVELTYS (loteprednol) loteprednol drops, gel OMNIPRED (prednisolone) OZURDEX (dexamethasone) PROLENSA (bromfenac) RETISERT (fluocinolone) TRIESENCE (triamcinolone)	

OPHTHALMICS, GLAUCOMA AGENTS

CLASS PA CRITERIA: Non-preferred agents will only be authorized if there is an allergy to all preferred agents in the corresponding sub-class.

COMBINATION AGENTS

COMBIGAN (brimonidine/timolol) dorzolamide/timolol SIMBRINZA (brinzolamide/brimonidine)	COSOPT PF (dorzolamide/timolol)	
BETA BLOCKERS		
BETOPTIC S (betaxolol) carteolol levobunolol timolol drops	betaxolol ISTALOL (timolol) timolol gel TIMOPTIC (timolol)	
CARBONIC ANHYDRASE INHIBITORS		
AZOPT (brinzolamide) dorzolamide	brinzolamide TRUSOPT (dorzolamide)	
PARASYMPATHOMIMETICS		
PHOSPHOLINE IODIDE (echothiophate iodide)	pilocarpine	
PROSTAGLANDIN ANALOGS		
latanoprost TRAVATAN-Z (travoprost)	bimatoprost LUMIGAN (bimatoprost) travoprost VYZULTA (latanoprostene)* XALATAN (latanoprost) XELPROS (latanoprost) 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) ROCKLATAN (netarsudil/latanoprost)		
SYMPATHOMIMETICS		
ALPHAGAN P Solution (brimonidine) brimonidine 0.2%	apraclonidine IOPIDINE (apraclonidine)	
OPIATE DEPENDENCE TREATMENTS		
CLASS PA CRITERIA: Bunavail and Zubsolv may only be approved with a documented intolerance or allergy to Suboxone strips AND buprenorphine/naloxone tablets. WV Medicaid's buprenorphine coverage policy may be viewed by clicking on the following hyperlink: Buprenorphine Coverage Policy and Related Forms		
buprenorphine/naloxone tablets* KLOXXADO SPRAY (naloxone) naloxone NARCAN NASAL SPRAY (naloxone) SUBLOCADE (buprenorphine soln)[CL] SUBOXONE FILM (buprenorphine/naloxone)* VIVITROL (naltrexone)	BUNAVAIL (buprenorphine/naloxone) buprenorphine tablets buprenorphine/naloxone film LUCEMYRA (lofexidine) ZUBSOLV (buprenorphine/naloxone)	* Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.
OTIC ANTIBIOTICS[AP]		
CLASS PA CRITERIA: Non-preferred agents require five (5) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		

CIPRO HC (ciprofloxacin/hydrocortisone) CIPRODEX (ciprofloxacin/dexamethasone) CORTISPORIN-TC (colistin/hydrocortisone/ neomycin) neomycin/polymyxin/HC solution/suspension ofloxacin	ciprofloxacin ciprofloxacin/dexamethasone) ciprofloxacin/fluocinolone 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) TRACLEER TABLET (bosentan)	ambrisentan bosentan OPSUMIT (macitentan) TRACLEER SUSP (bosentan)	
PAH AGENTS – PDE5s[CL]		
CLASS PA CRITERIA: Non-preferred agents require a thirty (30) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. Patients stabilized on non-preferred agents will be grandfathered.		
sildenafil tablets	ADCIRCA (tadalafil) REVATIO IV (sildenafil) REVATIO SUSPENSION (sildenafil) REVATIO TABLETS (sildenafil) sildenafil suspension (generic Revatio)	
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 (generic Flolan) VENTAVIS (iloprost)*	epoprostenol (generic Veletri) FLOLAN (epoprostenol) ORENITRAM ER (treprostinil) REMODULIN (treprostinil sodium) TYVASO (treprostinil) UPTRAVI (selexipag) VELETRI (epoprostenol)	*Ventavis will only be authorized for the treatment of pulmonary artery hypertension (WHO Group 1) in patients with NYHA Class III or IV symptoms.
PANCREATIC ENZYMES[AP]		
CLASS PA CRITERIA: Non-preferred agents require a thirty (30) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. For members with cystic fibrosis, a trial of a preferred agent will not be required.		
CREON ZENPEP	PANCREAZE PERTZYE 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 CALPHRON (calcium acetate) MAGNEBIND RX (calcium carbonate, folic acid, magnesium carbonate) PHOSLYRA (calcium acetate) sevelamer carbonate	AURYXIA (ferric citrate) FOSRENOL (lanthanum) lanthanum chewable RENAGEL (sevelamer) RENVELA (sevelamer carbonate) sevelamer carbonate powder packet VELPHORO (sucroferric oxyhydroxide)	

PITUITARY SUPPRESSIVE AGENTS, LHRH[CL]

CLASS PA CRITERIA: Unless otherwise noted, non-preferred agents are available only on appeal.

LUPANETA (leuprolide) LUPRON DEPOT KIT (leuprolide) LUPRON DEPOT-PED KIT (leuprolide) MYFEMBREE (relugolix, estradiol, norethindrone) ORILISSA (elagolix)* ORIAHNN (elagolix-estradiol-norethindrone)* SYNAREL (nafarelin) TRELSTAR (triptorelin) TRIPTODUR (triptorelin) VANTAS (histrelin) ZOLADEX (goserelin)	leuprolide SUPPRELIN LA KIT (histrelin)	* Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.

PLATELET AGGREGATION INHIBITORS

CLASS PA CRITERIA: Non-preferred agents require a thirty (30) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.

BRILINTA (ticagrelor) clopidogrel dipyridamole prasugrel	clopidogrel kit dipyridamole/aspirin EFFIENT (prasugrel) PLAVIX (clopidogrel) 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 MAKENA (hydroxyprogesterone caproate) VIAL	hydroxyprogesterone caproate	

PROGESTINS FOR CACHEXIA

CLASS PA CRITERIA: Non-preferred agents require a thirty (30) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.

Megestrol		

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.

NEXIUM PACKETS (esomeprazole)** omeprazole (Rx) pantoprazole PROTONIX GRANULES (pantoprazole)**	ACIPHEX (rabeprazole) ACIPHEX SPRINKLE (rabeprazole) DEXILANT (dexlansoprazole) esomeprazole magnesium lansoprazole Rx NEXIUM (esomeprazole) omeprazole/sodium bicarbonate (Rx) PREVACID CAPSULES (lansoprazole) PREVACID SOLUTABS (lansoprazole)** PRILOSEC Rx (omeprazole) PROTONIX DR TABLETS (pantoprazole) rabeprazole ZEGERID Rx (omeprazole/sodium bicarbonate)	*Maximum recommended doses of the PPIs and H2-receptor antagonists may be located at the BMS Pharmacy PA criteria page titled "Max PPI and H2RA" by clicking on the hyperlink. **Prior authorization is required for members nine (9) years of age or older for these agents.

SEDATIVE HYPNOTICS[AP]

CLASS PA CRITERIA: Non-preferred agents require thirty (30) day trials of all preferred agents in **BOTH** sub-classes before they will be approved, unless one (1) of the exceptions on the PA form is present. All agents except melatonin will be limited to fifteen (15) tablets in a thirty (30) day period. NOTE: WV Medicaid covers melatonin up to a maximum dose of 9 mg/day without a PA. Melatonin labeler code 51645 is preferred if available, however all NDCs are payable.

BENZODIAZEPINES

temazepam 15, 30 mg	estazolam flurazepam HALCION (triazolam) RESTORIL (temazepam) temazepam 7.5, 22.5 mg triazolam	

OTHERS

melatonin ROZEREM (ramelteon) zolpidem 5, 10 mg	AMBIEN (zolpidem) AMBIEN CR (zolpidem) BELSOMRA (suvorexant) DAYVIGO (lemborexant) EDLUAR (zolpidem) eszopiclone HETLIOZ (tasimelteon)[CL*] LUNESTA (eszopiclone) ramelteon	Strengths of zolpidem that are non-preferred (6.25 and 12.5 mg) must be created by combining or splitting the preferred doses (5 and 10 mg) of zolpidem, if appropriate. For treatment naïve female patients, zolpidem and zolpidem ER maximum dosages will be limited to 5 mg and 6.25 mg respectively per day.

	SILENOR (doxepin) zaleplon zolpidem ER 6.25, 12.5 mg	*Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.
SKELETAL MUSCLE RELAXANTS[AP]		
CLASS PA CRITERIA: See below for individual sub-class criteria.		
ACUTE MUSCULOSKELETAL RELAXANT AGENTS		
chlorzoxazone (generic PARAFON FORTE) cyclobenzaprine IR 5, 10 mg methocarbamol	AMRIX (cyclobenzaprine) carisoprodol* carisoprodol/ASA* carisoprodol/ASA/codeine* chlorzoxazone (generic LORZONE) cyclobenzaprine ER cyclobenzaprine IR 7.5 mg FEXMID (cyclobenzaprine) LORZONE (chlorzoxazone) metaxalone orphenadrine orphenadrine ER ROBAXIN (methocarbamol) SKELAXIN (metaxalone) 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. *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 tizanidine tablets	DANTRIUM (dantrolene) dantrolene tizanidine capsules OZOBAX SOLUTION (baclofen) ZANAFLEX (tizanidine)	Non-preferred agents require thirty (30) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.
STEROIDS, TOPICAL		
CLASS PA CRITERIA: Non-preferred agents require five (5) day trials of one (1) form of **EACH** preferred unique active ingredient in the corresponding potency group before they will be approved, unless one (1) of the exceptions on the PA form is present.		
VERY HIGH & HIGH POTENCY		
betamethasone dipropionate cream betamethasone valerate cream betamethasone valerate lotion betamethasone valerate oint clobetasol propionatecream, gel, ointment, solution clobetasol emollient clobetasol propionate shampoo fluocinonide gel triamcinolone acetonide cream, ointment	amcinonide APEXICON E (diflorasone diacetate) betamethasone dipropionate gel, lotion, ointment BRYHALI LOTION (halobetasol) clobetasol lotion clobetasol propionate foam CLOBEX (clobetasol propionate) CLODAN KIT (clobetasol propionate) CLODAN SHAMPOO (clobetasol propionate) desoximetasone cream/gel/ointment	

triamcinolone acetonide lotion	diflorasone diacetate DIPROLENE (betamethasone dipropionate/propylene glycol) fluocinonide cream fluocinonide ointment fluocinonide solution fluocinonide/emollient halcinonide cream halobetasol propionate HALOG (halcinonide) IMPEKLO LOTION (clobetasol propionate) KENALOG (triamcinolone acetonide) LEXETTE FOAM (halobetasol) OLUX (clobetasol propionate) OLUX-E (clobetasol propionate/emollient) PSORCON (diflorasone diacetate) TEMOVATE (clobetasol propionate) TOPICORT CREAM, GEL, OINTMENT (desoximetasone) TOPICORT SPRAY (desoximetasone) TOVET FOAM (clobetasol) ULTRAVATE (halobetasol propionate) ULTRAVATE PAC cream VANOS (fluocinonide)	
MEDIUM POTENCY		
fluticasone propionate cream, ointment mometasone furoate triamcinolone acetonide 0.025% and 0.1% cream	BESER LOTION (fluticasone) betamethasone valerate foam CLODERM (clocortolone pivalate) clocortolone cream CORDRAN (flurandrenolide) CUTIVATE (fluticasone propionate) fluocinolone acetonide cream, ointment, solution fluticasone propionate lotion hydrocortisone butyrate cream hydrocortisone butyrate ointment, solution hydrocortisone valerate LOCOID (hydrocortisone butyrate) LOCOID LIPOCREAM (hydrocortisone butyrate/emollient) LUXIQ (betamethasone valerate) PANDEL (hydrocortisone probutate) prednicarbate	
LOW POTENCY		
DERMA-SMOOTHE FS (fluocinolone acetonide) hydrocortisone acetate (Rx, OTC) hydrocortisone cream (Rx, OTC)	alclometasone dipropionate AQUA GLYCOLIC HC (hydrocortisone) CAPEX (fluocinolone acetonide) DESONATE (desonide)	

hydrocortisone lotion OTC hydrocortisone ointment (Rx, OTC) hydrocortisone solution OTC hydrocortisone-aloe cream OTC hydrocortisone-aloe ointment OTC	desonide cream, ointment desonide lotion fluocinolone oil hydrocortisone/mineral oil/petrolatum hydrocortisone acetate/urea hydrocortisone lotion hydrocortisone/aloe gel SCALPICIN OTC (hydrocortisone) SYNALAR (fluocinolone) TEXACORT (hydrocortisone)	

STIMULANTS AND RELATED AGENTS

CLASS PA CRITERIA: A PA is required for adults eighteen (18) years of age or older.

Non-preferred agents require a thirty (30) day trial of at least one preferred agent in the same subclass and with a similar duration of effect and mechanism of action, unless one (1) of the exceptions on the PA form is present. **NOTE**: Non-preferred agents will NOT be "grandfathered" for adults. Children under the age of 18 may continue their current therapy until the end of the school year after which they will be required to switch to a preferred agent.

AMPHETAMINES		
ADDERALL XR (amphetamine salt combination) amphetamine salt combination ER amphetamine salt combination IR dextroamphetamine ER dextroamphetamine IR	ADDERALL (amphetamine salt combination) ADZENYS XR ODT (amphetamine) ADZENYS ER SUSP (amphetamine) amphetamine tablets DESOXYN (methamphetamine) DEXEDRINE ER (dextroamphetamine) dextroamphetamine solution DYANAVEL XR SUSP (amphetamine) EVEKEO (amphetamine) EVEKEO ODT (amphetamine) methamphetamine MYDAYIS (dextroamphetamine/amphetamine salt)* PROCENTRA solution (dextroamphetamine)ZENZEDI (dextroamphetamine) VYVANSE CHEWABLE (lisdexamfetamine) VYVANSE CAPSULE (lisdexamfetamine)	**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. *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		
atomoxetine CONCERTA (methylphenidate) clonidine IR clonidine ER dexmethylphenidate IR dexmethylphenidate XR FOCALIN XR (dexmethylphenidate) guanfacine ER guanfacine IR	ADHANSIA XR (methylphenidate) APTENSIO XR (methylphenidate) AZSTARYS (dexmethylphenidate;serdexmethylphenidate) COTEMPLA XR ODT (methylphenidate) DAYTRANA (methylphenidate) FOCALIN IR (dexmethylphenidate) INTUNIV (guanfacine extended-release) JORNAY PM (methylphenidate)	* Strattera is limited to a maximum of 100 mg per day. **Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.

methylphenidate IR methylphenidate ER 24 tablet (generic CONCERTA) methylphenidate ER tablet (generic RITALIN SR) methylphenidate CD capsules methylphenidate solution QUILLICHEW ER (methylphenidate) QUILLIVANT XR (methylphenidate) RITALIN LA (methylphenidate)	METHYLIN SOLUTION (methylphenidate) methylphenidate chewable tablets methylphenidate ER capsule methylphenidate ER CD capsules methylphenidate ER LA capsule methylphenidate LA capsule QELBREE (viloxazine)** RITALIN (methylphenidate) STRATTERA (atomoxetine)*	
NARCOLEPTIC AGENTS		
armodafinil[CL] modafinil[CL] NUVIGIL (armodafinil) PROVIGIL (modafinil)	SUNOSI (solriamfetol)* WAKIX (pitolisant)**	* Sunosi is approvable only with documentation of treatment failure after 30-day trials of both armodafinil and modafinil. **Wakix is approvable only with documentation of treatment failure after 30-day trials of armodafinil, modafinil and Sunosi.
TETRACYCLINES		
CLASS PA CRITERIA: Non-preferred agents require ten (10) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.		
doxycycline hyclate capsules doxycycline hyclate 100 mg tablets doxycycline monohydrate 50, 100 mg capsules minocycline capsules	demeclocycline* DORYX (doxycycline hyclate) doxycycline hyclate 75, 150 mg tablets doxycycline hyclate tablet DR 75, 100, 150, 200 mg doxycycline hyclate tablet DR 50 mg doxycycline monohydrate 40, 75, 150 mg capsule doxycycline monohydrate tablet doxycycline monohydrate suspension MINOCIN (minocycline) minocycline ER capsules minocycline tablets MINOLIRA ER (minocycline) MORGIDOX KIT (doxycycline) ORACEA (doxycycline monohydrate) SOLODYN (minocycline) tetracycline VIBRAMYCIN CAPSULES, SUSPENSION, SYRUP (doxycycline) 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. Demeclocycline will also be authorized for SIADH.
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) ASACOL HD (mesalamine) balsalazide PENTASA (mesalamine) 250 mg PENTASA (mesalamine) 500 mg sulfasalazine	AZULFIDINE (sulfasalazine) budesonide ER tablet COLAZAL (balsalazide) DELZICOL (mesalamine) DIPENTUM (olsalazine) LIALDA (mesalamine) mesalamine UCERIS (budesonide) ZEPOSIA (ozanimod)	
RECTAL		
mesalamine	DELZICOL DR (mesalamine) mesalamine kit ROWASA (mesalamine) SF ROWASA (mesalamine) 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) nitroglycerin sublingual NITROSTAT SUBLINGUAL (nitroglycerin)	GONITRO SPRAY POWDER (nitroglycerin) nitroglycerin spray (generic NITROMIST) NITROLINGUAL SPRAY (nitroglycerin) NITROMIST (nitroglycerin)	

MISCELLANEOUS COVERED AGENTS

This category contains covered agents which either did not easily fit into a single PDL category or had criteria that was too lengthy to cite within the PDL itself. Full criteria for the agents listed below may be found by following this hyperlink: (https://dhhr.wv.gov/bms/BMS%20Pharmacy/Pages/PA-Criteria.aspx). Please note that some agents may be available only by billing the appropriate HCPCS code noted in the criteria.

Afinitor
Albenza and Emverm
Ampyra
Antifungal Agents
Austedo
Belbuca
Benlysta
Botox
Cabenuva
Carbaglu
CGRP Receptor Antagonists
Continuous Glucose Monitors

Corlanor
Cresemba
Cuvposa
Cytokine & CAM Antagonists
Diclegis
Dificid
Dojolvi
Droxidopa
Duavee
Dupixent
Epidiolex
Emflaza
Enspryng
Esbriet
Evrysdi
ExJade
Exondys 51
Fasenra
Ferriprox
Firazyr
Fuzeon
Gattex
Gralise
Growth Hormone for Adults
Growth Hormone for Children
Hepatitis C PA Criteria
Hereditary Angioedema Agents
Hetlioz
Home Infusion Drugs and Supplies
Horizant
HP Acthar
HyQvia
Increlex
Ingrezza
Jublia
Juxtapid
Kalydeco
Ketoconazole
Korlym
Kuvan
Kymriah
Kynamro
Lucemyra
Lutathera
Lupkynis
Luxturna

Makena
Max PPI an H2RA
Mozobil
Myalept
Mytesi
Natpara
Nexletol and Nexlizet
Non-Sedating Antihistamines
Nuvigil
Nucala
OFEV
Oforta
Omnipod
Orilissa
Oralair
Oriahnn
Orkambi
Osphena
Oxlumo
Palforzia
Palynziq
PCSK9 Inhibitor
Provigil
Qbrexza
Qelbree
Rectiv
Regranex

Restasis
Rilutek
Riluzole
Risperdal Consta
Ruconest
Sirturo
Spinraza
Spravato
Sprycel
Suboxone Policy
Symdeko
Synagis
Testosterone
Thalomid
Tobacco Cessation Policy
Trikafta
V-Go
Viberzi and Lotronex
Verquvo

Vyondys 53
Xanax XR
Xenazine
Xhance
Xifaxan
Xolair
Xyrem and Xywav
Yescarta
Zolgensma
Zulresso
Zurampic
Zyvox