DIVISION OF MEDICAID AND LONG-TERM CARE
Nebraska DHHS

PHARMACEUTICAL AND THERAPEUTICS COMMITTEE MEETING MINUTES
May 15, 2019 at 9 a.m. CST
Mahoney State Park, Peter Kiewit Lodge
Ashland, NE

Committee Members Present:
Claire Baker, M.D. (Chair)
Stacie Bleicher, M.D.
Chris Caudill, M.D.
Kyle Clarey, Pharm.D.
Allison Dering-Anderson, Pharm.D.
Gary Elsasser, Pharm.D.
Wade Fornander, M.D.
Laurie Humphries, M.D.
Joyce Juracek, Pharm.D.
Jessica Pohl, Pharm.D.
Ken Saunders, Pharm.D.
Linda Sobeski, Pharm.D. (Vice Chair)

Division of Medicaid and Long-Term Care Staff Present:
Jenny Minchow, Pharm.D.
Carisa Masek, Pharm.D., MBA, MPH

Magellan Medicaid Administration Staff Present:
Jill Bot, Pharm.D., Clinical Account Executive
Valarie Simmons, M.S., Account Executive

Managed Care Staff Present:
Shannon Nelson, Pharm. D., WellCare Director
Kevin Peterson, Pharm. D., NTC Director
Bernadette Ueda, Pharm. D., UHC Director

Committee Members Excused:
Eric Avery, M.D.
Jeffrey Gotschall, M.D.
Mary Hammond, Pharm.D.

I. **Opening of Public Meeting and Call to Order Committee Business**

i. Committee Chair called the meeting to order at 9:00am.The agenda was posted on the Nebraska Medicaid Pharmacy Magellan Medicaid website (https://nebraska.fhsc.com/PDL/PTcommittee.asp) on April 17, 2019. A copy of the Open Meetings Act and meeting materials distributed to members were made available to the public for review.

ii. Roll Call: See list above

iii. Conflict of Interest: No new conflicts of interest were reported.

iv. Approval of November 7, 2018 minutes was unanimously approved by all in attendance.

v. Department information: Jenny Minchow, Pharmacist for DHHS, Medicaid and Long-Term Care Division provided a department update.

I. Dr. Minchow introduced the new Pharmacy Director for Nebraska DHHS, Dr. Carisa Masek. Carisa started her role in February 2019. She replaced Dr. Shelly Nickerson who left Nebraska DHHS in 2018.

II. Public Testimony

Speaker Order	DRUG CLASS	Drug Name	PDL Status	Speaker Name	Affiliation
1	Pulmonary Arterial Hypertension	Opsumit/Uptravi	Non-Preferred	Josephine Garcia-Ferrer	Actelion
2	Hepatitis C	Epclusa sofusbuvir/velpatasvir-authorized generic	Non-Preferred	Stuart O'Brochta	Gilead
3	HIV/AIDS	Biktarvy	Non-Preferred	Stuart O'Brachta	Gilead
4	HIV/AIDS	Symtuza	Non-Preferred	Erin Hohman	Janssen
5	Hypoglycemics, Insulin	Tresiba	Non-Preferred	Marc Cook	Novo Nordisk
6	Hypoglycemics, Incretin Mimetic/Ehancers	Ozempic	Non-Preferred	Marc Cook	Novo Nordisk
8	Pulmonary Arterial Hypertension	Orenitram	Non-Preferred	Susan Steinbis	United Therapeutics Corporation
10	Migraines, Other	Aimovig	Non-Preferred	Christina Brandmeyer	Amgen
11	Multiple Sclerosis	Aubagio	Non-Preferred	Kevin Duhrkopf	Sanofi

III. Committee Closed Session

IV. Resume Open Session.

During the public open session, committee members vote publicly on decisions with regard to the Nebraska Preferred Drug List recommendations. Per the State of Nebraska P&T Committee By-Laws, the minutes reflect how each member voted or if the member was absent or not voting. The chairperson votes only in the event of a tie. The details of each vote and the associated PDL recommendations are presented in the following tables.

i. Consent Agenda

Consent Agenda

(1st) Motion: Caudill

(2nd) Motion: Dering Anderson

Discussion: Approve as written.

Voting – P&T Committee Members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Baker, Claire, M.D. (Chair) • ***Votes only in the event of a tie***				Fornander, Wade, M.D.	x		
Bleicher, Stacie, M.D.	x			Humphries, Laurie, M.D.	x		
Caudill, Christopher, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Clarey, Kyle, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Saunders, Kenneth, Pharm.D.	x		
Elsasser, Gary, RPh.	x			Sobeski, Linda, Pharm.D.	x		

Consent Agenda: Therapeutic categories (TC) with unchanged recommendations unless otherwise indicated.	
Angiotensin Modulators	Hypoglycemics, Insulin and Related Agents
Antibiotics, Topical	Hypoglycemics, Meglitinides
Antiemetics / Antivertigo Agents	Hypoglycemics, Metformins
Antifungals, Topical	Hypoglycemics, SGLT2
Antimigraine Agents, Triptans	Hypoglycemics, Sulfonylureas
Antivirals, Topical	Hypoglycemics, TZDs
Bladder Relaxant Preparations	Lincosamides / Oxazolidinones / Streptogramins
Bone Resorption Suppression and Related Agents	Lipotropics, Other
BPH - Benign Prostatic Hyperplasia Agents	Macrolides and Ketolides
Calcium Channel Blockers	Nitrofuran Derivatives
Cystic Fibrosis	PAH - Pulmonary Arterial Hypertension Agents
Diuretics	Pancreatic Enzymes
Fluoroquinolones, Oral	Pediatric Vitamin Preparations
Growth Hormone	Penicillins
H. Pylori Treatment	Phosphate Binders
Hepatitis B Agents	Prenatal Vitamins
Hepatitis C Agents	Proton Pump Inhibitors
Hypoglycemics, Alpha-glucosidase	Sinus Mode Inhibitors
Inhibitors	Skeletal Muscle Relaxants
Hypoglycemics, Incretin Mimetics / Enhancers	

ii. Therapeutic Class Reviews

Review Agenda – Acne Agents, Topical

(1st) Motion: Juracek

(2nd) Motion: Dering Anderson

Discussion: Add clindamycin gel (authorized generic for Clindagel) to preferred status and retain clindamycin gel (other manufacturer's generics) as non-preferred.

Voting – P&T Committee Members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Baker, Claire, M.D. (Chair) *Votes only in the event of a tie*				Fornander, Wade, M.D.		x	
Bleicher, Stacie, M.D.		x		Humphries, Laurie, M.D.	x		
Caudill, Christopher, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Clarey, Kyle, Pharm.D.	x			Pohl, Jessica, Pharm.D.		x	
Dering Anderson, Allison, Pharm.D.	x			Saunders, Kenneth, Pharm.D.	x		
Elsasser, Gary, RPh.	x			Sobeski, Linda, Pharm.D.	x		

Review Agenda – Analgesics, Opioids Long-Acting

(1st) Motion: Dering Anderson

(2nd) Motion: Juracek

Discussion: Approve as written with the addition of 12.5mg strength to P (it came out later).

Voting – P&T Committee Members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Baker, Claire, M.D. (Chair) *Votes only in the event of a tie*				Fornander, Wade, M.D.	x		
Bleicher, Stacie, M.D.	X			Humphries, Laurie, M.D.	x		
Caudill, Christopher, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Clarey, Kyle, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Saunders, Kenneth, Pharm.D.	x		
Elsasser, Gary, RPh.	x			Sobeski, Linda, Pharm.D.	x		

Review Agenda – Analgesics, Opioids Short-Acting

(1st) Motion: Dering Anderson

(2nd) Motion: Juracek

Discussion: Change Ultracet to non-preferred status and have patients use tramadol and APAP separately.

Voting – P&T Committee Members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Baker, Claire, M.D. (Chair) *Votes only in the event of a tie*				Fornander, Wade, M.D.		x	
Bleicher, Stacie, M.D.	x			Humphries, Laurie, M.D.	x		
Caudill, Christopher, M.D.		x		Juracek, Joyce, Pharm.D.	x		
Clarey, Kyle, Pharm.D.	x			Pohl, Jessica, Pharm.D.		x	
Dering Anderson, Allison, Pharm.D.	x			Saunders, Kenneth, Pharm.D.		x	
Elsasser, Gary, RPh.		x		Sobeski, Linda, Pharm.D.	x		

Review Agenda – Androgenic Agents

(1st) Motion: Dering Anderson

(2nd) Motion: Fornander

Discussion: Approve as written and limit use to FDA approved indications and gender dysphoria. Do not allow use for erectile dysfunction.

Voting – P&T Committee Members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Baker, Claire, M.D. (Chair) *Votes only in the event of a tie*				Fornander, Wade, M.D.	x		
Bleicher, Stacie, M.D.	x			Humphries, Laurie, M.D.	x		
Caudill, Christopher, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Clarey, Kyle, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Saunders, Kenneth, Pharm.D.	x		
Elsasser, Gary, RPh.	x			Sobeski, Linda, Pharm.D.	x		

Review Agenda – Angiotensin Modulator Combinations

(1st) Motion: Juracek

(2nd) Motion: Pohl

Discussion: Approve as written.

Voting – P&T Committee Members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Baker, Claire, M.D. (Chair) *Votes only in the event of a tie*				Fornander, Wade, M.D.	x		
Bleicher, Stacie, M.D.	x			Humphries, Laurie, M.D.	x		
Caudill, Christopher, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Clarey, Kyle, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Saunders, Kenneth, Pharm.D.	x		
Elsasser, Gary, RPh.	x			Sobeski, Linda, Pharm.D.	x		

Review Agenda – Antibiotics, Gastrointestinal

(1st) Motion: Elsasser

(2nd) Motion: Dering Anderson

Discussion: Add PA to allow patients to move to vancomycin capsule if unable to take vancomycin solution.

Voting – P&T Committee Members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Baker, Claire, M.D. (Chair) *Votes only in the event of a tie*				Fornander, Wade, M.D.	x		
Bleicher, Stacie, M.D.	x			Humphries, Laurie, M.D.	x		
Caudill, Christopher, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Clarey, Kyle, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Saunders, Kenneth, Pharm.D.	x		
Elsasser, Gary, RPh.	x			Sobeski, Linda, Pharm.D.	x		

Review Agenda – Antibiotics, Inhaled

(1st) Motion: Pohl

(2nd) Motion: Bleicher

Discussion: Approve as written.

Voting – P&T Committee Members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Baker, Claire, M.D. (Chair) *Votes only in the event of a tie*				Fornander, Wade, M.D.	x		
Bleicher, Stacie, M.D.	x			Humphries, Laurie, M.D.	x		
Caudill, Christopher, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Clarey, Kyle, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Saunders, Kenneth, Pharm.D.	x		
Elsasser, Gary, RPh.	x			Sobeski, Linda, Pharm.D.	x		

Review Agenda – Antibiotics, Vaginal

(1st) Motion: Fornander

(2nd) Motion: Pohl

Discussion: Approve as written.

Voting – P&T Committee Members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Baker, Claire, M.D. (Chair) *Votes only in the event of a tie*				Fornander, Wade, M.D.	x		
Bleicher, Stacie, M.D.	x			Humphries, Laurie, M.D.	x		
Caudill, Christopher, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Clarey, Kyle, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Saunders, Kenneth, Pharm.D.	x		
Elsasser, Gary, RPh.	x			Sobeski, Linda, Pharm.D.	x		

Review Agenda – Anticoagulants

(1st) Motion: Elsasser

(2nd) Motion: Fornander

Discussion: Approve as written.

Voting – P&T Committee Members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Baker, Claire, M.D. (Chair) *Votes only in the event of a tie*				Fornander, Wade, M.D.	x		
Bleicher, Stacie, M.D.	x			Humphries, Laurie, M.D.	x		
Caudill, Christopher, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Clarey, Kyle, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Saunders, Kenneth, Pharm.D.	x		
Elsasser, Gary, RPh.	x			Sobeski, Linda, Pharm.D.	x		

Review Agenda – Antifungals, Oral

(1st) Motion: Dering Anderson

(2nd) Motion: Juracek

Discussion: Approve as written.

Voting – P&T Committee Members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Baker, Claire, M.D. (Chair) *Votes only in the event of a tie*				Fornander, Wade, M.D.	x		
Bleicher, Stacie, M.D.	x			Humphries, Laurie, M.D.	x		
Caudill, Christopher, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Clarey, Kyle, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Saunders, Kenneth, Pharm.D.	x		
Elsasser, Gary, RPh.	x			Sobeski, Linda, Pharm.D.	x		

Review Agenda – Antimigraine Agents, Other

(1st) Motion: Elsasser

(2nd) Motion: Fornander

Discussion: Approve as written.

Voting – P&T Committee Members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Baker, Claire, M.D. (Chair) *Votes only in the event of a tie*				Fornander, Wade, M.D.	x		
Bleicher, Stacie, M.D.	x			Humphries, Laurie, M.D.	x		
Caudill, Christopher, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Clarey, Kyle, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Saunders, Kenneth, Pharm.D.	x		
Elsasser, Gary, RPh.	x			Sobeski, Linda, Pharm.D.	x		

Review Agenda – Antiparasitics, Topical

(1st) Motion: Dering Anderson

(2nd) Motion: Juracek

Discussion: Approve as written.

Voting – P&T Committee Members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Baker, Claire, M.D. (Chair) *Votes only in the event of a tie*				Fornander, Wade, M.D.	x		
Bleicher, Stacie, M.D.	x			Humphries, Laurie, M.D.	x		
Caudill, Christopher, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Clarey, Kyle, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Saunders, Kenneth, Pharm.D.	x		
Elsasser, Gary, RPh.	x			Sobeski, Linda, Pharm.D.	x		

V. Motion for closed session during lunch was unanimously approved by all in attendance. The meeting resumed open session at 1:00pm.

Review Agenda – Antivirals, Oral

(1st) Motion: Sobeski

(2nd) Motion: Dering Anderson

Discussion: Approve as written.

Voting – P&T Committee Members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Baker, Claire, M.D. (Chair) *Votes only in the event of a tie*				Fornander, Wade, M.D. Absent			
Bleicher, Stacie, M.D.	x			Humphries, Laurie, M.D.	x		
Caudill, Christopher, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Clarey, Kyle, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Saunders, Kenneth, Pharm.D.	x		
Elsasser, Gary, RPh.	x			Sobeski, Linda, Pharm.D.	x		

Review Agenda – Beta Blockers

(1st) Motion: Juracek

(2nd) Motion: Pohl

Discussion: Approve as written.

Voting – P&T Committee Members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Baker, Claire, M.D. (Chair) *Votes only in the event of a tie*				Fornander, Wade, M.D. Absent			
Bleicher, Stacie, M.D.	x			Humphries, Laurie, M.D.	x		
Caudill, Christopher, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Clarey, Kyle, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Saunders, Kenneth, Pharm.D.	x		
Elsasser, Gary, RPh.	x			Sobeski, Linda, Pharm.D.	x		

Review Agenda – Cephalosporins and Related Antibiotics

(1st) Motion: Juracek

(2nd) Motion: Bleicher

Discussion: Approve as written.

Voting – P&T Committee Members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Baker, Claire, M.D. (Chair) *Votes only in the event of a tie*				Fornander, Wade, M.D. Absent			
Bleicher, Stacie, M.D.	x			Humphries, Laurie, M.D.	x		
Caudill, Christopher, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Clarey, Kyle, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Saunders, Kenneth, Pharm.D.	x		
Elsasser, Gary, RPh.	x			Sobeski, Linda, Pharm.D.	x		

Review Agenda – Contraceptives, Oral

(1st) Motion: Elsasser

(2nd) Motion: Dering Anderson

Discussion: Approve as written.

Voting – P&T Committee Members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Baker, Claire, M.D. (Chair) *Votes only in the event of a tie*				Fornander, Wade, M.D. Absent			
Bleicher, Stacie, M.D.	x			Humphries, Laurie, M.D.	x		
Caudill, Christopher, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Clarey, Kyle, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Saunders, Kenneth, Pharm.D.	x		
Elsasser, Gary, RPh.	x			Sobeski, Linda, Pharm.D.	x		

Review Agenda – GI Motility, Chronic (formerly IBS)

(1st) Motion: Sobeski

(2nd) Motion: Saunders

Discussion: Approve as written.

Voting – P&T Committee Members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Baker, Claire, M.D. (Chair) *Votes only in the event of a tie*				Fornander, Wade, M.D. Absent			
Bleicher, Stacie, M.D.	x			Humphries, Laurie, M.D.	x		
Caudill, Christopher, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Clarey, Kyle, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Saunders, Kenneth, Pharm.D.	x		
Elsasser, Gary, RPh.	x			Sobeski, Linda, Pharm.D.	x		

Review Agenda – HIV/AIDS

(1st) Motion: Dering Anderson

(2nd) Motion: Juracek

Discussion: Approve as written.

Voting – P&T Committee Members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Baker, Claire, M.D. (Chair) *Votes only in the event of a tie*				Fornander, Wade, M.D. Absent			
Bleicher, Stacie, M.D.	x			Humphries, Laurie, M.D.	x		
Caudill, Christopher, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Clarey, Kyle, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Saunders, Kenneth, Pharm.D.	x		
Elsasser, Gary, RPh.	x			Sobeski, Linda, Pharm.D.	x		

Review Agenda – Immunosuppressives, Oral

(1st) Motion: Juracek

(2nd) Motion: Sobeski

Discussion: Approve as written.

Voting – P&T Committee Members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Baker, Claire, M.D. (Chair) *Votes only in the event of a tie*				Fornander, Wade, M.D. Absent			
Bleicher, Stacie, M.D.	x			Humphries, Laurie, M.D.	x		
Caudill, Christopher, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Clarey, Kyle, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Saunders, Kenneth, Pharm.D.	x		
Elsasser, Gary, RPh.	x			Sobeski, Linda, Pharm.D.	x		

Review Agenda – Lipotropics, Statins

(1st) Motion: Pohl

(2nd) Motion: Juracek

Discussion: Approve as written.

Voting – P&T Committee Members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Baker, Claire, M.D. (Chair) *Votes only in the event of a tie*				Fornander, Wade, M.D. Absent			
Bleicher, Stacie, M.D.	x			Humphries, Laurie, M.D.	x		
Caudill, Christopher, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Clarey, Kyle, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Saunders, Kenneth, Pharm.D.	x		
Elsasser, Gary, RPh.	x			Sobeski, Linda, Pharm.D.	x		

Review Agenda – Multiple Sclerosis Agents

(1st) Motion: Dering Anderson

(2nd) Motion: Juracek

Discussion: Approve as written.

Voting – P&T Committee Members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Baker, Claire, M.D. (Chair) *Votes only in the event of a tie*				Fornander, Wade, M.D. Absent			
Bleicher, Stacie, M.D.	x			Humphries, Laurie, M.D.	x		
Caudill, Christopher, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Clarey, Kyle, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Saunders, Kenneth, Pharm.D.	x		
Elsasser, Gary, RPh.	x			Sobeski, Linda, Pharm.D.	x		

Review Agenda – Opioid Dependence Treatments

(1st) Motion: Juracek

(2nd) Motion: Pohl

Discussion: Approve as written.

Voting – P&T Committee Members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Baker, Claire, M.D. (Chair) *Votes only in the event of a tie*				Fornander, Wade, M.D. Absent			
Bleicher, Stacie, M.D.	x			Humphries, Laurie, M.D.	x		
Caudill, Christopher, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Clarey, Kyle, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Saunders, Kenneth, Pharm.D.	x		
Elsasser, Gary, RPh.	x			Sobeski, Linda, Pharm.D.	x		

Review Agenda – Platelet Aggregation Inhibitors

(1st) Motion: Pohl

(2nd) Motion: Bleicher

Discussion: Approve as written.

Voting – P&T Committee Members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Baker, Claire, M.D. (Chair) *Votes only in the event of a tie*				Fornander, Wade, M.D. Absent			
Bleicher, Stacie, M.D.	x			Humphries, Laurie, M.D.	x		
Caudill, Christopher, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Clarey, Kyle, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Saunders, Kenneth, Pharm.D.	x		
Elsasser, Gary, RPh.	x			Sobeski, Linda, Pharm.D.	x		

Review Agenda – Tetracyclines

(1st) Motion: Dering Anderson

(2nd) Motion: Caudill

Discussion: Approve as written.

Voting – P&T Committee Members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Baker, Claire, M.D. (Chair) *Votes only in the event of a tie*				Fornander, Wade, M.D. Absent			
Bleicher, Stacie, M.D.	x			Humphries, Laurie, M.D.	x		
Caudill, Christopher, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Clarey, Kyle, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Saunders, Kenneth, Pharm.D.	x		
Elsasser, Gary, RPh.	x			Sobeski, Linda, Pharm.D.	x		

Review Agenda – Thyroid Hormones

(1st) Motion: Elsasser

(2nd) Motion: Pohl

Discussion: Approve as written.

Voting – P&T Committee Members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Baker, Claire, M.D. (Chair) *Votes only in the event of a tie*				Fornander, Wade, M.D. Absent			
Bleicher, Stacie, M.D.	x			Humphries, Laurie, M.D.	x		
Caudill, Christopher, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Clarey, Kyle, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Saunders, Kenneth, Pharm.D.	x		
Elsasser, Gary, RPh.	x			Sobeski, Linda, Pharm.D.	x		

Review Agenda – Ulcerative Colitis

(1st) Motion: Juracek

(2nd) Motion: Pohl

Discussion: Approve as written.

Voting – P&T Committee Members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Baker, Claire, M.D. (Chair) *Votes only in the event of a tie*				Fornander, Wade, M.D. Absent			
Bleicher, Stacie, M.D.	x			Humphries, Laurie, M.D.	x		
Caudill, Christopher, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Clarey, Kyle, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Saunders, Kenneth, Pharm.D.	x		
Elsasser, Gary, RPh.	x			Sobeski, Linda, Pharm.D.	x		

Review Agenda – Uterine Disorder Treatments (*NEW*)

(1st) Motion: Juracek

(2nd) Motion: Dering Anderson

Discussion: Change Orilissa to non-preferred status w/ PA criteria to include step therapy using ACOG guidance on quantity level limits and max daily dose and ICD10 code for diagnosis.

Voting – P&T Committee Members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Baker, Claire, M.D. (Chair) *Votes only in the event of a tie*				Fornander, Wade, M.D. Absent			
Bleicher, Stacie, M.D.	x			Humphries, Laurie, M.D.	x		
Caudill, Christopher, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Clarey, Kyle, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Saunders, Kenneth, Pharm.D.	x		
Elsasser, Gary, RPh.	x			Sobeski, Linda, Pharm.D.	x		

Review Agenda – Vasodilators, Coronary

(1st) Motion: Juracek

(2nd) Motion: Bleicher

Discussion: Approve as written, with the exception of adding drug specific criteria to BiDil limiting its use to heart failure as per prescribing information

Voting – P&T Committee Members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Baker, Claire, M.D. (Chair) *Votes only in the event of a tie*				Fornander, Wade, M.D. Absent			
Bleicher, Stacie, M.D.	x			Humphries, Laurie, M.D.	x		
Caudill, Christopher, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Clarey, Kyle, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Saunders, Kenneth, Pharm.D.	x		
Elsasser, Gary, RPh.	x			Sobeski, Linda, Pharm.D.	x		

ACNE AGENTS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ZELEX (azelaic acid) benzoyl peroxide **GEL, WASH, LOTION** OTC clindamycin/benzoyl peroxide (generic for Duac) *clindamcyin phosphate **GEL, PLEDGET, SOLUTION*** DIFFERIN **LOTION, CREAM, GEL RX** (adapalene) erythromycin **SOLUTION** PANOXYL 10% ACNE FOAMING WASH (benzoyl peroxide) OTC RETIN-A **GEL, CREAM**[AL]	adapalene **CREAM, GEL, GEL W/PUMP** (generic Differin) adapalene **SOLUTION** adapalene/benzoyl peroxide (generic EPIDUO) *ALTRENO (tretinoin)*[NR, AL] ATRALIN (tretinoin) AVAR (sulfacetamine sodium/sulfur) AVITA (tretinoin) BENZACLIN **GEL** (clindamycin/ benzoyl peroxide) BENZACLIN **W/PUMP** (clindamycin/benzoyl peroxide) BENZAPRO (benzoyl peroxide) benzoyl peroxide **CLEANSER**, **CLEANSING BAR**, OTC benzoyl peroxide **FOAM** (generic for Benzepro Foam) benzoyl peroxide **GEL** Rx clindamycin **FOAM, LOTION** clindamycin **GEL** (generic Clindagel) clindamycin/benzoyl peroxide (generic for Acanya) clindamycin/benzoyl peroxide (generic for Benzaclin) clindamycin/tretinoin (generic for Veltin & Ziana) dapsone (generic for ACZONE) DIFFERIN **GEL OTC** EPIDUO FORTE **GEL W/PUMP** erythromycin **GEL, PLEDGET** erythromycin-benzoyl peroxide (generic for Benzamycin) EVOCLIN (clindamycin) FABIOR (tazarotene foam) NEUAC (clindamycin/benzoyl peroxide) ONEXTON (clindamycin/benzoyl peroxide) OVACE PLUS (sulfacetamind sodium) *PLIXDA (adapalene) SWAB*[NR] RETIN-A MICRO (tretinoin microspheres) [AL] sulfacetamide sulfacetamide/sulfur SUMADAN (sulfacetamide/sulfur) tazarotene CREAM TAZORAC (tazarotene) TRETIN-X (tretinoin) tretinoin **CREAM, GEL**[AL] tretinoin microspheres (generic for Retin-A Micro) [AL]	▪ Non-preferred agents will be approved for patients who have failed THREE preferred agents within this drug class

ANALGESICS, OPIOID LONG-ACTING

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BUTRANS (buprenorphine, transdermal)[QL] EMBEDA (morphine sulfate/ naltrexone) fentanyl 25, 50, 75, 100 mcg **PATCH** morphine ER **TABLET** (generic for MS Contin, Oramorph SR) OXYCONTIN (oxycodone ER)	ARYMO ER (morphine sulfate ER)[QL] BELBUCA (buprenorphine, buccal)[CL] buprenorphine TRANSDERMAL (generic for Butrans)[QL] DURAGESIC MATRIX (fentanyl) fentanyl 37.5, 62.5, 87.5 mcg **PATCH**[CL] hydromorphone ER (generic for Exalgo)[CL] *HYSINGLA ER (hydrocodone, extended release)* KADIAN (morphine ER capsule) methadone [CL] MORPHABOND ER (morphine sulfate) morphine ER **CAPSULE** (generic for Avinza, Kadian) NUCYNTA ER (tapentadol)[CL] oxycodone ER (generic for re-formulated Oxycontin) oxymorphone ER (generic for Opana ER) tramadol extended release (generic for Conzip, Ryzolt, Ultram ER)[CL] XTAMPZA ER (oxycodone myristate)[QL] ZOHYDRO ER (hydrocodone bitartrate ER)	The Center for Disease Control (CDC) does not recommend long acting opioids when beginning opioid treatment. ▪ Preferred agents require previous use of a long acting opioid or documentation of a trial on a short acting agent within 90 days ▪ Non-preferred agents will be approved with failure on, or intolerance to TWO preferred agents within this drug class Drug-specific criteria: ▪ **Methadone:** Trial of preferred drug not required for end of life care ▪ **Oxycontin®:** Pain contract required for maximum quantity authorization

ANALGESICS, OPIOID SHORT-ACTING[QL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ORAL		▪ Non-preferred agents will be approved for patients who have failed THREE preferred agents within this drug class within the last 12 months ▪ Note: for short acting opiate tablets and capsules there is a maximum quantity limit of #150 per 30 days. ▪ Beginning Oct. 11, 2018: Opiate limits for opiate naïve patients will consist of -prescriptions limited to a 7 day supply, AND -initial opiate prescription fill limited to maximum of 50 Morphine Milligram Equivalents (MME) per day These limits may only be exceeded with patient specific documentation of medical necessity, with examples such as, cancer diagnosis, end-of-life care, palliative care, Sickle Cell Anemia, or prescriber attestation that patient is not recently opiate naive Drug-specific criteria: ▪ **Abstral®/Actiq®/Fentora®/ Onsolis®/ Subsys® (fentanyl):** Approved only for diagnosis of cancer AND current use of long-acting opiate ▪ **Apadaz:** Approval for 14 days or less ▪ **Nucynta®:** Approved only for diagnosis of acute pain, for 30 days or less ▪ **Tramadol/APAP:** Clinical reason why individual ingredients can't be used ▪ **Xartemis XR®:** Approved only for diagnosis of acute pain
acetaminophen/codeine **ELIXIR, TABLET**	*APADAZ (benzhydrocodone/APAP)[NR,CL,QL]*	
codeine **ORAL**	*benzhydrocodone/APAP (generic for Apadaz)[NR,CL,QL]*	
hydrocodone/APAP **SOLUTION, TABLET**	butalbital/caffeine/APAP w/codeine	
hydrocodone/ibuprofen	butalbital compound w/codeine (butalbital/ASA/caffeine/codeine)	
hydromorphone **TABLET**	carisoprodol compound-codeine (carisoprodol/ASA/codeine)	
morphine **CONC SOLUTION**, **SOLUTION, TABLET**	dihydrocodeine/acetamin/caffeine	
oxycodone **TABLET, SOLUTION**	dihydrocodeine/aspirin/caffeine (generic for Synalgos DC)	
oxycodone/APAP	FIORINAL/CODEINE (butalbital/ ASA/codeine/caffeine)	
tramadol	hydromorphone **ORAL LIQUID, TABLET, SUPPOSITORY** (generic for Dilaudid)	
tramadol/APAP (generic for Ultracet)	IBUDONE (hydrocodone/ibuprofen)	
	levorphanol	
	meperidine (generic for Demerol)	
	morphine **SUPPOSITORIES**	
	NALOCET (oxycodone/APAP)[NR]	
	NUCYNTA (tapentadol)[CL]	
	OXAYDO (oxycodone)[CL]	
	oxycodone **CAPSULE**	
	oxycodone/acetaminophen **SOLUTION**	
	oxycodone/aspirin	
	oxycodone **CONCENTRATE**	
	oxycodone/ibuprofen (generic for Combunox)	
	oxymorphone (generic for Opana)	
	pentazocine/naloxone	
	PRIMLEV (oxycodone/acetaminophen)	
	~~REPREXAIN (hydrocodone/ibuprofen)~~	
	ROXICODONE **TABLET** (oxycodone)	
	ROXYBOND (oxycodone)[NR]	
	XARTEMIS XR (oxycodone/ acetaminophen)	
	ZAMICET (hydrocodone/ acetaminophen)	

ANALGESICS, OPIOID SHORT-ACTING[QL] (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
NASAL		
	butorphanol **NASAL SPRAY**[QL] LAZANDA (fentanyl citrate)	
BUCCAL/TRANSMUCOSAL		
	ABSTRAL (fentanyl)CL fentanyl TRANSMUCOSAL (generic for Actiq)CL FENTORA (fentanyl)CL SUBSYS (fentanyl spray)CL	

ANDROGENIC DRUGS (Topical)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
*testosterone gel **PACKET, PUMP** (generic for Vogelxo)*	ANDRODERM (testosterone) *ANDROGEL (testosterone)* NATESTO (testosterone) testosterone gel **PACKET, PUMP** (generic for Androgel) testosterone (generic for Axiron) testosterone (generic for Fortesta) testosterone (generics for Testim)	▪ Non-preferred agents will be approved for patients who have failed ONE preferred agent within this drug class within the last 6 months Drug-specific criteria: ▪ **Androderm®/Androgel®:** Approved for Males only ▪ **Natesto®:** Approved for Males only with diagnosis of: Primary hypogonadism (congenital or acquired) OR Hypogonadotropic hypogonadism (congenital or acquired)

ANGIOTENSIN MODULATORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ACE INHIBITORS		▪ Non-preferred agents will be approved for patients who have failed TWO preferred agents within this drug class within the last 12 months ▪ Non-preferred combination products may be covered as individual prescriptions without prior authorization Drug-specific criteria: ▪ **Epaned® and Qbrelis® Oral Solution:** Clinical reason why oral tablet is not appropriate
benazepril (generic for Lotensin)	captopril (generic for Capoten)	
enalapril (generic for Vasotec)	EPANED (enalapril) **ORAL SOLUTION**	
lisinopril (generic for Prinivil/Zestril)	fosinopril (generic for Monopril)	
quinapril (generic for Accupril)	moexepril (generic for Univasc)	
ramipril (generic for Altace)	perindopril (generic for Aceon)	
	QBRELIS (lisinopril) **ORAL SOLUTION**	
	trandolapril (generic for Mavik)	
ACE INHIBITOR/DIURETIC COMBINATIONS		
benazepril/HCTZ (generic for Lotensin HCT)	captopril/HCTZ (generic for Capozide)	
enalapril/HCTZ (generic for Vaseretic)	fosinopril/HCTZ (generic for Monopril HCT)	
lisinopril/HCTZ (generic Prinzide/Zestoretic)	moexepril/HCTZ (generic for Uniretic)	
	quinapril/HCTZ (generic for Accuretic)	
ANGIOTENSIN RECEPTOR BLOCKERS		
irbesartan (generic for Avapro)	candesartan (generic for Atacand)	
losartan (generic for Cozaar)	EDARBI (azilsartan medoxomil)	
valsartan (generic for Diovan)	eprosartan (generic for Teveten)	
	olmesartan (generic for Benicar)	
	telmisartan (generic for Micardis)	

ANGIOTENSIN MODULATORS (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ANGIOTENSIN RECEPTOR BLOCKER/DIURETIC COMBINATIONS		▪ Non-preferred agents will be approved for patients who have failed TWO preferred agents within this drug class within the last 12 months ▪ Non-preferred combination products may be covered as individual prescriptions without prior authorization
irbesartan/HCTZ (generic for Avalide) losartan/HCTZ (generic for Hyzaar) valsartan-HCTZ (generic for Diovan-HCT)	candesartan/HCTZ (generic for Atacand-HCT) EDARBYCLOR (azilsartan/ chlorthalidone) olmesartan/HCTZ (generic for Benicar-HCT)	
ANGIOTENSIN MODULATOR/ CALCIUM CHANNEL BLOCKER COMBINATIONS		▪ **Angiotensin Modulator/Calcium Channel Blocker Combinations**: Combination agents may be approved if there has been a trial and failure of preferred agent
amlodipine/benazepril (generic for Lotrel) *amlodipine/valsartan (generic for Exforge)* *amlodipine/valsartan/HCTZ (generic for Exforge HCT)*	amlodipine/olmesartan (generic for Azor) amlodipine/olmesartan/HCTZ (generic for Tribenzor) amlodipine/telmisartan (generic for Twynsta) PRESTALIA (perindopril/amlodipine) trandolapril/verapamil (generic for Tarka)	
DIRECT RENIN INHIBITORS		▪ **Direct Renin Inhibitors/Direct Renin Inhibitor Combinations:** May be approved witha history of TWO preferred ACE Inhibitors or Angiotensin Receptor Blockers within the last 12 months
	aliskiren (generic for Tekturna)QL	
DIRECT RENIN INHIBITOR COMBINATIONS		
	TEKTURNA/HCT (aliskiren/HCTZ)	
NEPRILYSIN INHIBITOR COMBINATION		
ENTRESTO (sacubitril/valsartan)~~CL~~		
ANGIOTENSIN RECEPTOR BLOCKER/BETA-BLOCKER COMBINATIONS		
	BYVALSON (nevibolol/valsartan)	

ANTIBIOTICS, GASTROINTESTINAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
FIRVANQ (vancomycin) ***SOLUTION***^{NR} metronidazole **TABLET** neomycin vancomycin **COMPOUNDED ORAL SOLUTION**	ALINIA (nitazoxanide) **SUSPENSION** DIFICID (fidaxomicin) *FIRVANQ (vancomycin)* ***SOLUTION***^{NR} FLAGYL ER (metronidazole) metronidazole **CAPSULE** paromomycin SOLOSEC (secnidazole) tinidazole (generic for Tindamax) vancomycin **CAPSULE** (generic for Vancocin) XIFAXAN (rifaximin)	▪ Note: Although azithromycin, ciprofloxacin, and trimethoprim/ sulfmethoxazole are not included in this review, they are available without prior authorization Drug-specific criteria: ▪ **Alinia®:** Trial and failure with metronidazole is required for a diagnosis of giardiasis ▪ **Dificid®:** Trial and failure with oral vancomycin is required for a diagnosis of C. difficile diarrhea (pseudomembranous colitis) ▪ ~~**Firvanq:** Requires patient specific documentation of why the compounded product is not appropriate for patient~~ ▪ **Flagyl ER®:** Trial and failure with metronidazole is required ▪ **Flagyl®/Metronidazole 375mg capsules and Flagyl ER®/ Metronidazole 750mg ER tabs:** Clinical reason why the generic regular-release cannot be used ▪ **tinidazole:** Trial and failure/ contraindication to metronidazole required Approvable diagnoses include: Giardia Amebiasis intestinal or liver abscess Bacterial vaginosis or trichomoniasis ▪ **vancomycin capsules:** Trial and failure with metronidazole Trial may be bypassed if initial or recurrent episode of SEVERE C. difficile colitis SEVERE C. difficile colitis: Leukocytosis w/WBC ≥ 15,000 cells/microliter, OR Serum creatinine ≥ 1.5 times premorbid level Provider to provide labs for documentation ▪ **Xifaxan®:** Approvable diagnoses include: Travelers diarrhea resistant to quinolones Hepatic encephalopathy with treatment failure of lactulose or neomcin Diarrhea-Predominant IBS (IBS-D) 550mg strength only with treatment failure of Lomotil® AND Imodium®

ANTIBIOTICS, INHALED

Preferred Agents	ANon-Preferred Agents	Prior Authorization/Class Criteria
BETHKIS (tobramycin)[CL] KITABIS PAK (tobramycin)[CL] TOBI-PODHALER (tobramycin)[CL,QL]	*ARIKAYCE (amikacin liposomal inh susp)[NR]* CAYSTON (aztreonam lysine)[QL,CL] tobramycin (generic for Tobi)	▪ Diagnosis of Cystic Fibrosis is required for all agents ICD10 Group = E84, ICD9 = 277.00, 277.01, 277.02, 277.03, 277.09 Drug-specific criteria: ▪ **Arikayce:** Requires diagnosis of refractory MAC lung disease defined as patients who did not achieve negative sputum cultures after a minimum of 6 consecutive months of a multidrug background regimen therapy ▪ **Cayston®:** Trial of tobramycin via nebulizer and demonstration of TOBI® compliance required ▪ **Tobi Podhaler®:** Requires trial of tobramycin via nebulizer or documentation why nebulized tobramycin cannot be used

ANTIBIOTICS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
bacitracin **OINTMENT** bacitracin/polymyxin (generic for Polysporin) mupirocin **OINTMENT** (generic for Bactroban) neomycin/polymyxin/bacitracin (generic for Neosporin, Triple AB) neomycin/polymyxin/pramoxine neomycin/polymyxin/bacitracin/pramoxine	CENTANY (mupirocin) gentamicin **OINTMENT, CREAM** mupirocin **CREAM** (generic for Bactroban)	▪ Non-preferred agents will be approved for patients who have failed ALL preferred agents within this drug class within the last 12 months Drug-specific criteria: ▪ **Altabax®:** Approvable diagnoses of impetigo due to *S. Aureus* OR *S. pyogenes* with clinical reason mupirocin ointment cannot be used ▪ **Mupirocin® Cream:** Clinical reason the ointment cannot be used

ANTIBIOTICS, VAGINAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CLEOCIN **OVULES** (clindamycin) clindamycin **CREAM** (generic for Cleocin) CLINDESSE (clindamycin, vaginal) metronidazole, vaginal *NUVESSA (metronidazole, vaginal)* *VANDAZOLE (metronidazole, vaginal)*	CLEOCIN **CREAM** (clindamycin) METROGEL (metronidazole, vaginal)	▪ Non-preferred agents will be approved for patients who have failed a therapeutic trial (duration = 3 days) with ONE preferred agent within this drug class within the last 6 months

ANTICOAGULANTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ELIQUIS (apixaban) enoxaparin (generic for Lovenox) PRADAXA (dabigatran) warfarin (generic for Coumadin) XARELTO (rivaroxaban)[CL,QL]	fondaparinux (generic for Arixtra) FRAGMIN (dalteparin) SAVAYSA (edoxaban)[QL]	▪ Non-preferred agents will be approved for patients who have failed ONE preferred agent within this drug class within the last 12 months Drug-specific criteria: ▪ **Coumadin®:** Clinical reason generic warfarin cannot be used ▪ **Savaysa®:** Approved diagnoses include: Stroke and systemic embolism (SE) risk reduction in nonvalvular atrial fibrillation (NVAF) OR Treatment of deep vein thrombosis (DVT) and pulmonary embolism (PE) following 5-10 days of parenteral anticoagulent therapy ▪ ***Xarelto 2.5mg:*** *Use limited to reduce risk of major cardiovascular death, myocardial infarction, and stroke in patients with chronic coronary artery disease or peripheral artery disease*

ANTIEMETICS/ANTIVERTIGO AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CANNABINOIDS		▪ Non-preferred agents will be approved for patients who have failed ONE preferred agent within this drug class within the same group ▪ SYNDROS – documentation of inability to swallow solid dosage forms. Drug-specific criteria: ▪ **Akynzeo®/Emend®/Varubi®:** Approved for Moderately/Highly emetogenic chemotherapy with dexamethasone and a 5-HT3 antagonist WITHOUT trial of preferred agents Regimens include: AC combination (Doxorubicin or Epirubicin with Cyclophosphamide), Aldesleukin, Amifostine, Arsenic trioxide, Azacitidine, Bendamustine, Busulfan, Carmustine, Carbplatin, Cisplatin, Clofarabine, Cyclophosphamide, Cytarabine, Dacarbazine, Dactinomycin, Daunorubicin, Epirubicin, Etoposide, Hexamethylmelamine, Idarubicin, Ifosfamide, Imatinib, Interferon α, Irinotecan, Mechlorethamine, Melphalan, Methotrexate, Oxaliplatin, Procarbazine, Streptozotocin, Temozolomide ▪ **Diclegis®/Bonjesta:** Approved only for treatment of nausea and vomiting of pregnancy ▪ **Metozolv ODT®:** Documentation of inability to swallow or Clinical reason oral liquid cannot be used ▪ **Sancuso®/Zuplenz®:** Documentation of oral dosage form intolerance
dronabinol (generic for Marinol)[AL]	CESAMET (nabilone) SYNDROS (dronabinol)[AL, CL]	
5HT3 RECEPTOR BLOCKERS		
ondansetron (generic for Zofran)[QL] ondansetron ODT (generic for Zofran)[QL]	ANZEMET (dolasetron) granisetron (generic for Kytril) SANCUSO (granisetron)[CL] ZUPLENZ (ondansetron)	
NK-1 RECEPTOR ANTAGONIST		
	aprepitant (generic for Emend) [QL,CL] AKYNZEO (netupitant/palonosetron)[CL] VARUBI (rolapitant) **TABLET**[CL]	
TRADITIONAL ANTIEMETICS		
DICLEGIS (doxylamine/pyridoxine)[CL,QL] dimenhydrinate (generic for Dramamine) ~~hydroxyzine (generic for Vistaril)~~ meclizine (generic for Antivert) metoclopramide (generic for Reglan) phosphoric acid/dextrose/fructose **SOLUTION** (generic for Emetrol) prochlorperazine, oral (generic for Compazine) promethazine, oral (generic for Phenergan) promethazine **SUPPOSITORIES** 12.5mg, 25mg TRANSDERM-SCOP (scopolamine)	BONJESTA (doxylamine/pyridoxine)[CL,QL] COMPRO (prochlorperazine rectal) metoclopramide ODT(generic for Metozolv ODT) prochlorperazine **SUPPOSITORIES** (generic for Compazine) promethazine **SUPPOSITORIES** 50mg scopolamine transdermal trimethobenzamide, oral (generic for Tigan)	

ANTIFUNGALS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
clotrimazole (mucous membrane, troche) fluconazole **SUSPENSION, TABLET** (generic for Diflucan) griseofulvin **SUSPENSION** griseofulvin microsized **TABLET** nystatin **SUSPENSION, TABLET** terbinafine (generic for Lamisil)	CRESEMBA (isavuconazonium)[CL] flucytosine (generic for Ancobon)[CL] griseofulvin ultramicrosize (generic for GRIS-PEG) itraconazole (generic for Sporanox)[CL] ketoconazole (generic for Nizoral) NOXAFIL (posaconazole)[CL,AL] nystatin **POWDER,** oral ONMEL (itraconazole) ORAVIG (miconazole) *TOLSURA (itraconazole)[NR,CL]* voriconazole (generic for VFEND)[CL]	▪ Non-preferred agents will be approved for patients who have failed a trial of TWO diagnosis-appropriate preferred agents within this drug class Drug-specific criteria: ▪ **Cresemba®:** Approved for diagnosis of invasive aspergillosis or invasive mucomycosis ▪ **Flucytosine:** Approved for diagnosis of: Candida: Septicemia, endocarditis, UTIs Cryptococcus: Meningitis, pulmonary infections ▪ **Noxafil®:** No trial for diagnosis of Neutropenia Myelodysplastic Syndrome (MDS), Neutropenic Acute Myeloid Leukemia (AML), Neutropenic hematologic malignancies, Graft vs. Host disease(GVHD), Immunosuppression secondary to hematopoietic stem cell transplant ▪ **Noxafil® Suspension:** Oropharyngeal/esophageal candidiasis refractory to itraconazole and/or fluconazole ▪ **Onmel®:** Requires trial and failure or contraindication to terbinafine ▪ **Sporanox®/Itraconazole:** Approved for diagnosis of Aspergillosis, Blastomycosis, Histoplasmosis, Onychomycosis due to terbinafine-resistant dermatophytes, Oropharyngeal/ esophageal candidiasis refractory to fluconazole ▪ **Sporanox®:** Requires trial and failure of generic itraconazole ▪ **Sporanox® Liquid:** Clinical reason solid oral cannot be used ▪ **Tolsura:** Approved for diagnosis of Aspergillosis, Blastomycosis, and Histoplasmosis ▪ **Vfend®:** No trial for diagnosis of Myelodysplastic Syndrome (MDS), Neutropenic Acute Myeloid Leukemia (AML), Graft vs. Host disease (GVHD), Candidemia (candida krusei), Esophageal Candidiasis, Blastomycosis, *S. apiospermum* and *Fusarium spp.*, Oropharyngeal/esophageal candidiasis refractory to fluconazole

ANTIFUNGALS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ANTIFUNGAL		▪ Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class within the last 6 months Drug-specific criteria: ▪ **Extina:** Requires trial and failure or contraindication to other ketoconazole forms ▪ **Jublia:** Approved diagnoses includ Onychomycosis of the toenails due to *T.rubrum OR T. Mentagrophytes* ▪ **nystatin/triamcinolone:** Indivudual ingredients available without prior authorization ▪ **ciclopirox nail lacquer:** No trial required in diabetes, peripheral vascular disease (PVD), immunocompromised OR contraindication to oral terbinafine
clotrimazole **CREAM** (generic for Lotrimin) RX, OTC	ALEVAZOL (clotrimazole) OTC	
clotrimazole **SOLN** OTC	ciclopirox **CREAM, GEL, SUSPENSION** (generic for Ciclodan, Loprox)	
ketoconazole **CREAM, SHAMPOO** (generic for Nizoral)	ciclopirox **NAIL LACQUER** (generic for Penlac)	
LAMISIL (tervinafine) **SPRAY** OTC	ciclopirox **SHAMPOO** (generic for Loprox)	
LAMISIL AT **CREAM** (terbinafine) OTC	clotrimazole **SOLUTION** RX (generic for Lotrimin)	
miconazole **CREAM, POWDER** OTC	DESENEX AERO **POWDER** OTC (miconazole)	
nystatin	econazole (generic for Spectazole)	
terbinafine OTC (generic for Lamisil AT)	ERTACZO (sertaconazole)	
tolnaftate AERO POWDER, CREAM, POWDER,OTC (generic for Tinactin)	EXELDERM (sulconazole)	
	FUNGOID OTC	
	JUBLIA (efinaconazole)	
	KERIDYN (tavaborole)	
	ketoconazole **FOAM** (generic for Extina, Ketodan)	
	LAMISIL AT **GEL, SPRAY** (terbinafine) OTC	
	LOPROX (ciclopirox) **SUSPENSION, SHAMPOO, CREAM**	
	LOTRIMIN AF **CREAM** OTC (clotrimazole)	
	LOTRIMIN ULTRA (bufenafine)	
	luliconazole (generic for Luzu)	
	MENTAX (butenafine)	
	miconazole OTC **OINTMENT, SPRAY**	
	miconazole/zinc oxide/petrolatum (generic for Vusion)	
	naftifine (generic for Naftin)	
	oxiconazole (generic for Oxistat)	
	salicylic acid (generic Bensal HP)	
	tolnaftate **SPRAY,** OTC	
ANTIFUNGAL/STEROID COMBINATIONS		
clotrimazole/betamethasone **CREAM** (generic for Lotrisone)	clotrimazole/betamethasone **LOTION** (generic for Lotrisone)	
	nystatin/triamcinolone (generic for Mycolog)	

ANTIMIGRAINE AGENTS, OTHER

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
EMGALITY (galcanezumab-gnlm)[NR,CL] ***PEN, SYR***	*AIMOVIG AUTOINJECTOR (erenumab-aooe)*[NR, QL,CL] *AJOVY (fremanezumab-vfrm)*[NR, QL, CL] CAFERGOT (ergotamine/caffeine) CAMBIA (diclofenac potassium) dihydroergotamine mesylate **NASAL** ERGOMAR **SUBLINGUAL** (ergotamine tartrate) MIGERGOT (ergotamine/caffeine) **RECTAL** MIGRANAL (dihydroergotamine) **NASAL**	▪ Non-preferred agents will be approved for patients who have a contraindication OR trial failure of a triptan Drug-specific criteria: ▪ Cambia®: Requires diagnosis of migraine and documentation of why solid dosing forms not appropriate ▪ *Aimovig, Ajovy, and Emgality: Require ≥ 4 migraines per month for ≥ 3 months and has tried and failed a ≥ 1 month trial of two medications listed in the 2012 American Academy of Neurology/American Headache Society guidelines (examples include: antidepressants (amitriptyline, venlafaxine), Beta blockers (propranolol, metroprolol, timolol, atenolol), anti-epileptics (valproate, topiramate), ACE/ARB (lisinopril, candesartan)* ▪ *In addition, Aimovig and Ajovy require a trial of Emgality or patient specific documentation of why Emgality is not appropriate for patient*

ANTIMIGRAINE AGENTS, TRIPTANS[QL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ORAL		▪ Non-preferred agents will be approved for patients who have failed ALL preferred agents within this drug class Drug-specific criteria: ▪ **Sumavel® Dosepro:** Requires clinical reason sumatriptan injection cannot be used ▪ **Onzetra, Zembrace:** approved for patients who have failed ALL preferred agents
RELPAX (eletriptan)[QL] rizatriptan (generic for Maxalt) rizatriptan ODT (generic for Maxalt MLT) sumatriptan	almotriptan (generic for Axert) eletriptan (generic Relpax) frovatriptan (generic for Frova) IMITREX (sumatriptan) naratriptan (generic for Amerge) sumatriptan/naproxen (generic for Treximet) zolmitriptan (generic for Zomig/Zomig ZMT)	
NASAL		
sumatriptan	IMITREX (sumatriptan) ONZETRA XSAIL (sumatriptan) ZOMIG (zolmitriptan)	
INJECTABLE		
sumatriptan **KIT, SYRINGE, VIAL** sumatriptan **KIT (mfr SUN)**	IMITREX (sumatriptan) **INJECTION** SUMAVEL DOSEPRO (sumatriptan) ZEMBRACE SYMTOUCH (sumatriptan)	

ANTIPARASITICS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
NATROBA (spinosad) permethrin 1% OTC (generic for Nix) permethrin 5% RX (generic for Elimite) pyrethrin/piperonyl butoxide (generic for RID, A-200) SKLICE (ivermectin)	*CROTAN (crotamiton) LOTION[NR]* EURAX (crotamiton) **CREAM, LOTION** lindane malathion (generic for Ovide) spinosad (generic for Natroba) *VANALICE (piperonyl butoxide/pyrethrins)[NR]*	▪ Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class

ANTIVIRALS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ANTI-HERPETIC DRUGS		▪ Non-preferred agents will be approved for patients who have failed a 10-day trial of ONE preferred agent within the same group Drug-specific criteria: ▪ **Sitavig®:** Approved for recurrent herpes labialis (cold sores) in immunocompetent adults ▪ **Xofluza:** Requires clinical, patient specific reason that a preferred agent cannot be used
acyclovir (generic for Zovirax) famciclovir (generic for Famvir) valacyclovir (generic for Valtrex)	SITAVIG (acyclovir buccal)	
ANTI-INFLUENZA DRUGS		
oseltamivir (generic for Tamiflu)[QL] TAMIFLU (oseltamivir) [QL]	rimantadine (generic for Flumadine) *RELENZA (zanamivir)*[QL] *XOFLUZA (baloxavir marboxil)*[NR,QL,AL]	

ANTIVIRALS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	acyclovir CREAM, **OINTMENT** (generic for Zovirax) DENAVIR (penciclovir) XERESE (acyclovir/hydrocortisone)	▪ Non-preferred agents will be approved for patients who have failed a trial with ONE preferred ORAL Antiviral agent

BETA BLOCKERS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BETA BLOCKERS		▪ Non-preferred agents will be approved for patients who have failed TWO diagnosis-appropriate preferred agents within this drug class Drug-specific criteria: ▪ **Bystolic®:** Only ONE trial is required with Diagnosis of Obstructive Lung Disease ▪ **Coreg CR®:** Requires clinical reason generic IR product cannot be used ▪ **Hemangeol®:** Covered for diagnosis of Proliferating Infantile Hemangioma ▪ **Sotylize®:** Covered for diagnosis of life –threatening ventricular arrhythmias OR maintenance of normal sinus rhythm in highly symptomatic atrial fibrillation/flutter (AFIB/AFL) Requires clinical reason generic sotalol cannot be used
atenolol (generic for Tenormin)	acebutolol (generic for Sectral)	
atenolol/chlorthalidone(generic for Tenoretic)	betaxolol (generic for Kerlone)	
bisoprolol (generic for Zebeta)	BYSTOLIC (nebivolol)	
bisoprolol/HCTZ (generic for Ziac)	HEMANGEOL (propranolol) oral solution	
metoprolol (generic for Lopressor)	INDERAL XL (propranolol)	
metoprolol XL (generic for Toprol XL)	INNOPRAN XL (propranolol)	
propranolol (generic for Inderal)	*KAPSPARGO SPRINKLE (metoprolol ER)NR*	
propranolol extended release (generic for Inderal LA)	LEVATOL (penbutolol)	
	metoprolol/HCTZ (generic for Lopressor HCT)	
	nadolol (generic for Corgard)	
	nadolol/bendroflumethiazide (generic for Corzide)	
	pindolol (generic for Viskin)	
	propranolol/hydrochlorothiazide (generic for Inderide)	
	timolol (generic for Blocadren)	
	TOPROL XL (metoprolol)	
BETA- AND ALPHA-BLOCKERS		
carvedilol (generic for Coreg)	carvedilol ER (generic for Coreg CR)	
labetalol (generic for Trandate)		
ANTIARRHYTHMIC		
sotalol (generic for Betapace)	SOTYLIZE (sotalol)	

BLADDER RELAXANT PREPARATIONS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
oxybutynin & ER (generic for Ditropan/XL)	darifenacin ER (generic for Enablex)	▪ Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class Drug-specific criteria: ▪ **Myrbetriq®:** Covered without trial in contraindication to anticholinergic agents
TOVIAZ (fesoterodine ER)	GELNIQUE (oxybutynin)	
VESICARE (solifenacin)	flavoxate	
	MYRBETRIQ (mirabegron)	
	OXYTROL (oxybutynin)	
	tolterodine & ER (generic for Detrol/LA)	
	trospium & ER (generic for Sanctura/XR)	

BONE RESORPTION SUPRESSION AND RELATED DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BISPHOSPHONATES		▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within the same group
alendronate (generic for Fosamax) (daily and weekly formulations)	alendronate **SOLUTION** (generic for Fosamax)QL ATELVIA DR (risedronate) BINOSTO (alendronate) etidronate disodium (generic for Didronel) FOSAMAX PLUS DQL ibandronate (generic for Boniva)QL risedronate (generic for Actonel)QL	Drug-specific criteria: ▪ **Actonel® Combinations:** Covered as individual agents without prior authorization ▪ **Atelvia DR®:** Requires clinical reason alendronate cannot be taken on an empty stomach ▪ **Binosto®:** Requires clinical reason why alendronate tablets OR Fosamax® solution cannot be used ▪ **Etidronate disodium:** Trial not required for diagnosis of hetertrophic ossification ▪ **Forteo®:** Covered for high risk of fracture High risk of fracture: BMD -3 or worse Postmenopausal women with history of non-traumatic fractures Postmenopausal women with 2 or more clinical risk factors – Family history of non-traumatic fractures, DXA BMD T-score ≤ -2.5 at any site, Glucocorticoid use ≥ 6 months at 7.5 dose of prednisolone equivalent, Rheumatoid Arthritis Postmenopausal women with BMD T-score ≤ -2.5 at any site with any clinical risk factors – more than 2 units of alcohol per day, current smoker Men with primary or hypogonadal osteoporosis Osteoporosis associated with sustained systemic glucocorticoid therapy Trial of Miacalcin not required
OTHER BONE RESORPTION SUPPRESSION AND RELATED DRUGS		
calcitonin-salmon **NASAL** raloxifene (generic for Evista)	EVISTA (raloxifene) FORTEO (teriparatide)QL TYMLOS (abaloparatide)	

BPH (BENIGN PROSTATIC HYPERPLASIA TREATMENTS)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ALPHA BLOCKERS		▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: ▪ **Avodart®:** Covered for males only ▪ **Cardura XL®:** Requires clinical reason generic IR form cannot be used ▪ **Flomax®:** Females covered for a 7 day supply with diagnosis of acute kidney stones ▪ **Jalyn®:** Requires clinical reason why individual agents cannot be used ▪ **Proscar®:** Covered for males only ▪ **Uroxatral®:** Covered for males only
alfuzosin (generic for Uroxatral) doxazosin (generic for Cardura) tamsulosin (generic for Flomax) terazosin (generic for Hytrin)	CARDURA XL (doxazosin) silodosin (generic for Rapaflo)	
5-ALPHA-REDUCTASE (5AR) INHIBITORS		
dutasteride (generic for Avodart) finasteride (generic for Proscar)	dutasteride/tamsulosin (generic for Jalyn)	

CALCIUM CHANNEL BLOCKERS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
SHORT-ACTING		▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: ▪ **Nifedipine:** May be approved without trial for diagnosis of Preterm Labor or Pregnancy Induced Hypertension (PIH) ▪ **Nimodipine:** Covered without trial for diagnosis of subarachnoid hemorrhage
Dihydropyridines		
	isradipine (generic for Dynacirc) nicardipine (generic for Cardene) nifedipine (generic for Procardia) nimodipine (generic for Nimotop) NYMALIZE (nimodipine solution)	
Non-dihydropyridines		
diltiazem (generic for Cardizem) verapamil (generic for Calan, Isoptin)		
LONG-ACTING		
Dihydropyridines		
amlodipine (generic for Norvasc) nifedipine ER (generic for Procardia XL/Adalat CC)	felodipine ER (generic for Plendil) nisoldipine (generic for Sular)	
Non-dihydropyridines		
diltiazem ER (generic for Cardizem CD) verapamil ER **TABLET**	CALAN SR (verapamil) diltiazem LA (generic for Cardizem LA) MATZIM LA (diltiazem) TIAZAC (diltiazem) verapamil ER **CAPSULE** verapamil 360mg **CAPSULE** verapamil ER PM (generic for Verelan PM)	

CEPHALOSPORINS AND RELATED ANTIBIOTICS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BETA LACTAM/BETA-LACTAMASE INHIBITOR COMBINATIONS		▪ Non-preferred agents will be approved for patients who have failed a 3-day trial of ONE preferred agent within the same group ~~Drug-specific criteria:~~ ▪ ~~**Suprax® Tablet / Suspension:** Requires clinical reason why capsule or generic suspension cannot be used~~
amoxicillin/clavulanate **TABLETS, SUSPENSION**	amoxicillin/clavulanate, CHEWABLE amoxicillin/clavulanate XR (generic for Augmentin XR) AUGMENTIN **SUSPENSION**, **TABLET** (amoxicillin/clavulanate)	
CEPHALOSPORINS – First Generation		
cefadroxil **CAPSULE, SUSPENSION** (generic for Duricef) cephalexin **CAPSULE, SUSPENSION** (generic for Keflex)	cefadroxil **TABLET** (generic for Duricef) cephalexin **TABLET** **DAXBIA (cephalexin)**	
CEPHALOSPORINS – Second Generation		
cefprozil (generic for Cefzil) cefuroxime **TABLET** (generic for Ceftin)	cefaclor (generic for Ceclor) CEFTIN (cefuroxime) **TABLET, SUSPENSION**	
CEPHALOSPORINS – Third Generation		
cefdinir (generic for Omnicef)	cefixime **SUSPENSION** (generic for Suprax) cefpodoxime (generic for Vantin) *SUPRAX* ***CAPSULE, CHEWABLE TAB,*** **SUSPENSION, TABLET** (cefixime)	

CONTRACEPTIVES, ORAL

All reviewed agents are recommended preferred at this time

Only those products for review are listed.

Brand name products may be subject to Maximum Allowable Cost (MAC) pricing or require substitution with a generic equivalent

Specific agents can be looked up using the Drug Look-up Tool at:

https://druglookup.fhsc.com/druglookupweb/?client=nestate

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
econtra OTC (levonorgestrel) *new day OTC (levonorgestrel)* *aubra eq (levonorgestrel-ethinyl estradiol)* *BALCOLTRA (levonorgest/eth.estridial-iron)* *chateal eq (levonorgestrel-ethinyl estradiol)* *hailey 25 fe (norethindrone-e estradiol-iron)* *incassia (norethindrone)* *kelnor 1-50 (ethynodiol d ethinyl estradiol)* *mili (norgestimate-ethinyl estradiol)* *tarina (norethindrone-e estradiol-iron)* *tri-mili (norgestimate-ethinyl estradiol)* *tri-vylibra (norgestimate-ethinyl estradiol)* *tri-vylibra lo (norgestimate-ethinyl estradiol)* *tulana (norethindrone)* *tydemy (drospir/eth estra/levomefol ca)* *vylibra (norgestimate-ethinyl estradiol)*		

CYSTIC FIBROSIS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	KALYDECO **PACKET, TABLET** (ivacaftor)[QL, AL] ORKAMBI (lumacaftor/ivacaftor) PACKET, TABLET[QL, AL] SYMDEKO (tezacaftor/ivacaftor)[QL, AL]	Drug-specific criteria: ▪ **Kalydeco®:** Diagnosis of CF and documentation of the drug-specific, FDA-approved mutation of CFTR gene • Minimum age: 2 years ▪ **Orkambi®:** Diagnosis of CF and documentation of presence of two copies of the F580del mutation (homozygous) of CFTR gene • Minimum age: 6 years for tablet • Minimum age: 2 years for packet ▪ **Symdeko:** Diagnosis of CF and documentation of the drug specific, FDA approved mutation of CFTR gene**.** • Minimum age: 12 years

DIURETICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
SINGLE-AGENT PRODUCTS		▪ Non-preferred agents will be approved for patients who have failed a trial of **TWO** preferred agents within this drug class
amiloride **TABLET** bumetanide **TABLET** chlorothiazide **TABLET** chlorthalidone **TABLET** (generic for Diuril) furosemide **SOLUTION, TABLET** (generic for Lasix) hydrochlorothiazide **CAPSULE, TABLET** (generic for Microzide) indapamide **TABLET** metolazone **TABLET** spironolactone **TABLET** (generic for Aldactone) torsemide **TABLET**	CAROSPIR (spironolactone) **SUSPENSION** eplerenone **TABLET** (generic for Inspra) ethacrynic acid **CAPSULE** (generic for Edecrin)) methyclothiazide **TABLET**	
COMBINATION PRODUCTS		
amiloride/HCTZ **TABLET** spironolactone/HCTZ **TABLET** (generic for Aldactazide) triamterene/HCTZ **CAPSULE, TABLET** (generic for Dyazide, Maxzide (25))		

FLUOROQUINOLONES, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ciprofloxacin (generic for Cipro) levofloxacin **TABLET** (generic for Levaquin)	BAXDELA (delafloxacin) ciprofloxacin ER ciprofloxacin **SUSPENSION** (generic for Cipro) levofloxacin **SOLUTION** moxifloxacin (generic for Avelox) ofloxacin	▪ Non-preferred agents will be approved for patients who have failed a 3-day trial of ONE preferred agent within this drug class Drug-specific criteria: ▪ **Baxdela:** Coverable with documented intolerance or failure of preferred MRSA agents (clindamycin, doxycycline, linezolid, sulfamethoxazole/trimethoprim) ▪ **Ciprofloxacin Suspension:** Coverable with documented swallowing disorders ▪ **Levofloxacin Suspension:** Coverable with documented swallowing disorders ▪ **Ofloxacin:** Trial of preferred not required for diagnoses of Pelvic Inflammatory Disease OR Acute Epididymitis (non-gonorrhea)

GI MOTILITY, CHRONIC

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
AMITIZA (lubiprostone)[QL] LINZESS (linaclotide)[QL] MOVANTIK (naloxegol oxalate)[QL]	alosetron (generic for Lotronex) *MOTEGRITY (prucalopride succinate)*[NR] RELISTOR (methylnaltrexone) **TABLET**[QL] SYMPROIC (naldemedine) TRULANCE (plecanatide)[QL] VIBERZI (eluxodoline)	▪ Non-preferred agents will be approved for patients who have failed a 30-day trial of ONE preferred agent within this drug class Drug-specific criteria: ▪ **Lotronex®:** Covered for diagnosis of IBS Diarrhea Predominant type with trial and failure of loperamide AND diphenoxylate ▪ **Relistor®**: Covered for diagnosis of opioid-induced constipation in adults with chronic, non-cancer pain after trial of at least TWO OTC laxatives (senna, bisacodyl, etc.) and failure of Movantik ▪ **Symproic**: Covered for diagnosis of opioid-induced constipation in adult patients with chronic non-cancer pain after trial on at least TWO OTC laxatives and failure of Movantik ▪ **Trulance®:** Covered for diagnosis of either chronic idiopathic constipation or IBS with constipation after trial of at least TWO OTC laxatives (senna, bisacodyl, etc.) ▪ **Viberzi®:** Covered for diagnosis of IBS Diarrhea Predominant type with trial and failure of loperamide AND diphenoxylate

GROWTH HORMONE

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
GENOTROPIN (somatropin) NORDITROPIN (somatropin) NUTROPIN AQ (somatropin)	HUMATROPE (somatropin) OMNITROPE (somatropin) SAIZEN (somatropin) SEROSTIM (somatropin) ZOMACTON (somatropin) ZORBTIVE (somatropin)	Growth Hormone PA Form Growth Hormone Criteria

H. PYLORI TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
PYLERA (bismuth, metronidazole, tetracycline)QL	lansoprazole/amoxicillin/clarithromycin (generic for Prevpac)QL OMECLAMOX-PAK (omeprazole, clarithromycin, amoxicillin)QL	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

HEPATITIS B TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
entecavir **TABLET** lamivudine hbv **TABLET**	adefovir dipivoxil BARACLUDE (entecavir) **SOLUTION, TABLET** EPIVIR HBV (lamivudine) **TABLET, SOLUTION** HEPSERA (adefovir dipivoxil) VEMLIDY (tenofovir alafenamide fumarate)	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

HEPATITIS C TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
DIRECT ACTING ANTI-VIRAL		Hepatitis C Treatments PA Form Hepatitis C Criteria ▪ Non-preferred products require trial of preferred agents within the same group and will only be considered with documentation of why the preferred product within this drug class is not appropriate for patient ▪ Patients undergoing treatment at the time of preferred status change (January 2018) will be allowed to complete treatment with same drug as started on ▪ Patients newly eligible for Medicaid will be allowed to complete treatment with the original that treatment was initially authorized by another payor
MAVYRET (glecaprevir/pibrentasvir)CL VOSEVI (sofosbuvir/velpatasvir/ voxilaprev)CL	DAKLINZA (daclatasvir) CL OLYSIO (simeprevir)CL sofosbuvir/ledipasvir (generic for Harvoni)CL sofosbuvir/velpatasvir (generic for Epclusa)CL SOVALDI (sofosbuvir)CL TECHNIVIE (ombitasvir/paritaprevir/ ritonavir) CL VIEKIRA PAK~~/XR~~ (ombitasvir/ paritaprevir/ritonavir/dasabuvir)CL ZEPATIER (elbasvir/grazoprevir)CL	
RIBAVIRIN		
ribavirin 200mg **TABLET, CAPSULE**	REBETOL (ribavirin)	
INTERFERON		
PEGASYS (pegylated interferon alfa-2a) CL PEG-INTRON (pegylated interferon alfa-2b) CL		Drug-specific criteria:Trial with Mavyret not required in the following: ▪ **Epclusa**: For genotype 1-6 with decompensated cirrhosis along with ribavirin ▪ **Harvoni**: ○ For genotype 1 with decompensated cirrhosis along with ribavirin ○ For use in children ages 12 to 17 ○ Post liver transplant for genotype 1 or 4 ▪ **Vosevi:** Requires documentation of non-response after previous treatment course of Direct Acting Anti-viral agent (DAA) for genotype 1-6 without cirrhosis or with compensated cirrhosis

HIV / AIDS[CL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CCR5 ANTAGONISTS		▪ Non-preferred agents will be approved for patients who have a diagnosis of HIV/AIDS and patient specific documentation of why the preferred products within this drug class are not appropriate for patient ▪ Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy ▪ Diagnosis of HIV/AIDS required ▪ Prophylaxis, both pre and post exposure covered
SELZENTRY **SOLN, TAB** (maraviroc)		
FUSION INHIBITORS		
FUZEON **SUB-Q** (enfuvirtide)[QL]		
INTEGRASE STRAND TRANSFER INHIBITORS (INSTIs)		
ISENTRESS **CHEW TAB, POWDER PACK, TAB** (raltegravir)[QL] ISENTRESS HD (raltegravir) TIVICAY (dolutegravir)		
NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NNRTIs)		
EDURANT (rilpivirine) INTELENCE (etravirine)[QL] *PIFELTRO (doravirine)[NR,QL]* SUSTIVA CAP, TAB (efavirenz)	efavirenz (generic for Sustiva) *nevirapine **TAB** (generic for Viramune)* *nevirapine er (generic for Viramune XR)* *RESCRIPTOR (delavirdine)* *VIRAMUNE **SUSP***, **TAB** (nevirapine) VIRAMUNE XR (nevirapine extended release)	
NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTIs)		
abacavir **SOLN, TAB** (generic for Ziagen) EMTRIVA **CAP, SOLN** (emtricitabine) lamivudine **SOLN, TAB** (generic for Epivir) zidovudine **CAP, SYRUP, TAB** (generic for Retrovir)	*didanosine **CAP** DR (generic for Videx EC)* EPIVIR (lamivudine) RETROVIR (zidovudine) *stavudine **CAP, ~~SOLN~~** (generic for Zerit)* *VIDEX **SOLN** (didanosine)* VIDEX EC (didanosine) ~~ZERIT **CAP, SOLN** (stavudine)~~ ZIAGEN (abacavir)	

HIV / AIDS[CL] (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTIs)		
*tenofovir disoproxil fumarate **TAB** (generic for Viread)*	*VIREAD (tenofovir disoproxil fumarate)*	
PHARMACOKINETIC ENHANCER		
TYBOST (cobicistat)[QL]		
PROTEASE INHIBITORS		
*atazanavir **CAP** (generic for Reyataz)* LEXIVA **SUSP, TAB** (fosamprenavir) NORVIR **TAB** (ritonavir) PREZISTA **SUSP, TAB** darunavir)	*APTIVUS **CAP, SOLN** (tipranavir)* *CRIXIVAN (indinavir)* fosamprenavir **TAB** (generic for Lexiva) *INVIRASE (saquinavir)* *NORVIR **POWDER PACK**[NR]* *NORVIR **SOLN** (ritonavir)* *REYATAZ **CAP, POWDER PACK** (atazanavir)* ritonavir **TAB** (generic for Norvir) *VIRACEPT (nelfinavir)*	
COMBINATION NUCLEOS(T)IDE REVERSE TRANSCRIPTASE INHIBITORS		
abacavir/lamivudine (generic for Epzicom) abacavir/lamivudine/zidovudine (generic for Trizivir) *CIMDUO (lamivudine/tenofovir disoproxil fumarate)[NR,QL]* DESCOVY (emtricitabine/tenofovir alafenamide)[QL] lamivudine/zidovudine (generic for Combivir) TRUVADA (emtricitabine/tenofovir disoproxil fumarate)	COMBIVIR (lamivudine/zidovudine) EPZICOM (abacavir sulfate/lamivudine) TRIZIVIR (abacavir/ lamivudine/zidovudine)	

HIV / AIDS[CL] (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
COMBINATION PROTEASE INHIBITORS (PIs) or PIs plus PHARMACOKINETIC ENHANCER		
EVOTAZ(atazanavir sulfate/cobicistat)[QL]	KALETRA **SOLN** (lopinavir/ritonavir)	
KALETRA **TAB** (lopinavir/ritonavir)		
PREZCOBIX (darunavir/cobicistat)[QL]		
lopinavir/ritonavir **SOLN** (generic for Kaletra)		
COMBINATION PRODUCTS – MULTIPLE CLASSES		
ATRIPLA (tenofovir disoproxil fumarate/ emtricitabine/efavirenz)	*BIKTARVY (bictegravir/emtricitabine/ tenofovir alafenamide)[QL]*	
COMPLERA (rilpivirine/emtricitabine/tenofovir disoproxil fumarate)	*DOVATO (dolutegravir/lamifudine)[NR,QL]*	
DELSTRIGO (doravirine/lamivudine/tenofovir disoproxil fumarate)[NR,QL]	*JULUCA (dolutegravir/rilpivirine)[QL]*	
GENVOYA (elvitegravier/cobicistat/emtricitabine/tenofovir alafenamide)[QL, AL]	*SYMTUZA (darunavir, cobicistat, emtricitabine, tenofovir alafenamide)[NR,QL]*	
ODEFSEY (emtricitabine/rilpivirine/tenofovir alafenamide)[QL]	*TRIUMEQ (dolutegravir/abacavir/lamivudine)*	
STRIBILD (elvitegravir/cobicistat/emtricitabine/tenofovir disoproxil fumarate)[QL]		
SYMFI (efavirenz/lamivudine/tenofovir disoproxil fumarate)[NR,QL]		
SYMFI LO (efavirenz/lamivudine/ tenofovir disoproxil fumarate)[NR,QL]		

HYPOGLYCEMICS, ALPHA-GLUCOSIDASE INHIBITORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
acarbose (generic for Precose) Glyset (miglitol)	miglitol (generic for Glyset)	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
GLUCAGON-LIKE PEPTIDE-1 RECEPTOR AGONIST (GLP-1 RA)[CL]		Preferred agents require metformin trial and diagnosis of diabetes Non-preferred agents will be approved for patients who have: ▪ Failed a trial of TWO preferred agents within GLP-1 RA AND ▪ Diagnosis of diabetes with HbA1C ≥ 7 AND ▪ Trial of metformin, or contraindication or intolerance to metformin
BYDUREON (exenatide ER) subcutaneous BYDUREON **PEN** (exenatide ER) subcutaneous BYETTA (exenatide) subcutaneous VICTOZA (liraglutide) subcutaneous	ADLYXIN (lixisenatide) BYDUREON BCISE **PEN** (exenatide)[QL] OZEMPIC (semaglutide) TANZEUM (albiglutide) TRULICITY (dulaglutide)	
INSULIN/GLP-1 RA COMBINATIONS		
	SOLIQUA (insulin glargine/lixisenatide) XULTOPHY (insulin degludec/liraglutide)	
AMYLIN ANALOG		ALL criteria must be met ▪ Concurrent use of short-acting mealtime insulin ▪ Current therapy compliance ▪ No diagnosis of gastroparesis ▪ HbA1C ≤ 9% within last 90 days ▪ Fingerstick monitoring of glucose during initiation of therapy
	SYMLIN (pramlintide) subcutaneous	
DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITOR		Non-preferred agents within DPP-4 will be approved for patients who have failed a trial of ONE preferred agent within DPP-4
GLYXAMBI (empagliflozin/linagliptin)[QL] JANUMET (sitagliptin/metformin)[QL] JANUMET XR(sitagliptin/metformin)[QL] JANUVIA (sitagliptin)[QL] JENTADUETO (linagliptin/metformin)[QL] TRADJENTA (linagliptin)[QL]	alogliptin (generic for Nesina)[QL] alogliptin/metformin (generic for Kazano)[QL] JENTADUETO XR (linagliptin/metformin)[QL] KOMBIGLYZE XR (saxagliptin/metformin)[QL] ONGLYZA (saxagliptin)[QL] alogliptin/pioglitazone (generic for Oseni)[QL] QTERN (dapagliflozin/saxagliptin)[QL] STEGLUJAN (ertugliflozin/sitagliptin)[QL]	

HYPOGLYCEMICS, INSULIN AND RELATED DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
HUMALOG (insulin lispro) U-100 **CARTRIDGE, PEN, VIAL** HUMALOG MIX **VIAL** (insulin lispro/lispro protamine) HUMULIN (insulin) **VIAL** HUMULIN 70/30 **VIAL** HUMULIN U-500 **VIAL** HUMALOG MIX **PEN** (insulin lispro/lispro protamine) LANTUS SOLOSTAR **PEN** (insulin glargine) LANTUS (insulin glargine) **VIAL** LEVEMIR (insulin detemir) **PEN, VIAL** NOVOLOG (insulin aspart) **CARTRIDGE, PEN, VIAL** NOVOLOG MIX **PEN, VIAL** (insulin aspart/aspart protamine)	ADMELOG (insulin lispro) **PEN, VIAL** AFREZZA (regular insulin, inhaled) APIDRA (insulin glulisine) BASAGLAR (insulin glargine, rec) **PEN** FIASP (insulin aspart)**PEN, VIAL** HUMALOG JR. (insulin lispro) U-100 **PEN** HUMALOG (insulin lispro) U-200 **PEN** HUMULIN 70/30 **PEN** HUMULIN R U-500 **KWIKPEN**CL HUMULIN OTC **PEN** insulin lispro (generic for Humalog) **PEN, VIAL** NOVOLIN (insulin) NOVOLIN 70/30 **VIAL** TOUJEO SOLOSTAR (insulin glargine) TRESIBA (insulin degludec)	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: ▪ **Afrezza®:** Approved for T1DM on long-acting insulin with no current history of smoking or chronic lung disease ▪ **Humulin® R U-500 Kwikpen:** Approved for physical reasons – such as dexterity problems and vision impairment • Usage must be for self-administration, not only convenience • Patient requires >200 units/day • Safety reason patient can't use vial/syringe

HYPOGLYCEMICS, MEGLITINIDES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
repaglinide (generic for Prandin)	nateglinide (generic for Starlix) repaglinide/metformin (generic for Prandimet)	▪ Non-preferred agents will be approved for patients with: Failure of a trial of ONE preferred agent in another Hypoglycemic class OR T2DM and inadequate glycemic control

HYPOGLYCEMICS, METFORMINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
glipizide/metformin glyburide/metformin (generic for Glucovance) metformin & ER (generic for Glucophage/XR)	metformin ER (generic for Fortamet) metformin ER (generic for Glumetza) RIOMET (metformin)	▪ **Metformin ER (generic Fortamet®)/Glumetza®:** Requires clinical reason why generic Glucophage XR® cannot be used ▪ **Riomet®:** Prior authorization not required for age <7 years

HYPOGLYCEMICS, SGLT2

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
FARXIGA (dapagliflozin)[QL,CL] INVOKANA (canagliflozin)[CL] JARDIANCE (empagliflozin)[QL, CL]	INVOKAMET & XR (canagliflozin/metformin)[QL] SEGLUROMET (ertugliflozin/metformin) [QL] STEGLATRO (ertugliflozin)[QL] SYNJARDY (empagliflozin/metformin) SYNJARDY XR (empagliflozin/ metformin)[QL] XIGDUO XR (dapagliflozin/metformin)[QL]	▪ Preferred agents are Approved for diagnosis of diabetes AND a trial of metformin ▪ Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class

HYPOGLYCEMICS, SULFONYLUREAS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
glimepiride (generic for Amaryl) glipizide & ER (generic for Glucotrol/XL) glyburide & micronized (generic for Diabeta, Glynase)	chlorpropamide tolazamide tolbutamide	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

HYPOGLYCEMICS, TZD

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
THIZAOLIDINEDIONES (TZDs)		▪ Non-preferred agents will be approved for patients who have failed a trial of THE preferred agent within this drug class ▪ **Combination products:** Require clinical reason why individual ingredients cannot be used
pioglitazone (generic for Actos)	AVANDIA (rosiglitazone)	
TZD COMBINATIONS		
	pioglitazone/glimepiride (generic for Duetact) pioglitazone/metformin (generic for Actoplus Met)	

IMMUNOSUPPRESSIVES, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
azathiaprine (generic Imuran) cyclosporine, modified **CAPSULE** (generic for Neoral) mycophenolate mofetil **CAPSULE, TABLET** (generic for Cellcept) RAPAMUNE (sirolimus) **SOLUTION** tacrolimus	ASTAGRAF XL (tacrolimus) AZASAN (azathioprine) *cyclosporine* ***CAPSULE,*** **SOFTGEL** cyclosporine, modified **SOLUTION** (generic for Neoral) ENVARSUS XR (tacrolimus) GENGRAF (cyclosporine, modified) **CAPSULE, SOLUTION** mycophenolate mofetil **SUSPENSION** (generic for Cellcept) mycophenolic acid (mycophenolate sodium) MYFORTIC (mycophenolate sodium) PROGRAF (tacrolimus) **CAPSULE,** ***PACKET*** ***NR*** RAPAMUNE (sirolimus) **TABLET** SANDIMMUNE (cyclosporine) **CAPSULE, SOLUTION** *sirolimus* (generic for Rapamune) **SOLUTION,** ***TABLET*** ZORTRESS (everolimus)	Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class ▪ Patients established on existing therapy will be allowed to continue

LINCOSAMIDES / OXAZOLIDINONES / STREPTOGRAMINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
clindamycin **CAPSULE** clindamycin palmitate **SOLUTION** linezolid **TABLET**	CLEOCIN (clindamycin hcl) **CAPSULE** CLEOCIN PALMITATE (clindamycin palmitate hcl) linezolid **SUSPENSION** SIVEXTRO (tedizolid phosphate) ZYVOX (linezolid) **SUSPENSION, TABLET**	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

LIPOTROPICS, OTHER

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BILE ACID SEQUESTRANTS		▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: ▪ **Juxtapid®/ Kynamro®:** Approved for diagnosis of homozygous familial hypercholesterolemia (HoFH) OR Treatment failure/maximized dosing/contraindication to ALL the following: statins, ezetimibe, niacin, fibric acid derivatives, omega-3 agents, bile acid sequestrants Require faxed copy of REMS PA form ▪ **Lovaza®:** Approved for TG ≥ 500 ▪ **Praluent®:** Approved for diagnoses of: • atherosclerotic cardiovascular disease (ASCVD) • heterozygous familial hypercholesterolemia (HeFH) AND • Maximized high-intensity statin WITH ezetimibe for at 3 continuous months • Failure to reach target LDL-C levels: ASCVD - < 70 mg/dL, HeFH - < 100 mg/dL ▪ **Repatha®:** Approved for: • adult diagnoses of atherosclerotic cardiovascular disease (ASCVD) • heterozygous familial hypercholesterolemia (HeFH) • homozygous familial hypercholesterolemia (HoFH) in age ≥ 13 • statin-induce rhabdomyolysis AND • Maximized high-intensity statin WITH ezetimibe for 3+ continuous months • Failure to reach target LDL-C levels: ASCVD - < 70 mg/dL, HeFH - < 100 mg/dL • Concurrent use of maximally-tolerated statin must continue ▪ **Vascepa®:** Approved for TG ≥ 500 ▪ **WelChol®:** Trial not required for diabetes control and monotherapy with metformin, sulfonylurea, or insulin has been inadequate
cholestyramine (generic for Questran) colestipol **TABLETS** (generic for Colestid)	colesevelam (generic for Welchol) **TABLET, PACKET** colestipol **GRANULES** (generic for Colestid) QUESTRAN LIGHT (cholestyramine)	
TREATMENT OF HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA		
	JUXTAPID (lomitapide)CL KYNAMRO (mipomersen)CL	
FIBRIC ACID DERIVATIVES		
fenofibrate (generic for Tricor) gemfibrozil (generic for Lopid)	fenofibrate (generic for Antara, Fenoglide, Lipofen, Lofibra, Triglide) fenofibric acid (generic for Fibricor) fenofibric acid (generic for Trilipix)	
NIACIN		
niacin ER (generic for Niaspan)	NIACOR (niacin IR) NIASPAN (niacin ER)	
Several other forms of OTC Niacin and fish oil are also covered without prior authorization under Medicaid with a prescription		
OMEGA-3 FATTY ACIDS		
	omega-3 fatty acids (generic for Lovaza)CL VASCEPA (icosapent)CL	
CHOLESTEROL ABSORPTION INHIBITORS		
ezetimibe (generic for Zetia)		
PROPROTEIN CONVERTASE SUBTILISIN/KEXIN TYPE 9 (PCSK9) INHIBITORS		
	PRALUENT (alorocumab)CL REPATHA (evolocumab)CL	

LIPOTROPICS, STATINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
STATINS		▪ Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agent within this drug class, within the last 12 months Drug-specific criteria: ▪ **Altoprev®:** One of the TWO trials must be IR lovastatin ▪ **Combination products:** Require clinical reason why individual ingredients cannot be used ▪ **Lescol XL®:** Requires trial of TWO preferred agents AND trial of IR fluvastatin OR clinical reason IR cannot be used ▪ **Vytorin®:** Approved for 3-month continuous trial of ONE standard dose statin
atorvastatin (generic for Lipitor)QL lovastatin (generic for Altoprev) pravastatin (generic for Pravachol) rosuvastatin (generic for Crestor) simvastatin (generic for Zocor)	fluvastatin/ER (generic for Lescol/XL) LIVALO (pitavastatin) *ZYPITAMAG (pitavastatin)NR*	
STATIN COMBINATIONS		
	atorvastatin/amlodiine (generic for Caduet) simvastatin/ezetimibe (generic for Vytorin)	

MACROLIDES AND KETOLIDES, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
KETOLIDES		▪ **Ketek®:** Requires clinical resaon why patient cannot use preferred macrolide ▪ **Macrolides:** Require clinical reason why preferred products within this drug class cannot be used AND ≥ 3-day trial on a preferred macrolide
	KETEK (telithromycin)	
MACROLIDES		
azithromycin (generic for Zithromax) clarithromycin **TABLET, SUSPENSION** (generic for Biaxin)	clarithromycin ER (generic for Biaxin XL) E.E.S. **SUSPENSION, TABLET** ERY-TAB ERYPED **SUSPENSION** ERYTHROCIN erythromycin base **TABLET, CAPSULE** erythromycin ethylsuccinate **SUSPENSION** ~~PCE (erythromycin)~~ ~~ZMAX (azithromycin ER)~~ ZITHROMAX (azithromycin)	

MULTIPLE SCLEROSIS DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
AVONEX (interferon beta-1a)[QL] BETASERON (interferon beta-1b)[QL] COPAXONE **20mg** Syringe Kit (glatiramer)[QL] GILENYA (fingolimod)[QL] REBIF (interferon beta-1a)[QL] *TECFIDERA (dimethyl fumarate)*	AUBAGIO (teriflunomide) dalfampridine (generic to Ampyra)[QL] EXTAVIA (interferon beta-1b)[QL] glatiramer 20 mg/mL (generic for Copaxone) glatiramer 40 mg/mL (generic for Copaxone)[QL] *MAVENCLAD (cladiribine)[NR]* *MAYZENT (siponimod)[NR,QL]* PLEGRIDY (peginterferon beta-1a)[QL]	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: ▪ **Ampyra®:** Approved for diagnosis of gait disorder associated with MS AND EDSS score ≤ 7 ▪ **Plegridy®:** Approved for diagnosis of relapsing MS

NITROFURAN DERIVATIVES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
nitrofurantoin **SUSPENSION** (generic for Furadantin) nitrofurantoin macrocrystals **CAPSULE** (generic for Macrodantin) nitrofurantoin monohydrate-macrocrystals **CAPSULE** (generic for Macrobid)		▪ Non-preferred agents will be approved for patients who have failed a trial of **ONE** preferred agent within this drug class

OPIOID DEPENDENCE TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
SUBOXONE **FILM** (buprenorphine/naloxone)	BUNAVAIL (buprenorphine/naloxone) buprenorphine **SL** buprenorphine/naloxone **FILM, TAB, SL** *LUCEMYRA (lofexidine)[NR, QL]* ZUBSOLV (buprenorphine/naloxone)	Buprenorphine PA Form Buprenorphine Informed Consent Non-Preferred: Bunavail, buprenorphine SL, Buprenorphine/naloxone SL, Zubsolv: ▪ Diagnosis of Opioid Use Disorder, NOT approved for pain management ▪ Verification of "X" DEA license number of prescriber ▪ No concomitant opioids ▪ Failed trial of preferred drug or patient-specific documentation of why preferred product not appropiriate for patient Drug-specific criteria: ▪ **Lucemyra**: Approved for FDA approved indication and dosing per label. Trial of preferred product not required.

OPIOID-REVERSAL TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
naloxone **SYRINGE, VIAL** naltrexone **TABLET** NARCAN (naloxone) **SPRAY**		▪ Non-preferred agents will be approved with documentation of why preferred products within this drug class are not appropriate for the patient

PAH (PULMONARY ARTERIAL HYPERTENSION AGENTS), ORAL AND INHALED

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ADCIRCA (tadalafil) (for PAH only)[CL] LETAIRIS (ambrisentan) sildenafil (generic for Revatio) (for PAH only)[CL] TRACLEER **TABLET** (bosentan) TYVASO **INHALATION** (treprostinil) VENTAVIS **INHALATION** (iloprost)	ADEMPAS (riociguat) OPSUMIT (macitentan) ORENITRAM ER (treprostinil) REVATIO **SUSPENSION** (for PAH only)[CL] tadalafil (generic for Adcirca)[CL] TRACLEER **TABLETS FOR SUSPENSION** (bosentan) UPTRAVI (selexipag)	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class within the last 6 months Drug-specific criteria: ▪ **Adcirca®/Revatio®:** Approved for diagnosis of Pulmonary Arterial Hypertension (PAH) ▪ **Adempas®:** PAH: Requires clinical reason preferred agent cannot be used CTEPH: Approved for persistent/recurrent diagnosis after surgical treatment or inoperable CTEPH NOT for use in Pregnancy ▪ **Revatio® suspension:** Requires clinical reason why sildenafil tablets cannot be used

PANCREATIC ENZYMES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CREON ZENPEP (pancrelipase)	PANCREAZE (pancrelipase) PERTZYE (pancrelipase) VIOKACE (pancrelipase)	▪ Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class

PEDIATRIC VITAMIN PREPARATIONS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CHILD LITTLE ANIMALS VITAMINS CHEW OTC (pedi multivit 91/iron fum) **CHEW** child multivitamins chew otc (pedi multivit 19/folic acid) **CHEW** CHILDREN'S CHEW MULTIVIT-IRON OTC (pedi multivit 91/iron fum) **CHEW** children's chewables otc (pedi multivit 23/folic acid) **CHEW** children's vitamins with iron otc (pedi multivit/iron) fluoride/vitamins A,C,AND D (ped multivit A,C,D3, 21/fluoride) **DROPS** infant-toddler multivit drop OTC (pediatric multivit no. 165 drops) infant-toddler multivit-iron OTC (pedi mv no.164/ferrous sulfate drops) infant-toddler tri-vit drop (vit a pamintate/vit c/vit d3 drops) multivitamins with fluoride (pedi multivit 2/fluoride) **DROPS** multivits with iron and fluoride (pedi multivit 45/fluoride/iron) **DROPS** MVC-FLUORIDE (pedi multivit 12/fluoride) **CHEW TAB** ped mvit A,C,D3,No 21/fluoride **DROPS** pedi mvi no. 16 with fluoride **CHEW** pedi mvi 17 with fluoride **CHEW** POLY-VI-SOL OTC (pedi multivit 81) **DROPS** POLY-VI-SOL WITH IRON (pedi multivit 80/ferrous sulfate) **DROPS** TRI-VI-SOL OTC (vit A palmitate/vit C/Vit D3) **DROPS** tri-vite-fluoride 0.25 mg/ml, and 0.5 mg/ml VITALETS OTC (pedi multivit 36/iron) **CHEW**	AQUADEKS (pedi multivit 40/phytonadione) ESCAVITE (pedi multivit 47/iron/fluoride) ESCAVITE D (pedi multivit 78/iron/fluoride) **CHEW** ESCAVITE LQ (pedi multivit 86/iron/fluoride) FLORIVA (pedi multivit 85/fluoride) **CHEW** FLORIVA PLUS OTC and Rx (pedi multivit 130/fluoride) **DROPS** multivit A, B, D, E, K, ZN (pediatric multivit 153/D3/K) POLY-VI-FLOR (pedi multivit 33/fluoride) **CHEW** POLY-VI-FLOR (pedi multivit 37/fluoride) **DROPS** POLY-VI-FLOR w/IRON (pedi multivit 33/fluoride/iron) **CHEW** POLY-VI-FLOR w/IRON (pedi multivit 37/fluoride/iron) **DROPS** QUFLORA OTC and Rx (pedi multivit 84/fluoride) QUFLORA FE (pedi multivit 142/iron/fluoride) TRI-VI-FLORO (ped multivit A, C, D3, 38/fluoride)	▪ Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class Drug specific criteria: ▪ **Aquadeks**: Approved for diagnosis of Cystic Fibrosis

PENICILLINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
amoxicillin **CAPSULE, CHEWABLE TABLET, SUSP, TABLET** ampicillin **CAPSULE** dicloxacillin penicillin VK		▪ Non-preferred agents will be approved for patients who have failed a 3-day trial of ONE preferred agent within this drug class

PHOSPHATE BINDERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
calcium acetate **TABLET, CAPSULE** CALPHRON OTC (calcium acetate) RENAGEL (sevelamer HCl)	AURYXIA (ferric citrate) calcium acetate **CAPSULE** ELIPHOS (calcium acetate) lanthanum (generic for FOSRENOL) PHOSLO (calcium acetate) PHOSLYRA (calcium acetate) sevelamer carbonate (generic for Renvela) sevelamer hcl (generic for Renagel) VELPHORO (sucroferric oxyhydroxide)	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class within the last 6 months

PLATELET AGGREGATION INHIBITORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
AGGRENOX (dipyridamole/aspirin) aspirin BRILINTA (ticagrelor) clopidogrel (generic for Plavix) dipyridamole (generic for Persantine) *prasugrel (generic for Effient)*	aspirin/dipyridamole (generic for Aggrenox) ticlopidine (generic for Ticlid) YOSPRALA (aspirin/omeprazole) ZONTIVITY (vorapaxar)^{CL}	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class OR documented clopidogrel resistance Drug-specific criteria: ▪ **Zontivity®:** Approved for reduction of thrombotic cardiovascular events in history of MI or with peripheral artery disease (PAD) Use with aspirin and/or clopidogrel

PRENATAL VITAMINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
c-nate dha **SOFTGEL** complete natal dha (pnv2/iron b-g suc-p/fa/omega-3) calcium-pnv 28-1-250mg **SOFTGEL** classic prenatal **TABLET** (prenatal vit/fe fum/fa) COMPLETENATE **CHEWABLE** CONCEPT DHA **CAPSULE** CONCEPT OB **CAPSULE** elite-ob **CAPLET** (fe c/fa) folivane-ob **CAPSULE** (pnv#15/iron fum & ps cmp/fa) MARNATAL-F **CAPSULE** niva-plus **TABLET** (pnv with ca,no.74/iron/fa) PRENATA TAB **CHEW** pnv with ca, #72/iron/fa pnv-dha **SOFTGEL** (pnv combo#47/iron/fa #1/dha) pnv-ob+dha combo pack (pnv22/iron cbn&gluc/fa/dss/dha) pnv-vp-u **CAPSULE** prenaissance **CAPSULE** (pnv80/iron fum/fa/dss/dha) prenaissance plus **SOFTGEL** (pnv69/iron/fa/dss/dha) prenatal vitamin **TABLET** (pnv#124/iron/fa) prenatal no.137/iron/fa OTC pretab 29mg-1 **TABLET** (pnv#78/iron/fa) PUREFE PLUS PUREFE OB PLUS taron-c dha **CAPSULE** (pnv#16/iron fum &ps/fa/om-3) TARON-PREX PRENATAL TRINATAL RX 1 triveen-duo dha combo pack (pnv53/iron b-g hcl-p/fa/omega3) trust natal dha (pnv2/iron b-g suc-p/fa/omega-3) virtprex **CAPSULE** (pnv66/iron fum/fa/dss/dha) virt-c dha **SOFTGEL** (pnv#16/iron fum &ps/fa/om-3) virt-nate dha **SOFTGEL** (pnv 11-iron fum-fa-om3) virt-pm dha **SOFTGEL** (pnv combo#47/iron/fa #1/dha) virt-pn **TABLET** (pnv w-ca no.40/iron fum/fa cmb no.1) virt-pn plus **SOFTGEL** (pnv/ca no.68/iron/fa1/dha) virt-select **CAPSULE** (pnv80/iron fum/fa/dss/dha) virt-vite gt **TABLET** (prenatal vit 16/iron cb/fa/dss) VOL-PLUS **TABLET** vp-ch-pnv prenatal **SOFTGEL** vp-heme ob **TABLET** (pnv#21/iron/ps& heme polyp/fa) zatean-pn dha **CAPSULE** (pnv #47/iron/fa #1/dha) zatean-pn plus **SOFTGEL** (pnv/ca no.68/iron/fa1/dha)		▪ Non-preferred agents will be approved for patients who have failed a trial of or are intolerant to TWO preferred agents within this drug class Additional covered agents can be looked up using the Drug Look-up Tool at: https://druglookup.fhsc.com/druglookupweb/?client=nestate

PROTON PUMP INHIBITORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
omeprazole (generic for Prilosec) **RX** pantoprazole (generic for Protonix)	DEXILANT (dexlansoprazole) esomeprazole magnesium (generic for Nexium) esomeprazole strontium lansoprazole (generic for Prevacid) NEXIUM SUSPENSION (esomeprazole) omeprazole/sodium bicarbonate (generic for Zegerid RX) rabeprazole (generic for Aciphex)	▪ Non-preferred agents will be approved for patients who have failed an 8-week trial of BOTH preferred agents within this drug class **Pediatric Patients:** Patients ≤ 4 years of age – No PA required for Prevacid 30mg or omeprazole 20mg capsules (used to compound suspensions). Drug-specific criteria: ▪ **Prilosec®OTC/Omeprazole OTC:** EXCLUDED from coverage Acceptable as trial instead of Omeprazole 20mg ▪ **Prevacid Solutab**: may be approved after trial of compounded suspension. Patients ≥ 5 years if age- Only approve non-preferred for GI diagnosis if: ▪ Child can not swallow whole generic omeprazole capsules OR, ▪ Documentation that contents of capsule may not be sprinkled in applesauce

SINUS NODE INHIBITORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	CORLANOR (ivabradine)	▪ Diagnosis of Chronic Heart Failure with left ventricular ejection fraction less than or equal to 35%, AND ▪ Sinus rhythm with resting heart rate greater than or equal to 70 beats per minute, AND ▪ On maximally tolerated doses of beta-blockers OR have a contraindication to beta-blocker use

SKELETAL MUSCLE RELAXANTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
baclofen (generic for Lioresal) chlorzoxazone (generic for Parafon Forte) cyclobenzaprine (generic for Flexeril)[QL] methocarbamol (generic for Robaxin) tizanidine **TABLET** (generic for Zanaflex)	carisoprodol (generic for Soma)[CL] carisoprodol compound cyclobenzaprine ER (generic for AMRIX)[CL] dantrolene (generic for Dantrium) FEXMID (cyclobenzaprine) LORZONE (chlorzoxazone)[CL] metaxalone (generic for Skelaxin) orphenadrine ER PARAFON FORTE (chlorzoxazone) tizanidine **CAPSULE** ZANAFLEX (tizanidine) **CAPSULE, TABLET**	▪ Non-preferred agents will be approved for patients who have failed a 1-week trial of TWO preferred agents within this drug class Drug-specific criteria: ▪ **Amrix®/Fexmid®:** Requires clinical reason why IR cyclobenzaprine cannot be used Approved only for acute muscle spasms NOT approved for chronic use ▪ **carisoprodol:** Approved for Acute, musculoskeletal pain - NOT for chronic pain Use is limited to no more than 30 days Additional authorizations will not be granted for at least 6 months following the last dayy of previous course of therapy ▪ **Dantrolene:** Trial NOT required for treatment of spasticity from spinal cord injury ▪ **Lorzone®:** Requires clinical reason why chlorzoxazone cannot be used ▪ **Soma® 250mg:** Requires clinical reason why 350mg generic strength cannot be used ▪ **Zanaflex® Capsules:** Requires clinical reason generic cannot be used

TETRACYCLINES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
doxycycline hyclate IR (generic for Vibramycin) doxycycline monohydrate **50MG, 100MG CAPSULE** *doxycycline monohydrate **SUSP** (generic for Vibramycin 25MG)* *doxycycline monohydrate **TAB*** minocycline HCL **CAPSULE** (generic for Minocin, Dynacin) *minocycline HCL **TABLET** (generic for Dynacin, Murac)*	demeclocycline (generic for Declomycin)[CL] DORYX MPC DR (doxycycline pelletized) doxycycline hyclate DR (generic for Doryx) doxycycline monohydrate **40MG, 75MG and 150MG CAPSULES** (generic for Adoxa, Monodox, Oracea) minocycline HCL ER (generic for Solodyn) *NUZYRA (omadacycline)[NR]* tetracycline HCl (generic for Sumycin) VIBRAMYCIN **SUSP** (doxycycline) XIMINO (minocycline ER) **CAPSULE**[QL]	▪ Non-preferred agents will be approved for patients who have failed an 3-day trial of TWO preferred agents within this drug class Drug-specific criteria: ▪ **Demeclocycline:** Approved for diagnosis of SIADH ▪ **Doryx®/doxycycline hyclate DR/ Dynacin®/Oracea®/Solodyn®:** Requires clinical reason why generic doxycycline, minocycline or tetracycline cannot be used ▪ **Vibramycin® suspension:** May be approved with documented swallowing difficulty

THYROID HORMONES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
levothyroxine **TABLET** (generic for Synthroid) liothyronine **TABLET** (generic for Cytomel) thyroid, pork **TABLET**	LEVO-T (levothyroxine) THYROLAR **TABLET** (liotrix) TIROSINT **TABLET** (levothyroxine) *TIROSINT-SOL (LIQUID) (levothyroxine)[NR,CL]*	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: ▪ Tirosint-Sol: May be approved with documented swallowing difficulty

ULCERATIVE COLITIS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ORAL		▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: ▪ **Asacol HD®/Delzicol DR®/ Lialda®/Pentasa®:** Requires clinical reason why preferred mesalamine products cannot be used ▪ **Giazo®:** Requires clinical reason why generic balsalazide cannot be used NOT covered in females
APRISO (mesalamine) balsalazide (generic for Colazal) sulfasalazine / DR (generic for Azulfidine)	budesonide DR (generic Uceris) DELZICOL DR (mesalamine) DIPENTUM (olsalazine) GIAZO (balsalazide) mesalamine (generic for Lialda) mesalamine (generic for Asacol HD) PENTASA (mesalamine)	
RECTAL		
CANASA (mesalamine) *mesalamine (generic Rowasa)*	sf ROWASA (mesalamine) mesalamine (generic for Canasa) UCERIS (budesonide)	

UTERINE DISORDER TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ORILISSA (elagolix sodium)		Drug-specific criteria: ▪ ***Orilissa:*** *Requires trial and failure of oral contraceptive and NSAID*

VASODILATORS, CORONARY

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
isosorbide dinitrate **TABLET** isosorbide dinitrate ER, SA **TABLET (generic Dilatrate-SR and Isordil)** isosorbide mononitrate **TABLET** isosorbide mononitrate SR **TABLET** nitroglycerin **SUBLINGUAL, TRANSDERMAL** nitroglycerin ER **TABLET**	BIDIL (isosorbide dinitrate/hydralazine) GONITRO (nitroglycerin) NITRO-BID **OINTMENT** (nitroglycerin) NITRO-DUR (nitroglycerin) nitroglycerin **TRANSLINGUAL** (generic for Nitrolingual) NITROMIST (nitroglycerin) *NITROSTAT **SUBLINGUAL** (nitroglycerin)*	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

VI. Adjournment / Other Business

A vote to conclude the meeting was made at 2:45pm it was unanimously approved by all in attendance.

The next meeting of the Nebraska Medicaid Pharmaceutical and Therapeutics Committee is scheduled:
Date: Wednesday, November 13, 2019
Time: 9:00a.m – 3:00p.m CST
Location: Mahoney State Park, Peter Kiewit Lodge, 28500 West Park Hwy, Ashland, NE 68003

Recorded by: Valarie Simmons, M.S – Account Operations Executive, Magellan Rx Management, Magellan Health.