

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/Upravi	Non-Preferred	Josephine Garcia-Ferrer	Actelion
2	Hepatitis C	Epclusa sofosbuvir/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) • <i>Votes only in the event of a tie</i>						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	Nitrofurans 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 Node 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) <i>Votes only in the event of a tie</i>						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) <i>Votes only in the event of a tie</i>						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) <i>Votes only in the event of a tie</i>						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) <i>Votes only in the event of a tie</i>						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) <i>Votes only in the event of a tie</i>						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) <i>Votes only in the event of a tie</i>				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) <i>Votes only in the event of a tie</i>				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) <i>Votes only in the event of a tie</i>				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) <i>Votes only in the event of a tie</i>				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) <i>Votes only in the event of a tie</i>				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) <i>Votes only in the event of a tie</i>						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) <i>Votes only in the event of a tie</i>						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) <i>Votes only in the event of a tie</i>						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) <i>Votes only in the event of a tie</i>						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) <i>Votes only in the event of a tie</i>						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) <i>Votes only in the event of a tie</i>				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) <i>Votes only in the event of a tie</i>				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) <i>Votes only in the event of a tie</i>				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) <i>Votes only in the event of a tie</i>				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) <i>Votes only in the event of a tie</i>				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) <i>Votes only in the event of a tie</i>				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) <i>Votes only in the event of a tie</i>				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) <i>Votes only in the event of a tie</i>				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) <i>Votes only in the event of a tie</i>				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) <i>Votes only in the event of a tie</i>				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) <i>Votes only in the event of a tie</i>						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) <i>Votes only in the event of a tie</i>						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) <i>Votes only in the event of a tie</i>						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		

Nebraska Medicaid Preferred Drug List

With Prior Authorization Criteria - May 2018 P&T Proposed Changes - *Highlights* indicate proposed changes

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) <i>clindamycin phosphate GEL, PLEDGET, SOLUTION</i> 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) <i>ALTRENO (tretinoin)^{NR, AL}</i> 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 Benzacilin) 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) <i>PLIXDA (adapalene) SWAB^{NR}</i> 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}	<ul style="list-style-type: none"> ■ 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
<p>BUTRANS (buprenorphine, transdermal)^{QL}</p> <p>EMBEDA (morphine sulfate/ naltrexone) fentanyl 25, 50, 75, 100 mcg PATCH</p> <p>morphine ER TABLET (generic for MS Contin, Oramorph SR)</p> <p>OXYCONTIN (oxycodone ER)</p>	<p>ARYMO ER (morphine sulfate ER)^{QL}</p> <p>BELBUCA (buprenorphine, buccal)^{CL}</p> <p>buprenorphine TRANSDERMAL (generic for Butrans)^{QL}</p> <p>DURAGESIC MATRIX (fentanyl) fentanyl 37.5, 62.5, 87.5 mcg PATCH^{CL}</p> <p>hydromorphone ER (generic for Exalgo)^{CL}</p> <p><i>HYSINGLA ER (hydrocodone, extended release)</i></p> <p>KADIAN (morphine ER capsule)</p> <p>methadone ^{CL}</p> <p>MORPHABOND ER (morphine sulfate)</p> <p>morphine ER CAPSULE (generic for Avinza, Kadian)</p> <p>NUCYNTA ER (tapentadol)^{CL}</p> <p>oxycodone ER (generic for re-formulated Oxycontin)</p> <p>oxymorphone ER (generic for Opana ER)</p> <p>tramadol extended release (generic for Conzip, Ryzolt, Ultram ER)^{CL}</p> <p>XTAMPZA ER (oxycodone myristate)^{QL}</p> <p>ZOHYDRO ER (hydrocodone bitartrate ER)</p>	<p>The Center for Disease Control (CDC) does not recommend long acting opioids when beginning opioid treatment.</p> <ul style="list-style-type: none"> ▪ 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 <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> ▪ 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
<p>acetaminophen/codeine ELIXIR, TABLET</p> <p>codeine ORAL</p> <p>hydrocodone/APAP SOLUTION, TABLET</p> <p>hydrocodone/ibuprofen</p> <p>hydromorphone TABLET</p> <p>morphine CONC SOLUTION, SOLUTION, TABLET</p> <p>oxycodone TABLET, SOLUTION</p> <p>oxycodone/APAP</p> <p>tramadol</p> <p><i>tramadol/APAP (generic for Ultracet)</i></p>	<p>ORAL</p> <p><i>APADAZ (benzhydrocodone/APAP)^{NR,CL,QL}</i></p> <p><i>benzhydrocodone/APAP (generic for Apadaz)^{NR,CL,QL}</i></p> <p>butalbital/caffeine/APAP w/codeine</p> <p>butalbital compound w/codeine (butalbital/ASA/caffeine/codeine)</p> <p>carisoprodol compound-codeine (carisoprodol/ASA/codeine)</p> <p>dihydrocodeine/acetamin/caffeine</p> <p>dihydrocodeine/aspirin/caffeine (generic for Synalgos DC)</p> <p>FIORINAL/CODEINE (butalbital/ASA/codeine/caffeine)</p> <p>hydromorphone ORAL LIQUID, TABLET, SUPPOSITORY (generic for Dilaudid)</p> <p>IBUDONE (hydrocodone/ibuprofen)</p> <p>levorphanol</p> <p>meperidine (generic for Demerol)</p> <p>morphine SUPPOSITORIES</p> <p><i>NALOCET (oxycodone/APAP)^{NR}</i></p> <p>NUCYNTA (tapentadol)^{CL}</p> <p>OXAYDO (oxycodone)^{CL}</p> <p>oxycodone CAPSULE</p> <p>oxycodone/acetaminophen SOLUTION</p> <p>oxycodone/aspirin</p> <p>oxycodone CONCENTRATE</p> <p>oxycodone/ibuprofen (generic for Combunox)</p> <p>oxymorphone (generic for Opana)</p> <p>pentazocine/naloxone</p> <p>PRIMLEV (oxycodone/acetaminophen)</p> <p>REPRESAIN (hydrocodone/ibuprofen)</p> <p>ROXICODONE TABLET (oxycodone)</p> <p><i>ROXYBOND (oxycodone)^{NR}</i></p> <p>XARTEMIS XR (oxycodone/acetaminophen)</p> <p>ZAMICET (hydrocodone/acetaminophen)</p>	<ul style="list-style-type: none"> ■ 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 <ul style="list-style-type: none"> -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 naïve <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> ■ 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

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
<i>testosterone gel</i> PACKET, PUMP <i>(generic for Vogelxo)</i>	ANDRODERM (testosterone) <i>ANDROGEL (testosterone)</i> NATESTO (testosterone) testosterone gel PACKET, PUMP (generic for Androgel) testosterone (generic for Axiron) testosterone (generic for Fortesta) testosterone (generics for Testim)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed ONE preferred agent within this drug class within the last 6 months <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> 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		<ul style="list-style-type: none"> ▪ 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 <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> ▪ Epaned® and Qbrelis® Oral Solution: Clinical reason why oral tablet is not appropriate
benazepril (generic for Lotensin) enalapril (generic for Vasotec) lisinopril (generic for Prinivil/Zestril) quinapril (generic for Accupril) ramipril (generic for Altace)	captopril (generic for Capoten) EPANED (enalapril) ORAL SOLUTION fosinopril (generic for Monopril) moexepiril (generic for Univasc) perindopril (generic for Aceon) QBRELIS (lisinopril) ORAL SOLUTION trandolapril (generic for Mavik)	
ACE INHIBITOR/DIURETIC COMBINATIONS		
benazepril/HCTZ (generic for Lotensin HCT) enalapril/HCTZ (generic for Vaseretic) lisinopril/HCTZ (generic Prinzide/Zestoretic)	captopril/HCTZ (generic for Capozide) fosinopril/HCTZ (generic for Monopril HCT) moexepiril/HCTZ (generic for Uniretic) quinapril/HCTZ (generic for Accuretic)	
ANGIOTENSIN RECEPTOR BLOCKERS		
irbesartan (generic for Avapro) losartan (generic for Cozaar) valsartan (generic for Diovan)	candesartan (generic for Atacand) EDARBI (azilsartan medoxomil) 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			
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)	<ul style="list-style-type: none"> 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 	
ANGIOTENSIN MODULATOR/ CALCIUM CHANNEL BLOCKER COMBINATIONS			
amlodipine/benazepril (generic for Lotrel) <i>amlodipine/valsartan (generic for Exforge)</i> <i>amlodipine/valsartan/HCTZ (generic for Exforge HCT)</i>	amlodipine/olmesartan (generic for Azor) amlodipine/olmesartan/HCTZ (generic for Tribenzor) amlodipine/telmisartan (generic for Twynsta) PRESTALIA (perindopril/amlodipine) trandolapril/verapamil (generic for Tarka)	<ul style="list-style-type: none"> Angiotensin Modulator/Calcium Channel Blocker Combinations: Combination agents may be approved if there has been a trial and failure of preferred agent 	
DIRECT RENIN INHIBITORS			
	aliskiren (generic for Tekturna) ^{QL}	<ul style="list-style-type: none"> Direct Renin Inhibitors/Direct Renin Inhibitor Combinations: May be approved with history of TWO preferred ACE Inhibitors or Angiotensin Receptor Blockers within the last 12 months 	
DIRECT RENIN INHIBITOR COMBINATIONS			
	TEKTURNA/HCT (aliskiren/HCTZ)		
NEPRILYSIN INHIBITOR COMBINATION			
ENTRESTO (sacubitril/valsartan) ^{QL}			
ANGIOTENSIN RECEPTOR BLOCKER/BETA-BLOCKER COMBINATIONS			
	BYVALSON (nevigolol/valsartan)		

ANTIBIOTICS, GASTROINTESTINAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<p>FIRVANQ (vancomycin) SOLUTION^{NR}</p> <p>metronidazole TABLET</p> <p>neomycin</p> <p>vancomycin COMPOUNDED ORAL SOLUTION</p>	<p>ALINIA (nitazoxanide) SUSPENSION</p> <p>DIFICID (fidaxomicin)</p> <p>FIRVANQ (vancomycin) SOLUTION^{NR}</p> <p>FLAGYL ER (metronidazole)</p> <p>metronidazole CAPSULE</p> <p>paromomycin</p> <p>SOLOSEC (secnidazole)</p> <p>tinidazole (generic for Tindamax)</p> <p>vancomycin CAPSULE (generic for Vancocin)</p> <p>XIFAXAN (rifaximin)</p>	<ul style="list-style-type: none"> ■ Note: Although azithromycin, ciprofloxacin, and trimethoprim/sulfmethoxazole are not included in this review, they are available without prior authorization <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> ■ 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 <p>Approvable diagnoses include:</p> <p>Giardia</p> <p>Amebiasis intestinal or liver abscess</p> <p>Bacterial vaginosis or trichomoniasis ■ vancomycin capsules: Trial and failure with metronidazole <p>Trial may be bypassed if initial or recurrent episode of SEVERE C. difficile colitis</p> <p>SEVERE C. difficile colitis: Leukocytosis w/WBC ≥ 15,000 cells/microliter, OR Serum creatinine ≥ 1.5 times premorbid level</p> <p>Provider to provide labs for documentation</p> <ul style="list-style-type: none"> ■ Xifaxan[®]: Approvable diagnoses include: Travelers diarrhea resistant to quinolones Hepatic encephalopathy with treatment failure of lactulose or neomycin Diarrhea-Predominant IBS (IBS-D) 550mg strength only with treatment failure of Lomotil[®] AND Imodium[®] </p>

ANTIBIOTICS, INHALED

Preferred Agents	ANon-Preferred Agents	Prior Authorization/Class Criteria
BETHKIS (tobramycin) ^{CL} KITABIS PAK (tobramycin) ^{CL} TOBI-PODHALER (tobramycin) ^{CL,QL}	<i>ARIKAYCE (amikacin liposomal inh susp)^{NR}</i> CAYSTON (aztreonam lysine) ^{QL,CL} tobramycin (generic for Tobi)	<ul style="list-style-type: none"> Diagnosis of Cystic Fibrosis is required for all agents ICD10 Group = E84, ICD9 = 277.00, 277.01, 277.02, 277.03, 277.09 <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> 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)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed ALL preferred agents within this drug class within the last 12 months <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Altabax®: Approvable diagnoses of impetigo due to <i>S. Aureus</i> OR <i>S. pyogenes</i> 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
<p>CLEOCIN OVULES (clindamycin) clindamycin CREAM (generic for Cleocin) CLINDESSE (clindamycin, vaginal) metronidazole, vaginal <i>NUVESSA (metronidazole, vaginal)</i> <i>VANAZOLE (metronidazole, vaginal)</i></p>	<p>CLEOCIN CREAM (clindamycin) METROGEL (metronidazole, vaginal)</p>	<ul style="list-style-type: none"> 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
<p>ELIQUIS (apixaban) enoxaparin (generic for Lovenox) PRADAXA (dabigatran) warfarin (generic for Coumadin) XARELTO (rivaroxaban)^{CL,QL}</p>	<p>fondaparinux (generic for Arixtra) FRAGMIN (dalteparin) SAVAYSA (edoxaban)^{QL}</p>	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed ONE preferred agent within this drug class within the last 12 months <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> 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 anticoagulant therapy <i>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</i>

ANTIEMETICS/ANTIVERTIGO AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CANNABINOIDS		<ul style="list-style-type: none"> 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. <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Akynzeo®/Emend®/Varubi®: Approved for Moderately/Highly emetogenic chemotherapy with dexamethasone and a 5-HT3 antagonist WITHOUT trial of preferred agents <u>Regimens include:</u> 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}	<ul style="list-style-type: none"> ■ Non-preferred agents will be approved for patients who have failed a trial of TWO diagnosis-appropriate preferred agents within this drug class <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> ■ Cresemba®: Approved for diagnosis of invasive aspergillosis or invasive mucormycosis ■ 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, <i>S. apiospermum</i> and <i>Fusarium spp.</i>, Oropharyngeal/esophageal candidiasis refractory to fluconazole

ANTIFUNGALS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ANTIFUNGAL		
clotrimazole CREAM (generic for Lotrimin) RX, OTC clotrimazole SOLN OTC ketoconazole CREAM, SHAMPOO (generic for Nizoral) LAMISIL (terbinafine) SPRAY OTC LAMISIL AT CREAM (terbinafine) OTC miconazole CREAM, POWDER OTC nystatin terbinafine OTC (generic for Lamisil AT) tolnaftate AERO POWDER, CREAM, POWDER, OTC (generic for Tinactin)	ALEVAZOL (clotrimazole) OTC ciclopirox CREAM, GEL, SUSPENSION (generic for Ciclodan, Loprox) ciclopirox NAIL LACQUER (generic for Penlac) ciclopirox SHAMPOO (generic for Loprox) clotrimazole SOLUTION RX (generic for Lotrimin) DESENEA AERO POWDER OTC (miconazole) econazole (generic for Spectazole) ERTACZO (sertaconazole) 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	<ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> Extina: Requires trial and failure or contraindication to other ketoconazole forms Jublia: Approved diagnoses include Onychomycosis of the toenails due to <i>T.rubrum</i> OR <i>T. Mentagrophytes</i> nystatin/triamcinolone: Individual ingredients available without prior authorization ciclopirox nail lacquer: No trial required in diabetes, peripheral vascular disease (PVD), immunocompromised OR contraindication to oral terbinafine
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
<p>EMGALITY (<i>galcanezumab-gnlm</i>)^{NR,CL} PEN, SYR</p>	<p>AIMOVIG AUTOINJECTOR (<i>erenumab-aooe</i>)^{NR, QL,CL} AJOVY (<i>fremanezumab-vfrm</i>)^{NR, QL, CL} CAFERGOT (ergotamine/cafeine) CAMBIA (diclofenac potassium) dihydroergotamine mesylate NASAL ERGOMAR SUBLINGUAL (ergotamine tartrate) MIGERGOT (ergotamine/cafeine) RECTAL MIGRANAL (dihydroergotamine) NASAL</p>	<ul style="list-style-type: none"> ■ Non-preferred agents will be approved for patients who have a contraindication OR trial failure of a triptan <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> ■ Cambia®: Requires diagnosis of migraine and documentation of why solid dosing forms not appropriate ■ <i>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, metoprolol, timolol, atenolol), anti-epileptics (valproate, topiramate), ACE/ARB (lisinopril, candesartan)</i> ■ <i>In addition, Aimovig and Ajovy require a trial of Emgality or patient specific documentation of why Emgality is not appropriate for patient</i>

ANTIMIGRAINE AGENTS, TRIPTANS^{QL}

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria	
ORAL			
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)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed ALL preferred agents within this drug class Drug-specific criteria: <ul style="list-style-type: none"> Sumavel[®] Dosepro: Requires clinical reason sumatriptan injection cannot be used Onzetra, Zembrace: approved for patients who have failed ALL preferred agents 	
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}	<ul style="list-style-type: none"> 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		
acyclovir (generic for Zovirax) famciclovir (generic for Famvir) valacyclovir (generic for Valtrex)	SITAVIG (acyclovir buccal)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a 10-day trial of ONE preferred agent within the same group
ANTI-INFLUENZA DRUGS		
<i>oseltamivir (generic for Tamiflu)^{QL}</i> TAMIFLU (oseltamivir) ^{QL}	rimantadine (generic for Flumadine) <i>RELENZA (zanamivir)^{QL}</i> <i>XOFLUZA (baloxavir marboxil)^{NR, QL, AL}</i>	Drug-specific criteria: <ul style="list-style-type: none"> Sitavig[®]: Approved for recurrent herpes labialis (cold sores) in immunocompetent adults Xofluza: Requires clinical, patient specific reason that a preferred agent cannot be used

ANTIVIRALS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	acyclovir CREAM, OINTMENT (generic for Zovirax) DENA VIR (penciclovir) XERESE (acyclovir/hydrocortisone)	<ul style="list-style-type: none"> 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		<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed TWO diagnosis-appropriate preferred agents within this drug class <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> 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) atenolol/chlorthalidone(generic for Tenoretic) bisoprolol (generic for Zebeta) bisoprolol/HCTZ (generic for Ziac) metoprolol (generic for Lopressor) metoprolol XL (generic for Toprol XL) propranolol (generic for Inderal) propranolol extended release (generic for Inderal LA)	acebutolol (generic for Sectral) betaxolol (generic for Kerlone) BYSTOLIC (nebivolol) HEMANGEOL (propranolol) oral solution INDERAL XL (propranolol) INNOPRAN XL (propranolol) KAPSPARGO SPRINKLE (metoprolol ER)^{NR} 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) labetalol (generic for Trandate)	carvedilol ER (generic for Coreg CR)	
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) TOVIAZ (fesoterodine ER) VESICARE (solifenacin)	darifenacin ER (generic for Enablex) GELNIQUE (oxybutynin) flavoxate MYRBETRIQ (mirabegron) OXYTROL (oxybutynin) tolterodine & ER (generic for Detrol/LA) trospium & ER (generic for Sanctura/XR)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Myrbetriq®: Covered without trial in contraindication to anticholinergic agents

BONE RESORPTION SUPPRESSION AND RELATED DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BISPHOSPHONATES		
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 D ^{QL} ibandronate (generic for Boniva) ^{QL} risedronate (generic for Actonel) ^{QL}	<ul style="list-style-type: none"> ■ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within the same group Drug-specific criteria: <ul style="list-style-type: none"> ■ Actonel® Combinations: Covered as individual agents without prior authorization ■ Atelvia DR®: Requires clinical reason alendronate cannot be taken on an empty stomach
OTHER BONE RESORPTION SUPPRESSION AND RELATED DRUGS		
calcitonin-salmon NASAL raloxifene (generic for Evista)	EVISTA (raloxifene) FORTEO (teriparatide) ^{QL} TYMLOS (abaloparatide)	<ul style="list-style-type: none"> ■ Binosto®: Requires clinical reason why alendronate tablets OR Fosamax® solution cannot be used ■ Etidronate disodium: Trial not required for diagnosis of heterotrophic ossification ■ Forteo®: Covered for high risk of fracture <ul style="list-style-type: none"> 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

BPH (BENIGN PROSTATIC HYPERPLASIA TREATMENTS)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ALPHA BLOCKERS		
alfuzosin (generic for Uroxatral) doxazosin (generic for Cardura) tamsulosin (generic for Flomax) terazosin (generic for Hytrin)	CARDURA XL (doxazosin) silodosin (generic for Rapaflo)	<ul style="list-style-type: none"> ▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class
5-ALPHA-REDUCTASE (5AR) INHIBITORS		
dutasteride (generic for Avodart) finasteride (generic for Proscar)	dutasteride/tamsulosin (generic for Jalyn)	Drug-specific criteria: <ul style="list-style-type: none"> ▪ 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

CALCIUM CHANNEL BLOCKERS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
SHORT-ACTING		<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> 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) nifedipine (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		
amoxicillin/clavulanate TABLETS, SUSPENSION	amoxicillin/clavulanate, CHEWABLE amoxicillin/clavulanate XR (generic for Augmentin XR) AUGMENTIN SUSPENSION, TABLET (amoxicillin/clavulanate)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a 3-day trial of ONE preferred agent within the same group <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Suprax[®] Tablet / Suspension: Requires clinical reason why capsule or generic suspension cannot be used
CEPHALOSPORINS – First Generation		
cefadroxil CAPSULE, SUSPENSION (generic for Duricef)	cefadroxil TABLET (generic for Duricef)	
cephalexin CAPSULE, SUSPENSION (generic for Keflex)	cephalexin TABLET DAXBIA (cephalexin)	
CEPHALOSPORINS – Second Generation		
cefprozil (generic for Cefzil)	cefaclor (generic for Ceclor)	
cefuroxime TABLET (generic for Ceftin)	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
<p><i>econtra OTC (levonorgestrel)</i></p> <p><i>new day OTC (levonorgestrel)</i></p> <p><i>aubra eq (levonorgestrel-ethinyl estradiol)</i></p> <p><i>BALCOLTRA (levonorgest/eth.estrindial-iron)</i></p> <p><i>chateal eq (levonorgestrel-ethinyl estradiol)</i></p> <p><i>hailey 25 fe (norethindrone-e estradiol-iron)</i></p> <p><i>incassia (norethindrone)</i></p> <p><i>kelnor 1-50 (ethynodiol d ethinyl estradiol)</i></p> <p><i>mili (norgestimate-ethinyl estradiol)</i></p> <p><i>tarina (norethindrone-e estradiol-iron)</i></p> <p><i>tri-mili (norgestimate-ethinyl estradiol)</i></p> <p><i>tri-vylibra (norgestimate-ethinyl estradiol)</i></p> <p><i>tri-vylibra lo (norgestimate-ethinyl estradiol)</i></p> <p><i>tulana (norethindrone)</i></p> <p><i>tydemy (drospir/eth estro/levomefolca)</i></p> <p><i>vylibra (norgestimate-ethinyl estradiol)</i></p>		

CYSTIC FIBROSIS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	<p>KALYDECO PACKET, TABLET (ivacaftor)^{QL, AL}</p> <p>ORKAMBI (lumacaftor/ivacaftor) PACKET, TABLET^{QL, AL}</p> <p>SYMDEKO (tezacaftor/ivacaftor)^{QL, AL}</p>	<p>Drug-specific criteria:</p> <ul style="list-style-type: none"> ▪ Kalydeco®: Diagnosis of CF and documentation of the drug-specific, FDA-approved mutation of CFTR gene <ul style="list-style-type: none"> • Minimum age: 2 years ▪ Orkambi®: Diagnosis of CF and documentation of presence of two copies of the F580del mutation (homozygous) of CFTR gene <ul style="list-style-type: none"> • 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. <ul style="list-style-type: none"> • Minimum age: 12 years

DIURETICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
SINGLE-AGENT PRODUCTS		<ul style="list-style-type: none"> ▪ Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class
<p>amiloride TABLET</p> <p>bumetanide TABLET</p> <p>chlorothiazide TABLET</p> <p>chlorthalidone TABLET (generic for Diuril)</p> <p>furosemide SOLUTION, TABLET (generic for Lasix)</p> <p>hydrochlorothiazide CAPSULE, TABLET (generic for Microzide)</p> <p>indapamide TABLET</p> <p>metolazone TABLET</p> <p>spironolactone TABLET (generic for Aldactone)</p> <p>toremide TABLET</p>	<p>CAROSPIR (spironolactone) SUSPENSION</p> <p>eplerenone TABLET (generic for Inspra)</p> <p>ethacrynic acid CAPSULE (generic for Edecrin)</p> <p>methyclothiazide TABLET</p>	
COMBINATION PRODUCTS		
<p>amiloride/HCTZ TABLET</p> <p>spironolactone/HCTZ TABLET (generic for Aldactazide)</p> <p>triamterene/HCTZ CAPSULE, TABLET (generic for Dyazide, Maxzide (25))</p>		

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	<ul style="list-style-type: none"> ▪ Non-preferred agents will be approved for patients who have failed a 3-day trial of ONE preferred agent within this drug class <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> ▪ 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)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a 30-day trial of ONE preferred agent within this drug class <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> 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}	<ul style="list-style-type: none"> 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)	<ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> ▪ 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/voxicilaprev) ^{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		Drug-specific criteria: Trial with Mavyret not required in the following: <ul style="list-style-type: none"> ▪ Epclusa: For genotype 1-6 with decompensated cirrhosis along with ribavirin ▪ Harvoni: <ul style="list-style-type: none"> ○ 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
PEGASYS (pegylated interferon alfa-2a) ^{CL} PEG-INTRON (pegylated interferon alfa-2b) ^{CL}		

HIV / AIDS^{CL}

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CCR5 ANTAGONISTS		<ul style="list-style-type: none"> 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
SELZENTRY SOLN, TAB (maraviroc)		
FUSION INHIBITORS		<ul style="list-style-type: none"> 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
FUZEON SUB-Q (enfuvirtide) ^{QL}		
INTEGRASE STRAND TRANSFER INHIBITORS (INSTIs)		<ul style="list-style-type: none"> Diagnosis of HIV/AIDS required Prophylaxis, both pre and post exposure covered
ISENTRESS CHEW TAB, POWDER PACK, TAB (raltegravir) ^{QL}		
ISENTRESS HD (raltegravir)		
TIVICAY (dolutegravir)		
NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NNRTIs)		
EDURANT (rilpivirine)	efavirenz (generic for Sustiva)	
INTELENCE (etravirine) ^{QL}	<i>nevirapine TAB (generic for Viramune)</i>	
<i>PIFELTRO (doravirine)^{NR, QL}</i>	<i>nevirapine er (generic for Viramune XR)</i>	
SUSTIVA CAP, TAB (efavirenz)	<i>RESCRIPTOR (delavirdine)</i>	
	<i>VIRAMUNE SUSP, TAB (nevirapine)</i>	
	VIRAMUNE XR (nevirapine extended release)	
NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTIs)		
abacavir SOLN, TAB (generic for Ziagen)	<i>didanosine CAP DR (generic for Videx EC)</i>	
EMTRIVA CAP, SOLN (emtricitabine)	EPIVIR (lamivudine)	
lamivudine SOLN, TAB (generic for Eпивir)	RETROVIR (zidovudine)	
zidovudine CAP, SYRUP, TAB (generic for Retrovir)	<i>stavudine CAP, SOLN (generic for Zerit)</i>	
	<i>VIDEX SOLN (didanosine)</i>	
	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)		
<i>tenofovir disoproxil fumarate</i> TAB (generic for <i>Viread</i>)	<i>VIREAD</i> (<i>tenofovir disoproxil fumarate</i>)	
PHARMACOKINETIC ENHANCER		
TYBOST (<i>cobicistat</i>) ^{QL}		
PROTEASE INHIBITORS		
<i>atazanavir</i> CAP (generic for <i>Reyataz</i>) LEXIVA SUSP, TAB (<i>fosamprenavir</i>) NORVIR TAB (<i>ritonavir</i>) PREZISTA SUSP, TAB (<i>darunavir</i>)	<i>APTIVUS CAP, SOLN</i> (<i>tipranavir</i>) <i>CRIXIVAN</i> (<i>indinavir</i>) fosamprenavir TAB (generic for <i>Lexiva</i>) <i>INVIRASE</i> (<i>saquinavir</i>) <i>NORVIR POWDER PACK^{NR}</i> <i>NORVIR SOLN</i> (<i>ritonavir</i>) <i>REYATAZ CAP, POWDER PACK</i> (<i>atazanavir</i>) ritonavir TAB (generic for <i>Norvir</i>) <i>VIRACEPT</i> (<i>nelfinavir</i>)	
COMBINATION NUCLEOS(T)IDE REVERSE TRANSCRIPTASE INHIBITORS		
abacavir/lamivudine (generic for <i>Epzicom</i>) abacavir/lamivudine/zidovudine (generic for <i>Trizivir</i>) <i>CIMDUO</i> (<i>lamivudine/tenofovir disoproxil fumarate</i>) ^{NR, QL} DESCOVY (<i>emtricitabine/tenofovir alafenamide</i>) ^{QL} lamivudine/zidovudine (generic for <i>Combivir</i>) TRUVADA (<i>emtricitabine/tenofovir disoproxil fumarate</i>)	COMBIVIR (<i>lamivudine/zidovudine</i>) EPZICOM (<i>abacavir sulfate/lamivudine</i>) TRIZIVIR (<i>abacavir/ lamivudine/zidovudine</i>)	

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 TAB (lopinavir/ritonavir) PREZCOBIX (darunavir/cobicistat) ^{QL} lopinavir/ritonavir SOLN (generic for Kaletra)	KALETRA SOLN (lopinavir/ritonavir)	
COMBINATION PRODUCTS – MULTIPLE CLASSES		
ATRIPLA (tenofovir disoproxil fumarate/ emtricitabine/efavirenz) COMPLERA (rilpivirine/emtricitabine/tenofovir disoproxil fumarate) <i>DELSTRIGO (doravirine/lamivudine/tenofovir disoproxil fumarate)^{NR, QL}</i> GENVOYA (elvitegravir/cobicistat/emtricitabine/tenofovir alafenamide) ^{QL, AL} ODEFSEY (emtricitabine/rilpivirine/tenofovir alafenamide) ^{QL} STRIBILD (elvitegravir/cobicistat/emtricitabine/tenofovir disoproxil fumarate) ^{QL} <i>SYMFI (efavirenz/lamivudine/tenofovir disoproxil fumarate)^{NR, QL}</i> <i>SYMFI LO (efavirenz/lamivudine/tenofovir disoproxil fumarate)^{NR, QL}</i>	<i>BIKTARVY (bictegravir/emtricitabine/tenofovir alafenamide)^{QL}</i> <i>DOVATO (dolutegravir/lamifudine)^{NR, QL}</i> <i>JULUCA (dolutegravir/rilpivirine)^{QL}</i> <i>SYMTUZA (darunavir, cobicistat, emtricitabine, tenofovir alafenamide)^{NR, QL}</i> <i>TRIUMEQ (dolutegravir/abacavir/lamivudine)</i>	

HYPOGLYCEMICS, ALPHA-GLUCOSIDASE INHIBITORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
acarbose (generic for Precose) Glyset (miglitol)	miglitol (generic for Glyset)	<ul style="list-style-type: none"> 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
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)	Non-preferred agents will be approved for patients who have: <ul style="list-style-type: none"> Failed a trial of TWO preferred agents within GLP-1 RA AND <ul style="list-style-type: none"> Diagnosis of diabetes with HbA1C ≥ 7 AND Trial of metformin, or contraindication or intolerance to metformin
INSULIN/GLP-1 RA COMBINATIONS		
	SOLIQUA (insulin glargine/lixisenatide) XULTOPHY (insulin degludec/liraglutide)	<ul style="list-style-type: none"> Trial of metformin, or contraindication or intolerance to metformin
AMYLIN ANALOG		
	SYMLIN (pramlintide) subcutaneous	ALL criteria must be met <ul style="list-style-type: none"> Concurrent use of short-acting mealtime insulin Current therapy compliance No diagnosis of gastroparesis HbA1C $\leq 9\%$ within last 90 days Fingerstick monitoring of glucose during <u>initiation</u> of therapy
DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITOR		
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}	Non-preferred agents within DPP-4 will be approved for patients who have failed a trial of ONE preferred agent within DPP-4

HYPOGLYCEMICS, INSULIN AND RELATED DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<p>HUMALOG (insulin lispro) U-100 CARTRIDGE, PEN, VIAL</p> <p>HUMALOG MIX VIAL (insulin lispro/lispro protamine)</p> <p>HUMULIN (insulin) VIAL</p> <p>HUMULIN 70/30 VIAL</p> <p>HUMULIN U-500 VIAL</p> <p>HUMALOG MIX PEN (insulin lispro/lispro protamine)</p> <p>LANTUS SOLOSTAR PEN (insulin glargine)</p> <p>LANTUS (insulin glargine) VIAL</p> <p>LEVEMIR (insulin detemir) PEN, VIAL</p> <p>NOVOLOG (insulin aspart) CARTRIDGE, PEN, VIAL</p> <p>NOVOLOG MIX PEN, VIAL (insulin aspart/aspart protamine)</p>	<p>ADMELOG (insulin lispro) PEN, VIAL</p> <p>AFREZZA (regular insulin, inhaled)</p> <p>APIDRA (insulin glulisine)</p> <p>BASAGLAR (insulin glargine, rec) PEN</p> <p>FIASP (insulin aspart) PEN, VIAL</p> <p>HUMALOG JR. (insulin lispro) U-100 PEN</p> <p>HUMALOG (insulin lispro) U-200 PEN</p> <p>HUMULIN 70/30 PEN</p> <p>HUMULIN R U-500 KWIKPEN^{CL}</p> <p>HUMULIN OTC PEN</p> <p>insulin lispro (generic for Humalog) PEN, VIAL</p> <p>NOVOLIN (insulin)</p> <p>NOVOLIN 70/30 VIAL</p> <p>TOUJEO SOLOSTAR (insulin glargine)</p> <p>TRESIBA (insulin degludec)</p>	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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
<p>repaglinide (generic for Prandin)</p>	<p>nateglinide (generic for Starlix)</p> <p>repaglinide/metformin (generic for Prandimet)</p>	<ul style="list-style-type: none"> 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
<p>glipizide/metformin</p> <p>glyburide/metformin (generic for Glucovance)</p> <p>metformin & ER (generic for Glucophage/XR)</p>	<p>metformin ER (generic for Fortamet)</p> <p>metformin ER (generic for Glumetza)</p> <p>RIOMET (metformin)</p>	<ul style="list-style-type: none"> 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} SEGLUOMET (ertugliflozin/metformin) ^{QL} STEGLATRO (ertugliflozin) ^{QL} SYNJARDY (empagliflozin/metformin) SYNJARDY XR (empagliflozin/ metformin) ^{QL} XIGDUO XR (dapagliflozin/metformin) ^{QL}	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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
THIAOLIDINEDIONES (TZDs)		<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of THE preferred agent within this drug class
pioglitazone (generic for Actos)	AVANDIA (rosiglitazone)	
TZD COMBINATIONS		<ul style="list-style-type: none"> Combination products: Require clinical reason why individual ingredients cannot be used
	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) <i>cyclosporine</i> 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^{MR} RAPAMUNE (sirolimus) TABLET SANDIMMUNE (cyclosporine) CAPSULE, SOLUTION <i>sirolimus</i> (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 <ul style="list-style-type: none"> 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			
cholestyramine (generic for Questran) colestipol TABLETS (generic for Colestid)	colesevelam (generic for Welchol) TABLET, PACKET colestipol GRANULES (generic for Colestid) QUESTRAN LIGHT (cholestyramine)	<ul style="list-style-type: none"> ▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: <ul style="list-style-type: none"> ▪ 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: <ul style="list-style-type: none"> • atherosclerotic cardiovascular disease (ASCVD) • heterozygous familial hypercholesterolemia (HeFH) AND <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • adult diagnoses of atherosclerotic cardiovascular disease (ASCVD) • heterozygous familial hypercholesterolemia (HeFH) • homozygous familial hypercholesterolemia (HoFH) in age ≥ 13 • statin-induce rhabdomyolysis AND <ul style="list-style-type: none"> • 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 	
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 Fibracor) 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)			
PROTEIN 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		<ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> 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) <i>ZYPITAMAG (pitavastatin)^{NR}</i>	
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		<ul style="list-style-type: none"> Ketek®: Requires clinical reason why patient cannot use preferred macrolide
	KETEK (telithromycin)	
MACROLIDES		<ul style="list-style-type: none"> Macrolides: Require clinical reason why preferred products within this drug class cannot be used AND ≥ 3-day trial on a preferred macrolide
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} <i>TECFIDERA (dimethyl fumarate)</i>	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} <i>MAVENCLAD (cladribine)^{NR}</i> <i>MAYZENT (siponimod)^{NR, QL}</i> PLEGRIDY (peginterferon beta-1a) ^{QL}	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: <ul style="list-style-type: none"> 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 Macrochantin) nitrofurantoin monohydrate-macrocrystals CAPSULE (generic for Macrobid)		<ul style="list-style-type: none"> 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 <i>LUCEMYRA (lofexidine)^{NR, QL}</i> ZUBSOLV (buprenorphine/naloxone)	<p style="text-align: center;">Buprenorphine PA Form Buprenorphine Informed Consent</p> Non-Preferred: Bunavail, buprenorphine SL, Buprenorphine/naloxone SL, Zubsolv: <ul style="list-style-type: none"> 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 appropriate for patient Drug-specific criteria: <ul style="list-style-type: none"> 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		<ul style="list-style-type: none"> 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)	<ul style="list-style-type: none"> 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 <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> 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)	<ul style="list-style-type: none"> 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
<p>CHILD LITTLE ANIMALS VITAMINS CHEW OTC (pedi multivit 91/iron fum) CHEW</p> <p>child multivitamins chew otc (pedi multivit 19/folic acid) CHEW</p> <p>CHILDREN'S CHEW MULTIVIT-IRON OTC (pedi multivit 91/iron fum) CHEW</p> <p>children's chewables otc (pedi multivit 23/folic acid) CHEW</p> <p>children's vitamins with iron otc (pedi multivit/iron)</p> <p>fluoride/vitamins A,C,AND D (ped multivit A,C,D3, 21/fluoride) DROPS</p> <p>infant-toddler multivit drop OTC (pediatric multivit no. 165 drops)</p> <p>infant-toddler multivit-iron OTC (pedi mv no.164/ferrous sulfate drops)</p> <p>infant-toddler tri-vit drop (vit a pamintate/vit c/vit d3 drops)</p> <p>multivitamins with fluoride (pedi multivit 2/fluoride) DROPS</p> <p>multivits with iron and fluoride (pedi multivit 45/fluoride/iron) DROPS</p> <p>MVC-FLUORIDE (pedi multivit 12/fluoride) CHEW TAB</p> <p>ped mvit A,C,D3,No 21/fluoride DROPS</p> <p>pedi mvi no. 16 with fluoride CHEW</p> <p>pedi mvi 17 with fluoride CHEW</p> <p>POLY-VI-SOL OTC (pedi multivit 81) DROPS</p> <p>POLY-VI-SOL WITH IRON (pedi multivit 80/ferrous sulfate) DROPS</p> <p>TRI-VI-SOL OTC (vit A palmitate/vit C/Vit D3) DROPS</p> <p>tri-vite-fluoride 0.25 mg/ml, and 0.5 mg/ml</p> <p>VITALETS OTC (pedi multivit 36/iron) CHEW</p>	<p>AQUADEKS (pedi multivit 40/phytonadione)</p> <p>ESCAVITE (pedi multivit 47/iron/fluoride)</p> <p>ESCAVITE D (pedi multivit 78/iron/fluoride) CHEW</p> <p>ESCAVITE LQ (pedi multivit 86/iron/fluoride)</p> <p>FLORIVA (pedi multivit 85/fluoride) CHEW</p> <p>FLORIVA PLUS OTC and Rx (pedi multivit 130/fluoride) DROPS</p> <p>multivit A, B, D, E, K, ZN (pediatric multivit 153/D3/K)</p> <p>POLY-VI-FLOR (pedi multivit 33/fluoride) CHEW</p> <p>POLY-VI-FLOR (pedi multivit 37/fluoride) DROPS</p> <p>POLY-VI-FLOR w/IRON (pedi multivit 33/fluoride/iron) CHEW</p> <p>POLY-VI-FLOR w/IRON (pedi multivit 37/fluoride/iron) DROPS</p> <p>QUFLORA OTC and Rx (pedi multivit 84/fluoride)</p> <p>QUFLORA FE (pedi multivit 142/iron/fluoride)</p> <p>TRI-VI-FLORO (ped multivit A, C, D3, 38/fluoride)</p>	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class <p>Drug specific criteria:</p> <ul style="list-style-type: none"> 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		<ul style="list-style-type: none"> 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 oxvhdroxide)	<ul style="list-style-type: none"> 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) <i>prasugrel (generic for Effient)</i>	aspirin/dipyridamole (generic for Aggrenox) ticlopidine (generic for Ticlid) YOSPRALA (aspirin/omeprazole) ZONTIVITY (vorapaxar) ^{CL}	<ul style="list-style-type: none"> 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 <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> 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
<p>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)</p>		<ul style="list-style-type: none"> 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 <p>Additional covered agents can be looked up using the Drug Look-up Tool at: https://druglookup.fhsc.com/druglookupweb/?client=nestate</p>

PROTON PUMP INHIBITORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<p>omeprazole (generic for Prilosec) RX pantoprazole (generic for Protonix)</p>	<p>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)</p>	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed an 8-week trial of BOTH preferred agents within this drug class <p>Pediatric Patients: Patients ≤ 4 years of age – No PA required for Prevacid 30mg or omeprazole 20mg capsules (used to compound suspensions).</p> <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> 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
	<p>CORLANOR (ivabradine)</p>	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> ▪ Non-preferred agents will be approved for patients who have failed a 1-week trial of TWO preferred agents within this drug class <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> ▪ 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 day 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 <i>doxycycline monohydrate SUSP (generic for Vibramycin 25MG)</i> <i>doxycycline monohydrate TAB</i> minocycline HCL CAPSULE (generic for Minocin, Dynacin) <i>minocycline HCL TABLET (generic for Dynacin, Murac)</i>	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) <i>NUZYRA (omadacycline)^{NR}</i> tetracycline HCl (generic for Sumycin) VIBRAMYCIN SUSP (doxycycline) XIMINO (minocycline ER) CAPSULE ^{QL}	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a 3-day trial of TWO preferred agents within this drug class Drug-specific criteria: <ul style="list-style-type: none"> 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) <i>TIROSINT-SOL (LIQUID) (levothyroxine)^{NR,CL}</i>	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: <ul style="list-style-type: none"> Tirosint-Sol: May be approved with documented swallowing difficulty

ULCERATIVE COLITIS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ORAL		
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)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: <ul style="list-style-type: none"> 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
RECTAL		
CANASA (mesalamine) <i>mesalamine (generic Rowasa)</i>	sf ROWASA (mesalamine) mesalamine (generic for Canasa) UCERIS (budesonide)	

UTERINE DISORDER TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<i>ORILISSA (elagolix sodium)</i>		Drug-specific criteria: <ul style="list-style-type: none"> 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 <i>(nitroglycerin)</i>	<ul style="list-style-type: none"> 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.