DIVISION OF MEDICAID AND LONG-TERM CARE
Nebraska DHHS

PHARMACEUTICAL AND THERAPEUTICS COMMITTEE MEETING MINUTES
May 13, 2020 at 9 a.m. CST
Virtual Meeting via ZOOM Webinar

Committee Members Present:
Eric Avery, M.D. (Vice Chair)
Claire Baker, M.D.
Stacie Bleicher, M.D.
Kyle Clarey, Pharm.D.
Allison Dering-Anderson, Pharm.D.
Gary Elsasser, Pharm.D. **(Morning Only)**
Wade Fornander, M.D. **(Morning Only)**
Jeffrey Gotschall, M.D. **(Morning Only)**
Mary Hammond, Pharm.D.
Jennifer Hill, M.D.
Laurie Humphries, M.D.
Joyce Juracek, Pharm.D.
Rachelle Kaspar-Cope, M.D.
Lauren Nelson, M.D.
Jessica Pohl, Pharm.D.
Linda Sobeski, Pharm.D. (Chair)

Division of Medicaid and Long-Term Care Staff Present:
Carisa Masek, Pharm.D., MBA, MPH
Leah Spencer, R.N., M.Ed.
Dianne Garside, Pharm.D.
Ken Saunders, Pharm.D.

Magellan Medicaid Administration Staff Present:
Jessica Czechowski, Pharm.D., Clinical Account Executive
Nikia Bennette-Carter, Pharm.D., Clinical Account Executive
Valarie Simmons, M.S., Account Executive

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

Committee Members Excused:
Gary Elsasser, Pharm.D. **(Afternoon Only)**
Wade Fornander, M.D. **(Afternoon Only)**
Jeffrey Gotschall, M.D. **(Afternoon Only)**

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

i. The meeting was called to order at 9:00am CT. A copy of the Agenda, Open Meetings Act, and Proposed Preferred Drug List (PDL) were posted on the Nebraska Medicaid Pharmacy website (https://nebraska.fhsc.com/PDL/PTcommittee.asp).

(1st) Motion: **Avery**	(2nd) Motion: **Dering-Anderson**
Unanimously approved by all in attendance.	

ii. Roll Call: See list above.

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

iv. Approval of November 13, 2019 P&T Committee Meeting Minutes:

(1st) Motion: **Baker**	(2nd) Motion: **Fornander**
Unanimously approved by all in attendance.	

i. Department information: No updates were presented.

II. Public Testimony

Speaker Order	DRUG CLASS	Drug Name	PDL Status	Speaker Name	Affiliation
1	Anti-Migraine Agents	Nurtec ODT	NP	Chelsea Leroue	Biohaven Pharma
2	Anti-Migraine Agents-Other	Ajovy	P	Maggie Murphy	Teva Pharmaceuticals
3	Multiple Sclerosis Drugs	Vumerity	NP	Tami Sova	Biogen
4	Multiple Sclerosis Drugs	Tecfidera	P	Tami Sova	Biogen
5	Multiple Sclerosis Drugs	Aubagio	NP	Kevin Duhrkopf	Sanofi
6	Multiple Sclerosis Drugs	Mayzent	NP	Kerri Hoernmann	Novartis
7	HIV/AIDS Combination products-multiple classes	Dovato	NP	Terra Stone	ViiV Healthcare
8	HIV/AIDS Combination products-multiple classes	Juluca	NP	Terra Stone	ViiV Healthcare
9	Anticoagulants	Xarelto	P	Erin Hohman	Janssen
10	Hypoglycemics SGLT2	Invokana	P	Erin Hohman	Janssen
11	HIV/AIDS	Symtuza	NP	Erin Hohman	Janssen
12	HIV/AIDS Combination products-multiple classes	Biktarvy	P	Manasa Velagapudi	CHIP Health CVMC Bergan Mercy
13	HIV/AIDS Combination products-multiple classes	Biktarvy	P	Stuart O'Brochta	Gilead
14	Hepatitis B	Velmidy	NP	Stuart O'Brochta	GIlead
15	Hepatitis C	Epclusa	NP	Stuart O'Brochta	Gilead
16	Hepatitis C Treatments Direct Acting Anti-Viral	Epclusa	NP	Sandeep Mukherjee	CHP/Creighton University
17	Hepatitis C	Mavyret	P	Holly Budlong	AbbVie
18	Pancreatic Enzymes	Creon	P	Holly Budlong	AbbVie
19	Uterine Disorder Treatment-Endometriosis	Orilissa	P	Holly Budlong	AbbVie
20	Growth Hormones	Genotropin	P	James Baumann	Pfizer
21	Bladder Relaxant Preparations	Toviaz	P	James Baumann	Pfizer
22	PAH (pulmonary arterial hypertension) oral or inhaled	Orenitram	NP	Amy Heidenreich	United Therapeutics
23	Hypoglycemics, Incretin Mimetics/Enhancers	Ozempic	NP	Ryan Flugge	Novo Nordisk
24	Hypoglycemics, Incretin Mimetics/Enhancers	Rybelsus	NP	Ryan Flugge	Novo Nordisk
25	Hypoglycemics, Insulin and Related Drugs	Tresiba	NP	Ryan Flugge	Novo Nordisk
26	Glucagon Agents	Gvoke	NP	Stevan Tomich	Xeris Pharmaceuticals
27	Beta Blockers, oral	Hemangeol	NP	Christine Cazeau	Pierre Fabre USA, Inc.
28	Anticoagulants	Eliquis	P	Rick Szymialis	Bristol Myers Squibb

III. Committee Closed Session.

(1st) Motion: **Baker**	(2nd) Motion: **Gotschall**
Unanimously approved by all in attendance.	

IV. Resume Open Session.

(1st) Motion: **Avery**	(2nd) Motion: **Hill**
Unanimously approved by all in attendance.	

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: Dering-Anderson							
(2nd) Motion: Fornander							
Discussion: Approve as written.							
Voting – P&T Committee Members Does not include absent or excused members	**Yes**	**No**	**Abstain**	**Voting – P&T Committee Members**	**Yes**	**No**	**Abstain**
Avery, Eric, M.D. (Vice Chair)	x			Humphries, Laurie, M.D.	x		
Baker, Claire, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Bleicher, Stacie, M.D.	x			Kaspar-Cope, Rachelle, M.D.	x		
Clarey, Kyle, Pharm.D.	x			Nelson, Lauren, M.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Hammond, Mary, M.D.	x			Sobeski, Linda, Pharm.D. (Chair) • ***Votes only in the event of a tie***			
Hill, Jennifer, M.D.	x						

Consent Agenda: Therapeutic categories (TC) with unchanged recommendations unless otherwise indicated.	
Analgesics, Opioids Short-Acting	Hypoglycemics, Metformins
Antibiotics, Gastrointestinal	Hypoglycemics, Sulfonylureas
Antibiotics, Inhaled	Hypoglycemics, TZDs
Antibiotics, Topical	Immunosuppressives, Oral
Antiemetics / Antivertigo Agents	Lincosamides / Oxazolidinones / Streptogramins
Antifungals, Oral	Lipotropics, Other
Antifungals, Topical	Macrolides and Ketolides
Antivirals, Topical	Opioid Dependence Treatments
Beta-Blockers	Pancreatic Enzymes
BPH - Benign Prostatic Hyperplasia Agents	Pediatric Vitamin Preparations
Cephalosporins and Related Antibiotics	Penicillins
Diuretics	Platelet Aggregation Inhibitors
Fluoroquinolones, Oral	Proton Pump Inhibitors
GI Motility, Chronic (formerly IBS)	Sinus Mode Inhibitors
H. Pylori Treatment	Skeletal Muscle Relaxants
Hepatitis B Agents	Tetracyclines
Hepatitis C Agents	Uterine Disorder Treatments
Hypoglycemics, Alpha-glucosidase Inhibitors	Vasodilators, Coronary

Hypoglycemics, Meglitinides	

ii. Therapeutic Class Reviews

Review Agenda – Acne Agents, Topical

(1st) Motion: Dering-Anderson

(2nd) Motion: Juracek

Discussion: Approve as written.

Voting – P&T Committee Members Does not include absent or excused members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D. (Vice Chair)	x			Humphries, Laurie, M.D.	x		
Baker, Claire, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Bleicher, Stacie, M.D.	x			Kaspar-Cope, Rachelle, M.D.	x		
Clarey, Kyle, Pharm.D.	x			Nelson, Lauren, M.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Hammond, Mary, M.D.	x			Sobeski, Linda, Pharm.D. (Chair) • ***Votes only in the event of a tie***			
Hill, Jennifer, M.D.	x						

Review Agenda – Analgesics, Opioids Long-Acting

(1st) Motion: Avery

(2nd) Motion: Juracek

Discussion: Approve as written.

Voting – P&T Committee Members Does not include absent or excused members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D. (Vice Chair)	x			Humphries, Laurie, M.D.	x		
Baker, Claire, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Bleicher, Stacie, M.D.	x			Kaspar-Cope, Rachelle, M.D.	x		
Clarey, Kyle, Pharm.D.	x			Nelson, Lauren, M.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Hammond, Mary, M.D.	x			Sobeski, Linda, Pharm.D. (Chair) • ***Votes only in the event of a tie***			
Hill, Jennifer, M.D.	x						

Review Agenda – Androgenic Agents

(1st) Motion: Baker

(2nd) Motion: Avery

Discussion: Approve as written.

Voting – P&T Committee Members Does not include absent or excused members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D. (Vice Chair)	x			Humphries, Laurie, M.D.	x		
Baker, Claire, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Bleicher, Stacie, M.D.	x			Kaspar-Cope, Rachelle, M.D.	x		
Clarey, Kyle, Pharm.D.	x			Nelson, Lauren, M.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Hammond, Mary, M.D.	x			Sobeski, Linda, Pharm.D. (Chair) • ***Votes only in the event of a tie***			
Hill, Jennifer, M.D.	x						

Review Agenda – Angiotensin Modulators

(1st) Motion: Avery

(2nd) Motion: Juracek

Discussion: Approve as written.

Voting – P&T Committee Members Does not include absent or excused members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D. (Vice Chair)	x			Humphries, Laurie, M.D.	x		
Baker, Claire, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Bleicher, Stacie, M.D.	x			Kaspar-Cope, Rachelle, M.D.	x		
Clarey, Kyle, Pharm.D.	x			Nelson, Lauren, M.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Hammond, Mary, M.D.	x			Sobeski, Linda, Pharm.D. (Chair) • ***Votes only in the event of a tie***			
Hill, Jennifer, M.D.	x						

Review Agenda – Angiotensin Modulators Combinations

(1st) Motion: Avery

(2nd) Motion: Dering-Anderson

Discussion: Approve as written.

Voting – P&T Committee Members Does not include absent or excused members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D. (Vice Chair)	x			Humphries, Laurie, M.D.	x		
Baker, Claire, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Bleicher, Stacie, M.D.	x			Kaspar-Cope, Rachelle, M.D.	x		
Clarey, Kyle, Pharm.D.	x			Nelson, Lauren, M.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Hammond, Mary, M.D.	x			Sobeski, Linda, Pharm.D. (Chair) • ***Votes only in the event of a tie***			
Hill, Jennifer, M.D.	x						

Review Agenda – Antibiotics, Vaginal

(1st) Motion: Hill

(2nd) Motion: Baker

Discussion: Approve as written.

Voting – P&T Committee Members Does not include absent or excused members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D. (Vice Chair)	x			Humphries, Laurie, M.D.	x		
Baker, Claire, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Bleicher, Stacie, M.D.	x			Kaspar-Cope, Rachelle, M.D.	x		
Clarey, Kyle, Pharm.D.	x			Nelson, Lauren, M.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Hammond, Mary, M.D.	x			Sobeski, Linda, Pharm.D. (Chair) • ***Votes only in the event of a tie***			
Hill, Jennifer, M.D.	x						

Review Agenda – Anticoagulants

(1st) Motion: Avery

(2nd) Motion: Juracek

Discussion: Approve as written.

Voting – P&T Committee Members Does not include absent or excused members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D. (Vice Chair)	x			Humphries, Laurie, M.D.	x		
Baker, Claire, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Bleicher, Stacie, M.D.	x			Kaspar-Cope, Rachelle, M.D.	x		
Clarey, Kyle, Pharm.D.	x			Nelson, Lauren, M.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Hammond, Mary, M.D.	x			Sobeski, Linda, Pharm.D. (Chair) • ***Votes only in the event of a tie***			
Hill, Jennifer, M.D.	x						

Review Agenda – Antimigraine Agents, Other

(1st) Motion: Juracek

(2nd) Motion: Hill

Discussion: Approve as written.

Voting – P&T Committee Members Does not include absent or excused members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D. (Vice Chair)	x			Humphries, Laurie, M.D.	x		
Baker, Claire, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Bleicher, Stacie, M.D.	x			Kaspar-Cope, Rachelle, M.D.	x		
Clarey, Kyle, Pharm.D.	x			Nelson, Lauren, M.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Hammond, Mary, M.D.	x			Sobeski, Linda, Pharm.D. (Chair) • ***Votes only in the event of a tie***			
Hill, Jennifer, M.D.	x						

Review Agenda – Antimigraine Agents, Triptans

(1st) Motion: Juracek

(2nd) Motion: Avery

Discussion: Approve as written.

Voting – P&T Committee Members Does not include absent or excused members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D. (Vice Chair)	x			Humphries, Laurie, M.D.	x		
Baker, Claire, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Bleicher, Stacie, M.D.	x			Kaspar-Cope, Rachelle, M.D.	x		
Clarey, Kyle, Pharm.D.	x			Nelson, Lauren, M.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Hammond, Mary, M.D.	x			Sobeski, Linda, Pharm.D. (Chair) • ***Votes only in the event of a tie***			
Hill, Jennifer, M.D.	x						

Review Agenda – Antiparasitics, Topical

(1st) Motion: Avery

(2nd) Motion: Juracek

Discussion: Approve as written.

Voting – P&T Committee Members Does not include absent or excused members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D. (Vice Chair)	x			Humphries, Laurie, M.D.	x		
Baker, Claire, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Bleicher, Stacie, M.D.	x			Kaspar-Cope, Rachelle, M.D.	x		
Clarey, Kyle, Pharm.D.	x			Nelson, Lauren, M.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Hammond, Mary, M.D.	x			Sobeski, Linda, Pharm.D. (Chair) • ***Votes only in the event of a tie***			
Hill, Jennifer, M.D.	x						

Review Agenda – Antivirals, Oral

(1st) Motion: Hill

(2nd) Motion: Juracek

Discussion: Approve as written.

Voting – P&T Committee Members Does not include absent or excused members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D. (Vice Chair)	x			Humphries, Laurie, M.D.	x		
Baker, Claire, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Bleicher, Stacie, M.D.	x			Kaspar-Cope, Rachelle, M.D.	x		
Clarey, Kyle, Pharm.D.	x			Nelson, Lauren, M.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Hammond, Mary, M.D.	x			Sobeski, Linda, Pharm.D. (Chair) • ***Votes only in the event of a tie***			
Hill, Jennifer, M.D.	x						

Review Agenda – Bladder Relaxant Preparations

(1st) Motion: Hill

(2nd) Motion: Juracek

Discussion: Approve as written.

Voting – P&T Committee Members Does not include absent or excused members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D. (Vice Chair)	x			Humphries, Laurie, M.D.	x		
Baker, Claire, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Bleicher, Stacie, M.D.	x			Kaspar-Cope, Rachelle, M.D.	x		
Clarey, Kyle, Pharm.D.	x			Nelson, Lauren, M.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Hammond, Mary, M.D.	x			Sobeski, Linda, Pharm.D. (Chair) • ***Votes only in the event of a tie***			
Hill, Jennifer, M.D.	x						

Review Agenda – Bone Resorption Suppression and Related Agents

(1st) Motion: Juracek

(2nd) Motion: Hill

Discussion: Approve as written.

Voting – P&T Committee Members Does not include absent or excused members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D. (Vice Chair)	x			Humphries, Laurie, M.D.	x		
Baker, Claire, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Bleicher, Stacie, M.D.	x			Kaspar-Cope, Rachelle, M.D.	x		
Clarey, Kyle, Pharm.D.	x			Nelson, Lauren, M.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Hammond, Mary, M.D.	x			Sobeski, Linda, Pharm.D. (Chair) • ***Votes only in the event of a tie***			
Hill, Jennifer, M.D.	x						

Review Agenda – Calcium Channel Blockers

(1st) Motion: Dering-Anderson

(2nd) Motion: Juracek

Discussion: Approve as written.

Voting – P&T Committee Members Does not include absent or excused members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D. (Vice Chair)	x			Humphries, Laurie, M.D.	x		
Baker, Claire, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Bleicher, Stacie, M.D.	x			Kaspar-Cope, Rachelle, M.D.	x		
Clarey, Kyle, Pharm.D.	x			Nelson, Lauren, M.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Hammond, Mary, M.D.	x			Sobeski, Linda, Pharm.D. (Chair) • ***Votes only in the event of a tie***			
Hill, Jennifer, M.D.	x						

Review Agenda – Contraceptives, Oral

(1st) Motion: Hill

(2nd) Motion: Avery

Discussion: Approve as written.

Voting – P&T Committee Members Does not include absent or excused members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D. (Vice Chair)	x			Humphries, Laurie, M.D.	x		
Baker, Claire, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Bleicher, Stacie, M.D.	x			Kaspar-Cope, Rachelle, M.D.	x		
Clarey, Kyle, Pharm.D.	x			Nelson, Lauren, M.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Hammond, Mary, M.D.	x			Sobeski, Linda, Pharm.D. (Chair) • ***Votes only in the event of a tie***			
Hill, Jennifer, M.D.	x						

Review Agenda – Cystic Fibrosis

(1st) Motion: Avery

(2nd) Motion: Juracek

Discussion: Approve as written.

Voting – P&T Committee Members Does not include absent or excused members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D. (Vice Chair)	x			Humphries, Laurie, M.D.	x		
Baker, Claire, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Bleicher, Stacie, M.D.	x			Kaspar-Cope, Rachelle, M.D.	x		
Clarey, Kyle, Pharm.D.	x			Nelson, Lauren, M.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Hammond, Mary, M.D.	x			Sobeski, Linda, Pharm.D. (Chair) • ***Votes only in the event of a tie***			
Hill, Jennifer, M.D.	x						

Review Agenda – Glucagon Agents - *NEW

(1st) Motion: Avery

(2nd) Motion: Juracek

Discussion: Approve as written.

Voting – P&T Committee Members Does not include absent or excused members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D. (Vice Chair)	x			Humphries, Laurie, M.D.	x		
Baker, Claire, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Bleicher, Stacie, M.D.	x			Kaspar-Cope, Rachelle, M.D.	x		
Clarey, Kyle, Pharm.D.	x			Nelson, Lauren, M.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Hammond, Mary, M.D.	x			Sobeski, Linda, Pharm.D. (Chair) • ***Votes only in the event of a tie***			
Hill, Jennifer, M.D.	x						

Review Agenda – Growth Hormone

(1st) Motion: Baker

(2nd) Motion: Juracek

Discussion: Approve as written.

Voting – P&T Committee Members Does not include absent or excused members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D. (Vice Chair)	x			Humphries, Laurie, M.D.	x		
Baker, Claire, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Bleicher, Stacie, M.D.	x			Kaspar-Cope, Rachelle, M.D.	x		
Clarey, Kyle, Pharm.D.	x			Nelson, Lauren, M.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Hammond, Mary, M.D.	x			Sobeski, Linda, Pharm.D. (Chair) • ***Votes only in the event of a tie***			
Hill, Jennifer, M.D.	x						

Review Agenda – HAE Treatments - *NEW

(1st) Motion: Juracek

(2nd) Motion: Hill

Discussion: Approve as written.

Voting – P&T Committee Members Does not include absent or excused members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D. (Vice Chair)	x			Humphries, Laurie, M.D.	x		
Baker, Claire, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Bleicher, Stacie, M.D.	x			Kaspar-Cope, Rachelle, M.D.	x		
Clarey, Kyle, Pharm.D.	x			Nelson, Lauren, M.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Hammond, Mary, M.D.	x			Sobeski, Linda, Pharm.D. (Chair) • ***Votes only in the event of a tie***			
Hill, Jennifer, M.D.	x						

Review Agenda – HIV/AIDS

(1st) Motion: Dering-Anderson

(2nd) Motion: Avery

Discussion: Approve as written.

Voting – P&T Committee Members Does not include absent or excused members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D. (Vice Chair)	x			Humphries, Laurie, M.D.	x		
Baker, Claire, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Bleicher, Stacie, M.D.	x			Kaspar-Cope, Rachelle, M.D.	x		
Clarey, Kyle, Pharm.D.	x			Nelson, Lauren, M.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Hammond, Mary, M.D.	x			Sobeski, Linda, Pharm.D. (Chair) • ***Votes only in the event of a tie***			
Hill, Jennifer, M.D.	x						

Review Agenda – Hypoglycemics, Incretin Mimetics / Enhancers

(1st) Motion: Baker

(2nd) Motion: Hill

Discussion: Approve as written. Baker would like to see drug with cardiovascular benefits added to the Preferred list. Suggested, Trulicity.

Voting – P&T Committee Members Does not include absent or excused members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D. (Vice Chair)	x			Humphries, Laurie, M.D.	x		
Baker, Claire, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Bleicher, Stacie, M.D.	x			Kaspar-Cope, Rachelle, M.D.	x		
Clarey, Kyle, Pharm.D.	x			Nelson, Lauren, M.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Hammond, Mary, M.D.	x			Sobeski, Linda, Pharm.D. (Chair) • ***Votes only in the event of a tie***			
Hill, Jennifer, M.D.	x						

Review Agenda – Hypoglycemics, Insulin and Related Agents

(1st) Motion: Baker

(2nd) Motion: Hammond

Discussion: Approve as written.

Voting – P&T Committee Members Does not include absent or excused members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D. (Vice Chair)	x			Humphries, Laurie, M.D.	x		
Baker, Claire, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Bleicher, Stacie, M.D.	x			Kaspar-Cope, Rachelle, M.D.	x		
Clarey, Kyle, Pharm.D.	x			Nelson, Lauren, M.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Hammond, Mary, M.D.	x			Sobeski, Linda, Pharm.D. (Chair) • ***Votes only in the event of a tie***			
Hill, Jennifer, M.D.	x						

Review Agenda – Hypoglycemics, SGLT2

(1st) Motion: Baker

(2nd) Motion: Hammond

Discussion: Approve as written.

Voting – P&T Committee Members Does not include absent or excused members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D. (Vice Chair)	x			Humphries, Laurie, M.D.	x		
Baker, Claire, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Bleicher, Stacie, M.D.	x			Kaspar-Cope, Rachelle, M.D.	x		
Clarey, Kyle, Pharm.D.	x			Nelson, Lauren, M.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Hammond, Mary, M.D.	x			Sobeski, Linda, Pharm.D. (Chair) • ***Votes only in the event of a tie***			
Hill, Jennifer, M.D.	x						

Review Agenda – Lipotropics, Statins

(1st) Motion: Hammond

(2nd) Motion: Hill

Discussion: Approve as written.

Voting – P&T Committee Members Does not include absent or excused members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D. (Vice Chair)	x			Humphries, Laurie, M.D.	x		
Baker, Claire, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Bleicher, Stacie, M.D.	x			Kaspar-Cope, Rachelle, M.D.	x		
Clarey, Kyle, Pharm.D.	x			Nelson, Lauren, M.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Hammond, Mary, M.D.	x			Sobeski, Linda, Pharm.D. (Chair) • ***Votes only in the event of a tie***			
Hill, Jennifer, M.D.	x						

Review Agenda – Multiple Sclerosis Agents

(1st) Motion: Juracek

(2nd) Motion: Bleicher

Discussion: Approve as written.

Voting – P&T Committee Members Does not include absent or excused members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D. (Vice Chair)	x			Humphries, Laurie, M.D.	x		
Baker, Claire, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Bleicher, Stacie, M.D.	x			Kaspar-Cope, Rachelle, M.D.	x		
Clarey, Kyle, Pharm.D.	x			Nelson, Lauren, M.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Hammond, Mary, M.D.	x			Sobeski, Linda, Pharm.D. (Chair) • ***Votes only in the event of a tie***			
Hill, Jennifer, M.D.	x						

Review Agenda – Nitrofuran Derivatives

(1st) Motion: Juracek

(2nd) Motion: Hill

Discussion: Approve as written.

Voting – P&T Committee Members Does not include absent or excused members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D. (Vice Chair)	x			Humphries, Laurie, M.D.	x		
Baker, Claire, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Bleicher, Stacie, M.D.	x			Kaspar-Cope, Rachelle, M.D.	x		
Clarey, Kyle, Pharm.D.	x			Nelson, Lauren, M.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Hammond, Mary, M.D.	x			Sobeski, Linda, Pharm.D. (Chair) • ***Votes only in the event of a tie***			
Hill, Jennifer, M.D.	x						

Review Agenda – PAH – Pulmonary Arterial Hypertension Agents

(1st) Motion: Baker

(2nd) Motion: Avery

Discussion: Approve as written.

Voting – P&T Committee Members Does not include absent or excused members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D. (Vice Chair)	x			Humphries, Laurie, M.D.	x		
Baker, Claire, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Bleicher, Stacie, M.D.	x			Kaspar-Cope, Rachelle, M.D.	x		
Clarey, Kyle, Pharm.D.	x			Nelson, Lauren, M.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Hammond, Mary, M.D.	x			Sobeski, Linda, Pharm.D. (Chair) • ***Votes only in the event of a tie***			
Hill, Jennifer, M.D.	x						

Review Agenda – Phosphate Binders

(1st) Motion: Dering-Anderson

(2nd) Motion: Juracek

Discussion: Approve as written.

Voting – P&T Committee Members Does not include absent or excused members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D. (Vice Chair)	x			Humphries, Laurie, M.D.	x		
Baker, Claire, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Bleicher, Stacie, M.D.	x			Kaspar-Cope, Rachelle, M.D.	x		
Clarey, Kyle, Pharm.D.	x			Nelson, Lauren, M.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Hammond, Mary, M.D.	x			Sobeski, Linda, Pharm.D. (Chair) • ***Votes only in the event of a tie***			
Hill, Jennifer, M.D.	x						

Review Agenda – Prenatal Vitamins

(1st) Motion: Hill

(2nd) Motion: Juracek

Discussion: Approve as written.

Voting – P&T Committee Members Does not include absent or excused members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D. (Vice Chair)	x			Humphries, Laurie, M.D.	x		
Baker, Claire, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Bleicher, Stacie, M.D.	x			Kaspar-Cope, Rachelle, M.D.	x		
Clarey, Kyle, Pharm.D.	x			Nelson, Lauren, M.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Hammond, Mary, M.D.	x			Sobeski, Linda, Pharm.D. (Chair) • ***Votes only in the event of a tie***			
Hill, Jennifer, M.D.	x						

Review Agenda – Thyroid Hormones

(1st) Motion: Baker

(2nd) Motion: Hammond

Discussion: Approve as written.

Voting – P&T Committee Members Does not include absent or excused members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D. (Vice Chair)	x			Humphries, Laurie, M.D.	x		
Baker, Claire, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Bleicher, Stacie, M.D.	x			Kaspar-Cope, Rachelle, M.D.	x		
Clarey, Kyle, Pharm.D.	x			Nelson, Lauren, M.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Hammond, Mary, M.D.	x			Sobeski, Linda, Pharm.D. (Chair) • ***Votes only in the event of a tie***			
Hill, Jennifer, M.D.	x						

Review Agenda – Ulcerative Colitis							
(1st) Motion: Juracek							
(2nd) Motion: Hill							
Discussion: Approve as written.							
Voting – P&T Committee Members Does not include absent or excused members	**Yes**	**No**	**Abstain**	**Voting – P&T Committee Members**	**Yes**	**No**	**Abstain**
Avery, Eric, M.D. (Vice Chair)	x			Humphries, Laurie, M.D.	x		
Baker, Claire, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Bleicher, Stacie, M.D.	x			Kaspar-Cope, Rachelle, M.D.	x		
Clarey, Kyle, Pharm.D.	x			Nelson, Lauren, M.D.	x		
Dering Anderson, Allison, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Hammond, Mary, M.D.	x			Sobeski, Linda, Pharm.D. (Chair) • ***Votes only in the event of a tie***			
Hill, Jennifer, M.D.	x						

VI. Complete Copy of Proposed PDL

Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

May 2020 P&T Proposed Changes *Red Highlights* indicate proposed changes

ACNE AGENTS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
AZELEX (azelaic acid) benzoyl peroxide (BPO) **GEL, WASH, LOTION** OTC clindamycin/BPO (generic Duac) clindamycin phosphate **SOLUTION** DIFFERIN **LOTION, CREAM, Rx-GEL** (adapalene) DIFFERIN **GEL** (adapalene) OTC erythromycin **SOLUTION** PANOXYL 10% **WASH** (BPO) OTC *tretinoin **CREAM, GEL**[AL] (generic Retin-A)*	adapalene (generic differin) adapalene/BPO (generic Epiduo) *AKLIEF (trifarotene)* [AL] ALTRENO (tretinoin)[AL] *AMZEEQ (minocycline)* *ARAZLO (tazarotene)*[AL,NR] ATRALIN (tretinoin) AVAR (sulfacetamide sodium/sulfur) AVITA (tretinoin) BENZACLIN **PUMP** (clindamycin/BPO) benzoyl peroxide **CLEANSER**, **CLEANSING BAR** OTC benzoyl peroxide **FOAM** (generic Benzepro) benzoyl peroxide **GEL** Rx *benzoyl peroxide **TOWELETTE** OTC* clindamycin **FOAM, LOTION** clindamycin **GEL** *clindamycin phosphate **PLEDGET*** clindamycin/BPO (generic Acanya, Benzaclin) **GEL** clindamycin/tretinoin (generic Veltin, Ziana) dapsone (generic Aczone) EPIDUO FORTE **GEL PUMP** (adapalene/BPO) erythromycin **GEL, PLEDGET** erythromycin-BPO (generic for Benzamycin) EVOCLIN (clindamycin) FABIOR (tazarotene foam) NEUAC (clindamycin/BPO) ONEXTON (clindamycin/BPO) OVACE PLUS (sulfacetamide sodium) PLIXDA (adapalene) SWAB *RETIN-A **GEL, CREAM**[AL] (tretinoin)* sulfacetamide sulfacetamide/sulfur SUMADAN (sulfacetamide/sulfur) tazarotene **CREAM** (generic Tazorac) TRETIN-X (tretinoin) tretinoin microspheres (generic for Retin-A Micro) [AL]	▪ Non-preferred agents will be approved for patients who have failed THREE preferred agents within this drug class

ANALGESICS, OPIOID LONG-ACTING

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

ANALGESICS, OPIOID SHORT-ACTING[QL]

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

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

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
NASAL		
	butorphanol **SPRAY**[QL] LAZANDA (fentanyl citrate)	
BUCCAL/TRANSMUCOSAL[CL]		Drug-specific criteria: ▪ **Abstral®/Actiq®/Fentora®/ Onsolis (fentanyl):** Approved only for diagnosis of cancer AND current use of long-acting opiate
	ABSTRAL (fentanyl)[CL] fentanyl **TRANSMUCOSAL** (generic Actiq)[CL] FENTORA (fentanyl)[CL]	

ANDROGENIC AGENTS (Topical)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
*testosterone **PUMP** (generic Androgel)*	ANDRODERM (testosterone) NATESTO (testosterone) testosterone PACKET (generic Androgel) *testosterone **GEL**, **PACKET, PUMP** (generic Vogelxo)[CL]* testosterone (generic Axiron) testosterone (generic Fortesta) testosterone (generic Testim)	▪ Preferred agents approved for diagnosis of Primary hypogonadism (congenital or acquired) or Hypogonadotropic hypogonadism. Off label use for the following will be considered with documentation of necessity: female to male transsexual – gender dysphoria, weight gain, male osteoporosis, delayed puberty in males, corticosteroid-induced hypogonadism and osteoporosis, inoperable carcinoma of the breast, postpartum breast pain and engorgement, and menopause ▪ In addition, non-preferred agents will be approved for patients who have failed ONE preferred agent within this drug class within the last 6 months Drug-specific criteria: ▪ **Androderm®/Androgel®:** Approved for Males only ▪ **Natesto®:** Approved for Males only with diagnosis of: Primary hypogonadism (congenital or acquired) OR Hypogonadotropic hypogonadism (congenital or acquired)

ANGIOTENSIN MODULATORS

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

ANGIOTENSIN MODULATORS (Continued)

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

ANTIBIOTICS, GASTROINTESTINAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
FIRVANQ (vancomycin) **SOLUTION** metronidazole **TABLET** neomycin	ALINIA (nitazoxanide) **SUSPENSION** DIFICID (fidaxomicin) FLAGYL ER (metronidazole) metronidazole **CAPSULE** paromomycin SOLOSEC (secnidazole) tinidazole (generic Tindamax) vancomycin **CAPSULE** (generic Vancocin) XIFAXAN (rifaximin)	▪ Note: Although azithromycin, ciprofloxacin, and trimethoprim/ sulfmethoxazole are not included in this review, they are available without prior authorization Drug-specific criteria: ▪ **Alinia®:** Trial and failure with metronidazole is required for a diagnosis of giardiasis ▪ **Dificid®:** Trial and failure with oral vancomycin is required for a diagnosis of C. difficile diarrhea (pseudomembranous colitis) ▪ **Flagyl ER®:** Trial and failure with metronidazole is required ▪ **Flagyl®/Metronidazole 375mg capsules and Flagyl ER®/ Metronidazole 750mg ER tabs:** Clinical reason why the generic regular-release cannot be used ▪ **tinidazole:** Trial and failure/ contraindication to metronidazole required Approvable diagnoses include: Giardia Amebiasis intestinal or liver abscess Bacterial vaginosis or trichomoniasis ▪ **vancomycin capsules:** Requires patient specific documentation of why the Firvanq/vancomycin solution is not appropriate for patient ▪ **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®

ANTIBIOTICS, INHALED

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

ANTIBIOTICS, TOPICAL

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

ANTIBIOTICS, VAGINAL

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

ANTICOAGULANTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ELIQUIS (apixaban) enoxaparin (generic Lovenox) PRADAXA (dabigatran) warfarin (generic Coumadin) XARELTO (rivaroxaban) 10 mg, 15 mg, 20 mg XARELTO (rivaroxaban) 2.5 mg[CL,QL]	*BEVYXXA (betrixaban)*[QL] fondaparinux (generic Arixtra) FRAGMIN (dalteparin) SAVAYSA (edoxaban)[QL]	▪ Non-preferred agents will be approved for patients who have failed ONE preferred agent within this drug class within the last 12 months Drug-specific criteria: ▪ **Coumadin®:** Clinical reason generic warfarin cannot be used ▪ **Savaysa®:** Approved diagnoses include: Stroke and systemic embolism (SE) risk reduction in nonvalvular atrial fibrillation (NVAF) OR Treatment of deep vein thrombosis (DVT) and pulmonary embolism (PE) following 5-10 days of parenteral anticoagulant therapy ▪ **Xarelto 2.5mg:** Use limited to reduction of risk of major cardiovascular events (cardiovascular death, myocardial infarction, and stroke) in patients with chronic coronary artery disease or peripheral artery disease

ANTIEMETICS/ANTIVERTIGO AGENTS

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

ANTIFUNGALS, ORAL

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

ANTIFUNGALS, TOPICAL

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

ANTIMIGRAINE AGENTS, OTHER

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
AJOVY (fremanezumab-vfrm) CL, QL EMGALITY 120 mg/mL (galcanezumab-gnlm) CL, QL **PEN, SYRINGE**	AIMOVIG (erenumab-aooe)CL,QL CAFERGOT (ergotamine/caffeine) CAMBIA (diclofenac potassium) dihydroergotamine mesylate **NASAL** *EMGALITY 100 mg (galcanezumab-gnlm)CL,QL* ***SYRINGE*** ERGOMAR **SUBLINGUAL** (ergotamine tartrate) MIGERGOT (ergotamine/caffeine) **RECTAL** MIGRANAL (dihydroergotamine) **NASAL** *NURTEC ODT (rimegepant)QL* *REYVOW (lasmiditan)AL, QL* ***TABLET*** *UBRELVY (ubrogepant)AL, QL* ***TABLET***	▪ Non-preferred agents will be approved for patients who have a contraindication OR trial failure of a triptan Drug-specific criteria: ▪ Cambia®: Requires diagnosis of migraine and documentation of why solid dosing forms not appropriate ▪ Emgality indicated for treatment of episodic cluster headaches ▪ Aimovig, Ajovy, and Emgality: Require ≥ 4 migraines per month for ≥ 3 months and has tried and failed a ≥ 1 month trial of two medications listed in the 2012 American Academy of Neurology/American Headache Society guidelines (examples include: antidepressants (amitriptyline, venlafaxine), Beta blockers (propranolol, metroprolol, timolol, atenolol), anti-epileptics (valproate, topiramate), ACE/ARB (lisinopril, candesartan) ▪ In addition, Aimovig and Ajovy require a trial of Emgality or patient specific documentation of why Emgality is not appropriate for patient

ANTIMIGRAINE AGENTS, TRIPTANS[QL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ORAL		▪ Non-preferred agents will be approved for patients who have failed ALL preferred agents within this drug class Drug-specific criteria: ▪ **Sumavel® Dosepro:** Requires clinical reason sumatriptan injection cannot be used ▪ **Onzetra, Zembrace:** approved for patients who have failed ALL preferred agents
rizatriptan (generic Maxalt) rizatriptan ODT (generic Maxalt MLT) sumatriptan	almotriptan (generic Axert) eletriptan (generic Relpax) frovatriptan (generic Frova) IMITREX (sumatriptan) naratriptan (generic Amerge) *RELPAX (eletriptan)*[QL] sumatriptan/naproxen (generic Treximet) zolmitriptan (generic Zomig/Zomig ZMT)	
NASAL		
sumatriptan	IMITREX (sumatriptan) ONZETRA XSAIL (sumatriptan) *TOSYMRA (sumatriptan)* ZOMIG (zolmitriptan)	
INJECTABLE		
sumatriptan **KIT, SYRINGE, VIAL**	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 Nix) permethrin 5% RX (generic Elimite) pyrethrin/piperonyl butoxide (generic RID, A-200)	CROTAN (crotamiton) LOTION EURAX (crotamiton) **CREAM, LOTION** lindane malathion (generic Ovide) *SKLICE (ivermectin)* spinosad (generic Natroba) VANALICE (piperonyl butoxide/pyrethrins)	▪ Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class

ANTIVIRALS, ORAL

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

ANTIVIRALS, TOPICAL

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

BETA BLOCKERS, ORAL

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

BLADDER RELAXANT PREPARATIONS

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

BONE RESORPTION SUPRESSION AND RELATED DRUGS

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

BPH (BENIGN PROSTATIC HYPERPLASIA) TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ALPHA BLOCKERS		▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: ▪ **Alfuzosin/dutasteride/finasteride** • 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
alfuzosin (generic Uroxatral) doxazosin (generic Cardura) tamsulosin (generic Flomax) terazosin (generic Hytrin)	CARDURA XL (doxazosin) silodosin (generic Rapaflo)	
5-ALPHA-REDUCTASE (5AR) INHIBITORS		
dutasteride (generic for Avodart) finasteride (generic for Proscar)	dutasteride/tamsulosin (generic for Jalyn)	

CALCIUM CHANNEL BLOCKERS, ORAL

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

CEPHALOSPORINS AND RELATED ANTIBIOTICS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BETA LACTAM/BETA-LACTAMASE INHIBITOR COMBINATIONS		▪ Non-preferred agents will be approved for patients who have failed a 3-day trial of ONE preferred agent within the same group
amoxicillin/clavulanate **TABLETS, SUSPENSION**	amoxicillin/clavulanate **CHEWABLE** amoxicillin/clavulanate ER (generic Augmentin XR) AUGMENTIN (amoxicillin/clavulanate) **SUSPENSION**, **TABLET**	
CEPHALOSPORINS – First Generation		
cefadroxil **CAPSULE, SUSPENSION** (generic Duricef) cephalexin **CAPSULE, SUSPENSION** (generic Keflex)	cefadroxil **TABLET** (generic Duricef) cephalexin **TABLET** DAXBIA (cephalexin)	
CEPHALOSPORINS – Second Generation		
cefprozil (generic Cefzil) cefuroxime **TABLET** (generic Ceftin)	cefaclor (generic Ceclor) CEFTIN (cefuroxime) **TABLET, SUSPENSION**	
CEPHALOSPORINS – Third Generation		
cefdinir (generic Omnicef)	cefixime **CAPSULE**, **SUSPENSION** (generic Suprax) cefpodoxime (generic 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
afirmelle (levonorgestrel/ethinyl estradiol) *aurovela (norethindrone/ethinyl estradiol)* *aurovela 21 (norethindrone/ethinyl estradiol)* *aurovela fe (norethindrone/ethinyl estradiol-iron)* *aurovela 24 fe (norethindrone/ethinyl estradiol-iron)* *ayuna (levonorgestrel/ethinyl estradiol)* *cyred eq (desogestrel/ethinyl estradiol)* *hailey 21 (norethindrone/ethinyl estradiol)* *jasmiel (drospirenone/ethinyl estradiol)* *kalliga (desogestrel/ethinyl estradiol)* *lo-zumandimine (drospirenone/ethinyl estradiol)* *simliya (desogestrel/ethinyl estradiol/ethinyl estradiol)* *simpesse (levonorgestrel/ethinyl estradiol/ethinyl estradiol)* *SLYND (drospirenone)* *tarina 24 fe (norethindrone/ethinyl estradiol-iron)* *tri-lo-mili (norgestimate/ethinyl estradiol)* *vienva (levonorgestrel/ethinyl estradiol)* *zumandimine (drospirenone/ethinyl estradiol)*		

CYSTIC FIBROSIS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	KALYDECO **PACKET, TABLET** (ivacaftor)[QL, AL] ORKAMBI (lumacaftor/ivacaftor) **PACKET, TABLET**[QL, AL] SYMDEKO (tezacaftor/ivacaftor)[QL, AL] *TRIKAFTA (elexacaftor, tezacaftor, ivacaftor)[AL]*	Drug-specific criteria: ▪ **Kalydeco®:** Diagnosis of CF and documentation of the drug-specific, FDA-approved mutation of CFTR gene ▪ **Orkambi®:** Diagnosis of CF and documentation of presence of two copies of the F580del mutation (homozygous) of CFTR gene ▪ **Symdeko:** Diagnosis of CF and documentation of the drug specific, FDA approved mutation of CFTR gene. ▪ ***Trikafta:*** *Diagnosis of CF and documentation of at least one F508del mutation in the CFTR gene*

DIURETICS

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

FLUOROQUINOLONES, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ciprofloxacin **TABLET** (generic Cipro) levofloxacin **TABLET** (generic Levaquin)	BAXDELA (delafloxacin) ciprofloxacin ER ciprofloxacin **SUSPENSION** (generic Cipro) levofloxacin **SOLUTION** moxifloxacin (generic Avelox) ofloxacin	▪ Non-preferred agents will be approved for patients who have failed a 3-day trial of ONE preferred agent within this drug class Drug-specific criteria: ▪ **Baxdela:** Coverable with documented intolerance or failure of preferred MRSA agents (clindamycin, doxycycline, linezolid, sulfamethoxazole/trimethoprim) ▪ **Ciprofloxacin/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 Lotronex) MOTEGRITY (prucalopride succinate) RELISTOR (methylnaltrexone) **TABLET**[QL] SYMPROIC (naldemedine) TRULANCE (plecanatide)[QL] VIBERZI (eluxodoline)	▪ Non-preferred agents will be approved for patients who have failed a 30-day trial of ONE preferred agent within this drug class Drug-specific criteria: ▪ **Lotronex®:** Covered for diagnosis of IBS Diarrhea Predominant type with trial and failure of loperamide AND diphenoxylate ▪ **Relistor®**: Covered for diagnosis of opioid-induced constipation in adults with chronic, non-cancer pain after trial of at least TWO OTC laxatives (senna, bisacodyl, etc.) and failure of Movantik ▪ **Symproic**: Covered for diagnosis of opioid-induced constipation in adult patients with chronic non-cancer pain after trial on at least TWO OTC laxatives and failure of Movantik ▪ **Trulance®:** Covered for diagnosis of either chronic idiopathic constipation or IBS with constipation after trial of at least TWO OTC laxatives (senna, bisacodyl, etc.) ▪ **Viberzi®:** Covered for diagnosis of IBS Diarrhea Predominant type with trial and failure of loperamide AND diphenoxylate

GLUCAGON AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
*glucagon **INJECTION***	*diazoxide **SUSP** (generic Proglycem)*	
*PROGLYCEM (diazoxide) **SUSP***	*GLUCAGON EMERGENCY (glucagon) **INJ KIT** (Fresenius)*	
*GLUCAGON EMERGENCY (glucagon) **INJ KIT** (Lilly)*	*GVOKE (glucagon) **PEN**, **SYRINGE***	
*BAQSIMI (glucagon) **NASAL***		

GROWTH HORMONES

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

H. PYLORI TREATMENTS

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

HAE TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BERINERT (C1 esterase inhibitor, human) ***INTRAVENOUS*** *FIRAZYR (icatibant acetate)* ***SUB-Q*** *HAEGARDA (C1 esterase inhibitor, human)* ***SUB-Q***	*icatibant acetate (generic for FIRAZYR)* ***SUB-Q*** *KALBITOR (ecallantide)* ***SUB-Q*** *TAKHZYRO (lanadelumab-flyo)* ***SUB-Q*** *RUCONEST (recombinant human C1 inhibitor)* ***INTRAVENOUS*** *CINRYZE (C1 esterase inhibitor, human)* ***INTRAVENOUS***	

HEPATITIS B TREATMENTS

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

HEPATITIS C TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
DIRECT ACTING ANTI-VIRAL		Hepatitis C Treatments PA Form Hepatitis C Criteria ▪ Non-preferred products require trial of preferred agents within the same group and will only be considered with documentation of why the preferred product within this drug class is not appropriate for patient ▪ Patients newly eligible for Medicaid will be allowed to complete treatment with the original that treatment was initially authorized by another payor Drug-specific criteria: Trial with Mavyret not required in the following: ▪ **Epclusa**: For genotype 1-6 with decompensated cirrhosis along with ribavirin ▪ **Harvoni**: o For genotype 1 with decompensated cirrhosis along with ribavirin o Post liver transplant for genotype 1 or 4 o For pediatric patients ages 3 to 11 years old with FDA indications ▪ **Sovaldi:** o For pediatric patients ages 3 to 11 years old with genotype 2 or 3 chronic HCV infection without cirrhosis or with compensated cirrhosis in combination with ribavirin ▪ **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
MAVYRET (glecaprevir/pibrentasvir)CL VOSEVI (sofosbuvir/velpatasvir/ voxilaprev)CL	DAKLINZA (daclatasvir) CL sofosbuvir/ledipasvir (generic Harvoni)CL sofosbuvir/velpatasvir (generic Epclusa)CL SOVALDI TABLET (sofosbuvir)CL VIEKIRA PAK (ombitasvir/ paritaprevir/ritonavir/dasabuvir)CL ZEPATIER (elbasvir/grazoprevir)CL	
RIBAVIRIN		
ribavirin 200mg **CAPSULE, TABLET**		
INTERFERON		
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		▪ 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, including, but not limited to, drug resistance or concomitant conditions not recommended with preferred agents ▪ Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy ▪ Diagnosis of HIV/AIDS required OR ▪ Pre and Post Exposure Prophylaxis
SELZENTRY **SOLN, TAB** (maraviroc)		
FUSION INHIBITORS		
FUZEON **SUB-Q** (enfuvirtide)[QL]		
INTEGRASE STRAND TRANSFER INHIBITORS (INSTIs)		
ISENTRESS (raltegravir)[QL]		
ISENTRESS HD (raltegravir)		
TIVICAY (dolutegravir)		
NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NNRTIs)		
EDURANT (rilpivirine)	efavirenz (generic Sustiva)	
INTELENCE (etravirine)[QL]	nevirapine IR, ER (generic Viramune/Viramune XR)	
PIFELTRO (doravirine)[QL]	RESCRIPTOR (delavirdine)	
SUSTIVA **CAPSULE, TABLET** (efavirenz)	VIRAMUNE (nevirapine) **SUSP**	
NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTIs)		
abacavir **SOLN, TABLET** (generic Ziagen)	didanosine DR (generic Videx EC)	
EMTRIVA **CAPSULE, SOLN** (emtricitabine)	EPIVIR (lamivudine)	
lamivudine **SOLN, TABLET** (generic Epivir)	RETROVIR (zidovudine)	
zidovudine **CAPSULE, SYRUP, TABLET** (generic Retrovir)	stavudine **CAPSULE** (generic Zerit)	
	VIDEX (didanosine) **SOLN**	
	ZIAGEN (abacavir)	
NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTIs)		
tenofovir **TABLET** (generic Viread)		
PHARMACOKINETIC ENHANCER		
TYBOST (cobicistat)[QL]		
PROTEASE INHIBITORS		
atazanavir **CAPSULE** (generic Reyataz)	APTIVUS **CAPSULE, SOLN** (tipranavir)	
LEXIVA **SUSP, TABLET** (fosamprenavir)	CRIXIVAN (indinavir)	
NORVIR (ritonavir) **TAB**	fosamprenavir **TAB** (generic Lexiva)	
PREZISTA (darunavir) **SUSP, TABLET**	INVIRASE (saquinavir)	
	NORVIR **POWDER, SOLN** (ritonavir)	
	REYATAZ **POWDER** (atazanavir)	
	ritonavir **TABLET** (generic Norvir)	
	VIRACEPT (nelfinavir)	

HIV / AIDS[CL] (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
COMBINATION PROTEASE INHIBITORS (PIs) or PIs plus PHARMACOKINETIC ENHANCER		
EVOTAZ (atazanavir/cobicistat)[QL] KALETRA **TAB** (lopinavir/ritonavir) PREZCOBIX (darunavir/cobicistat)[QL] lopinavir/ritonavir **SOLN** (generic Kaletra)	KALETRA **SOLN** (lopinavir/ritonavir)	
COMBINATION NUCLEOS(T)IDE REVERSE TRANSCRIPTASE INHIBITORS		
abacavir/lamivudine (generic Epzicom) abacavir/lamivudine/zidovudine (generic Trizivir) CIMDUO (lamivudine/tenofovir)[QL] DESCOVY (emtricitabine/tenofovir)[QL] lamivudine/zidovudine (generic Combivir) TRUVADA (emtricitabine/tenofovir)	COMBIVIR (lamivudine/zidovudine) EPZICOM (abacavir sulfate/lamivudine) *TEMIXYS (lamivudine/tenofovir)[QL]* TRIZIVIR (abacavir/lamivudine/zidovudine)	
COMBINATION PRODUCTS – MULTIPLE CLASSES		
ATRIPLA (tenofovir/emtricitabine/efavirenz) BIKTARVY (bictegravir/emtricitabine/tenofovir)[QL] COMPLERA (rilpivirine/emtricitabine/tenofovir) DELSTRIGO (doravirine/lamivudine/tenofovir)[QL] GENVOYA (elvitegravier/cobicistat/emtricitabine/tenofovir)[QL, AL] ODEFSEY (emtricitabine/rilpivirine/tenofovir)[QL] STRIBILD (elvitegravir/cobicistat/emtricitabine/tenofovir)[QL] SYMFI (efavirenz/lamivudine/tenofovir)[QL] SYMFI LO (efavirenz/lamivudine/tenofovir)[QL] TRIUMEQ (dolutegravir/abacavir/lamivudine)	*DOVATO (dolutegravir/lamivudine)[QL]* JULUCA (dolutegravir/rilpivirine)[QL] *SYMTUZA (darunavir/cobicistat/emtricitabine/tenofovir)[QL]*	

HYPOGLYCEMICS, ALPHA-GLUCOSIDASE INHIBITORS

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

HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS

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

HYPOGLYCEMICS, INSULIN AND RELATED DRUGS

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

HYPOGLYCEMICS, MEGLITINIDES

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

HYPOGLYCEMICS, METFORMINS

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

HYPOGLYCEMICS, SGLT2

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

HYPOGLYCEMICS, SULFONYLUREAS

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

HYPOGLYCEMICS, TZD

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

IMMUNOSUPPRESSIVES, ORAL

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

LINCOSAMIDES / OXAZOLIDINONES / STREPTOGRAMINS

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

LIPOTROPICS, OTHER

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BILE ACID SEQUESTRANTS		▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: ▪ **Colesevelam**: Trial not required for diabetes control and monotherapy with metformin, sulfonylurea, or insulin has been inadequate ▪ **Juxtapid®/ Kynamro®:** o Approved for diagnosis of homozygous familial hypercholesterolemia (HoFH) OR o Treatment failure/maximized dosing/contraindication to ALL the following: statins, ezetimibe, niacin, fibric acid derivatives, omega-3 agents, bile acid sequestrants o Require faxed copy of REMS PA form ▪ **Lovaza®:** Approved for TG ≥ 500 ▪ Several other forms of OTC Niacin and fish oil are also covered without prior authorization under Medicaid with a prescription ▪ **Vascepa®:** Approved for TG ≥ 500
cholestyramine (generic Questran) colestipol **TABLETS** (generic Colestid)	colesevelam (generic Welchol) **TABLET, PACKET** colestipol **GRANULES** (generic Colestid) QUESTRAN LIGHT (cholestyramine)	
TREATMENT OF HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA		
	JUXTAPID (lomitapide)[CL] KYNAMRO (mipomersen)[CL]	
FIBRIC ACID DERIVATIVES		
fenofibrate (generic Tricor) gemfibrozil (generic Lopid)	fenofibrate (generic Antara/Fenoglide/ Lipofen/Lofibra/Triglide) fenofibric acid (generic Fibricor/Trilipix)	
NIACIN		
niacin ER (generic for Niaspan)	NIACOR (niacin IR) NIASPAN (niacin ER)	
OMEGA-3 FATTY ACIDS		
	omega-3 fatty acids (generic for Lovaza)[CL] VASCEPA (icosapent)[CL]	
CHOLESTEROL ABSORPTION INHIBITORS		
ezetimibe (generic for Zetia)		

LIPOTROPICS, OTHER (continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
PROPROTEIN CONVERTASE SUBTILISIN/KEXIN TYPE 9 (PCSK9) INHIBITORS		
	PRALUENT (alorocumab)[CL] REPATHA (evolocumab)[CL]	▪ **Praluent®:** Approved for diagnoses of: • atherosclerotic cardiovascular disease (ASCVD) • heterozygous familial hypercholesterolemia (HeFH) AND • Maximized high-intensity statin WITH ezetimibe for at 3 continuous months • Failure to reach target LDL-C levels: ASCVD - < 70 mg/dL, HeFH - < 100 mg/dL ▪ **Repatha®:** Approved for: • adult diagnoses of atherosclerotic cardiovascular disease (ASCVD) • heterozygous familial hypercholesterolemia (HeFH) • homozygous familial hypercholesterolemia (HoFH) in age ≥ 13 • statin-induce rhabdomyolysis AND • Maximized high-intensity statin WITH ezetimibe for 3+ continuous months • Failure to reach target LDL-C levels: ASCVD - < 70 mg/dL, HeFH - < 100 mg/dL • Concurrent use of maximally-tolerated statin must continue

LIPOTROPICS, STATINS

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

MACROLIDES AND KETOLIDES, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
MACROLIDES		▪ Require clinical reason why preferred products within this drug class cannot be used AND ≥ 3-day trial on a preferred product
azithromycin (generic Zithromax) clarithromycin **TABLET, SUSPENSION** (generic Biaxin)	clarithromycin ER (generic Biaxin XL) E.E.S. **SUSPENSION, TABLET** (erythromycin ethylsuccinate) ERY-TAB (erythromycin) ERYPED **SUSPENSION** (erythromycin) ERYTHROCIN (erythromycin) erythromycin base **TABLET, CAPSULE** erythromycin ethylsuccinate **SUSPENSION**	

MULTIPLE SCLEROSIS DRUGS

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

NITROFURAN DERIVATIVES

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

OPIOID DEPENDENCE TREATMENTS

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

PAH (PULMONARY ARTERIAL HYPERTENSION AGENTS), ORAL AND INHALED

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

PANCREATIC ENZYMES

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

PEDIATRIC VITAMIN PREPARATIONS

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

PENICILLINS

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

PHOSPHATE BINDERS

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

PLATELET AGGREGATION INHIBITORS

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

PRENATAL VITAMINS

Additional covered 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
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) MARNATAL-F **CAPSULE** PRENATA TAB **CHEW** pnv with ca, #72/iron/fa 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-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-nate dha **SOFTGEL** (pnv 11-iron fum-fa-om3) 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 plus **SOFTGEL** (pnv/ca no.68/iron/fa1/dha)	*FOLIVANE-OB **CAPSULE** (pnv#15/iron fum & ps cmp/fa)* *NIVA-PLUS **TABLET** (pnv with ca,no.74/iron/fa)* *PNV-DHA **SOFTGEL** (pnv combo#47/iron/fa #1/dha)* *TARON-C DHA **CAPSULE** (pnv#16/iron fum &ps/fa/om-3)* *VIRT-C DHA **SOFTGEL** (pnv#16/iron fum &ps/fa/om-3)* *VIRT-PM DHA **SOFTGEL** (pnv combo#47/iron/fa #1/dha)* *ZATEAN-PN DHA **CAPSULE** (pnv #47/iron/fa #1/dha)*	▪ Non-preferred agents will be approved for patients who have failed a trial of or are intolerant to TWO preferred agents within this drug class

PROTON PUMP INHIBITORS

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

SINUS NODE INHIBITORS

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

SKELETAL MUSCLE RELAXANTS

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

TETRACYCLINES

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

THYROID HORMONES

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

ULCERATIVE COLITIS

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

UTERINE DISORDER TREATMENT - ENDOMETRIOSIS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ORILISSA (elagolix sodium)[QL,CL]		Drug-specific criteria: **Orilissa:** Requires an FDA approved indication, must follow FDA dosing guidelines, and have had a trial and failure of an NSAID and oral contraceptive

VASODILATORS, CORONARY

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
isosorbide dinitrate **TABLET** isosorbide dinitrate ER, SA **TABLET (generic Dilatrate-SR/Isordil)** isosorbide mono IR/SR **TABLET** nitroglycerin **SUBLINGUAL, TRANSDERMAL** nitroglycerin ER **TABLET**	BIDIL (isosorbide dinitrate/ hydralazine)[CL] GONITRO (nitroglycerin) NITRO-BID **OINTMENT** (nitroglycerin) NITRO-DUR (nitroglycerin) nitroglycerin **TRANSLINGUAL** (generic Nitrolingual) NITROMIST (nitroglycerin)	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: ▪ **BiDil:** Approved for the treatment of heart failure as an adjunct therapy to standard therapy in self-identified black patients

VII. Adjournment / Other Business

iii. A vote to conclude the meeting was made at 3:00pm.

(1st) Motion: **Avery**	(2nd) Motion: **Juracek**
Unanimously approved by all in attendance.	

The next meeting of the Nebraska Medicaid Pharmaceutical and Therapeutics Committee is scheduled:

Date: Wednesday, November 4, 2020
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.