

**DIVISION OF MEDICAID AND LONG-TERM CARE**  
Nebraska DHHS

**PHARMACEUTICAL AND THERAPEUTICS COMMITTEE MEETING MINUTES**

November 3, 2021 at 9 a.m. CST  
Mahoney State Park, Peter Kiewit Lodge  
28500 West Park Hwy, Ashland, NE 68003

and

Virtual Webinar via Zoom

Meeting Registration Link:

[https://magellanhealth.zoom.us/webinar/register/WN\\_FS3TRbbIQp68Cr349WiDmA](https://magellanhealth.zoom.us/webinar/register/WN_FS3TRbbIQp68Cr349WiDmA)

**Committee Members Present:**

Eric Avery, M.D. (Vice Chair / New Chair effective 11/03/2021)

Claire Baker, M.D.

Andrew Bendlin, Pharm.D.

Allison Dering-Anderson, Pharm.D. (New Vice Chair effective 11/03/2021) (Morning and ½ Afternoon)

Wade Fornander, M.D.

Jennifer Hill, M.D. (½ Morning and Afternoon)

Laurie Humphries, M.D.

Joyce Juracek, Pharm.D.

Rachelle Kaspar-Cope, M.D. (½ Morning and Partial Afternoon)

Jessica Pohl, Pharm.D.

Linda Sobeski, Pharm.D. (Chair)

Bradley Sundsboe, Pharm.D. (Morning Only)

**Division of Medicaid and Long-Term Care Staff Present:**

Dianne Garside, Pharm.D.

Spencer Moore, Pharm.D.

Ken Saunders, Pharm.D.

Leah Spencer, R.N., M.Ed.

**Magellan Medicaid Administration Staff Present:**

Nikia Bennette-Carter, Pharm.D., Clinical Account Executive

Elanah Figueroa, B.A., Account Executive

**Managed Care Staff Present:**

Shannon Nelson, Pharm. D., Healthy Blue

Bernadette Ueda, Pharm. D., United Healthcare

Jamie Benson, Pharm.D., Nebraska Total Care

**Committee Members Excused:**

Stacie Bleicher, M.D.

Gary Elsasser, Pharm.D.

Mary Hammond, Pharm.D.

**Committee Members Unexcused:**

Jeffrey Gotschall, M.D.

Lauren Nelson, M.D.

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

- a. The meeting was called to order at 9:00am CST. A copy of the Agenda, Opening Meetings Act, and meeting materials were posted on the Nebraska Medicaid Pharmacy website (<https://nebraska.fhsc.com/PDL/PTcommittee.asp>) and made available at the physical meeting site for public viewing.

(1<sup>st</sup>) Motion: Avery

(2<sup>nd</sup>) Motion: Hill

**Opening of Meetings and Call to Order unanimously approved by all in attendance.**

- b. Roll Call: See list above.
- c. Conflict of Interest: No new conflicts of interest were reported.
- d. Approval of May 12, 2021 P&T Committee Meeting Minutes.

(1 <sup>st</sup> ) Motion: <b>Humphries</b>	(2 <sup>nd</sup> ) Motion: <b>Dering-Anderson</b>
<b>Minutes Approval unanimously approved by all in attendance.</b>	

- e. Election of Board Chair.

(1 <sup>st</sup> ) Motion: <b>Baker</b>	(2 <sup>nd</sup> ) Motion: <b>Dering-Anderson</b>
<b>Election of Board Chair unanimously approved by all in attendance to elect Eric Avery, MD</b>	

- f. Election of Vice Chair.

(1 <sup>st</sup> ) Motion: <b>Baker</b>	(2 <sup>nd</sup> ) Motion: <b>Hill</b>
<b>Election of Vice Chair unanimously approved by all in attendance to elect Allison Dering-Anderson, PharmD</b>	

- g. Department information: Dianne Garside notified committee and public attendees that a copy of the Open Meetings Act is located on the NE DHHS pharmacy website and in the back of the Mahoney State Park meeting room. She thanked Linda Sobeski for her services, leadership, and time on the board with her position for the last two years. Dianne announced effective October 1<sup>st</sup>, 2021, Heritage Health Adult Expansion (Medicaid Expansion) switched to a single category where over 53,000 enrolled adults now have coverage that includes medical, dental, vision, pharmacy, and over-the-counter coverage.

## 2. Public Testimony

Speaker Order	DRUG CLASS	Drug Name	PDL Status	Speaker Name	Affiliation
1	Colony Stimulating Factors	Nyvepria	NP	Sam Garas	Pfizer
2	Colony Stimulating Factors	Nivestym	NP	Sam Garas	Pfizer
3	Cytokine & CAM Antagonists	Cosentyx	NP	Sarah Sanders	Novartis
4	Bronchodilators, Beta Agonist	Proair Digihaler	NP	Dave Miley	Teva
5	Glucocorticoids, Inhaled	Armonair Digihaler	NP	Dave Miley	Teva
6	Glucocorticoids, Inhaled	Airduo Digihaler	NP	Dave Miley	Teva
7	Hemophilia	Jivi	NP	Bashir Kalayeh	Bayer
8	Immunomodulators, Atopic Dermatitis	Dupixent	NP	Vinay Mehta, MD	No Affiliation
9	Oncology Agents, Hematologic	Brukinsa	NP	Hoa Pham	Beigene

## 3. Committee Closed Session

(1 <sup>st</sup> ) Motion: <b>Sobeski</b>	(2 <sup>nd</sup> ) Motion: <b>Fornander</b>
<b>Committee Closed Session unanimously approved by all in attendance.</b>	

## 4. Resume Open Session

(1 <sup>st</sup> ) Motion: <b>Baker</b>	(2 <sup>nd</sup> ) Motion: <b>Juracek</b>
<b>Resume Open Session unanimously approved by all in attendance.</b>	

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.

a. Consent Agenda

Consent Agenda								
<b>(1<sup>st</sup>) Motion:</b> Baker								
<b>(2<sup>nd</sup>) Motion:</b> Dering-Anderson								
<b>Discussion:</b> Committee removed two Consent Agenda categories and added them to Therapeutic Class Reviews: (Oncology, Oral – Prostate and Immunomodulators, Atopic Dermatitis). Approve amended Consent Agenda.								
<b>Voting – P&amp;T Committee Members</b> <b>Does not include excused or unexcused members</b>			Yes	No	Abstain	<b>Voting – P&amp;T Committee Members</b>		
Avery, Eric, M.D. (Chair) <i>Votes only in the event of a tie</i>						Humphries, Laurie, M.D.		
Baker, Claire, M.D.			x			Juracek, Joyce, Pharm.D.		
Bendlin, Andrew, Pharm.D.			x			Pohl, Jessica, Pharm.D.		
Dering-Anderson, Allison, Pharm.D. (Vice Chair)			x			Sundsboe, Bradley, Pharm.D.		
Fornander, Wade, M.D.			x			Sobeski, Linda, Pharm.D.		

Consent Agenda: Therapeutic categories (TC) with unchanged recommendations unless otherwise indicated.	
Alzheimer's Agents	Immunomodulators, Topical
Anthelmintics	Intranasal Rhinitis Agents
Anti-Allergens, Oral	Leukotriene Modifiers
Antihistamines, Minimally Sedating	Oncology, Oral – Hematologic
Antihypertensives, Sympatholytics	Oncology, Oral – Skin
Antihyperuricemics	Ophthalmic Antibiotic-Steroid Combinations
Antiparkinson's	Ophthalmic, Antibiotics
Antipsoriatics, Oral	Otic Antibiotics
Antipsoriatics, Topical	Otic Anti-Infectives & Anesthetics
Anxiolytics	Progesterone (hydroxyprogesterone caproate)
Bile Salts	Sickle Cell Treatment
COPD Agents	Steroids, Topical High
Cough and Cold, Opiate	Steroids, Topical Low
Enzyme Replacement, Gaucher's Disease	Steroids, Topical Medium
Epinephrine, Self-Injected	Thrombopoiesis Stimulating Proteins
Erythropoiesis Stimulating Proteins	
Histamine II Receptor Blockers	
Idiopathic Pulmonary Fibrosis	

b. Therapeutic Class Reviews

Review Agenda – Bronchodilators, Beta Agonist											
<b>(1<sup>st</sup>) Motion:</b> Dering-Anderson											
<b>(2<sup>nd</sup>) Motion:</b> Fornander											
<b>Discussion:</b> Approve as written.											
Voting – P&T Committee Members <small>Does not include excused or unexcused members</small>			Yes	No	Abstain	Voting – P&T Committee Members			Yes	No	Abstain
Avery, Eric, M.D. (Chair) <i>Votes only in the event of a tie</i>						Humphries, Laurie, M.D.			x		
Baker, Claire, M.D.			x			Juracek, Joyce, Pharm.D.			x		
Bendlin, Andrew, Pharm.D.			x			Pohl, Jessica, Pharm.D.			x		
Dering-Anderson, Allison, Pharm.D. (Vice Chair)			x			Sundsboe, Bradley, Pharm.D.			x		
Fornander, Wade, M.D			x			Sobeski, Linda, Pharm.D.			x		

Review Agenda – Colony Stimulating Factors											
<b>(1<sup>st</sup>) Motion:</b> Sobeski											
<b>(2<sup>nd</sup>) Motion:</b> Baker											
<b>Discussion:</b> Approve as written.											
Voting – P&T Committee Members <small>Does not include excused or unexcused members</small>			Yes	No	Abstain	Voting – P&T Committee Members			Yes	No	Abstain
Avery, Eric, M.D. (Chair) <i>Votes only in the event of a tie</i>						Humphries, Laurie, M.D.			x		
Baker, Claire, M.D.			x			Juracek, Joyce, Pharm.D.			x		
Bendlin, Andrew, Pharm.D.			x			Pohl, Jessica, Pharm.D.			x		
Dering-Anderson, Allison, Pharm.D. (Vice Chair)			x			Sundsboe, Bradley, Pharm.D.			x		
Fornander, Wade, M.D			x			Sobeski, Linda, Pharm.D.			x		

## Review Agenda – Cytokine and CAM Antagonists

**(1<sup>st</sup>) Motion:** Fornander

**(2<sup>nd</sup>) Motion:** Baker

**Discussion:** Approve as written.

<b>Voting – P&amp;T Committee Members</b> <small>Does not include excused or unexcused members</small>	Yes	No	Abstain	<b>Voting – P&amp;T Committee Members</b>	Yes	No	Abstain
Avery, Eric, M.D. (Chair) <i>Votes only in the event of a tie</i>				Humphries, Laurie, M.D.	x		
Baker, Claire, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Bendlin, Andrew, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Dering-Anderson, Allison, Pharm.D. (Vice Chair)	x			Sundsboe, Bradley, Pharm.D.	x		
Fornander, Wade, M.D	x			Sobeski, Linda, Pharm.D.	x		

## Review Agenda – Glucocorticoids, Inhaled

**(1<sup>st</sup>) Motion:** Dering-Anderson

**(2<sup>nd</sup>) Motion:** Sobeski

**Discussion:** Approve as written.

<b>Voting – P&amp;T Committee Members</b> <small>Does not include excused or unexcused members</small>	Yes	No	Abstain	<b>Voting – P&amp;T Committee Members</b>	Yes	No	Abstain
Avery, Eric, M.D. (Chair) <i>Votes only in the event of a tie</i>				Humphries, Laurie, M.D.	x		
Baker, Claire, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Bendlin, Andrew, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Dering-Anderson, Allison, Pharm.D. (Vice Chair)	x			Sundsboe, Bradley, Pharm.D.	x		
Fornander, Wade, M.D	x			Sobeski, Linda, Pharm.D.	x		

## Review Agenda – Glucocorticoids, Oral

**(1<sup>st</sup>) Motion:** Sobeski

**(2<sup>nd</sup>) Motion:** Fornander

**Discussion:** Approve as written.

<b>Voting – P&amp;T Committee Members</b> <b>Does not include excused or unexcused members</b>	Yes	No	Abstain	<b>Voting – P&amp;T Committee Members</b>	Yes	No	Abstain
Avery, Eric, M.D. (Chair) <i>Votes only in the event of a tie</i>				Humphries, Laurie, M.D.	x		
Baker, Claire, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Bendlin, Andrew, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Dering-Anderson, Allison, Pharm.D. (Vice Chair)	x			Sundsboe, Bradley, Pharm.D.	x		
Fornander, Wade, M.D	x			Sobeski, Linda, Pharm.D.	x		

## Review Agenda – Hemophilia Treatment

**(1<sup>st</sup>) Motion:** Baker

**(2<sup>nd</sup>) Motion:** Dering-Anderson

**Discussion:** Approve with changes. Eric Avery recommended to move Alprolix to Preferred on PDL, and committee agreed during voting. There was also discussion on Advate due to written testimony, however no criteria or PDL changes were recommended.

<b>Voting – P&amp;T Committee Members</b> <b>Does not include excused or unexcused members</b>	Yes	No	Abstain	<b>Voting – P&amp;T Committee Members</b>	Yes	No	Abstain
Avery, Eric, M.D. (Chair) <i>Votes only in the event of a tie</i>				Humphries, Laurie, M.D.	x		
Baker, Claire, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Bendlin, Andrew, Pharm.D.	x			Pohl, Jessica, Pharm.D.	x		
Dering-Anderson, Allison, Pharm.D. (Vice Chair)	x			Sundsboe, Bradley, Pharm.D.	x		
Fornander, Wade, M.D	x			Sobeski, Linda, Pharm.D.	x		

5. Committee Moved to Closed Session (Working Lunch)

(1 <sup>st</sup> ) Motion: Sobeski	(2 <sup>nd</sup> ) Motion: Baker
<b>Committee Moved to Closed Session unanimously approved by all in attendance.</b>	

6. Committee Open Session – Consideration of Therapeutic Class Reviews – Resume Open Session:

(1 <sup>st</sup> ) Motion: Sobeski	(2 <sup>nd</sup> ) Motion: Baker
<b>Resume Open Session unanimously approved by all in attendance.</b>	

a. Therapeutic Class Reviews (continued)

Review Agenda – Immunomodulators, Asthma											
<b>(1<sup>st</sup>) Motion:</b> Dering-Anderson											
<b>(2<sup>nd</sup>) Motion:</b> Fornander											
<b>Discussion:</b> Approve as written. Committee recommended the asthma Prior Authorization Criteria for Dupixent to be placed under this class and have to fail a preferred agent in this specific class for asthma.											
Voting – P&T Committee Members <small>Does not include excused or unexcused members</small>			Yes	No	Abstain	Voting – P&T Committee Members			Yes	No	Abstain
Avery, Eric, M.D. (Chair) <i>Votes only in the event of a tie</i>						Hill, Jennifer, M.D.			x		
Baker, Claire, M.D.			x			Humphries, Laurie, M.D.			x		
Bendlin, Andrew, Pharm.D.			x			Juracek, Joyce, Pharm.D.			x		
Dering-Anderson, Allison, Pharm.D. (Vice Chair)			x			Pohl, Jessica, Pharm.D.			x		
Fornander, Wade, M.D.			x			Sobeski, Linda, Pharm.D.			x		

Review Agenda – Immunomodulators, Atopic Dermatitis											
<b>(1<sup>st</sup>) Motion:</b> Sobeski											
<b>(2<sup>nd</sup>) Motion:</b> Baker											
<b>Discussion:</b> Approve as written.											
Voting – P&T Committee Members <small>Does not include excused or unexcused members</small>			Yes	No	Abstain	Voting – P&T Committee Members			Yes	No	Abstain
Avery, Eric, M.D. (Chair) <i>Votes only in the event of a tie</i>						Hill, Jennifer, M.D.			x		
Baker, Claire, M.D.			x			Humphries, Laurie, M.D.			x		
Bendlin, Andrew, Pharm.D.			x			Juracek, Joyce, Pharm.D.			x		
Dering-Anderson, Allison, Pharm.D. (Vice Chair)			x			Pohl, Jessica, Pharm.D.			x		
Fornander, Wade, M.D.			x			Sobeski, Linda, Pharm.D.			x		

**Review Agenda – Methotrexate**

**(1<sup>st</sup>) Motion:** Baker

**(2<sup>nd</sup>) Motion:** Dering-Anderson

**Discussion:** Approve as written.

<b>Voting – P&amp;T Committee Members</b> <b>Does not include excused or unexcused members</b>	<b>Yes</b>	<b>No</b>	<b>Abstain</b>	<b>Voting – P&amp;T Committee Members</b>	<b>Yes</b>	<b>No</b>	<b>Abstain</b>
Avery, Eric, M.D. (Chair) <i>Votes only in the event of a tie</i>				Hill, Jennifer, M.D.	x		
Baker, Claire, M.D.	x			Humphries, Laurie, M.D.	x		
Bendlin, Andrew, Pharm.D.	x			Juracek, Joyce, Pharm.D.	x		
Dering-Anderson, Allison, Pharm.D. (Vice Chair)	x			Pohl, Jessica, Pharm.D.	x		
Fornander, Wade, M.D	x			Sobeski, Linda, Pharm.D.	x		

**Review Agenda – Movement Disorders**

**(1<sup>st</sup>) Motion:** Dering-Anderson

**(2<sup>nd</sup>) Motion:** Sobeski

**Discussion:** Approve as written.

<b>Voting – P&amp;T Committee Members</b> <b>Does not include excused or unexcused members</b>	<b>Yes</b>	<b>No</b>	<b>Abstain</b>	<b>Voting – P&amp;T Committee Members</b>	<b>Yes</b>	<b>No</b>	<b>Abstain</b>
Avery, Eric, M.D. (Chair) <i>Votes only in the event of a tie</i>				Hill, Jennifer, M.D.	x		
Baker, Claire, M.D.	x			Humphries, Laurie, M.D.	x		
Bendlin, Andrew, Pharm.D.	x			Juracek, Joyce, Pharm.D.	x		
Dering-Anderson, Allison, Pharm.D. (Vice Chair)	x			Pohl, Jessica, Pharm.D.	x		
Fornander, Wade, M.D.	x			Sobeski, Linda, Pharm.D.	x		

## Review Agenda – NSAIDS

(1<sup>st</sup>) Motion: Sobeski

(2<sup>nd</sup>) Motion: Bendlin

Discussion: Approve as written.

<b>Voting – P&amp;T Committee Members</b> <small>Does not include excused or unexcused members</small>	Yes	No	Abstain	<b>Voting – P&amp;T Committee Members</b>	Yes	No	Abstain
Avery, Eric, M.D. (Chair) <i>Votes only in the event of a tie</i>				Humphries, Laurie, M.D.	x		
Baker, Claire, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Bendlin, Andrew, Pharm.D.	x			Kaspar-Cope, Rachelle, M.D.	x		
Dering-Anderson, Allison, Pharm.D. (Vice Chair)	x			Pohl, Jessica, Pharm.D.	x		
Fornander, Wade, M.D.	x			Sobeski, Linda, Pharm.D.	x		
Hill, Jennifer, M.D.	x						

## Review Agenda – Oncology, Oral- Breast

(1<sup>st</sup>) Motion: Hill

(2<sup>nd</sup>) Motion: Baker

Discussion: Approve as written.

<b>Voting – P&amp;T Committee Members</b> <small>Does not include excused or unexcused members</small>	Yes	No	Abstain	<b>Voting – P&amp;T Committee Members</b>	Yes	No	Abstain
Avery, Eric, M.D. (Chair) <i>Votes only in the event of a tie</i>				Humphries, Laurie, M.D.	x		
Baker, Claire, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Bendlin, Andrew, Pharm.D.	x			Kaspar-Cope, Rachelle, M.D.	x		
Dering-Anderson, Allison, Pharm.D. (Vice Chair)	x			Pohl, Jessica, Pharm.D.	x		
Fornander, Wade, M.D.	x			Sobeski, Linda, Pharm.D.	x		
Hill, Jennifer, M.D.	x						

## Review Agenda – Oncology, Oral – Lung

**(1<sup>st</sup>) Motion:** Bendlin

**(2<sup>nd</sup>) Motion:** Baker

**Discussion:** Approve as written.

<b>Voting – P&amp;T Committee Members</b> <small>Does not include excused or unexcused members</small>	Yes	No	Abstain	<b>Voting – P&amp;T Committee Members</b>	Yes	No	Abstain
Avery, Eric, M.D. (Chair) <i>Votes only in the event of a tie</i>				Humphries, Laurie, M.D.	x		
Baker, Claire, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Bendlin, Andrew, Pharm.D.	x			Kaspar-Cope, Rachelle, M.D.	x		
Dering-Anderson, Allison, Pharm.D. (Vice Chair)	x			Pohl, Jessica, Pharm.D.	x		
Fornander, Wade, M.D.	x			Sobeski, Linda, Pharm.D.	x		
Hill, Jennifer, M.D.	x						

## Review Agenda – Oncology, Oral – Other

**(1<sup>st</sup>) Motion:** Dering-Anderson

**(2<sup>nd</sup>) Motion:** Sobeski

**Discussion:** Approve as written.

<b>Voting – P&amp;T Committee Members</b> <small>Does not include excused or unexcused members</small>	Yes	No	Abstain	<b>Voting – P&amp;T Committee Members</b>	Yes	No	Abstain
Avery, Eric, M.D. (Chair) <i>Votes only in the event of a tie</i>				Humphries, Laurie, M.D.	x		
Baker, Claire, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Bendlin, Andrew, Pharm.D.	x			Kaspar-Cope, Rachelle, M.D.	x		
Dering-Anderson, Allison, Pharm.D. (Vice Chair)	x			Pohl, Jessica, Pharm.D.	x		
Fornander, Wade, M.D.	x			Sobeski, Linda, Pharm.D.	x		
Hill, Jennifer, M.D.	x						

## Review Agenda – Oncology, Oral – Prostate

**(1<sup>st</sup>) Motion:** Baker

**(2<sup>nd</sup>) Motion:** Dering-Anderson

**Discussion:** Committee recommended Zytiga be moved from Non-Preferred to Preferred on the PDL.

<b>Voting – P&amp;T Committee Members</b> <small>Does not include excused or unexcused members</small>	Yes	No	Abstain	<b>Voting – P&amp;T Committee Members</b>	Yes	No	Abstain
Avery, Eric, M.D. (Chair) <i>Votes only in the event of a tie</i>				Humphries, Laurie, M.D.	x		
Baker, Claire, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Bendlin, Andrew, Pharm.D.	x			Kaspar-Cope, Rachelle, M.D.	x		
Dering-Anderson, Allison, Pharm.D. (Vice Chair)	x			Pohl, Jessica, Pharm.D.	x		
Fornander, Wade, M.D.	x			Sobeski, Linda, Pharm.D.	x		
Hill, Jennifer, M.D.	x						

## Review Agenda – Oncology, Oral – Renal Cell

**(1<sup>st</sup>) Motion:** Fornander

**(2<sup>nd</sup>) Motion:** Hill

**Discussion:** Approve as written.

<b>Voting – P&amp;T Committee Members</b> <small>Does not include excused or unexcused members</small>	Yes	No	Abstain	<b>Voting – P&amp;T Committee Members</b>	Yes	No	Abstain
Avery, Eric, M.D. (Chair) <i>Votes only in the event of a tie</i>				Humphries, Laurie, M.D.	x		
Baker, Claire, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Bendlin, Andrew, Pharm.D.	x			Kaspar-Cope, Rachelle, M.D.	x		
Dering-Anderson, Allison, Pharm.D. (Vice Chair)	x			Pohl, Jessica, Pharm.D.	x		
Fornander, Wade, M.D.	x			Sobeski, Linda, Pharm.D.	x		
Hill, Jennifer, M.D.	x						

**Review Agenda – Ophthalmic, Allergic Conjunctivitis**

**(1<sup>st</sup>) Motion:** Baker

**(2<sup>nd</sup>) Motion:** Sobeski

**Discussion:** Approve as written.

<b>Voting – P&amp;T Committee Members</b> <small>Does not include excused or unexcused members</small>	Yes	No	Abstain	<b>Voting – P&amp;T Committee Members</b>	Yes	No	Abstain
Avery, Eric, M.D. (Chair) <i>Votes only in the event of a tie</i>				Humphries, Laurie, M.D.	x		
Baker, Claire, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Bendlin, Andrew, Pharm.D.	x			Kaspar-Cope, Rachelle, M.D.	x		
Fornander, Wade, M.D.	x			Pohl, Jessica, Pharm.D.	x		
Hill, Jennifer, M.D.	x			Sobeski, Linda, Pharm.D.	x		

**Review Agenda – Ophthalmic, Anti-Inflammatories**

**(1<sup>st</sup>) Motion:** Fornander

**(2<sup>nd</sup>) Motion:** Sobeski

**Discussion:** Approve as written.

<b>Voting – P&amp;T Committee Members</b> <small>Does not include excused or unexcused members</small>	Yes	No	Abstain	<b>Voting – P&amp;T Committee Members</b>	Yes	No	Abstain
Avery, Eric, M.D. (Chair) <i>Votes only in the event of a tie</i>				Humphries, Laurie, M.D.	x		
Baker, Claire, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Bendlin, Andrew, Pharm.D.	x			Kaspar-Cope, Rachelle, M.D.	x		
Fornander, Wade, M.D.	x			Pohl, Jessica, Pharm.D.	x		
Hill, Jennifer, M.D.	x			Sobeski, Linda, Pharm.D.	x		

## Review Agenda – Ophthalmic, Anti-Inflammatory/Immunomodulator

**(1<sup>st</sup>) Motion:** Baker

**(2<sup>nd</sup>) Motion:** Hill

**Discussion:** Approve as written.

<b>Voting – P&amp;T Committee Members</b> <small>Does not include excused or unexcused members</small>	Yes	No	Abstain	<b>Voting – P&amp;T Committee Members</b>	Yes	No	Abstain
Avery, Eric, M.D. (Chair) <i>Votes only in the event of a tie</i>				Humphries, Laurie, M.D.	x		
Baker, Claire, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Bendlin, Andrew, Pharm.D.	x			Kaspar-Cope, Rachelle, M.D.	x		
Fornander, Wade, M.D.	x			Pohl, Jessica, Pharm.D.	x		
Hill, Jennifer, M.D.	x			Sobeski, Linda, Pharm.D.	x		

## Review Agenda – Ophthalmic, Glaucoma Agents

**(1<sup>st</sup>) Motion:** Sobeski

**(2<sup>nd</sup>) Motion:** Kaspar-Cope

**Discussion:** Approve as written.

<b>Voting – P&amp;T Committee Members</b> <small>Does not include excused or unexcused members</small>	Yes	No	Abstain	<b>Voting – P&amp;T Committee Members</b>	Yes	No	Abstain
Avery, Eric, M.D. (Chair) <i>Votes only in the event of a tie</i>				Humphries, Laurie, M.D.	x		
Baker, Claire, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Bendlin, Andrew, Pharm.D.	x			Kaspar-Cope, Rachelle, M.D.	x		
Fornander, Wade, M.D.	x			Pohl, Jessica, Pharm.D.	x		
Hill, Jennifer, M.D.	x			Sobeski, Linda, Pharm.D.	x		

## Review Agenda – Sedative Hypnotics

**(1<sup>st</sup>) Motion:** Sobeski

**(2<sup>nd</sup>) Motion:** Fornander

**Discussion:** Approve as written.

<b>Voting – P&amp;T Committee Members</b> <small>Does not include excused or unexcused members</small>	Yes	No	Abstain	<b>Voting – P&amp;T Committee Members</b>	Yes	No	Abstain
Avery, Eric, M.D. (Chair) <i>Votes only in the event of a tie</i>				Humphries, Laurie, M.D.	x		
Baker, Claire, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Bendlin, Andrew, Pharm.D.	x			Kaspar-Cope, Rachelle, M.D.	x		
Fornander, Wade, M.D.	x			Pohl, Jessica, Pharm.D.	x		
Hill, Jennifer, M.D.	x			Sobeski, Linda, Pharm.D.	x		

## Review Agenda – Steroids, Topical Very High

**(1<sup>st</sup>) Motion:** Baker

**(2<sup>nd</sup>) Motion:** Hill

**Discussion:** Approve as written.

<b>Voting – P&amp;T Committee Members</b> <small>Does not include excused or unexcused members</small>	Yes	No	Abstain	<b>Voting – P&amp;T Committee Members</b>	Yes	No	Abstain
Avery, Eric, M.D. (Chair) <i>Votes only in the event of a tie</i>				Humphries, Laurie, M.D.	x		
Baker, Claire, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Bendlin, Andrew, Pharm.D.	x			Kaspar-Cope, Rachelle, M.D.	x		
Fornander, Wade, M.D.	x			Pohl, Jessica, Pharm.D.	x		
Hill, Jennifer, M.D.	x			Sobeski, Linda, Pharm.D.	x		

**Review Agenda – Stimulants ADHD and Related Drugs**

**(1<sup>st</sup>) Motion:** Humphries

**(2<sup>nd</sup>) Motion:** Hill

**Discussion:** Approve as written.

<b>Voting – P&amp;T Committee Members</b> <small>Does not include excused or unexcused members</small>	Yes	No	Abstain	<b>Voting – P&amp;T Committee Members</b>	Yes	No	Abstain
Avery, Eric, M.D. (Chair) <i>Votes only in the event of a tie</i>				Humphries, Laurie, M.D.	x		
Baker, Claire, M.D.	x			Juracek, Joyce, Pharm.D.	x		
Bendlin, Andrew, Pharm.D.	x			Kaspar-Cope, Rachelle, M.D.	x		
Fornander, Wade, M.D.	x			Pohl, Jessica, Pharm.D.	x		
Hill, Jennifer, M.D.	x			Sobeski, Linda, Pharm.D.	x		

b. Complete Copy of Proposed PDL

**Nebraska Medicaid - Preferred Drug List with Prior Authorization Criteria**

**November 2021 P&T Proposed Changes *Red Highlights* indicated proposed changes**

## ALZHEIMER'S AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>CHOLINESTERASE INHIBITORS</b>		
donepezil (generic for Aricept) donepezil ODT (generic for Aricept ODT) EXELON Transdermal (rivastigmine)	donepezil 23 (generic for Aricept 23) galantamine (generic for Razadyne) <b>SOLUTION, TABLET</b> galantamine ER (generic for Razadyne ER) rivastigmine (generic for Exelon)	Non-preferred agents will be approved for patients who have failed a 120-day trial of ONE preferred agent within this drug class within the last 6 months <b>OR</b> Current, stabilized therapy of the non-preferred agent within the previous 45 days
<b>NMDA RECEPTOR ANTAGONIST</b>		
memantine (generic for Namenda)	memantine ER (generic for Namenda XR) memantine <b>SOLUTION</b> (generic for Namenda) NAMENDA (memantine) NAMZARIC (memantine/donepezil)	Drug-specific criteria: <b>Donepezil 23:</b> Requires donepezil 10mg/day for at least 3 months AND clinical reason as to why 5mg or 10mg tablets can't be used (to deliver 20mg or 25mg)

## ANTHELMINTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
albendazole (generic for Albenza) BILTRICIDE (praziquantel) ivermectin (generic for Stromectol)	ALBENZA (albendazole) EMVERM (mebendazole) <sup>CL</sup> praziquantel (generic for Biltricide) STROMECTOL (ivermectin)	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: <ul style="list-style-type: none"> <li>▪ <b>Emverm:</b> Approval will be considered for indications not covered by preferred agents</li> </ul>

## ANTI-ALLERGENS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	<p>ORALAIR (sweet vernal/orchard/rye/timothy/kentucky blue grass mixed pollen allergen extract)</p> <p>PALFORZIA <sup>AL,CL</sup> (peanut allergen powder-dnfp)</p>	<p>Drug-specific criteria:</p> <p><b>ORALAIR</b></p> <p>Confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for Sweet Vernal, Orchard, Perennial Rye, Timothy, and Kentucky Blue Grass Mixed Pollens.</p> <p>For use in patients 10 through 65 years of age.</p> <p><b>PALFORZIA</b></p> <ul style="list-style-type: none"> <li>• <i>Confirmed diagnosis of peanut allergy by allergist</i></li> <li>• <i>For use in patients ages 4 to 17; it may be continued in patients 18 years and older with documentation of previous use within the past 90 days</i></li> <li>• <i>Initial dose and increase titration doses should be given in a healthcare setting</i></li> <li>• <i>Should not be used in patients with uncontrolled asthma or concurrently on a NSAID</i></li> </ul>

## ANTIHISTAMINES, MINIMALLY SEDATING

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
cetirizine <b>TABLET, SOLUTION (Rx only)</b> (generic for Zyrtec)  loratadine <b>TABLET, SOLUTION</b> (generic for Claritin)  levocetirizine <b>TABLET</b> (generic for Xyzal)	cetirizine <b>CHEWABLE</b> (generic for Zyrtec)  cetirizine <b>SOLUTION (OTC)</b> desloratadine (generic for Clarinex) desloratadine ODT (generic for Clarinex Reditabs)  fexofenadine (generic for Allegra)  fexofenadine 180mg (generic for Allegra 180mg) <sup>QL</sup>  levocetirizine (generic for Xyzal) <b>SOLUTION</b>	Non-preferred agents will be approved for patients who have failed TWO preferred agents within this drug class  Combination products not covered – individual products may be covered

## ANTIHYPERTENSIVES, SYMPATHOLYTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CATAPRES-TTS (clonidine)  clonidine <b>TABLET</b> (generic for Catapres)  guanfacine (generic for Tenex)  methyldopa	clonidine <b>TRANSDERMAL</b>  methyldopa/hydrochlorothiazide	Non-preferred agents will be approved for patients who have failed a 30-day trial with ONE preferred agent within this drug class

## ANTIHYPURICEMICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
allopurinol (generic for Zyloprim) MITIGARE (colchicine) probenecid probenecid/colchicine (generic for Col-Probenecid)	colchicine <b>TABLET</b> (generic for Colcrys) <sup>CL</sup> colchicine <b>CAPSULE</b> (generic for Mitigare) febuxostat (generic for Uloric) <sup>CL</sup> <b>GLOPERBA SOLN</b> (colchicine) <sup>CL,QL</sup>	Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class <b>colchicine tablet</b> <sup>®</sup> : Approved without trial for familial Mediterranean fever OR pericarditis <b>Gloperba</b> : <i>Approved for documented swallowing disorder</i> <b>Uloric</b> <sup>®</sup> : Clinical reason why allopurinol cannot be used

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## ANTIPARKINSON'S AGENTS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>ANTICHOLINERGICS</b>		Non-preferred agents will be approved for patients who have failed ONE preferred agents within this drug class
benztropine (generic for Cogentin) trihexyphenidyl (generic for Artane)		
<b>COMT INHIBITORS</b>		Drug-specific criteria: <b>Carbidopa/Levodopa ODT:</b> Approved for documented swallowing disorder <b>COMT Inhibitors:</b> Approved if using as add-on therapy with levodopa-containing drug
	entacapone (generic for Comtan) tolcapone (generic for Tasmar)	
<b>DOPAMINE AGONISTS</b>		<b>Gocovri:</b> Required diagnosis of Parkinson's disease and had trial of or is intolerant to amantadine AND must be used as an add-on therapy with levodopa-containing drug <b>Inbrija:</b> Approval upon diagnosis of Parkinson's disease and concurrent treatment with carbidopa/levodopa agent <b>Neupro®:</b> For Parkinsons: Clinical reason required why preferred agent cannot be used For Restless Leg (RLS): Requires trial OR Contraindication to ropinirole AND pramipexole
pramipexole (generic for Mirapex) ropinirole (generic for Requip)	bromocriptine (generic for Parlodel) ropinirole ER (generic for Requip ER) <sup>CL</sup> NEUPRO (rotigotine) <sup>CL</sup> pramipexole ER (generic for Mirapex ER) <sup>CL</sup> ropinirole ER (generic for Requip XL) <sup>CL</sup>	
<b>MAO-B INHIBITORS</b>		<b>Nourianz:</b> Approval upon diagnosis of Parkinson's disease and concurrent treatment with carbidopa/levodopa agent <b>Osmolex ER:</b> Required diagnosis of Parkinson's disease or drug-induced extrapyramidal reactions and had trial of or is intolerant to amantadine IR
selegiline <b>CAPSULE, TABLET</b> (generic for Eldepryl)	rasagiline (generic for Azilect) <sup>QL</sup> XADAGO (safinamide) ZELAPAR (selegiline) <sup>CL</sup>	
<b>OTHER ANTIPARKINSON'S DRUGS</b>		<b>Pramipexole ER:</b> Required diagnosis of Parkinson's along with preferred agent trial <b>Ropinerole ER:</b> Required diagnosis of Parkinson's along with preferred agent trial <b>Zelapar®:</b> Approved for documented swallowing disorder
amantadine <b>CAPSULE, SYRUP TABLET</b> (generic for Symmetrel) carbidopa/levodopa (generic for Sinemet) carbidopa/levodopa ER (generic for Sinemet CR) levodopa/carbidopa/entacapone (generic for Stalevo)	APOKYN (apomorphine) <b>SUB-Q</b> carbidopa (generic for Lodosyn) carbidopa/levodopa ODT (generic for Parcopa) DUOPA (carbidopa/levodopa) GOCOVRI (amantadine) <sup>QL</sup> INBRIJA (levodopa) INHALER <sup>CL,QL</sup> KYNMOBI (apomorphine) <sup>QL</sup> , <b>KIT, SUBLINGUAL</b> NOURIANZ (istradefylline) <sup>CL,QL</sup> OSMOLEX ER (amantadine) <sup>QL</sup> RYTARY (carbidopa/levodopa) STALEVO (ledopa/carbidopa/entacapone)	

## ANTIPSORIATICS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
acitretin (generic for Soriatane)	methoxsalen (generic for Oxsoresalen-Ultra)  SORIATANE (acitretin)	Non-preferred agents will be approved for patients who have failed a trial with THE preferred agent within this drug class  Trial of acitretin (Pregnancy category X) not required in pregnancy or while attempting or planning pregnancy

## ANTIPSORIATICS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
calcipotriene <b>CREAM, OINTMENT, SOLUTION,</b>	calcitriol (generic for Vectical)  calcipotriene/betamethasone <b>OINTMENT</b> (generic for Taclonex)  <i>calcipotriene/betamethasone <b>SUSP</b> (generic for Taclonex Scalp)</i>  CALCITRENE (calcipotriene)  DOVONEX <b>CREAM</b> (calcipotriene)  DUOBRII  (halobetasol prop/tazarotene)  ENSTILAR (calcipotriene/betamethasone)  SORILUX (calcipotriene)	Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class

## ANXIOLYTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
alprazolam <b>TABLET</b> (generic for Xanax)	alprazolam ER (generic for Xanax XR)	<p>Non-preferred agents will be approved for patients who have failed a trial with TWO preferred agents within this drug class</p> <p>Drug-specific criteria:</p> <p><b>Diazepam IntensoI®:</b> Requires clinical reason why diazepam solution cannot be used</p> <p><b>Alprazolam IntensoI®:</b> Requires trial of diazepam solution OR lorazepam IntensoI®</p>
buspirone (generic for Buspar)	alprazolam ODT	
chlordiazepoxide	alprazolam <b>INTENSOL</b> <sup>CL</sup>	
diazepam <b>TABLET, SOLUTION</b> (generic for Valium)	clorazepate (generic for Tranxene-T)	
lorazepam <b>INTENSOL, TABLET</b> (generic for Ativan)	diazepam <b>INTENSOL</b> <sup>CL</sup>	
	meprobamate	
	oxazepam	

## BILE SALTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ursodiol <b>CAPSULE</b> 300mg (generic for Actigall)	CHENODAL (chenodiol)	<p>Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class</p>
ursodiol 250mg <b>TABLET</b> (generic for URSO)	CHOLBAM (cholic acid)	
ursodiol 500mg <b>TABLET</b> (generic for URSO FORTE)	OCALIVA (obeticholic acid)	

## BRONCHODILATORS, BETA AGONIST

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class	
<b>INHALERS – Short Acting</b>			
PROAIR HFA (albuterol) <b>albuterol HFA (generic for ProAir HFA)</b>	albuterol HFA (Proventil HFA, Ventolin HFA) levalbuterol HFA (generic for Xopenex HFA) <i>PROAIR DIGIHALER (albuterol)</i> PROAIR RESPICLICK (albuterol) PROVENTIL HFA (albuterol)	Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class  Drug-specific criteria:  <b>Xopenex®</b> : Covered for cardiac diagnoses or side effect of tachycardia with albuterol product	
<b>INHALERS – Long Acting</b>			
SEREVENT (salmeterol)	ARCAPTA NEOHALER (indacaterol) STRIVERDI RESPIMAT (olodaterol)		
<b>INHALATION SOLUTION</b>			
albuterol (2.5mg/3ml premix or 2.5mg/0.5ml) albuterol 100 mg/20 mL albuterol low dose (0.63mg/3ml & 1.25mg/3ml)	<b>arformoterol tartrate (generic Brovana)<sup>NR</sup></b> BROVANA (arformoterol) <b>formoterol fumarate (generic Performist)<sup>NR</sup></b> levalbuterol (generic for Xopenex) PERFOROMIST (formoterol)		
<b>ORAL</b>			
albuterol <b>SYRUP</b>	albuterol <b>TABLET</b> albuterol ER (generic for Vospire ER) metaproterenol (formerly generic for Alupent) terbutaline (generic for Brethine)		

## COLONY STIMULATING FACTORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
NEUPOGEN (filgrastim) <b>VIAL</b>	GRANIX (tbo-filgrastim) NEUPOGEN <b>DISP SYR</b> (filgrastim) NIVESTYM <b>SYR,VIAL</b> (filgrastim-aafi) Nyvepria (pegfilgrastim-apgf) <sup>NR</sup> ZARXIO (filgrastim-sndz) ZIEXTENZO <b>SYR</b> (pegfilgrastim-bmez)	Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

## COPD (CHRONIC OBSTRUCTIVE PULMONARY DISEASE) AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>INHALERS</b>		Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class OR Patient specific documentation of inability to use traditional inhaler device.  Drug-specific criteria:  <b>Daliresp®:</b> Covered for diagnosis of severe COPD associated with chronic bronchitis  Requires trial of a bronchodilator  Requires documentation of one exacerbation in last year upon initial review
ANORO ELLIPTA (umeclidinium/vilanterol)	BEVESPI AEROSPHERE (glycopyrolate/formoterol)	
ATROVENT HFA (ipratropium)	DUAKLIR PRESSAIR (aclidinium br and formoterol fum)	
COMBIVENT RESPIMAT (albuterol/ipratropium)	INCRUSE ELIPTA (umeclidinium)	
SPIRIVA (tiotropium)	SEEBRI NEOHALER (glycopyrolate)	
STIOLTO RESPIMAT (tiotropium/olodaterol)	SPIRIVA RESPIMAT (tiotropium) TUDORZA PRESSAIR (aclidinium br) UTIBRON NEOHALER (indacaterol/glycopyrolate)	
<b>INHALATION SOLUTION</b>		
albuterol/ipratropium (generic for Duoneb)	LONHALA (glycopyrrolate inhalation soln)	
ipratropium <b>SOLUTION</b> (generic for Atrovent)	YUPELRI (revefenacin)	
<b>ORAL AGENT</b>		
	DALIRESP (roflumilast) <sup>CL, QL</sup>	

## COUGH AND COLD, OPIATE COMBINATION

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	guaifenesin/codeine <b>LIQUID</b> hydrocodone/homatropine SYRUP promethazine/codeine <b>SYRUP</b> promethazine/phenylephrine/codeine SYRUP pseudoephedrine/codeine/ guaifenesin (generic for Lortuss EX, Tusnel C, Virtussin DAC)	Non-preferred agents will be approved for patients who have failed a trial of ONE dextromethorphan product All codeine or hydrocodone containing cough and cold combinations are limited to $\geq 18$ years of age

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## CYTOKINE & CAM ANTAGONISTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ENBREL (etanercept) <b>KIT, MINI CART, PEN</b> <sup>QL</sup>	ACTEMRA (tocilizumab) <b>SUB-Q</b>	Preferred agents will be approved with FDA-approved indication – ICD-10 diagnosis code is required.
HUMIRA (adalimumab) <sup>QL</sup>	ARCALYST (niloncept)	
ENBREL (etanercept) <b>VIAL</b> <sup>QL</sup>	CIMZIA (certolizumab pegol) <sup>QL</sup>	Non-preferred agents will be approved for FDA-approved indications in patients who have failed a trial of ONE preferred agent within this drug class, or upon diagnosis for non-preferred agent with FDA-approved indication if no preferred agent has FDA approval for diagnosis.
OTEZLA (apremilast) <b>ORAL</b> <sup>CL,QL</sup>	COSENTYX (secukinumab)	
	ENSPRYNG (satralizumab-mwge) <b>SUB-Q</b>	Drug-specific criteria: <b>Otezla:</b> Requires a trial of Humira <b>Olumiant:</b> Requires documentation of inadequate response or intolerance to methotrexate and an inadequate response to one or more TNF antagonist therapies. <b>Rinvoq:</b> Requires documentation of inadequate response or intolerance to methotrexate
	ILUMYA (tildrakizumab) <b>SUB-Q</b>	
	KEVZARA (sarilumab) <b>SUB-Q, PEN, SYRINGE</b>	* <b>Xeljanz, Xeljanz XR:</b> Requires documentation of inadequate response or intolerance to methotrexate. Diagnosis of Juvenile Idiopathic Arthritis for ages 2 years old and older does not require documentation of treatment failure with methotrexate. Diagnosis of moderate to severe ulcerative colitis (UC) requires documentation of treatment failure with a Tumor Necrosis Factor blocker agent; does not require documentation of treatment failure with methotrexate.
	KINERET (anakinra)	
	OLUMIANT (baricitinib) <b>ORAL</b> <sup>CL,QL</sup>	
	ORENCIA (abatacept) <b>SUB-Q</b>	
	RINVOQ ER (upadacitinib) <sup>CL,QL</sup>	
	SILIQ (brodalumab)	
	SIMPONI (golimumab)	
	SKYRIZI (risankizumab-rzaa)	
	<b>SKYRIZI PEN (risankizumab-rzaa)</b> <sup>QL,NR</sup>	
	STELARA (ustekinumab) <b>SUB-Q</b>	
	TALTZ (ixekizumab) <sup>AL</sup>	
	TREMFYA (guselkumab) <sup>QL</sup>	
	XELJANZ (tofacitinib) <b>ORAL, SOLM</b> <sup>CL,QL</sup>	
	XELJANZ XR (tofacitinib) <b>ORAL</b> <sup>CL,QL</sup>	

## ENZYME REPLACEMENT, GAUCHERS DISEASE

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ZAVESCA (miglustat) <sup>CL</sup>	CERDELGA (eliglustat)  miglustat (generic Zavesca)	Non-preferred agents require clinical documentation why the preferred product within this drug class is not appropriate  Drug-specific criteria:  <b>Zavesca:</b> Approved for mild to moderate type 1 Gaucher disease for whom enzyme replacement therapy is not a therapeutic option

## EPINEPHRINE, SELF-INJECTED<sup>QL</sup>

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
epinephrine (AUTHORIZED GENERIC for Epipen/ Epipen Jr.) <b>AUTOINJECTOR</b>	epinephrine (generic for Adrenaclick)  epinephrine (generic for Epipen/ Epipen Jr.) <b>AUTOINJECTOR</b>  EPIPEN (epinephrine) <b>AUTOINJ</b>  EPIPEN JR. (epinephrine) <b>AUTOINJ</b>  SYMJEPI (epinephrine) <b>PFS</b>	Non-preferred agents require clinical documentation why the preferred product within this drug class is not appropriate  Brand name product may be authorized in event of documented national shortage of generic product.

## ERYTHROPOIESIS STIMULATING PROTEINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
RETACRIT (EPOETIN ALFA-EPBX)	EPOGEN (rHuEPO)  PROCRI (rHuEPO)	Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

## GLUCOCORTICIDS, INHALED

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>GLUCOCORTICIDS</b>		
ASMANEX (mometasone) <sup>QL,AL</sup> FLOVENT HFA (fluticasone) PULMICORT FLEXHALER (budesonide)	AEROSPAN (flunisolide) ALVESCO (ciclesonide) <sup>AL,CL</sup> <b>ARMONAIR DIGIHALER</b> <i>(fluticasone)<sup>AL,NR,QL</sup></i> ARMONAIR RESPICLICK (fluticasone) <sup>AL</sup> ARNUITY ELLIPTA (fluticasone) ASMANEX HFA (mometasone) <sup>CL,AL,QL</sup> FLOVENT DISKUS (fluticasone) QVAR (beclomethasone) QVAR Redihaler (beclomethasone)	Non-preferred agents within the Glucocorticoids and Glucocorticoid/Bronchodilator Combo groups 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: <b>budesonide respules:</b> Covered without PA for age ≤ 8 years OR for diagnosis of eosinophilic esophagitis in patients ≥ 9 years, by GI biopsy or upper endoscopy. For other indications, must have failed a trial of two preferred agents within this drug class, within the last 6 months.
<b>GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS</b>		
ADVAIR DISKUS (fluticasone/salmeterol) <sup>QL</sup> ADVAIR HFA (fluticasone/salmeterol) <sup>QL</sup> DULERA (mometasone/formoterol) SYMBICORT (budesonide/ formoterol)	AIRDUO DIGIHALER (fluticasone/salmeterol) <sup>AL,QL</sup> BREO ELLIPTA (fluticasone/vilanterol) BREZTRI (budesonide/formoterol/glycopyrrolate) <sup>QL</sup> Budesonide/formoterol (generic for Symbicort) fluticasone/salmeterol (generic for Advair Diskus) <sup>QL</sup> fluticasone/salmeterol (generic for Airduo Respiclick) TRELEGY ELLIPTA (fluticasone/umeclidinium/vilanterol) WIXELA INHUB (generic for Advair Diskus) <sup>QL</sup>	
<b>INHALATION SOLUTION</b>		
	budesonide <b>RESPULES</b> (generic for Pulmicort)	

## GLUCOCORTICIDS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
budesonide EC <b>CAPSULE</b> (generic for Entocort EC)	<i>ALKINDI (hydrocortisone) GRANULES<sup>AL/NR</sup></i>	<p>Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agents within this drug class within the last 6 months</p> <p>Drug-specific criteria:</p> <p><b>Emflaza:</b> Indicated for the treatment of Duchenne muscular dystrophy (DMD) in patients 2 years of age and older</p> <p><b>Intensol Products:</b> Patient specific documentation of why the less concentrated solution is not appropriate for the patient</p>
dexamethasone <b>TABLET</b>	CORTEF (hydrocortisone)	
dexamethasone <b>ELIXIR, SOLN</b>	cortisone <b>TABLET</b>	
hydrocortisone <b>TABLET</b>	dexamethasone <b>INTENSOL</b>	
methylprednisolone tablet (generic for Medrol)	DEXPAK (dexamethasone)	
prednisolone <b>SOLUTION</b>	DXEVO (dexamethasone)	
prednisolone sodium phosphate	EMFLAZA (deflazacort) <b>SUSPENSION, TABLET<sup>CL</sup></b>	
prednisone <b>DOSE PAK</b>	ENTOCORT EC (budesonide)	
prednisone <b>TABLET</b>	methylprednisolone 8mg, 16mg, 32mg	
	<i>ORTIKOS ER (budesonide)<sup>AL,QL</sup></i>	
	PEDIAPRED (prednisolone sodium phosphate)	
	prednisolone sodium phosphate (generic for Millipred/Veripred)	
	prednisolone sodium phosphate <b>ODT</b>	
	prednisone <b>SOLUTION</b>	
	prednisone <b>INTENSOL</b>	
	RAYOS DR (prednisone) <b>TABLET</b>	

## HEMOPHILIA TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>FACTOR VIII</b>		<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class</li> <li><i>Patients receiving a hemophilia agent which moved from preferred to non-preferred status on 1-21-21 will be allowed to continue same therapy</i></li> </ul>
ALPHANATE HELIXATE FS HUMATE-P NOVOEIGHT NUWIQ XYNTHA KIT, SOLOFUSE	ADVATE ADYNOVATE AFSTYLA ELOCTATE ESPEROCT HEMOFIL-M JIVI <sup>AL</sup> KOATE-DVI KIT KOATE-DVI VIAL KOGENATE FS KOVALTRY OBIZUR RECOMBINATE	
<b>FACTOR IX</b>		
BENEFIX	ALPHANINE SD ALPROLIX IDELVION IXINITY MONONINE PROFILNINE SD REBINYN RIXUBIS	
<b>FACTOR VIIa AND PROTHROMBIN COMPLEX-PLASMA DERIVED</b>		
NOVOSEVEN RT	FEIBA NF SEVENFACT <sup>AL,NR</sup>	
<b>FACTOR X AND XIII PRODUCTS</b>		
COAGADEX CORIFACT	TRETTEN	
<b>VON WILLEBRAND PRODUCTS</b>		
WILATE	VONVENDI	
<b>BISPECIFIC FACTORS</b>		
HEMLIBRA		

## HISTAMINE II RECEPTOR BLOCKERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
famotidine <b>TABLET</b> (generic for Pepcid) nizatidine <b>SOLUTION</b> (generic for Axid)	cimetidine <b>TABLET, SOLUTION</b> <sup>CL</sup> (generic for Tagamet) famotidine <b>SUSPENSION</b> nizatidine <b>CAP</b> (generic for Axid) ranitidine <b>CAPSULE</b> , (generic for Zantac) ranitidine OTC, SYRUP, TABLET (generic for Zantac)	Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class  Drug-specific criteria: <b>Cimetidine:</b> Approved for viral <i>M. contagiosum</i> or common wart <i>V. Vulgaris</i> treatment  <b>cimetidine solution/ famotidine suspension/ranitidine syrup:</b> Requires clinical reason why nizatidine syrup cannot be used *** <b>famotidine suspension is authorized during shortage of nizatidine syrup.</b> ***

## IDIOPATHIC PULMONARY FIBROSIS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
OFEV (nintedanib esylate) <sup>CL</sup>	ESBRIET (pirfenidone)	Non-preferred agent requires trial of preferred agent within this drug class FDA approved indication required – ICD-10 diagnosis code

## IMMUNOMODULATORS, ASTHMA<sup>CL</sup>

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<p>FASENRA (benralizumab)<sup>AL</sup> <b>PEN</b></p> <p>XOLAIR (omalizumab) <b>SYR<sup>AL,NR,QL</sup></b></p>	<p>NUCALA (mepolizumab)<sup>AL</sup></p> <p><b>AUTO-INJ, SYR,</b></p>	<p>Non-preferred agent requires trial of preferred agent within this drug class with the same indication</p> <p>Drug Specific Criteria:</p> <p><b>Dupixent:</b> See criteria listed under the Immunomodulator, Atopic Dermatitis class</p> <p><b>Fasenra:</b> is indicated for patient 12 years and older for add on maintenance treatment of severe asthma, and with an eosinophilic phenotype</p> <p><b>Nucala:</b> is indicated for</p> <ul style="list-style-type: none"> <li>-Patients 6 years and older for add on maintenance treatment of severe asthma, and with an eosinophilic phenotype</li> <li>-Patients 12 years and older with hypereosinophilic syndrome (HES) for <math>\geq 6</math> months without identifiable non-hematologic secondary cause</li> <li>-Patients 18 years and older for add-on maintenance treatment of chronic rhinosinusitis with nasal polyps (CRWSwNP) with inadequate response to nasal corticosteroids.</li> <li>-Adult patients with eosinophilic granulomatosis with polyangiitis</li> </ul> <p><b>Xolair:</b> is indicated for</p> <ul style="list-style-type: none"> <li>-Moderate to severe persistent asthma in adults and pediatric patients 6 years of age and older with a positive skin test or in vitro reactivity to a perennial aeroallergen and symptoms that are inadequately controlled with inhaled corticosteroids</li> <li>-Nasal polyps in adult patients 18 years of age and older with inadequate response to nasal corticosteroids, as add-on maintenance treatment</li> <li>-Chronic spontaneous urticaria (CSU) in adults and adolescents 12 years of age and older who remain symptomatic despite H1 antihistamine treatment</li> </ul>

## IMMUNOMODULATORS, ATOPIC DERMATITIS<sup>AL</sup>

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<p>ELIDEL (pimecrolimus)</p> <p>EUCRISA (crisaborole)<sup>CL,QL</sup></p>	<p>DUPIXENT (dupilumab)<sup>AL,CL</sup></p> <p>DUPIXENT <b>PEN</b><sup>AL</sup></p> <p>pimecrolimus (generic for Elidel)</p> <p>tacrolimus (generic for Protopic)<sup>CL</sup></p>	<ul style="list-style-type: none"> <li>Non-preferred agents require: Trial of a topical steroid AND Trial of one preferred product within this drug class</li> </ul> <p>Drug-specific criteria:</p> <p><b>Dupixent:</b> Indicated for</p> <ul style="list-style-type: none"> <li>- for the treatment of patients aged 6 years and older with moderate-to-severe atopic dermatitis whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable. DUPIXENT can be used with or without topical corticosteroids.</li> <li>- as an add-on maintenance treatment in patients with moderate-to-severe asthma aged 12 years and older with an eosinophilic phenotype or with oral corticosteroid dependent asthma</li> <li>- as an add-on maintenance treatment in adult patients with inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP)</li> </ul> <p><b>Eucrisa:</b> Requires use and failure of 1</p>

## IMMUNOMODULATORS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<p>imiquimod (generic for Aldara)</p>	<p>ALDARA (imiquimod)</p> <p>imiquimod (generic for Zyclara)</p> <p>podofilox (generic for Condylox)</p> <p>VEREGEN (sinecatechins)</p> <p>ZYCLARA (imiquimod)</p>	<p>Non-preferred agents require clinical reason why preferred agent within this drug class cannot be used</p>

## INTRANASAL RHINITIS DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>ANTICHOLINERGICS</b>		Non-preferred agents will be approved for patients who have failed a 30-day trial of ONE preferred agent within this drug class
ipratropium (generic for Atrovent)		
<b>ANTI-HISTAMINES</b>		Drug-specific criteria: <ul style="list-style-type: none"> <li>▪ <b>mometasone:</b> Prior authorization NOT required for children ≤ 12 years</li> <li>▪ <b>budesonide:</b> Approved for use in Pregnancy (Pregnancy Category B)</li> <li>▪ <b>Veramyst®:</b> Prior authorization NOT required for children ≤ 12 years</li> <li>▪ <b>Xhance:</b> Indicated for treatment of nasal polyps in ≥ 18 years only</li> </ul>
azelastine 0.1% (generic for Astelin)	azelastine 0.15% (generic for Astepro) azelastine/fluticasone (generic for Dymista) olopatadine (generic for Patanase)	
<b>CORTICOSTEROIDS</b>		
fluticasone (generic for Flonase)	BECONASE AQ (beclomethasone) budesonide Rx (generic for Rhinocort) flunisolide (generic for Nasalide) mometasone (generic for Nasonex) OMNARIS (ciclesonide) QNASL 40 & 80 (beclomethasone) TICANASE (fluticasone) VERAMYST (fluticasone) XHANCE (fluticasone) ZETONNA (ciclesonide)	

## LEUKOTRIENE MODIFIERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
montelukast <b>TABLET/CHEWABLE</b> (generic for Singulair) <sup>AL</sup>	montelukast <b>GRANULES</b> (generic for Singulair) <sup>CL, AL</sup> zafirlukast (generic for Accolate) zileuton ER (generic for Zyflo CR) ZYFLO (zileuton)	Non-preferred agents will be approved for patients who have failed a 30-day trial of THE preferred agent within this drug class  Drug-specific criteria: <b>montelukast granules:</b> PA not required for age < 2 years

## METHOTREXATE

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
methotrexate <b>PF VIAL, TABLET, VIAL</b>	OTREXUP (methotrexate) <b>SUB-Q</b> RASUVO (methotrexate) <b>SUB-Q</b> <b>REDITREX</b> (methotrexate) <b>SUB-Q</b> <sup>AL, NR</sup> TREXALL (methotrexate) <b>TABLET</b> XATMEP (methotrexate) <b>SOLUTION</b>	Non-preferred agents will be approved for FDA-approved indications  Drug-specific criteria: <b>Xatmep™</b> : Indicated for pediatric patients only

## MOVEMENT DISORDERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
AUSTEDO (deutetrabenazine) <sup>CL</sup> <b>INGREZZA (valbenazine)<sup>CL</sup> CAP</b> tetrabenazine (generic for Xenazine) <sup>CL</sup>	INGREZZA (valbenazine) <sup>CL</sup> <b>INITIATION PACK</b> XENAZINE (tetrabenazine) <sup>CL</sup>	Non-preferred agent requires trial of Austedo  All drugs require an FDA approved indication – ICD-10 diagnosis code required.  Drug-specific criteria: <b>Austedo</b> : Diagnosis of Tardive Dyskinesia or chorea associated with Huntington's Disease; Requires a Step through tetrabenazine with the diagnosis of chorea associated with Huntington's Disease <b>Ingrezza</b> : Diagnosis of Tardive Dyskinesia in adults <del>and Trial of Austedo</del> <b>tetrabenazine</b> : Diagnosis of chorea with Huntington's Disease

## NSAIDs, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>COX-I SELECTIVE</b>		<p>Non-preferred agents within COX-1 SELECTIVE group will be approved for patients who have failed no less than 30-day trial of TWO preferred agents within this drug class</p> <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> <li>▪ <b>Arthrotec®</b>: Requires clinical reason why individual ingredients cannot be used</li> <li>▪ <b>Duexis®/Vimovo®</b>: Requires clinical reason why individual agents cannot be used</li> <li>▪ <b>meclofenamate</b>: Approvable without trial of preferred agents for menorrhagia</li> </ul>
<p>diclofenac sodium (generic for Voltaren)</p> <p>ibuprofen OTC, Rx (generic for Advil, Motrin) <b>CHEW, DROPS, SUSPENSION, TABLET</b></p> <p>indomethacin <b>CAPSULE</b> (generic for Indocin)</p> <p>ketorolac (generic for Toradol)</p> <p>meloxicam <b>TABLET</b> (generic for Mobic)</p> <p>nabumetone (generic for Relafen)</p> <p>naproxen Rx, OTC (generic for Naprosyn)</p> <p>naproxen enteric coated</p> <p>sulindac (generic for Clinoril)</p>	<p>diclofenac potassium (generic for Cataflam, Zipsor)</p> <p>diclofenac SR (generic for Voltaren-XR)</p> <p>diflunisal (generic for Dolobid)</p> <p>etodolac &amp; SR (generic for Lodine/XL)</p> <p>fenoprofen (generic for Nalfon)</p> <p>flurbiprofen (generic for Ansaid)</p> <p>ibuprofen OTC (generic for Advil, Motrin) <b>CAPSULE</b></p> <p>indomethacin ER (generic for Indocin)</p> <p><b>INDOCIN RECTAL, SUSPENSION</b></p> <p>ketoprofen &amp; ER (generic for Orudis)</p> <p>meclofenamate (generic for Meclomen)</p> <p>mefenamic acid (generic for Ponstel)</p> <p><b>meloxicam CAP</b> (generic Vivlodex)<sup>CL, NR, QL</sup></p> <p>naproxen CR (generic for Naprelan)</p> <p>naproxen <b>SUSPENSION</b> (generic for Naprosyn)</p> <p>naproxen sodium (generic for Anaprox)</p> <p><i>naproxen-esomeprazole (generic for Vimovo)</i></p> <p>oxaprozin (generic for Daypro)</p> <p>piroxicam (generic for Feldene)</p> <p>QMIIZ ODT (meloxicam)<sup>QL</sup></p> <p>RELAFEN DS (nabumetone)</p> <p>tolmetin (generic for Tolectin)</p> <p>Ketorolac Nasal (generic for Sprix)<sup>QL</sup></p>	

## NSAIDs, ORAL (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>COX-I SELECTIVE (continued)</b>		
	<p><b>ALL BRAND NAME NSAIDs including:</b></p> <p>CAMBIA (diclofenac oral solution)</p> <p>DUEXIS (ibuprofen/famotidine)<sup>CL</sup></p> <p>ibuprofen/famotidine (generic Duexis)<sup>CL,NR</sup></p> <p>SPRIX (ketorolac nasal spray) <b>NASAL</b><sup>QL, CL</sup></p> <p>TIVORBEX (indomethacin)</p> <p>VIVLODEX (meloxicam submicronized)</p> <p>ZIPSOR (diclofenac)</p> <p>ZORVOLEX (diclofenac)</p> <p>KETEK (telithromycin)</p>	<p>Drug-specific criteria:</p> <ul style="list-style-type: none"> <li>▪ <b>Sprix®</b>: Approved for patients unable to tolerate, swallow OR absorb oral NSAIDs OR contraindication OR trial of TWO preferred oral NSAIDs</li> <li>▪ <b>Tivorbex®</b>: Requires clinical reason why indomethacin capsules cannot be used</li> <li>▪ <b>Zorvolex®</b>: Requires trial of oral diclofenac OR clinical reason why diclofenac potassium/sodium cannot be used</li> </ul>
<b>NSAID/GI PROTECTANT COMBINATIONS</b>		
	<p>diclofenac/misoprostol (generic for Arthrotec)</p>	
<b>COX-II SELECTIVE</b>		
<p>celecoxib (generic for Celebrex)</p>		

## NSAIDs, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<p>diclofenac sodium <b>GEL (OTC only)</b></p>	<p>diclofenac (generic for Pennsaid Solution)<sup>CL</sup></p> <p>FLECTOR <b>PATCH</b> (diclofenac)<sup>CL</sup></p> <p>LICART <b>PATCH</b> (diclofenac)<sup>CL</sup></p> <p>PENNSAID <b>PACKET, PUMP</b> (diclofenac)<sup>CL</sup></p> <p>VOLTAREN <b>GEL</b> (diclofenac)<sup>CL</sup></p>	<p>Non-preferred agents will be approved for patients who have failed ONE preferred agent within this drug class</p> <p>Drug Specific Criteria</p> <p><b>Flector®/Licart:</b> Approved for diagnosis of acute pain due to sprain/strain/contusion AND trial of oral diclofenac OR clinical reason patient cannot use oral dosage form</p> <p><b>Pennsaid®:</b> Approved for osteoarthritis of the knees AND trial of oral diclofenac OR clinical reason patient cannot use oral dosage form</p> <p><b>Pennsaid® Pump:</b> Requires clinical reason why 1.5% solution cannot be used</p> <p><b>Voltaren®:</b> Approved for diagnosis of osteoarthritis AND trial of oral diclofenac OR clinical reason patient cannot use oral dosage form</p>

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NOTE: Other oral oncology agents not listed here may also be available. See <https://nebraska.fhsc.com/default.asp> for coverage information and prior authorization status for products not listed.

## ONCOLOGY AGENTS, ORAL, BREAST

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>CDK 4/6 INHIBITOR</b>		<p>Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines</p> <p>Drug-specific criteria</p> <ul style="list-style-type: none"> <li>▪ <b>anastrozole:</b> May be approved for malignant neoplasm of male breast (male breast cancer)</li> <li>▪ <b>capecitabine:</b> Requires trial of Xeloda or clinical reason Xeloda cannot be used</li> <li>▪ <b>Fareston®:</b> Require clinical reason why tamoxifen cannot be used</li> <li>▪ <b>letrozole:</b> Approved for diagnosis of breast cancer with day supply greater than 12 – NOT approved for short term use</li> <li>▪ <b>Soltamox:</b> May be approved with documented swallowing difficulty</li> </ul>
IBRANCE (palbociclib)	KISQALI (ribociclib) KISQALI FEMARA <b>CO-PACK</b> VERZENIO (abemaciclib)	
<b>CHEMOTHERAPY</b>		
cyclophosphamide XELODA (capecitabine)	capecitabine (generic for Xeloda) <sup>CL</sup>	
<b>HORMONE BLOCKADE</b>		
anastrozole (generic for Arimidex) exemestane (generic for Aromasin) letrozole (generic for Femara) tamoxifen citrate (generic for Nolvadex)	SOLTAMOX <b>SOLN</b> (tamoxifen) <sup>CL</sup> toremifene (generic for Fareston) <sup>CL</sup>	
<b>OTHER</b>		
	NERLYNX (neratinib) PIQRAY (alpelisib) <i>lapatinib (generic Tykerb)<sup>CL,NR</sup></i> TALZENNA (talazoparib tosylate) <sup>QL</sup> TUKYSA(tucatinib) <sup>QL</sup>	

NOTE: Other oral oncology agents not listed here may also be available. See <https://nebraska.fhsc.com/default.asp> for coverage information and prior authorization status for products not listed.

## ONCOLOGY AGENTS, ORAL, HEMATOLOGIC

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>ALL</b>		<ul style="list-style-type: none"> <li>▪ Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines</li> </ul> <p>Drug-specific criteria</p> <ul style="list-style-type: none"> <li>▪ <b>Hydrea®:</b> Requires clinical reason why generic cannot be used</li> <li>▪ <b>Melphalan:</b> Requires trial of Alkeran or clinical reason Alkeran cannot be used</li> <li>▪ <b>Purixan:</b> Prior authorization not required for age ≤12 or for documented swallowing disorder</li> <li>▪ <b>Tabloid:</b> Prior authorization not required for age &lt;19</li> <li>▪ <b>Tasigna:</b> Patients receiving Tasigna, which changed from preferred to non-preferred on 1-17-19 will be allowed to continue therapy</li> <li>▪ <b>Xpovio:</b> Indicated for relapsed or refractory multiple myeloma. Requires concomitant therapy with dexamethasone</li> </ul>
mercaptopurine	PURIXAN (mercaptopurine) <sup>AL</sup>	
<b>AML</b>		
	DAURISMO (glasdegib maleate) <sup>QL</sup> IDHIFA (enasidenib) RYDAPT (midostaurin) TIBSOVO (ivosidenib) <sup>QL</sup> XOSPATA (gilteritinib) <sup>QL</sup>	
<b>CLL</b>		
IMBRUVICA (ibrutinib) LEUKERAN (chlorambucil) VENCLEXTA (venetoclax)	COPIKTRA (duvelisib) <sup>QL</sup> ZYDELIG (idelalisib)	
<b>CML</b>		
hydroxyurea (generic for Hydrea) imatinib (generic for Gleevec) MYLERAN (busulfan) SPRYCEL (dasatinib)	BOSULIF (bosutinib) GLEEVEC (imatinib) HYDREA (hydroxyurea) ICLUSIG (ponatinib) TASIGNA (nilotinib) <sup>CL</sup>	
<b>MPN</b>		
JAKAFI (ruxolitinib)		
<b>MYELOMA</b>		
ALKERAN (melphalan) REVLIMID (lenalidomide)	FARYDAK (panobinostat) melphalan (generic for Alkeran) NINLARO (ixazomib) POMALYST (pomalidomide) THALOMID (thalidomide) XPOVIO (selinexor) <sup>CL</sup>	
<b>OTHER</b>		
MATULANE (procarbazine) TABLOID (thioguanine) tretinoin (generic for Vesanoïd)	BRUKINSA (zanubrutinib) <sup>QL</sup> CALQUENCE (acalabrutinib) <sup>QL</sup> INREBIC (fedratinib dihydrochloride) <sup>QL</sup> INQOVI (decitabine/cedazuridine) ZOLINZA (vorinostat)	

NOTE: Other oral oncology agents not listed here may also be available. See <https://nebraska.fhsc.com/default.asp> for coverage information and prior authorization status for products not listed.

## ONCOLOGY AGENTS, ORAL, LUNG

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>ALK</b>		<ul style="list-style-type: none"> <li>Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines</li> </ul> <p>Drug-Specific Criteria</p> <ul style="list-style-type: none"> <li><b>Iressa/ Xalkori:</b> Patients receiving Iressa or Xalkori prior to 1/21/21 (which changed from preferred to non-preferred) will be allowed to continue current treatment</li> </ul>
ALECENSA (alectinib)	ALUNBRIG (brigatinib) LORBRENA (lorlatinib) <sup>QL</sup> ZYKADIA (ceritinib) <b>CAPSULE, TABLET</b>	
<b>ALK / ROS1 / NTRK</b>		
	ROZLYTREK (entrectinib) <sup>AL,QL</sup> XALKORI (crizotinib)	
<b>EGFR</b>		
TAGRISSO (osimertinib)	erlotinib (generic for Tarceva) GILOTRIF (afatinib) IRESSA (gefitinib) TARCEVA (erlotinib) VIZIMPRO (dacomitinib) <sup>QL</sup>	
<b>OTHER</b>		
	GAVRETO ( <i>pralsetinib</i> ) <sup>QL</sup> HYCAMTIN (topotecan) <i>LUMAKRAS (sotrasib)</i> <sup>NR, QL</sup> <i>RETEVMO (selpercatinib)</i> <sup>AL</sup> <i>TABRECTA (capmatinib)</i> <sup>QL</sup> <i>TEPMETKO (tepotinib)</i> <sup>NR, QL</sup>	

NOTE: Other oral oncology agents not listed here may also be available. See <https://nebraska.fhsc.com/default.asp> for coverage information and prior authorization status for products not listed.

## ONCOLOGY AGENTS, ORAL, OTHER

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CAPRELSA (vandetanib)	BALVERSA (erdafitinib)	Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines
GLEOSTINE (lomustine)	COMETRIQ (cabozantinib)	
LYNPARZA (olaparib)	HEXALEN (altretamine)	
temozolomide (generic for Temodar)	KOSELUGO (selumetinib) <sup>AL</sup>	
ZEJULA (niraparib)	LONSURF (trifluridine/tipiracil)	
	PEMAZYRE (pemigatinib) <sup>QL</sup>	
	RUBRACA (rucaparib)	
	STIVARGA (regorafenib)	
	TAZVERIK (tazemetostat) <sup>AL</sup>	
	TURALIO (pexidartinib) <sup>QL</sup>	
	TRUSELTIQ (infigratinib) <b>CAPSULE<sup>NR</sup></b>	
	VITRAKVI (larotrectinib) <b>CAPSULE, SOLUTION<sup>QL</sup></b>	

NOTE: Other oral oncology agents not listed here may also be available. See <https://nebraska.fhsc.com/default.asp> for coverage information and prior authorization status for products not listed.

## ONCOLOGY AGENTS, ORAL, PROSTATE

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
abiraterone (generic for Zytiga) <sup>CL</sup>	EMCYT (estramustine)	<p>Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines</p> <p>Drug Specific Criteris</p> <p><b>Zytiga:</b> Patients receiving Zytiga prior to 1/21/21 (which changed from preferred to non-preferred) will be allowed to continue current treatment</p>
bicalutamide (generic for Casodex)	ERLEADA (apalutamide) <sup>QL</sup>	
flutamide	nilutamide (generic for Nilandron)	
XTANDI (enzalutamide) <sup>AL,QL</sup>	NUBEQA (darolutamide) <sup>QL</sup>	
	YONSA (abiraterone acetone, submicronized)	
	ZYTIGA (abiraterone) <sup>CL</sup>	

## ONCOLOGY AGENTS, ORAL, RENAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
INLYTA (axitinib)	AFINITOR DISPERZ (everolimus) <sup>CL</sup>	<p>Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines</p> <p>Drug-specific criteria</p> <ul style="list-style-type: none"> <li>▪ <b>Afinitor:</b> Patients receiving Afinitor, which changed from preferred to non-preferred on 1-17-19 will be allowed to continue therapy</li> </ul>
LENVIMA (lenvatinib)	CABOMETYX (cabozantinib)	
SUTENT (sunitinib)	everolimus (generic for Afinitor)	
VOTRIENT (pazopanib)	NEXAVAR (sorafenib)	
	sunitinib malate (generic for Sutent) <sup>NR</sup>	

## ONCOLOGY AGENTS, ORAL, SKIN

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>BASAL CELL</b>		<ul style="list-style-type: none"> <li>Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines</li> </ul>
ERIVEDGE (vismodegib)	ODOMZO (sonidegib) <sup>CL</sup>	
<b>BRAF MUTATION</b>		Drug-specific criteria
MEKINIST (trametinib)	BRAFTOVI (encorafenib)	<ul style="list-style-type: none"> <li><b>Odomzo:</b> Patients receiving Odomzo, which changed from preferred to non-preferred on 1-17-19 will be allowed to continue therapy</li> </ul>
TAFINLAR (dabrafenib)	COTELLIC (cobimetinib)	
	MEKTOVI (binimetinib)	
	ZELBORAF (vemurafenib)	

## OPHTHALMICS, ALLERGIC CONJUNCTIVITIS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ALREX (loteprednol 0.2%) cromolyn (generic for Opticrom) ketotifen OTC (generic for Zaditor) olopatadine OTC (generic Pataday once daily, Pataday twice daily) olopatadine 0.1% (generic for Patanol)	ALOCRIAL (nedocromil) ALOMIDE (Iodoxamide) azelastine (generic for Optivar) BEPREVE (bepotastine besilate) bepotastine besilate (generic for Bepreve) <sup>NR</sup> EMADINE (emedastine) epinastine (generic for Elestat) LASTACAFT (alcaftadine) olopatadine 0.2% (generic for Pataday) PATADAY XS (olopatadine 0.7%) <sup>NR</sup> PATADAY OTC (olopatadine 0.2%) PAZEO (olopatadine 0.7%) ZERVIAE (certirizine) <sup>AL</sup>	<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class</li> </ul>

## OPHTHALMICS, ANTIBIOTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>FLUOROQUINOLONES</b>		<ul style="list-style-type: none"> <li>▪ Non-preferred agents will be approved for patients who have failed a one-month trial of TWO preferred agent within this drug class</li> <li>▪ <b>Azasite®</b>: Approval only requires trial of erythromycin</li> </ul> <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> <li>▪ <b>Natacyn®</b>: Approved for documented fungal infection</li> </ul>
ciprofloxacin <b>SOLUTION</b> (generic for Ciloxan) ofloxacin (generic for Ocuflox)	BESIVANCE (besifloxacin) CILOXAN (ciprofloxacin) gatifloxacin 0.5% (generic for Zymaxid) levofloxacin MOXEZA (moxifloxacin) moxifloxacin (generic for Vigamox) moxifloxacin (generic for Moxeza) VIGAMOX (moxifloxacin)	
<b>MACROLIDES</b>		
erythromycin	AZASITE (azithromycin) <sup>CL</sup>	
<b>AMINOGLYCOSIDES</b>		
gentamicin <b>OINTMENT</b> gentamicin <b>SOLUTION</b> tobramycin (generic for Tobrex drops)	TOBREX <b>OINTMENT</b> (tobramycin)	
<b>OTHER OPHTHALMIC AGENTS</b>		
bacitracin/polymyxin B (generic Polysporin) polymyxin B/trimethoprim (generic for Polytrim)	bacitracin NATACYN (natamycin) <sup>CL</sup> neomycin/bacitracin/polymyxin B <b>OINTMENT</b> neomycin/polymyxin B/gramicidin NEOSPORIN (neomycin/polymyxin B/gramicidin) sulfacetamide <b>SOLUTION</b> (generic for Bleph-10) sulfacetamide <b>OINTMENT</b>	

## OPHTHALMICS, ANTIBIOTIC-STEROID COMBINATIONS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
neomycin/polymyxin/dexamethasone (generic for Maxitrol)  sulfacetamide/prednisolone  <b>TOBRADEX SUSPENSION, OINTMENT</b> (tobramycin and dexamethasone)	BLEPHAMIDE (prednisolone and sulfacetamide)  BLEPHAMIDE S.O.P.  neomycin/polymyxin/HC  neomycin/bacitracin/poly/HC  <b>PRED-G SUSPENSION, OINTMENT</b> (prednisolone/gentamicin)  tobramycin/dexamethasone <b>SUSPENSION</b> (generic for Tobradex)  TOBRADEX S.T. (tobramycin and dexamethasone)  ZYLET (loteprednol, tobramycin)	<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class</li> </ul>

## OPHTHALMICS, ANTI-INFLAMMATORIES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>CORTICOSTEROIDS</b>		
fluorometholone 0.1% (generic for FML) <b>OINTMENT</b> LOTEMAX <b>SOLUTION</b> (loteprednol 0.5%) MAXIDEX (dexamethasone) PRED MILD (prednisolone 0.12%)	dexamethasone (generic for Maxidex) DUREZOL (difluprednate) FLAREX (fluorometholone) FML (fluorometholone 0.1% <b>SOLUT.</b> ) FML FORTE (fluorometholone 0.25%) FML S.O.P. (fluorometholone 0.1%) INVELTYS (loteprednol etabonate) LOTEMAX <b>OINTMENT, GEL</b> (loteprednol) loteprednol <b>GEL (generic for Lotemax Gel)</b> <sup>NR</sup> loteprednol 0.5% SOLUTION (generic for Lotemax SOLUTION) prednisolone acetate 1% (gen. for Omnipred, Pred Forte) prednisolone sodium phosphate prednisolone sodium phosphate 1%	<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class</li> <li><b>NSAID class:</b> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent</li> </ul>
<b>NSAID</b>		
diclofenac (generic for Voltaren) ketorolac 0.5% (generic for Acular)	ACUVAIL (ketorolac 0.45%) BROMSITE (bromfenac) bromfenac 0.09% (generic for Bromday) flurbiprofen (generic for Ocufer) ILEVRO (nepafenac 0.3%) ketorolac LS 0.4% (generic for Acular LS) NEVANAC (nepafenac) PROLENSA (bromfenac 0.07%)	

## OPHTHALMICS, ANTI-INFLAMMATORY / IMMUNOMODULATORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
RESTASIS (cyclosporine) RESTASIS MULTIDOSE (cyclosporine) XIIDRA (lifitegrast)	CEQUA (cyclosporine) <sup>QL</sup> EYSUVIS (loteprednol etabonate) <sup>NR,QL</sup>	<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class</li> </ul>

## OPHTHALMICS, GLAUCOMA

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>MIOTICS</b>		<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class</li> </ul>
pilocarpine	PHOSPHOLINE IODIDE (echothiophate iodide)	
<b>SYMPATHOMIMETICS</b>		
Alphagan P (brimonidine 0.15%) brimonidine 0.2% (generic for Alphagan)	Alphagan P (brimonidine 0.1%) apraclonidine (generic for Iopidine) brimonidine P 0.15%	
<b>BETA BLOCKERS</b>		
levobunolol (generic for Betagan) timolol (generic for Timoptic)	betaxolol (generic for Betoptic) BETIMOL (timolol) BETOPTIC S (betaxolol) carteolol (generic for Ocupress) timolol (generic for Istalol) timolol (generic for Timoptic Ocudose) <sup>NR</sup> TIMOPTIC OCUDOSE TIMOPTIC XE (timolol gel forming solution)	
<b>CARBONIC ANHYDRASE INHIBITORS</b>		
dorzolamide (generic for Trusopt)	AZOPT (brinzolamide) brinzolamide (generic for Azopt) <sup>NR</sup>	
<b>PROSTAGLANDIN ANALOGS</b>		
latanoprost (generic for Xalatan) TRAVATAN Z (travoprost)	bimatoprost (generic for Lumigan) travoprost (generic for Travatan Z) VYZULTA (latanoprostene) XALATAN (latanoprost) ZIOPTAN (tafluprost)	
<b>COMBINATION DRUGS</b>		
COMBIGAN (brimonidine/timolol) dorzolamide/timolol (generic for Cosopt)	dorzolamide/timolol PF (generic for Cosopt PF) SIMBRINZA (brinzolamide/brimonidine)	
<b>OTHER</b>		<ul style="list-style-type: none"> <li>Drug-specific criteria:               <ul style="list-style-type: none"> <li><b>Rhopressa and Rocklatan:</b> Electronically approved for patients who have a trial of ONE generic agent, within ophthalmics-glaucoma within 60 days</li> </ul> </li> </ul>
RHOPRESSA (netarsudil) <sup>CL</sup> ROCKLATAN (netarsudil and latanoprost) <sup>CL</sup>		

## OTIC ANTI-INFECTIVES & ANESTHETICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
acetic acid (generic for Vosol)	acetic acid/hydrocortisone (generic for Vosol HC)	<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a trial of the preferred agent within this drug class</li> </ul>

## OTIC ANTIBIOTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CIPRODEX (ciprofloxacin/dexamethasone)  neomycin/polymyxin/hydrocortisone (generic for Cortisporin)  ofloxacin (generic for Floxin)	CIPRO HC (ciprofloxacin/ hydrocortisone)  ciprofloxacin  ciprofloxacin/dexamethasone (generic for CIPRODEX)  COLY-MYCIN S(neomycin/ hydrocortisone/colistin)  OTOVEL (ciprofloxacin/fluocinolone)	<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class</li> </ul>

## PROGESTERONE (hydroxyprogesterone caproate)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>MAKENA AUTO INJECTOR</b> (hydroxyprogesterone caproate)	hydroxyprogesterone caproate  (generic Makena)  MAKENA (hydroxyprogesterone caproate) <b>SDV</b>	<ul style="list-style-type: none"> <li>When filled as outpatient prescription, use limited to:               <ul style="list-style-type: none"> <li>Singleton pregnancy AND</li> <li>Previous Pre-term delivery AND</li> <li>No more than 20 doses (administered between 16 -36 weeks gestation)</li> <li>Maximum of 30 days per dispensing</li> </ul> </li> </ul>

## SEDATIVE HYPNOTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>BENZODIAZEPINES</b>		
temazepam 15mg, 30mg (generic for Restoril)	estazolam (generic for ProSom) flurazepam (generic for Dalmane) temazepam (generic for Restoril) 7.5mg, 22.5mg triazolam (generic for Halcion)	<ul style="list-style-type: none"> <li>▪ <b>Lunesta®/ Rozerem®/zolpidem ER:</b> Requires a trial with generic zolpidem within the last 12 months AND Trial OR Clinical reason why zaleplon and preferred benzodiazepine cannot be used</li> <li>▪ <b>Edluar®:</b> Requires a trial with generic zolpidem within the last 12 months AND Trial OR Clinical reason why zaleplon and preferred benzodiazepine cannot be used and Requires documentation of swallowing disorder</li> </ul>
<b>OTHERS</b>		
zaleplon (generic for Sonata) zolpidem (generic for Ambien)	BELSOMRA (suvorexant) <sup>AL,QL</sup> DAYVIGO (lemborexant) <sup>AL,QL</sup> doxepin (generic for Silenor) EDLUAR (zolpidem sublingual) eszopiclone (generic for Lunesta) HETLIOZ (tasimelteon) <sup>CL</sup> HETLIOZ LQ (tasimelteon) <b>SUSP</b> <sup>AL,NR, QL</sup> ramelteon (generic for Rozerem) zolpidem ER (generic for Ambien CR) zolpidem SL (generic for Intermezzo)	<ul style="list-style-type: none"> <li>▪ <b>flurazepam/triazolam:</b> Requires trial of preferred benzodiazepine</li> <li>▪ <b>Hetlioz®:</b> Requires trial with generic zolpidem within last 12 months AND clinical reason why zaleplon AND preferred benzodiazepine cannot be used</li> <li>▪ <b>Silenor®:</b> Must meet ONE of the following:                             <ul style="list-style-type: none"> <li>○ Contraindication to preferred oral sedative hypnotics</li> <li>○ Medical necessity for doxepin dose &lt; 10mg</li> <li>○ Age greater than 65 years old or hepatic impairment (3mg dose will be approved if this criteria is met)</li> </ul> </li> <li>▪ <b>temazepam 7.5mg/22.5mg:</b> Requires clinical reason why 15mg/30mg cannot be used</li> <li>▪ <b>zolpidem/zolpidem ER:</b> Maximum daily dose for females: Zolpidem 5mg; Zolpidem ER® 6.25mg</li> <li>▪ <b>zolpidem SL:</b> Requires clinical reason why half of zolpidem tablet cannot be used</li> </ul>

## SICKLE CELL ANEMIA TREATMENT<sup>AL</sup>

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<p><i>DROXIA (hydroxyurea)</i></p>	<p><i>ENDARI (L-glutamine)<sup>CL</sup></i></p> <p><i>OXBRYTA (voxelotor)<sup>CL</sup></i></p> <p><i>SIKLOS (hydroxyurea)</i></p>	<p>Drug-Specific Criteria</p> <ul style="list-style-type: none"> <li>▪ <b>Endari:</b> Patient must have documented two or more hospital admissions per year due to sickle cell crisis despite maximum hydroxyurea dosage.</li> <li>▪ <b>Oxbryta:</b> Not indicated for sickle cell crisis. Patient must have had at least one sickle cell-related vaso-occlusive event within the past 12 months; AND baseline hemoglobin is 5.5 g/dL ≤ 10.5 g/dL; AND patient is not receiving concomitant, prophylactic blood transfusion therapy</li> <li>▪ <b>Siklos:</b> Approved for use in patients ages 2 to 17 years old</li> </ul>

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## STEROIDS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>LOW POTENCY</b>		<ul style="list-style-type: none"> <li>Low Potency Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class</li> </ul>
hydrocortisone OTC & RX <b>CREAM, LOTION, OINTMENT (Rx only)</b> hydrocortisone/aloe <b>OINTMENT</b> SCALPICIN OTC (hydrocortisone)	ALA-CORT (hydrocortisone) <b>CREAM</b> ALA-SCALP HP (hydrocortisone) alclometasone dipropionate (generic for Aclovate) CAPEX <b>SHAMPOO</b> (fluocinolone) DESONATE (desonide) <b>GEL</b> desonide <b>LOTION</b> (generic for Desowen) desonide <b>CREAM, OINTMENT</b> (generic for former products Desowen, Tridesilon) fluocinolone 0.01% <b>OIL</b> (generic for DERMA-SMOOTHIE-FS) hydrocortisone/aloe <b>CREAM</b> hydrocortisone <b>OTC OINTMENT</b> MICORT-HC (hydrocortisone) TEXACORT (hydrocortisone)	
<b>MEDIUM POTENCY</b>		<ul style="list-style-type: none"> <li>Medium Potency Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class</li> </ul>
fluticasone propionate <b>CREAM, OINTMENT</b> (generic for Cutivate) mometasone furoate <b>CREAM, OINTMENT, SOLUTION</b> (generic for Elocon)	betamethasone valerate (generic for Luxiq) clocortolone (generic for Cloderm) fluocinolone acetonide (generic for Synalar) flurandrenolide (generic for Cordran) fluticasone propionate <b>LOTION</b> (generic for Cutivate) hydrocortisone butyrate (generic for Locoid) hydrocortisone butyrate/emoll (generic for Locoid Lipocream) hydrocortisone valerate (generic for Westcort) PANDEL (hydrocortisone probutate 0.1%) prednicarbate (generic for Dermatop)	

## STEROIDS, TOPICAL (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>HIGH POTENCY</b>		
triamcinolone acetonide <b>OINTMENT, CREAM</b> triamcinolone <b>LOTION</b>	amcinonide <b>CREAM, LOTION, OINTMENT</b> betamethasone dipropionate betamethasone / propylene glycol betamethasone valerate desoximetasone diflorasone diacetate fluocinonide <b>SOLUTION</b> fluocinonide <b>CREAM, GEL, OINTMENT</b> fluocinonide emollient halcinonide <b>CREAM</b> (generic for Halog) HALOG (halcinonide) <b>CREAM, OINT, SOLN</b> KENALOG AEROSOL (triamcinolone) SERNIVO (betamethasone dipropionate) triamcinolone <b>SPRAY</b> (generic for Kenalog spray) TRIANEX <b>OINTMENT</b> (triamcinolone) VANOS (fluocinonide)	<ul style="list-style-type: none"> <li>High Potency Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class</li> </ul>
<b>VERY HIGH POTENCY</b>		
clobetasol emollient (generic for Temovate-E) clobetasol propionate <b>CREAM, GEL, OINTMENT, SOLUTION</b> halobetasol propionate (generic for Ultravate)	APEXICON-E (diflorasone) BRYHALI (halobetasol prop) <b>LOTION</b> clobetasol <b>SHAMPOO, LOTION</b> clobetasol propionate <b>FOAM, SPRAY</b> CLOBEX (clobetasol) halobetasol propionate <b>FOAM</b> (generic for Lexette) <sup>AL,QL</sup> <b>IMPEKLO (clobetasol) LOTION<sup>AL,NR</sup></b> LEXETTE(halobetasol propionate) <sup>AL,QL</sup> OLUX-E /OLUX/OLUX-E CP (clobetasol)	<ul style="list-style-type: none"> <li>Very High Potency Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class</li> </ul>

## STIMULANTS AND RELATED AGENTS<sup>AL</sup>

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>CNS STIMULANTS</b>		<ul style="list-style-type: none"> <li>Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class</li> </ul> <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> <li><b>Procentra®</b>: May be approved with documentation of swallowing disorder</li> <li><b>Zenedi®</b>: Requires clinical reason generic dextroamphetamine IR cannot be used</li> </ul>
<b>Amphetamine type</b>		
ADDERALL XR (amphetamine salt combo)	ADZENYS XR (amphetamine)	
amphetamine salt combination IR	amphetamine ER (generic for Adzenys ER) <b>SUSPENSION</b>	
VYVANSE (lisdexamfetamine) <b>CAPSULE, CHEWABLE</b>	amphetamine salt combination ER (generic for Adderall XR)	
	amphetamine sulfate (generic for Evekeo)	
	<b>AZSTARYS (serdexmethylphenidate and dexamethylphenidate)<sup>AL,NR,QL</sup></b>	
	dextroamphetamine (generic for Dexedrine)	
	dextroamphetamine <b>SOLUTION</b> (generic for Procentra)	
	dextroamphetamine ER (generic for Dexedrine ER)	
	DYANAVEL XR (amphetamine)	
	EVEKEO ODT (amphetamine sulfate)	
	MYDAYIS (amphetamine salt combo) <sup>QL</sup>	
	methamphetamine (generic for Desoxyn)	
	ZENZEDI (dextroamphetamine)	

## STIMULANTS AND RELATED ADHD DRUGS (Continued)<sup>AL</sup>

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>Methylphenidate type</b>		
<p>CONCERTA (methylphenidate ER)<sup>QL</sup> 18mg, 27mg, 36mg, 54mg</p> <p>dexmethylphenidate (generic for Focalin IR)</p> <p>FOCALIN XR (dexmethylphenidate)</p> <p>METHYLIN <b>SOLUTION</b> (methylphenidate)</p> <p>methylphenidate (generic for Ritalin)</p> <p>methylphenidate <b>SOLUTION</b> (generic for Methylin)</p> <p>QUILLICHEW ER <b>CHEWTAB</b> (methylphenidate)</p>	<p>ADHANSIA XR (methylphenidate)<sup>QL</sup></p> <p>APTENSIO XR (methylphenidate)</p> <p>COTEMPLA XR-ODT (methylphenidate)<sup>QL</sup></p> <p>DAYTRANA <b>PATCH</b> (methylphenidate)<sup>QL</sup></p> <p>dexmethylphenidate XR (generic for Focalin XR)</p> <p>FOCALIN IR (dexmethylphenidate)</p> <p>JORNAY PM (methylphenidate)<sup>QL</sup></p> <p>methylphenidate 50/50 (generic for Ritalin LA)</p> <p><i>methylphenidate 30/70</i> (generic for Metadate CD)</p> <p>methylphenidate ER 18mg, 27mg, 36mg, 54mg (generic Concerta)<sup>QL</sup></p> <p>methylphenidate ER <b>CAP</b> (generic for Aptensio XR)<sup>QL</sup></p> <p>Methylphenidate ER (generic for Metadate ER)</p> <p>methylphenidate ER 72mg (generic for RELEXII)<sup>QL</sup></p> <p>methylphenidate ER (generic for Ritalin SR)</p> <p>QUILLIVANT XR <b>SUSP</b> (methylphenidate)</p> <p>RITALIN (methylphenidate)</p>	<ul style="list-style-type: none"> <li>▪ Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class</li> <li>▪ Maximum accumulated dose of 108mg per day for ages &lt; 18</li> <li>▪ Maximum accumulated dose of 72mg per day for ages &gt; 19</li> </ul> <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> <li>▪ <b>Daytrana®</b>: May be approved in history of substance use disorder by parent, caregiver, or patient. May be approved with documentation of difficulty swallowing</li> </ul>

## STIMULANTS AND RELATED ADHD DRUGS (Continued)<sup>AL</sup>

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<b>MISCELLANEOUS</b>		<b>Note: generic guanfacine IR and clonidine IR are available without prior authorization</b>
atomoxetine (generic for Strattera) <sup>QL</sup>	clonidine ER (generic for Kapvay) <sup>QL</sup>	
guanfacine ER (generic for Intuniv) <sup>QL</sup>	<b>QELBREE (viloxazine)<sup>NR,QL</sup></b>	
	STRATTERA (atomoxetine)	
<b>ANALEPTICS</b>		Drug-specific criteria:
	armodafinil (generic for Nuvigil) <sup>CL</sup>	<ul style="list-style-type: none"> <li>▪ <b>armodafinil and Sunosi:</b> Require trial of modafinil</li> </ul>
	modafanil (generic for Provigil) <sup>CL</sup>	<ul style="list-style-type: none"> <li>▪ <b>armodafinil and modafinil:</b> approved only for:               <ul style="list-style-type: none"> <li>○ Sleep Apnea with documentation/confirmation via sleep study and documentation that C-PAP has been maxed</li> <li>○ Narcolepsy with documentation of diagnosis via sleep study</li> <li>○ Shift Work Sleep Disorder (only approvable for 6 months) with work schedule verified and documented. Shift work is defined as working the all night shift</li> </ul> </li> </ul>
	SUNOSI (solriamfetol) <sup>CL,QL</sup>	
	WAKIX (pitolisant) <sup>CL,QL</sup>	<ul style="list-style-type: none"> <li>▪ <b>Sunosi</b> approved only for:               <ul style="list-style-type: none"> <li>○ Sleep Apnea with documentation/confirmation via sleep study and documentation that C-PAP has been maxed</li> <li>○ Narcolepsy with documentation of diagnosis via sleep study</li> </ul> </li> <li>▪ <i>Wakix: approved only for excessive daytime sleepiness in adults with narcolepsy with documentation of narcolepsy diagnosis via sleep study</i></li> </ul>

## THROMBOPOIESIS STIMULATING PROTEINS<sup>CL</sup>

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<p><i>PROMACTA (eltrombopag) <b>TABLET</b><sup>CL</sup></i></p>	<p><i>DOPTELET (avatrombopag)</i></p> <p><i>MULPLETA (lusutrombopag)</i></p> <p><i>PROMACTA (eltrombopag) <b>SUSP</b></i></p> <p><i>TAVALISSE (fostamatinib)</i></p>	<ul style="list-style-type: none"> <li>▪ All agents will be approved with FDA-approved indication, ICD-10 code is required.</li> <li>▪ Non-preferred agents require a trial of a preferred agent with the same indication or a contraindication.</li> </ul> <p>Drug-Specific Criteria</p> <ul style="list-style-type: none"> <li>▪ <b>Doptelet/Mulpleta:</b> Approved for one course of therapy for a scheduled procedure with a risk of bleeding for treatment of thrombocytopenia in adult patients with chronic liver disease</li> </ul>

DRAFT

## 7. Adjournment / Old Business

- a. MCO Pharmacy Directors asked the committee to review November 2019 minute notes and consider requiring an ICD10 approved diagnosis for pharmacy claims adjudication under the Stimulants drug class. Currently, the MCO's can offer and provide Prior Authorization requirements for patients to still obtain approval for off-label usage if clinically appropriate. Topic was deferred as a recommendation for the state's Drug Utilization Review (DUR) board.
- b. Hepatitis C Data: Dianne Garside notified the committee and public attendees that Hepatitis C claims data (paid and rejected) were reviewed as requested from the prior May 2021 meeting. The P&T Committee had made a request for claims data to determine if Epclusa and its generic were being denied appropriately. In conclusion, the generic of Epclusa did move to Preferred after May 2021 P&T, and no concerns were found with the reviewed claims data.
- c. A vote to conclude the meeting was made at 2:10 pm CST.

(1<sup>st</sup>) Motion: **Baker**

(2<sup>nd</sup>) Motion: **Sobeski**

**Vote to conclude meeting unanimously approved by all in attendance.**

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

**Date: Wednesday, May 11, 2022**

**Time: 9:00a.m – 5:00 PM CST**

**Location:**

**Mahoney State Park, Peter Kiewit Lodge**

**28500 West Park Hwy**

**Ashland, NE 68003**

Recorded by: Elanah Figueroa, B.A. – Account Operations Executive, Magellan Rx Management, Magellan Health.