# DIVISION OF MEDICAID AND LONG-TERM CARE

Nebraska Department of Health and Human Services

# PHARMACEUTICAL AND THERAPEUTICS (P&T) COMMITTEE MEETING MINUTES

Wednesday, November 15th, 2023 at 9:00 AM CST
Mahoney State Park, Peter Kiewit Lodge
28500 West Park Hwy, Ashland, NE 68003

**Committee Members Present:**
Eric Avery, M.D. **(Outgoing Chair)**
Claire Baker, M.D.
Andrew Bendlin, Pharm.D.
Cassie Cowles, APRN
Allison Dering-Anderson, Pharm.D. **(Outgoing Vice Chair/Incoming Chair)**
Wade Fornander, M.D. **(Incoming Vice Chair)**
C. Jose Friesen, M.D.
Jennifer Hill, M.D.
Joyce Juracek, Pharm.D.
Rachelle Kaspar-Cope, M.D.
Sarah Stewart-Bouckaert, Pharm.D.
Bradley Sundsboe, Pharm.D.

**Division of Medicaid and Long-Term Care Staff Present:**
Dianne Garside, Pharm.D.
Spencer Moore, Pharm.D.
Leah Spencer, R.N., M.Ed.

**Magellan Medicaid Administration Staff Present:**
Nikia Bennette-Carter, Pharm.D., Clinical Account Executive
Jessica Czechowski, Pharm.D., Pharmacist Account Executive

**Managed Care Staff Present:**
Jamie Benson, Pharm.D., Nebraska Total Care
Gerette Augusta, Pharm.D. Healthy Blue
Bernadette Ueda, Pharm. D., United Healthcare of Nebraska

**Committee Members Excused:**
Stephen Dolter, M.D.
Gary Elsasser, Pharm.D.
Lauren Nelson, M.D.
Jessica Pohl, Pharm.D.
Linda Sobeski, Pharm.D.

**Committee Members Unexcused:**
N/A

1. **Opening of Public Meeting and Call to Order Committee Business**
    - **a.** The meeting was called to order by the Committee chair at 9:00 AM CST. The agenda was posted on the Nebraska Medicaid Pharmacy website (https://nebraska.fhsc.com/PDL/PTcommittee.asp) on 10/16/2023. A copy of the Open Meetings Act and meeting materials distributed to members were made available at the physical meeting site for public viewing.
    - b. Roll Call: See list above.
    - c. Conflict of Interest: No new conflicts of interest were reported.
    - d. Approval of May 10th, 2023 P&T Committee Meeting Minutes.

| Approval of May 10th, 2023 P&T Committee Meeting Minutes |
|---|
| **(1st) Motion:** Dering-Anderson |
| **(2nd) Motion:** Juracek |

| **Discussion:** Approve as written. | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Voting – P&T Committee Members**<br>**Does not include excused or unexcused members** | **Yes** | **No** | **Abstain** | **Voting – P&T Committee Members** | **Yes** | **No** | **Abstain** |
| Avery, Eric, M.D. (Chair) | X | | | Friesen, C. Jose, M.D. | X | | |
| Baker, Claire, M.D. | X | | | Hill, Jennifer, M.D. | X | | |
| Bendlin, Andrew, Pharm.D. | X | | | Juracek, Joyce, Pharm.D. | X | | |
| Cowles, Cassie, APRN | X | | | Kaspar-Cope, Rachelle M.D. | X | | |
| Dering-Anderson, Allison, Pharm.D. (Vice Chair) | X | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |
| Fornander, Wade, M.D. | X | | | Sundsboe, Bradley, Pharm.D. | X | | |

e. Election of Committee Chair and Vice Chair:

| **Election of Chair** | | | | | | | |
|---|---|---|---|---|---|---|---|
| **(1st) Motion:** Baker | | | | | | | |
| **(2nd) Motion:** Friesen | | | | | | | |
| **Discussion:** Ally Dering-Anderson nominated | | | | | | | |
| **Voting – P&T Committee Members**<br>**Does not include excused or unexcused members** | **Yes** | **No** | **Abstain** | **Voting – P&T Committee Members** | **Yes** | **No** | **Abstain** |
| Avery, Eric, M.D. (Chair) | X | | | Friesen, C. Jose, M.D. | X | | |
| Baker, Claire, M.D. | X | | | Hill, Jennifer, M.D. | X | | |
| Bendlin, Andrew, Pharm.D. | X | | | Juracek, Joyce, Pharm.D. | X | | |
| Cowles, Cassie, APRN | X | | | Kaspar-Cope, Rachelle M.D. | X | | |
| Dering-Anderson, Allison, Pharm.D. (Vice Chair) | | | X | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |
| Fornander, Wade, M.D. | X | | | Sundsboe, Bradley, Pharm.D. | X | | |

| **Election of Vice Chair** | | | | | | | |
|---|---|---|---|---|---|---|---|
| **(1st) Motion:** Baker | | | | | | | |
| **(2nd) Motion:** Friesen | | | | | | | |
| **Discussion:** Wade Fornander nominated | | | | | | | |
| **Voting – P&T Committee Members**<br>**Does not include excused or unexcused members** | **Yes** | **No** | **Abstain** | **Voting – P&T Committee Members** | **Yes** | **No** | **Abstain** |
| Avery, Eric, M.D. | X | | | Friesen, C. Jose, M.D. | X | | |
| Baker, Claire, M.D. | X | | | Hill, Jennifer, M.D. | X | | |

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|---|---|---|---|---|---|---|---|
| Bendlin, Andrew, Pharm.D. | X | | | Juracek, Joyce, Pharm.D. | X | | |
| Cowles, Cassie, APRN | X | | | Kaspar-Cope, Rachelle M.D. | X | | |
| Dering-Anderson, Allison, Pharm.D. (Chair) | X | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |
| Fornander, Wade, M.D. | | | X | Sundsboe, Bradley, Pharm.D. | X | | |

f. Department information: Dianne Garside provided updates to the committee and public attendees of revisions approved by the DUR Board for Hepatitis C drug therapy criteria with removal of abstinence of alcohol and IV drug use. She also announced that the new contract term for Nebraska Medicaid's managed care program, Heritage Health, begins on January 1, 2024, and includes Molina Healthcare, Nebraska Total Care, and United Healthcare. Dianne thanked Dr. Avery for his leadership, commitment, and serving as Chair for the past two years.

2. **Public Testimony**

| Speaker Order | DRUG CLASS | Drug Name | PDL Status | Speaker Name | Affiliation |
|---|---|---|---|---|---|
| **1** | Cytokines & CAM Antagonists | Rinvoq | NP | Heather Freml | AbbVie |
| **2** | Cytokines & CAM Antagonists | Skyrizi | NP | Heather Freml | AbbVie |
| **3** | Hemophilia Treatments | Sevenfact | NP | Ian Mitchell | HEMA Biologics |
| **4** | Hemophilia Treatments | Esperoct | NP | Allison Duchman | Novo Nordisk |
| **5** | Hemophilia Treatments | Rebinyn | NP | Allison Duchman | Novo Nordisk |
| **6** | Hemophilia Treatments | Tretten | NP | Allison Duchman | Novo Nordisk |
| **7** | Immunomodulators, Asthma | Tezspire | NP | Charles Dahm | Amgen |
| **8** | Movement Disorders | Austedo XR | P | Dave Miley | Teva |
| **9** | Oncology Agents, Oral – Prostate | Orgovyx | NP | Janis Pruett | Sumitomo Pharma |

a. While the above speakers registered per the policies and procedures, the following yielded their time back to the committee and did not speak:
   i. Ian Mitchell – Absent
   ii. Dave Miley – Deferred
   iii. Janis Pruett - Deferred

3. **Committee Closed Session**

| **(1st) Motion:** Friesen | **(2nd) Motion:** Hill |
|---|---|
| **Committee Closed Session unanimously approved by all in attendance.** | |

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4. **Resume Open Session**

| **(1st) Motion:** Avery | **(2nd) Motion:** Baker |
|---|---|
| **Resume Open Session unanimously approved by all in attendance.** | |

*During the public open session, committee members vote publicly on decisions with regards 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. Discussion:

**Agenda Time Listing**

**(1st) Motion:** Friesen

**(2nd) Motion:** Baker

**Discussion:** Future meeting agendas should list start times as approximate to allow for resuming open sessions early.

| **Voting – P&T Committee Members**<br>**Does not include excused or unexcused members** | **Yes** | **No** | **Abstain** | **Voting – P&T Committee Members** | **Yes** | **No** | **Abstain** |
|---|---|---|---|---|---|---|---|
| Avery, Eric, M.D. | X | | | Friesen, C. Jose, M.D. | X | | |
| Baker, Claire, M.D. | X | | | Hill, Jennifer, M.D. | X | | |
| Bendlin, Andrew, Pharm.D. | X | | | Juracek, Joyce, Pharm.D. | X | | |
| Cowles, Cassie, APRN | X | | | Kaspar-Cope, Rachelle M.D. | X | | |
| Dering-Anderson, Allison, Pharm.D. (Chair)<br>***Votes only in the event of a tie*** | | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |
| Fornander, Wade, M.D. | X | | | Sundsboe, Bradley, Pharm.D. | X | | |

b. Consent Agenda

**Consent Agenda**

**(1st) Motion:** Avery

**(2nd) Motion:** Juracek

**Discussion:** Baker motioned to remove Sickle Cell Anemia Treatments. Approve amended Consent Agenda.

| **Voting – P&T Committee Members**<br>**Does not include excused or unexcused members** | **Yes** | **No** | **Abstain** | **Voting – P&T Committee Members** | **Yes** | **No** | **Abstain** |
|---|---|---|---|---|---|---|---|
| Avery, Eric, M.D. | X | | | Friesen, C. Jose, M.D. | X | | |
| Baker, Claire, M.D. | X | | | Hill, Jennifer, M.D. | X | | |

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|---|---|---|---|---|---|---|---|
| Bendlin, Andrew, Pharm.D. | X | | | Juracek, Joyce, Pharm.D. | X | | |
| Cowles, Cassie, APRN | X | | | Kaspar-Cope, Rachelle M.D. | X | | |
| Dering-Anderson, Allison, Pharm.D. (Chair) ***Votes only in the event of a tie*** | | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |
| Fornander, Wade, M.D. | X | | | Sundsboe, Bradley, Pharm.D. | X | | |

| **Consent Agenda: Therapeutic categories (TC) with unchanged recommendations unless otherwise indicated.** | |
|---|---|
| ALZHEIMER'S AGENTS | LEUKOTRIENE MODIFIERS |
| ANTHELMINTICS | METHOTREXATE |
| ANTIHYPERTENSIVES, SYMPATHOLYTICS | OPHTHALMIC ANTIBIOTICS |
| ANTIPARKINSON'S AGENTS | OPHTHALMICS, ANTI-INFLAMMATORIES |
| ANTIPSORIATICS, ORAL | OTIC ANTI-INFECTIVES & ANESTHETICS |
| ANXIOLYTICS | SICKLE CELL ANEMIA TREATMENTS ***(REMOVED)*** |
| BILE SALTS | STEROIDS, TOPICAL HIGH |
| COUGH AND COLD, NARCOTIC | STEROIDS, TOPICAL MEDIUM |
| ENZYME REPLACEMENT, GAUCHERS DISEASE | STEROIDS, TOPICAL VERY HIGH |
| GLUCOCORTICOIDS, ORAL | THROMBOPOIESIS STIMULATING PROTEINS |
| HISTAMINE II RECEPTOR BLOCKERS | |

c. Therapeutic Class Reviews

**Review Agenda – ANTI-ALLERGENS, ORAL**

**(1st) Motion:** Baker

**(2nd) Motion:** Hill

**Discussion:** Approved as written.

| **Voting – P&T Committee Members** Does not include excused or unexcused members | **Yes** | **No** | **Abstain** | **Voting – P&T Committee Members** | **Yes** | **No** | **Abstain** |
|---|---|---|---|---|---|---|---|
| Avery, Eric, M.D. | X | | | Friesen, C. Jose, M.D. | X | | |
| Baker, Claire, M.D. | X | | | Hill, Jennifer, M.D. | X | | |
| Bendlin, Andrew, Pharm.D. | X | | | Juracek, Joyce, Pharm.D. | X | | |
| Cowles, Cassie, APRN | X | | | Kaspar-Cope, Rachelle M.D. | X | | |
| Dering-Anderson, Allison, Pharm.D. (Chair) ***Votes only in the event of a tie*** | | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |
| Fornander, Wade, M.D. | X | | | Sundsboe, Bradley, Pharm.D. | X | | |

**Review Agenda – ANTIHISTAMINES, MINIMALLY SEDATING**

**(1st) Motion:** Avery

**(2nd) Motion:** Fornander

**Discussion:** Approved as written.

| Voting – P&T Committee Members<br>Does not include excused or unexcused members | Yes | No | Abstain | Voting – P&T Committee Members | Yes | No | Abstain |
|---|---|---|---|---|---|---|---|
| Avery, Eric, M.D. | X | | | Friesen, C. Jose, M.D. | X | | |
| Baker, Claire, M.D. | X | | | Hill, Jennifer, M.D. | X | | |
| Bendlin, Andrew, Pharm.D. | X | | | Juracek, Joyce, Pharm.D. | X | | |
| Cowles, Cassie, APRN | X | | | Kaspar-Cope, Rachelle M.D. | X | | |
| Dering-Anderson, Allison, Pharm.D. (Chair)<br>***Votes only in the event of a tie*** | | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |
| Fornander, Wade, M.D. | X | | | Sundsboe, Bradley, Pharm.D. | X | | |

## Review Agenda – ANTIHYPERURICEMICS

**(1st) Motion:** Friesen

**(2nd) Motion:** Juracek

**Discussion:** Approved as written.

| Voting – P&T Committee Members<br>Does not include excused or unexcused members | Yes | No | Abstain | Voting – P&T Committee Members | Yes | No | Abstain |
|---|---|---|---|---|---|---|---|
| Avery, Eric, M.D. | X | | | Friesen, C. Jose, M.D. | X | | |
| Baker, Claire, M.D. | X | | | Hill, Jennifer, M.D. | X | | |
| Bendlin, Andrew, Pharm.D. | X | | | Juracek, Joyce, Pharm.D. | X | | |
| Cowles, Cassie, APRN | X | | | Kaspar-Cope, Rachelle M.D. | X | | |
| Dering-Anderson, Allison, Pharm.D. (Chair)<br>***Votes only in the event of a tie*** | | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |
| Fornander, Wade, M.D. | X | | | Sundsboe, Bradley, Pharm.D. | X | | |

## Review Agenda – ANTIPSORIATICS, TOPICAL

**(1st) Motion:** Hill

**(2nd) Motion:** Juracek

**Discussion:** Approved as written.

| Voting – P&T Committee Members<br>Does not include excused or unexcused members | Yes | No | Abstain | Voting – P&T Committee Members | Yes | No | Abstain |
|---|---|---|---|---|---|---|---|
| Avery, Eric, M.D. | X | | | Friesen, C. Jose, M.D. | X | | |

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|---|---|---|---|---|---|---|---|
| Baker, Claire, M.D. | X | | | Hill, Jennifer, M.D. | X | | |
| Bendlin, Andrew, Pharm.D. | X | | | Juracek, Joyce, Pharm.D. | X | | |
| Cowles, Cassie, APRN | X | | | Kaspar-Cope, Rachelle M.D. | X | | |
| Dering-Anderson, Allison, Pharm.D. (Chair)<br>***Votes only in the event of a tie*** | | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |
| Fornander, Wade, M.D. | X | | | Sundsboe, Bradley, Pharm.D. | X | | |

**Review Agenda – BRONCHODILATORS, BETA AGONIST**

**(1st) Motion:** Avery

**(2nd) Motion:** Juracek

**Discussion:** Approved as written.

| **Voting – P&T Committee Members**<br>**Does not include excused or unexcused members** | **Yes** | **No** | **Abstain** | **Voting – P&T Committee Members** | **Yes** | **No** | **Abstain** |
|---|---|---|---|---|---|---|---|
| Avery, Eric, M.D. | X | | | Friesen, C. Jose, M.D. | X | | |
| Baker, Claire, M.D. | X | | | Hill, Jennifer, M.D. | X | | |
| Bendlin, Andrew, Pharm.D. | X | | | Juracek, Joyce, Pharm.D. | X | | |
| Cowles, Cassie, APRN | X | | | Kaspar-Cope, Rachelle M.D. | X | | |
| Dering-Anderson, Allison, Pharm.D. (Chair)<br>***Votes only in the event of a tie*** | | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |
| Fornander, Wade, M.D. | X | | | Sundsboe, Bradley, Pharm.D. | X | | |

**Review Agenda – COLONY STIMULATING AGENTS**

**(1st) Motion:** Hill

**(2nd) Motion:** Juracek

**Discussion:** Approved as written.

| **Voting – P&T Committee Members**<br>**Does not include excused or unexcused members** | **Yes** | **No** | **Abstain** | **Voting – P&T Committee Members** | **Yes** | **No** | **Abstain** |
|---|---|---|---|---|---|---|---|
| Avery, Eric, M.D. | X | | | Friesen, C. Jose, M.D. | X | | |
| Baker, Claire, M.D. | X | | | Hill, Jennifer, M.D. | X | | |
| Bendlin, Andrew, Pharm.D. | X | | | Juracek, Joyce, Pharm.D. | X | | |
| Cowles, Cassie, APRN | X | | | Kaspar-Cope, Rachelle M.D. | X | | |
| Dering-Anderson, Allison, Pharm.D. (Chair)<br>***Votes only in the event of a tie*** | | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |

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| Fornander, Wade, M.D. | X | | | Sundsboe, Bradley, Pharm.D. | X | | |
|---|---|---|---|---|---|---|---|

## Review Agenda – COPD AGENTS

**(1st) Motion:** Kaspar-Cope

**(2nd) Motion:** Juracek

**Discussion:** Approved as written.

| **Voting – P&T Committee Members** Does not include excused or unexcused members | Yes | No | Abstain | **Voting – P&T Committee Members** | Yes | No | Abstain |
|---|---|---|---|---|---|---|---|
| Avery, Eric, M.D. | X | | | Friesen, C. Jose, M.D. | X | | |
| Baker, Claire, M.D. | X | | | Hill, Jennifer, M.D. | X | | |
| Bendlin, Andrew, Pharm.D. | X | | | Juracek, Joyce, Pharm.D. | X | | |
| Cowles, Cassie, APRN | X | | | Kaspar-Cope, Rachelle M.D. | X | | |
| Dering-Anderson, Allison, Pharm.D. (Chair) ***Votes only in the event of a tie*** | | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |
| Fornander, Wade, M.D. | X | | | Sundsboe, Bradley, Pharm.D. | X | | |

## Review Agenda – CYTOKINE AND CAM ANTAGONISTS

**(1st) Motion:** Juracek

**(2nd) Motion:** Fornander

**Discussion:** Approved as written.

| **Voting – P&T Committee Members** Does not include excused or unexcused members | Yes | No | Abstain | **Voting – P&T Committee Members** | Yes | No | Abstain |
|---|---|---|---|---|---|---|---|
| Avery, Eric, M.D. | X | | | Friesen, C. Jose, M.D. | X | | |
| Baker, Claire, M.D. | X | | | Hill, Jennifer, M.D. | X | | |
| Bendlin, Andrew, Pharm.D. | X | | | Juracek, Joyce, Pharm.D. | X | | |
| Cowles, Cassie, APRN | X | | | Kaspar-Cope, Rachelle M.D. | X | | |
| Dering-Anderson, Allison, Pharm.D. (Chair) ***Votes only in the event of a tie*** | | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |
| Fornander, Wade, M.D. | X | | | Sundsboe, Bradley, Pharm.D. | X | | |

## Review Agenda – EPINEPHRINE, SELF-INJECTED

**(1st) Motion:** Friesen

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| **(2nd) Motion:** Avery |
|---|
| **Discussion:** Approved as written. |

| **Voting – P&T Committee Members** Does not include excused or unexcused members | Yes | No | Abstain | **Voting – P&T Committee Members** | Yes | No | Abstain |
|---|---|---|---|---|---|---|---|
| Avery, Eric, M.D. | X | | | Friesen, C. Jose, M.D. | X | | |
| Baker, Claire, M.D. | X | | | Hill, Jennifer, M.D. | X | | |
| Bendlin, Andrew, Pharm.D. | X | | | Juracek, Joyce, Pharm.D. | X | | |
| Cowles, Cassie, APRN | X | | | Kaspar-Cope, Rachelle M.D. | X | | |
| Dering-Anderson, Allison, Pharm.D. (Chair) ***Votes only in the event of a tie*** | | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |
| Fornander, Wade, M.D. | X | | | Sundsboe, Bradley, Pharm.D. | X | | |

| **Review Agenda – ERYTHROPOIESIS STIMULATING PROTEINS** |
|---|
| **(1st) Motion:** Juracek |
| **(2nd) Motion:** Hill |
| **Discussion:** Approved as written. |

| **Voting – P&T Committee Members** Does not include excused or unexcused members | Yes | No | Abstain | **Voting – P&T Committee Members** | Yes | No | Abstain |
|---|---|---|---|---|---|---|---|
| Avery, Eric, M.D. | X | | | Friesen, C. Jose, M.D. | X | | |
| Baker, Claire, M.D. | X | | | Hill, Jennifer, M.D. | X | | |
| Bendlin, Andrew, Pharm.D. | X | | | Juracek, Joyce, Pharm.D. | X | | |
| Cowles, Cassie, APRN | X | | | Kaspar-Cope, Rachelle M.D. | X | | |
| Dering-Anderson, Allison, Pharm.D. (Chair) ***Votes only in the event of a tie*** | | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |
| Fornander, Wade, M.D. | X | | | Sundsboe, Bradley, Pharm.D. | X | | |

| **Review Agenda – GLUCOCORTICOIDS, INHALED** |
|---|
| **(1st) Motion:** Fornander |
| **(2nd) Motion:** Juracek |
| **Discussion:** Approved as written. |

| **Voting – P&T Committee Members** Does not include excused or unexcused members | Yes | No | Abstain | **Voting – P&T Committee Members** | Yes | No | Abstain |
|---|---|---|---|---|---|---|---|
| Avery, Eric, M.D. | X | | | Friesen, C. Jose, M.D. | X | | |

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|---|---|---|---|---|---|---|---|
| Baker, Claire, M.D. | X | | | Hill, Jennifer, M.D. | X | | |
| Bendlin, Andrew, Pharm.D. | X | | | Juracek, Joyce, Pharm.D. | X | | |
| Cowles, Cassie, APRN | X | | | Kaspar-Cope, Rachelle M.D. | X | | |
| Dering-Anderson, Allison, Pharm.D. (Chair)<br>***Votes only in the event of a tie*** | | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |
| Fornander, Wade, M.D. | X | | | Sundsboe, Bradley, Pharm.D. | X | | |

## Review Agenda – HEMOPHILIA TREATMENTS

**(1st) Motion:** Avery

**(2nd) Motion:** Hill

**Discussion:** Approved as written. Allison Duchman (NovoNordisk) shared population estimates of ~200 Hemophilia A and ~40 Hemophilia B patients in Nebraska in response to a question from the Chair. This data may include neighboring states.

| **Voting – P&T Committee Members**<br>**Does not include excused or unexcused members** | **Yes** | **No** | **Abstain** | **Voting – P&T Committee Members** | **Yes** | **No** | **Abstain** |
|---|---|---|---|---|---|---|---|
| Avery, Eric, M.D. | X | | | Friesen, C. Jose, M.D. **(Not present during voting)** | | | |
| Baker, Claire, M.D. | X | | | Hill, Jennifer, M.D. | X | | |
| Bendlin, Andrew, Pharm.D. | X | | | Juracek, Joyce, Pharm.D. | X | | |
| Cowles, Cassie, APRN | X | | | Kaspar-Cope, Rachelle M.D. | X | | |
| Dering-Anderson, Allison, Pharm.D. (Chair)<br>***Votes only in the event of a tie*** | | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |
| Fornander, Wade, M.D. | X | | | Sundsboe, Bradley, Pharm.D. | X | | |

## Review Agenda – IDIOPATHIC PULMONARY FIBROSIS

**(1st) Motion:** Fornander

**(2nd) Motion:** Juracek

**Discussion:** Approved as written.

| **Voting – P&T Committee Members**<br>**Does not include excused or unexcused members** | **Yes** | **No** | **Abstain** | **Voting – P&T Committee Members** | **Yes** | **No** | **Abstain** |
|---|---|---|---|---|---|---|---|
| Avery, Eric, M.D. | X | | | Friesen, C. Jose, M.D. | X | | |
| Baker, Claire, M.D. | X | | | Hill, Jennifer, M.D. | X | | |
| Bendlin, Andrew, Pharm.D. | X | | | Juracek, Joyce, Pharm.D. | X | | |
| Cowles, Cassie, APRN | X | | | Kaspar-Cope, Rachelle M.D. | X | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Dering-Anderson, Allison, Pharm.D. (Chair)<br>***Votes only in the event of a tie*** | | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |
| Fornander, Wade, M.D. | X | | | Sundsboe, Bradley, Pharm.D. | X | | |

## Review Agenda – IMMUNOMODULATORS, ASTHMA

**(1st) Motion:** Hill

**(2nd) Motion:** Juracek

**Discussion:** Approved as written.

| **Voting – P&T Committee Members**<br>**Does not include excused or unexcused members** | **Yes** | **No** | **Abstain** | **Voting – P&T Committee Members** | **Yes** | **No** | **Abstain** |
|---|---|---|---|---|---|---|---|
| Avery, Eric, M.D. | X | | | Friesen, C. Jose, M.D. | X | | |
| Baker, Claire, M.D. | X | | | Hill, Jennifer, M.D. | X | | |
| Bendlin, Andrew, Pharm.D. | X | | | Juracek, Joyce, Pharm.D. | X | | |
| Cowles, Cassie, APRN | X | | | Kaspar-Cope, Rachelle M.D. | X | | |
| Dering-Anderson, Allison, Pharm.D. (Chair)<br>***Votes only in the event of a tie*** | | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |
| Fornander, Wade, M.D. | X | | | Sundsboe, Bradley, Pharm.D. | X | | |

## Review Agenda – IMMUNOMODULATORS, ATOPIC DERMATITIS

**(1st) Motion:** Avery

**(2nd) Motion:** Hill

**Discussion:** Approved as written.

| **Voting – P&T Committee Members**<br>**Does not include excused or unexcused members** | **Yes** | **No** | **Abstain** | **Voting – P&T Committee Members** | **Yes** | **No** | **Abstain** |
|---|---|---|---|---|---|---|---|
| Avery, Eric, M.D. | X | | | Friesen, C. Jose, M.D. | X | | |
| Baker, Claire, M.D. | X | | | Hill, Jennifer, M.D. | X | | |
| Bendlin, Andrew, Pharm.D. | X | | | Juracek, Joyce, Pharm.D. | X | | |
| Cowles, Cassie, APRN | X | | | Kaspar-Cope, Rachelle M.D. | X | | |
| Dering-Anderson, Allison, Pharm.D. (Chair)<br>***Votes only in the event of a tie*** | | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |
| Fornander, Wade, M.D. | X | | | Sundsboe, Bradley, Pharm.D. | X | | |

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| Review Agenda – IMMUNOMODULATORS, TOPICAL | | | | | | | |
|---|---|---|---|---|---|---|---|
| **(1st) Motion:** Friesen | | | | | | | |
| **(2nd) Motion:** Fornander | | | | | | | |
| **Discussion:** Approved as written. | | | | | | | |
| **Voting – P&T Committee Members** Does not include excused or unexcused members | **Yes** | **No** | **Abstain** | **Voting – P&T Committee Members** | **Yes** | **No** | **Abstain** |
| Avery, Eric, M.D. | X | | | Friesen, C. Jose, M.D. | X | | |
| Baker, Claire, M.D. | X | | | Hill, Jennifer, M.D. | X | | |
| Bendlin, Andrew, Pharm.D. | X | | | Juracek, Joyce, Pharm.D. | X | | |
| Cowles, Cassie, APRN | X | | | Kaspar-Cope, Rachelle M.D. | X | | |
| Dering-Anderson, Allison, Pharm.D. (Chair) ***Votes only in the event of a tie*** | | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |
| Fornander, Wade, M.D. | X | | | Sundsboe, Bradley, Pharm.D. | X | | |

| Review Agenda – INTRANASAL RHINTIS AGENTS | | | | | | | |
|---|---|---|---|---|---|---|---|
| **(1st) Motion:** Hill | | | | | | | |
| **(2nd) Motion:** Juracek | | | | | | | |
| **Discussion:** Approved as written. | | | | | | | |
| **Voting – P&T Committee Members** Does not include excused or unexcused members | **Yes** | **No** | **Abstain** | **Voting – P&T Committee Members** | **Yes** | **No** | **Abstain** |
| Avery, Eric, M.D. | X | | | Friesen, C. Jose, M.D. | X | | |
| Baker, Claire, M.D. | X | | | Hill, Jennifer, M.D. | X | | |
| Bendlin, Andrew, Pharm.D. | X | | | Juracek, Joyce, Pharm.D. | X | | |
| Cowles, Cassie, APRN | X | | | Kaspar-Cope, Rachelle M.D. | X | | |
| Dering-Anderson, Allison, Pharm.D. (Chair) ***Votes only in the event of a tie*** | | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |
| Fornander, Wade, M.D. | X | | | Sundsboe, Bradley, Pharm.D. | X | | |

| Review Agenda – MOVEMENT DISORDERS |
|---|
| **(1st) Motion:** Friesen |
| **(2nd) Motion:** Hill |
| **Discussion:** Approved as written. |

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| Voting – P&T Committee Members<br>Does not include excused or unexcused members | Yes | No | Abstain | Voting – P&T Committee Members | Yes | No | Abstain |
|---|---|---|---|---|---|---|---|
| Avery, Eric, M.D. | X | | | Friesen, C. Jose, M.D. | X | | |
| Baker, Claire, M.D. | X | | | Hill, Jennifer, M.D. | X | | |
| Bendlin, Andrew, Pharm.D. | X | | | Juracek, Joyce, Pharm.D. | X | | |
| Cowles, Cassie, APRN | X | | | Kaspar-Cope, Rachelle M.D. | X | | |
| Dering-Anderson, Allison, Pharm.D. (Chair)<br>***Votes only in the event of a tie*** | | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |
| Fornander, Wade, M.D. | X | | | Sundsboe, Bradley, Pharm.D. | X | | |

## Review Agenda – NSAIDS

**(1st) Motion:** Kaspar-Cope

**(2nd) Motion:** Juracek

**Discussion:** Approved as written.

| Voting – P&T Committee Members<br>Does not include excused or unexcused members | Yes | No | Abstain | Voting – P&T Committee Members | Yes | No | Abstain |
|---|---|---|---|---|---|---|---|
| Avery, Eric, M.D. | X | | | Friesen, C. Jose, M.D. | X | | |
| Baker, Claire, M.D. | X | | | Hill, Jennifer, M.D. | X | | |
| Bendlin, Andrew, Pharm.D. | X | | | Juracek, Joyce, Pharm.D. | X | | |
| Cowles, Cassie, APRN | X | | | Kaspar-Cope, Rachelle M.D. | X | | |
| Dering-Anderson, Allison, Pharm.D. (Chair)<br>***Votes only in the event of a tie*** | | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |
| Fornander, Wade, M.D. | X | | | Sundsboe, Bradley, Pharm.D. | X | | |

## Review Agenda – ONCOLOGY, ORAL – BREAST

**(1st) Motion:** Avery

**(2nd) Motion:** Friesen

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

| Voting – P&T Committee Members<br>Does not include excused or unexcused members | Yes | No | Abstain | Voting – P&T Committee Members | Yes | No | Abstain |
|---|---|---|---|---|---|---|---|
| Avery, Eric, M.D. | X | | | Friesen, C. Jose, M.D. | X | | |
| Baker, Claire, M.D. | X | | | Hill, Jennifer, M.D. | X | | |

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| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Bendlin, Andrew, Pharm.D. | X | | | Juracek, Joyce, Pharm.D. | X | | |
| Cowles, Cassie, APRN | X | | | Kaspar-Cope, Rachelle M.D. | X | | |
| Dering-Anderson, Allison, Pharm.D. (Chair)<br>***Votes only in the event of a tie*** | | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |
| Fornander, Wade, M.D. | X | | | Sundsboe, Bradley, Pharm.D. | X | | |

## Review Agenda – ONCOLOGY, ORAL – HEMATOLOGIC

**(1st) Motion:** Avery

**(2nd) Motion:** Baker

**Discussion:** Approved as written.

| **Voting – P&T Committee Members**<br>Does not include excused or unexcused members | **Yes** | **No** | **Abstain** | **Voting – P&T Committee Members** | **Yes** | **No** | **Abstain** |
|---|---|---|---|---|---|---|---|
| Avery, Eric, M.D. | X | | | Friesen, C. Jose, M.D. | X | | |
| Baker, Claire, M.D. | X | | | Hill, Jennifer, M.D. | X | | |
| Bendlin, Andrew, Pharm.D. | X | | | Juracek, Joyce, Pharm.D. | X | | |
| Cowles, Cassie, APRN | X | | | Kaspar-Cope, Rachelle M.D. | X | | |
| Dering-Anderson, Allison, Pharm.D. (Chair)<br>***Votes only in the event of a tie*** | | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |
| Fornander, Wade, M.D. | X | | | Sundsboe, Bradley, Pharm.D. | X | | |

## Review Agenda – ONCOLOGY, ORAL – LUNG

**(1st) Motion:** Avery

**(2nd) Motion:** Baker

**Discussion:** Committee recommended Alecensa and Tagrisso be moved from Preferred to Non-preferred on the PDL.

| **Voting – P&T Committee Members**<br>Does not include excused or unexcused members | **Yes** | **No** | **Abstain** | **Voting – P&T Committee Members** | **Yes** | **No** | **Abstain** |
|---|---|---|---|---|---|---|---|
| Avery, Eric, M.D. | X | | | Friesen, C. Jose, M.D. | X | | |
| Baker, Claire, M.D. | X | | | Hill, Jennifer, M.D. | X | | |
| Bendlin, Andrew, Pharm.D. | X | | | Juracek, Joyce, Pharm.D. | X | | |
| Cowles, Cassie, APRN | X | | | Kaspar-Cope, Rachelle M.D. | X | | |
| Dering-Anderson, Allison, Pharm.D. (Chair)<br>***Votes only in the event of a tie*** | | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |

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| Fornander, Wade, M.D. | X | | | Sundsboe, Bradley, Pharm.D. | X | | |
|---|---|---|---|---|---|---|---|

## Review Agenda – ONCOLOGY, ORAL – OTHER

**(1st) Motion:** Avery

**(2nd) Motion:** Juracek

**Discussion:** Approved as written.

| **Voting – P&T Committee Members** Does not include excused or unexcused members | Yes | No | Abstain | **Voting – P&T Committee Members** | Yes | No | Abstain |
|---|---|---|---|---|---|---|---|
| Avery, Eric, M.D. | X | | | Friesen, C. Jose, M.D. | X | | |
| Baker, Claire, M.D. | X | | | Hill, Jennifer, M.D. | X | | |
| Bendlin, Andrew, Pharm.D. | X | | | Juracek, Joyce, Pharm.D. | X | | |
| Cowles, Cassie, APRN | X | | | Kaspar-Cope, Rachelle M.D. | X | | |
| Dering-Anderson, Allison, Pharm.D. (Chair) ***Votes only in the event of a tie*** | | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |
| Fornander, Wade, M.D. | X | | | Sundsboe, Bradley, Pharm.D. | X | | |

## Review Agenda – ONCOLOGY, ORAL – PROSTATE

**(1st) Motion:** Avery

**(2nd) Motion:** Juracek

**Discussion:** Approved as written.

| **Voting – P&T Committee Members** Does not include excused or unexcused members | Yes | No | Abstain | **Voting – P&T Committee Members** | Yes | No | Abstain |
|---|---|---|---|---|---|---|---|
| Avery, Eric, M.D. | X | | | Friesen, C. Jose, M.D. | X | | |
| Baker, Claire, M.D. | X | | | Hill, Jennifer, M.D. | X | | |
| Bendlin, Andrew, Pharm.D. | X | | | Juracek, Joyce, Pharm.D. | X | | |
| Cowles, Cassie, APRN | X | | | Kaspar-Cope, Rachelle M.D. | X | | |
| Dering-Anderson, Allison, Pharm.D. (Chair) ***Votes only in the event of a tie*** | | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |
| Fornander, Wade, M.D. | X | | | Sundsboe, Bradley, Pharm.D. | X | | |

## Review Agenda – ONCOLOGY, ORAL – RENAL CELL

**(1st) Motion:** Avery

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(2nd) **Motion:** Fornander

**Discussion:** Approved as written.

| Voting – P&T Committee Members<br>Does not include excused or unexcused members | Yes | No | Abstain | Voting – P&T Committee Members | Yes | No | Abstain |
|---|---|---|---|---|---|---|---|
| Avery, Eric, M.D. | X | | | Friesen, C. Jose, M.D. | X | | |
| Baker, Claire, M.D. | X | | | Hill, Jennifer, M.D. | X | | |
| Bendlin, Andrew, Pharm.D. | X | | | Juracek, Joyce, Pharm.D. | X | | |
| Cowles, Cassie, APRN | X | | | Kaspar-Cope, Rachelle M.D. | X | | |
| Dering-Anderson, Allison, Pharm.D. (Chair)<br>***Votes only in the event of a tie*** | | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |
| Fornander, Wade, M.D. | X | | | Sundsboe, Bradley, Pharm.D. | X | | |

## Review Agenda – ONCOLOGY, ORAL – SKIN

(1st) **Motion:** Hill

(2nd) **Motion:** Juracek

**Discussion:** Approved as written.

| Voting – P&T Committee Members<br>Does not include excused or unexcused members | Yes | No | Abstain | Voting – P&T Committee Members | Yes | No | Abstain |
|---|---|---|---|---|---|---|---|
| Avery, Eric, M.D. | X | | | Friesen, C. Jose, M.D. | X | | |
| Baker, Claire, M.D. | X | | | Hill, Jennifer, M.D. | X | | |
| Bendlin, Andrew, Pharm.D. | X | | | Juracek, Joyce, Pharm.D. | X | | |
| Cowles, Cassie, APRN | X | | | Kaspar-Cope, Rachelle M.D. | X | | |
| Dering-Anderson, Allison, Pharm.D. (Chair)<br>***Votes only in the event of a tie*** | | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |
| Fornander, Wade, M.D. | X | | | Sundsboe, Bradley, Pharm.D. | X | | |

## Review Agenda – OPHTHALMIC, ANTIBIOTICS-STEROID COMBINATIONS

(1st) **Motion:** Friesen

(2nd) **Motion:** Kaspar-Cope

**Discussion:** Approved as written.

| Voting – P&T Committee Members<br>Does not include excused or unexcused members | Yes | No | Abstain | Voting – P&T Committee Members | Yes | No | Abstain |
|---|---|---|---|---|---|---|---|
| Avery, Eric, M.D. | X | | | Friesen, C. Jose, M.D. | X | | |

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| Voting – P&T Committee Members | Yes | No | Abstain | Voting – P&T Committee Members | Yes | No | Abstain |
|---|---|---|---|---|---|---|---|
| Baker, Claire, M.D. | X | | | Hill, Jennifer, M.D. | X | | |
| Bendlin, Andrew, Pharm.D. | X | | | Juracek, Joyce, Pharm.D. | X | | |
| Cowles, Cassie, APRN | X | | | Kaspar-Cope, Rachelle M.D. | X | | |
| Dering-Anderson, Allison, Pharm.D. (Chair)<br>***Votes only in the event of a tie*** | | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |
| Fornander, Wade, M.D. | X | | | Sundsboe, Bradley, Pharm.D. | X | | |

## Review Agenda – OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS

**(1st) Motion:** Avery

**(2nd) Motion:** Juracek

**Discussion:** Approved as written.

| **Voting – P&T Committee Members**<br>**Does not include excused or unexcused members** | **Yes** | **No** | **Abstain** | **Voting – P&T Committee Members** | **Yes** | **No** | **Abstain** |
|---|---|---|---|---|---|---|---|
| Avery, Eric, M.D. | X | | | Friesen, C. Jose, M.D. | X | | |
| Baker, Claire, M.D. | X | | | Hill, Jennifer, M.D. | X | | |
| Bendlin, Andrew, Pharm.D. | X | | | Juracek, Joyce, Pharm.D. | X | | |
| Cowles, Cassie, APRN | X | | | Kaspar-Cope, Rachelle M.D. | X | | |
| Dering-Anderson, Allison, Pharm.D. (Chair)<br>***Votes only in the event of a tie*** | | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |
| Fornander, Wade, M.D. | X | | | Sundsboe, Bradley, Pharm.D. | X | | |

## Review Agenda – OPHTHALMICS ANTI-INFLAMMATORY/IMMUNOMODULATOR

**(1st) Motion:** Juracek

**(2nd) Motion:** Friesen

**Discussion:** Approved as written.

| **Voting – P&T Committee Members**<br>**Does not include excused or unexcused members** | **Yes** | **No** | **Abstain** | **Voting – P&T Committee Members** | **Yes** | **No** | **Abstain** |
|---|---|---|---|---|---|---|---|
| Avery, Eric, M.D. | X | | | Friesen, C. Jose, M.D. | X | | |
| Baker, Claire, M.D. | X | | | Hill, Jennifer, M.D. | X | | |
| Bendlin, Andrew, Pharm.D. | X | | | Juracek, Joyce, Pharm.D. | X | | |
| Cowles, Cassie, APRN | X | | | Kaspar-Cope, Rachelle M.D. | X | | |
| Dering-Anderson, Allison, Pharm.D. (Chair)<br>***Votes only in the event of a tie*** | | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |

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| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Fornander, Wade, M.D. | X | | | Sundsboe, Bradley, Pharm.D. | X | | |

| Review Agenda – OPHTHALMICS, GLAUCOMA AGENTS |
|---|
| **(1st) Motion:** Hill |
| **(2nd) Motion:** Juracek |
| **Discussion:** Approved as written. |

| **Voting – P&T Committee Members** Does not include excused or unexcused members | Yes | No | Abstain | **Voting – P&T Committee Members** | Yes | No | Abstain |
|---|---|---|---|---|---|---|---|
| Avery, Eric, M.D. | X | | | Friesen, C. Jose, M.D. | X | | |
| Baker, Claire, M.D. | X | | | Hill, Jennifer, M.D. | X | | |
| Bendlin, Andrew, Pharm.D. | X | | | Juracek, Joyce, Pharm.D. | X | | |
| Cowles, Cassie, APRN | X | | | Kaspar-Cope, Rachelle M.D. | X | | |
| Dering-Anderson, Allison, Pharm.D. (Chair) ***Votes only in the event of a tie*** | | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |
| Fornander, Wade, M.D. | X | | | Sundsboe, Bradley, Pharm.D. | X | | |

| Review Agenda – OPIATE DEPENDENCE TREATMENTS |
|---|
| **(1st) Motion:** Kaspar-Cope |
| **(2nd) Motion:** Juracek |
| **Discussion:** Approved as written. |

| **Voting – P&T Committee Members** Does not include excused or unexcused members | Yes | No | Abstain | **Voting – P&T Committee Members** | Yes | No | Abstain |
|---|---|---|---|---|---|---|---|
| Avery, Eric, M.D. | X | | | Friesen, C. Jose, M.D. | X | | |
| Baker, Claire, M.D. | X | | | Hill, Jennifer, M.D. | X | | |
| Bendlin, Andrew, Pharm.D. | X | | | Juracek, Joyce, Pharm.D. | X | | |
| Cowles, Cassie, APRN | X | | | Kaspar-Cope, Rachelle M.D. | X | | |
| Dering-Anderson, Allison, Pharm.D. (Chair) ***Votes only in the event of a tie*** | | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |
| Fornander, Wade, M.D. | X | | | Sundsboe, Bradley, Pharm.D. | X | | |

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## Review Agenda – OTIC ANTIBIOTICS

**(1st) Motion:** Fornander

**(2nd) Motion:** Juracek

**Discussion:** Approved as written.

| **Voting – P&T Committee Members** Does not include excused or unexcused members | Yes | No | Abstain | **Voting – P&T Committee Members** | Yes | No | Abstain |
|---|---|---|---|---|---|---|---|
| Avery, Eric, M.D. | X | | | Friesen, C. Jose, M.D. | X | | |
| Baker, Claire, M.D. | X | | | Hill, Jennifer, M.D. | X | | |
| Bendlin, Andrew, Pharm.D. | X | | | Juracek, Joyce, Pharm.D. | X | | |
| Cowles, Cassie, APRN | X | | | Kaspar-Cope, Rachelle M.D. | X | | |
| Dering-Anderson, Allison, Pharm.D. (Chair) *Votes only in the event of a tie* | | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |
| Fornander, Wade, M.D. | X | | | Sundsboe, Bradley, Pharm.D. | X | | |

## Review Agenda – SEDATIVE HYPNOTICS

**(1st) Motion:** Hill

**(2nd) Motion:** Juracek

**Discussion:** Approved as written.

| **Voting – P&T Committee Members** Does not include excused or unexcused members | Yes | No | Abstain | **Voting – P&T Committee Members** | Yes | No | Abstain |
|---|---|---|---|---|---|---|---|
| Avery, Eric, M.D. | X | | | Friesen, C. Jose, M.D. | X | | |
| Baker, Claire, M.D. | X | | | Hill, Jennifer, M.D. | X | | |
| Bendlin, Andrew, Pharm.D. | X | | | Juracek, Joyce, Pharm.D. | X | | |
| Cowles, Cassie, APRN | X | | | Kaspar-Cope, Rachelle M.D. | X | | |
| Dering-Anderson, Allison, Pharm.D. (Chair) *Votes only in the event of a tie* | | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |
| Fornander, Wade, M.D. | X | | | Sundsboe, Bradley, Pharm.D. | X | | |

## Review Agenda – STEROID, TOPICAL LOW

**(1st) Motion:** Hill

**(2nd) Motion:** Juracek

**Discussion:** Approved as written.

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| Voting – P&T Committee Members<br>Does not include excused or unexcused members | Yes | No | Abstain | Voting – P&T Committee Members | Yes | No | Abstain |
|---|---|---|---|---|---|---|---|
| Avery, Eric, M.D. | X | | | Friesen, C. Jose, M.D. | X | | |
| Baker, Claire, M.D. | X | | | Hill, Jennifer, M.D. | X | | |
| Bendlin, Andrew, Pharm.D. | X | | | Juracek, Joyce, Pharm.D. | X | | |
| Cowles, Cassie, APRN | X | | | Kaspar-Cope, Rachelle M.D. | X | | |
| Dering-Anderson, Allison, Pharm.D. (Chair)<br>***Votes only in the event of a tie*** | | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |
| Fornander, Wade, M.D. | X | | | Sundsboe, Bradley, Pharm.D. | X | | |

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| Review Agenda – STIMULANTS AND RELATED AGENTS |
|---|
| **(1st) Motion:** Juracek |
| **(2nd) Motion:** Baker |
| **Discussion:** The Committee moved to approve as written with the addition of criteria for the non-preferred agents in the Miscellaneous subclass to require a trial and failure of one preferred agent within the subclass. |

| Voting – P&T Committee Members<br>Does not include excused or unexcused members | Yes | No | Abstain | Voting – P&T Committee Members | Yes | No | Abstain |
|---|---|---|---|---|---|---|---|
| Avery, Eric, M.D. | X | | | Friesen, C. Jose, M.D. | X | | |
| Baker, Claire, M.D. | X | | | Hill, Jennifer, M.D. | X | | |
| Bendlin, Andrew, Pharm.D. | X | | | Juracek, Joyce, Pharm.D. | X | | |
| Cowles, Cassie, APRN | X | | | Kaspar-Cope, Rachelle M.D. | X | | |
| Dering-Anderson, Allison, Pharm.D. (Chair)<br>***Votes only in the event of a tie*** | | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |
| Fornander, Wade, M.D. | X | | | Sundsboe, Bradley, Pharm.D. | X | | |

| Review Agenda – SICKLE CELL ANEMIA |
|---|
| **(1st) Motion:** Baker |
| **(2nd) Motion:** Cowles |
| **Discussion:** Approved as written. |

| Voting – P&T Committee Members<br>Does not include excused or unexcused members | Yes | No | Abstain | Voting – P&T Committee Members | Yes | No | Abstain |
|---|---|---|---|---|---|---|---|
| Avery, Eric, M.D. | X | | | Friesen, C. Jose, M.D. | X | | |
| Baker, Claire, M.D. | X | | | Hill, Jennifer, M.D. | X | | |

| Bendlin, Andrew, Pharm.D. | X | | | Juracek, Joyce, Pharm.D. | X | | |
|---|---|---|---|---|---|---|---|
| Cowles, Cassie, APRN | X | | | Kaspar-Cope, Rachelle M.D. | X | | |
| Dering-Anderson, Allison, Pharm.D. (Chair) ***Votes only in the event of a tie*** | | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |
| Fornander, Wade, M.D. | X | | | Sundsboe, Bradley, Pharm.D. | X | | |

d. Complete Copy of Proposed PDL

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

November 2023 P&T Proposed PDL

Noted in Red Font that Become Effective January 19, 2024

For the most up to date list of covered drugs consult the **Drug Lookup** on the Nebraska Medicaid website at https://druglookup.fhsc.com/druglookupweb/?client=nestate.

- **PDMP Check Requirements** – Nebraska Medicaid providers are required to check the prescription drug history in the statewide PDMP before prescribing CII controlled substances to certain Medicaid beneficiaries (exemption to this requirement are for beneficiaries receiving cancer treatment, hospice/palliative care, or in long-term care facilities). If not able to check the PDMP, then provider is required to document good faith effort, including reasons why unable to conduct the check and may be required to submit documentation to the State upon request.
    - PDMP check requirements are under Section 5042 of the SUPPORT for Patients and Communities Act, consistent with section 1944 of the Social Security Act [42 U.S.C. 1396w-3a], beginning October 1, 2021.
- **Opioids** – The maximum opioid dose covered will decrease from 120 Morphine Milligram Equivalents (MME) per day to 90 Morphine Milligram Equivalents (MME) per day (beginning December 1, 2020).

**Non-Preferred Drug Coverage**

Class and drug-specific therapeutic trial and failure requirements are found within this document. Examples of non-preferred exception criteria include:

- Adverse reaction to preferred drugs
- Allergy to preferred drugs
- Contraindication to preferred drugs
- Documentation of inability to swallow solid dosage forms

Specific Class Prior Authorization forms can be found within the PDL class listings and at: https://nebraska.fhsc.com/priorauth/paforms.asp

- Immunomodulators Self-Injectable PA Form
- Opioid Dependence Treatment PA Form
- Opioid Dependence Treatment Informed Consent
- Growth Hormone PA Form
- HAE Treatments PA Form
- Hepatitis C PA Form

For all other class medically-necessary coverage, quantity, and high dose requests use the following:

Documentation of Medical Necessity PA Form

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# ALZHEIMER'S AGENTS

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| **CHOLINESTERASE INHIBITORS** | | ▪ 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<br>**OR**<br>▪ Current, stabilized therapy of the non-preferred agent within the previous 45 days<br><br>Drug-specific criteria:<br>▪ **Donepezil 23:** 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) |
| donepezil (generic Aricept)<br>donepezil **ODT** (generic Aricept ODT)<br>rivastigmine **PATCH** (generic for Exelon Patch) | ADLARITY (donepezil) **PATCH**<br>ARICEPT (donepezil)<br>donepezil 23 (generic Aricept 23)[CL]<br>EXELON (rivastigmine) **PATCH**<br>galantamine (generic Razadyne) **SOLN, TAB**<br>galantamine ER (generic Razadyne ER)<br>rivastigmine **CAPS** (generic Exelon) | |
| **NMDA RECEPTOR ANTAGONIST** | | |
| memantine (generic Namenda) | memantine **ER** (generic Namenda XR)<br>memantine **SOLN** (generic Namenda)<br>NAMENDA (memantine)<br>NAMZARIC (memantine/donepezil) | |

# ANTHELMINTICS

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| albendazole (generic for Albenza)<br>BILTRICIDE (praziquantel)<br>ivermectin (generic for Stromectol) | EMVERM (mebendazole)[CL]<br>praziquantel (generic for Biltricide)<br>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<br><br>Drug-specific criteria:<br>▪ **Emverm**: Approval will be considered for indications not covered by preferred agents |

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# ANTI-ALLERGENS, ORAL

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| | GRASTEK (timothy grass pollen allergen)[AL,NR,QL]<br><br>ODACTRA (Dermatophagoides farinae and Dermatophagoides pteronyssinus)[AL,NR,QL]<br><br>ORALAIR (sweet vernal/orchard/rye/ timothy/kentucky blue grass mixed pollen allergen extract)[CL]<br><br>PALFORZIA (peanut allergen powder-dnfp)[AL,CL]<br><br>RAGWITEK (weed pollen-short ragweed)[AL,NR,QL] | **All agents require initial dose to be given in a healthcare setting**<br><br>Drug-specific criteria:<br><br>**GRASTEK**<br>• Confirmed by positive skin test or in vitro testing for pollen specific IgE antibodies for Timothy grass or cross-reactive grass pollens.<br>• For use in persons 5 through 65 years of age.<br>**ODACTRA**<br>• Confirmed by positive skin test to licensed house dust mite allergen extracts or in vitro testing for IgE antibodies to *Dermatophagoides farinae and Dermatophagoides pteronyssinus* house dust mite<br>• For use in persons 12 through 65 years of age<br>**ORALAIR**<br>▪ 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.<br>▪ For use in patients 5 through 65 years of age.<br>**PALFORZIA**<br>▪ Confirmed diagnosis of peanut allergy by allergist<br>▪ 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<br>▪ Initial dose and increase titration doses should be given in a healthcare setting<br>▪ Should not be used in patients with uncontrolled asthma or concurrently on a NSAID<br>**RAGWITEK**<br>• Confirmed by positive skin test or in vitro testing for pollen specific IgE antibodies for short ragweed pollen.<br>• For use in patients 5 through 65 years of age. |

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# ANTIHISTAMINES, MINIMALLY SEDATING

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| cetirizine **TAB** (generic Zyrtec)<br><br>cetirizine **SOLN (OTC)** (generic Zyrtec)<br><br>loratadine **TAB, SOLN** (generic Claritin)<br><br>levocetirizine **TAB** (generic Xyzal) | cetirizine **CHEWABLE** (generic Zyrtec)<br><br>cetirizine **SOLN (Rx)** (generic Zyrtec)<br><br>desloratadine (generic Clarinex)<br><br>desloratadine ODT (generic Clarinex Reditabs)<br><br>fexofenadine (generic Allegra)<br><br>fexofenadine 180mg (generic Allegra 180mg)[QL]<br><br>levocetirizine (generic Xyzal) **SOLN**<br><br>loratadine **CAPS, CHEWABLE, ODT** (generic Claritin Reditabs) | ▪ Non-preferred agents will be approved for patients who have failed TWO preferred agents within this drug class<br><br>▪ Combination products not covered – individual products may be covered |

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# ANTIHYPERTENSIVES, SYMPATHOLYTICS

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| clonidine TAB (generic Catapres)<br><br>clonidine **TRANSDERMAL**<br><br>guanfacine (generic Tenex)<br><br>methyldopa | 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<br>▪ ~~clonidine TRANSDERMAL will be authorized during shortage of CATAPRES-TTS~~ |

# ANTIHYPERURICEMICS

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| allopurinol (generic Zyloprim)<br><br>colchicine **TAB** (generic Colcrys)[CL]<br><br>probenecid<br><br>probenecid/colchicine (generic Col-Probenecid) | allopurinol[NR] 200mg<br><br>colchicine **CAPS** (generic Mitigare)<br><br>febuxostat (generic Uloric)[CL]<br><br>GLOPERBA **SOLN** (colchicine)[CL,QL]<br><br>MITIGARE (colchicine) | ▪ Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class<br>▪ ~~**colchicine tablet®:** Approved without trial for familial Mediterranean fever OR pericarditis~~<br>▪ **Gloperba:** Approved for documented swallowing disorder<br>▪ **Uloric/febuxostat:** Clinical reason why allopurinol cannot be used |

# ANTIPARKINSON'S AGENTS, ORAL

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

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## ANTIPSORIATICS, ORAL

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| acitretin (generic Soriatane) | methoxsalen (generic Oxsoralen-Ultra) | ▪ Non-preferred agents will be approved for patients who have failed a trial with THE preferred agent within this drug class<br>▪ 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 **CREAM, OINT, SOLN** | calcitriol (generic Vectical)[AL] **OINT**<br><br>calcipotriene/betamethasone **OINT** **(**generic Taclonex)<br><br>calcipotriene/betamethasone **SUSP** (generic Taclonex Scalp)<br><br>CALCITRENE (calcipotriene)<br><br>DOVONEX **CREAM** (calcipotriene)<br><br>DUOBRII<br><br>(halobetasol prop/tazarotene<br><br>ENSTILAR (calcipotriene/betamethasone)<br><br>SORILUX (calcipotriene)<br><br>VTAMA (tapinarof)[AL,NR] **CREAM**<br><br>ZORYVE (roflumilast)[AL,NR] **CREAM** | ▪ Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class |

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# ANXIOLYTICS

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

# BILE SALTS

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| ursodiol **CAPSULE** 300 mg (generic Actigall)<br><br>ursodiol 250 mg **TABLET** (generic URSO)<br><br>ursodiol 500 mg **TABLET** (generic URSO FORTE) | BYLVAY (odevixibat) **CAP, PELLET**<br><br>CHENODAL (chenodiol)<br><br>CHOLBAM (cholic acid)<br><br>LIVMARLI (maralixibat) **SOLN**[AL]<br><br>OCALIVA (obeticholic acid)<br><br>RELTONE (ursodiol 200mg,400mg) **CAP** | ▪ Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class |

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# BRONCHODILATORS, BETA AGONIST

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| **INHALERS – Short Acting** | | ▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class<br><br>Drug-specific criteria:<br><br>▪ **Xopenex/levalbuterol solution:** Covered for cardiac diagnoses or side effect of tachycardia with albuterol product |
| albuterol HFA (generic Proventil HFA)<br><br>PROVENTIL HFA (albuterol)<br><br>VENTOLIN HFA (albuterol)<br><br>XOPENEX HFA (levalbuterol HFA) | albuterol HFA (generic ProAir HFA and Ventolin HFA)<br><br>levalbuterol HFA (generic Xopenex HFA)<br><br>PROAIR DIGIHALER (albuterol)<br><br>PROAIR RESPICLICK (albuterol) | |
| **INHALERS – Long Acting** | | |
| SEREVENT (salmeterol) | STRIVERDI RESPIMAT (olodaterol) | |
| **INHALATION SOLUTION** | | |
| albuterol (2.5mg/3ml premix or 2.5mg/0.5ml)<br><br>albuterol 100 mg/20 mL<br><br>albuterol low dose (0.63mg/3ml & 1.25mg/3ml) | arformoterol tartrate (generic Brovana)<br><br>BROVANA (arformoterol)<br><br>formoterol fumarate (generic Perforomist)<br><br>levalbuterol (generic for Xopenex)[CL]<br><br>PERFOROMIST (formoterol) | |
| **ORAL** | | |
| albuterol **SYRUP** | albuterol **TAB**<br><br>albuterol ER (generic for Vospire ER)<br><br>metaproterenol (formerly generic for Alupent)<br><br>terbutaline (generic for Brethine) | |

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## COLONY STIMULATING FACTORS

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| FYLNETRA (pegfilgrastim-pbbk)[NR] **SYR**<br><br>NEUPOGEN (filgrastim) **DISP SYR**<br><br>NEUPOGEN (filgrastim) **VIAL** | FULPHILA (pegfilgrastim-jmdb) **SUB-Q**<br><br>GRANIX (tbo-filgrastim) **SYR**<br><br>LEUKINE (sargramostim) **VIAL**<br><br>NEULASTA (pegfilgrastim) **SYR**<br><br>NIVESTYM (filgrastim-aafi) **SYR,VIAL**<br><br>NYVEPRIA (pegfilgrastim-apgf) **SYR**<br><br>RELEUKO (filgrastim-ayow) **SYR**, **VIAL**<br><br>STIMUFEND (pegfilgrastim-fpgk)[NR] **SYR**<br><br>UDENYCA (pegfilgrastim-cbqv)[NR] **AUTOINJ**<br><br>UDENYCA (pegfilgrastim-cbqv) **SUB-Q**<br><br>ZARXIO (filgrastim-sndz) **SYR**<br><br>ZIEXTENZO (pegfilgrastim-bmez) **SYR** | ▪ 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 |
|---|---|---|
| **INHALERS** | | ▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class<br>▪ Oral agents will be approved for patient specific documentation of inability to use traditional inhaler device.<br><br>Drug-specific criteria:<br><br>**Daliresp/roflumilast:**<br>• Covered for diagnosis of severe COPD associated with chronic bronchitis<br>• Requires trial of a bronchodilator<br>• Requires documentation of one exacerbation in last year upon initial review |
| ANORO ELLIPTA (umeclidinium/vilanterol)<br><br>ATROVENT HFA (ipratropium)<br><br>COMBIVENT RESPIMAT (albuterol/ ipratropium)<br><br>SPIRIVA (tiotropium)<br><br>STIOLTO RESPIMAT (tiotropium/ olodaterol) | BEVESPI AEROSPHERE (glycopyrolate/formoterol)<br><br>DUAKLIR PRESSAIR (aclidinium br and formoterol fum)<br><br>INCRUSE ELIPTA (umeclidnium)<br><br>SPIRIVA RESPIMAT (tiotropium)<br><br>tiotropium (generic Spiriva)[NR]<br><br>TUDORZA PRESSAIR (aclidinium br) | |
| **INHALATION SOLUTION** | | |
| albuterol/ipratropium (generic Duoneb)<br><br>ipratropium **SOLN** (generic Atrovent) | LONHALA (glycopyrrolate inhalation soln)<br><br>YUPELRI (revefenacin) | |
| **ORAL AGENT** | | |
| roflumilast (generic Daliresp)[CL,NR,QL] | DALIRESP (roflumilast)[CL, QL] | |

## COUGH AND COLD, OPIATE COMBINATION

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| | guaifenesin/codeine **LIQUID**<br><br>hydrocodone/homatropine SYRUP<br><br>promethazine/codeine **SYRUP**<br><br>promethazine/phenylephrine/codeine SYRUP | ▪ Non-preferred agents will be approved for patients who have failed a trial of ONE dextromethorphan product<br>▪ All codeine or hydrocodone containing cough and cold combinations are limited to ≥ 18 years of age |

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# CYTOKINE & CAM ANTAGONISTS

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| COSENTYX (secukinumab)[AL] **PEN, SYRINGE**<br><br>ENBREL (etanercept) **KIT, MINI CART, PEN, SYRINGE, VIAL**[QL]<br><br>HUMIRA (adalimumab)[QL]**PEN, SYR**<br><br>OTEZLA (apremilast) **ORAL TAB**[CL,QL] | ACTEMRA (tocilizumab) **SUB-Q**<br>ADALIMUMAB-ADAZ(CF)(biosim for Hyrimoz)[AL,NR] **PEN,SYR**<br>ADALIMUMAB-FKJP (biosim for Hulio)[AL,NR] **PEN, SYR**<br>AMJEVITA (adalimumab-atto)[AL,NR] **AUTOINJ, SYR**<br>ARCALYST (nilonacept) **VIAL**<br>CIBINQO (abrocitinib)[AL,QL] **ORAL TAB**<br>CIMZIA (certolizumab pegol)[QL]**SYR, KIT**<br>CYLTEZO (adalimumab-adbm)[AL,NR] **PEN SYRINGE**<br>ENSPRYNG (satralizumab-mwge) **SUB-Q**<br>HADLIMA (adalimumab- bwwd)[AL, NR] **PUSHTOUCH, SYRINGE**<br>HADLIMA (CF) (adalimumab- bwwd)[AL,NR] **PUSHTOUCH, SYRINGE**<br>HULIO (adalimumab-fkjp)[AL, NR] **PEN, SYRINGE**<br>HYRIMOZ(CF) (adalimumab-adaz)[AL,NR] **PEN, SYRINGE**<br>IDACIO (adalimumab-aacf)[AL,NR] **PEN, SYRINGE**<br>ILUMYA (tildrakizumab) **SUB-Q**<br>KEVZARA (sarilumab) **SUB-Q, PEN, SYRINGE**<br>KINERET (anakinra) **SYR**<br>OLUMIANT (baricitinib) [CL,QL] **TAB**<br>ORENCIA (abatacept**) SUB-Q**<br>RINVOQ ER (upadacitinib)[CL,QL] **TAB**<br>SILIQ (brodalumab) **SYR**<br>SIMPONI (golimumab) **PEN, SYR**<br>SKYRIZI (risankizamab-rzaa) **PEN**[QL], **SYR**, **ON-BODY**[QL]<br>SOTYKTU (deucravacitinib)[NR] **TAB**<br>STELARA (ustekinumab) **SUB-Q**<br>TALTZ (ixekizumab)[AL] **AUTOINJ, SYR**<br>TREMFYA (guselkumab)[QL] **AUTOINJ, SYR**<br>XELJANZ (tofacitinib) **SOLN, TAB**[CL,QL]<br>XELJANZ XR (tofacitinib) **TAB**[CL,QL]<br>YUFLYMA (CF) (adalimumab-aaty)[AL,NR] **AUTOINJ, SYR**<br>YUSIMRY (CF) (adalimumab-aqvh)[AL,NR] **PEN AUTOINJ, PEN, KIT** | ▪ Preferred agents will be approved with FDA-approved indication – ICD-10 diagnosis code is required.<br>▪ Non-preferred agents will be approved for FDA-approved indications in patients who have failed a trial of TWO preferred agents within this drug class, or upon diagnosis for non-preferred agent with FDA-approved indication if no preferred agent has FDA approval for diagnosis.<br><br>**JAK-Inhibitors**: For FDA approved indications that require a patient to have had an inadequate response to a TNF blocker, documentation of an inadequate response is required.<br><br>Drug-specific criteria:<br>▪ **Cosentyx:** Requires treatment failure of Enbrel OR Humira with the same FDA-approved indications and age limits.<br>▪<br>▪ **Otezla**: Requires a trial of Humira |

## ENZYME REPLACEMENT, GAUCHER'S DISEASE

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

## EPINEPHRINE, SELF-INJECTED [QL]

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| AUVI-Q 0.1mg (epinenephrine)[NR]<br><br>epinephrine (AUTHORIZED GENERIC Epipen/ Epipen Jr.) **AUTOINJ**<br><br>EPIPEN (epinephrine) **AUTOINJ**<br><br>EPIPEN JR. (epinephrine) **AUTOINJ** | AUVI-Q 0.15mg,0.3mg (epinenephrine) **AUTOINJ**[NR]<br><br>epinephrine (generic for Adrenaclick)<br><br>epinephrine (generic for Epipen/ Epipen Jr.) **AUTOINJ**<br><br>SYMJEPI (epinephrine) **PFS** | ▪ Non-preferred agents require clinical documentation why a preferred product within this drug class is not appropriate |

## ERYTHROPOIESIS STIMULATING PROTEINS

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| ARANESP (darbepoetin alfa) [NR] **DISP SYR, VIAL**<br><br>EPOGEN (rHuEPO)<br><br>RETACRIT (EPOETIN ALFA-EPBX) *Pfizer manufacturer only* | PROCRIT (rHuEPO)<br><br>RETACRIT (epoetin alfa) *Vifor manufacturer only* | ▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class |

# GLUCOCORTICOIDS, INHALED

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| **GLUCOCORTICOIDS** | | ▪ 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<br><br>Drug-specific criteria:<br><br>▪ **budesonide respules:** 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. |
| ARNUITY ELLIPTA (fluticasone)[AL]<br><br>ASMANEX (mometasone)[QL,AL]<br><br>FLOVENT HFA (fluticasone)<br><br>PULMICORT FLEXHALER (budesonide) | ALVESCO (ciclesonide)[AL,CL]<br><br>ARMONAIR DIGIHALER (fluticasone)[AL,QL]<br><br>ARMONAIR RESPICLICK (fluticasone)[AL]<br><br>ASMANEX HFA (mometasone)[CL,AL,QL]<br><br>FLOVENT DISKUS (fluticasone)<br><br>fluticasone HFA (generic Flovent HFA) | |
| **GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS** | | |
| ADVAIR DISKUS (fluticasone/ salmeterol)[QL]<br><br>ADVAIR HFA (fluticasone/salmeterol)[QL]<br><br>DULERA (mometasone/formoterol)<br><br>SYMBICORT (budesonide/ formoterol)<br><br>TRELEGY ELLIPTA (fluticasone/ umeclidinium/vilanterol) | AIRDUO DIGIHALER (fluticasone/salmeterol)[AL,QL]<br><br>AIRSUPRA HFA (albuterol and budesonide)[NR]<br><br>BREO ELLIPTA (fluticasone/vilanterol)<br><br>BREZTRI (budesonide/formoterol/ glycopyrrolate)[QL]<br><br>budesonide/formoterol (generic Symbicort)<br><br>fluticasone/salmeterol (generic Advair Diskus)[QL]<br><br>fluticasone/salmeterol (generic Advair HFA)[NR,QL]<br><br>fluticasone/salmeterol (generic Airduo Respiclick)<br><br>fluticasone/vilanterol (Breo Ellipta)<br><br>WIXELA INHUB (generic Advair Diskus)[QL] | |
| **INHALATION SOLUTION** | | |
| | budesonide **RESPULES** (generic Pulmicort) | |

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## GLUCOCORTICOIDS, ORAL

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| budesonide EC **CAPS** (generic Entocort EC)<br><br>dexamethasone **ELIXIR, SOLN**<br><br>dexamethasone **TAB**<br><br>hydrocortisone **TAB**<br><br>methylprednisolone tablet (generic Medrol)<br><br>prednisolone **SOLN**<br><br>prednisolone sodium phosphate<br><br>prednisone **DOSE PAK**<br><br>prednisone **TAB** | ALKINDI (hydrocortisone)[AL] **GRANULES**<br><br>CORTEF (hydrocortisone)<br><br>cortisone **TAB**<br><br>dexamethasone **INTENSOL**<br><br>EMFLAZA (deflazacort) [CL]**SUSP, TAB**<br><br>ENTOCORT EC (budesonide)<br><br>HEMADY (dexamethasone)<br><br>methylprednisolone 8mg, 16mg, 32mg<br><br>ORTIKOS ER (budesonide)[AL,QL]<br><br>prednisolone sodium phosphate (generic Millipred/Veripred)<br><br>prednisolone sodium phosphate **ODT**<br><br>prednisone **SOLN**<br><br>prednisone **INTENSOL**<br><br>RAYOS DR (prednisone) **TAB**<br><br>TARPEYO (budesonide) **CAPS** | ▪ 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<br><br>Drug-specific criteria:<br><br>▪ **Emflaza:** Indicated for the treatment of Duchenne muscular dystrophy (DMD) in patients 2 years of age and older<br>▪ **Intensol Products:** Patient specific documentation of why the less concentrated solution is not appropriate for the patient<br>▪ Tarpeyo: Indicated for the treatment of primary immunoglobulin A nephropathy (IgAN) |

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# HEMOPHILIA TREATMENTS

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| **FACTOR VIII** | | ▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class |
| ALPHANATE<br>HUMATE-P<br>KOVALTRY<br>NOVOEIGHT<br>NUWIQ<br>XYNTHA **KIT, SOLOFUSE** | ADVATE<br>ADYNOVATE<br>AFSTYLA<br>ALTUVIIIO[NR]<br>ELOCTATE<br>ESPEROCT<br>HEMOFIL-M<br>JIVI[AL]<br>KOATE-DVI **KIT**<br>KOATE-DVI **VIAL**<br>KOGENATE FS<br>OBIZUR<br>RECOMBINATE | |
| **FACTOR IX** | | |
| ALPROLIX<br>BENEFIX | ALPHANINE SD<br>IDELVION<br>IXINITY<br>PROFILNINE SD<br>REBINYN<br>RIXUBIS | |
| **FACTOR VIIa AND PROTHROMBIN COMPLEX-PLASMA DERIVED** | | |
| NOVOSEVEN RT | FEIBA NF<br>SEVENFACT[AL] | |
| **FACTOR X AND XIII PRODUCTS** | | |
| COAGADEX<br>CORIFACT | TRETTEN | |
| **VON WILLEBRAND PRODUCTS** | | |
| WILATE | VONVENDI | |
| **BISPECIFIC FACTORS** | | |
| HEMLIBRA | | |

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## HISTAMINE II RECEPTOR BLOCKERS

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| famotidine **TAB**<br><br>famotidine **SUSP** | cimetidine **TAB, SOLN**[CL] (generic Tagamet)<br><br>nizatidine **CAPS** (generic Axid)<br><br>ranitidine **SYRUP, TAB** | ▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class<br><br>Drug-specific criteria:<br><br>▪ **Cimetidine:** Approved for viral M. contagiosum or common wart V. Vulgaris treatment |

## IDIOPATHIC PULMONARY FIBROSIS

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| OFEV (nintedanib esylate)[CL]<br><br>pirfenidone (generic Esbriet)[QL] **CAP, TAB** | ESBRIET (pirfenidone)[QL] | ▪ Non-preferred agent requires a reason why any of the preferred agents can't be used<br>▪ FDA approved indication required – ICD-10 diagnosis code |

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# IMMUNOMODULATORS, ASTHMA [CL]

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| FASENRA (benralizumab)[AL] **PEN**<br><br>XOLAIR (omalizumab) **SYR**[AL,QL] | NUCALA (mepolizumab)[AL] **AUTO-INJ, SYR**<br><br>TEZSPIRE (Tezepelumab-ekko)[NR] **PEN** | [Immunomodulators Self-Injectable PA Form](#)<br><br>▪ All agents require prior authorization AND an FDA-approved diagnosis for approval<br>▪ Non-preferred agents require a trial of a preferred agent within this drug class with the same indication<br>▪ For asthma indications: All agents must be prescribed by or in consultation with an allergist, immunologist, or pulmonologist<br>▪ Agents listed may have other FDA approved indications, and will be subject to prior authorization<br><br>**Drug Specific Criteria:**<br><br>▪ **Dupixent**: (For other indications, see Immunomodulators, Atopic Dermatitis therapeutic class)<br>▪ **For Eosinophilic Asthma or Corticosteroid Dependent Asthma**: Patients must be ages 6 and older. Documentation of moderate to severe asthma with either eosinophils >/= 150 + 1 exacerbation OR oral corticosteroid dependency AND prior drug therapy of med-high or max-tolerated inhaled corticosteroid + controller OR max-tolerated inhaled corticosteroid / long acting beta agonist combo |

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# IMMUNOMODULATORS, ATOPIC DERMATITIS [AL]

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| ADBRY (tralokinumab-ldrm) **SUB-Q**[AL,QL]<br><br>DUPIXENT (dupilumab)[AL,CL] **PEN,SYR**<br><br>ELIDEL (pimecrolimus)<br><br>EUCRISA (crisaborole)[CL,QL]<br><br>tacrolimus (generic Protopic) | OPZELURA (ruxolitinib phosphate)[AL,QL]<br><br>pimecrolimus (generic Elidel)<br><br>PROTOPIC (tacrolimus) | [Immunomodulators Self-Injectable PA Form]<br><br>• Non-preferred agents require: Trial of a topical steroid AND trial of one preferred product within this drug class<br>Drug-specific criteria:<br>• **ADBRY:** May be approved after a trial or failure of a topical corticosteroid AND a topical calcineurin inhibitor<br>• **Dupixent**:<br>▪ **Atopic Dermatitis**: May be approved after a maximum of a 90-day trial or failure of a topical corticosteroid AND a topical calcineurin inhibitor ~~within the previous 24 months. Initial approval for 6 months and 12 months thereafter with physician attestation~~<br>▪ **Eosinophilic Esophagitis**: Trial, failure, or technique difficulty to a swallowed topical corticosteroid or treatment failure of a proton pump inhibitor. Prescribed by, or in consultation with an allergist, gastroenterologist, or immunologist. Documentation that the Patient has a confirmed diagnosis of eosinophilic esophagitis with > 15 eosinophils/high-power field.<br>▪ **Nasal Polyps**: May be approved with documentation of treatment failure or contraindication within the previous year to an intranasal corticosteroid OR systemic corticosteroid therapy OR prior nasal surgery. Prescribed by, or in consultation with an allergist, pulmonologist, or otolaryngologist [ENT]. ~~Initial approval for 6 months and 12 months thereafter with physician attestation~~<br>▪ **Prurigo Nodularis**: Patient must have a diagnosis of Prurigo Nodularis with provider attestation of > 20 nodular lesions. Trial and failure of a topical corticosteroid. Prescribed by, or in consultation with an allergist, dermatologist, or immunologist.<br>▪ **Eucrisa**: May be approved after a 30 day trial failure of a preferred topical corticosteroid (TCS) or topical calcineurin inhibitor (TCI) within the past 180 days; Maximum of 300 grams per year<br>▪ **Opzelura**: May be approved for a diagnosis of Atopic Dermatitis and after a trial/failure of a topical steroid and trial of a preferred agent |

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## IMMUNOMODULATORS, TOPICAL

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| imiquimod (generic for Aldara) | HYFTOR (sirolimus)[AL,NR]<br><br>imiquimod (generic for Zyclara)<br><br>podofilox (generic for Condylox)<br><br>VEREGEN (sinecatechins)<br><br>ZYCLARA (imiquimod) | ▪ Non-preferred agents require clinical reason why preferred agent within this drug class cannot be used |

# INTRANASAL RHINITIS DRUGS

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| **ANTICHOLINERGICS** | | Non-preferred agents will be approved for patients who have failed a 30-day trial of ONE preferred agent within this drug class<br><br>Drug-specific criteria:<br><br>▪ **mometasone:** Prior authorization NOT required for children ≤ 12 years<br>▪ **budesonide:** Approved for use in Pregnancy (Pregnancy Category B)<br>▪ **Xhance:** Indicated for treatment of nasal polyps in $\geq$ 18 years only |
| ipratropium (generic for Atrovent) | | |
| **ANTIHISTAMINES** | | |
| azelastine 0.1% (generic for Astelin) | azelastine 0.15% (generic for Astepro)<br><br>azelastine/fluticasone (generic for Dymista)<br><br>olopatadine (generic for Patanase)<br><br>RYALTRIS (olopatadine/mometasone)[AL,NR] | |
| **CORTICOSTEROIDS** | | |
| fluticasone **Rx** (generic Flonase) | BECONASE AQ (beclomethasone)<br><br>budesonide Rx (generic for Rhinocort)<br><br>flunisolide (generic for Nasalide)<br><br>fluticasone **OTC** (generic Flonase OTC)<br><br>mometasone (generic for Nasonex)<br><br>OMNARIS (ciclesonide)<br><br>QNASL 40 & 80 (beclomethasone)<br><br>XHANCE (fluticasone)<br><br>ZETONNA (ciclesonide) | |

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## LEUKOTRIENE MODIFIERS

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| montelukast (generic for Singulair)<br><br>**TAB**[QL]**/CHEWABLE**[AL] | montelukast **GRANULES** (generic Singulair)[CL, AL]<br><br>zafirlukast (generic Accolate)<br><br>zileuton ER (generic Zyflo CR)<br><br>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<br><br>Drug-specific criteria:<br><br>▪ **montelukast granules:** PA not required for age < 2 years |

## METHOTREXATE

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| methotrexate **PF VIAL, TABLET, VIAL** | OTREXUP (methotrexate) **SUB-Q**<br><br>RASUVO (methotrexate) **SUB-Q**<br><br>REDITREX (methotrexate) **SUB-Q**<br><br>TREXALL (methotrexate) **TABLET**<br><br>XATMEP (methotrexate) **SOLN** | Non-preferred agents require a trial of the preferred agent AND will be approved for an FDA-approved indication<br><br>Drug-specific criteria:<br><br>▪ **Xatmep**[TM]:Indicated for pediatric patients only |

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## MOVEMENT DISORDERS

| FPreferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| AUSTEDO (deutetrabenazine)[CL]<br><br>AUSTEDO XR (deutetrabenazine)[CL] ER TAB, TITRATION PACK<br><br>INGREZZA (valbenazine)[AL,CLQL] **CAPS**<br><br>tetrabenazine (generic Xenazine)[CL] | INGREZZA (valbenazine) [AL,CLQL] **INITIATION PACK**<br><br>XENAZINE (tetrabenazine)[CL] | All drugs require an FDA approved indication – ICD-10 diagnosis code required.<br><br>Non-preferred agents require a trial and failure of a preferred agent with the same indication or a clinical reason why a preferred agent in this class cannot be used.<br><br>Drug-specific criteria:<br>▪ **Austedo/Austedo XR/ Ingrezza:** 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<br>▪ **tetrabenazine:** Diagnosis of chorea with Huntington's Disease |

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# NSAIDs, ORAL

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| **COX-I SELECTIVE** | | ▪ 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 |
| diclofenac sodium (generic Voltaren) | diclofenac potassium (generic Cataflam, Zipsor) | Drug-specific criteria: |
| ibuprofen **OTC, Rx** (generic Advil, Motrin) **CHEW, DROPS, SUSP**, **TAB** | diclofenac SR (generic Voltaren-XR) | ▪ **meclofenamate**: Approvable without trial of preferred agents for menorrhagia |
| ibuprofen OTC (generic Advil, Motrin) **CAPS** | diflunisal (generic Dolobid) | ▪ **Sprix/ketorolac:** Approved for patients unable to tolerate, swallow OR absorb oral NSAIDs OR contraindication OR trial of TWO preferred oral NSAIDs |
| indomethacin **CAPS** (generic Indocin) | etodolac & SR (generic Lodine/XL) | |
| ketorolac (generic Toradol) | fenoprofen (generic Nalfon) | |
| meloxicam **TAB** (generic Mobic) | flurbiprofen (generic Ansaid) | |
| nabumetone (generic Relafen) | ibuprofen/famotidine (generic Duexis)[CL] | |
| naproxen Rx, OTC (generic Naprosyn) | indomethacin ER (generic Indocin) | |
| naproxen enteric coated | ketoprofen & ER (generic Orudis) | |
| sulindac (generic Clinoril) | ketorolac **NASAL** [QL] (generic Sprix) | |
| | meclofenamate (generic Meclomen) | |
| | mefenamic acid (generic Ponstel) | |
| | meloxicam **CAP** (generic Vivlodex)[CL, QL] | |
| | meloxicam **SUSP** (generic Mobic) | |
| | naproxen **CR** (generic Naprelan) | |
| | naproxen **SUSP** (generic Naprosyn) | |
| | naproxen sodium (generic Anaprox) | |
| | naproxen-esomeprazole (generic Vimovo) | |
| | oxaprozin (generic Daypro) | |
| | piroxicam (generic Feldene) | |
| | tolmetin (generic Tolectin) | |
| | **ALL BRAND NAME NSAIDs including:** | |
| | DUEXIS (ibuprofen/famotidine)[CL] | |
| | NALFON (fenoprofen) | |
| | RELAFEN DS (nabumetone) | |

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## NSAIDs, ORAL (Continued)

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| **NSAID/GI PROTECTANT COMBINATIONS** | | ▪ All combination agents require a clinical reason why individual agents can't be used separately |
| | diclofenac/misoprostol (generic Arthrotec) | |
| **COX-II SELECTIVE** | | |
| celecoxib (generic Celebrex) | | |

# NSAIDs, TOPICAL

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| diclofenac sodium **GEL (OTC only)**<br>PENNSAID (diclofenac)[CL] **PUMP** | diclofenac **PUMP** (generic Pennsaid)[CL]<br>diclofenac **SOLN** (generic Pennsaid)<br>FLECTOR **PATCH** (diclofenac)[CL]<br>LICART **PATCH** (diclofenac)[CL]<br>PENNSAID (diclofenac)[CL] **PACKET**<br>VOLTAREN (diclofenac)[CL] **GEL** | ▪ Non-preferred agents will be approved for patients who have failed ONE preferred agent within this drug class AND a clinical reason why patient cannot use oral dosage form. |

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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 |
|---|---|---|
| **CDK 4/6 INHIBITOR** | | ▪ 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<br>▪ Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy<br><br>Drug-specific critera<br><br>▪ **anastrozole:** May be approved for malignant neoplasm of male breast (male breast cancer)<br>▪ **Fareston/toremifene:** Require clinical reason why tamoxifen cannot be used<br>▪ **letrozole:** Approved for diagnosis of breast cancer with day supply greater than 12 – NOT approved for short term use<br>▪ **Soltamox:** May be approved with documented swallowing difficulty |
| IBRANCE (palbociclib) **CAP, TAB** | KISQALI (ribociclib)<br>KISQALI FEMARA **CO-PACK**<br>VERZENIO (abemaciclib) | |
| **CHEMOTHERAPY** | | |
| capecitabine (generic Xeloda)<br>cyclophosphamide | XELODA (capecitabine) | |
| **HORMONE BLOCKADE** | | |
| anastrozole (generic Arimidex)<br>exemestane (generic Aromasin)<br>letrozole (generic Femara)<br>tamoxifen citrate (generic Nolvadex) | ORSERDU (elacestrant)[NR]<br>SOLTAMOX **SOLN** (tamoxifen)[CL]<br>toremifene (generic Fareston)[CL] | |
| **OTHER** | | |
| | NERLYNX (neratinib)<br>PIQRAY (alpelisib)<br>lapatinib (generic Tykerb)<br>TALZENNA (talazoparib tosylate) [QL]<br>TUKYSA(tucatinib)[QL] | |

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# ONCOLOGY AGENTS, ORAL, HEMATOLOGIC

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| **ALL** | | ▪ 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<br>▪ Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy<br><br>Drug-specific critera<br><br>▪ **Hydrea®:** Requires clinical reason why generic cannot be used<br>~~▪ **Melphalan:** Requires trial of Alkeran or clinical reason Alkeran cannot be used~~<br>▪ **Purixan:** Prior authorization not required for age ≤12 or for documented swallowing disorder<br>▪ **Tabloid:** Prior authorization not required for age <19<br>▪ **Xpovio:** Indicated for relapsed or refractory multiple myeloma. Requires concomitant therapy with dexamethasone |
| mercaptopurine | PURIXAN (mercaptopurine)[AL] | |
| **AML** | | |
| | DAURISMO (glasdegib maleate)[QL]<br>IDHIFA (enasidenib)<br>REZLIDHIA (olutasidenib)[NR,QL]<br>RYDAPT (midostaurin)<br>TIBSOVO (ivosidenib)[QL]<br>VANFLYTA (quizartinib)[NR]<br>XOSPATA (gilteritinib)[QL] | |
| **CLL** | | |
| LEUKERAN (chlorambucil) | COPIKTRA (duvelisib)[QL]<br>IMBRUVICA (ibrutinib)<br>VENCLEXTA (venetoclax)<br>ZYDELIG (idelalisib) | |
| **CML** | | |
| hydroxyurea (generic Hydrea)<br>imatinib (generic Gleevec)<br>MYLERAN (busulfan) | BOSULIF (bosutinib)<br>GLEEVEC (imatinib)<br>HYDREA (hydroxyurea)<br>ICLUSIG (ponatinib)<br>SCEMBLIX (asciminib)<br>SPRYCEL (dasatinib)<br>TASIGNA (nilotinib)[CL] | |
| **MPN** | | |
| | JAKAFI (ruxolitinib) | |
| **MYELOMA** | | |
| melphalan (generic Alkeran)<br>REVLIMID[QL] (lenalidomide) | lenalidomide[QL] (generic Revlimid)<br>NINLARO (ixazomib)<br>POMALYST (pomalidomide)<br>THALOMID (thalidomide)<br>XPOVIO (selinexor)[CL] | |
| **OTHER** | | |
| MATULANE (procarbazine)<br>TABLOID (thioguanine)<br>tretinoin (generic Vesanoid)[AL] | BRUKINSA (zanubrutinib[QL]<br>CALQUENCE (acalabrutinib)[QL]<br>INREBIC (fedratinib dihydrochloride)[QL]<br>INQOVI (decitabine/cedazuridine)<br>VONJO (pacritinib)[QL]<br>ZOLINZA (vorinostat) | |

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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, LUNG

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| **ALK** | | ▪ 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<br>▪ Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy |
| ALECENSA (alectinib) | ALUNBRIG (brigatinib)^QL^<br>LORBRENA (lorlatinib)^QL^<br>ZYKADIA (ceritinib) **CAPS, TAB** | |
| **ALK / ROS1 / NTRK** | | |
| | ROZLYTREK (entrectinib)^AL,QL^<br>XALKORI (crizotinib) | |
| **EGFR** | | |
| erlotinib (generic for Tarceva)<br>TAGRISSO (osimertinib) | EXKIVITY (mobocertinib)^QL^<br>gefitinib (generic Iressa)^NR^<br>GILOTRIF (afatinib)<br>IRESSA (gefitinib)<br>TARCEVA (erlotinib)<br>VIZIMPRO (dacomitinib)^QL^ | |
| **OTHER** | | |
| | GAVRETO (pralsetinib)^QL^<br>HYCAMTIN (topotecan)<br>KRAZATI (adagrasib)^NR^<br>LUMAKRAS (sotrasib)^QL^<br>RETEVMO (selpercatinib)^AL^<br>TABRECTA (capmatinib)^QL^<br>TEPMETKO (tepotinib)^QL^ | |

**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 |
|---|---|---|
| temozolomide (generic Temodar) | AYVAKIT (avapritinib)[AL,QL]<br>BALVERSA (erdafitinib)<br>CAPRELSA (vandetanib)<br>COMETRIQ (cabozantinib)<br>HEXALEN (altretamine)<br>JAYPIRCA (pirtobrutinib)[NR]<br>KOSELUGO (selumetinib)[AL]<br>LONSURF (trifluridine/tipiracil)<br>LYNPARZA (olaparib)<br>LYTGOBI (futibatinib)[NR]<br>PEMAZYRE (pemigatinib)[QL]<br>QINLOCK (ripretinib)<br>RUBRACA (rucaparib)<br>STIVARGA (regorafenib)<br>TAZVERIK (tazemetostat)[AL]<br>TURALIO (pexidartinib)[QL]<br>TRUSELTIQ (infigratinib) **CAPS**<br>VITRAKVI (larotrectinib) **CAPS, SOLN**<br>ZEJULA (niraparib) **CAPS, TABS**[NR] | ▪ 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<br>▪ Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy |

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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, PROSTATE

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| abiraterone (generic Zytiga)[AL,QL]<br><br>bicalutamide (generic Casodex)<br><br>flutamide<br><br>XTANDI (enzalutamide)[AL,QL] **CAP, TAB** | AKEEGA (niraparib/abiraterone)[NR]<br><br>EMCYT (estramustine)<br><br>ERLEADA (apalutamide)[QL]<br><br>nilutamide (generic Nilandron)<br><br>NUBEQA (darolutamide) [QL]<br><br>ORGOVYX (relugolix)[AL]<br><br>YONSA (abiraterone acetonide, submicronized)<br><br>ZYTIGA (abiraterone)[AL,QL] | ▪ 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<br>▪ Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy |

# ONCOLOGY AGENTS, ORAL, RENAL

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| SUTENT (sunitinib)<br><br>VOTRIENT (pazopanib) | AFINITOR DISPERZ (everolimus)[CL]<br><br>CABOMETYX (cabozantinib)<br><br>everolimus (generic Afinitor)<br><br>everolimus **SUSP** (generic Afinitor Disperz)<br><br>FOTIVDA (tivozanib)<br><br>INLYTA (axitinib)<br><br>LENVIMA (lenvatinib)<br><br>NEXAVAR (sorafenib)<br><br>sorafenib (generic Nexavar)<br><br>sunitinib malate (generic Sutent)<br><br>WELIREG (belzutifan)[QL] | ▪ 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<br>▪ Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy |

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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, SKIN

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| **BASAL CELL** | | ▪ 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<br>▪ Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy |
| ERIVEDGE (vismodegib) | ODOMZO (sonidegib)[CL] | |
| **BRAF MUTATION** | | |
| MEKINIST (trametinib)<br><br>TAFINLAR (dabrafenib) | BRAFTOVI (encorafenib)<br><br>COTELLIC (cobimetinib)<br><br>MEKINIST (trametinib)[NR] **SOLN**<br><br>MEKTOVI (binimetinib)<br><br>TAFINLAR (dabrafenib)[NR] **SUSP**<br><br>ZELBORAF (vemurafenib) | |

## OPHTHALMICS, ALLERGIC CONJUNCTIVITIS

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| ALREX (loteprednol 0.2%)<br><br>cromolyn (generic Opticrom)<br><br>ketotifen **OTC** (generic Zaditor)<br><br>olopatadine **OTC** (Pataday once daily)<br><br>olopatadine **OTC** (Pataday twice daily) | ALOCRIL (nedocromil)<br><br>ALOMIDE (lodoxamide)<br><br>azelastine (generic Optivar)<br><br>BEPREVE (bepotastine besilate)<br><br>bepotastine besilate (generic Bepreve)<br><br>epinastine (generic Elestat)<br><br>LASTACAFT (alcaftadine)<br><br>LASTACAFT (alcaftadine) **OTC**<br><br>olopatadine **DROPS** (generic Pataday)<br><br>olopatadine 0.1% (generic Patanol)<br><br>PATADAY XS (olopatadine 0.7%)<br><br>PATADAY **OTC** (olopatadine 0.2%)<br><br>ZERVIATE (certirizine)[AL] | ▪ Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class |

## OPHTHALMICS, ANTIBIOTICS

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| **FLUOROQUINOLONES** | | ▪ Non-preferred agents will be approved for patients who have failed a one-month trial of TWO preferred agent within this drug class<br>▪ **Azasite®:** Approval only requires trial of erythromycin<br><br>Drug-specific criteria:<br><br>▪ **Natacyn®:** Approved for documented fungal infection |
| ciprofloxacin **SOLN** (generic Ciloxan)<br><br>ofloxacin (generic Ocuflox) | BESIVANCE (besifloxacin)<br><br>CILOXAN (ciprofloxacin)<br><br>gatifloxacin 0.5% (generic Zymaxid)<br><br>levofloxacin<br><br>MOXEZA (moxifloxacin)<br><br>moxifloxacin (generic Vigamox)<br><br>moxifloxacin (generic Moxeza)<br><br>VIGAMOX (moxifloxacin) | |
| **MACROLIDES** | | |
| erythromycin | AZASITE (azithromycin)[CL] | |
| **AMINOGLYCOSIDES** | | |
| gentamicin **SOLN**<br><br>tobramycin (generic Tobrex drops) | TOBREX **OINT** (tobramycin) | |
| **OTHER OPHTHALMIC AGENTS** | | |
| bacitracin/polymyxin B (generic Polysporin)<br><br>polymyxin B/trimethoprim (generic Polytrim) | bacitracin<br><br>NATACYN (natamycin)[CL]<br><br>neomycin/bacitracin/polymyxin B **OINT**<br><br>neomycin/polymyxin B/gramicidin<br><br>NEOSPORIN (neomycin/polymyxin B/gramcidin)<br><br>sulfacetamide **SOLN** (generic Bleph-10)<br><br>sulfacetamide **OINT** | |

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# OPHTHALMICS, ANTIBIOTIC-STEROID COMBINATIONS

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| neomycin/polymyxin/dexamethasone (generic Maxitrol)<br><br>sulfacetamide/prednisolone<br><br>TOBRADEX **SUSP, OINT** (tobramycin and dexamethasone)<br><br>tobramycin/dexamethasone **SUSP** (generic TobraDex) *Falcon manufacturer only* | BLEPHAMIDE (prednisolone and sulfacetamide)<br><br>BLEPHAMIDE S.O.P.<br><br>neomycin/polymyxin/HC<br><br>neomycin/bacitracin/poly/HC<br><br>PRED-G **SUSP, OINT** (prednisolone/gentamicin)<br><br>tobramycin/dexamethasone **SUSP** (generic TobraDex) *all other manufacturers*<br><br>TOBRADEX S.T. (tobramycin and dexamethasone)<br><br>ZYLET (loteprednol, tobramycin) | ▪ Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class |

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# OPHTHALMICS, ANTI-INFLAMMATORIES

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| **CORTICOSTEROIDS** | | ▪ **ALL sub-classes unless listed below:** Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents<br><br>▪ **NSAID class:** Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within the same sub-class |
| fluorometholone 0.1% (generic FML) **OINT**<br><br>LOTEMAX **SOLN** (loteprednol 0.5%)<br><br>MAXIDEX (dexamethasone)<br><br>PRED MILD (prednisolone 0.12%) | dexamethasone (generic Maxidex)<br><br>difluprednate (generic Durezol)<br><br>DUREZOL (difluprednate)<br><br>FLAREX (fluorometholone)<br><br>FML (fluorometholone 0.1% **SOLN**)<br><br>FML FORTE (fluorometholone 0.25%)<br><br>FML S.O.P. (fluorometholone 0.1%)<br><br>INVELTYS (loteprednol etabonate)<br><br>LOTEMAX **OINT, GEL** (loteprednol)<br><br>loteprednol **GEL** (generic Lotemax Gel)<br><br>loteprednol 0.5% **SOLN** (generic Lotemax SOLN)<br><br>prednisolone acetate 1% (generic Omnipred, Pred Forte)<br><br>prednisolone sodium phosphate<br><br>prednisolone sodium phosphate 1% | |
| **NSAID** | | |
| diclofenac (generic Voltaren)<br><br>ketorolac 0.5% (generic Acular) | ACUVAIL (ketorolac 0.45%)<br><br>BROMSITE (bromfenac)<br><br>bromfenac 0.09% (generic Bromday)<br><br>flurbiprofen (generic Ocufen)<br><br>ILEVRO (nepafenac 0.3%)<br><br>ketorolac LS 0.4% (generic Acular LS)<br><br>NEVANAC (nepafenac)<br><br>PROLENSA (bromfenac 0.07%) | |

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## OPHTHALMICS, ANTI-INFLAMMATORY / IMMUNOMODULATORS

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| RESTASIS (cyclosporine)<br><br>RESTASIS MULTIDOSE (cyclosporine)<br><br>XIIDRA (lifitegrast) | CEQUA (cyclosporine) [QL]<br><br>EYSUVIS (loteprednol etabonate)[QL]<br><br>MIEBO (perfluorohexyloctane)[NR]<br><br>TYRVAYA (varenicline tartrate)[QL]<br><br>VERKAZIA (cyclosporine emulsion)[NR] | • Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class |

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# OPHTHALMICS, GLAUCOMA

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| **MIOTICS** | | ▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class<br>Drug-specific criteria:<br>▪ **Rhopressa and Rocklatan:** Electronically approved for patients who have a trial of ONE generic agent, within ophthalmics - glaucoma within 60 days |
| pilocarpine | PHOSPHOLINE IODIDE (echothiophate iodide)<br>VUITY (pilocarpine) | |
| **SYMPATHOMIMETICS** | | |
| ALPHAGAN P (brimonidine 0.15%)<br>brimonidine 0.2% (generic for Alphagan) | ALPHAGAN P (brimonidine 0.1%)<br>apraclonidine (generic for Iopidine)<br>brimonidine P 0.15%<br>brimonidine 0.1% (generic Alphagan P 0.1%)[NR] | |
| **BETA BLOCKERS** | | |
| levobunolol (generic Betagan)<br>timolol (generic Timoptic) | betaxolol (generic Betoptic)<br>BETIMOL (timolol)<br>BETOPTIC S (betaxolol)<br>carteolol (generic Ocupress)<br>timolol (generic Istalol)<br>timolol (generic Timoptic Ocudose)<br>TIMOPTIC OCUDOSE<br>TIMOPTIC XE (timolol gel forming solution) | |
| **CARBONIC ANHYDRASE INHIBITORS** | | |
| dorzolamide (generic for Trusopt) | AZOPT (brinzolamide)<br>brinzolamide (generic Azopt) | |
| **PROSTAGLANDIN ANALOGS** | | |
| latanoprost (generic Xalatan)<br>TRAVATAN Z (travoprost) | bimatoprost (generic Lumigan)<br>IYUZEH (latanoprost)[NR]<br>tafluprost (generic Zioptan)[NR]<br>travoprost (generic Travatan Z)<br>VYZULTA (latanoprostene)<br>XALATAN (latanoprost)<br>ZIOPTAN (tafluprost) | |
| **COMBINATION DRUGS** | | |
| COMBIGAN (brimonidine/timolol)<br>dorzolamide/timolol (generic Cosopt) | brimonidine/timolol (generic Combigan)<br>COSOPT (dorzolamide/timolol)<br>dorzolamide/timolol PF (generic Cosopt PF)<br>SIMBRINZA (brinzolamide/brimonidine) | |
| **OTHER** | | |
| RHOPRESSA (netarsudil)[CL]<br>ROCKLATAN (netarsudil and latanoprost)[CL] | | |

# OPIOID DEPENDENCE TREATMENTS

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| buprenorphine **SL**<br><br>buprenorphine/naloxone **TAB (SL)**<br><br>SUBOXONE **FILM** (buprenorphine/ naloxone) | buprenorphine/naloxone **FILM**<br><br>LUCEMYRA (lofexidine)[CL,QL]<br><br>ZUBSOLV (buprenorphine/naloxone) | Opioid Dependence Treatment PA Form<br><br>Opioid Dependence Treatment Informed Consent<br><br>▪ Non-preferred agents require a treatment failure of a preferred drug or patient-specific documentation of why a preferred product is not appropriate for the patient.<br><br>Drug-specific criteria:<br><br>▪ **Lucemyra**: Approved for FDA approved indication and dosing per label. Trial of preferred product not required. |

# OPIOID-REVERSAL TREATMENTS

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| naloxone **NASAL, SYR, VIAL**<br><br>naltrexone **TAB** | KLOXXADO (naloxone) **NASAL**<br><br>naloxone (generic Narcan)[NR] **OTC NASAL**<br><br>NARCAN (naloxone) **NASAL Rx**<br><br>NARCAN (naloxone)[NR] **NASAL OTC**<br><br>OPVEE (nalmefene)[AL,NR] **NASAL**<br><br>ZIMHI (naloxone) **SYR** | • Non-preferred agents will be approved with documentation of why preferred products within this drug class are not appropriate for the patient |

# 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) | ▪ Non-preferred agents will be approved for patients who have failed a trial of the preferred agent within this drug class |

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## OTIC ANTIBIOTICS

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| CIPRO HC (ciprofloxacin/ hydrocortisone)<br><br>CIPRODEX (ciprofloxacin/dexamethasone)<br><br>ciprofloxacin/dexamethasone (generic for CIPRODEX)<br><br>neomycin/polymyxin/hydrocortisone (generic Cortisporin)<br><br>ofloxacin (generic Floxin) | ciprofloxacin<br><br>ciprofloxacin/fluocinolone (generic Otovel)<br><br>CORTISPORIN TC (colistin/neomycin thonzonium/hydrocortisone<br><br>OTOVEL (ciprofloxacin/fluocinolone) | ▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class |

## SEDATIVE HYPNOTICS

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| **BENZODIAZEPINES** | | **Benzodiazepines Criteria**<br><br>▪ Non-preferred agents require a trial of the preferred benzodiazepine agent<br>▪ temazepam 7.5/22.5 mg: Requires clinical reason why 15 mg/30 mg cannot be used |
| temazepam 15 mg, 30 mg (generic for Restoril) | estazolam (generic for ProSom)<br><br>temazepam (generic for Restoril) 7.5 mg, 22.5 mg<br><br>triazolam (generic for Halcion) | |
| **OTHERS** | | **Others Criteria**<br><br>▪ Non-preferred agents require a trial of TWO preferred agents in the OTHERS sub-category<br>▪ **Silenor/ doxepin Tablet**: Must meet ONE of the following:<br>○ Contraindication to all of the preferred oral sedative hypnotics agents in the OTHERS sub-category<br>○ Medical necessity for doxepin dose < 10 mg<br>○ Age greater than 65 years old or hepatic impairment (3 mg dose will be approved if this criteria is met)<br>▪ **zolpidem/zolpidem ER**: Maximum daily dose for females: zolpidem 5 mg; zolpidem ER 6.25 mg<br>▪ **zolpidem SL**: Requires clinical reason why half of zolpidem tablet cannot be used or documented swallowing disorder |
| zaleplon (generic for Sonata)<br><br>zolpidem (generic for Ambien) | BELSOMRA (suvorexant) [AL,QL]<br><br>DAYVIGO (lemborexant) [AL,QL]<br><br>doxepin (generic for Silenor)<br><br>EDLUAR (zolpidem sublingual)<br><br>eszopiclone (generic for Lunesta)<br><br>HETLIOZ (tasimelteon)[CL]<br><br>HETLIOZ LQ (tasimelteon)**SUSP** [AL,QL]<br><br>QUVIVIQ (daridorexant)[QL]<br><br>ramelteon (generic for Rozerem)<br><br>tasimelteon (generic for Hetlioz) [CL,NR]<br><br>zolpidem[NR,QL] **CAP**<br><br>zolpidem ER (generic for Ambien CR)<br><br>zolpidem SL (generic for Intermezzo) | |

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# SICKLE CELL ANEMIA TREATMENT [AL]

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| DROXIA (hydroxyurea)<br><br>ENDARI (L-glutamine)[CL] | OXBRYTA (voxelotor)[CL]<br><br>SIKLOS (hydroxyurea) | Drug-Specific Criteria<br><br>▪ **Endari:** Patient must have documented two or more hospital admissions per year due to sickle cell crisis despite maximum hydroxyurea dosage.<br>▪ **Oxbryta**: Not inidcated 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 $\leq$ 10.5 g/dL; AND patient is not receiving concomitant, prophylactic blood tranfusion therapy<br>▪ **Siklos**: May be approved for use in patients ages 2 to 17 years old without a trial of Droxia |

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## STEROIDS, TOPICAL

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| **LOW POTENCY** | | ▪ Low Potency Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class |
| DERMA-SMOOTHE FS (fluocinolone)<br><br>hydrocortisone OTC & RX **CREAM, LOTION, OINT (Rx only)**<br><br>hydrocortisone/aloe **OINT** | alclometasone dipropionate (generic Aclovate)<br><br>DESONATE (desonide) **GEL**<br><br>desonide **LOTION** (generic Desowen)<br><br>desonide **CREAM, OINT** (generic Desowen, Tridesilon)<br><br>fluocinolone 0.01% **OIL** (generic DERMA-SMOOTHE-FS)<br><br>hydrocortisone/aloe **CREAM**<br><br>hydrocortisone **OTC OINT**<br><br>HYDROXYM (hydrocortisone)[NR] **GEL**<br><br>TEXACORT (hydrocortisone) | |
| **MEDIUM POTENCY** | | ▪ Medium Potency Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class |
| fluticasone propionate **CREAM, OINT** (generic for Cutivate)<br><br>mometasone furoate **CREAM, OINT, SOLN** (generic for Elocon) | betamethasone valerate (generic Luxiq)<br><br>clocortolone (generic Cloderm)<br><br>fluocinolone acetonide (generic Synalar)<br><br>flurandrenolide (generic Cordran)<br><br>fluticasone propionate **LOTION** (generic Cutivate)<br><br>hydrocortisone butyrate (generic Locoid)<br><br>hydrocortisone butyrate/emoll (generic Locoid Lipocream)<br><br>hydrocortisone valerate (generic Westcort)<br><br>PANDEL (hydrocortisone probutate 0.1%)<br><br>prednicarbate (generic Dermatop) | |

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## STEROIDS, TOPICAL (Continued)

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| **HIGH POTENCY** | | ▪ High Potency Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class |
| triamcinolone acetonide **OINTMENT, CREAM**<br><br>triamcinolone **LOTION** | amcinonide **CREAM, LOTION, OINTMENT**<br><br>betamethasone dipropionate<br><br>betamethasone / propylene glycol<br><br>betamethasone valerate<br><br>desoximetasone<br><br>diflorasone diacetate<br><br>fluocinonide **SOLN**<br><br>fluocinonide **CREAM, GEL, OINT**<br><br>fluocinonide emollient<br><br>halcinonide **CREAM** (generic Halog)<br><br>HALOG (halcinonide) **CREAM**, **OINT, SOLN**<br><br>KENALOG AEROSOL (triamcinolone)<br><br>SERNIVO (betamethasone dipropionate)<br><br>triamcinolone **SPRAY** (generic Kenalog spray)<br><br>VANOS (fluocinonide) | |
| **VERY HIGH POTENCY** | | ▪ Very High Potency Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class |
| clobetasol emollient (generic Temovate-E)<br><br>clobetasol propionate **CREAM**, **OINT, SOLN**<br><br>halobetasol propionate (generic Ultravate) | APEXICON-E (diflorasone)<br><br>BRYHALI (halobetasol prop) **LOTION**<br><br>clobetasol **SHAMPOO, LOTION**<br><br>clobetasol propionate **GEL**, **FOAM, SPRAY**<br><br>halobetasol propionate **FOAM** (generic Lexette) [AL,QL]<br><br>IMPEKLO (clobetasol) **LOTION**[AL]<br><br>LEXETTE(halobetasol propionate) [AL,QL]<br><br>OLUX-E /OLUX/OLUX-E CP (clobetasol) | |

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# STIMULANTS AND RELATED AGENTS [AL]

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| **CNS STIMULANTS** | | ▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class<br><br>Drug-specific criteria:<br><br>▪ **Procentra/ dextroamphetamine solution:** May be approved with documentation of swallowing disorder<br>▪ **Zenzedi®:** Requires clinical reason generic dextroamphetamine IR cannot be used |
| **Amphetamine type** | | |
| ADDERALL XR (amphetamine salt combo)<br><br>amphetamine salt combination IR<br><br>DYANAVEL XR (amphetamine)[QL]<br><br>VYVANSE (lisdexamfetamine)[QL] **CAPS, CHEWABLE** | ADZENYS XR (amphetamine)<br><br>amphetamine ER (generic Adzenys ER) **SUSP**<br><br>amphetamine salt combination ER (generic Adderall XR)<br><br>amphetamine sulfate (generic Evekeo)<br><br>dextroamphetamine (generic for Dexedrine)<br><br>dextroamphetamine **SOLN** (generic Procentra)<br><br>dextroamphetamine ER (generic Dexedrine ER)<br><br>EVEKEO ODT (amphetamine sulfate)<br><br>lisdexamfetamine (generic<br><br>Vyvanse)Chew)[AL,NR,QL] **CHEW**<br><br>lisdexamfetamine (generic<br><br>Vyvanse)[AL,NR,QL] **CAP**<br><br>methamphetamine (generic Desoxyn)<br><br>MYDAYIS (amphetamine salt combo)[QL]<br><br>methamphetamine (generic Desoxyn)<br><br>XELSTRYM (detroamphetamine)[AL,NR,QL] **PATCH**<br><br>ZENZEDI (dextroamphetamine) | |

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## STIMULANTS AND RELATED ADHD DRUGS (Continued)[AL]

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| **Methylphenidate type** | | ▪ Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class<br>▪ Maximum accumulated dose of 108mg per day for ages < 18<br>▪ Maximum accumulated dose of 72mg per day for ages > 19<br><br>Drug-specific criteria:<br><br>▪ **Daytrana/ methylphenidate Patch :** May be approved in history of substance use disorder by parent, caregiver, or patient. May be approved with documentation of difficulty swallowing<br><br>▪ **QuilliChew ER**: May be approved for children ≤ 12 years of age OR with documentation of difficulty swallowing |
| CONCERTA (methylphenidate ER)[QL] 18 mg, 27 mg, 36 mg, 54 mg<br><br>DAYTRANA **PATCH** (methylphenidate)[QL]<br><br>dexmethylphenidate (generic for Focalin IR)<br><br>dexmethylphenidate (generic Focalin XR)<br><br>METHYLIN **SOLN** (methylphenidate)<br><br>methylphenidate (generic Ritalin)<br><br>methylphenidate **SOLN** (generic Methylin)<br><br>QUILLICHEW ER **CHEWTAB** (methylphenidate)<br><br>QUILLIVANT XR (methylphenidate)**SUSP** | ADHANSIA XR (methylphenidate) [QL]<br><br>APTENSIO XR (methylphenidate)<br><br>AZSTARYS (serdexmethylphenidate and dexmethylphenidate)[QL]<br><br>COTEMPLA XR-ODT (methylphenidate)[QL]<br><br>FOCALIN IR (dexmethylphenidate)<br><br>FOCALIN XR (dexmethylphenidate)<br><br>JORNAY PM (methylphenidate) [QL]<br><br>methylphenidate CHEW<br><br>methylphenidate ER (generic Relexxii 45 mg and 63 mg)[NR,QL]<br><br>methylphenidate 30/70 (generic Metadate CD)<br><br>methylphenidate 50/50 (generic Ritalin LA)<br><br>methylphenidate ER **CAP** (generic Aptensio XR)[QL]<br><br>methylphenidate ER 18 mg, 27 mg, 36 mg, 54 mg (generic Concerta)[QL]<br><br>methylphenidate ER (generic Metadate ER)<br><br>methylphenidate ER 72 mg (generic RELEXXII)[QL]<br><br>methylphenidate ER (generic Ritalin SR)<br><br>methylphenidate TD24[AL] **PATCH** (generic Daytrana)<br><br>RELEXXII ER (methylphenidate 45mg and 63mg)[AL,NR,QL] **TAB**<br><br>RITALIN (methylphenidate) | |

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## STIMULANTS AND RELATED ADHD DRUGS (Continued)[AL]

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| **MISCELLANEOUS** | | **Note:** generic guanfacine IR and clonidine IR are available without prior authorization |
| atomoxetine (generic Strattera)[QL]<br>guanfacine ER (generic Intuniv)[QL]<br>QELBREE (viloxazine)[QL] | clonidine ER (generic Kapvay)[QL]<br>STRATTERA (atomoxetine) | |
| **ANALEPTICS** | | Drug-specific criteria: |
| | armodafinil (generic Nuvigil)[CL]<br>modafanil (generic Provigil)[CL]<br>SUNOSI (solriamfetol)[CL,QL]<br>WAKIX (pitolisant)[CL,QL] | ▪ **armodafinil and *Sunosi*:** Require trial of modafinil<br>▪ **armodafinil and modafinil:** approved only for:<br>○ Sleep Apnea with documentation/confirmation via sleep study and documentation that C-PAP has been maxed<br>○ Narcolepsy with documentation of diagnosis via sleep study<br>○ 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<br>▪ **Sunosi** approved only for:<br>○ Sleep Apnea with documentation/confirmation via sleep study and documentation that C-PAP has been maxed<br>○ Narcolepsy with documentation of diagnosis via sleep study<br>▪ **Wakix**: approved only for excessive daytime sleepiness in adults with narcolepsy with documentation of narcolepsy diagnosis via sleep study |

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# THROMBOPOIESIS STIMULATING PROTEINS CL

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| PROMACTA (eltrombopag) **TAB** | DOPTELET (avatrombopag)<br><br>MULPLETA (lusutrombopag)<br><br>PROMACTA (eltrombopag) **SUSP**<br><br>TAVALISSE (fostamatinib) | ▪ All agents will be approved with FDA-approved indication, ICD-10 code is required.<br>▪ Non-preferred agents require a trial of a preferred agent with the same indication or a contraindication.<br>Drug-Specific Criteria<br>▪ **Doptelet/Mulpleta**: 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 |

*Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.*
CL – Prior Authorization / Class Criteria apply
QL – Quantity/Duration Limit
AL– Age Limit
NR – Product was not reviewed - New Drug criteria will apply

5. **Adjournment / Old Business**

   a. No old business topics were discussed by the committee.
   b. A vote to conclude the meeting was made at 12:01 PM CST.

| **(1st) Motion:** Avery | **(2nd) Motion:** Kaspar-Cope |
|---|---|
| **Vote to conclude meeting unanimously approved by all in attendance.** | |

**The next Nebraska Medicaid Pharmaceutical and Therapeutics (P&T) Committee meeting is scheduled for:**

**Date:**
Wednesday, May 8th, 2024

**Time:**
9:00 AM – 5:00 PM CST

**Location:**
Mahoney State Park, Peter Kiewit Lodge
28500 West Park Hwy
Ashland, NE 68003

Recorded by: Jessica Czechowski, PharmD – Pharmacist Account Executive
Magellan Rx Management, Magellan Medicaid Administration, LLC.

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