DIVISION OF MEDICAID AND LONG-TERM CARE
Nebraska Department of Health and Human Services

PHARMACEUTICAL AND THERAPEUTICS (P&T) COMMITTEE MEETING MINUTES

Wednesday, May 8th 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.
Claire Baker, M.D.
Andrew Bendlin, Pharm.D.
Cassie Cowles, APRN
Allison Dering-Anderson, Pharm.D. **(Chair)**
Stephen Dolter, M.D.
Wade Fornander, M.D. **(Vice Chair)**
C. Jose Friesen, M.D. (Morning Only)
Jennifer Hill, M.D.
Linda Sobeski, Pharm.D.
Sarah Stewart-Bouckaert, Pharm.D.
Bradley Sundsboe, Pharm.D.
Laura Klug, 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
ShaLeigh Hammons, CPhT, Account Operations Executive

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

Committee Members Excused:
Kaspar-Cope, Rachelle M.D.
Stephen Salzbrenner, M.D
Joyce Juracek, Pharm. D.
Jessica Pohl, 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 Monday, April 8th. 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.** Introduction of new committee members. Dianne Garside welcomed Laura Klug, Pharm.D. and Stephen Salzbrenner, M.D. as the newest committee members. Dr. Salzbrenner was unable to attend.
   - **c.** Roll Call: See list above.
   - **d.** Conflict of Interest: No new conflicts of interest were reported.
   - **e.** Approval of November 15th, 2023 P&T Committee Meeting Minutes.

Approval of November 15th, 2023 P&T Committee Meeting Minutes							
(1st) Motion: Friesen							
(2nd) Motion: Hill							
Discussion: Approve 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			Klug, Laura, Pharm.D.	X		
Cowles, Cassie, APRN	X			Sobeski, Linda, Pharm.D.	X		
Dering-Anderson, Allison, Pharm.D. (Chair) ***Votes only in the event of a tie***				Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.			X	Sundsboe, Bradley, Pharm.D.	X		
Fornander, Wade, M.**D.** (Vice Chair)	X						

f. Department information: Dianne Garside notified the committee and public attendees of P&T committee member updates. She announced the resignation of committee members, Dr. Gary Elsasser and Dr. Lauren Nelson, and provided updates on the current open positions on the committee.

2. **Public Testimony**

Speaker Order	DRUG CLASS	Drug Name	PDL Status	Speaker Name	Affiliation
1	Cystic Fibrosis,Oral	Trikafta	NP	Chad Duncan	Vertex Pharmaceuticals
2	Cystic Fibrosis, Oral	Orkambi	NP	Chad Duncan	Vertex Pharmaceuticals
3	Growth Hormones			Monina Cabrera, M.D.	Children's Nebraska
4	Growth Hormones			Sophia Schmidt	Children's Nebraska
5	Growth Hormes	Sogroya	NP	Charles DiPaula	Novo Nordisk
6	HAE Treatments	Orladeyo	NP	Giuseppe Miranda	BioCryst
7	Lipotropics, Other	Repatha	NP	Sarah Smith	Amgen

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. Chad Duncan-deferred for Orkambi

3. **Committee Closed Session**

(1st) Motion: Avery	**(2nd) Motion:** Fornander
Committee Closed Session unanimously approved by all in attendance.	

4. **Resume Open Session**

(1st) Motion: Baker	**(2nd) Motion:** Friesen
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. Consent Agenda

Consent Agenda

(1st) Motion: Hill

(2nd) Motion: Avery

Discussion:
Committee removed three Consent Agenda categories and added them to Therapeutic Class Reviews: Anticoagulants; Opioid Dependence Treatments; and Analgesics, Opioid Long-Acting. The Committee approved the amended Consent Agenda.

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			Klug, Laura, Pharm.D.	X		
Cowles, Cassie, APRN	X			Sobeski, Linda, Pharm.D.	X		
Dering-Anderson, Allison, Pharm.D. (Chair) **Votes ONLY in the event of a tie**				Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley, Pharm.D.	X		
Fornander, Wade, M.**D**. (Vice Chair)	X						

Consent Agenda: Therapeutic categories (TC) with unchanged recommendations unless otherwise indicated.	
ANALGESICS, OPIOIDS LONG-ACTING **(REMOVED)**	HYPOGLYCEMICS, ALPHA-GLUCOSIDASE INHIBITORS
ANGIOTENSIN MODULATORS	HYPOGLYCEMICS, MEGLITINIDES
ANGIOTENSIN MODULATOR COMBINATIONS	HYPOGLYCEMICS, METOFORMINS
ANTIBIOTICS, INHALED	HYPOGLYCEMICS, SULFONYLUREAS
ANTICOAGULANTS **(REMOVED)**	HYPOGLYCEMICS, TZDS
ANTIFUNGALS, ORAL	IMMUNOSUPPRESSIVES, ORAL
ANTIMIGRAINE AGENTS, TRIPTANS	LINCOSAMIDES/ OXAZOLIDINONES/ STREPTOGRAMINS
ANTIPARASITICS, TOPICALS	LIPOTROPICS, OTHER
ANTIVIRALS, ORAL	MACROLIDES AND KETOLIDES
BONE RESORPTION SUPPRESSION AND RELATED AGENTS	MULTIPLE SCLEROSIS AGENTS
BPH- BENIGN PROSTATIC HYPERPLASIA AGENTS	NITROFURAN DERIVATIVES
CALCIUM CHANNEL BLOCKERS	OPIOID DEPENDENCE TREATMENTS **(REMOVED)**
CEPHALOSPORINS AND RELATED ANTIBIOTICS	PANCREATIC ENZYMES
FLUOROQUINOLONES, ORAL	PENICILLINS
GLUCAGON AGENTS	PLATELET AGGREGATION INHIBITORS
HAE TREATMENTS	SINUS NODE INHIBITORS
HEPATITIS B AGENTS	TETRACYCLINES **(Removed after previous acceptance revoked)**
HEPATITIS C AGENTS	UTERINE DISORDER TREATMENTS
HEPATITIS C COURSES	

b. Therapeutic Class Reviews

Review Agenda – ACNE AGENTS, 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			Klug, Laura, Pharm.D.	X		
Cowles, Cassie, APRN	X			Sobeski, Linda, Pharm.D.	X		
Dering-Anderson, Allison, Pharm.D. (Chair) **Votes ONLY in the event of a tie**				Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley, Pharm.D.	X		
Fornander, Wade, M.D. (Vice Chair)	X						

Review Agenda – ANALGESICS, OPIOIDS SHORT-ACTING							
(1st) Motion: Sobeski							
(2nd) Motion: Cowles							
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			Klug, Laura, Pharm.D.	X		
Cowles, Cassie, APRN	X			Sobeski, Linda, Pharm.D.	X		
Dering-Anderson, Allison, Pharm.D. (Chair) **Votes ONLY in the event of a tie**				Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley, Pharm.D.	X		
Fornander, Wade, M.D. (Vice Chair)	X						

Review Agenda – ANDROGENIC AGENTS							
(1st) Motion: Avery							
(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			Klug, Laura, Pharm.D.	X		
Cowles, Cassie, APRN	X			Sobeski, Linda, Pharm.D.	X		
Dering-Anderson, Allison, Pharm.D. (Chair) **Votes ONLY in the event of a tie**				Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley, Pharm.D.	X		
Fornander, Wade, M.D. (Vice Chair)	X						

Review Agenda – ANTIBIOTICS, GASTROINTESTINAL							
(1st) Motion: Avery							
(2nd) Motion: Cowles							
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			Klug, Laura, Pharm.D.	X		
Cowles, Cassie, APRN	X			Sobeski, Linda, Pharm.D.	X		
Dering-Anderson, Allison, Pharm.D. (Chair) **Votes ONLY in the event of a tie**				Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley, Pharm.D.	X		
Fornander, Wade, M.D. (Vice Chair)	X						

Review Agenda – ANTIBIOTICS, TOPICAL							
(1st) Motion: Hill							
(2nd) Motion: Friesen							
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			Klug, Laura, Pharm.D.	X		
Cowles, Cassie, APRN	X			Sobeski, Linda, Pharm.D.	X		
Dering-Anderson, Allison, Pharm.D. (Chair) **Votes ONLY in the event of a tie**				Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley, Pharm.D.	X		
Fornander, Wade, M.D. (Vice Chair)	X						

Review Agenda – ANTIBIOTICS, VAGINAL

(1st) Motion: Avery

(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			Klug, Laura, Pharm.D.	X		
Cowles, Cassie, APRN	X			Sobeski, Linda, Pharm.D.	X		
Dering-Anderson, Allison, Pharm.D. (Chair) **Votes ONLY in the event of a tie**				Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley, Pharm.D.	X		
Fornander, Wade, M.D. (Vice Chair)	X						

Review Agenda – ANTIEMETICS/ ANTIVERTIGO AGENTS

(1st) Motion: Fornander

(2nd) Motion: Cowles

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			Klug, Laura, Pharm.D.	X		
Cowles, Cassie, APRN	X			Sobeski, Linda, Pharm.D.	X		
Dering-Anderson, Allison, Pharm.D. (Chair) **Votes ONLY in the event of a tie**				Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley, Pharm.D.	X		
Fornander, Wade, M.D. (Vice Chair)	X						

Review Agenda – ANTIFUNGALS, TOPICAL							
(1st) Motion: Cowles							
(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			Klug, Laura, Pharm.D.	X		
Cowles, Cassie, APRN	X			Sobeski, Linda, Pharm.D.	X		
Dering-Anderson, Allison, Pharm.D. (Chair) **Votes ONLY in the event of a tie**				Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley, Pharm.D.	X		
Fornander, Wade, M.D. (Vice Chair)	X						

Review Agenda – ANTIMIGRAINE AGENTS, OTHER							
(1st) Motion: Avery							
(2nd) Motion: Sobeski							
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			Klug, Laura, Pharm.D.	X		
Cowles, Cassie, APRN	X			Sobeski, Linda, Pharm.D.	X		
Dering-Anderson, Allison, Pharm.D. (Chair) **Votes ONLY in the event of a tie**				Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley, Pharm.D.	X		
Fornander, Wade, M.D. (Vice Chair)	X						

Review Agenda – ANTIVIRALS, TOPICAL

(1st) Motion: Cowles

(2nd) Motion: Dolter

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			Klug, Laura, Pharm.D.	X		
Cowles, Cassie, APRN	X			Sobeski, Linda, Pharm.D.	X		
Dering-Anderson, Allison, Pharm.D. (Chair) **Votes ONLY in the event of a tie**				Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley, Pharm.D.	X		
Fornander, Wade, M.D. (Vice Chair)	X						

Review Agenda – BETA BLOCKERS

(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			Klug, Laura, Pharm.D.	X		
Cowles, Cassie, APRN	X			Sobeski, Linda, Pharm.D.	X		
Dering-Anderson, Allison, Pharm.D. (Chair) **Votes ONLY in the event of a tie**				Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley, Pharm.D.	X		
Fornander, Wade, M.D. (Vice Chair)	X						

Review Agenda – BLADDER RELAXANT PREPARATIONS							
(1st) Motion: Hill							
(2nd) Motion: Dolter							
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			Klug, Laura, Pharm.D.	X		
Cowles, Cassie, APRN	X			Sobeski, Linda, Pharm.D.	X		
Dering-Anderson, Allison, Pharm.D. (Chair) **Votes ONLY in the event of a tie**				Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley, Pharm.D.	X		
Fornander, Wade, M.D. (Vice Chair)	X						

5. **Committee Moved to Closed Session (Working Lunch)**

(1st) Motion: Avery	**(2nd) Motion:** Hill
Committee Moved to Closed Session unanimously approved by all in attendance	

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

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

a. Therapeutic Class Reviews (continued)

Review Agenda – CONTRACEPTIVES, ORAL							
(1st) Motion: Avery							
(2nd) Motion: Hill							
Discussion: Approved as written. Since all reviewed agents are recommended preferred, list all agents under the Preferred column on the P&T proposed PDL in the future.							
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			Fornander, Wade, M.D. **(Vice Chair)**	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D.	X			Klug, Laura, Pharm.D.	X		
Cowles, Cassie, APRN	X			Sobeski, Linda, Pharm.D.	X		
Dering-Anderson, Allison, Pharm.D. (Chair) **Votes ONLY in the event of a tie**				Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley, Pharm.D.	X		

Review Agenda – CYSTIC FIBROSIS							
(1st) Motion: Fornander							
(2nd) Motion: Cowles							
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			Fornander, Wade, M.D. **(Vice Chair)**	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D.	X			Klug, Laura, Pharm.D.	X		
Cowles, Cassie, APRN	X			Sobeski, Linda, Pharm.D.	X		
Dering-Anderson, Allison, Pharm.D. (Chair) **Votes ONLY in the event of a tie**				Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley, Pharm.D.	X		

Review Agenda – DIURETICS							
(1st) Motion: Sobeski							
(2nd) Motion: Avery							
Discussion: Sobeski motioned to add to the PA criteria that spironolactone suspension can be approved for patients with difficulties swallowing solid oral dosage forms. The committee voted to approve as written while adding the PA criteria for spironolactone suspension.							
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			Fornander, Wade, M.D. **(Vice Chair)**	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D.	X			Klug, Laura, Pharm.D.	X		
Cowles, Cassie, APRN	X			Sobeski, Linda, Pharm.D.	X		
Dering-Anderson, Allison, Pharm.D. (Chair) **Votes ONLY in the event of a tie**				Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley, Pharm.D.	X		

Review Agenda – GI MOTILITY, CHRONIC							
(1st) Motion: Sobeski							
(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			Fornander, Wade, M.D. **(Vice Chair)**	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D.	X			Klug, Laura, Pharm.D.	X		
Cowles, Cassie, APRN	X			Sobeski, Linda, Pharm.D.	X		
Dering-Anderson, Allison, Pharm.D. (Chair) **Votes ONLY in the event of a tie**				Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley, Pharm.D.	X		

Review Agenda – GROWTH HORMONE

(1st) Motion: Baker

(2nd) Motion: Hill

Discussion: The committee discussed recommendations provided in public testimony from Dr. Monina Cabrera, to not require a bone scan to determine bone age in children < 5 y/o, eliminate cortisol level requirements, and eliminate requirement of serum IGF-1 or IGFBP3 values. The committee recommended the state to bring these suggestions to the Medicaid Medical Director, who then can collaborate with Dr. Cabrera, if needed. The committee 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			Fornander, Wade, M.D. **(Vice Chair)**	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D.	X			Klug, Laura, Pharm.D.	X		
Cowles, Cassie, APRN	X			Sobeski, Linda, Pharm.D.	X		
Dering-Anderson, Allison, Pharm.D. (Chair) **Votes ONLY in the event of a tie**				Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley, Pharm.D.	X		

Review Agenda – H. PYLORI TREATMENT

(1st) Motion: Baker

(2nd) Motion: Cowles

Discussion: Klug discussed Pylera being in short supply and can't use the separate ingredients since tetracycline is listed as non-preferred in the Tetracycline class. Avery asks if can go back and revoke the previous consent and pull the Tetracycline class and is told yes. The committee 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			Fornander, Wade, M.D. **(Vice Chair)**	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D.	X			Klug, Laura, Pharm.D.	X		
Cowles, Cassie, APRN	X			Sobeski, Linda, Pharm.D.	X		
Dering-Anderson, Allison, Pharm.D. (Chair) **Votes ONLY in the event of a tie**				Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley, Pharm.D.	X		

Review Agenda – HIV/ AIDS							
(1st) Motion: Hill							
(2nd) Motion: Dolter							
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			Fornander, Wade, M.D. **(Vice Chair)**	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D.	X			Klug, Laura, Pharm.D.	X		
Cowles, Cassie, APRN	X			Sobeski, Linda, Pharm.D.	X		
Dering-Anderson, Allison, Pharm.D. (Chair) **Votes ONLY in the event of a tie**				Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley, Pharm.D.	X		

Review Agenda – HYPOGLYCEMICS, INCRETIN MIMETICS/ ENHANCERS							
(1st) Motion: Sobeski							
(2nd) Motion: Cowles							
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			Fornander, Wade, M.D. **(Vice Chair)**	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D.	X			Klug, Laura, Pharm.D.	X		
Cowles, Cassie, APRN	X			Sobeski, Linda, Pharm.D.	X		
Dering-Anderson, Allison, Pharm.D. (Chair) **Votes ONLY in the event of a tie**				Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley, Pharm.D.	X		

Review Agenda – HYPOGLYCEMICS, INSULIN AND RELATED AGENTS							
(1st) Motion: Avery							
(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			Fornander, Wade, M.D. **(Vice Chair)**	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D.	X			Klug, Laura, Pharm.D.	X		
Cowles, Cassie, APRN	X			Sobeski, Linda, Pharm.D.	X		
Dering-Anderson, Allison, Pharm.D. (Chair) **Votes ONLY in the event of a tie**				Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D. (Vice Chair)	X			Sundsboe, Bradley, Pharm.D.	X		

Review Agenda – HYPOGLYCEMICS, SGLT2							
(1st) Motion: Fornander							
(2nd) Motion: Dolter							
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			Fornander, Wade, M.D. **(Vice Chair)**	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D.	X			Klug, Laura, Pharm.D.	X		
Cowles, Cassie, APRN	X			Sobeski, Linda, Pharm.D.	X		
Dering-Anderson, Allison, Pharm.D. (Chair) **Votes ONLY in the event of a tie**				Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley, Pharm.D.	X		

Review Agenda – LIPOTROPICS, STATINS							
(1st) Motion: Avery							
(2nd) Motion: Dolter							
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			Fornander, Wade, M.D. **(Vice Chair)**	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D.	X			Klug, Laura, Pharm.D.	X		
Cowles, Cassie, APRN	X			Sobeski, Linda, Pharm.D.	X		
Dering-Anderson, Allison, Pharm.D. (Chair) **Votes ONLY in the event of a tie**				Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley, Pharm.D.	X		

Review Agenda – PAH- PULMONARY ARTERIAL HYPERTENSION AGENTS							
(1st) Motion: Avery							
(2nd) Motion: Dolter							
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			Fornander, Wade, M.D. **(Vice Chair)**	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D.	X			Klug, Laura, Pharm.D.	X		
Cowles, Cassie, APRN	X			Sobeski, Linda, Pharm.D.	X		
Dering-Anderson, Allison, Pharm.D. (Chair) **Votes ONLY in the event of a tie**				Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley, Pharm.D.	X		

Review Agenda – PEDIATRIC VITAMIN PREPARATIONS

(1st) Motion: Cowles

(2nd) Motion: Dolter

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			Fornander, Wade, M.D. **(Vice Chair)**	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D.	X			Klug, Laura, Pharm.D.	X		
Cowles, Cassie, APRN	X			Sobeski, Linda, Pharm.D.	X		
Dering-Anderson, Allison, Pharm.D. (Chair) **Votes ONLY in the event of a tie**				Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley, Pharm.D.	X		

Review Agenda – PHOSPHATE BINDERS

(1st) Motion: Cowles

(2nd) Motion: Dolter

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			Fornander, Wade, M.D. **(Vice Chair)**	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D.	X			Klug, Laura, Pharm.D.	X		
Cowles, Cassie, APRN	X			Sobeski, Linda, Pharm.D.	X		
Dering-Anderson, Allison, Pharm.D. (Chair) **Votes ONLY in the event of a tie**				Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley, Pharm.D.	X		

Review Agenda – PRENATAL VITAMINS

(1st) Motion: Avery

(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			Fornander, Wade, M.D. **(Vice Chair)**	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D.	X			Klug, Laura, Pharm.D.	X		
Cowles, Cassie, APRN	X			Sobeski, Linda, Pharm.D.	X		
Dering-Anderson, Allison, Pharm.D. (Chair) **Votes ONLY in the event of a tie**				Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley, Pharm.D.	X		

Review Agenda – PROTON PUMP INHIBITORS

(1st) Motion: Hill

(2nd) Motion: Avery

Discussion: Hill motioned to change the wording of the Proton Pump Inhibitor PA criteria to say “non-preferred agents will be approved when patients have failed an 8-week trial of 3 preferred agents”. Approved as written with addition of the update to the PA criteria.

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			Fornander, Wade, M.D. **(Vice Chair)**	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D.	X			Klug, Laura, Pharm.D.	X		
Cowles, Cassie, APRN	X			Sobeski, Linda, Pharm.D.	X		
Dering-Anderson, Allison, Pharm.D. (Chair) **Votes ONLY in the event of a tie**				Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley, Pharm.D.	X		

Review Agenda – SKELETAL MUSCLE RELAXANTS

(1st) Motion: Fornander

(2nd) Motion: Avery

Discussion: Sobeski questioned if need criteria to allow baclofen suspension to be approved for difficulty swallowing and moved to approve, but discussion began on whether the preferred tablets could be crushed. It was determined that tablets can be crushed and if need suspension then placing swallowing disorder on the PA request with documentation results in a quicker approval time. Sobeski withdrew her original motion. The committee 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			Fornander, Wade, M.D. **(Vice Chair)**	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D.	X			Klug, Laura, Pharm.D.	X		
Cowles, Cassie, APRN	X			Sobeski, Linda, Pharm.D.	X		
Dering-Anderson, Allison, Pharm.D. (Chair) **Votes ONLY in the event of a tie**				Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley, Pharm.D.	X		

Review Agenda – THYROID HORMONES

(1st) Motion: Avery

(2nd) Motion: Dolter

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			Fornander, Wade, M.D. **(Vice Chair)**	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D.	X			Klug, Laura, Pharm.D.	X		
Cowles, Cassie, APRN	X			Sobeski, Linda, Pharm.D.	X		
Dering-Anderson, Allison, Pharm.D. (Chair) **Votes ONLY in the event of a tie**				Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley, Pharm.D.	X		

Review Agenda – ULCERATIVE COLITIS							
(1st) Motion: Dolter							
(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			Fornander, Wade, M.D. **(Vice Chair)**	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D.	X			Klug, Laura, Pharm.D.	X		
Cowles, Cassie, APRN	X			Sobeski, Linda, Pharm.D.	X		
Dering-Anderson, Allison, Pharm.D. (Chair) **Votes ONLY in the event of a tie**				Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley, Pharm.D.	X		

Review Agenda – VASODILATORS, CORONARY							
(1st) Motion: Fornander							
(2nd) Motion: Sobeski							
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			Fornander, Wade, M.D. **(Vice Chair)**	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D.	X			Klug, Laura, Pharm.D.	X		
Cowles, Cassie, APRN	X			Sobeski, Linda, Pharm.D.	X		
Dering-Anderson, Allison, Pharm.D. (Chair) **Votes ONLY in the event of a tie**				Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley, Pharm.D.	X		

Review Agenda – ANALGESICS, OPIOIDS LONG-ACTING

(1st) Motion: Fornander

(2nd) Motion: Sobeski

Discussion: Cowles motioned to pull this class from the Consent Agenda to question why methadone was not a preferred drug. The committee discussed safety issues and risks. When used appropriately for pain or cancer diagnosis, it is approved in a short turn-around time. 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			Fornander, Wade, M.D. **(Vice Chair)**	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D.	X			Klug, Laura, Pharm.D.	X		
Cowles, Cassie, APRN	X			Sobeski, Linda, Pharm.D.	X		
Dering-Anderson, Allison, Pharm.D. (Chair) **Votes ONLY in the event of a tie**				Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley, Pharm.D.	X		

Review Agenda – ANTICOAGULANTS

(1st) Motion: Avery

(2nd) Motion: Baker

Discussion: Avery motioned to pull this class from the Consent Agenda to discuss moving Pradaxa from P to NP and its generic, dabigatran from NP to P as a cost-effective option. The committee voted to move both Pradaxa and dabigatran.

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			Fornander, Wade, M.D. **(Vice Chair)**	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D.	X			Klug, Laura, Pharm.D.	X		
Cowles, Cassie, APRN	X			Sobeski, Linda, Pharm.D.	X		
Dering-Anderson, Allison, Pharm.D. (Chair) **Votes ONLY in the event of a tie**				Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley, Pharm.D.	X		

Review Agenda – OPIOID DEPENDENCE TREATMENTS							
(1st) Motion: Sobeski							
(2nd) Motion: Hill							
Discussion: Dr. Sobeski motioned to pull this class from the Consent Agenda for discussion. Nebraska separates the Opioid Dependence Treatments into two separate classes: Opioid Dependence Treatments and Opioid-Reversal Treatments. Though Magellan lists them as one class, the committee would like to have them listed separately on the P&T agenda so they can be reviewed and voted on separately in the future. 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			Fornander, Wade, M.D. **(Vice Chair)**	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D.	X			Klug, Laura, Pharm.D.	X		
Cowles, Cassie, APRN	X			Sobeski, Linda, Pharm.D.	X		
Dering-Anderson, Allison, Pharm.D. (Chair) **Votes ONLY in the event of a tie**				Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley, Pharm.D.	X		

Review Agenda – TETRACYCLINES							
(1st) Motion: Avery							
(2nd) Motion: Baker							
Discussion: Avery motioned to revoke previous acceptance of the Tetracyclines class and pull from the Consent Agenda. Dolter seconds the motion. The committee discussed moving tetracycline to preferred on the PDL so there would be another option of separating the ingredients in Pylera during any supply issues. The committee voted to move tetracycline from NP to P.							
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			Fornander, Wade, M.D. **(Vice Chair)**	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D.	X			Klug, Laura, Pharm.D.	X		
Cowles, Cassie, APRN	X			Sobeski, Linda, Pharm.D.	X		
Dering-Anderson, Allison, Pharm.D. (Chair) **Votes ONLY in the event of a tie**				Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley, Pharm.D.	X		

b. Complete Copy of Proposed PDL

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

May 2024 P&T Proposed PDL
Noted in Red Font that Become Effective July 19, 2024

For the most up to date list of covered drugs consult the **Drug Lookup** on the Nebraska Medicaid website at https://ne.magellanrx.com/drug-lookup.

- **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 is 90 Morphine Milligram Equivalents (MME) per day.

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

ACNE AGENTS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
adapalene (generic Differin) **GEL (OTC/Rx), GEL PUMP** adapalene/BPO (generic Epiduo) benzoyl peroxide (BPO) **WASH, LOTION** clindamycin/BPO (generic BenzaClin) **GEL**, **PUMP** clindamycin/BPO (generic Duac) clindamycin phosphate **PLEDGET** clindamycin phosphate **SOLUTION** erythromycin **GEL** erythromycin **SOLN** erythromycin-BPO (generic for Benzamycin) RETIN-A (tretinoin)[AL] **CREAM**, **GEL**	adapalene (generic Differin) **CREAM** adapalene/BPO (generic Epiduo Forte) ALTRENO (tretinoin)[AL] AMZEEQ (minocycline) ARAZLO (tazarotene)[AL] ATRALIN (tretinoin) AVAR (sulfacetamide sodium/sulfur) AVITA (tretinoin) AZELEX (azelaic acid) BENZEFOAM (benzoyl peroxide) benzoyl peroxide **CLEANSER**, **CLEANSING BAR** OTC benzoyl peroxide **FOAM** (generic BenzePro) benzoyl peroxide **GEL** OTC benzoyl peroxide **GEL** Rx benzoyl peroxide **TOWELETTE** OTC CABTREO (clindamycin phosphate/BPO/adapalene)[AL,NR] **GEL** clindamycin **FOAM, LOTION** clindamycin **GEL** clindamycin phosphate (generic for Clindagel) **GEL** clindamycin/BPO (generic Acanya) **GEL** clindamycin/BPO **PUMP**(generic Onexton)[AL, NR] clindamycin/tretinoin (generic Veltin, Ziana) dapsone (generic Aczone) erythromycin **PLEDGET** erythromycin-BPO (generic for Benzamycin) EVOCLIN (clindamycin)	▪ Non-preferred agents will be approved for patients who have failed THREE preferred agents within this drug class

ACNE AGENTS, TOPICAL (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	FABIOR (tazarotene) **FOAM** NEUAC (clindamycin/BPO) ONEXTON (clindamycin/BPO) OVACE PLUS (sulfacetamide sodium) RETIN-A MICRO (tretinoin) sulfacetamide sulfacetamide/sulfur **CLEANSER, LOTION, MED PAD, SUSP** sulfacetamide sodium/sulfur **CLEANSER**[NR]**, CREAM** sulfacetamide sodium **CLEANSER ER** SUMADAN (sulfacetamide/sulfur) tazarotene (generic Tazorac) **CREAM** tazarotene **FOAM** (generic Fabior) tazarotene **GEL** (generic Tazorac) TRETIN-X (tretinoin) tretinoin (generic Avita, Retin-A) [AL] **CREAM, GEL** tretinoin microspheres (generic Retin-A Micro) [AL] **GEL, GEL PUMP** WINLEVI (clascoterone)[AL]	▪ Non-preferred agents will be approved for patients who have failed THREE preferred agents within this drug class

ANALGESICS, OPIOID LONG-ACTING

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

ANALGESICS, OPIOID SHORT-ACTING [QL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ORAL		
acetaminophen/codeine **ELIXIR, TAB** codeine **TAB** hydrocodone/APAP **SOLN, TAB** hydrocodone/ibuprofen hydromorphone **TAB** morphine **CONC SOLN**, **SOLN, TAB** oxycodone **TAB, SOLN** oxycodone/APAP Tramadol 50 **TAB**[AL] (generic Ultram)	APADAZ (benzhydrocodone/APAP)[CL] benzhydrocodone/APAP (generic Apadaz)[CL] butalbital/caffeine/APAP/codeine butalbital compound w/codeine (butalbital/ASA/caffeine/codeine) carisoprodol compound-codeine (carisoprodol/ASA/codeine) dihydrocodeine/APAP/caffeine dihydrocodeine/aspirin/caffeine hydromorphone **LIQUID, SUPPOSITORY** (generic Dilaudid) levorphanol meperidine (generic Demerol) morphine **SUPPOSITORIES** NALOCET (oxycodone/APAP) NUCYNTA (tapentadol)[CL] oxycodone **CAPS** oxycodone/APAP **SOLN** oxycodone **CONCENTRATE** oxymorphone IR (generic Opana) pentazocine/naloxone PROLATE (oxycodone/APAP) **SOLN,TAB** ROXICODONE (oxycodone) ROXYBOND (oxycodone) SEGLENTIS (celecoxib/tramadol)[AL] tramadol 25mg[NR] tramadol 100mg (generic Ultram)[AL] tramadol (generic Qdolo)[AL,QL] **SOLN** tramadol/APAP (generic Ultracet)	▪ Non-preferred agents will be approved for patients who have failed THREE preferred agents within this drug class within the last 12 months ▪ Note: for short acting opiate tablets and capsules there is a maximum quantity limit of #150 per 30 days. ▪ Opiate limits for opiate naïve patients will consist of -prescriptions limited to a 7 day supply, AND -initial opiate prescription fill limited to maximum of 50 Morphine Milligram Equivalents (MME) per day These limits may only be exceeded with patient specific documentation of medical necessity, with examples such as, cancer diagnosis, end-of-life care, palliative care, Sickle Cell Anemia, or prescriber attestation that patient is not recently opiate naive Drug-specific criteria: ▪ **Apadaz/ benzhydrocodone-APAP:** Approval for 14 days or less ▪ **Nucynta®:** Approved only for diagnosis of acute pain, for 30 days or less

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

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

ANDROGENIC AGENTS (TOPICAL) [CL]

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

ANGIOTENSIN MODULATORS

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

ANGIOTENSIN MODULATORS (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ANGIOTENSIN RECEPTOR BLOCKER/DIURETIC COMBINATIONS		▪ Non-preferred agents will be approved for patients who have failed TWO preferred agents within this drug class within the last 12 months ▪ Non-preferred combination products may be covered as individual prescriptions without prior authorization
irbesartan/HCTZ (generic Avalide) losartan/HCTZ (generic Hyzaar) olmesartan/HCTZ (generic Benicar-HCT) valsartan/HCTZ (generic Diovan-HCT)	candesartan/HCTZ (generic Atacand-HCT) EDARBYCLOR (azilsartan/ chlorthalidone) telmisartan/HCTZ (generic Micardis-HCT)	
ANGIOTENSIN MODULATOR/ CALCIUM CHANNEL BLOCKER COMBINATIONS		
amlodipine/benazepril (generic Lotrel) amlodipine/olmesartan (generic Azor) amlodipine/valsartan (generic Exforge) amlodipine/valsartan/HCTZ (generic Exforge HCT)	amlodipine/olmesartan/HCTZ (generic Tribenzor) amlodipine/telmisartan (generic Twynsta) PRESTALIA (perindopril/amlodipine) trandolapril/verapamil (generic Tarka)	
DIRECT RENIN INHIBITORS		
	aliskiren (generic Tekturna)[QL]	
DIRECT RENIN INHIBITOR COMBINATIONS		
	TEKTURNA/HCT (aliskiren/HCTZ)	▪ **Direct Renin Inhibitors/Direct Renin Inhibitor Combinations:** May be approved witha history of TWO preferred ACE Inhibitors or Angiotensin Receptor Blockers within the last 12 months
NEPRILYSIN INHIBITOR COMBINATION		
ENTRESTO (sacubitril/valsartan)[CL,QL]		
ANGIOTENSIN RECEPTOR BLOCKER/BETA-BLOCKER COMBINATIONS		
	BYVALSON (nevibolol/valsartan)	Drug Specific Criteria • **Entresto:** May be approved in patients ages >1 years old and with a diagnosis of heart failure

ANTIBIOTICS, GASTROINTESTINAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
FIRVANQ (vancomycin)[QL] **SOLN** metronidazole **TABLET** neomycin tinidazole (generic Tindamax)[CL]	AEMCOLO (rifamycin)[NR] DIFICID (fidaxomicin) [CL] **TAB, SUSP** LIKMEZ (metronidazole)[NR] **SUSP** metronidazole[CL] **CAPS** nitazoxanide (generic Alinia) **TAB**[AL, CL, QL] paromomycin SOLOSEC (secnidazole) vancomycin **CAPS** (generic Vancocin)[CL] vancomycin (generic Firvanq)[NR,QL] VOWST (fecal microbiota spores)[AL,NR,QL] XIFAXAN (rifaximin)[CL]	▪ Note: Although azithromycin, ciprofloxacin, and trimethoprim/ sulfmethoxazole are not included in this review, they are available without prior authorization Drug-specific criteria: ▪ **Alinia/ nitazoxanide :** Trial and failure with metronidazole is required for a diagnosis of giardiasis ▪ **Dificid®:** For diagnosis of C. difficile diarrhea (pseudomembranous colitis), **t**rial and failure or intolerance to oral vancomycin is required. For diagnosis of relapsed or recurrent C. difficile, an appropriate ICD-10 diagnosis code must be submitted for coverage. ▪ **Flagyl®/Metronidazole 375mg capsules and / Metronidazole 750mg ER tabs:** Clinical reason why the generic regular release cannot be used ▪ **tinidazole:** Approvable diagnoses include: Giardia Amebiasis intestinal or liver abscess Bacterial vaginosis or trichomoniasis ▪ **vancomycin capsules:** Requires patient specific documentation of why the Firvanq/vancomycin solution is not appropriate for patient ▪ **Xifaxan®:** Approvable diagnoses include: Travelers's diarrhea resistant to quinolones Hepatic encephalopathy with treatment failure of lactulose or neomycin Diarrhea-Predominant IBS (IBS-D) 550mg strength only with treatment failure of Lomotil® AND Imodium®

ANTIBIOTICS, INHALED [CL]

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

ANTIBIOTICS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
bacitracin **OINT** bacitracin zinc[NR] **OINT OTC** bacitracin/polymyxin (generic Polysporin) mupirocin **OINT** (generic Bactroban) neomycin/polymyxin/bacitracin (generic Neosporin, Triple AB) neomycin/polymyxin/pramoxine neomycin/polymyxin/bacitracin/ pramoxine	CENTANY (mupirocin) gentamicin **OINT, CREAM** mupirocin **CREAM** (generic Bactroban)[CL]	▪ Non-preferred agents will be approved for patients who have failed ALL preferred agents within this drug class within the last 12 months Drug-specific criteria: ▪ **Mupirocin® Cream:** Clinical reason the ointment cannot be used

ANTIBIOTICS, VAGINAL

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

ANTICOAGULANTS

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

ANTIEMETICS/ANTIVERTIGO AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CANNABINOIDS		▪ Non-preferred agents will be approved for patients who have failed ONE preferred agent within this drug class within the same group
dronabinol (generic Marinol)[AL]	CESAMET (nabilone)	
5HT3 RECEPTOR BLOCKERS		Drug-specific criteria:
ondansetron (generic Zofran/Zofran ODT)[QL]	ANZEMET (dolasetron) granisetron (generic Kytril) SANCUSO (granisetron)[CL] ZUPLENZ (ondansetron)	▪ **Akynzeo/Varubi:** Approved for Moderately/Highly emetogenic chemotherapy with dexamethasone and a 5-HT3 antagonist ▪ Regimens include: AC combination (Doxorubicin or Epirubicin with Cyclophosphamide), Aldesleukin, Amifostine, Arsenic trioxide, Azacitidine, Bendamustine, Busulfan, Carmustine, Carbplatin, Cisplatin, Clofarabine, Cyclophosphamide, Cytarabine, Dacarbazine, Dactinomycin, Daunorubicin, Epirubicin, Etoposide, Hexamethylmelamine, Idarubicin, Ifosfamide, Imatinib, Interferon α, Irinotecan, Mechlorethamine, Melphalan, Methotrexate, Oxaliplatin, Procarbazine, Streptozotocin, Temozolomide
NK-1 RECEPTOR ANTAGONIST		
aprepitant (generic Emend) **CAPS** [QL]	AKYNZEO (netupitant/palonosetron)[CL] aprepitant (generic Emend) **PACK** EMEND (aprepitant) **CAPS, PACK, POWDER** [QL] VARUBI (rolapitant) **TAB**[CL]	
TRADITIONAL ANTIEMETICS		▪ **Diclegis/doxylamine-pyridoxine/ Bonjesta:** Approved only for treatment of nausea and vomiting of pregnancy ▪ **Metozolv/ metoclopramide ODT:** Documentation of inability to swallow or Clinical reason oral liquid cannot be used ▪ **Sancuso/Zuplenz:** Documentation of oral dosage form intolerance
DICLEGIS (doxylamine/pyridoxine)[CL,QL] dimenhydrinate (generic Dramamine) **OTC** meclizine (generic Antivert) metoclopramide (generic Reglan) phosphoric acid/dextrose/fructose (generic Emetrol) **SOLN** prochlorperazine(generic Compazine) promethazine (generic Phenergan) **SYRUP**, **TAB** promethazine 12.5mg, 25mg **SUPPOSITORY** scopolamine **TRANSDERMAL**	BONJESTA (doxylamine/pyridoxine)[CL,QL] COMPRO (prochlorperazine) doxylamine/pyridoxine (generic Diclegis)[CL,QL] metoclopramide **ODT** (generic Metozolv ODT) prochlorperazine **SUPPOSITOR**Y (generic Compazine) promethazine **SUPPOSITORY** 50mg TRANSDERM-SCOP (scopolamine) trimethobenzamide **TAB** (generic Tigan)	

ANTIFUNGALS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
clotrimazole (mucous membrane, troche) fluconazole **SUSP, TAB** (generic Diflucan) griseofulvin **SUSP** griseofulvin microsized **TAB** nystatin **SUSP, TAB** terbinafine (generic Lamisil)	BREXAFEMME (ibrexafungerp)[QL] CRESEMBA (isavuconazonium)[CL] flucytosine (generic Ancobon)[CL] griseofulvin ultramicrosize (generic GRIS-PEG) itraconazole (generic Sporanox)[CL] ketoconazole (generic Nizoral) NOXAFIL (posaconazole) [AL] **SUSP, TAB** NOXAFIL (posaconazole) [AL,CL] **POWDERMIX** nystatin **POWDER** posaconazole (generic Noxafil)[AL,CL] TOLSURA (itraconazole)[CL] VIVJOA (oteseconazole) **CAPS** voriconazole (generic VFEND)[CL]	▪ Non-preferred agents will be approved for patients who have failed a trial of TWO diagnosis-appropriate preferred agents within this drug class Drug-specific criteria: ▪ **Cresemba:** Approved for diagnosis of invasive aspergillosis or invasive mucormycosis ▪ **Flucytosine:** Approved for diagnosis of: Candida: Septicemia, endocarditis, UTIs Cryptococcus: Meningitis, pulmonary infections ▪ **Noxafil/ posaconazole:** No trial for diagnosis of Neutropenia Myelodysplastic Syndrome (MDS), Neutropenic Acute Myeloid Leukemia (AML), Neutropenic hematologic malignancies, Graft vs. Host disease(GVHD), Immunosuppression secondary to hematopoietic stem cell transplant ▪ **Noxafil Powdermix:** pediatric patients 2 years of age and older who weigh 40 kg or less ▪ **Noxafil/ posaconazole Suspension:** Oropharyngeal/esophageal candidiasis refractory to itraconazole and/or fluconazole ▪ **Sporanox/itraconazole:** Approved for diagnosis of Aspergillosis, Blastomycosis, Histoplasmosis, Onychomycosis due to terbinafine-resistant dermatophytes, Oropharyngeal/ esophageal candidiasis refractory to fluconazole ▪ **Sporanox/ itraconazole Liquid:** Clinical reason solid oral cannot be used ▪ **Tolsura:** Approved for diagnosis of Aspergillosis, Blastomycosis, and Histoplasmosis and requires a trial and failure of generic itraconazole ▪ **Vfend/ voriconazole:** No trial for diagnosis of Myelodysplastic Syndrome (MDS), Neutropenic Acute Myeloid Leukemia (AML), Graft vs. Host disease (GVHD), Candidemia (candida krusei), Esophageal Candidiasis, Blastomycosis, *S. apiospermum* and *Fusarium spp.*, Oropharyngeal/esophageal candidiasis refractory to fluconazole

ANTIFUNGALS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ANTIFUNGAL		
clotrimazole **CREAM** (generic Lotrimin) **OTC, RX** clotrimazole **SOLN OTC** ketoconazole **CREAM, SHAMPOO** (generic Nizoral) LAMISIL (terbinafine) **SPRAY OTC** miconazole **CREAM, POWDER OTC** nystatin terbinafine OTC (generic Lamisil AT) tolnaftate (generic Tinactin) **AERO POWDER-OTC, CREAM-OTC**, **SOLN-OTC**	ALEVAZOL (clotrimazole) OTC ciclopirox **CREAM, GEL, SUSP** (generic Ciclodan, Loprox) ciclopirox **NAIL LACQUER**[CL] (generic Penlac) ciclopirox **SHAMPOO** (generic Loprox) clotrimazole **SOLN** RX (generic Lotrimin) DESENEX **POWDER OTC** (miconazole) econazole (generic Spectazole) ERTACZO (sertaconazole) EXELDERM (sulconazole) FUNGOID (miconazole) **OTC** JUBLIA (efinaconazole)[CL] ketoconazole **FOAM**[CL] (generic Extina, Ketodan) LOPROX (ciclopirox) **SUSP, SHAMPOO, CREAM** LOTRIMIN AF **CREAM** OTC (clotrimazole) LOTRIMIN ULTRA (butenafine) luliconazole (generic Luzu) MENTAX (butenafine) miconazole OTC **OINT, SPRAY, SOLN** miconazole/zinc oxide/petrolatum (generic Vusion) naftifine **CREAM, GEL** (generic Naftin) oxiconazole (generic Oxistat) salicylic acid (generic Bensal HP) tavaborole **SOLN**[CL] (generic Kerydin) tolnaftate (generic Tinactin) **POWDER-OTC** VOTRIZA-AL (clotrimazole)[NR] **LOTION OTC**	▪ Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class within the last 6 months Drug-specific criteria: ▪ **Extina/Ketodan/ ketoconazole foam:** Requires trial and failure or contraindication to other ketoconazole forms ▪ **Jublia and tavaborole:** Approved diagnoses include Onychomycosis of the toenails due to *T.rubrum OR T. Mentagrophytes* ▪ **ciclopirox nail lacquer:** No trial required in diabetes, peripheral vascular disease (PVD), immunocompromised OR contraindication to oral terbinafine
ANTIFUNGAL/STEROID COMBINATIONS		
clotrimazole/betamethasone **CREAM** (generic Lotrisone) nystatin/triamcinolone (generic Mycolog) **CREAM, OINT**	clotrimazole/betamethasone **LOTION** (generic Lotrisone)	

ANTIMIGRAINE AGENTS, OTHER

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
AIMOVIG (erenumab-aooe)[CL,QL] AJOVY (fremanezumab-vfrm) [CL, QL] **PEN, Autoinjector** AJOVY (fremanezumab-vfrm) **Autoinjector 3-pack**[CL,QL] EMGALITY 120 mg/mL (galcanezumab-gnlm) [CL, QL] **PEN, SYRINGE** NURTEC ODT (rimegepant)[AL,CL,QL] QULIPTA (atogepant)[AL QL] UBRELVY (ubrogepant)[AL,CL, QL] **TAB**	diclofenac (generic Cambia) **POWDER** dihydroergotamine mesylate **NASAL** ELYXYB (celecoxib)[AL,QL] **SOLN** EMGALITY 100 mg (galcanezumab-gnlm) [CL,QL] **SYR** MIGERGOT (ergotamine/caffeine) **RECTAL** MIGRANAL (dihydroergotamine) **NASAL** REYVOW (lasmiditan)[AL, CL,QL] **TAB** TRUDHESA (dihydroergotamine mesylate)[AL,QL] **NASAL** ZAVZPRET (zavegepant)[AL,NR,QL] **NASAL**	▪ In addition, all non-preferred agents will require a failed trial or contraindication of a preferred agent of the same indication ▪ **For Acute Treatment**: agents will be approved for patients who have a failed trial or a contraindication to a triptan. ▪ **For Prophylactic Treatment**: Require ≥ 4 migraines per month for ≥ 3 months and has tried and failed a ≥ 1 month trial of two medications listed in the 2012 American Academy of Neurology/American Headache Society guidelines (examples include: antidepressants (amitriptyline, venlafaxine), Beta blockers (propranolol, metroprolol, atenolol), anti-epileptics (valproate, topiramate), ACE (lisinopril) Drug-specific criteria: ▪ **Emgaility 100mg** will only be approved for treatment of Episodic Cluster Headache ▪ **Nurtec ODT:** for use in acute treatment, will be approved for patients who have a failed trial or a contraindication to a triptan. For use in preventative treatment, will be approved for patients who have a failed trial of ONE preferred injectable CGRP. ▪ **Qulipta:** May be approved for patients who have a failed trial of ONE preferred injectable CGRP

ANTIMIGRAINE AGENTS, TRIPTANS [QL]

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

ANTIPARASITICS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
NATROBA (spinosad) permethrin 1% OTC (generic Nix) permethrin 5% RX (generic Elimite) pyrethrin/piperonyl butoxide (generic RID, A-200)	CROTAN (crotamiton) **LOTION** EURAX (crotamiton) **CREAM, LOTION** ivermectin (generic Sklice) **LOTION** lindane malathion (generic Ovide) spinosad (generic Natroba) VANALICE (piperonyl butoxide/pyrethrins)	▪ Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class within the past 6 months

ANTIVIRALS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ANTI-HERPETIC DRUGS		▪ Non-preferred agents will be approved for patients who have failed a 10-day trial of ONE preferred agent within the same group Drug-specific criteria: ▪ **Acyclovir Susp:** Prior authorization NOT required for children ≤ 12 years old ▪ **Sitavig®:** Approved for recurrent herpes labialis (cold sores) in immunocompetent adults ▪ **Xofluza:** Requires clinical, patient specific reason that a preferred agent cannot be used
acyclovir (generic Zovirax) famciclovir (generic Famvir) valacyclovir (generic Valtrex)	acyclovir (generic for Zovirax)[CL] **SUSP** SITAVIG (acyclovir buccal)[CL]	
ANTI-INFLUENZA DRUGS		
oseltamivir (generic Tamiflu)[QL] **CAPS, SUSP**	rimantadine (generic Flumadine) RELENZA (zanamivir)[QL] TAMIFLU (oseltamivir)[QL] **CAPS, SUSP** XOFLUZA (baloxavir marboxil)[AL,CL,QL]	

ANTIVIRALS, TOPICAL

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

BETA BLOCKERS, ORAL

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

BLADDER RELAXANT PREPARATIONS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
fesoterodine ER (generic Toviaz) MYRBETRIQ (mirabegron)[AL] **TAB** oxybutynin IR, ER (generic Ditropan/Ditropan XL)	darifenacin ER (generic Enablex) flavoxate HCL GELNIQUE (oxybutynin) GEMTESA (vibegron)[AL,QL] MYRBETRIQ (mirabegron) **SUSP**[AL,CL,QL] oxybutynin 2.5mg[NR] OXYTROL (oxybutynin) solifenacin (generic Vesicare) tolterodine IR, ER (generic Detrol/ Detrol LA) TOVIAZ (fesoterodine ER) trospium IR, ER (generic Sanctura/ Sanctura XR) VESICARE (solifenacin) VESICARE LS **SUSP** (solifenacin) [AL]	▪ Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class Drug-specific criteria: ▪ **Myrbetriq suspension:** Covered for pediatric patients ≥ 3 years old with a diagnosis of Neurogenic Detrusor Overactivity (NDO)

BONE RESORPTION SUPPRESSION AND RELATED DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BISPHOSPHONATES		▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within the same group Drug-specific criteria: ▪ **Actonel® Combinations:** Covered as individual agents without prior authorization ▪ **Atelvia DR®:** Requires clinical reason alendronate cannot be taken on an empty stomach ▪ **Binosto®:** Requires clinical reason why alendronate tablets OR Fosamax® solution cannot be used ▪ **Etidronate disodium:** Trial not required for diagnosis of hetertrophic ossification ▪ **Forteo/ teriparatide:** Covered for high risk of fracture High risk of fracture: • BMD -3 or worse • Postmenopausal women with history of non-traumatic fractures • Postmenopausal women with 2 or more clinical risk factors ○ Family history of non-traumatic fractures ○ DXA BMD T-score ≤ -2.5 at any site ○ Glucocorticoid use ≥ 6 months at 7.5 dose of prednisolone equivalent ○ Rheumatoid Arthritis • Postmenopausal women with BMD T-score ≤ -2.5 at any site with any clinical risk factors ○ More than 2 units of alcohol per day ○ Current smoker • Men with primary or hypogonadal osteoporosis • Osteoporosis associated with sustained systemic glucocorticoid therapy • Trial of calcitonin-salmon not required • Maximum of 24 months treatment per lifetime
alendronate (generic Fosamax) **TAB** ibandronate (generic Boniva)[QL]	alendronate **SOLN** (generic Fosamax)[QL] ATELVIA DR (risedronate) BINOSTO (alendronate) etidronate disodium (generic Didronel) FOSAMAX PLUS D[QL] risedronate (generic Actonel)[QL]	
OTHER BONE RESORPTION SUPPRESSION AND RELATED DRUGS		
calcitonin-salmon **NASAL** FORTEO (teriparatide)[CL,QL] raloxifene (generic Evista)	EVISTA (raloxifene) teriparatide (generic Forteo) [CL,QL] TYMLOS (abaloparatide)	

BPH (BENIGN PROSTATIC HYPERPLASIA) TREATMENTS

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

CALCIUM CHANNEL BLOCKERS, ORAL

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

CEPHALOSPORINS AND RELATED ANTIBIOTICS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BETA LACTAM/BETA-LACTAMASE INHIBITOR COMBINATIONS		▪ Non-preferred agents will be approved for patients who have failed a 3-day trial of ONE preferred agent within the same group Drug Specific Criteria • **Cefixime**- May be approved for a diagnosis of gonorrhea, with an appropriate ICD-10 diagnosis code without a 3-day trial of a preferred agent • **Cefpodoxime**- May be approved for a diagnosis of pyelonephritis, with an appropriate ICD-10 diagnosis code without a 3-day trial of a preferred agent
amoxicillin/clavulanate **TAB, SUSP**	amoxicillin/clavulanate **CHEWABLE** amoxicillin/clavulanate ER (generic Augmentin XR) AUGMENTIN (amoxicillin/clavulanate) **SUSP, TAB**	
CEPHALOSPORINS – First Generation		
cefadroxil **CAPS, SUSP** (generic Duricef) cephalexin **CAPS, SUSP** (generic Keflex)	cefadroxil **TAB** (generic Duricef) cephalexin **TAB**	
CEPHALOSPORINS – Second Generation		
cefprozil (generic Cefzil) cefuroxime **TAB** (generic Ceftin)	cefaclor (generic Ceclor) CEFTIN (cefuroxime) **TAB, SUSP**	
CEPHALOSPORINS – Third Generation		
cefdinir (generic Omnicef)	cefixime (generic Suprax) **CAPS**, **SUSP** cefpodoxime (generic Vantin) SUPRAX (cefixime) **CAPS, CHEWABLE TAB, SUSP, TAB**	

CONTRACEPTIVES, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
All reviewed agents are recommended preferred at this time *Only those products for review are listed.* Brand name products may be subject to Maximum Allowable Cost (MAC) pricing or require substitution with a generic equivalent Specific agents can be looked up using the Drug Look-up Tool at: https://druglookup.fhsc.com/druglookupweb/?client=nestate	JOYEAUX (levonorgestrel and ethinyl estradiol and ferrous fumarate kit)[NR] levonorgestrel and ethinyl estradiol/ iron (generic Balcoltra)[NR] TURQOZ (norgestrel and ethinyl estradiol kit)[NR]	

CYSTIC FIBROSIS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	BRONCHITOL (mannitol) AL,CL,QL KALYDECO **PACKET, TAB** (ivacaftor)QL, AL ORKAMBI (lumacaftor/ivacaftor) **PACKET, TAB** QL, AL SYMDEKO (tezacaftor/ivacaftor)QL, AL TRIKAFTA(elexacaftor, tezacaftor, ivacaftor)AL, CL **PACKET**CL,NR**, TAB**	Drug-specific criteria: ▪ **Bronchitol**: Approved for diagnosis of CF and documentation that the patient has passed the BRONCHITOL Tolerance Test ▪ **Kalydeco®:** Diagnosis of CF and documentation of the drug-specific, FDA-approved mutation of CFTR gene ▪ **Orkambi®:** Diagnosis of CF and documentation of presence of two copies of the F580del mutation (homozygous) of CFTR gene ▪ **Symdeko:** Diagnosis of CF and documentation of the drug specific, FDA approved mutation of CFTR gene**.** ▪ **Trikafta:** Diagnosis of CF and documentation of at least one F508del mutation in the CFTR gene

DIURETICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
SINGLE-AGENT PRODUCTS		▪ Non-preferred agents will be approved for patients who have failed a trial of **TWO** preferred agents within this drug class ▪ **Eplerenone**: Will be approved with a failed trial or intolerance to spironolactone, a trial with two preferred agents is not required. ▪ **Kerendia**: For diagnosis of chronic kidney disease associated with Type-II diabetes in adults, trial of a preferred agent not required.
amiloride **TAB** bumetanide **TAB** chlorothiazide **TAB** chlorthalidone **TAB** (generic Diuril) furosemide **SOLN, TAB** (generic Lasix) hydrochlorothiazide **CAPS, TAB** (generic Microzide) indapamide **TAB** metolazone **TAB** spironolactone **TAB** (generic Aldactone) torsemide **TAB**	CAROSPIR (spironolactone) **SUSP** eplerenone **TAB** (generic Inspra)CL ethacrynic acid **CAPS** (generic Edecrin) KERENDIA (finerenone) **TAB** CL,QL spironolactone (generic Carospir)NR **SUSP** THALITONE (chlorthalidone) **TAB** triamterene (generic Dyrenium)	
COMBINATION PRODUCTS		
amiloride/HCTZ **TAB** spironolactone/HCTZ **TAB** (generic Aldactazide) triamterene/HCTZ **CAPS, TAB** (generic Dyazide, Maxzide)		

FLUOROQUINOLONES, ORAL

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

GI MOTILITY, CHRONIC

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

GLUCAGON AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BAQSIMI (glucagon)[AL,QL] **NASAL** GLUCAGON EMERGENCY (glucagon)[QL] **INJ KIT** (Lilly) glucagon[QL] **INJ** PROGLYCEM (diazoxide) **SUSP** ZEGALOGUE (dasiglucagon)[AL, QL] **AUTO-INJ**	diazoxide **SUSP** (generic Proglycem) GLUCAGON EMERGENCY (glucagon)[QL] **INJ KIT** (Fresenius) GVOKE (glucagon)[AL,QL] **KIT**, **PEN**, **SYR, VIAL** ZEGALOGUE (dasiglucagon)[AL, QL] **SYR**	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

GROWTH HORMONES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
GENOTROPIN (somatropin) NORDITROPIN (somatropin)	HUMATROPE (somatropin) NGENLA (somatrogon-ghla)[AL,NR] NUTROPIN AQ (somatropin) OMNITROPE (somatropin) SAIZEN (somatropin) SEROSTIM (somatropin) SKYTROFA (lonapegsomatropin-tcgd) SOGROYA (somapacitan-beco)[NR] ZOMACTON (somatropin) ZORBTIVE (somatropin)	Growth Hormone PA Form Growth Hormone Criteria

H. PYLORI TREATMENTS

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

HAE TREATMENTS [CL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BERINERT (C1 esterase inhibitor, human) **INTRAVENOUS** HAEGARDA (C1 esterase inhibitor, human)[AL,CL] **SUB-Q** icatibant acetate (generic FIRAZYR)[AL] **SUB-Q**	CINRYZE (C1 esterase inhibitor, human)[AL,CL] **INTRAVENOUS** FIRAZYR (icatibant acetate)[AL] **SUB-Q** ORLADEYO (berotralstat) **CAP**[AL,QL] RUCONEST (recombinant human C1 inhibitor)[AL] **INTRAVENOUS** TAKHZYRO (lanadelumab-flyo)[AL,CL] **VIAL** TAKHZYRO (lanadelumab-flyo)[AL,CL] **SYRINGE**	HAE Treatments PA Form • All agents require documentation of diagnosis of Type I or Type II HAE and deficient or dysfunctional C1 esterase inhibitor enzyme. Concomitant use with ACE inhibitors, NSAIDs, or estrogen-containing products is contraindicated • Non-preferred agents will be approved for patients who have a failed trial or a contraindication to ONE preferred agent within this drug class with the same indication. Drug-Specific Criteria • **Cinryze, Haegarda, Orladeyo, and Takhzyro,** require a history of two or more HAE attacks monthly

HEPATITIS B TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
entecavir **TAB**	adefovir dipivoxil BARACLUDE (entecavir) **SOLN, TAB** EPIVIR HBV (lamivudine) **TAB, SOLN** lamivudine hbv **TAB** VEMLIDY (tenofovir alafenamide fumarate)	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug Specific Criteria ▪ **tenofovir disoproxil fumarate (generic Viread) tablet**: Diagnosis for use required. May be indicated for chronic hepatitis B or HIV-1 infection. ○ See HIV/AIDS class for drug listing and placement

HEPATITIS C TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
DIRECT ACTING ANTI-VIRAL		Hepatitis C Treatments PA Form Hepatitis C Criteria ▪ Non-preferred products require trial of preferred agents within the same group and/or will only be considered with documentation of why the preferred product within this drug class is not appropriate for patient ▪ Patients newly eligible for Medicaid will be allowed to complete treatment with the original that treatment was initially authorized by another payor Drug-specific criteria: Trial with with a preferred agent not required in the following: ▪ **Harvoni/ ledipasvir-sofosbuvir**: ○ Post liver transplant for genotype 1 or 4 ▪ **Vosevi:** Requires documentation of non-response after previous treatment course of Direct Acting Anti-viral agent (DAA) for genotype 1-6 without cirrhosis or with compensated cirrhosis
MAVYRET (glecaprevir/pibrentasvir) **TAB**[CL], **PELLET**[AL,CL] sofosbuvir/velpatasvir (generic Epclusa)[CL] VOSEVI (sofosbuvir/velpatasvir/ voxilaprevir)[CL]	HARVONI 200/45MG, **TAB** (ledipasvir/sofosbuvir)[CL] HARVONI (ledipasvir/sofosbuvir)[CL] **PELLET** ledipasvir/sofosbuvir (generic Harvoni)[CL] SOVALDI (sofosbuvir)[CL] **PELLET** SOVALDI **TAB** (sofosbuvir)[CL] VIEKIRA **PAK** (ombitasvir/ paritaprevir/ritonavir/dasabuvir)[CL] ZEPATIER (elbasvir/grazoprevir)[CL]	
RIBAVIRIN		
ribavirin 200mg **CAPSULE, TAB**		
INTERFERON		
PEGASYS (pegylated interferon alfa-2a) [CL]		

HIV / AIDS [CL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CAPSID INHIBITOR		▪ All agents require: ○ Diagnosis of HIV/AIDS required, OR ○ Diagnosis of Pre and Post Exposure Prophylaxis ▪ Non-preferred agents will be approved for patients who have a diagnosis of HIV/AIDS and patient specific documentation of why the preferred products within this drug class are not appropriate for patient, including, but not limited to, drug resistance or concomitant conditions not recommended with preferred agents ▪ Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy
	SUNLENCA (lenacapavir)[QL]	
CCR5 ANTAGONISTS		
SELZENTRY **SOLN, TAB** (maraviroc)	maraviroc (generic Selzentry)	
FUSION INHIBITORS		
FUZEON **SUB-Q** (enfuvirtide)[QL]		
HIV-1 ATTACHMENT INHIBITOR		
	RUKOBIA ER (fostemsavir)[AL,QL]	
INTEGRASE STRAND TRANSFER INHIBITORS (INSTIs)		
ISENTRESS (raltegravir)[QL] ISENTRESS HD (raltegravir) TIVICAY (dolutegravir)	TIVICAY PD (dolutegravir)	
NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NNRTIs)		
EDURANT (rilpivirine) efavirenz **CAPS, TABLET** (generic Sustiva) INTELENCE (etravirine)[QL] PIFELTRO (doravirine)[QL]	etravirine (generic Intelence)[QL] nevirapine IR, ER (generic Viramune/Viramune XR) basglaSUSTIVA **CAPS, TABLET** (efavirenz) VIRAMUNE (nevirapine) **SUSP**	
NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTIs)		
abacavir **SOLN, TABLET** (generic Ziagen) EMTRIVA **CAPS, SOLN** (emtricitabine) lamivudine **SOLN, TABLET** (generic Epivir) zidovudine **CAPS, SYRUP, TABLET** (generic Retrovir)	didanosine DR (generic Videx EC) emtricitabine **CAPS** (generic for Emtriva) EPIVIR (lamivudine) RETROVIR (zidovudine) stavudine **CAPS** (generic Zerit) ZIAGEN (abacavir)	
NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTIs)		
tenofovir **TABLET** (generic Viread)	VIREAD (tenofovir) **POWDER**	
PHARMACOKINETIC ENHANCER		
	TYBOST (cobicistat)[QL]	

HIV / AIDS [CL] (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
PROTEASE INHIBITORS		▪ All agents require: ○ Diagnosis of HIV/AIDS required, OR ○ Diagnosis of Pre and Post Exposure Prophylaxis ▪ Non-preferred agents will be approved for patients who have a diagnosis of HIV/AIDS and patient specific documentation of why the preferred products within this drug class are not appropriate for patient, including, but not limited to, drug resistance or concomitant conditions not recommended with preferred agents ▪ Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy
atazanavir **CAPS** (generic Reyataz) NORVIR (ritonavir) **TAB** PREZISTA (darunavir) **TAB** ritonavir TAB (generic Norvir)	APTIVUS **CAPS, SOLN** (tipranavir) CRIXIVAN (indinavir) DARUNAVIR [AL,NR] **TAB** fosamprenavir **TAB** (generic Lexiva) LEXIVA **SUSP** (fosamprenavir) LEXIVA **TAB** (fosamprenavir) NORVIR **POWDER, SOLN** (ritonavir) PREZISTA (darunavir) **SUSP** REYATAZ **POWDER** (atazanavir) VIRACEPT (nelfinavir)	
COMBINATION PROTEASE INHIBITORS (PIs) or PIs plus PHARMACOKINETIC ENHANCER		▪ All agents require: ○ Diagnosis of HIV/AIDS required; OR ○ Diagnosis of Pre and Post Exposure Prophylaxis ▪ Non-preferred agents will be approved for patients who have a diagnosis of HIV/AIDS and patient specific documentation of why the preferred products within this drug class are not appropriate for patient, including, but not limited to, drug resistance or concomitant conditions not recommended with preferred agents ▪ Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy
EVOTAZ (atazanavir/cobicistat)[QL] lopinavir/ritonavir **SOLN, TAB** (generic Kaletra)	KALETRA **SOLN** (lopinavir/ritonavir) KALETRA **TAB** (lopinavir/ritonavir) PREZCOBIX (darunavir/cobicistat)[QL]	
COMBINATION NUCLEOS(T)IDE REVERSE TRANSCRIPTASE INHIBITORS		
abacavir/lamivudine (generic Epzicom) CIMDUO (lamivudine/tenofovir)[QL] DESCOVY (emtricitabine/tenofovir)[QL] emtricitabine/tenofovir (generic Truvada) lamivudine/zidovudine (generic Combivir)	abacavir/lamivudine/zidovudine (generic Trizivir) COMBIVIR (lamivudine/zidovudine) EPZICOM (abacavir sulfate/lamivudine) TRIZIVIR (abacavir/lamivudine/zidovudine) TRUVADA (emtricitabine/tenofovir)	

HIV / AIDS [CL] (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
COMBINATION PRODUCTS – MULTIPLE CLASSES		▪ All agents require: ○ Diagnosis of HIV/AIDS required, OR ○ Diagnosis of Pre and Post Exposure Prophylaxis ▪ Non-preferred agents will be approved for patients who have a diagnosis of HIV/AIDS and patient specific documentation of why the preferred products within this drug class are not appropriate for patient, including, but not limited to, drug resistance or concomitant conditions not recommended with preferred agents ▪ Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy
BIKTARVY (bictegravir/emtricitabine/tenofovir)[QL] COMPLERA (rilpivirine/emtricitabine/tenofovir) DELSTRIGO (doravirine/lamivudine/tenofovir)[QL] DOVATO (dolutegravir/lamivudine)[QL] efavirenz/emtricitabine/tenofovir (generic Atripla)[CL] GENVOYA (elvitegravier/cobicistat/emtricitabine/tenofovir)[QL, AL] JULUCA (dolutegravir/rilpivirine)[QL] ODEFSEY (emtricitabine/rilpivirine/tenofovir)[QL] STRIBILD (elvitegravir/cobicistat/emtricitabine/tenofovir)[QL] SYMFI (efavirenz/lamivudine/tenofovir)[QL] SYMFI LO (efavirenz/lamivudine/tenofovir)[QL] SYMTUZA (darunavir/cobicistat/emtricitabine/tenofovir)[QL] TRIUMEQ (dolutegravir/abacavir/lamivudine)	ATRIPLA (efavirenz/emtricitabine/tenofovir) efavirenz/lamivudine/tenofovir (generic for Symfi)[QL] efavirenz/lamivudine/tenofovir (generic for Symfi Lo)[QL] TRIUMEQ PD (abacavir, dolutegravir, and lamivudine) **SUSP**	

HYPOGLYCEMICS, ALPHA-GLUCOSIDASE INHIBITORS

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

HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS

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

HYPOGLYCEMICS, INSULIN AND RELATED DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
APIDRA (insulin glulisine) **SOLOSTAR, VIAL** HUMALOG (insulin lispro) U-100 **CARTRIDGE, PEN, VIAL** HUMALOG JR. (insulin lispro) U-100 **KWIKPEN** HUMALOG MIX **VIAL** (insulin lispro/lispro protamine) HUMALOG MIX **KWIKPEN** (insulin lispro/lispro protamine) HUMULIN (insulin) **VIAL** HUMULIN 70/30 **VIAL** HUMULIN U-500 **VIAL** HUMULIN R U-500 **KWIKPEN**CL HUMULIN OTC **PEN** HUMULIN 70/30 OTC **PEN** insulin aspart (generic for Novolog) insulin aspart/insulin aspart protamine **PEN, VIAL**(generic for Novolog Mix) insulin glargine **PEN, VIAL** insulin lispro (generic for Humalog) **PEN, VIAL, JR KWIKPEN** LANTUS SOLOSTAR **PEN** (insulin glargine) LANTUS (insulin glargine) **VIAL** LEVEMIR (insulin detemir) **PEN, VIAL** NOVOLIN (insulin) **PEN** NOVOLOG (insulin aspart) **CARTRIDGE, FLEXPEN, VIAL** NOVOLOG MIX **FLEXPEN** (insulin aspart/aspart protamine)	ADMELOG (insulin lispro) **PEN, VIAL** AFREZZA (regular insulin) **INHALATION** BASAGLAR (insulin glargine, rec) **PEN, TEMPO PEN**NR FIASP (insulin aspart) **CARTRIDGE, PEN, VIAL** HUMALOG (insulin lispro) **TEMPO PEN**NR HUMALOG (insulin lispro)CL U-200 **KWIKPEN** insulin degludec (generic Tresiba) 100U/mL **PEN**, **VIAL** insulin degludec (generic Tresiba) 200U/mL **PEN** insulin glargine (Toujeo)NR insulin glargine max (Toujeo Max)NR insulin glargine-YFGN **PEN, VIAL** (generic for Semglee-YFGN) insulin lispro/lispro protamine **KWIKPEN** (Humalog Mix Kwikpen) LYUMJEV **KWIKPEN, VIAL**(insulin lispro-aabc) LYUMJEV (insulin lispro-aabc) **TEMPO PEN** NOVOLIN (insulin) NOVOLIN 70/30 **VIAL**(insulin) NOVOLOG MIX (insulin aspart/aspart protamine) **VIAL** REZVOGLAR (insulin glargine-aglr)NR **KWIKPEN** SEMGLEE (insulin glargine) **PEN, VIAL** SEMGLEE YFGN (insulin glargine) **PEN, VIAL** TOUJEO SOLOSTAR (insulin glargine) TRESIBA (insulin degludec)	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: ▪ **Afrezza®:** Approved for T1DM on long-acting insulin with no current history of smoking or chronic lung disease • **Humulin® R U-500 Kwikpen:** May be approved for patients who require >200 units/day ▪ **Humalog U-200 Pen:** May be approved for patients who require > 100 units/day AND using an insulin pump

HYPOGLYCEMICS, MEGLITINIDES

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

HYPOGLYCEMICS, METFORMINS

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

HYPOGLYCEMICS, SGLT2

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
FARXIGA (dapagliflozin) CL.QL INVOKAMET (canagliflozin/ metformin) CL.QL INVOKANA (canagliflozin)CL JARDIANCE (empagliflozin) CL.QL SYNJARDY (empagliflozin/metformin)AL,CL,QL XIGDUO XR (dapagliflozin/metformin)CL.QL	dapagliflozinCL.NR,QL (generic Farxiga) dapagliflozin/metforminCL.NR.QL (generic Xigduo) INPEFA (sotagliflozin)NR,QL **TAB** INVOKAMET XR (canagliflozin/metformin)QL SEGLUROMET (ertugliflozin/metformin) QL STEGLATRO (ertugliflozin)QL SYNJARDY XR (empagliflozin/ metformin)AL,QL	Preferred agents require a diagnosis of Type II diabetes AND a trial and failure or intolerance to metformin, **OR** A diagnosis of ASCVD or Heart Failure, or Chronic Kidney Disease associated with a diagnosis of Type II diabetes (no metformin trial required) ▪ Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class Drug Specific Criteria: - **Farxiga/ dapagliflozin:** May be approved for a diagnosis of Heart Failure without a diagnosis of diabetes - May be approved for a diagnosis of chronic kidney disease at risk of progression without a diagnosis of diabetes • **Jardiance:** May be approved for a diagnosis of Heart Failure without a diagnosis of diabetes

HYPOGLYCEMICS, SULFONYLUREAS

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

HYPOGLYCEMICS, TZD

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

IMMUNOSUPPRESSIVES, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
azathioprine (generic Imuran) azathioprine (generic Azasan)[NR] cyclosporine, modified (generic Neoral) **CAPS** everolimus (generic Zortress)[AL] mycophenolate (generic Cellcept) **CAPS, TAB** RAPAMUNE (sirolimus) **SOLN** RAPAMUNE (sirolimus) **TAB** tacrolimus sirolimus (generic Rapamune) **SOLN, TAB**	ASTAGRAF XL (tacrolimus) AZASAN (azathioprine) cyclosporine **CAP**, **SOFTGEL** cyclosporine, modified (generic Neoral) **SOLN** ENVARSUS XR (tacrolimus) GENGRAF (cyclosporine, modified) **CAP, SOLN** mycophenolate (generic Cellcept) **SUSP** mycophenolic acid MYFORTIC (mycophenolate sodium) PROGRAF (tacrolimus) **CAPS, PACKET** REZUROCK (belumosudil)[AL,QL] **TAB** SANDIMMUNE (cyclosporine) **CAPS, SOLN** TAVNEOS (avacopan)[QL] **CAPS** ZORTRESS (everolimus) [AL]	Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class ▪ Patients established on existing therapy will be allowed to continue Drug Specific Criteria ▪ **Tavneos** (avacopan) ○ No trial of a preferred agent required with appropriate FDA indications with concurrent use of standard therapy, including glucocorticoids

LINCOSAMIDES / OXAZOLIDINONES / STREPTOGRAMINS

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

LIPOTROPICS, OTHER

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BILE ACID SEQUESTRANTS		▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: ▪ **Colesevelam**: Trial not required for diabetes control and monotherapy with metformin, sulfonylurea, or insulin has been inadequate ▪ **Juxtapid®/ Kynamro®:** ○ Approved for diagnosis of homozygous familial hypercholesterolemia (HoFH) OR ○ Treatment failure/maximized dosing/contraindication to ALL the following: statins, ezetimibe, niacin, fibric acid derivatives, omega-3 agents, bile acid sequestrants ○ Require faxed copy of REMS PA form
cholestyramine (generic Questran) colestipol **TAB** (generic Colestid)	colesevelam (generic Welchol) **TAB, PACKET** colestipol **GRANULES** (generic Colestid) QUESTRAN LIGHT (cholestyramine)	
TREATMENT OF HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA		
	JUXTAPID (lomitapide)[CL] KYNAMRO (mipomersen)[CL]	
FIBRIC ACID DERIVATIVES		
fenofibrate (generic Tricor) fenofibrate (generic Lofibra) gemfibrozil (generic Lopid)	fenofibric acid (generic Fibricor/Trilipix) fenofibrate (generic Antara/Fenoglide/ Lipofen/Triglide)	
NIACIN		
niacin ER (generic Niaspan)	NIACOR (niacin IR)	
OMEGA-3 FATTY ACIDS		
omega-3 fatty acids (generic Lovaza) VASCEPA (icosapent)	icosapent (generic Vascepa)[CL] omega-3 OTC	
CHOLESTEROL ABSORPTION INHIBITORS		
ezetimibe (generic Zetia)	NEXLETOL (bempedoic acid) NEXLIZET (bempedoic acid/ ezetimibe)[QL]	

LIPOTROPICS, OTHER (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
PROPROTEIN CONVERTASE SUBTILISIN/KEXIN TYPE 9 (PCSK9) INHIBITORS		
PRALUENT (alorocumab)[CL]	REPATHA (evolocumab)[CL]	▪ **Praluent®:** Approved for diagnoses of: • atherosclerotic cardiovascular disease (ASCVD) • heterozygous familial hypercholesterolemia (HeFH) • Homozygous familial hypercholesterolemia (HoFH) as an adjunct to other LDL-C lowering therapies • AND • Trial and failure or intolerance to a statin for 8 continuous weeks • Failure to reach target LDL-C levels: ASCVD - < 70 mg/dL, HeFH - < 100 mg/dL ▪ **Repatha®:** May be approved for: • adult diagnoses of atherosclerotic cardiovascular disease (ASCVD) • heterozygous familial hypercholesterolemia (HeFH) in adults and pediatric patients aged 10 years and older • homozygous familial hypercholesterolemia (HoFH) in adults and pediatric patients aged 10 years and older AND • Maximized high-intensity statin WITH ezetimibe for 3+ continuous months • Failure to reach target LDL-C levels: ASCVD - < 70 mg/dL, HeFH - < 100 mg/dL • Concurrent use of maximally-tolerated statin must continue, except for statin-induced rhabdomyolysis or a contraindication to a statin

LIPOTROPICS, STATINS

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

MACROLIDES AND KETOLIDES, ORAL

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

MULTIPLE SCLEROSIS DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
AVONEX (interferon beta-1a)[QL] BETASERON (interferon beta-1b)[QL] COPAXONE 20mg (glatiramer)[QL] dimethyl fumarate (generic for Tecfidera) fingolimod (generic Gilenya)[QL] KESIMPTA (Ofatumumab)[CL,QL] teriflunomide (generic Aubagio)[QL]	AUBAGIO (teriflunomide)[QL] BAFIERTAM (monomethyl fumarate)[QL] dalfampridine (generic Ampyra)[QL] EXTAVIA (interferon beta-1b)[QL] GILENYA (fingolimod)[QL] glatiramer (generic Copaxone)[QL] MAVENCLAD (cladribine) MAYZENT (siponimod)[QL] PLEGRIDY (peginterferon beta-1a)[QL] PONVORY (ponesimod) REBIF (interferon beta-1a)[QL] TASCENSO ODT (fingolimod) **TAB**[AL] TECFIDERA (dimethyl fumarate) VUMERITY (diroximel)[QL] ZEPOSIA (ozanimod)[AL,CL,QL]	▪ Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agent within this drug class Drug-specific criteria: ▪ **Ampyra/ dalfampridine:** Approved for diagnosis of gait disorder associated with MS AND EDSS score ≤ 7 ▪ **Plegridy:** Approved for diagnosis of relapsing MS ▪ **Kesimpta:** Approved for patients who have failed a trial of a preferred injectable agent within this class ▪ **Zeposia:** Approved for a diagnosis of relapsing forms of multiple sclerosis (MS) with trial of ONE preferred agent OR a diagnosis of moderately to severely active ulcerative colitis and treatment failure of Humira.

NITROFURAN DERIVATIVES

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

OPIOID DEPENDENCE TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
buprenorphine **SL** buprenorphine/naloxone **TAB (SL)** SUBOXONE **FILM** (buprenorphine/ naloxone)	buprenorphine/naloxone **FILM** LUCEMYRA (lofexidine)[CL,QL] ZUBSOLV (buprenorphine/naloxone)	Opioid Dependence Treatment PA Form Opioid Dependence Treatment Informed Consent ▪ 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. Drug-specific criteria: ▪ **Lucemyra**: Approved for FDA approved indication and dosing per label. Trial of preferred product not required.

OPIOID-REVERSAL TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
naloxone **NASAL(Rx), SYR, VIAL** naltrexone **TAB**	KLOXXADO (naloxone) **NASAL** naloxone (generic Narcan) **OTC NASAL** NARCAN (naloxone) **NASAL** NARCAN (naloxone) **NASAL OTC** OPVEE (nalmefene)[AL] **NASAL** 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

PAH (PULMONARY ARTERIAL HYPERTENSION AGENTS), ORAL AND INHALED

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

PANCREATIC ENZYMES

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

PEDIATRIC VITAMIN PREPARATIONS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CHILD MVI (mvi, ped mvi no. 19/FA, ped mvi no. 17) **OTC CHEW** CHILDREN'S MVI-IRON **OTC CHEW** (ped mvi no. 91/iron fum) CHILDREN'S CHEWABLES **OTC** (ped mvi no. 25/FA, ped mvi no. 31 /iron/FA, ped mvi no.17/iron sulf) CHILDREN'S VITAMINS W/ IRON **CHEW OTC** (mvi with iron) FLUORIDE/VITAMINS A,C,AND D **DROPS** (ped mvi A,C,D3 no.21/ fluoride) MULTIVITAMINS W/ FLUORIDE (PEDI MVI NO.2 W-FLUORIDE) **DROPS** MULTIVITS W/ IRON & FLUORIDE **DROPS** (ped mvi no. 45/fluoride/iron) PED MVI NO. 16 w/ FLUORIDE **CHEW** PED MVI NO.17 W/ FLUORIDE **CHEW** POLY-VITAMIN (ped mvi no. 212) **DROPS OTC** POLY-VITAMIN W/ IRON (ped mvi no. 207 w/ferrous sulf) **DROPS OTC** TRI-VI-SOL (vit A palmitate/vit C/vit D3) TRI-VITAMIN W/ FLUORIDE (ped mvi A,C, D3 no. 21/fluoride)	DEKAs PLUS[AL] FLORIVA (ped mvi no.85/fluoride) **CHEW** FLORIVA PLUS (ped mvi no.161/fluoride) **OTC DROP** MULTI-VIT-FLOR (ped mvi no.205/fluoride) **CHEW** PEDI MVI NO.242/FLUORIDE CHEW[NR] **OTC** POLY-VI-FLOR (ped mvi no.217/fluoride, ped mvi no. 205/fluoride) **CHEW** POLY-VI-FLOR (ped mvi no.213 w/fluoride) **DROPS** POLY-VI-FLOR W/ IRON (ped mvi no. 205/fluoride/iron) **CHEW** POLY-VI-FLOR W/ IRON (ped mvi no. 214/fluoride/iron) **DROP** QUFLORA (ped mvi no.84/fluoride, ped mvi no. 63/fluoride, ped mvi no. 83/fluoride) QUFLORA FE (ped mvi 142/iron/fluoride, ped mvi no. 151/iron/fluoride) **CHEW** QUFLORA (ped mvi no.157/ fluoride) **OTC** TRI-VI-FLOR (ped mvi A,C,D3 no.38/fluoride) **DROPS**	▪ Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class Drug specific criteria: ▪ **DEKAs Plus**: Approved for diagnosis of Cystic Fibrosis and does not require a trial of a preferred agent

PENICILLINS

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

PHOSPHATE BINDERS

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

PLATELET AGGREGATION INHIBITORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
aspirin BRILINTA (ticagrelor) clopidogrel (generic Plavix) dipyridamole (generic Persantine) prasugrel (generic Effient)	aspirin/dipyridamole (generic Aggrenox) ticlopidine (generic Ticlid) YOSPRALA (aspirin/omeprazole)	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class OR documented clopidogrel resistance

Additional covered agents can be looked up using the Drug Look-up Tool at:
https://druglookup.fhsc.com/druglookupweb/?client=nestate

PRENATAL VITAMINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
COMPLETENATE CHEW TAB EXPECTA PRENATAL **OTC** FE C/FA MARNATAL-F PNV NO.118/IRON FUMARATE/FA **CHEW TAB** PNV W-CA NO.40/IRON FUM/FA CMB NO.1 PNV WITH CA,NO.72/IRON/FA PNV#16/IRON FUM & PS/FA/OM-3 PNV2/IRON B-G SUC-P/FA/OMEGA-3 PNV2/IRON B-G SUC-P/FA/OMEGA-3 PRENATAL VIT #76/IRON, CARB/FA PRENATAL VIT/FE FUMARATE/FA **OTC** PRENATAL VITAMIN OTC PUREFE OB PLUS PUREFE PLUS STUART ONE **OTC** TRINATAL RX 1 VITAFOL **CHEW TAB** VITAFOL ULTRA	CITRANATAL B-CALM DERMACINRX PRENATRIX **OTC** DERMACINRX PRETRATE **OTC** ENBRACE HR FE C/VIT C/VIT B12/FA OTC MULTI-MAC **OTC** NESTABS NESTABS ABC NESTABS DHA NESTABS ONE OB COMPLETE ONE OB COMPLETE PETITE OB COMPLETE PREMIER OB COMPLETE **TAB** OB COMPLETE WITH DHA PNV 11-IRON FUM-FOLIC ACID-OM3 PNV119/IRON FUMARATE/FA/DSS PNV COMBO#47/IRON/FA #1/DHA PNV NO.15/IRON FUM & PS CMP/FA PNV WITH CA NO.68/IRON/FA NO.1/DHA PNV WITH CA, NO.74/IRON/FA **OTC** PRENATAL + DHA **OTC** PRENATAL MULTI OTC PRENATE AM PRENATE **CHEW TAB** PRENATE DHA PRENATE ELITE PRENATE ENHANCE PRENATE ESSENTIAL PRENATE MINI PRENATE PIXIE PRENATE RESTORE PRENATE STAR PRIMACARE SELECT-OB **CHEW TAB** SELECT-OB + DHA TENDERA-OB OTC TRICARE TRINATAL RX 1 TRISTART DHA VITAFOL FE+ VITAFOL NANO VITAFOL-OB VITAFOL-OB+DHA VITAFOL-ONE WESTGEL DHA	▪ Non-preferred agents will be approved for patients who have failed a trial of or are intolerant to TWO preferred agents within this drug class

PROTON PUMP INHIBITORS

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

SINUS NODE INHIBITORS

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

SKELETAL MUSCLE RELAXANTS

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

TETRACYCLINES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
doxycycline hyclate IR (generic Vibramycin) doxycycline monohydrate **50MG, 100MG CAPS** doxycycline monohydrate **SUSP, TAB** (generic Vibramycin) minocycline HCl **CAPS** (generic Dynacin/ Minocin/Myrac)	demeclocycline (generic Declomycin)[CL] DORYX MPC DR (doxycycline pelletized) doxycycline hyclate DR (generic Doryx) doxycycline monohydrate 40MG, 75MG and 150MG **CAP** (generic Adoxa/Monodox/ Oracea) minocycline HCl **TAB** (generic Dynacin/Myrac) minocycline HCl ER (generic Solodyn) NUZYRA (omadacycline) tetracycline VIBRAMYCIN **SUSP** (doxycycline) XIMINO (minocycline ER)[QL]	▪ Non-preferred agents will be approved for patients who have failed a sequential 3-day trial of TWO preferred agents within this drug class Drug-specific criteria: ▪ **Demeclocycline:** Approved for diagnosis of SIADH ▪ **doxycycline suspension:** May be approved with documented swallowing difficulty

THYROID HORMONES

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

ULCERATIVE COLITIS

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

UTERINE DISORDER TREATMENT

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
MYFEMBREE (relugolix/ estradiol/ norethindrone acetate)[AL, CL,QL] ORIAHNN (elagolix/ estradiol/ norethindrone)[AL,CL] ORILISSA (elagolix sodium)[QL,CL]		Drug-specific criteria: • **Myfembree, Orilissa, and Oriahnn:** Requires an FDA approved indication, must follow FDA dosing guidelines, and have had a trial and failure of an NSAID and oral contraceptive ○ Total duration of treatment is max of 24 months

VASODILATORS, CORONARY

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
isosorbide dinitrate **TAB** isosorbide dinitrate ER, SA **TAB (generic Dilatrate-SR/Isordil)** isosorbide dinitrate/hydralazine (Bidil)[CL] isosorbide mono IR/SR **TAB** nitroglycerin **SUBLINGUAL, TRANSDERMAL** nitroglycerin ER **TAB**	BIDIL (isosorbide dinitrate/ hydralazine)[CL] GONITRO (nitroglycerin) isosorbide dinitrate **TAB (Oceanside Pharm MFR only)** NITRO-BID **OINT** (nitroglycerin) NITRO-DUR (nitroglycerin) nitroglycerin **TRANSLINGUAL** (generic Nitrolingual) VERQUVO (vericiguat)[AL,CL,QL]	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: ▪ **BiDil/ isosorbide dinitrate hydralazine:** Approved for the treatment of heart failure as an adjunct therapy to standard therapy in self-identified black patients ▪ **Verquvo:** Approved for use in patients following a recent hospitalization for HF within the past 6 months OR need for outpatient IV diuretics, in adults with symptomatic chronic HF and EF less than 45%

7. **Adjournment / Old Business**

   a. No old business topics were discussed by the committee.
   b. A vote to conclude the meeting was made at 1:55 PM CST.

(1st) Motion: Baker	**(2nd) Motion:** Avery
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, November 13th, 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: ShaLeigh Hammons, CPhT – Account Operations Executive
Magellan Rx Management, Prime Therapeutics