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

PHARMACEUTICAL AND THERAPEUTICS (P&T) COMMITTEE MEETING MINUTES

Wednesday, November 13th 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.
Cassie Cowles, APRN
Allison Dering-Anderson, Pharm.D. (First hour Only) **(Chair)**
Stephen Dolter, M.D.
Wade Fornander, M.D. **(Vice Chair)**
Jennifer Hill, M.D.
Laura Klug, Pharm.D.
Stephen Salzbrenner, M.D
Sarah Stewart-Bouckaert, 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.
Lee Stutzman, Pharm.D.

Prime Therapeutics 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., Molina
Bernadette Ueda, Pharm. D., United Healthcare of Nebraska

Committee Members Excused:
Claire Baker, M.D.
Andrew Bendlin, Pharm.D.
C. Jose Friesen, M.D.
Joyce Juracek, Pharm.D.
Jessica Pohl, Pharm.D.
Bradley Sundsboe, 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 9:04 AM CST. The agenda was posted on the Nebraska Medicaid Pharmacy website (https://nebraska.fhsc.com/PDL/PTcommittee.asp) on Monday, October 14th. 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 Stephen Salzbrenner, M.D. as the newest committee member since he was unable to attend in May.
   - **c.** Roll Call: See list above.
   - **d.** Conflict of Interest: Dr. Salzbrenner explained that he is working on a new PA software tool.
   - **e.** Approval of May 8th, 2024 P&T Committee Meeting Minutes.

Approval of May 8th, 2024 P&T Committee Meeting Minutes							
(1st) Motion: Avery							
(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			Hill, Jennifer, M.D.	X		
Cowles, Cassie, APRN	X			Klug, Laura, Pharm.D.	X		
Dering-Anderson, Allison, Pharm.D. (Chair) ***Votes only in the event of a tie***	X			Salzbrenner, Stephen, M.D.			X
Dolter, Stephen, M.D.	X			Stewart-Bouckaert, Sarah, 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 and department updates. She announced the resignation of committee members, Dr. Rachelle Kaspar-Cope and Dr. Linda Sobeski, and introduced the new Pharmacy Director, Lee Stutzman, PharmD. She asked for suggestions from the committee members for P&T dates surrounding the second meeting in 2025.

g. Prime Announcement: Nikia Bennette-Carter, Clinical Account Manager for Prime Therapeutics, formerly Magellan RX Management announced the official change of name to Prime Therapeutics. The committee asked if this update and the acquisition had been approved by the Nebraska Medicaid legal department. Leah Spencer confirmed with Carisa Schweitzer- Masek that it had been reviewed and approved by legal. The committee also questioned if this change could be considered a conflict of interest. Nikia assured the committee it was not and made the following statement: “100% of rebates collected go to the State agency for management. Given the recent press about the pharmaceutical industry, I think it is important for the attendees to understand that the decisions made by this Committee do NOT impact the compensation that Prime Therapeutics receives for our PDL services. Similarly, the decisions made by the Committee do NOT impact the compensation of Prime employees. Bottom line Prime is not incentivized to recommend any one product over another.

2. **Public Testimony**

Speaker Order	DRUG CLASS	Drug Name	PDL Status	Speaker Name	Affiliation
1	Cytokine & CAM Antagonists	Bimzelx	NP	Loral Showalter	UCB
2	Cytokine & CAM Antagonists	Tremfya	NP	Kai Thompson	Johnson & Johnson
3	Cytokine & CAM Antagonists	Otezla	P	Becky Waltner	Amgen
4	Movement Disorders	Austedo	P	Dave Miley	Teva
5	Immunomodulators, Atopic Dermatitis	Zoryve	NP	Brett Stephenson	Arcutis Biotherapeutics
6	Antipsoriatics, Topical	Zoryve	NP	Brett Stephenson	Arcutis Biotherapeutics
7	Stimulants & Related ADHD Drugs	Sunosi	NP	Ronnie Depue	Axsome Therapeutics

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. Becky Waltner for Enbrel

ii. Becky Waltner for Tezspire
iii. Dave Miley for Simlandi
iv. Brent Milovac for Adbry

3. **Committee Closed Session**

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

4. **Resume Open Session**

A motion was made to Resume Open Session and was unanimously approved by all in attendance.
Due to a prior disclosed obligation, Chairperson, Dr. Allison Dering-Anderson had to leave the meeting. The Vice-Chair, Dr. Wade Fornander presided over the meeting in her absence.

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: Avery
(2nd) Motion: Cowles
Discussion: Committee removed one Consent Agenda class and added it to Therapeutic Class Reviews: Oncology, Oral-Prostate. 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			Hill, Jennifer, M.D.	X		
Cowles, Cassie, APRN	X			Klug, Laura, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Salzbrenner, Stephen, M.D.	X		
Fornander, Wade, M.D. (Vice Chair) ***Votes only in the event of a tie***				Stewart-Bouckaert, Sarah, Pharm.D.	X		

Consent Agenda: Therapeutic categories (TC) with unchanged recommendations unless otherwise indicated.	
ALZHEIMER'S AGENTS	IMMUNOMODULATORS, ASTHMA
ANTHELMINTICS	LEUKOTRIENE MODIFIERS
ANTI-ALLERGENS, ORAL	ONCOLOGY, ORAL - PROSTATE **(Removed)**
ANTIHISTAMINES, MINIMALLY SEDATING	OPHTHALMIC ANTIBIOTICS
ANTIPSORIATICS, TOPICAL	OPHTHALMIC ANTIBIOTIC-STEROID COMBINATIONS
ANXIOLYTICS	OPHTHALMICS, GLAUCOMA AGENTS
BRONCHODILATORS, BETA AGONIST	OTIC ANTI-INFECTIVES & ANESTHETICS

COUGH AND COLD, NARCOTIC	STEROIDS, TOPICAL LOW
ENZYME REPLACEMENT, GAUCHERS DISEASE	STEROIDS, TOPICAL MEDIUM
EPINEPHRINE, SELF-INJECTED	STEROIDS, TOPICAL HIGH
HEMOPHILIA TREATMENT	STEROIDS, TOPICAL VERY HIGH

b. Therapeutic Class Reviews

Review Agenda – ANTIHYPERTENSIVES, SYMPATHOLYTICS

(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			Hill, Jennifer, M.D.	X		
Cowles, Cassie, APRN	X			Klug, Laura, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Salzbrenner, Stephen, M.D.	X		
Fornander, Wade, M.D. (Vice Chair) ***Votes only in the event of a tie***				Stewart-Bouckaert, Sarah, Pharm.D.	X		

Review Agenda – ANTIHYPERURICEMICS

(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			Hill, Jennifer, M.D.	X		
Cowles, Cassie, APRN	X			Klug, Laura, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Salzbrenner, Stephen, M.D.	X		
Fornander, Wade, M.D. (Vice Chair) ***Votes only in the event of a tie***				Stewart-Bouckaert, Sarah, Pharm.D.	X		

Review Agenda – ANTIPARKINSON'S 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			Hill, Jennifer, M.D.	X		
Cowles, Cassie, APRN	X			Klug, Laura, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Salzbrenner, Stephen, M.D.	X		
Fornander, Wade, M.D. (Vice Chair) ***Votes only in the event of a tie***				Stewart-Bouckaert, Sarah, Pharm.D.	X		

Review Agenda – ANTIPSORIATICS, ORAL

(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			Hill, Jennifer, M.D.	X		
Cowles, Cassie, APRN	X			Klug, Laura, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Salzbrenner, Stephen, M.D.	X		
Fornander, Wade, M.D. (Vice Chair) ***Votes only in the event of a tie***				Stewart-Bouckaert, Sarah, Pharm.D.	X		

Review Agenda – BILE SALTS							
(1st) Motion: Dolter							
(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			Hill, Jennifer, M.D.	X		
Cowles, Cassie, APRN	X			Klug, Laura, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Salzbrenner, Stephen, M.D.	X		
Fornander, Wade, M.D. (Vice Chair) ***Votes only in the event of a tie***				Stewart-Bouckaert, Sarah, Pharm.D.	X		

Review Agenda – COLONY STIMULATING FACTORS							
(1st) Motion: Hill							
(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			Hill, Jennifer, M.D.	X		
Cowles, Cassie, APRN	X			Klug, Laura, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Salzbrenner, Stephen, M.D.	X		
Fornander, Wade, M.D. (Vice Chair) ***Votes only in the event of a tie***				Stewart-Bouckaert, Sarah, Pharm.D.	X		

Review Agenda – COPD AGENTS							
(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			Hill, Jennifer, M.D.	X		
Cowles, Cassie, APRN	X			Klug, Laura, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Salzbrenner, Stephen, M.D.	X		
Fornander, Wade, M.D. (Vice Chair) ***Votes only in the event of a tie***				Stewart-Bouckaert, Sarah, Pharm.D.	X		

Review Agenda – CYTOKINE AND CAM ANTAGONISTS							
(1st) Motion: Dolter							
(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			Hill, Jennifer, M.D.	X		
Cowles, Cassie, APRN	X			Klug, Laura, Pharm.D.	X		
Dolter, Stephen, M.D	X			Salzbrenner, Stephen, M.D.	X		
Fornander, Wade, M.D. (Vice Chair) ***Votes only in the event of a tie***				Stewart-Bouckaert, Sarah, Pharm.D.	X		

Review Agenda – ERYTHROPOIESIS STIMULATING PROTEINS							
(1st) Motion: Dolter							
(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			Hill, Jennifer, M.D.	X		
Cowles, Cassie, APRN	X			Klug, Laura, Pharm.D.	X		
Dolter, Stephen, M.D	X			Salzbrenner, Stephen, M.D.	X		
Fornander, Wade, M.D. (Vice Chair) ***Votes only in the event of a tie***				Stewart-Bouckaert, Sarah, Pharm.D.	X		

Review Agenda – GLUCOCORTICOIDS, INHALED							
(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			Hill, Jennifer, M.D.	X		
Cowles, Cassie, APRN	X			Klug, Laura, Pharm.D.	X		
Dolter, Stephen, M.D	X			Salzbrenner, Stephen, M.D.	X		
Fornander, Wade, M.D. (Vice Chair) ***Votes only in the event of a tie***				Stewart-Bouckaert, Sarah, Pharm.D.	X		

Review Agenda – GLUCOCORTICOIDS, ORAL							
(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			Hill, Jennifer, M.D.	X		
Cowles, Cassie, APRN	X			Klug, Laura, Pharm.D.	X		
Dolter, Stephen, M.D	X			Salzbrenner, Stephen, M.D.	X		
Fornander, Wade, M.D. (Vice Chair) ***Votes only in the event of a tie***				Stewart-Bouckaert, Sarah, Pharm.D.	X		

Review Agenda – HISTAMINE II RECEPTOR BLOCKER							
(1st) Motion: Dolter							
(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			Hill, Jennifer, M.D.	X		
Cowles, Cassie, APRN	X			Klug, Laura, Pharm.D.	X		
Dolter, Stephen, M.D	X			Salzbrenner, Stephen, M.D.	X		
Fornander, Wade, M.D. (Vice Chair) ***Votes only in the event of a tie***				Stewart-Bouckaert, Sarah, Pharm.D.	X		

Review Agenda – IDIOPATHIC PULMONARY FIBROSIS							
(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			Hill, Jennifer, M.D.	X		
Cowles, Cassie, APRN	X			Klug, Laura, Pharm.D.	X		
Dolter, Stephen, M.D	X			Salzbrenner, Stephen, M.D.	X		
Fornander, Wade, M.D. (Vice Chair) ***Votes only in the event of a tie***				Stewart-Bouckaert, Sarah, Pharm.D.	X		

Review Agenda – IMMUNOMODULATORS, ATOPIC DERMATITIS							
(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			Hill, Jennifer, M.D.	X		
Cowles, Cassie, APRN	X			Klug, Laura, Pharm.D.	X		
Dolter, Stephen, M.D	X			Salzbrenner, Stephen, M.D.	X		
Fornander, Wade, M.D. (Vice Chair) ***Votes only in the event of a tie***				Stewart-Bouckaert, Sarah, Pharm.D.	X		

Review Agenda – IMMUNOMODULATORS, TOPICAL							
(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			Hill, Jennifer, M.D.	X		
Cowles, Cassie, APRN	X			Klug, Laura, Pharm.D.	X		
Dolter, Stephen, M.D	X			Salzbrenner, Stephen, M.D.	X		
Fornander, Wade, M.D. (Vice Chair) ***Votes only in the event of a tie***				Stewart-Bouckaert, Sarah, Pharm.D.	X		

Review Agenda – INTRANASAL RHINITIS 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			Hill, Jennifer, M.D.	X		
Cowles, Cassie, APRN	X			Klug, Laura, Pharm.D.	X		
Dolter, Stephen, M.D	X			Salzbrenner, Stephen, M.D.	X		
Fornander, Wade, M.D. (Vice Chair) ***Votes only in the event of a tie***				Stewart-Bouckaert, Sarah, Pharm.D.	X		

Review Agenda – METHOTREXATE							
(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			Hill, Jennifer, M.D.	X		
Cowles, Cassie, APRN	X			Klug, Laura, Pharm.D.	X		
Dolter, Stephen, M.D	X			Salzbrenner, Stephen, M.D.	X		
Fornander, Wade, M.D. (Vice Chair) ***Votes only in the event of a tie***				Stewart-Bouckaert, Sarah, Pharm.D.	X		

Review Agenda – MOVEMENT DISORDERS							
(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			Hill, Jennifer, M.D.	X		
Cowles, Cassie, APRN	X			Klug, Laura, Pharm.D.	X		
Dolter, Stephen, M.D	X			Salzbrenner, Stephen, M.D.	X		
Fornander, Wade, M.D. (Vice Chair) ***Votes only in the event of a tie***				Stewart-Bouckaert, Sarah, Pharm.D.	X		

Review Agenda – NSAIDs							
(1st) Motion: Dolter							
(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			Hill, Jennifer, M.D.	X		
Cowles, Cassie, APRN	X			Klug, Laura, Pharm.D.	X		
Dolter, Stephen, M.D	X			Salzbrenner, Stephen, M.D.	X		
Fornander, Wade, M.D. (Vice Chair) ***Votes only in the event of a tie***				Stewart-Bouckaert, Sarah, Pharm.D.	X		

Review Agenda – ONCOLOGY, ORAL- BREAST							
(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			Hill, Jennifer, M.D.	X		
Cowles, Cassie, APRN	X			Klug, Laura, Pharm.D.	X		
Dolter, Stephen, M.D	X			Salzbrenner, Stephen, M.D.	X		
Fornander, Wade, M.D. (Vice Chair) ***Votes only in the event of a tie***				Stewart-Bouckaert, Sarah, Pharm.D.	X		

Review Agenda – ONCOLOGY, ORAL- HEMATOLOGIC							
(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			Hill, Jennifer, M.D.	X		
Cowles, Cassie, APRN	X			Klug, Laura, Pharm.D.	X		
Dolter, Stephen, M.D	X			Salzbrenner, Stephen, M.D.	X		
Fornander, Wade, M.D. (Vice Chair) ***Votes only in the event of a tie***				Stewart-Bouckaert, Sarah, Pharm.D.	X		

Review Agenda – ONCOLOGY, ORAL- LUNG							
(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			Hill, Jennifer, M.D.	X		
Cowles, Cassie, APRN	X			Klug, Laura, Pharm.D.	X		
Dolter, Stephen, M.D	X			Salzbrenner, Stephen, M.D.	X		
Fornander, Wade, M.D. (Vice Chair) ***Votes only in the event of a tie***				Stewart-Bouckaert, Sarah, Pharm.D.	X		

Review Agenda – ONCOLOGY, ORAL- OTHER							
(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			Hill, Jennifer, M.D.	X		
Cowles, Cassie, APRN	X			Klug, Laura, Pharm.D.	X		
Dolter, Stephen, M.D	X			Salzbrenner, Stephen, M.D.	X		
Fornander, Wade, M.D. (Vice Chair) ***Votes only in the event of a tie***				Stewart-Bouckaert, Sarah, Pharm.D.	X		

Review Agenda – ONCOLOGY, ORAL- PROSTATE							
(1st) Motion: Avery							
(2nd) Motion: Hill							
Discussion: Avery made a motion to move Xtandi from P to NP.							
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			Hill, Jennifer, M.D.	X		
Cowles, Cassie, APRN	X			Klug, Laura, Pharm.D.	X		
Dolter, Stephen, M.D	X			Salzbrenner, Stephen, M.D.	X		
Fornander, Wade, M.D. (Vice Chair) ***Votes only in the event of a tie***				Stewart-Bouckaert, Sarah, Pharm.D.	X		

Review Agenda – ONCOLOGY, ORAL- RENAL CELL							
(1st) Motion: Avery							
(2nd) Motion: Cowles							
Discussion: Avery made a motion to move generic everolimus tablet 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			Hill, Jennifer, M.D.	X		
Cowles, Cassie, APRN	X			Klug, Laura, Pharm.D.	X		
Dolter, Stephen, M.D	X			Salzbrenner, Stephen, M.D.	X		
Fornander, Wade, M.D. (Vice Chair) ***Votes only in the event of a tie***				Stewart-Bouckaert, Sarah, Pharm.D.	X		

Review Agenda – ONCOLOGY, ORAL- SKIN							
(1st) Motion: Avery							
(2nd) Motion: Cowles							
Discussion: Avery made a motion to move Erivedge from P to NP.							
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			Hill, Jennifer, M.D.	X		
Cowles, Cassie, APRN	X			Klug, Laura, Pharm.D.	X		
Dolter, Stephen, M.D	X			Salzbrenner, Stephen, M.D.	X		
Fornander, Wade, M.D. (Vice Chair) ***Votes only in the event of a tie***				Stewart-Bouckaert, Sarah, Pharm.D.	X		

Review Agenda – OPHTHALMICS FOR ALLERGIC CONJUCTIVITIS							
(1st) Motion: Hill							
(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			Hill, Jennifer, M.D.	X		
Cowles, Cassie, APRN	X			Klug, Laura, Pharm.D.	X		
Dolter, Stephen, M.D	X			Salzbrenner, Stephen, M.D.	X		
Fornander, Wade, M.D. (Vice Chair) ***Votes only in the event of a tie***				Stewart-Bouckaert, Sarah, Pharm.D.	X		

Review Agenda – OPHTHALMICS, ANTI-INFLAMMATORIES							
(1st) Motion: Dolter							
(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 – OPHTHALMICS, ANTI-INFLAMMTORY/IMMUNOMODULATOR							
(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			Hill, Jennifer, M.D.	X		
Cowles, Cassie, APRN	X			Klug, Laura, Pharm.D.	X		
Dolter, Stephen, M.D	X			Salzbrenner, Stephen, M.D.	X		
Fornander, Wade, M.D. (Vice Chair) ***Votes only in the event of a tie***				Stewart-Bouckaert, Sarah, Pharm.D.	X		

Review Agenda – OTIC ANTIBIOTICS							
(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			Hill, Jennifer, M.D.	X		
Cowles, Cassie, APRN	X			Klug, Laura, Pharm.D.	X		
Dolter, Stephen, M.D	X			Salzbrenner, Stephen, M.D.	X		
Fornander, Wade, M.D. (Vice Chair) ***Votes only in the event of a tie***				Stewart-Bouckaert, Sarah, Pharm.D.	X		

Review Agenda – SEDATIVE HYPNOTICS							
(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			Hill, Jennifer, M.D.	X		
Cowles, Cassie, APRN	X			Klug, Laura, Pharm.D.	X		
Dolter, Stephen, M.D	X			Salzbrenner, Stephen, M.D.	X		
Fornander, Wade, M.D. (Vice Chair) ***Votes only in the event of a tie***				Stewart-Bouckaert, Sarah, Pharm.D.	X		

Review Agenda – SICKLE CELL ANEMIA TREATMENTS							
(1st) Motion: Hill							
(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			Hill, Jennifer, M.D.	X		
Cowles, Cassie, APRN	X			Klug, Laura, Pharm.D.	X		
Dolter, Stephen, M.D	X			Salzbrenner, Stephen, M.D.	X		
Fornander, Wade, M.D. (Vice Chair) ***Votes only in the event of a tie***				Stewart-Bouckaert, Sarah, Pharm.D.	X		

Review Agenda – STIMULANTS AND RELATED 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			Hill, Jennifer, M.D.	X		
Cowles, Cassie, APRN	X			Klug, Laura, Pharm.D.	X		
Dolter, Stephen, M.D	X			Salzbrenner, Stephen, M.D.	X		
Fornander, Wade, M.D. (Vice Chair) ***Votes only in the event of a tie***				Stewart-Bouckaert, Sarah, Pharm.D.	X		

Review Agenda – THROMBOPOIESIS STIMULATING PROTEINS							
(1st) Motion: Dolter							
(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			Hill, Jennifer, M.D.	X		
Cowles, Cassie, APRN	X			Klug, Laura, Pharm.D.	X		
Dolter, Stephen, M.D	X			Salzbrenner, Stephen, M.D.	X		
Fornander, Wade, M.D. (Vice Chair) ***Votes only in the event of a tie***				Stewart-Bouckaert, Sarah, Pharm.D.	X		

c. Complete Copy of Proposed PDL

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Jim Pillen, Governor

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

November 2024 P&T Proposed PDL
Noted in Red Font are the changes that become effective January 17, 2025

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

- **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].
- **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

ALZHEIMER'S AGENTS

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

ANTHELMINTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
albendazole (generic Albenza) BILTRICIDE (praziquantel) ivermectin (generic Stromectol)	EMVERM (mebendazole)[CL] praziquantel (generic Biltricide) STROMECTOL (ivermectin)	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class within the last 6 months Drug-specific criteria: ▪ **Emverm**: Approval will be considered for indications not covered by preferred agents

ANTI-ALLERGENS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	GRASTEK (timothy grass pollen allergen) AL,QL ODACTRA (Dermatophagoides farinae and Dermatophagoides pteronyssinus)AL,QL ORALAIR (sweet vernal/orchard/rye/ timothy/kentucky blue grass mixed pollen allergen extract)CL PALFORZIA (peanut allergen powder-dnfp) AL,CL **CAPS, SACHET** RAGWITEK (weed pollen-short ragweed)AL,QL	**All agents require initial dose to be given in a healthcare setting** Drug-specific criteria: **GRASTEK** • Confirmed by positive skin test or in vitro testing for pollen specific IgE antibodies for Timothy grass or cross-reactive grass pollens. • For use in persons 5 through 65 years of age. **ODACTRA** • Confirmed by positive skin test to licensed house dust mite allergen extracts or in vitro testing for IgE antibodies to Dermatophagoides farinae and Dermatophagoides pteronyssinus house dust mite • For use in persons 12 through 65 years of age **ORALAIR** • Confirmed by positive skin test or in vitro testing for pollen specific IgE antibodies for Sweet Vernal, Orchard, Perennial Rye, Timothy, and Kentucky Blue Grass Mixed Pollens. • For use in patients 5 through 65 years of age. **PALFORZIA** • Confirmed diagnosis of peanut allergy by allergist • For use in patients ages 4 to 17; it may be continued in patients 18 years and older with documentation of previous use within the past 90 days • Initial dose and increase titration doses should be given in a healthcare setting • Should not be used in patients with uncontrolled asthma or concurrently on a NSAID **RAGWITEK** • Confirmed by positive skin test or in vitro testing for pollen specific IgE antibodies for short ragweed pollen. • For use in patients 5 through 65 years of age.

ANTIHISTAMINES, MINIMALLY SEDATING

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
cetirizine **TAB-OTC** (generic Zyrtec) cetirizine **SOLN-OTC** (generic Zyrtec) loratadine **TAB-OTC, SOLN-OTC** (generic Claritin) levocetirizine **TAB (OTC/Rx)** (generic Xyzal)	cetirizine (generic Zyrtec) **CAPS**, **CHEW-OTC** cetirizine (generic Zyrtec) **SOLN-Rx** desloratadine (generic Clarinex) desloratadine ODT (generic Clarinex Reditabs) fexofenadine 60mg (generic Allegra) fexofenadine (generic Allegra 180mg)^{QL} 180mg fexofenadine (generic Allegra) **SOLN-OTC** levocetirizine (generic Xyzal) **SOLN** loratadine (generic Claritin Reditabs) **CAPS, CHEW-OTC, ODT-OTC**	▪ Non-preferred agents will be approved for patients who have failed TWO preferred agents within this drug class ▪ Combination products not covered – individual products may be covered

ANTIHYPERTENSIVES, SYMPATHOLYTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
clonidine **TAB** (generic Catapres) clonidine **TRANSDERMAL** guanfacine (generic Tenex) methyldopa	clonidine ER (generic Nexiclon)^{NR} methyldopa/hydrochlorothiazide NEXICLON XR (clonidine ER)^{NR} **TAB**	▪ Non-preferred agents will be approved for patients who have failed a 30-day trial with ONE preferred agent within this drug class ▪ **Nexiclon/ clonidine ER**: clinical reason why the preferred clonidine tablet or transdermal cannot be used

ANTIHYPERURICEMICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
allopurinol (generic Zyloprim) colchicine **TAB** (generic Colcrys) probenecid	allopurinol 200mg colchicine **CAPS** (generic Mitigare) COLCRYS (colchicine) febuxostat (generic Uloric)^{CL} GLOPERBA **SOLN** (colchicine)^{CL,QL} MITIGARE (colchicine) probenecid/colchicine (generic Col-Probenecid)	▪ Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class ▪ **Gloperba:** Approved for documented swallowing disorder ▪ **Uloric/febuxostat:** Clinical reason why allopurinol cannot be used

ANTIPARKINSON'S AGENTS

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

ANTIPSORIATICS, ORAL

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

ANTIPSORIATICS, TOPICAL

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

ANXIOLYTICS

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

BILE SALTS

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

BRONCHODILATORS, BETA AGONIST

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

COLONY STIMULATING FACTORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
FULPHILA (pegfilgrastim-jmdb) **SUB-Q** NEUPOGEN **DISP SYR** NEUPOGEN (filgrastim) **VIAL**	FYLNETRA (pegfilgrastim-pbbk) GRANIX (tbo-filgrastim) **SYR, VIAL** LEUKINE (sargramostim) NEULASTA (pegfilgrastim) **SYR** NIVESTYM (filgrastim-aafi) **SYR,VIAL** NYVEPRIA (pegfilgrastim-apgf) RELEUKO (filgrastim-ayow) **SYR**,~~**VIAL**~~ ROLVEDON (eflapegrastim-xnst)**SYR** STIMUFEND (pegfilgrastim-fpgk) **SYR** UDENYCA (pegfilgrastim-cbqv) **AUTOINJ** UDENYCA (pegfilgrastim-cbqv) **SUB-Q** ZARXIO (filgrastim-sndz) ZIEXTENZO **SYR** (pegfilgrastim-bmez)	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

COPD (CHRONIC OBSTRUCTIVE PULMONARY DISEASE) AGENTS

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

COUGH AND COLD, OPIATE COMBINATION

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

CYTOKINE & CAM ANTAGONISTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ADALIMUMAB-ADBM(CF)[AL,NR] 50mg/mL **KIT, PEN-KIT** ADALIMUMAB-ADBM(CF)[AL,NR] 100mg/mL **KIT, PEN-KIT** COSENTYX (secukinumab)[AL] **PEN, SYRINGE** CYLTEZO (adalimumab-adbm)[AL] **50mg/mL KIT, PEN-KIT** CYLTEZO (adalimumab-adbm)[AL] (CF) **100mg/mL KIT, PEN-KIT** ENBREL (etanercept) **KIT, MINI CART, PEN, SYRINGE, VIAL**[QL] HUMIRA (adalimumab)[QL] OTEZLA (apremilast) **TAB**[CL,QL]	ABRILADA **KIT** (adalimumab-afzb)[AL,NR] (CF) ABRILADA **PEN KIT** (adalimumab-afzb)[AL,NR] (CF) ACTEMRA (tocilizumab) **SUB-Q** ADALIMUMAB-AACF (CF)[AL,NR] **PEN KIT, SYR KIT** ADALIMUMAB-AATY (CF)[AL,NR] **KIT, PEN KIT** ADALIMUMAB-ADAZ(CF)(biosim for Hyrimoz)[AL] **PEN, SYR** ADALIMUMAB-ADBM(CF)[AL,NR] **50mg/mL KIT, PEN-KIT** (Quallent) ADALIMUMAB-ADBM(CF)[AL,NR] 100mg/Ml **KIT, PEN-KIT** (Quallent) ADALIMUMAB-FKJP (biosim for Hulio)[AL] **PEN, SYRINGE** ADALIMUMAB-RYVK[AL,NR] (biosim for Simlandi) **KIT** ADALIMUMAB-RYVK[AL,NR] (biosim for Simlandi) **PEN KIT** AMJEVITA (adalimumab-atto)[AL] **AUTOINJ, SYR** AMJEVITA(adalimumab-atto)[AL,NR] **KIT** AMJEVITA(adalimumab-atto)[AL,NR] **PEN KIT** ARCALYST (nilonacept) BIMZELX (bimekizumab-bkzx)[AL,NR] **PEN, SYR** CIBINQO (abrocitinib)[AL,QL] CIMZIA (certolizumab pegol)[QL] ENSPRYNG (satralizumab-mwge) **SUB-Q** ENTYVIO (vedolizumab)[AL,NR] **PEN**	▪ Preferred agents will be approved with FDA-approved indication – ICD-10 diagnosis code is required. ▪ Non-preferred agents will be approved for FDA-approved indications in patients who have failed a trial of TWO preferred agents within this drug class, or upon diagnosis for non-preferred agent with FDA-approved indication if no preferred agent has FDA approval for diagnosis. **JAK-Inhibitors**: For FDA approved indications that require a patient to have had an inadequate response to a TNF blocker, documentation of an inadequate response is required. Drug-specific criteria: **Cosentyx:** Requires treatment failure of Enbrel OR Humira with the same FDA-approved indications and age limits. **Otezla**: Requires a trial of Humira

CYTOKINE & CAM ANTAGONISTS, continued

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	HADLIMA (adalimumab- bwwd)[AL] **PUSHTOUCH**, **SYRINGE** HADLIMA (CF) (adalimumab- bwwd)[AL] **PUSHTOUCH, SYRINGE** HULIO (adalimumab-fkjp)[AL] **PEN, SYRINGE** HYRIMOZ(CF) (adalimumab-adaz)[AL] **PEN, SYRINGE** IDACIO (adalimumab-aacf)[AL] **PE**N, **SYRINGE** ILUMYA (tildrakizumab) SUB-Q KEVZARA (sarilumab) **SUB-Q, PEN, SYRINGE** KINERET (anakinra) LITFULO (ritlecitinib)[AL,NR] **CAPS** OLUMIANT (baricitinib) **TAB**[CL,QL] OMVOH (mirikizumab-mrkz)[AL,NR] **PEN SYRINGE**[NR] ORENCIA (abatacept**) SUB-Q** RINVOQ ER (upadacitinib)[CL,QL] RINVOQ (upadacitinib)[AL,NR,QL] LQ **SOLN** SILIQ (brodalumab) SIMLANDI (CF) (adalimumab-ryvk)[AL,NR] **KIT** SIMPONI (golimumab) SKYRIZI (risankizamab-rzaa) **SYR** SKYRIZI **ON-BODY** (risankizamab-rzaa)[QL] SKYRIZI **PEN** (risankizamab-rzaa)[QL] SOTYKTU (deucravacitinib) **TAB** SPEVIGO (spesolimab-sbzo)[AL,NR] **SYR** STELARA (ustekinumab) **SUB-Q** TALTZ (ixekizumab)[AL] TREMFYA (guselkumab)[QL] TYENNE (tocilizumab-aazg)[AL,NR] **AUTOINJ** TYENNE (tocilizumab-aazg)[AL,NR] **SYR**	▪ Preferred agents will be approved with FDA-approved indication – ICD-10 diagnosis code is required. ▪ Non-preferred agents will be approved for FDA-approved indications in patients who have failed a trial of TWO preferred agents within this drug class, or upon diagnosis for non-preferred agent with FDA-approved indication if no preferred agent has FDA approval for diagnosis. **JAK-Inhibitors**: For FDA approved indications that require a patient to have had an inadequate response to a TNF blocker, documentation of an inadequate response is required. Drug-specific criteria: **Cosentyx:** Requires treatment failure of Enbrel OR Humira with the same FDA-approved indications and age limits. **Otezla**: Requires a trial of Humira

CYTOKINE & CAM ANTAGONISTS, continued

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	VELSIPITY (etrasimod)[NR,QL] **TAB** XELJANZ (tofacitinib) **TAB, SOLN**[CL,QL] XELJANZ XR (tofacitinib) **TAB**[CL,QL] YUFLYMA 100mg/mL (CF) (adalimumab- aaty)[AL] **KIT,PEN KIT** YUFLYMA 80mg/mL (CF) (adalimumab- aaty)[AL,NR] **AUTOINJ, PEN, KIT** YUSIMRY (CF) (adalimumab-aqvh)[AL] **PEN KIT** ZYMFENTRA **PEN, SYR** (infliximab-dyyb)[NR]	▪ Preferred agents will be approved with FDA-approved indication – ICD-10 diagnosis code is required. ▪ Non-preferred agents will be approved for FDA-approved indications in patients who have failed a trial of TWO preferred agents within this drug class, or upon diagnosis for non-preferred agent with FDA-approved indication if no preferred agent has FDA approval for diagnosis. **JAK-Inhibitors**: For FDA approved indications that require a patient to have had an inadequate response to a TNF blocker, documentation of an inadequate response is required. Drug-specific criteria: **Cosentyx:** Requires treatment failure of Enbrel OR Humira with the same FDA-approved indications and age limits. **Otezla**: Requires a trial of Humira

ENZYME REPLACEMENT, GAUCHER'S DISEASE

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

EPINEPHRINE, SELF-INJECTED [QL]

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

ERYTHROPOIESIS STIMULATING PROTEINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ARANESP (darbopoetine alfa) **DISP SYR, VIAL** EPOGEN (rHuEPO) RETACRIT (epoetin alfa-epbx) *Pfizer manufacturer only*	PROCRIT (rHuEPO) RETACRIT (epoetin alfa-epbx) *Vifor manufacturer only* VAFSEO (vadadustat)[NR] **TAB**	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

GLUCOCORTICOIDS, INHALED

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
GLUCOCORTICOIDS		▪ Non-preferred agents within the Glucocorticoids and Glucocorticoid/Bronchodilator Combo groups will be approved for patients who have failed a trial of TWO preferred agents within this drug class within the last 6 months Drug-specific criteria: ▪ **budesonide respules:** Covered without PA for age ≤ 8 years OR for diagnosis of eosinophilic esophagitis in patients ≥ 9 years, by GI biopsy or upper endoscopy. For other indications, must have failed a trial of two preferred agents within this drug class, within the last 6 months. ▪ ~~**fluticasone HFA:** Covered without PA for age ≤ 8 years~~
ARNUITY ELLIPTA (fluticasone) ASMANEX (mometasone)[QL,AL] ASMANEX HFA (mometasone)[QL] FLOVENT HFA (fluticasone) fluticasone HFA (generic Flovent HFA)[CL] PULMICORT FLEXHALER (budesonide)	ALVESCO (ciclesonide)[AL,CL] ARMONAIR DIGIHALER (fluticasone)[AL,QL] FLOVENT DISKUS (fluticasone) fluticasone (generic Flovent Diskus)[NR] QVAR Redihaler (beclomethasone)	
GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS		
ADVAIR DISKUS (fluticasone/ salmeterol)[QL] ADVAIR HFA (fluticasone/salmeterol)[QL] DULERA (mometasone/formoterol) SYMBICORT (budesonide/ formoterol) TRELEGY ELLIPTA (fluticasone/ umeclidinium/vilanterol)	AIRDUO DIGIHALER (fluticasone/salmeterol)[AL,QL] AIRSUPRA HFA (albuterol and budesonide)[AL] BREO ELLIPTA (fluticasone/vilanterol) BREZTRI (budesonide/formoterol/ glycopyrrolate)[QL] budesonide/formoterol (generic for Symbicort) fluticasone/salmeterol (generic for Advair Diskus)[QL] fluticasone/salmeterol (generic Advair HFA)[QL] fluticasone/salmeterol (generic for Airduo Respiclick) fluticasone/vilanterol (Breo Ellipta)	
INHALATION SOLUTION		
	Budesonide 0.25mg,0.5mg, 1mg **RESPULES** (generic for Pulmicort)	

GLUCOCORTICOIDS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
budesonide EC **CAPS** (generic Entocort EC) dexamethasone **ELIXIR, SOLN** dexamethasone **TAB** hydrocortisone **TAB** methylprednisolone 4mg, dose pack tablet (generic Medrol) prednisolone **SOLN** prednisolone sodium phosphate prednisone **DOSE PAK** prednisone **TAB**	ALKINDI (hydrocortisone) **GRANULES**[AL] CORTEF (hydrocortisone) cortisone **TAB** dexamethasone **INTENSOL** dexamethasone **TAB DOSE PACK** EOHILIA (budesonide)[AL,NR,QL] **SUSP** HEMADY (dexamethasone) MEDROL (methylprednisolone) DS PACK methylprednisolone 8mg, 16mg, 32mg (generic Medrol) prednisolone sodium phosphate (generic Millipred/Veripred) prednisolone sodium phosphate **ODT** prednisone **SOLN** prednisone **INTENSOL** RAYOS DR (prednisone) **TAB** TAPERDEX (dexamethasone) TARPEYO (budesonide) **CAPS**	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class within the last 6 months Drug-specific criteria: ▪ **Intensol Products:** Patient specific documentation of why the less concentrated solution is not appropriate for the patient ▪ Tarpeyo: Indicated for the treatment of primary immunoglobulin A nephropathy (IgAN)

HEMOPHILIA TREATMENTS

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

HISTAMINE II RECEPTOR BLOCKERS

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

IDIOPATHIC PULMONARY FIBROSIS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
pirfenidone (generic Esbriet)[QL] **CAPS, TAB**	ESBRIET (pirfenidone)[QL] **CAPS, TAB** OFEV (nintedanib esylate)[CL]	▪ Non-preferred agent requires trial of preferred agent within this drug class with the same indication ▪ FDA approved indication required – ICD-10 diagnosis code

IMMUNOMODULATORS, ASTHMA [CL]

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

IMMUNOMODULATORS, ATOPIC DERMATITIS [AL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ADBRY (tralokinumab-ldrm) [AL,CL,QL] **SYR** ADBRY 300mg/2mL (tralokinumab-ldrm) [AL,NR] **AUTOINJ** DUPIXENT (dupilumab)[AL,CL] **PEN,SYR** ELIDEL (pimecrolimus) EUCRISA (crisaborole)[CL,QL] pimecrolimus (generic Elidel) tacrolimus (generic for Protopic)	OPZELURA (ruxolitinib phosphate) **CREAM**[AL,CL,QL] pimecrolimus (generic Elidel)- ***Oceanside Mfr only*** ZORYVE (roflumilast)[AL,NR] **CREAM** ZORYVE (roflumilast)[AL,NR] **FOAM**	Immunomodulators Self-Injectable PA Form (For Adbry and Dupixent only) ▪ Non-preferred agents require: Trial of a topical steroid AND Trial of one preferred product within this drug class Drug-specific criteria: • **ADBRY:** May be approved after a trial or failure of a topical corticosteroid AND a topical calcineurin inhibitor ▪ **Dupixent**: 1. **Atopic Dermatitis**: May be approved after a maximum of a 90-day trial or failure of a topical corticosteroid AND a topical calcineurin inhibitor 2. **Eosinophilic Esophagitis**: Trial, failure, or technique difficulty to a swallowed topical corticosteroid or treatment failure of a proton pump inhibitor. Prescribed by, or in consultation with an allergist, gastroenterologist, or immunologist. Documentation that the Patient has a confirmed diagnosis of eosinophilic esophagitis with ≥ 15 eosinophils/high-power field. 3. **Nasal Polyps**: May be approved with documentation of treatment failure or contraindication within the previous year to an intranasal corticosteroid OR systemic corticosteroid therapy OR prior nasal surgery. Prescribed by, or in consultation with an allergist, pulmonologist, or otolaryngologist [ENT]. 4. **Prurigo Nodularis**: Patient must have a diagnosis of Prurigo Nodularis with provider attestation of > 20 nodular lesions. Trial and failure of a topical corticosteroid. Prescribed by, or in consultation with an allergist, dermatologist, or immunologist. • **Eucrisa**: May be approved after a 30 day trial failure of a preferred topical corticosteroid (TCS) or topical calcineurin inhibitor (TCI) within the past 180 days; Maximum of 300 grams per year ▪ **Opzelura**: May be approved for a diagnosis of Atopic Dermatitis and after a trial/failure of a topical steroid and trial of a preferred agent

IMMUNOMODULATORS, TOPICAL

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

INTRANASAL RHINITIS

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

LEUKOTRIENE MODIFIERS

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

METHOTREXATE

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

MOVEMENT DISORDERS

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

NSAIDs, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
COX-I SELECTIVE		▪ Non-preferred agents within COX-1 SELECTIVE group will be approved for patients who have failed no less than 30-day trial of TWO preferred agents within this drug class Drug-specific criteria: ▪ **meclofenamate**: Approvable without trial of preferred agents for menorrhagia ▪ **Sprix/ketoralac Nasal:** Approved for patients unable to tolerate, swallow OR absorb oral NSAIDs OR contraindication OR trial of TWO preferred oral NSAIDs
diclofenac sodium (generic Voltaren) ibuprofen **OTC, Rx** (generic Advil, Motrin) **CHEW, DROPS, SUSP**, **TAB** ibuprofen OTC (generic Advil, Motrin) **CAPS** indomethacin (generic Indocin) **CAPS** ketorolac (generic Toradol) meloxicam (generic Mobic) **TAB** nabumetone (generic Relafen) naproxen enteric coated naproxen sodium **OTC** (generic Naprosyn) naproxen **TAB** (generic Naprosyn) sulindac (generic Clinoril)	diclofenac potassium (generic Cataflam, Zipsor) diclofenac SR (generic Voltaren-XR) diflunisal (generic Dolobid) etodolac & SR (generic Lodine/XL) fenoprofen (generic Nalfon) flurbiprofen (generic Ansaid) ibuprofen/famotidine (generic Duexis)[CL] indomethacin (generic Indocin) **SUSP** indomethacin ER (generic Indocin) ketoprofen & ER (generic Orudis) LOFENA (diclofenac potassium) meclofenamate (generic Meclomen) mefenamic acid (generic Ponstel) meloxicam (generic Vivlodex)[CL, QL] **CAP** meloxicam (generic Mobic) **SUSP** naproxen CR (generic Naprelan) naproxen (generic Naprosyn) **SUSP** naproxen sodium (generic Anaprox) **RX** naproxen-esomeprazole (generic Vimovo) oxaprozin (generic Daypro) piroxicam (generic Feldene) tolmetin (generic Tolectin) ketorolac (generic Sprix Nasal) [QL] **NASAL**	

NSAIDs, ORAL (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
COX-I SELECTIVE (continued)		▪ All combination agents require a clinical reason why individual agents can't be used separately
	ALL BRAND NAME NSAIDs including: DUEXIS (ibuprofen/famotidine)[CL] NALFON (fenoprofen) RELAFEN DS (nabumetone)	
NSAID/GI PROTECTANT COMBINATIONS		
	diclofenac/misoprostol (generic Arthrotec)	
COX-II SELECTIVE		
celecoxib (generic Celebrex)	celecoxib (generic Celebrex) *Actavis, Greenstone, Lupin, Mylan, PD-Rx Mfrs only*	

NSAIDs, TOPICAL

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

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

ONCOLOGY AGENTS, ORAL, BREAST

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CDK 4/6 INHIBITOR		▪ Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines ▪ Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy Drug-specific critera ▪ **anastrozole:** May be approved for malignant neoplasm of male breast (male breast cancer) ▪ **Fareston/toremifene:** Require clinical reason why tamoxifen cannot be used ▪ **letrozole:** Approved for diagnosis of breast cancer with day supply greater than 12 – NOT approved for short term use ▪ **Soltamox:** May be approved with documented swallowing difficulty
	IBRANCE (palbociclib) **CAPS, TAB** KISQALI (ribociclib) KISQALI/ FEMARA **CO-PACK** VERZENIO (abemaciclib)	
CHEMOTHERAPY		
capecitabine (generic Xeloda) cyclophosphamide	XELODA (capecitabine)	
HORMONE BLOCKADE		
anastrozole (generic Arimidex) exemestane (generic Aromasin) letrozole (generic Femara) tamoxifen citrate (generic Nolvadex)	ORSERDU (elacestrant) SOLTAMOX **SOLN** (tamoxifen)CL toremifene (generic Fareston)CL	
OTHER		
	NERLYNX (neratinib) PIQRAY (alpelisib) lapatinib (generic Tykerb) TALZENNA (talazoparib tosylate) QL TUKYSA (tucatinib)QL TRUQAP (capivasertib)NR	

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

ONCOLOGY AGENTS, ORAL, HEMATOLOGIC

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

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

ONCOLOGY AGENTS, ORAL, LUNG

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ALK		▪ Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines ▪ Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy
	ALECENSA (alectinib) ALUNBRIG (brigatinib)QL LORBRENA (lorlatinib) QL ZYKADIA (ceritinib) **TAB**	
ALK / ROS1 / NTRK		
	AUGTYRO (repotrectinib)NR**CAPS** ROZLYTREK (entrectinib)QL**CAPS, PELLETSNR** XALKORI (crizotinib) **CAPS, PELLETSNR**	
EGFR		
erlotinib (generic for Tarceva)	gefitinib (generic Iressa) GILOTRIF (afatinib) IRESSA (gefitinib) LAZCLUZE (lazertinib)NR TAGRISSO (osimertinib) TARCEVA (erlotinib) VIZIMPRO (dacomitinib)QL	
OTHER		
	GAVRETO (pralsetinib)QL HYCAMTIN (topotecan) KRAZATI (adagrasib) LUMAKRAS (sotrasib)QL RETEVMO (selpercatinib)AL TABRECTA (capmatinib)QL TEPMETKO (tepotinib) QL	

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

ONCOLOGY AGENTS, ORAL, OTHER

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
temozolomide (generic Temodar)	AYVAKIT (avapritinib)[AL,QL] BALVERSA (erdafitinib) CAPRELSA (vandetanib) COMETRIQ (cabozantinib) FRUZAQLA (fruquintinib)[NR] **CAPS** IWILFIN (eflornithine)[NR] JAYPIRCA (pirtobrutinib) KOSELUGO (selumetinib)[AL] LONSURF (trifluridine/tipiracil) LYNPARZA (olaparib) LYTGOBI (futibatinib) OGSIVEO (nirogacestat)[NR] **TAB** PEMAZYRE (pemigatinib)[QL] QINLOCK (ripretinib) RUBRACA (rucaparib) STIVARGA (regorafenib) TAZVERIK (tazemetostat)[AL] TURALIO (pexidartinib)[QL] VITRAKVI (larotrectinib) **CAPS, SOLN** VORANIGO (vorasidenib)[AL,NR] **TABS** ZEJULA (niraparib) **TABS**	▪ Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines ▪ Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy

ONCOLOGY AGENTS, ORAL, PROSTATE

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
abiraterone (generic Zytiga)[AL,QL] bicalutamide (generic Casodex) XTANDI (enzalutamide)[AL,QL] **CAPS, TAB**	AKEEGA (niraparib/abiraterone) ERLEADA (apalutamide)[QL] nilutamide (generic Nilandron) NUBEQA (darolutamide) [QL] ORGOVYX (relugolix)[AL] YONSA (abiraterone acetonide, submicronized) ZYTIGA (abiraterone)[AL,QL]	▪ Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines ▪ Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy

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

ONCOLOGY AGENTS, ORAL, RENAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
sunitinib malate (generic Sutent) VOTRIENT (pazopanib)	AFINITOR DISPERZ (everolimus)[CL] CABOMETYX (cabozantinib) everolimus (generic Afinitor) TAB everolimus TAB for **SUSP** (generic Afinitor Disperz) FOTIVDA (tivozanib) INLYTA (axitinib) LENVIMA (lenvatinib) NEXAVAR (sorafenib) PAZOPANIB (generic Votrient)[NR] **TAB** sorafenib (generic Nexavar) SUTENT (sunitinib) TORPENZ (generic everolimus)[NR] **TAB** WELIREG (belzutifan)[QL]	▪ Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines ▪ Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy

ONCOLOGY AGENTS, ORAL, SKIN

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BASAL CELL		▪ Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines ▪ Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy
ERIVEDGE (vismodegib)	ODOMZO (sonidegib)[CL]	
BRAF MUTATION		
MEKINIST (trametinib) TAFINLAR (dabrafenib)	BRAFTOVI (encorafenib) COTELLIC (cobimetinib) MEKINIST (trametinib) **SOLN** MEKTOVI (binimetinib) OJEMDA (tovorafenib)[NR] **SUSP[AL], TAB** TAFINLAR (dabrafenib) **SUSP** ZELBORAF (vemurafenib)	

OPHTHALMICS, ANTIBIOTICS

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

OPHTHALMICS, ANTIBIOTIC-STEROID COMBINATIONS

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

OPHTHALMICS, ALLERGIC CONJUNCTIVITIS

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

OPHTHALMICS, ANTI-INFLAMMATORIES

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

OPHTHALMICS, ANTI-INFLAMMATORY / IMMUNOMODULATORS

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

OPHTHALMICS, GLAUCOMA

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
MIOTICS		▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: **Rhopressa and Rocklatan:** Electronically approved for patients who have a trial of ONE generic glaucoma agent, within ophthalmic, glaucoma class - within ~~60~~ 180 days
pilocarpine	PHOSPHOLINE IODIDE (echothiophate iodide) VUITY (pilocarpine)	
SYMPATHOMIMETICS		
ALPHAGAN P (brimonidine 0.15%) brimonidine 0.2% (generic for Alphagan)	ALPHAGAN P (brimonidine 0.1%) apraclonidine (generic Iopidine) brimonidine P 0.15% (generic Alphagan P 0.15%) brimonidine 0.1% (generic Alphagan P 0.1%)	
BETA BLOCKERS		
levobunolol (generic for Betagan) timolol (generic for Timoptic)	betaxolol (generic Betoptic) BETIMOL (timolol) BETOPTIC S (betaxolol) carteolol (generic Ocupress) timolol MALEATE (generic Istalol) timolol (generic Timoptic Ocudose) TIMOPTIC OCUDOSE	
CARBONIC ANHYDRASE INHIBITORS		
dorzolamide (generic for Trusopt)	AZOPT (brinzolamide) brinzolamide (generic Azopt)	
PROSTAGLANDIN ANALOGS		
latanoprost (generic for Xalatan) TRAVATAN Z (travoprost)	bimatoprost (generic Lumigan) IYUZEH (latanoprost) tafluprost (generic Zioptan) travoprost (generic Travatan Z) VYZULTA (latanoprostene) XALATAN (latanoprost) XELPROS (latanoprost) ZIOPTAN (tafluprost)	
COMBINATION DRUGS		
COMBIGAN (brimonidine/timolol) dorzolamide/timolol (generic Cosopt)	brimonidine/timolol (generic Combigan) COSOPT (dorzolamide/timolol) dorzolamide/timolol PF (generic Cosopt PF) SIMBRINZA (brinzolamide/brimonidine)	

OPHTHALMICS, GLAUCOMA (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
OTHER		
RHOPRESSA (netarsudil)[CL] ROCKLATAN (netarsudil and latanoprost) [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: ▪ **Rhopressa and Rocklatan:** Electronically approved for patients who have a trial of ONE generic glaucoma agent, within ophthalmic, glaucoma class - within ~~60~~ 180 days

OTIC ANTIBIOTICS

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

OTIC ANTI-INFECTIVES & ANESTHETICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
acetic acid (generic for Vosol)	acetic acid/hydrocortisone (generic for Vosol HC)	▪ Non-preferred agents will be approved for patients who have failed a trial of the preferred agent within this drug class

SEDATIVE HYPNOTICS

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

SICKLE CELL ANEMIA TREATMENT [AL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
DROXIA (hydroxyurea) ENDARI (L-glutamine)[CL]	GLUTAMINE POWD PACK (generic Endari)[NR] OXBRYTA (voxelotor)[CL] SIKLOS (hydroxyurea)	Drug-Specific Criteria ▪ **Endari:** Patient must have documented two or more hospital admissions per year due to sickle cell crisis despite maximum hydroxyurea dosage. ▪ **Oxbryta**: Not inidcated for sickle cell crisis. Patient must have had at least one sickle cell-related vaso-occlusive event within the past 12 months; AND baseline hemoglobin is 5.5 g/dL ≤ 10.5 g/dL; AND patient is not receiving concomitant, prophylactic blood tranfusion therapy ▪ **Siklos**: May be approved for use in patients ages 2 to 17 years old without a trial of Droxia

STEROIDS, TOPICAL

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

STEROIDS, TOPICAL (Continued)

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

STIMULANTS AND RELATED ADHD DRUGS [AL]

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

STIMULANTS AND RELATED ADHD DRUGS (Continued)[AL]

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

STIMULANTS AND RELATED ADHD DRUGS (Continued)[AL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
MISCELLANEOUS		**Note:** generic guanfacine IR and clonidine IR are available without prior authorization • Non-preferred agents will be approve for patients who have failed a trial of ONE preferred agent within this class Drug-specific criteria: ▪ **armodafinil and Sunosi:** Require trial of modafinil ▪ **armodafinil and modafinil:** approved only for: ○ Sleep Apnea with documentation/confirmation via sleep study and documentation that C-PAP has been maxed ○ Narcolepsy with documentation of diagnosis via sleep study ○ Shift Work Sleep Disorder (only approvable for 6 months) with work schedule verified and documented. Shift work is defined as working the all night shift ▪ **Sunosi** approved only for: ○ Sleep Apnea with documentation/confirmation via sleep study and documentation that C-PAP has been maxed ○ Narcolepsy with documentation of diagnosis via sleep study ▪ **Wakix**: approved only for excessive daytime sleepiness in adults with narcolepsy with documentation of narcolepsy diagnosis via sleep study
atomoxetine (generic Strattera)[QL] guanfacine ER (generic Intuniv)[QL] QELBREE (viloxazine)[QL]	clonidine ER (generic Kapvay)[QL] ONYDA XR (clonidine ER)[NR] **SUSP** STRATTERA (atomoxetine)	
ANALEPTICS		
	armodafinil (generic Nuvigil)[CL] modafanil (generic Provigil)[CL] SUNOSI (solriamfetol) [CL,QL] WAKIX (pitolisant)[CL,QL]	

THROMBOPOIESIS STIMULATING PROTEINS [CL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
PROMACTA (eltrombopag) **TAB**	ALVAIZ (eltrombopag choline)[AL,NR] DOPTELET (avatrombopag) MULPLETA (lusutrombopag) PROMACTA (eltrombopag) **SUSP** TAVALISSE (fostamatinib)	▪ All agents will be approved with FDA-approved indication, ICD-10 code is required. ▪ Non-preferred agents require a trial of a preferred agent with the same indication or a contraindication. Drug-Specific Criteria ▪ **Doptelet/Mulpleta**: Approved for one course of therapy for a scheduled procedure with a risk of bleeding for treatment of thrombocytopenia in adult patients with chronic liver disease

5. **Adjournment / Old Business**

   a. No old business topics were discussed by the committee.
   b. A vote to conclude the meeting was made at 11:51 AM CST.

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

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

Date:
Wednesday, May 14th, 2025

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
Prime Therapeutics