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

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

Wednesday, October 29th at 9:00 AM CST
Mahoney State Park, Peter Kiewit Lodge
28500 West Park Hwy, Ashland, NE 68003

**Committee Members Present:**
Eric Avery, M.D.
Claire Baker, M.D.
Andrew Bendlin, Pharm.D. **(Incoming Chair)**
Cassie Cowles, APRN
Allison Dering-Anderson, Pharm.D. **(Outgoing Chair)**
Stephen Dolter, M.D.
Laura Klug, Pharm.D.
Steven Rose, D.O.
Stephen Salzbrenner, M.D
Sarah Stewart-Bouckaert, Pharm.D.
Bradley Sundsboe, Pharm.D.

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

**Prime Therapeutics Staff Present:**
Sandy Pranger, R.Ph., Sr. Director, Clinical Account Services
ShaLeigh Hammons, CPhT, Account Manager Senior

**Managed Care Staff Present:**
Jamie Benson, Pharm.D., Nebraska Total Care
Michael Labadie, Pharm. D., Molina
Bernadette Ueda, Pharm. D., United Healthcare of Nebraska

**Committee Members Excused:**
Jennifer Hill, M.D.
Wade Fornander, M.D.
C. Jose Friesen, M.D.
Joyce Juracek, Pharm.D.
Jessica Pohl, Pharm.D.

**Committee Members Unexcused:**
N/A

1. **Opening of Public Meeting and Call to Order Committee Business**
   - **a.** The meeting was called to order by the Committee Chair at 9:00 AM CST. The agenda was posted on the Nebraska Medicaid Pharmacy website (https://nebraska.fhsc.com/PDL/PTcommittee.asp) on Monday, September 29, 2025. A copy of the Open Meetings Act and meeting materials distributed to members were made available at the physical meeting site for public viewing.
   - **b.** Roll Call: See list above.
   - **c.** Conflict of Interest: None disclosed.
   - **d.** Approval of May 14th, 2025, P&T Committee Meeting Minutes.

| Approval of May 14th, 2025 P&T Committee Meeting Minutes | | | | | | | |
|---|---|---|---|---|---|---|---|
| **(1st) Motion:** Dering-Anderson | | | | | | | |
| **(2nd) Motion:** Dolter | | | | | | | |
| **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 | | | Klug, Laura, Pharm.D. | X | | |
| Baker, Claire, M.D. | | | X | Rose, Steven, D.O. | X | | |
| Bendlin, Andrew, Pharm.D. | X | | | Salzbrenner, Stephen, M.D. | | | X |
| Cowles, Cassie, APRN | X | | | Stewart-Bouckaert, Sarah, Pharm.D. | | | X |
| Dering-Anderson, Ally, Pharm.D. | X | | | Sundsboe, Bradley Pharm.D. | X | | |
| Dolter, Stephen, M.D. | X | | | | | | |

**e.** Election of Committee Chair and Vice Chair: Andrew Bendlin, Pharm.D. volunteered to be Chair and was unanimously confirmed by the committee. There were no nominations or volunteers for Vice-Chair.

**f.** Department Information:The department thanked Dr. Dering-Anderson for serving as the Committee Chair for the past two years and let the committee know that they were thankful for Dr. Fornander's service as Vice-Chair.

2. **Public Testimony**

| Speaker Order | DRUG CLASS | Drug Name | PDL Status | Speaker Name | Affiliation |
|---|---|---|---|---|---|
| 1 | Cytokine & CAM Antagonists | Tremfya | NP | Julie Vandaveer | Johnson & Johnson |
| 2 | Epinephrine, Self-Administered | Neffy Spray | NP | Kevin Schreur | ARS Pharmaceuticals |
| 3 | Glucocorticoids, Inhaled | Airsupra | NP | Anthony Staresinic | AstraZeneca |
| 4 | Hemophilia Treatments | Qfitlia | NP | Kyrie Smith-Jones | Sanofi |
| 5 | Immunomodulators, Asthma | Tezspire | NP | Elizabeth (Claire) Elson | Amgen |
| 6 | Immunomodulators, Asthma | Tezspire | NP | Michaela Abbott | Allergy, Asthma & Immunology Associates, PC |
| 7 | Immunomodulators, Atopic Dermatitis | Nemluvio | NP | Nabi Kamyabi | Galderma |
| 8 | Immunomodulators, Atopic Dermatitis | Anzupgo | NP | Linly Stevens | Leo Pharma |
| 9 | Immunomodulators, Atopic Dermatitis | Opzelura | NP | Sam Brantman | Incyte Dermatology |
| 10 | Sickle Cell Anemia Treatment | Xromi | NP | Keith Boesen | Rare Disease Therapeutics |

3. **Committee Closed Session**

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

4. **Resume Open Session**

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

*During the public open session, committee members vote publicly on decisions with regards to the Nebraska Preferred Drug List recommendations. Per the State of Nebraska P&T Committee By-Laws, the minutes reflect how each member voted or if the member was absent or not voting. The chairperson votes only in the event of a tie. The details of each vote and the associated PDL recommendations are presented in the following tables.*

**a.** Consent Agenda

| **Consent Agenda** |
|---|
| **(1st) Motion:** Dering-Anderson |
| **(2nd) Motion:** Avery |
| **Discussion:**<br>Dr. Dering-Anderson motioned to remove the Immunomodulators, Asthma class. The Committee approved the amended Consent Agenda. |

| **Voting – P&T Committee Members**<br>**Does not include excused or unexcused members** | **Yes** | **No** | **Abstain** | **Voting – P&T Committee Members** | **Yes** | **No** | **Abstain** |
|---|---|---|---|---|---|---|---|
| Avery, Eric, M.D. | X | | | Klug, Laura, Pharm.D. | X | | |
| Baker, Claire, M.D. | X | | | Rose, Steven, D.O. | X | | |
| Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie*** | | | | Salzbrenner, Stephen, M.D. | X | | |
| Cowles, Cassie, APRN | X | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |
| Dering-Anderson, Ally, Pharm.D. | X | | | Sundsboe, Bradley Pharm.D. | X | | |
| Dolter, Stephen, M.D. | X | | | | | | |

| **Consent Agenda: Therapeutic categories (TC) with unchanged recommendations unless otherwise indicated.** | |
|---|---|
| ANTHELMINTICS | LEUKOTRIENE MODIFIERS |
| ANTI-ALLERGENS, ORAL | METHOTREXATE |
| ANTIHISTAMINES, MINIMALLY SEDATING | MOVEMENT DISORDERS |
| ANTIHYPERTENSIVES, SYMPATHOLYTICS | ONCOLOGY, ORAL - LUNG |
| ANTIHYPERURICEMICS | ONCOLOGY, ORAL - PROSTATE |
| ANTIPSORIATICS, ORAL | ONCOLOGY, ORAL - RENAL CELL |
| ANTIPSORIATICS, TOPICAL | ONCOLOGY, ORAL - SKIN |
| BRONCHODILATORS, BETA AGONIST | OPHTHALMIC ANTIBIOTICS |
| COLONY STIMULATING FACTORS | OPHTHALMIC ANTIBIOTIC-STEROID COMBINATIONS |
| COUGH AND COLD, NARCOTIC | OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS |
| ENZYME REPLACEMENT, GAUCHERS DISEASE | OPHTHALMICS, ANTI-INFLAMMATORIES |
| ERYTHROPOIESIS STIMULATING PROTEINS | OTIC ANTIBIOTICS |
| HISTAMINE II RECEPTOR BLOCKER | OTIC ANTI-INFECTIVES & ANESTHETICS |
| IDIOPATHIC PULMONARY FIBROSIS | SEDATIVE HYPNOTICS |
| IMMUNOMODULATORS, ASTHMA **(REMOVED)** | STEROIDS, TOPICAL MEDIUM |

| | |
|---|---|
| IMMUNOMODULATORS, TOPICAL | STEROIDS, TOPICAL VERY HIGH |
| INTRANASAL RHINITIS AGENTS | |

**b.** Therapeutic Class Reviews

| **Review Agenda – ALZHEIMER'S 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 | | | Klug, Laura, Pharm.D. | X | | |
| Baker, Claire, M.D. | X | | | Rose, Steven, D.O. | X | | |
| Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie*** | | | | Salzbrenner, Stephen, M.D. | X | | |
| Cowles, Cassie, APRN | X | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |
| Dering-Anderson, Ally, Pharm.D. | X | | | Sundsboe, Bradley Pharm.D. | X | | |
| Dolter, Stephen, M.D. | X | | | | | | |

| **Review Agenda – ANTIPARKINSON'S AGENTS** | | | | | | | |
|---|---|---|---|---|---|---|---|
| **(1st) Motion:** Dering-Anderson | | | | | | | |
| **(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 | | | Klug, Laura, Pharm.D. | X | | |
| Baker, Claire, M.D. | X | | | Rose, Steven, D.O. | X | | |
| Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie*** | | | | Salzbrenner, Stephen, M.D. | X | | |
| Cowles, Cassie, APRN | X | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |
| Dering-Anderson, Ally, Pharm.D. | X | | | Sundsboe, Bradley Pharm.D. | X | | |
| Dolter, Stephen, M.D. | X | | | | | | |

| Review Agenda – ANXIOLYTICS | | | | | | | |
|---|---|---|---|---|---|---|---|
| **(1st) Motion:** Cowles | | | | | | | |
| **(2nd) Motion:** Baker | | | | | | | |
| **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 | | | Klug, Laura, Pharm.D. | X | | |
| Baker, Claire, M.D. | X | | | Rose, Steven, D.O. | X | | |
| Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie*** | | | | Salzbrenner, Stephen, M.D. | X | | |
| Cowles, Cassie, APRN | X | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |
| Dering-Anderson, Ally, Pharm.D. | X | | | Sundsboe, Bradley Pharm.D. | X | | |
| Dolter, Stephen, M.D. | X | | | | | | |

| Review Agenda – BILE SALTS | | | | | | | |
|---|---|---|---|---|---|---|---|
| **(1st) Motion:** Cowles | | | | | | | |
| **(2nd) Motion:** Rose | | | | | | | |
| **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 | | | Klug, Laura, Pharm.D. | X | | |
| Baker, Claire, M.D. | X | | | Rose, Steven, D.O. | X | | |
| Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie*** | | | | Salzbrenner, Stephen, M.D. | X | | |
| Cowles, Cassie, APRN | X | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |
| Dering-Anderson, Ally, Pharm.D. | X | | | Sundsboe, Bradley Pharm.D. | X | | |

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|---|---|---|---|---|---|---|---|
| Dolter, Stephen, M.D. | X | | | | | | |

## Review Agenda – COPD Agents

**(1st) Motion:** Dolter

**(2nd) Motion:** Cowles

**Discussion:** Approved as written.

| Voting – P&T Committee Members<br>Does not include excused or unexcused members | Yes | No | Abstain | Voting – P&T Committee Members | Yes | No | Abstain |
|---|---|---|---|---|---|---|---|
| Avery, Eric, M.D. | X | | | Klug, Laura, Pharm.D. | X | | |
| Baker, Claire, M.D. | X | | | Rose, Steven, D.O. | X | | |
| Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie*** | | | | Salzbrenner, Stephen, M.D. | X | | |
| Cowles, Cassie, APRN | X | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |
| Dering-Anderson, Ally, Pharm.D. | X | | | Sundsboe, Bradley Pharm.D. | X | | |
| Dolter, Stephen, M.D. | X | | | | | | |

## Review Agenda – CYTOKINE AND CAM ANTAGONISTS

**(1st) Motion:** Dering-Anderson

**(2nd) Motion:** Cowles

**Discussion**: The committee discussed adding subclasses to the PDL. Approved as written.

| Voting – P&T Committee Members<br>Does not include excused or unexcused members | Yes | No | Abstain | Voting – P&T Committee Members | Yes | No | Abstain |
|---|---|---|---|---|---|---|---|
| Avery, Eric, M.D. | X | | | Klug, Laura, Pharm.D. | X | | |
| Baker, Claire, M.D. | X | | | Rose, Steven, D.O. | X | | |
| Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie*** | | | | Salzbrenner, Stephen, M.D. | X | | |
| Cowles, Cassie, APRN | X | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |
| Dering-Anderson, Ally, Pharm.D. | X | | | Sundsboe, Bradley Pharm.D. | X | | |
| Dolter, Stephen, M.D. | X | | | | | | |

## Review Agenda – EPINEPHRINE, SELF-ADMINISTERED

**(1st) Motion:** Avery

**(2nd) Motion:** Salzbrenner

**Discussion:** The committee discussed advantages of using Neffy nasal spray and recommended moving it from NP to P with removal of the PDL criteria.

| Voting – P&T Committee Members<br>Does not include excused or unexcused members | Yes | No | Abstain | Voting – P&T Committee Members | Yes | No | Abstain |
|---|---|---|---|---|---|---|---|
| Avery, Eric, M.D. | X | | | Klug, Laura, Pharm.D. | X | | |
| Baker, Claire, M.D. | X | | | Rose, Steven, D.O. | X | | |
| Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie*** | | | | Salzbrenner, Stephen, M.D. | X | | |
| Cowles, Cassie, APRN | X | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |
| Dering-Anderson, Ally, Pharm.D. | X | | | Sundsboe, Bradley Pharm.D. | X | | |
| Dolter, Stephen, M.D. | X | | | | | | |

## Review Agenda – GLUCOCORTICOIDS, INHALED

**(1st) Motion:** Baker

**(2nd) Motion:** Dering-Anderson

**Discussion:** Baker made a motion to keep Trelegy Ellipta Preferred.

| Voting – P&T Committee Members<br>Does not include excused or unexcused members | Yes | No | Abstain | Voting – P&T Committee Members | Yes | No | Abstain |
|---|---|---|---|---|---|---|---|
| Avery, Eric, M.D. | X | | | Klug, Laura, Pharm.D. | X | | |
| Baker, Claire, M.D. | X | | | Rose, Steven, D.O. | X | | |
| Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie*** | | | | Salzbrenner, Stephen, M.D. | X | | |
| Cowles, Cassie, APRN | X | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |

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|---|---|---|---|---|---|---|---|
| Dering-Anderson, Ally, Pharm.D. | X | | | Sundsboe, Bradley Pharm.D. | X | | |
| Dolter, Stephen, M.D. | X | | | | | | |

## Review Agenda – GLUCOCORTICOIDS, ORAL

**(1st) Motion:** Dering-Anderson

**(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 | | | Klug, Laura, Pharm.D. | X | | |
| Baker, Claire, M.D. | X | | | Rose, Steven, D.O. | X | | |
| Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie*** | | | | Salzbrenner, Stephen, M.D. | X | | |
| Cowles, Cassie, APRN | X | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |
| Dering-Anderson, Ally, Pharm.D. | X | | | Sundsboe, Bradley Pharm.D. | X | | |
| Dolter, Stephen, M.D. | X | | | | | | |

## Review Agenda – HEMOPHILIA TREATMENT

**(1st) Motion:** Avery

**(2nd) Motion:** Cowles

**Discussion:** Avery discussed clarification on the subclasses and which preferred agents are required to fail before use of a non-preferred agent. 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 | | | Klug, Laura, Pharm.D. | X | | |
| Baker, Claire, M.D. | X | | | Rose, Steven, D.O. | X | | |
| Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie*** | | | | Salzbrenner, Stephen, M.D. | X | | |
| Cowles, Cassie, APRN | X | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |

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|---|---|---|---|---|---|---|---|
| Dering-Anderson, Ally, Pharm.D. | X | | | Sundsboe, Bradley Pharm.D. | X | | |
| Dolter, Stephen, M.D. | X | | | | | | |

## Review Agenda – IMMUNOMODULATORS, ASTHMA

**(1st) Motion:** Baker

**(2nd) Motion:** Dering-Anderson

**Discussion:** The committee voted to add drug-specific criteria for Tezspire, that would not require a trial of a preferred agent for severe non-type II asthma and to indent Dupixent's indications in the criteria.

| Voting – P&T Committee Members<br>Does not include excused or unexcused members | Yes | No | Abstain | Voting – P&T Committee Members | Yes | No | Abstain |
|---|---|---|---|---|---|---|---|
| Avery, Eric, M.D. | | | X | Klug, Laura, Pharm.D. | X | | |
| Baker, Claire, M.D. | X | | | Rose, Steven, D.O. | X | | |
| Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie*** | | | | Salzbrenner, Stephen, M.D. | X | | |
| Cowles, Cassie, APRN | X | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |
| Dering-Anderson, Ally, Pharm.D. | X | | | Sundsboe, Bradley Pharm.D. | X | | |
| Dolter, Stephen, M.D. | X | | | | | | |

## Review Agenda – IMMUNOMODULATORS, ATOPIC DERMATITIS

**(1st) Motion:** Dering-Anderson

**(2nd) Motion:** Baker

**Discussion:** The committee recommended indenting Dupixent's indications in the criteria.

| Voting – P&T Committee Members<br>Does not include excused or unexcused members | Yes | No | Abstain | Voting – P&T Committee Members | Yes | No | Abstain |
|---|---|---|---|---|---|---|---|
| Avery, Eric, M.D. | X | | | Klug, Laura, Pharm.D. | X | | |
| Baker, Claire, M.D. | X | | | Rose, Steven, D.O. | X | | |

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|---|---|---|---|---|---|---|---|
| Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie*** | | | | Salzbrenner, Stephen, M.D. | X | | |
| Cowles, Cassie, APRN | X | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |
| Dering-Anderson, Ally, Pharm.D. | X | | | Sundsboe, Bradley Pharm.D. | X | | |
| Dolter, Stephen, M.D. | X | | | | | | |

## Review Agenda – NSAIDS

**(1st) Motion:** Dering-Anderson

**(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 | | | Klug, Laura, Pharm.D. | X | | |
| Baker, Claire, M.D. | X | | | Rose, Steven, D.O. | X | | |
| Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie*** | | | | Salzbrenner, Stephen, M.D. | X | | |
| Cowles, Cassie, APRN | X | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |
| Dering-Anderson, Ally, Pharm.D. | X | | | Sundsboe, Bradley Pharm.D. | X | | |
| Dolter, Stephen, M.D. | X | | | | | | |

## Review Agenda – ONCOLOGY, ORAL-BREAST

**(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 | | | Klug, Laura, Pharm.D. | X | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Baker, Claire, M.D. | X | | | Rose, Steven, D.O. | X | | |
| Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie*** | | | | Salzbrenner, Stephen, M.D. | X | | |
| Cowles, Cassie, APRN | X | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |
| Dering-Anderson, Ally, Pharm.D. | X | | | Sundsboe, Bradley Pharm.D. | X | | |
| Dolter, Stephen, M.D. | X | | | | | | |

## Review Agenda – ONCOLOGY, ORAL- HEMATOLOGIC

**(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 | | | Klug, Laura, Pharm.D. | X | | |
| Baker, Claire, M.D. | X | | | Rose, Steven, D.O. | X | | |
| Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie*** | | | | Salzbrenner, Stephen, M.D. | X | | |
| Cowles, Cassie, APRN | X | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |
| Dering-Anderson, Ally, Pharm.D. | X | | | Sundsboe, Bradley Pharm.D. | X | | |
| Dolter, Stephen, M.D. | X | | | | | | |

## Review Agenda – ONOLOGY, 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 | | | Klug, Laura, Pharm.D. | X | | |
| Baker, Claire, M.D. | X | | | Rose, Steven, D.O. | X | | |

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|---|---|---|---|---|---|---|---|
| Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie*** | | | | Salzbrenner, Stephen, M.D. | X | | |
| Cowles, Cassie, APRN | X | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |
| Dering-Anderson, Ally, Pharm.D. | X | | | Sundsboe, Bradley Pharm.D. | X | | |
| Dolter, Stephen, M.D. | X | | | | | | |

## Review Agenda – OPHTHALMICS, DRY EYE AGENTS

**(1st) Motion:** Cowles

**(2nd) Motion:** Rose

**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 | | | Klug, Laura, Pharm.D. | X | | |
| Baker, Claire, M.D. | X | | | Rose, Steven, D.O. | X | | |
| Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie*** | | | | Salzbrenner, Stephen, M.D. | X | | |
| Cowles, Cassie, APRN | X | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |
| Dering-Anderson, Ally, Pharm.D. | X | | | Sundsboe, Bradley Pharm.D. | X | | |
| Dolter, Stephen, M.D. | X | | | | | | |

## Review Agenda – OPHTHALMICS, GLAUCOMA AGENTS

**(1st) Motion:** Dering- Anderson

**(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 | | | Klug, Laura, Pharm.D. | X | | |
| Baker, Claire, M.D. | X | | | Rose, Steven, D.O. | X | | |
| Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie*** | | | | Salzbrenner, Stephen, M.D. | X | | |
| Cowles, Cassie, APRN | X | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |
| Dering-Anderson, Ally, Pharm.D. | X | | | Sundsboe, Bradley Pharm.D. | X | | |
| Dolter, Stephen, M.D. | X | | | | | | |

## Review Agenda – SICKLE CELL ANEMIA TREATMENTS

**(1st) Motion:** Baker

**(2nd) Motion:** Dering-Anderson

**Discussion:** The committee recommended adding drug specific criteria for Xromi for ages 6 months to 2 years old does not require a trial of Droxia.

| **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 | | | Klug, Laura, Pharm.D. | X | | |
| Baker, Claire, M.D. | X | | | Rose, Steven, D.O. | X | | |
| Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie*** | | | | Salzbrenner, Stephen, M.D. | X | | |
| Cowles, Cassie, APRN | X | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |
| Dering-Anderson, Ally, Pharm.D. | X | | | Sundsboe, Bradley, Pharm.D. | X | | |
| Dolter, Stephen, M.D. | X | | | | | | |

## Review Agenda – STEROIDS, TOPICAL HIGH

**(1st) Motion:** Dering-Anderson

**(2nd) Motion:** Baker

**Discussion:** Approved as written.

| Voting – P&T Committee Members<br>Does not include excused or unexcused members | Yes | No | Abstain | Voting – P&T Committee Members | Yes | No | Abstain |
|---|---|---|---|---|---|---|---|
| Avery, Eric, M.D. | X | | | Klug, Laura, Pharm.D. | X | | |
| Baker, Claire, M.D. | X | | | Rose, Steven, D.O. | X | | |
| Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie*** | | | | Salzbrenner, Stephen, M.D. | X | | |
| Cowles, Cassie, APRN | X | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |
| Dering-Anderson, Ally, Pharm.D. | X | | | Sundsboe, Bradley Pharm.D. | X | | |
| Dolter, Stephen, M.D. | X | | | | | | |

## Review Agenda – STEROIDS, TOPICAL LOW

**(1st) Motion:** Dering-Anderson

**(2nd) Motion:** Dolter

**Discussion:** Approved as written.

| Voting – P&T Committee Members<br>Does not include excused or unexcused members | Yes | No | Abstain | Voting – P&T Committee Members | Yes | No | Abstain |
|---|---|---|---|---|---|---|---|
| Avery, Eric, M.D. | X | | | Klug, Laura, Pharm.D. | X | | |
| Baker, Claire, M.D. | X | | | Rose, Steven, D.O. | X | | |
| Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie*** | | | | Salzbrenner, Stephen, M.D. | X | | |
| Cowles, Cassie, APRN | X | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |
| Dering-Anderson, Ally, Pharm.D. | X | | | Sundsboe, Bradley Pharm.D. | X | | |
| Dolter, Stephen, M.D. | X | | | | | | |

## Review Agenda – STIMULANTS AND RELATED AGENTS

**(1st) Motion:** Cowles

**(2nd) Motion:** Klug

| **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 | | | Klug, Laura, Pharm.D. | X | | |
| Baker, Claire, M.D. | X | | | Rose, Steven, D.O. | X | | |
| Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie*** | | | | Salzbrenner, Stephen, M.D. | X | | |
| Cowles, Cassie, APRN | X | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |
| Dering-Anderson, Ally, Pharm.D. | X | | | Sundsboe, Bradley Pharm.D. | X | | |
| Dolter, Stephen, M.D. | X | | | | | | |

## Review Agenda – THROMBOPOIESIS STIMULATING PROTEINS

| **(1st) Motion:** Avery | | | | | | | |
|---|---|---|---|---|---|---|---|
| **(2nd) Motion:** Rose | | | | | | | |
| **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 | | | Klug, Laura, Pharm.D. | X | | |
| Baker, Claire, M.D. | X | | | Rose, Steven, D.O. | X | | |
| Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie*** | | | | Salzbrenner, Stephen, M.D. | X | | |
| Cowles, Cassie, APRN | X | | | Stewart-Bouckaert, Sarah, Pharm.D. | X | | |
| Dering-Anderson, Ally, Pharm.D. | X | | | Sundsboe, Bradley Pharm.D. | X | | |
| Dolter, Stephen, M.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

October 2025 P&T Proposed PDL
In Red Font are the changes that become effective January 16, 2026

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

- **PDMP Check Requirements** – Nebraska Medicaid providers are required to check the prescription drug history in the statewide PDMP before prescribing CII controlled substances to certain Medicaid beneficiaries (exemption to this requirement are for beneficiaries receiving cancer treatment, hospice/palliative care, or in long-term care facilities). If not able to check the PDMP, then provider is required to document good faith effort, including reasons why unable to conduct the check and may be required to submit documentation to the State upon request.
  - PDMP check requirements are under Section 5042 of the SUPPORT for Patients and Communities Act, consistent with section 1944 of the Social Security Act [42 U.S.C. 1396w-3a].
- **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<br>**OR**<br>▪ Current, stabilized therapy of the non-preferred agent within the previous 45 days<br><br>Drug-specific criteria:<br>▪ **Donepezil 23:** Requires donepezil 10mg/day for at least 3 months AND clinical reason as to why 5mg or 10mg tablets can't be used (to deliver 20mg or 25mg) |
| donepezil (generic Aricept)<br>donepezil ODT (generic Aricept ODT)<br>rivastigmine **PATCH** (generic for Exelon Patch) | ADLARITY (donepezil) **PATCH**<br>ARICEPT (donepezil)<br>donepezil 23 (generic Aricept 23)[CL]<br>EXELON (rivastigmine) **PATCH**<br>galantamine (generic Razadyne) **SOLN, TAB**<br>galantamine ER (generic Razadyne ER)<br>rivastigmine **CAPS** (generic Exelon)<br>ZUNVEYL DR (benzgalantamine)[NR] | |
| **NMDA RECEPTOR ANTAGONIST** | | |
| memantine (generic Namenda) | memantine ER (generic Namenda XR)<br>memantine **SOLN** (generic Namenda)<br>memantine/donepezil (generic Namzaric)[NR]<br>NAMENDA (memantine)<br>NAMZARIC (memantine/donepezil) | |

## ANTHELMINTICS

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

## ANTI-ALLERGENS, ORAL

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

## ANTIHISTAMINES, MINIMALLY SEDATING

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

## ANTIHYPERTENSIVES, SYMPATHOLYTICS

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| clonidine TAB (generic Catapres)<br>clonidine **TRANSDERMAL**<br>guanfacine (generic Tenex)<br>methyldopa | clonidine ER (generic Nexiclon)<br>methyldopa/hydrochlorothiazide<br>NEXICLON XR (clonidine ER) **TAB** | ▪ Non-preferred agents will be approved for patients who have failed a 30-day trial with ONE preferred agent within this drug class<br>Drug Specific Criteria<br>▪ 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)<br>colchicine **TAB** (generic Colcrys)<br>probenecid | allopurinol 200mg<br>colchicine **CAPS** (generic Mitigare)<br>febuxostat (generic Uloric)[CL]<br>GLOPERBA **SOLN** (colchicine)[CL,QL]<br>MITIGARE (colchicine)<br>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<br>▪ **Gloperba:** Approved for documented swallowing disorder<br>▪ **Uloric/febuxostat:** Clinical reason why allopurinol cannot be used |

## ANTIPARKINSON'S AGENTS, ORAL

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

## ANTIPSORIATICS, ORAL

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

## ANTIPSORIATICS, TOPICAL

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| calcipotriene **CREAM, OINT, SOLN** | calcitriol (generic Vectical)[AL] **OINT**<br>calcipotriene **FOAM** (generic Sorilux)<br>calcipotriene/betamethasone **OINT** (generic Taclonex)<br>calcipotriene/betamethasone **SUSP** (generic Taclonex Scalp)<br>ENSTILAR (calcipotriene/betamethasone)<br>SORILUX (calcipotriene)<br>ZORYVE 0.3% (roflumilast)[AL] **CREAM** | ▪ Non-preferred agents will be approved for patients who have failed a trial with a preferred agent within this drug class |

## ANXIOLYTICS

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

## BILE SALTS

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

## BRONCHODILATORS, BETA AGONIST

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

## COLONY STIMULATING FACTORS

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| FULPHILA (pegfilgrastim-jmdb) **SUB-Q**<br>FYLNETRA (pegfilgrastim-pbbk)<br>NEUPOGEN **DISP SYR**<br>NEUPOGEN (filgrastim) **VIAL** | GRANIX (tbo-filgrastim)<br>LEUKINE (sargramostim)<br>NEULASTA (pegfilgrastim) **SYR**<br>NIVESTYM (filgrastim-aafi) **SYR,VIAL**<br>NYVEPRIA (pegfilgrastim-apgf)<br>RELEUKO (filgrastim-ayow) **SYR**<br>ROLVEDON (eflapegrastim-xnst) **SYR**<br>STIMUFEND (pegfilgrastim-fpgk)<br>UDENYCA (pegfilgrastim-cbqv) **AUTOINJ**<br>UDENYCA (pegfilgrastim-cbqv) **SUB-Q**<br>ZARXIO (filgrastim-sndz)<br>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.<br><br>Drug-specific criteria:<br>▪ **Daliresp/roflumilast:**<br>Covered for diagnosis of severe COPD associated with chronic bronchitis<br>Requires trial of a bronchodilator<br>Requires documentation of one exacerbation in last year upon initial review<br>▪ **Dupixent** (For other indications, see Immunomodulators, Atopic Dermatitis and Asthma therapeutic classes)**:**<br>• **For COPD and an Eosinophilic Phenotype**: Requires documentation of inadequately controlled COPD with eosinophils ≥ 300 cells/microliter AND two exacerbations OR one exacerbation that led to hospitalization while on and adherent to a ≥ 90-day trial of triple therapy (LABA + LAMA + ICS). Prescribed by, or in consultation with a pulmonologist, immunologist, or an allergist. |
| ANORO ELLIPTA (umeclidinium/vilanterol)<br>ATROVENT HFA (ipratropium)<br>COMBIVENT RESPIMAT (albuterol/ ipratropium)<br>SPIRIVA (tiotropium)<br>SPIRIVA RESPIMAT (tiotropium)<br>STIOLTO RESPIMAT (tiotropium/olodaterol) | BEVESPI AEROSPHERE (glycopyrolate/formoterol)<br>INCRUSE ELLIPTA (umeclidnium)<br>tiotropium (generic Spiriva)<br>umeclidinium/vilanterol (generic Anoro Ellipta)[NR] | |
| **INHALATION SOLUTION** | | |
| albuterol/ipratropium (generic Duoneb)<br>ipratropium **SOLN** (generic Atrovent) | OHTUVAYRE (ensifentrine) inhalation suspension<br>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**<br>hydrocodone/homatropine **SYRUP**<br>promethazine/codeine **SYRUP**<br>promethazine/phenylephrine/codeine **SYRUP** | ▪ Non-preferred agents will be approved for patients who have failed a trial of ONE dextromethorphan product<br>▪ All codeine or hydrocodone containing cough and cold combinations are limited to ≥ 18 years of age |

## CYTOKINE & CAM ANTAGONISTS

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| ADALIMUMAB-ADBM(CF)[AL] 50mg/mL **KIT, PEN-KIT**<br>ADALIMUMAB-ADBM(CF)[AL]100mg/mL KIT, PEN-KIT<br>ENBREL (etanercept) **KIT, MINI CART, PEN, SYR, VIAL**[QL]<br>HADLIMA (adalimumab- bwwd)[AL] **PUSHTOUCH**, **SYR**<br>HADLIMA (CF) (adalimumab- bwwd)[AL] **PUSHTOUCH, SYR**<br>OTEZLA (apremilast) **TAB**[QL]<br>PYZCHIVA (ustekinumab-ttwe, Stelara biosimilar)[AL,NR] **SYR**<br>STEQEYMA (ustekinumab-stba)[AL, NR] **SYR**<br>TALTZ (ixekizumab)[AL] **AUTOINJ, SYR** | ABRILADA (adalimumab-afzb)[AL] (CF) **KIT, PEN-KIT**<br>ACTEMRA (tocilizumab) **SUB-Q**<br>ADALIMUMAB-AACF (CF)[AL] **PEN* KIT, SYR-KIT**<br>ADALIMUMAB-AATY (CF)[AL] **PEN KIT**<br>ADALIMUMAB-ADAZ(CF)(biosim for Hyrimoz)[AL] KIT[NR],**PEN,SYR**<br>ADALIMUMAB-ADBM(CF)[AL] 50mg/mL **KIT, PEN-KIT** (Quallent)<br>ADALIMUMAB-ADBM(CF)[AL] 100mg/mL **KIT, PEN-KIT** (Quallent)<br>ADALIMUMAB-FKJP (biosim for Hulio)[AL] **PEN, SYR**<br>ADALIMUMAB-RYVK[AL] (biosim for Simlandi) **KIT, PEN-KIT**<br>AMJEVITA (adalimumab-atto)[AL] **AUTOINJ, SYR**<br>AMJEVITA(adalimumab-atto)[AL] **KIT, PEN-KIT**<br>ARCALYST (nilonacept)<br>BIMZELX (bimekizumab-bkzx)[AL] **PEN, SYR**<br>CIBINQO (abrocitinib)[AL,QL]<br>CIMZIA (certolizumab pegol)[QL]<br>COSENTYX (secukinumab)[AL,QL] **PEN, SYR**<br>CYLTEZO (adalimumab-adbm)[AL] 50mg/mL**KIT, PEN-KIT**<br>CYLTEZO (adalimumab-adbm)[AL] 100mg/mL **KIT, PEN-KIT**<br>ENSPRYNG (satralizumab-mwge) **SUB-Q**<br>ENTYVIO (vedolizumab)[AL] **PEN** | ▪ Preferred agents will be approved with FDA-approved indication – ICD-10 diagnosis code is required.<br>▪ Non-preferred agents will be approved for FDA-approved indications in patients who have failed a trial of TWO preferred agents within this drug class, or upon diagnosis for non-preferred agent with FDA-approved indication if no preferred agent has FDA approval for diagnosis.<br><br>**JAK-Inhibitors:** For FDA approved indications that require a patient to have had an inadequate response to a TNF blocker, documentation of an inadequate response to TWO preferred TNF blockers of different active ingredients is required unless preferred products don't have the appropriate indication.<br><br>Drug-specific criteria:<br>~~**Cosentyx:** Requires treatment failure of Enbrel OR Humira with the same FDA-approved indications and age limits.~~<br>**Pyzchiva/Steqeyma:** Requires a trial and failure of a preferred TNF blocker with the same indication. |

## CYTOKINE & CAM ANTAGONISTS, continued

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| | HULIO (adalimumab-fkjp)[AL] **PEN, SYR**<br>HUMIRA (adalimumab)[QL]<br>HYRIMOZ(CF) (adalimumab-adaz)[AL] **PEN, SYR**<br>IDACIO (adalimumab-aacf)[AL] **PEN, SYR**<br>ILUMYA (tildrakizumab) SUB-Q<br>IMULDOSA (ustekinumab-srlf, Stelara biosimilar)[AL,NR] **SYR**<br>KEVZARA (sarilumab) **SUB-Q, PEN, SYR**<br>KINERET (anakinra)<br>LITFULO (ritlecitinib)[AL] **CAPS**<br>LEQSELVI (deuruxolitinib)[NR] **TAB**<br>OLUMIANT (baricitinib) **TAB**[CL,QL]<br>OMVOH (mirikizumab-mrkz)[AL] 100mg, 200mg,300mg **PEN**[NR],**SYR**[NR]<br>ORENCIA (abatacept) **SUB-Q**<br>OTULFI (ustekinumab-aauz biosimilars Stelara)[AL, NR] **SYR**<br>RINVOQ ER (upadacitinib)[CL,QL]<br>RINVOQ (upadacitinib)[AL,QL] LQ **SOLN** | ▪ Preferred agents will be approved with FDA-approved indication – ICD-10 diagnosis code is required.<br>▪ Non-preferred agents will be approved for FDA-approved indications in patients who have failed a trial of TWO preferred agents within this drug class, or upon diagnosis for non-preferred agent with FDA-approved indication if no preferred agent has FDA approval for diagnosis.<br><br>**JAK-Inhibitors:** For FDA approved indications that require a patient to have had an inadequate response to a TNF blocker, documentation of an inadequate response to TWO preferred TNF blockers of different active ingredients is required unless preferred products don't have the appropriate indication.<br><br>Drug-specific criteria:<br>~~**Cosentyx:** Requires treatment failure of Enbrel OR Humira with the same FDA-approved indications and age limits.~~<br>**Pyzchiva/Steqeyma:** Requires a trial and failure of a preferred TNF blocker with the same indication. |

## CYTOKINE & CAM ANTAGONISTS, continued

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| | SELARSDI (biosimilar- Stelara)[AL, NR] **SYR**<br>SIMLANDI (CF) (adalimumab-ryvk)[AL] **KIT**<br>SIMPONI (golimumab)<br>SKYRIZI (risankizamab-rzaa) **SYR**<br>SKYRIZI **ON-BODY** (risankizamab-rzaa)[QL]<br>SKYRIZI **PEN** (risankizamab-rzaa)[QL]<br>SOTYKTU (deucravacitinib) **TAB**<br>SPEVIGO (spesolimab-sbzo)[AL] **SYR**<br>STELARA (ustekinumab)[AL] **SUB-Q, VIAL** [NR]<br>TREMFYA (guselkumab)[QL] **AUTOINJ, PEN**[NR] **SYR**<br>TYENNE (tocilizumab-aazg)[AL] **AUTOINJ, SYR**<br>USTEKINUMAB[AL,NR] **SYR, VIAL**<br>USTEKINUMAB-AEKN (biosimilar to Stelara)[AL,NR] **SYR**<br>USTEKINUMAB-TTWE[AL,NR] **SYR**<br>VELSIPITY (etrasimod)[QL] **TAB**<br>XELJANZ (tofacitinib) **TAB, SOLN**[CL,QL]<br>XELJANZ XR (tofacitinib) **TAB**[CL,QL]<br>YESINTEK (ustejinumab-kfce)[AL,NR] **SYR, VIAL**<br>YUFLYMA 100mg/mL (CF) (adalimumab-aaty)[AL] **KIT,PEN-KIT**<br>YUFLYMA 80mg/mL (CF) (adalimumab- aaty)[AL] **AUTOINJ, PEN, KIT**<br>YUSIMRY (CF) (adalimumab-aqvh)[AL] **PEN KIT**<br>ZYMFENTRA (infliximab-dyyb) **PEN, SYR** | ▪ Preferred agents will be approved with FDA-approved indication – ICD-10 diagnosis code is required.<br>▪ Non-preferred agents will be approved for FDA-approved indications in patients who have failed a trial of TWO preferred agents within this drug class, or upon diagnosis for non-preferred agent with FDA-approved indication if no preferred agent has FDA approval for diagnosis.<br><br>**JAK-Inhibitors:** For FDA approved indications that require a patient to have had an inadequate response to a TNF blocker, documentation of an inadequate response to TWO preferred TNF blockers of different active ingredients is required unless preferred products don't have the appropriate indication.<br><br>Drug-specific criteria:<br>~~**Cosentyx:** Requires treatment failure of Enbrel OR Humira with the same FDA-approved indications and age limits.~~<br>**Pyzchiva/Steqeyma:** Requires a trial and failure of a preferred TNF blocker with the same indication. |

## ENZYME REPLACEMENT, GAUCHER'S DISEASE

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

## EPINEPHRINE, SELF-ADMINISTERED [QL]

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| AUVI-Q 0.1mg (epinephrine)<br>epinephrine (AUTHORIZED GENERIC Epipen/ Epipen Jr.) **AUTOINJ**<br>EPIPEN (epinephrine) **AUTOINJ**<br>EPIPEN JR. (epinephrine) **AUTOINJ** | AUVI-Q 0.15mg (epinephrine)<br>AUVI-Q 0.3mg (epinephrine)<br>epinephrine (generic Adrenaclick)<br>epinephrine (generic Epipen/ Epipen Jr.) **AUTOINJ**<br>NEFFY (epinephrine) **Nasal Spray**[NR] | ▪ Non-preferred agents require clinical documentation why the preferred productswithin this drug class ~~is~~ are not appropriate<br>Drug-specific criteria:<br>**Neffy Nasal Spray:** Requires a documented clinical reason why a preferred agent in this class can't be used. |

## ERYTHROPOIESIS STIMULATING PROTEINS

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| ARANESP (darbopoetine alfa) **DISP SYR, VIAL**<br>EPOGEN (rHuEPO)<br>RETACRIT (epoetin alfa-epbx) *Pfizer manufacturer only* | PROCRIT (rHuEPO)<br>RETACRIT (epoetin alfa-epbx) *Vifor manufacturer only*<br>VAFSEO (vadadustat) **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<br><br>Drug-specific criteria:<br>▪ **budesonide respules:** Covered without PA for age ≤ 8 years<br>OR for diagnosis of eosinophilic esophagitis in patients ≥ 9 years, by GI biopsy or upper endoscopy. For other indications, must have failed a trial of two preferred agents within this drug class, within the last 6 months. |
| ARNUITY ELLIPTA (fluticasone)<br>ASMANEX (mometasone)[QL,AL]<br>ASMANEX HFA (mometasone)[QL]<br>fluticasone HFA (generic Flovent HFA)<br>PULMICORT FLEXHALER (budesonide) | ALVESCO (ciclesonide)[AL,CL]<br>ARMONAIR DIGIHALER (fluticasone)[AL,QL]<br>fluticasone (generic Flovent Diskus)<br>fluticasone furoate (generic Arnuity Ellipta) [NR,AL]<br>QVAR Redihaler (beclomethasone) | |
| **GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS** | | |
| ADVAIR DISKUS (fluticasone/ salmeterol)[QL]<br>ADVAIR HFA (fluticasone/salmeterol)[QL]<br>DULERA (mometasone/formoterol)<br>SYMBICORT (budesonide/ formoterol) | AIRDUO DIGIHALER (fluticasone/salmeterol)[AL,QL]<br>AIRSUPRA HFA (albuterol and budesonide)[AL]<br>BREO ELLIPTA (fluticasone/vilanterol)<br>BREZTRI (budesonide/formoterol/ glycopyrrolate)[QL]<br>budesonide/formoterol (generic for Symbicort)<br>fluticasone/salmeterol (generic for Advair Diskus)[QL]<br>fluticasone/salmeterol (generic for Advair HFA)[QL]<br>fluticasone/salmeterol (generic for Airduo Respiclick)<br>fluticasone/vilanterol (Breo Ellipta)<br>TRELEGY ELLIPTA (fluticasone/ umeclidinium/vilanterol) | |
| **INHALATION SOLUTION** | | |
| | budesonide **RESPULES** (generic for Pulmicort) | |

## GLUCOCORTICOIDS, ORAL

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

## HEMOPHILIA TREATMENTS

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

## HISTAMINE II RECEPTOR BLOCKERS

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| famotidine **TAB** (generic for Pepcid)<br>famotidine **SUSP** | cimetidine **TAB, SOLN**[CL] (generic Tagamet)<br>famotidine **CHEW-TAB**<br>nizatidine **CAPS** (generic for Axid) | ▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class<br><br>Drug-specific criteria:<br>▪ **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] | ESBRIET (pirfenidone)[QL]<br>OFEV (nintedanib esylate)[CL] | ▪ Non-preferred agent requires trial of preferred agent within this drug class with the same indication<br>▪ FDA approved indication required – ICD-10 diagnosis code |

## IMMUNOMODULATORS, ASTHMA [CL]

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

## IMMUNOMODULATORS, ATOPIC DERMATITIS [AL]

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| ADBRY (tralokinumab-ldrm) [AL,CL,QL] **SUB-Q**<br>ADBRY 300mg/2mL (tralokinumab-ldrm) [AL,CL,QL] **AUTOINJ**<br>DUPIXENT (dupilumab)[AL,CL] **PEN,SYR**<br>EBGLYSS (lebrikizumab-lbkz)[AL,NR,QL] **PEN, SYRINGE**<br>EUCRISA (crisaborole)[CL,QL]<br>pimecrolimus (generic Elidel)<br>tacrolimus (generic Protopic) | ANZUPGO (delgocitinib)[NR,QL] **CREAM**<br>NEMLUVIO (nemolizumab-ilto)[AL,NR]<br>OPZELURA (ruxolitinib phosphate) **CREAM**[AL,CL,QL]<br>VTAMA (tapinarof)[AL] **CREAM** | Immunomodulators Self-Injectable PA Form<br>▪ Non-preferred agents require: Trial of a topical steroid AND Trial of one preferred product within this drug class with same indication. Non-preferred biologics also require treatment failure of a preferred biologic with the same indication.<br>Drug-specific criteria:<br>• **ADBRY/Ebglyss:** May be approved after a trial or failure of a topical corticosteroid AND a topical calcineurin inhibitor<br>▪ **Dupixent**: (For other indications, see Immunomodulators, Asthma and COPD therapeutic classes):<br>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<br>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.<br>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].<br>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.<br>• **Eucrisa**: May be approved after a 30 day trial failure of a preferred topical corticosteroid (TCS) or topical calcineurin inhibitor (TCI) within the past 180 days; Maximum of 300 grams per year<br>▪ **Opzelura**: May be approved for a diagnosis of Atopic Dermatitis and after a trial/failure of a topical steroid and trial of a preferred agent |

## IMMUNOMODULATORS, ATOPIC DERMATITIS [AL], continued

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| | ZORYVE 0.15% (roflumilast)[AL] **CREAM**<br>ZORYVE 0.3% (roflumilast)[AL,CL] **FOAM** | Immunomodulators Self-Injectable PA Form<br>▪ Non-preferred agents require: Trial of a topical steroid AND Trial of one preferred product within this drug class with same indication.<br><br>**Drug Specific Criteria**<br>▪ **Zoryve Foam**- Trial of a topical steroid AND Trial of one preferred product within this drug class with same indication AND Trial of a topical antifungal. |

## IMMUNOMODULATORS, TOPICAL

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

## INTRANASAL RHINITIS AGENTS

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

## LEUKOTRIENE MODIFIERS

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

## METHOTREXATE

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

## MOVEMENT DISORDERS

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

## 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<br><br>Drug-specific criteria:<br>▪ **meclofenamate**: Approvable without trial of preferred agents for menorrhagia<br>▪ **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)<br>ibuprofen OTC, Rx (generic Advil, Motrin) **CHEW, DROPS, SUSP**, **TAB**<br>ibuprofen OTC (generic Advil, Motrin) **CAPS**<br>indomethacin (generic Indocin) **CAPS**<br>ketorolac (generic Toradol)<br>meloxicam (generic Mobic) **TAB**<br>nabumetone (generic Relafen)<br>naproxen Rx, OTC (generic Naprosyn)<br>naproxen enteric coated<br>sulindac (generic Clinoril) | diclofenac potassium (generic Cataflam, Zipsor)<br>diclofenac SR (generic Voltaren-XR)<br>diflunisal (generic Dolobid)<br>etodolac & SR (generic Lodine/XL)<br>fenoprofen (generic Nalfon)<br>flurbiprofen (generic Ansaid)<br>ibuprofen/famotidine (generic Duexis)[CL]<br>ibuprofen 300mg **TAB**<br>indomethacin ER (generic Indocin)<br>ketoprofen & ER (generic Orudis)<br>meclofenamate (generic Meclomen)<br>mefenamic acid (generic Ponstel)<br>meloxicam (generic Vivlodex)[CL, QL] **CAP**<br>meloxicam (generic Mobic) **SUSP**<br>naproxen CR (generic Naprelan)<br>naproxen (generic Naprosyn) **SUSP**<br>naproxen sodium (generic Anaprox)<br>naproxen-esomeprazole (generic Vimovo)<br>oxaprozin (generic Daypro)<br>piroxicam (generic Feldene)<br>tolmetin (generic Tolectin)<br>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:**<br>DOLOBID (diflunisal) 250 MG **TABLET** AL,NR<br>DUEXIS (ibuprofen/famotidine)CL<br>NALFON (fenoprofen) | |
| **NSAID/GI PROTECTANT COMBINATIONS** | | |
| | diclofenac/misoprostol (generic Arthrotec) | |
| **COX-II SELECTIVE** | | |
| celecoxib (generic Celebrex) | | |

## NSAIDs, TOPICAL

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| diclofenac sodium **GEL (OTC only)**<br>PENNSAID **PUMP** (diclofenac) | diclofenac **PUMP** (generic Pennsaid)CL<br>diclofenac **SOLN** (generic Pennsaid)<br>FLECTOR **PATCH** (diclofenac)CL<br>LICART **PATCH** (diclofenac)CL<br>PENNSAID **PACKET** (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<br>▪ Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy<br><br>Drug-specific critera<br>▪ **anastrozole:** May be approved for malignant neoplasm of male breast (male breast cancer)<br>▪ **Fareston/toremifene:** Require clinical reason why tamoxifen cannot be used<br>▪ **letrozole:** Approved for diagnosis of breast cancer with day supply greater than 12 – NOT approved for short term use<br>▪ **Soltamox:** May be approved with documented swallowing difficulty |
| | IBRANCE (palbociclib)<br>KISQALI (ribociclib)<br>KISQALI FEMARA **CO-PACK**<br>VERZENIO (abemaciclib) | |
| **CHEMOTHERAPY** | | |
| capecitabine (generic Xeloda)<br>cyclophosphamide | XELODA (capecitabine) | |
| **HORMONE BLOCKADE** | | |
| anastrozole (generic Arimidex)<br>exemestane (generic Aromasin)<br>letrozole (generic Femara)<br>tamoxifen citrate (generic Nolvadex) | ORSERDU (elacestrant)<br>SOLTAMOX **SOLN** (tamoxifen)CL<br>toremifene (generic Fareston)CL | |
| **OTHER** | | |
| | ITOVEBI (inavolisib)NR<br>NERLYNX (neratinib)<br>PIQRAY (alpelisib)<br>lapatinib (generic Tykerb)<br>TALZENNA (talazoparib tosylate) QL<br>TUKYSA (tucatinib)QL<br>TRUQAP (capivasertib) | |

**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<br>▪ Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy<br><br>Drug-specific critera<br>▪ **Hydrea®:** Requires clinical reason why generic cannot be used<br>▪ **Purixan:** Prior authorization not required for age ≤12 or for documented swallowing disorder<br>▪ **Xpovio:** Indicated for relapsed or refractory multiple myeloma. Requires concomitant therapy with dexamethasone |
| mercaptopurine | PURIXAN (mercaptopurine)[AL]<br>mercaptopurine (generic Purixan)[NR]<br>**SUSP** | |
| **AML** | | |
| | DAURISMO (glasdegib maleate)[QL]<br>IDHIFA (enasidenib)<br>REZLIDHIA (olutasidenib)[QL]<br>RYDAPT (midostaurin)<br>TIBSOVO (ivosidenib)[QL]<br>VANFLYTA (quizartinib)<br>XOSPATA (gilteritinib) [QL] | |
| **CLL** | | |
| | COPIKTRA (duvelisib) [QL]<br>IMBRUVICA (ibrutinib)<br>VENCLEXTA (venetoclax)<br>ZYDELIG (idelalisib) | |
| **CML** | | |
| hydroxyurea (generic for Hydrea)<br>imatinib (generic for Gleevec) | BOSULIF (bosutinib)<br>DANZITEN (nilotinib)[NR]<br>dasatinib (generic Sprycel)[NR]<br>GLEEVEC (imatinib)<br>HYDREA (hydroxyurea)<br>ICLUSIG (ponatinib)<br>IMKELDI (imatinib)[NR]<br>nilotinib HCL (generic Tasigna)[NR]<br>nilotinib TARTRATE (generic Dansiten)[NR]<br>SCEMBLIX (asciminib)<br>SPRYCEL (dasatinib) | |

**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, continued

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| **MPN** | | |
| | JAKAFI (ruxolitinib) | |
| **MYELOMA** | | |
| REVLIMID[QL] (lenalidomide) | lenalidomide[QL] (generic Revlimid)<br>NINLARO (ixazomib)<br>POMALYST (pomalidomide)<br>THALOMID (thalidomide)<br>XPOVIO (selinexor) [CL] | |
| **OTHER** | | |
| MATULANE (procarbazine)<br>tretinoin (generic for Vesanoid)[AL] | BRUKINSA (zanubrutinib[QL]<br>CALQUENCE (acalabrutinib)[QL]<br>INREBIC (fedratinib dihydrochloride)[QL]<br>INQOVI (decitabine/cedazuridine)<br>OJJAARA (momelotinib)<br>REVUFORJ (revumenib)[NR] **TAB**<br>VONJO (pacritinib)[QL]<br>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<br>▪ Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy |
| | ALECENSA (alectinib)<br>ALUNBRIG (brigatinib)QL<br>LORBRENA (lorlatinib) QL<br>ZYKADIA (ceritinib) **CAPS, TAB** | |
| **ALK / ROS1 / NTRK** | | |
| | AUGTYRO (repotrectinib) **CAPS**<br>ROZLYTREK (entrectinib)QL**CAPS, PELLETS**<br>XALKORI (crizotinib) **CAPS, PELLETS** | |
| **EGFR** | | |
| erlotinib (generic for Tarceva) | gefitinib (generic Iressa)<br>GILOTRIF (afatinib)<br>IRESSA (gefitinib)<br>LAZCLUZE (lazertinib)<br>TAGRISSO (osimertinib)<br>TARCEVA (erlotinib)<br>VIZIMPRO (dacomitinib)QL | |
| **OTHER** | | |
| | GAVRETO (pralsetinib)QL<br>HYCAMTIN (topotecan)<br>KRAZATI (adagrasib)<br>LUMAKRAS (sotrasib)QL<br>RETEVMO (selpercatinib)AL<br>TABRECTA (capmatinib)QL<br>TEPMETKO (tepotinib) QL | |

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

## ONCOLOGY AGENTS, ORAL, OTHER

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| temozolomide (generic Temodar) | AVMAPKI-FAKZYNJA (avutometinib/ defactinib)[NR] **Combo-Pack**<br>AYVAKIT (avapritinib)[AL,QL]<br>BALVERSA (erdafitinib)<br>CAPRELSA (vandetanib)<br>COMETRIQ (cabozantinib)<br>FRUZAQLA (fruquintinib) **CAPS**<br>GOMEKLI (mirdametinib)[AL,NR] **CAPS, TABS FOR ORAL SUSP**<br>IWILFIN (eflornithine)<br>JAYPIRCA (pirtobrutinib)<br>KOSELUGO (selumetinib)[AL]<br>LONSURF (trifluridine/tipiracil)<br>LYNPARZA (olaparib)<br>LYTGOBI (futibatinib)<br>OGSIVEO (nirogacestat) **TAB**<br>PEMAZYRE (pemigatinib)[QL]<br>QINLOCK (ripretinib)<br>ROMVIMZA (vimseltinib)[NR] **CAPS**<br>RUBRACA (rucaparib)<br>STIVARGA (regorafenib)<br>TAZVERIK (tazemetostat)[AL]<br>TURALIO (pexidartinib)[QL]<br>VITRAKVI (larotrectinib) **CAPS, SOLN**<br>VORANIGO (vorasidenib)[AL] **TABS**<br>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<br>▪ 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]<br>bicalutamide (generic Casodex) | AKEEGA (niraparib/abiraterone)<br>ERLEADA (apalutamide)[QL]<br>nilutamide (generic Nilandron)<br>NUBEQA (darolutamide) [QL]<br>ORGOVYX (relugolix)[AL]<br>XTANDI (enzalutamide)[AL,QL]<br>YONSA (abiraterone acetonide, submicronized)<br>ZYTIGA (abiraterone)[AL,QL] | ▪ Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines<br>▪ Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy |

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

## ONCOLOGY AGENTS, ORAL, SKIN

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

## OPHTHALMICS, ALLERGIC CONJUNCTIVITIS

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

## OPHTHALMICS, ANTIBIOTICS

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

## OPHTHALMICS, ANTIBIOTIC-STEROID COMBINATIONS

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

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

## OPHTHALMICS, DRY EYE AGENTS

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| RESTASIS (cyclosporine)<br>RESTASIS MULTIDOSE (cyclosporine)<br>XIIDRA (lifitegrast) | CEQUA (cyclosporine) QL<br>cyclosporine (generic Restasis)<br>EYSUVIS (loteprednol etabonate)QL<br>MIEBO (perfluorohexyloctane)<br>TRYPTYR (acoltremon)NR **SOLN**<br>TYRVAYA (varenicline tartrate)QL<br>VERKAZIA (cyclosporine emulsion)<br>VEVYE (cyclosporine) | ▪ 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<br>Drug-specific criteria:<br>▪ **Rhopressa and Rocklatan:** Electronically approved for patients who have a trial of ONE generic agent, within ophthalmic - glaucoma within 180 days |
| pilocarpine | VUITY (pilocarpine) | |
| **SYMPATHOMIMETICS** | | |
| ALPHAGAN P (brimonidine 0.15%)<br>brimonidine 0.2% (generic for Alphagan) | ALPHAGAN P (brimonidine 0.1%)<br>apraclonidine (generic Iopidine)<br>brimonidine P 0.15% (generic Alphagan P 0.15%)<br>brimonidine 0.1% (generic Alphagan P 0.1%) | |
| **BETA BLOCKERS** | | |
| levobunolol (generic for Betagan)<br>timolol (generic for Timoptic) | betaxolol (generic Betoptic)<br>BETIMOL (timolol)<br>BETOPTIC S (betaxolol)<br>carteolol (generic Ocupress)<br>timolol (generic Betimol)[NR]<br>timolol (generic Istalol)<br>timolol (generic Timoptic Ocudose) | |
| **CARBONIC ANHYDRASE INHIBITORS** | | |
| dorzolamide (generic for Trusopt) | brinzolamide (generic Azopt) | |
| **PROSTAGLANDIN ANALOGS** | | |
| latanoprost (generic for Xalatan)<br>TRAVATAN Z (travoprost) | bimatoprost (generic Lumigan)<br>IYUZEH (latanoprost)<br>tafluprost (generic Zioptan)<br>travoprost (generic Travatan Z)<br>VYZULTA (latanoprostene)<br>XALATAN (latanoprost)<br>ZIOPTAN (tafluprost) | |
| **COMBINATION DRUGS** | | |
| COMBIGAN (brimonidine/timolol)<br>dorzolamide/timolol (generic Cosopt) | brimonidine/timolol (generic Combigan)<br>COSOPT (dorzolamide/timolol)<br>dorzolamide/timolol PF (generic Cosopt PF)<br>SIMBRINZA (brinzolamide/brimonidine) | |

## OPHTHALMICS, GLAUCOMA (Continued)

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| **OTHER** | | |
| RHOPRESSA (netarsudil)[CL]<br>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<br>Drug-specific criteria:<br>▪ **Rhopressa and Rocklatan:** Electronically approved for patients who have a trial of ONE generic agent, within the ophthalmic - glaucoma class within 180 days |

## 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 |

## OTIC ANTIBIOTICS

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

**Additional covered agents can be looked up using the Drug Look-up Tool at:**

https://ne.primetherapeutics.com/drug-lookup

## SEDATIVE HYPNOTICS

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

## SICKLE CELL ANEMIA TREATMENT [AL]

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

## STEROIDS, TOPICAL

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

## STEROIDS, TOPICAL (Continued)

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

## 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<br><br>Drug-specific criteria:<br>▪ **Procentra/ dextroamphetamine soln:** May be approved with documentation of swallowing disorder<br>▪ **Zenzedi®:** Requires clinical reason generic dextroamphetamine IR cannot be used |
| **Amphetamine type** | | |
| amphetamine salt combination ER (generic Adderall XR)<br><br>amphetamine salt combination IR<br><br>DYANAVEL XR (amphetamine)QL<br><br>lisdexamfetamine (generic Vyvanse Chew)[QL] **CHEW**<br><br>lisdexamfetamine (generic Vyvanse)[QL] **CAP**<br><br>VYVANSE (lisdexamfetamine)[QL] **CAPS, CHEWABLE** | ADDERALL XR (amphetamine salt combo)<br>ADZENYS XR (amphetamine) **ODT**<br>amphetamine salt combination ER (generic Mydayis) **CAP**<br>amphetamine sulfate (generic Evekeo)<br>dextroamphetamine (generic Dexedrine) **TAB**<br>dextroamphetamine (generic Procentra) **SOLN**<br>dextroamphetamine ER (generic Dexedrine ER Spansule) **CAPS**<br>EVEKEO ODT (amphetamine sulfate)<br>methamphetamine (generic Desoxyn)<br>MYDAYIS (amphetamine salt combo)[QL]<br>XELSTRYM (detroamphetamine)[QL] **PATCH**<br>ZENZEDI (dextroamphetamine) | |

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

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| **Methylphenidate type** | | ▪ Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class<br><br>▪ Maximum accumulated dose of 108mg per day for ages < 18<br><br>▪ Maximum accumulated dose of 72mg per day for ages > 19<br><br>Drug-specific criteria:<br>▪ **Daytrana/methylphenidate patch**: May be approved in history of substance use disorder by parent, caregiver, or patient. May be approved with documentation of difficulty swallowing<br><br>▪ **QuilliChew ER**: May be approved for children ≤ 12 years of age OR with documentation of difficulty swallowing |
| CONCERTA (methylphenidate ER)[QL] 18 mg, 27 mg, 36 mg, 54 mg | APTENSIO XR (methylphenidate) | |
| DAYTRANA **PATCH** (methylphenidate)[QL] | AZSTARYS (serdexmethylphenidate and dexmethylphenidate)[QL] | |
| dexmethylphenidate (generic for Focalin IR) | COTEMPLA XR-ODT (methylphenidate)[QL] | |
| dexmethylphenidate ER (generic Focalin XR) | FOCALIN IR (dexmethylphenidate) | |
| METHYLIN **SOLN** (methylphenidate) | FOCALIN XR (dexmethylphenidate) | |
| methylphenidate (generic Ritalin) | JORNAY PM (methylphenidate) [QL] | |
| methylphenidate **SOLN** (generic Methylin) | methylphenidate **CHEW** | |
| QUILLICHEW ER **CHEWTAB** (methylphenidate) | methylphenidate ER (45 mg and 63 mg)[QL] | |
| QUILLIVANT XR (methylphenidate)**SUSP** | 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 ER 72 mg (generic RELEXXII)[QL] | |
| | methylphenidate ER (generic Ritalin LA) | |
| | 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<br>• Non-preferred agents will be approve for patients who have failed a trial of ONE preferred agent within this class<br>Drug-specific criteria:<br>▪ **Wakix and Sunosi:** Require trial of armodafinil or modafinil<br>▪ **armodafinil and modafinil:** approved only for:<br>○ Sleep Apnea with documentation/confirmation via sleep study and documentation that C-PAP has been maxed<br>○ Narcolepsy with documentation of diagnosis via sleep study<br>○ Shift Work Sleep Disorder (only approvable for 6 months) with work schedule verified and documented. Shift work is defined as working the all night shift<br>▪ **Sunosi** approved only for:<br>○ Sleep Apnea with documentation/confirmation via sleep study and documentation that C-PAP has been maxed<br>○ Narcolepsy with documentation of diagnosis via sleep study<br>▪ **Wakix**: approved only for excessive daytime sleepiness in adults with narcolepsy with documentation of narcolepsy diagnosis via sleep study |
| atomoxetine (generic Strattera) [QL]<br>guanfacine ER (generic Intuniv)[QL]<br>QELBREE (viloxazine)[QL] | clonidine ER (generic Kapvay)[QL]<br>INTUNIV (guanfacine)<br>Onyda XR (clonidine suspension, extended release) [QL]<br>STRATTERA (atomoxetine) | |
| **ANALEPTICS** | | |
| | armodafinil (generic Nuvigil)[CL]<br>modafanil (generic Provigil)[CL]<br>SUNOSI (solriamfetol) [CL,QL]<br>WAKIX (pitolisant)[CL,QL] | |

## THROMBOPOIESIS STIMULATING PROTEINS [CL]

| Preferred Agents | Non-Preferred Agents | Prior Authorization/Class Criteria |
|---|---|---|
| PROMACTA (eltrombopag) **TAB** | ALVAIZ (eltrombopag choline)[AL]<br>DOPTELET (avatrombopag)[AL] **TAB**<br>Eltrombopag (generic Promacta)[NR] **SUSP, TAB**<br>MULPLETA (lusutrombopag)<br>PROMACTA (eltrombopag) **SUSP**<br>TAVALISSE (fostamatinib) | ▪ All agents will be approved with FDA-approved indication, ICD-10 code is required.<br>▪ Non-preferred agents require a trial of a preferred agent with the same indication or a contraindication.<br>Drug-Specific Criteria<br>▪ **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 11:57 AM CST.

| | |
|---|---|
| **(1st) Motion:** Klug | **(2nd) Motion:** Cowles |
| **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 13th, 2026

**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 Manager Senior -Prime Therapeutics