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

PHARMACEUTICAL AND THERAPEUTICS (P&T) COMMITTEE MEETING MINUTES

Wednesday, May 13th at 9:00 AM CDT
Mahoney State Park, Peter Kiewit Lodge
28500 West Park Hwy, Ashland, NE 68003

Committee Members Present:
Eric Avery, M.D.
Claire Baker, M.D. **(Incoming Vice-Chair)**
Andrew Bendlin, Pharm.D. **(Chair)**
Cassie Cowles, APRN
Allison Dering-Anderson, Pharm.D.
Jennifer Hill, M.D.
Jessica Pohl, Pharm.D.
Steven Rose, D.O.

Division of Medicaid and Long-Term Care Staff Present:
Dianne Garside, Pharm.D.
Spencer Moore, Pharm.D.
Lee Stutzman, Pharm.D.

Prime Therapeutics Staff Present:
Nikia Bennette-Carter, Pharm.D., Clinical Account Executive
ShaLeigh Hammons, CPhT, Account Operations Executive
Sandy Pranger, Pharm.D., Sr. Director, Clinical Account Services
Renesha Yarbrough, Pharm.D., Clinical Account Manager

Managed Care Staff Present:
Jamie Benson, Pharm.D., Nebraska Total Care
Michael Labadie, Pharm. D., Molina Healthcare
Megan Petersen Pharm. D., United Healthcare of Nebraska

Committee Members Excused:
Stephen Dolter, M.D.
Wade Fornander, M.D.
C. Jose Friesen, M.D.
Laura Klug, Pharm.D.
Stephen Salzbrenner, M.D.
Sarah Stewart- Bouckaert, Pharm.D.
Bradley Sundsboe, M.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 CDT. The agenda was posted on the Nebraska Medicaid Pharmacy website (https://nebraska.fhsc.com/PDL/PTcommittee.asp) on Monday, April 13th. A copy of the Open Meetings Act and meeting materials distributed to members were made available at the physical meeting site for public viewing.
   - **b.** Roll Call: See list above.
   - **c.** Conflict of Interest: No new conflicts of interest were reported.
   - **d.** Approval of October 29th, 2025, P&T Committee Meeting Minutes.

Approval of October 29, 2025 P&T Committee Meeting Minutes							
(1st) Motion: Dering- Anderson							
(2nd) Motion: Hill							
Discussion: Approve as written.							
Voting – P&T Committee Members Does not include excused or unexcused members	**Yes**	**No**	**Abstain**	**Voting – P&T Committee Members**	**Yes**	**No**	**Abstain**
Avery, Eric, M.D.	X			Dering-Anderson, Allison, Pharm.D.	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Pohl, Jessica, Pharm.D.	X		
Cowles, Cassie, APRN	X			Rose, Steven, D.O.	X		

e. Election of Committee Vice-Chair: Claire Baker volunteered to be Vice-Chair and was unanimously confirmed by the committee.

f. Department Information: Dianne Garside provided an update that Joyce Juracek resigned from the committee. Dianne thanked her for her years of service on the committee.

2. **Public Testimony**

Speaker Order	DRUG CLASS	Drug Name	PDL Status	Speaker Name	Affiliation
1	Antimigraine Agents, Other	Ajovy	P	Dave Miley	Teva
4	HAE Treatments	Orladeyo	NP	Jeff Martin	BioCryst
6	Antimigraine Agents, Other	Nurtec	P	Kelly Krogh	Pfizer

a. While the above speakers registered per the policies and procedures, the following yielded their time back to the committee and did not speak:

i. Craig Fjeldheim for Qulipta and Ubrelvy
ii. Jeffrey Baldwin for Repatha
iii. Kelly Krogh for Ngenla

3. **Committee Closed Session**

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

4. **Resume Open Session**

(1st) Motion: Dering-Anderson	**(2nd) Motion:** Baker
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: Avery							
(2nd) Motion: Dering-Anderson							
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			Dering-Anderson, Allison, Pharm.D.	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Pohl, Jessica, Pharm.D.	X		
Cowles, Cassie, APRN	X			Rose, Steven, D.O.	X		

Consent Agenda: Therapeutic categories (TC) with unchanged recommendations unless otherwise indicated.	
Acne Agents, Topical	Hepatitis C Agents
Analgesics, Opioids Long Acting	Hypoglycemics, Alpha-glucosidase Inhibitors
Angiotensin Modulator Combinations	Hypoglycemics, Meglitinides
Antibiotics, Inhaled	Hypoglycemics, Metformins
Antiemetics / Antivertigo Agents	Hypoglycemics, Sulfonylureas
Antifungals, Oral	Hypoglycemics, TZDs
Antivirals, General	Immunosuppressives, Oral
Antivirals, Oral	Lipotropics, Statins
Antivirals, Topical	Nitrofuran Derivatives
Bladder Relaxant Preparations	Opioid Dependence Treatments
Cephalosporins and Related Antibiotics	Pancreatic Enzymes
Cystic Fibrosis, Oral	Pediatric Vitamin Preparations
Fluoroquinolones, Oral	Proton Pump Inhibitors
GI Motility, Chronic	Sinus Node Inhibitors
Growth Hormone	Tetracyclines
H. Pylori Treatment	Ulcerative Colitis
Hepatitis B Agents	Uterine Disorder Treatment

b. Therapeutic Class Reviews

Review Agenda – ANALGESICS, OPIOIDS SHORT-ACTING							
(1st) Motion: Avery							
(2nd) Motion: Hill							
Discussion: Approved as written.							
Voting – P&T Committee Members Does not include excused or unexcused members	**Yes**	**No**	**Abstain**	**Voting – P&T Committee Members**	**Yes**	**No**	**Abstain**
Avery, Eric, M.D.	X			Dering-Anderson, Allison, Pharm.D.	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Pohl, Jessica, Pharm.D.	X		
Cowles, Cassie, APRN	X			Rose, Steven, D.O.	X		

Review Agenda – ANDROGENIC AGENTS							
(1st) Motion: Rose							
(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			Dering-Anderson, Allison, Pharm.D.	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Pohl, Jessica, Pharm.D.	X		
Cowles, Cassie, APRN	X			Rose, Steven, D.O.	X		

Review Agenda – ANGIOTENSIN MODULATORS

(1st) Motion: Cowles

(2nd) Motion: Dering-Anderson

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			Dering-Anderson, Allison, Pharm.D.	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Pohl, Jessica, Pharm.D.	X		
Cowles, Cassie, APRN	X			Rose, Steven, D.O.	X		

Review Agenda – ANTIBIOTICS, GI

(1st) Motion: Hill

(2nd) Motion: Baker

Discussion: Avery asks the State to review PDL criteria for Dificid and fidaxomicin. 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			Dering-Anderson, Allison, Pharm.D.	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Pohl, Jessica, Pharm.D.	X		
Cowles, Cassie, APRN	X			Rose, Steven, D.O.	X		

Review Agenda – ANTIBIOTICS, VAGINAL							
(1st) Motion: Rose							
(2nd) Motion: Pohl							
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			Dering-Anderson, Allison, Pharm.D.	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Pohl, Jessica, Pharm.D.	X		
Cowles, Cassie, APRN	X			Rose, Steven, D.O.	X		

Review Agenda – ANTIBIOTICS, TOPICAL							
(1st) Motion: Hill							
(2nd) Motion: Dering-Anderson							
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			Dering-Anderson, Allison, Pharm.D.	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Pohl, Jessica, Pharm.D.	X		
Cowles, Cassie, APRN	X			Rose, Steven, D.O.	X		

Review Agenda – ANTICOAGULANTS							
(1st) Motion: Avery							
(2nd) Motion: Baker							
Discussion: Approved as written with removal of criteria from the PDL that mentions brand name Coumadin since it is no longer available.							
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			Dering-Anderson, Allison, Pharm.D.	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Pohl, Jessica, Pharm.D.	X		
Cowles, Cassie, APRN	X			Rose, Steven, D.O.	X		

Review Agenda – ANTIFUNGALS, TOPICAL							
(1st) Motion: Dering-Anderson							
(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			Dering-Anderson, Allison, Pharm.D.	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Pohl, Jessica, Pharm.D.	X		
Cowles, Cassie, APRN	X			Rose, Steven, D.O.	X		

Review Agenda – ANTIMIGRAINE AGENTS, OTHER

(1st) Motion: Avery

(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			Dering-Anderson, Allison, Pharm.D.	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Pohl, Jessica, Pharm.D.	X		
Cowles, Cassie, APRN	X			Rose, Steven, D.O.	X		

Review Agenda – ANTIMIGRAINE AGENTS, TRIPTANS

(1st) Motion: Dering-Anderson

(2nd) Motion: Pohl

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			Dering-Anderson, Allison, Pharm.D.	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Pohl, Jessica, Pharm.D.	X		
Cowles, Cassie, APRN	X			Rose, Steven, D.O.	X		

Review Agenda – ANTIPARASITICS, TOPICAL

(1st) Motion: Hill

(2nd) Motion: Cowles

Discussion: Approved as written.

Voting – P&T Committee Members Does not include excused or unexcused members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D.	X			Dering-Anderson, Allison, Pharm.D.	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Pohl, Jessica, Pharm.D.	X		
Cowles, Cassie, APRN	X			Rose, Steven, D.O.	X		

Review Agenda – BETA-BLOCKERS

(1st) Motion: Baker

(2nd) Motion: Dering-Anderson

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			Dering-Anderson, Allison, Pharm.D.	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Pohl, Jessica, Pharm.D.	X		
Cowles, Cassie, APRN	X			Rose, Steven, D.O.	X		

Review Agenda – BONE RESORPTION SUPPRESSION AND RELATED AGENTS							
(1st) Motion: Baker							
(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			Dering-Anderson, Allison, Pharm.D.	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Pohl, Jessica, Pharm.D.	X		
Cowles, Cassie, APRN	X			Rose, Steven, D.O.	X		

Review Agenda – BPH- BENIGN PROSTATIC HYPERPLASIA AGENTS							
(1st) Motion: Avery							
(2nd) Motion: Hill							
Discussion: Approved as written.							
Voting – P&T Committee Members Does not include excused or unexcused members	**Yes**	**No**	**Abstain**	**Voting – P&T Committee Members**	**Yes**	**No**	**Abstain**
Avery, Eric, M.D.	X			Dering-Anderson, Allison, Pharm.D.	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Pohl, Jessica, Pharm.D.	X		
Cowles, Cassie, APRN	X			Rose, Steven, D.O.	X		

Review Agenda – CALCIUM CHANNEL BLOCKERS							
(1st) Motion: Dering- Anderson							
(2nd) Motion: Pohl							
Discussion: Approved as written. Prime Therapeutics noted that Norliqva should have been highlighted in red on the P&T PDL since it was presented as moving from non-preferred to preferred.							
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			Dering-Anderson, Allison, Pharm.D.	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Pohl, Jessica, Pharm.D.	X		
Cowles, Cassie, APRN	X			Rose, Steven, D.O.	X		

Review Agenda – CONTRACEPTIVES, ORAL							
(1st) Motion: Hill							
(2nd) Motion: Dering-Anderson							
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			Dering-Anderson, Allison, Pharm.D.	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Pohl, Jessica, Pharm.D.	X		
Cowles, Cassie, APRN	X			Rose, Steven, D.O.	X		

Review Agenda – DIURETICS							
(1st) Motion: Dering-Anderson							
(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			Dering-Anderson, Allison, Pharm.D.	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Pohl, Jessica, Pharm.D.	X		
Cowles, Cassie, APRN	X			Rose, Steven, D.O.	X		

Review Agenda – GLUCAGON AGENTS							
(1st) Motion: Baker							
(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			Dering-Anderson, Allison, Pharm.D.	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Pohl, Jessica, Pharm.D.	X		
Cowles, Cassie, APRN	X			Rose, Steven, D.O.	X		

Review Agenda – HAE TREATMENTS							
(1st) Motion: Avery							
(2nd) Motion: Dering-Anderson							
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			Dering-Anderson, Allison, Pharm.D.	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Pohl, Jessica, Pharm.D.	X		
Cowles, Cassie, APRN	X			Rose, Steven, D.O.	X		

Review Agenda – HIV/AIDs							
(1st) Motion: Baker							
(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			Dering-Anderson, Allison, Pharm.D.	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Pohl, Jessica, Pharm.D.	X		
Cowles, Cassie, APRN	X			Rose, Steven, D.O.	X		

Review Agenda – HYPOGLYCEMICS, INCRETIN MIMETICS/ ENHANCERS							
(1st) Motion: Dering-Anderson							
(2nd) Motion: Avery							
Discussion: Approved as written. Committee would like the state to consider changing the class name for the Hypoglycemics classes to "Diabetes Mellitus".							
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			Dering-Anderson, Allison, Pharm.D.	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Pohl, Jessica, Pharm.D.	X		
Cowles, Cassie, APRN	X			Rose, Steven, D.O.	X		

Review Agenda – HYPOGLYCEMICS, INSULIN AND RELATED AGENTS							
(1st) Motion: Baker							
(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			Dering-Anderson, Allison, Pharm.D.	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Pohl, Jessica, Pharm.D.	X		
Cowles, Cassie, APRN	X			Rose, Steven, D.O.	X		

Review Agenda – HYPOGLYCEMICS, SGLT2							
(1st) Motion: Rose							
(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			Dering-Anderson, Allison, Pharm.D.	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Pohl, Jessica, Pharm.D.	X		
Cowles, Cassie, APRN	X			Rose, Steven, D.O.	X		

Review Agenda – LINCOSAMIDES/ OXAZOLIDINONES/ STREPTOGRAMINS							
(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			Dering-Anderson, Allison, Pharm.D.	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Pohl, Jessica, Pharm.D.	X		
Cowles, Cassie, APRN	X			Rose, Steven, D.O.	X		

Review Agenda – LIPOTROPICS, OTHER							
(1st) Motion: Avery							
(2nd) Motion: Dering-Anderson							
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			Dering-Anderson, Allison, Pharm.D.	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Pohl, Jessica, Pharm.D.	X		
Cowles, Cassie, APRN	X			Rose, Steven, D.O.	X		

Review Agenda – MACROLIDES AND KETOLIDES							
(1st) Motion: Cowles							
(2nd) Motion: Hill							
Discussion: Approved as written.							
Voting – P&T Committee Members Does not include excused or unexcused members	**Yes**	**No**	**Abstain**	**Voting – P&T Committee Members**	**Yes**	**No**	**Abstain**
Avery, Eric, M.D.	X			Dering-Anderson, Allison, Pharm.D.	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Pohl, Jessica, Pharm.D.	X		
Cowles, Cassie, APRN	X			Rose, Steven, D.O.	X		

Review Agenda – MULTIPLE SCLEROSIS AGENTS							
(1st) Motion: Hill							
(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			Dering-Anderson, Allison, Pharm.D.	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Pohl, Jessica, Pharm.D.	X		
Cowles, Cassie, APRN	X			Rose, Steven, D.O.	X		

Review Agenda – OPIOID REVERSAL AGENTS							
(1st) Motion: Pohl							
(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			Dering-Anderson, Allison, Pharm.D.	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Pohl, Jessica, Pharm.D.	X		
Cowles, Cassie, APRN	X			Rose, Steven, D.O.	X		

Review Agenda – PAH- PULMONARY ARTERIAL HYPERTENSION AGENTS							
(1st) Motion: Dering- Anderson							
(2nd) Motion: Hill							
Discussion: Approved as written.							
Voting – P&T Committee Members Does not include excused or unexcused members	**Yes**	**No**	**Abstain**	**Voting – P&T Committee Members**	**Yes**	**No**	**Abstain**
Avery, Eric, M.D.	X			Dering-Anderson, Allison, Pharm.D.	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Pohl, Jessica, Pharm.D.	X		
Cowles, Cassie, APRN	X			Rose, Steven, D.O.	X		

Review Agenda – PENICILLINS							
(1st) Motion: Dering-Anderson							
(2nd) Motion: Hill							
Discussion: Approved as written.							
Voting – P&T Committee Members Does not include excused or unexcused members	**Yes**	**No**	**Abstain**	**Voting – P&T Committee Members**	**Yes**	**No**	**Abstain**
Avery, Eric, M.D.	X			Dering-Anderson, Allison, Pharm.D.	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Pohl, Jessica, Pharm.D.	X		
Cowles, Cassie, APRN	X			Rose, Steven, D.O.	X		

Review Agenda – PHOSPHATE BINDERS							
(1st) Motion: Avery							
(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			Dering-Anderson, Allison, Pharm.D.	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Pohl, Jessica, Pharm.D.	X		
Cowles, Cassie, APRN	X			Rose, Steven, D.O.	X		

Review Agenda – PLATELET AGGREGATION INHIBITORS							
(1st) Motion: Pohl							
(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			Dering-Anderson, Allison, Pharm.D.	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Pohl, Jessica, Pharm.D.	X		
Cowles, Cassie, APRN	X			Rose, Steven, D.O.	X		

Review Agenda – PRENATAL VITAMINS							
(1st) Motion: Hill							
(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			Dering-Anderson, Allison, Pharm.D.	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Pohl, Jessica, Pharm.D.	X		
Cowles, Cassie, APRN	X			Rose, Steven, D.O.	X		

Review Agenda – SKELETAL MUSCLE RELAXANTS							
(1st) Motion: Avery							
(2nd) Motion: Dering-Anderson							
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			Dering-Anderson, Allison, Pharm.D.	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Pohl, Jessica, Pharm.D.	X		
Cowles, Cassie, APRN	X			Rose, Steven, D.O.	X		

Review Agenda – THYROID HORMONES							
(1st) Motion: Pohl							
(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			Dering-Anderson, Allison, Pharm.D.	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Pohl, Jessica, Pharm.D.	X		
Cowles, Cassie, APRN	X			Rose, Steven, D.O.	X		

Review Agenda – VASODILATORS, CORONARY							
(1st) Motion: Hill							
(2nd) Motion: Dering-Anderson							
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			Dering-Anderson, Allison, Pharm.D.	X		
Baker, Claire, M.D.	X			Hill, Jennifer, M.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Pohl, Jessica, Pharm.D.	X		
Cowles, Cassie, APRN	X			Rose, Steven, D.O.	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

May 2026 P&T Proposed Changes

Red Highlights indicate proposed changes

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

ACNE AGENTS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
adapalene (generic Differin) **GEL (OTC/Rx), GEL PUMP** adapalene/BPO (generic Epiduo) benzoyl peroxide (BPO) **LOTION-OTC** benzoyl peroxide (BPO) 5% **WASH, 10% WASH,** benzoyl peroxide **GEL OTC** clindamycin/BPO (generic BenzaClin) **GEL, PUMP** clindamycin/BPO (generic Duac) clindamycin phosphate **PLEDGET** clindamycin phosphate **SOLN** erythromycin **GEL** erythromycin **SOLN** erythromycin-BPO (generic for Benzamycin) tretinoin (generic Avita, Retin-A) [AL,] **CREAM, GEL**	adapalene (generic Differin) **CREAM** adapalene/BPO (generic Epiduo Forte) ALTRENO (tretinoin)[AL] AMZEEQ (minocycline) ATRALIN (tretinoin) AVAR (sulfacetamide sodium/sulfur) AVITA (tretinoin) AZELEX (azelaic acid) BENZEFOAM (benzoyl peroxide) benzoyl peroxide **CLEANSER**, **CLEANSING BAR OTC** benzoyl peroxide **FOAM** (generic BenzePro) benzoyl peroxide **GEL Rx** benzoyl peroxide **TOWELETTE OTC** clindamycin **FOAM, LOTION** clindamycin **GEL** clindamycin phosphate (generic Clindagel) **GEL** clindamycin/BPO (generic Acanya) **GEL** clindamycin/BPO **PUMP** (generic Onexton)[AL] clindamycin/tretinoin (generic Veltin, Ziana) dapsone (generic Aczone) **GEL** DIFFERIN (adapalene) **CREAM, GEL-OTC, GEL PUMP** erythromycin **PLEDGET** EVOCLIN (clindamycin) **FOAM**	▪ Non-preferred agents will be approved for patients who have failed THREE preferred agents within this drug class ▪ All retinoid products have a maximum age limit of 20 without a diagnosis of acne

ACNE AGENTS, TOPICAL (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	FABIOR (tazarotene) **FOAM** NEUAC (clindamycin/BPO) OVACE PLUS (sulfacetamide sodium) sulfacetamide **CLEANSER**, **SHAMPOO**, **SUSP** sulfacetamide sodium ER **CLEANSER** sulfacetamide/sulfur sulfacetamide/sulfur **CLEANSER, CREAM, LOTION, PLEDGETS, SUSP** sulfacetamide sodium/ sulfur **CLEANSER** sulfacetamide/sulfur/urea **CLEANSER** SUMADAN (sulfacetamide/sulfur) tazarotene (generic Tazorac) **CREAM** tazarotene **FOAM** (generic Fabior) tazarotene **GEL** (generic Tazorac) tretinoin (generic Atralin) [AL] **GEL** tretinoin microspheres (generic Retin-A Micro) [AL] **GEL PUMP** TWYNEO (treinoin/BPO) **CREAM** WINLEVI (clascoterone)[AL]	▪ Non-preferred agents will be approved for patients who have failed THREE preferred agents within this drug class ▪ All retinoid products have a maximum age limit of 20 without a diagnosis of acne

ANALGESICS, OPIOID LONG-ACTING

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

ANALGESICS, OPIOID SHORT-ACTING [QL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ORAL		▪ Non-preferred agents will be approved for patients who have failed THREE preferred agents within this drug class within the last 12 months. ▪ Note: for short acting opiate tablets and capsules there is a maximum quantity limit of #150 per 30 days. ▪ Opiate limits for opiate naïve patients will consist of: -prescriptions limited to a 7 day supply, AND -initial opiate prescription fill limited to maximum of 50 Morphine Milligram Equivalents (MME) per day These limits may only be exceeded with patient specific documentation of medical necessity, with examples such as, cancer diagnosis, end-of-life care, palliative care, Sickle Cell Anemia, or prescriber attestation that patient is not recently opiate naive Drug-specific criteria: ▪ **Nucynta/ tapentadol:** Approved only for diagnosis of acute pain, for 30 days or less
acetaminophen/codeine **ELIXIR, TAB** codeine **TAB** hydrocodone/APAP **SOLN, TAB** hydrocodone/ibuprofen hydromorphone **TAB** morphine **CONC SOLN**, **SOLN, TAB** oxycodone **TAB, SOLN** oxycodone/APAP tramadol 50 **TAB**[AL] (generic Ultram)	butalbital/caffeine/APAP/codeine butalbital compound w/codeine (butalbital/ASA/caffeine/codeine) carisoprodol compound-codeine (carisoprodol/ASA/codeine) dihydrocodeine/APAP/caffeine hydrocodone/APAP SOLN (generic Zolvit)[NR] hydromorphone **LIQUID, SUPPOSITORY** (generic Dilaudid) levorphanol (generic Xyvona) meperidine (generic Demerol) morphine **SUPPOSITORIES** NALOCET (oxycodone/APAP) NUCYNTA (tapentadol)[CL] oxycodone **CAPS** oxycodone/APAP **SOLN** oxycodone **CONCENTRATE** oxymorphone IR (generic Opana) pentazocine/naloxone ROXICODONE (oxycodone) ROXYBOND (oxycodone) SEGLENTIS (celecoxib/tramadol)[AL] tapentadol (generic Nucynta) [CL, NR] tramadol 25mg tramadol 75mg tramadol 100mg (generic Ultram)[AL] tramadol (generic Qdolo)[AL] **SOLN** tramadol/APAP (generic Ultracet)	

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

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

ANDROGENIC AGENTS (TOPICAL) [CL]

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

ANGIOTENSIN MODULATORS

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

ANGIOTENSIN MODULATORS (Continued)

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

ANTIBIOTICS, GASTROINTESTINAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
metronidazole **TAB** neomycin tinidazole (generic Tindamax) vancomycin (generic Firvanq)[QL] **SOLN** vancomycin **CAPS** (generic Vancocin)[~~CL~~]	AEMCOLO (rifamycin) **TAB** DIFICID (fidaxomicin) [CL] **TAB, SUSP** fidaxomicin (generic Dificid)[CL,NR] **TAB** FIRVANQ (vancomycin)[QL] **SOLN** LIKMEZ (metronidazole) **SUSP** metronidazole **CAPS** [CL] metronidazole 125mg **TAB** [CL] nitazoxanide (generic Alinia) **TAB**[AL, CL, QL] paromomycin SOLOSEC (secnidazole) VOWST (fecal microbiota spores)[AL,QL] XIFAXAN (rifaximin)	▪ Note: Although azithromycin, ciprofloxacin, and trimethoprim/ sulfmethoxazole are not included in this review, they are available without prior authorization Drug-specific criteria: ▪ **Alinia /nitazoxanide tablet:** Trial and failure with metronidazole is required for a diagnosis of giardiasis ▪ **Dificid®/ fidaxomicin:** For diagnosis of C. difficile diarrhea (pseudomembranous colitis), trial and failure or intolerance to oral vancomycin is required. For diagnosis of relapsed or recurrent C. difficile, an appropriate ICD-10 diagnosis code must be submitted for coverage. ▪ **metronidazole CAPS/ metronidazole 125mg TAB-** requires a clinical reason why preferred metronidazole tablet cannot be used ▪ ~~**vancomycin capsules:** Requires patient specific documentation of why the Firvanq/vancomycin solution is not appropriate for patient~~

ANTIBIOTICS, INHALED [CL]

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

ANTIBIOTICS, TOPICAL

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

ANTIBIOTICS, VAGINAL

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

ANTICOAGULANTS

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

ANTIEMETICS/ANTIVERTIGO AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CANNABINOIDS		▪ Non-preferred agents will be approved for patients who have failed ONE preferred agent within this drug class within the same subclass
dronabinol (generic Marinol)[AL]		
5HT3 RECEPTOR BLOCKERS		Drug-specific criteria:
ondansetron (generic Zofran/Zofran ODT)[QL]	ANZEMET (dolasetron) granisetron (generic Kytril) ondansetron 16mg ODT (generic Zofran ODT) SANCUSO (granisetron)[CL]	▪ **Akynzeo®:** Approved for Moderately/Highly emetogenic chemotherapy with dexamethasone and a 5-HT3 antagonist ▪ Regimens include: AC combination (Doxorubicin or Epirubicin with Cyclophosphamide), Aldesleukin, Amifostine, Arsenic trioxide, Azacitidine, Bendamustine, Busulfan, Carmustine, Carbplatin, Cisplatin, Clofarabine, Cyclophosphamide, Cytarabine, Dacarbazine, Dactinomycin, Daunorubicin, Epirubicin, Etoposide, Hexamethylmelamine, Idarubicin, Ifosfamide, Imatinib, Interferon α, Irinotecan, Mechlorethamine, Melphalan, Methotrexate, Oxaliplatin, Procarbazine, Streptozotocin, Temozolomide ▪ **Diclegis/doxylamine-pyridoxine)/ Bonjesta:** Approved only for treatment of nausea and vomiting of pregnancy ▪ **Sancuso®:** Documentation of oral dosage form intolerance
NK-1 RECEPTOR ANTAGONIST		
aprepitant (generic Emend) **CAPS** [QL]	AKYNZEO (netupitant/palonosetron)[CL] aprepitant (generic Emend) **PACK** EMEND (aprepitant) **CAPS, PACK, POWDER** [QL]	
TRADITIONAL ANTIEMETICS		
DICLEGIS (doxylamine/pyridoxine)[CL,QL] dimenhydrinate (generic Dramamine) **OTC** meclizine (generic Antivert) metoclopramide (generic Reglan) phosphoric acid/dextrose/fructose (generic Emetrol) **SOLN** prochlorperazine(generic Compazine) promethazine (generic Phenergan) **SYRUP**, **TAB** promethazine 12.5mg, 25mg **SUPPOSITORY** scopolamine **TRANSDERMAL** TRANSDERM-SCOP (scopolamine)	BONJESTA (doxylamine/pyridoxine)[CL,QL] COMPRO (prochlorperazine) doxylamine/pyridoxine (generic Diclegis)[CL,QL] prochlorperazine **SUPPOSITOR**Y (generic Compazine) promethazine **SUPPOSITORY** 50mg trimethobenzamide **TAB** (generic Tigan)	

ANTIFUNGALS, ORAL

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

ANTIFUNGALS, TOPICAL

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

ANTIMIGRAINE AGENTS, OTHER

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

ANTIMIGRAINE AGENTS, TRIPTANS [QL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ORAL		▪ Non-preferred agents will be approved for patients who have failed ALL preferred agents within this drug class Drug-specific criteria: ▪ **Zembrace:** approved for patients who have failed ALL preferred agents
rizatriptan (generic Maxalt) rizatriptan ODT (generic Maxalt MLT) sumatriptan	almotriptan (generic Axert) eletriptan (generic Relpax) frovatriptan (generic Frova) IMITREX (sumatriptan) naratriptan (generic Amerge) RELPAX (eletriptan)[QL] sumatriptan/naproxen (generic Treximet) SYMBRAVO (rizatriptan benzoate/meloxicam)[AL,NR] **TAB** zolmitriptan (generic Zomig)	
NASAL		
IMITREX (sumatriptan) sumatriptan (generic Imitrex Nasal)	TOSYMRA (sumatriptan) zolmitriptan (generic Zomig) ZOMIG (zolmitriptan)	
INJECTABLE		
sumatriptan **SYRINGE, VIAL**	sumatriptan **KIT** ZEMBRACE SYMTOUCH (sumatriptan)[CL]	

ANTIPARASITICS, TOPICAL

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

ANTIVIRALS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ANTI-COVID-19 DRUGS		▪ Non-preferred agents will be approved for patients who have failed a 10-day trial of ONE preferred agent within the same subclass
PAXLOVID (nirmatrelvir/ritonavir)[CL,QL]		
ANTI-HERPETIC DRUGS		Drug-specific criteria: ▪ **Acyclovir Susp:** Prior authorization NOT required for children ≤ 12 years old ▪ **Paxlovid**: Requires a diagnosis of COVID-19 and is limited to 1 dose pack per 30 days ▪ **Xofluza:** Requires clinical, patient specific reason that a preferred agent cannot be used
acyclovir (generic Zovirax) famciclovir (generic Famvir) valacyclovir (generic Valtrex)	acyclovir (generic Zovirax)[CL] **SUSP**	
ANTI-INFLUENZA DRUGS		
oseltamivir (generic Tamiflu)[QL] **CAPS, SUSP**	rimantadine (generic Flumadine) RELENZA (zanamivir)[QL] TAMIFLU (oseltamivir)[QL] **CAPS, SUSP** XOFLUZA (baloxavir marboxil)[AL,CL,QL]	

ANTIVIRALS, TOPICAL

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

BETA BLOCKERS, ORAL

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

BLADDER RELAXANT PREPARATIONS

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

BONE RESORPTION SUPPRESSION AND RELATED DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BISPHOSPHONATES		▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within the same subclass Drug-specific criteria: **Atelvia DR®:** Requires clinical reason alendronate cannot be taken on an empty stomach **Binosto®:** Requires clinical reason why alendronate tablets OR Fosamax® solution cannot be used **Forteo/ teriparatide:** Covered for high risk of fracture High risk of fracture: • BMD -3 or worse • Postmenopausal women with history of non-traumatic fractures • Postmenopausal women with 2 or more clinical risk factors ○ Family history of non-traumatic fractures ○ DXA BMD T-score ≤ -2.5 at any site ○ Glucocorticoid use ≥ 6 months at 7.5 dose of prednisolone equivalent ○ Rheumatoid Arthritis • Postmenopausal women with BMD T-score ≤ -2.5 at any site with any clinical risk factors ○ More than 2 units of alcohol per day ○ Current smoker • Men with primary or hypogonadal osteoporosis • Osteoporosis associated with sustained systemic glucocorticoid therapy • Trial of calcitonin-salmon not required • Maximum of 24 months treatment per lifetime **Bonsity**: Requires clinical reason why Forteo cannot be used
alendronate (generic Fosamax) **TAB** ibandronate (generic Boniva)QL	alendronate **SOLN** (generic Fosamax)QL ATELVIA DR (risedronate)CL BINOSTO (alendronate)CL FOSAMAX PLUS D (alendronate sodium/ cholecalciferol)QL risedronate (generic Actonel)QL	
OTHER BONE RESORPTION SUPPRESSION AND RELATED DRUGS		
calcitonin-salmon **NASAL** FORTEO (teriparatide)CL,QL raloxifene (generic Evista)	BONSITY (teriparatide) CL,NR,QL EVISTA (raloxifene) teriparatide (generic Forteo) CL,QL TYMLOS (abaloparatide)	

BPH (BENIGN PROSTATIC HYPERPLASIA) TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ALPHA BLOCKERS		▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within the same subclass. Drug-specific criteria: ▪ **Alfuzosin/dutasteride/finasteride** • Covered for males only ▪ **Cardura XL®:** Requires clinical reason generic IR form cannot be used ▪ **Flomax/ tamsulosin:** Covered for males and may be covered for females for a 7-day supply with diagnosis of acute kidney stones ▪ **Jalyn/ dutasteride-tamsulosin:** Requires clinical reason why individual agents cannot be used ▪ **Tezruly**: Clinical reason why oral tablet is not appropriate
alfuzosin (generic Uroxatral)CL doxazosin (generic Cardura) tamsulosin (generic Flomax)CL terazosin (generic Hytrin)	CARDURA XL (doxazosin)CL silodosin (generic Rapaflo) TEZRULY (terazosin)CL,NR **SOLN**	
5-ALPHA-REDUCTASE (5AR) INHIBITORS		
dutasteride (generic Avodart)CL finasteride (generic Proscar)CL	dutasteride/tamsulosin (generic Jalyn)CL	

CALCIUM CHANNEL BLOCKERS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
SHORT-ACTING		▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within the same subclass. Drug-specific criteria: ▪ **Katerzia/ Norliqva/Sdamlo:** May be approved with documented swallowing difficulty. Katerzia and Sdamlo also require a clinical reason Norliqva can't be used. ▪ **Nifedipine:** May be approved without trial for diagnosis of Preterm Labor or Pregnancy Induced Hypertension (PIH) ▪ **Nimodipine:** Covered without trial for diagnosis of subarachnoid hemorrhage ▪ **Nimodipine solution**: Covered without trial for diagnosis of subarachnoid hemorrhage and documented swallowing difficulty
Dihydropyridines		
	isradipine (generic Dynacirc) nicardipine (generic Cardene) nifedipine (generic Procardia)CL nimodipine (generic Nimotop)CL nimodipine (generic Nymalize)CL **SOLN** NYMALIZE (nimodipine) **SOLN**	
Non-dihydropyridines		
diltiazem (generic Cardizem) verapamil (generic Calan/Isoptin)		
LONG-ACTING		
Dihydropyridines		
amlodipine (generic Norvasc) nifedipine ER (generic Procardia XL/ Adalat CC) NORLIQVA (amlodipine)AL,CL,QL **SOLN**	felodipine ER (generic Plendil) KATERZIA (amlodipine)CL,QL **SUSP** levamlodipine (generic Conjupri) nisoldipine (generic Sular) SDAMLO (amlodipine)AL,CL,NR **SOLN**	
Non-dihydropyridines		
diltiazem ER (generic Cardizem CD) verapamil ER **TAB**	diltiazem ER (generic Cardizem LA) MATZIM LA (diltiazem ER) TIAZAC (diltiazem) verapamil ER **CAPS** verapamil 360mg **CAPS** verapamil ER (generic Verelan PM) verapamil SR (generic Verelan) **CAPS**	

CEPHALOSPORINS AND RELATED ANTIBIOTICS, ORAL

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

CONTRACEPTIVES, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
All reviewed agents are recommended preferred at this time *Only those products for review are listed.* Brand name products may be subject to Maximum Allowable Cost (MAC) pricing or require substitution with a generic equivalent Specific agents can be looked up using the Drug Look-up Tool at: https://ne.primetherapeutics.com/drug-lookup AVERI (desogestrel and ethinyl estradiol kit)[NR] GALBRIELA (norethindrone/ethinyl estradiol/ferrous fumarate)[NR] **CHEW** LUIZZA (norethindrone ac/eth estradiol)[NR] MELEYA (norethindrone)[NR] ORQUIDEA (norethindrone)[NR] ROSYRAH (levonorgestrel/ ethinyl estradiol/ ethinyl estradiol kit)[NR] XARAH FE (norethindrone acetate and ethinyl estradiol and ferrous fumarate)[NR] XELRIA FE (norethindrone and ethinyl estradiol and ferrous fumarate)[NR] YASMIN (drospirenone and ethinyl estradiol)[NR]		

CYSTIC FIBROSIS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	ALYFTREK (vanzacaftor; tezacaftor. deutivacaftor)[AL,CL] **TAB** BRONCHITOL (mannitol) [AL,CL,QL] KALYDECO **PACKET, TAB** (ivacaftor)[AL,CL,QL] ORKAMBI (lumacaftor/ivacaftor) **PACKET, TAB** [AL,CL,QL] SYMDEKO (tezacaftor/ivacaftor)[AL,CL,QL] TRIKAFTA(elexacaftor, tezacaftor, ivacaftor)[AL, CL] **PACKET, TAB**	Drug-specific criteria: ▪ **Alyfrek:** Diagnosis of CF and documentation of at least one F508del mutation or another responsive mutation in the CFTR gene. ▪ **Bronchitol**: Approved for diagnosis of CF and documentation that the patient has passed the BRONCHITOL Tolerance Test ▪ **Kalydeco®:** Diagnosis of CF and documentation of the drug-specific, FDA-approved mutation of CFTR gene ▪ **Orkambi®:** Diagnosis of CF and documentation of presence of two copies of the F580del mutation (homozygous) of CFTR gene ▪ **Symdeko:** Diagnosis of CF and documentation of the drug specific, FDA approved mutation of CFTR gene. ▪ **Trikafta:** Diagnosis of CF and documentation of at least one F508del mutation in the CFTR gene or a mutation that is responsive to Trikafta based on clinical and/or in vitro data

DIURETICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
SINGLE-AGENT PRODUCTS		▪ Non-preferred agents will be approved for patients who have failed a trial of **TWO** preferred agents within this drug class. Drug Specific Criteria: ▪ **eplerenone**: Will be approved with a failed trial or intolerance to spironolactone, a trial with two preferred agents is not required. ▪ **Kerendia**: For diagnosis of chronic kidney disease associated with Type-II diabetes in adults. Also for diagnosis of heart failure in adults with LVEF of 40% or greater. ▪ **spironolactone suspension**: May be approved without trial of a preferred agent if there is a clinical reason why preferred spironolactone solid dosage form cannot be used.
amiloride **TAB** bumetanide **TAB** chlorthalidone (generic Diuril) **TAB** furosemide (generic Lasix) **SOLN, TAB** hydrochlorothiazide (generic Microzide) **CAPS, TAB** indapamide **TAB** KERENDIA (finerenone) **TAB** CL,QL metolazone **TAB** spironolactone (generic Aldactone)AL **TAB** torsemide **TAB**	CAROSPIR (spironolactone)AL **SUSP** eplerenone (generic Inspra)CL **TAB** ethacrynic acid (generic Edecrin) **CAPS** HEMICLOR (chlorthalidone)NR TAB INZIRQO (hydrochlorothiazide)NR.QL **SUSP** spironolactone (generic Carospir)AL,CL **SUSP** THALITONE (chlorthalidone) **TAB** triamterene (generic Dyrenium)	
COMBINATION PRODUCTS		
amiloride/HCTZ **TAB** spironolactone/HCTZ **TAB** (generic Aldactazide) triamterene/HCTZ **CAPS, TAB** (generic Dyazide, Maxzide)		

FLUOROQUINOLONES, ORAL

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

GI MOTILITY, CHRONIC

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
LINZESS (linaclotide)[AL,QL] lubiprostone (generic Amitiza)[AL,QL]	alosetron (generic Lotronex)[CL] AMITIZA (lubiprostone)[AL, QL] IBSRELA (tenapanor)[AL,~~CL~~,QL] MOTEGRITY (prucalopride succinate) MOVANTIK (naloxegol oxalate)[QL] prucalopride (generic Motegrity) SYMPROIC (naldemedine)[~~CL~~] VIBERZI (eluxodoline)[CL]	▪ Non-preferred agents will be approved for patients who have failed a 30-day trial of ONE preferred agent within this drug class with the same indication Drug-specific criteria: ▪ **Lotronex/ alosetron:** Covered for diagnosis of IBS Diarrhea Predominant type with trial and failure of loperamide AND diphenoxylate ▪ **Viberzi®:** Covered for diagnosis of IBS Diarrhea Predominant type with trial and failure of loperamide AND diphenoxylate

GLUCAGON AGENTS

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

GROWTH HORMONES

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

H. PYLORI TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
PYLERA (bismuth, metronidazole, tetracycline)[QL]	bismuth,metronidazole,tetracycline (generic Pylera)[QL] lansoprazole/amoxicillin/clarithromycin (generic Prevpac)[QL] OMECLAMOX-PAK (omeprazole, clarithromycin, amoxicillin)[QL] TALICIA (omeprazole/amoxicillin/rifabutin) VOQUEZNA (vonoprazan)[CL,QL]	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-Specific Criteria • **Voquezna**: For the diagnosis of erosive esophagitis or heartburn associated with non-erosive GERD, will require confirmation by initial endoscopy and a trial/failure or a contraindication of two different PPIs (8 weeks each) up to maximally indicated doses in the past 180days. Length of therapy for erosive esophagitis is 240 days max per calendar year and 4 weeks for heartburn associated with non-erosive GERD.

HAE TREATMENTS [CL]

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

HEPATITIS B TREATMENTS

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

HEPATITIS C TREATMENTS

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

HIV / AIDS [CL]

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

HIV / AIDS [CL] (Continued)

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

HIV / AIDS [CL] (Continued)

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

HYPOGLYCEMICS, ALPHA-GLUCOSIDASE INHIBITORS

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

HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
GLUCAGON-LIKE PEPTIDE-1 RECEPTOR AGONIST (GLP-1 RA)[AL,CL,QL]		**GLP-1 RA Criteria**
OZEMPIC (semaglutide)[AL,QL] TRULICITY (dulaglutide) [AL,QL] VICTOZA (liraglutide)[AL,QL]	BYDUREON BCISE **PEN** (exenatide) [AL,QL] BYETTA (exenatide) [AL,QL] subcutaneous exenatide (generic Byetta) [AL,QL] liraglutide (generic Victoza) [AL,QL] MOUNJARO (tirzepatide) [AL,QL] **PEN** RYBELSUS (semaglutide) [AL,QL] 1.5mg, 3mg, 4mg, 7mg, 9mg, 14mg	Preferred agents require a diagnosis of Type II diabetes AND a trial and failure or intolerance to metformin **OR** A diagnosis of ASCVD associated with a diagnosis of Type II diabetes (no metformin trial required) Non-preferred agents will be approved for patients who have: ▪ Failed a trial of TWO preferred agents within GLP-1 RA; AND ▪ Diagnosis of diabetes with HbA1C ≥ 7; AND ▪ Trial of metformin, or contraindication or intolerance to metformin
INSULIN/GLP-1 RA COMBINATIONS		
	SOLIQUA (insulin glargine/lixisenatide) XULTOPHY (insulin degludec/liraglutide)	
AMYLIN ANALOG[CL]		**Amylin Analog Criteria**
	SYMLIN (pramlintide) subcutaneous	ALL criteria must be met ▪ Concurrent use of short-acting mealtime insulin ▪ Current therapy compliance ▪ No diagnosis of gastroparesis ▪ HbA1C ≤ 9% within last 90 days ▪ Monitoring of glucose during initiation of therapy
DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITOR[AL,CL,QL]		**DPP-4 Inhibitor Criteria**
JANUMET (sitagliptin/metformin) JANUVIA (sitagliptin) JENTADUETO (linagliptin/metformin) TRADJENTA (linagliptin)	alogliptin (generic Nesina) alogliptin/metformin (generic Kazano) alogliptin/pioglitazone (generic Oseni) BRYNOVIN (sitagliptin)[NR,QL] SOLN GLYXAMBI (empagliflozin/linagliptin) JANUMET XR (sitagliptin/metformin) JENTADUETO XR (linagliptin/metformin) KOMBIGLYZE XR (saxagliptin/metformin) ONGLYZA (saxagliptin) QTERN (dapagliflozin/saxagliptin)	Preferred agents require a diagnosis of Type II diabetes AND a trial and failure or intolerance to metformin. Non-preferred DPP-4s will be approved for patients who have failed a trial of ONE preferred agent within the DPP-4 inhibitor class

HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITOR[AL,CL,QL]		
	saxagliptin (generic Onglyza) saxagliptin/metformin ER (generic Kombiglyze ER) sitagliptin (generic Zituvio) sitagliptin/ metformin (Zituvimet) sitagliptin/ metformin ER (Zituvimet XR)[NR] STEGLUJAN (ertugliflozin/sitagliptin) TRIJARDY XR (empagliflozin/linagliptin/metformin) ZITUVIMET (sitagliptin/metformin) **TAB**[QL] ZITUVIMET XR (sitagliptin/ metformin ER) **TAB**[QL] ZITUVIO (sitagliptin)	

HYPOGLYCEMICS, INSULIN AND RELATED DRUGS

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

HYPOGLYCEMICS, INSULIN AND RELATED DRUGS, continued

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	MERILOG (insulin aspart-szjj)[NR] **SOLOSTAR PEN** MERILOG (insulin aspart-szjj)[NR] **VIAL** NOVOLIN (insulin) **PEN-OTC**, **VIAL-OTC** NOVOLIN 70/30 VIAL (insulin) NOVOLOG (insulin aspart) **CARTRIDGE, PEN, VIAL** NOVOLOG MIX (insulin aspart/aspart protamine) **PEN, VIAL** REZVOGLAR (insulin glargine-aglr) **KWIKPEN** SEMGLEE (insulin glargine) **PEN, VIAL** SEMGLEE YFGN (insulin glargine) **PEN, VIAL** TOUJEO SOLOSTAR (insulin glargine)	Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

HYPOGLYCEMICS, MEGLITINIDES

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

HYPOGLYCEMICS, METFORMINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
metformin IR & ER (generic Glucophage/Glucophage XR)	metformin IR 750 mg metformin ER (generic Fortamet/Glumetza)[CL] metformin **SOLN** (generic Riomet)[CL] RIOMET ER (metformin ER)[AL]	▪ **Metformin ER (generic Fortamet®)/Glumetza®:** Requires clinical reason why generic Glucophage XR® cannot be used ▪ **Metformin solution:** Prior authorization not required for age <7 years

HYPOGLYCEMICS, SGLT2[CL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
FARXIGA (dapagliflozin)[QL] JARDIANCE (empagliflozin) [QL] SYNJARDY (empagliflozin/metformin)[AL,QL] XIGDUO XR (dapagliflozin/metformin)[QL]	dapagliflozin[CL,NR,QL] (generic Farxiga) dapagliflozin/metformin[QL] (generic Xigduo) INPEFA (sotagliflozin)[QL] **TAB** INVOKAMET (canagliflozin/ metformin) [QL] INVOKAMET XR (canagliflozin/metformin)[QL] INVOKANA (canagliflozin) SEGLUROMET (ertugliflozin/metformin) [QL] STEGLATRO (ertugliflozin)[QL] SYNJARDY XR (empagliflozin/ metformin)[AL,QL]	Preferred agents require a diagnosis of Type II diabetes AND a trial and failure or intolerance to metformin, **OR** A diagnosis of ASCVD or Heart Failure, or Chronic Kidney Disease associated with a diagnosis of Type II diabetes (no metformin trial required) ▪ Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class Drug Specific Criteria: - **Farxiga/ dapagliflozin:** May be approved for a diagnosis of Heart Failure without a diagnosis of diabetes - May be approved for a diagnosis of chronic kidney disease at risk of progression without a diagnosis of diabetes - **dapagliflozin**: requires a clinical reason why the preferred Farxiga cannot be used • **Jardiance:** May be approved for a diagnosis of Heart Failure without a diagnosis of diabetes

HYPOGLYCEMICS, SULFONYLUREAS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
glimepiride 1mg, 2mg, 4mg, 6mg, 8mg (generic Amaryl) glipizide IR & ER (generic Glucotrol/ Glucotrol XL) glyburide (generic Diabeta/Glynase)	chlorpropamide glimepiride 3mg (generic Amaryl) tolazamide tolbutamide	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class
SULFONYLUREA COMBINATIONS		
glipizide/metformin glyburide/metformin (generic Glucovance)		

HYPOGLYCEMICS, TZD

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

IMMUNOSUPPRESSIVES, ORAL

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

LINCOSAMIDES / OXAZOLIDINONES / STREPTOGRAMINS

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

LIPOTROPICS, OTHER

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BILE ACID SEQUESTRANTS		▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within the same subclass. Drug-specific criteria: ▪ **Colesevelam**: Trial not required for diabetes control and monotherapy with metformin, sulfonylurea, or insulin has been inadequate ▪ **Juxtapid/ Kynamro:** ○ Approved for diagnosis of homozygous familial hypercholesterolemia (HoFH) OR ○ Treatment failure/maximized dosing/contraindication to ALL the following: statins, ezetimibe, niacin, fibric acid derivatives, omega-3 agents, bile acid sequestrants ○ Require faxed copy of REMS PA form ▪ **Tryngolza:** Approved for diagnosis of familial chylomicronemia syndrome and fasting triglycerides equal to or greater than 880 mg/dL within the past 90 days and used in combination with a low-fat diet of 20 gm or less of fat per day
cholestyramine (generic Questran) colestipol **TAB** (generic Colestid)	colesevelam (generic Welchol)[CL] **TAB, PACKET** colestipol (generic Colestid) **GRANULES** QUESTRAN LIGHT (cholestyramine)	
TREATMENT OF HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA		
	JUXTAPID (lomitapide)[CL] KYNAMRO (mipomersen)[CL]	
TREATMENT OF FAMILIAL CHYLOMICRONEMIA SYNDROME (FCS)		
	TRYNGOLZA (olezarsen)[AL,CL,QL] **INJ** REDEMPLO (plozasiran)[NR] **SYR**	
FIBRIC ACID DERIVATIVES		
fenofibrate (generic Tricor) fenofibrate (generic Lofibra) gemfibrozil (generic Lopid)	fenofibric acid (generic Fibricor/Trilipix) fenofibrate (generic Antara/Fenoglide/ Lipofen/Triglide)	
NIACIN		
niacin ER (generic Niaspan)	NIACOR (niacin IR)	
OMEGA-3 FATTY ACIDS		
icosapent (generic Vascepa)[CL] omega-3 fatty acids (generic Lovaza)	omega-3 **OTC**	
CHOLESTEROL ABSORPTION INHIBITORS		
ezetimibe (generic Zetia)	NEXLETOL (bempedoic acid) NEXLIZET (bempedoic acid/ ezetimibe)[QL]	

LIPOTROPICS, OTHER (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
PROPROTEIN CONVERTASE SUBTILISIN/KEXIN TYPE 9 (PCSK9) INHIBITORS		
PRALUENT (alirocumab)[CL] REPATHA (evolocumab)[CL] **SURECLICK, SYR**	REPATHA (evolocumab)[CL] **PUSHTRONEX**	**Drug-Specific Criteria** **Praluent and Repatha**: May be approved for diagnoses of: • Atherosclerotic cardiovascular disease (ASCVD) in adults • Heterozygous familial hypercholesterolemia (HeFH) ○ Praluent ≥ 8 years of age ○ Repatha ≥ 10 years of age • Homozygous familial hypercholersterolemia (HoFH) ○ Praluent ≥ 18 years of age ○ Repatha ≥ 10 years of age AND • Trial and failure or intolerance to a statin plus ezetimibe for 8 continuous weeks • Concurrent use of a maximally tolerated statin must continue, except for statin-induced rhabdomyolysis or a contraindication to a statin • Failure to reach target LDL-C levels: ○ ASCVD – < 70 mg/dL ○ Very high risk ASCVD- < 55mg/dL ○ HeFH – < 100 mg/dL

LIPOTROPICS, STATINS

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

MACROLIDES AND KETOLIDES, ORAL

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

MULTIPLE SCLEROSIS DRUGS

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

NITROFURAN DERIVATIVES

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

OPIOID DEPENDENCE TREATMENTS

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

OPIOID-REVERSAL TREATMENTS

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

PAH (PULMONARY ARTERIAL HYPERTENSION AGENTS), ORAL AND INHALED

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

PANCREATIC ENZYMES

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

PEDIATRIC VITAMIN PREPARATIONS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CHILD MVI (mvi, ped mvi no. 19/FA, ped mvi no. 17) **OTC CHEW** CHILDREN'S MVI-IRON **OTC CHEW** (ped mvi no. 91/iron fum) CHILDREN'S CHEWABLES **OTC** (ped mvi no. 25/FA, ped mvi no. 31 /iron/FA, ped mvi no.17/iron sulf) CHILDREN'S VITAMINS W/ IRON **CHEW OTC** (mvi with iron) FLUORIDE/VITAMINS A,C,AND D **DROPS** (ped mvi A,C,D3 no.21/ fluoride) MULTIVITAMINS W/ FLUORIDE (PEDI MVI NO.2 W-FLUORIDE) **DROPS** MULTIVITS W/ IRON & FLUORIDE **DROPS** (ped mvi no. 45/fluoride/iron) PED MVI NO.17 W/ FLUORIDE **CHEW** POLY-VITAMIN (ped mvi no. 212) **DROPS OTC** POLY-VITAMIN W/ IRON (ped mvi no. 207 w/ferrous sulf) **DROPS OTC** TRI-VITAMIN W/ FLUORIDE (ped mvi A,C, D3 no. 21/fluoride)	DEKAs PLUS[AL, CL] FLORAFOL(mvi and fluoride) **CHEW OTC, DROPS-OTC** FLORAFOL FE PEDIATRIC **DROPS OTC** FLORIVA (ped mvi no.85/fluoride) **CHEW** FLORIVA PLUS (ped mvi no.161/fluoride) **OTC-DROPS** MULTI-VIT-FLOR (ped mvi no.205/fluoride) **CHEW** PEDI MULTIVIT A,C,AND D3 NO.21 **DROPS OTC** PEDI MVI NO.22 WITH FLUORIDE[NR] **DROPS-OTC** PEDI MVI NO.242/FLUORIDE **CHEW-OTC** POLY-VI-FLOR (ped mvi no.217/fluoride, ped mvi no. 205/fluoride) **CHEW** POLY-VI-FLOR (ped mvi no.213 w/fluoride) **DROPS** POLY-VI-FLOR W/ IRON (ped mvi no. 205/fluoride/iron) **CHEW** POLY-VI-FLOR W/ IRON (ped mvi no. 214/fluoride/iron) **DROPS**	▪ Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class Drug specific criteria: ▪ **DEKAs Plus**: Approved for diagnosis of Cystic Fibrosis and does not require a trial of a preferred agent

PEDIATRIC VITAMIN PREPARATIONS, continued

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	QUFLORA (ped mvi no.84/fluoride, ped mvi no. 63/fluoride, ped mvi no. 83/fluoride) QUFLORA FE (ped mvi 142/iron/fluoride, ped mvi no. 151/iron/fluoride) **CHEW** QUFLORA (ped mvi no.157/ fluoride) **OTC** SOLUVITA A,C,D WITH FLUORIDE **DROPS OTC** TRI-VI-FLOR (ped mvi A,C,D3 no.38/fluoride) **DROPS**	▪ Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class Drug specific criteria: ▪ **DEKAs Plus**: Approved for diagnosis of Cystic Fibrosis and does not require a trial of a preferred agent

PENICILLINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
amoxicillin **CAPS, CHEWABLE TAB, SUSP, TAB** ampicillin **CAPS** dicloxacillin penicillin VK	PIVYA (pivmecillinam)[AL,CL,NR] **TAB**	Drug Specific Criteria • **Pivya tablets**: Approved for treatment of female patients 18 years of age and older with uncomplicated urinary tract infections (uUTI) caused by E. coli, Proteus mirabilis and Staphylococcus saprophyticus. Also requires a trial/failure of nitrofurantoin ER, trimethoprim, or trimethoprim/sulfamethoxazole or clinical reason they can't be used.

PHOSPHATE BINDERS

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

PLATELET AGGREGATION INHIBITORS

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

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

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

PRENATAL VITAMINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
FE C/FA PNV 2/IRON B-G SUC-P/FA/OMEGA-3 PNV NO.118/IRON FUMARATE/FA **CHEW TAB** PNV NO.15/IRON FUM & PS CMP/FA PNV WITH CA, NO.72/IRON/FA PNV WITH CA, NO.74/IRON/FA **OTC** PNV#16/IRON FUM & PS/FA/OM-3 PNV119/IRON FUMARATE/FA/DSS PRENATAL MULTI **OTC** PRENATAL VIT #76/IRON, CARB/FA PRENATAL VIT/FE FUMARATE/FA **OTC** SELECT-OB + DHA STUART ONE **OTC** TENDERA-OB **OTC** TRICARE TRINATAL RX 1 VITAFOL **CHEW TAB** VITAFOL FE+ VITAFOL ULTRA VITAFOL-OB VITAFOL-OB+DHA VITAFOL-ONE	ALTRIXA OB[NR] **OTC** CITRANATAL B-CALM COMPLETENATE **CHEW TAB** ENBRACE HR MARNATAL-F MATRONEX TABLET **OTC**[NR] MULTI-MAC **OTC** NATAL PNV (pnv no.164/iron/folate no.6) NEO-VITAL RX TAB **OTC** NESTABS NESTABS ABC NESTABS DHA NESTABS ONE OB COMPLETE ONE OB COMPLETE PETITE OB COMPLETE PREMIER OB COMPLETE **TAB** OB COMPLETE WITH DHA **OTC** ONE NATAL RX **TAB OTC**[NR] PNV 11-IRON FUM-FOLIC ACID-OM3 PNV COMBO#47/IRON/FA #1/DHA PNV W-CA NO.40/IRON FUM/FA CMB NO.1 PNV WITH CA NO.68/IRON/FA NO.1/DHA PRENATAL + DHA **OTC** PRENATE AM PRENATE **CHEW TAB** PRENATE DHA PRENATE ELITE PRENATE ENHANCE PRENATE ESSENTIAL PRENATE MINI PRENATE PIXIE PRENATE RESTORE PRENATE STAR PRIMACARE PROVIDA OB (prenatal vit 65/iron fum,ps/fa) SELECT-OB **CHEW TAB** TRISTART DHA VITAFOL NANO WESTGEL DHA	▪ Non-preferred agents will be approved for patients who have failed a trial of or are intolerant to TWO preferred agents within this drug class

PROTON PUMP INHIBITORS

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

SINUS NODE INHIBITORS

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

SKELETAL MUSCLE RELAXANTS

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

TETRACYCLINES

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

THYROID HORMONES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
levothyroxine (generic Synthroid) **TAB** liothyronine (generic Cytomel) **TAB** thyroid, pork **TAB** UNITHROID (levothyroxine)	ADTHYZA (thyroid, pork) ERMEZA (levothyroxine) **SOLN** EUTHYROX (levothyroxine) LEVO-T (levothyroxine) levothyroxine **CAPS** (generic Tirosint) RENTHYROID (thyroid,pork)[NR] **TAB** SYNTHROID (levothyroxine) **TAB** THYQUIDITY (levothyroxine) **SOLN**	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

ULCERATIVE COLITIS

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

UTERINE DISORDER TREATMENT

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

VASODILATORS, CORONARY

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

5. **Adjournment / Old Business**

   a. A motion was made to conclude the meeting at 11:12AM CDT.

(1st) Motion: Baker	**(2nd) Motion:** Hill

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

Date:
Wednesday, October 28th, 2026

Time:
9:00 AM – 5:00 PM CDT

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

Recorded by: ShaLeigh Hammons, CPhT – Account Manager Senior, Prime Therapeutics