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

PHARMACEUTICAL AND THERAPEUTICS (P&T) COMMITTEE MEETING MINUTES

Wednesday, October 28th 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.
Andrew Bendlin, Pharm.D. **(Chair)**
Cassie Cowles, APRN
Stephen Dolter, M.D.
Stacie Dyer, Pharm.D.
Jennifer Hill, M.D.
Laura Klug, Pharm.D.
Stephen Salzbrenner, M.D
Sarah Stewart-Bouckaert, Pharm.D.
Bradley Sundsboe, Pharm.D.
Heather Wiese, DNP

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

Prime Therapeutics Staff Present:
ShaLeigh Hammons, CPhT, Account Manager Senior
Nikia Bennette-Carter, Pharm.D., Clinical Account Manager

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

Committee Members Excused:
Allison Dering-Anderson, Pharm.D.
Claire Baker, M.D. **(Vice-Chair)**
Wade Fornander, M.D.
C. Jose Friesen, M.D.
Jessica Pohl, Pharm.D.
Steven Rose, D.O.

Committee Members Unexcused:
N/A

1. **Opening of Public Meeting and Call to Order Committee Business**
   - **a.** The meeting was called to order by the Committee Chair at 9:00 AM CST. The agenda was posted on the Nebraska Medicaid Pharmacy website (https://nebraska.fhsc.com/PDL/PTcommittee.asp) on Monday, September 28, 2026. A copy of the Open Meetings Act and meeting materials distributed to members were made available at the physical meeting site for public viewing.
   - **b.** Roll Call: See list above.
   - **c.** Conflict of Interest: None disclosed.
   - **d.** Approval of May 13th, 2026, P&T Committee Meeting Minutes.

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Approval of May 13th, 2026 P&T Committee Meeting Minutes							
(1st) Motion: Avery							
(2nd) Motion: Wiese							
Discussion: Approve as written.							
Voting – P&T Committee Members Does not include excused or unexcused members	**Yes**	**No**	**Abstain**	**Voting – P&T Committee Members**	**Yes**	**No**	**Abstain**
Avery, Eric, M.D.	X			Klug, Laura, Pharm.D.			X
Bendlin, Andrew, Pharm.D. (Chair)			X	Salzbrenner, Stephen, M.D.			X
Cowles, Cassie, APRN			X	Stewart-Bouckaert, Sarah, Pharm.D.			X
Dolter, Stephen, M.D.			X	Sundsboe, Bradley Pharm.D.			X
Dyer, Stacie, Pharm.D.			X	Wiese, Heather, DNP	X		
Hill, Jennifer, M.D.	X						

e. Department Information: The Department provided an update that the Nebraska DHHS Medicaid Director had resigned and Jeremy Brunssen is currently the Interim Director. Two new P&T members, Stacie Dyer, Pharm.D. and Heather Wiese, DNP, were introduced as new Committee members.

f. Approval of Bylaw updates.

Approval of P&T Bylaw Updates							
(1st) Motion: Hill							
(2nd) Motion: Cowles							
Discussion: Approve as written.							
Voting – P&T Committee Members Does not include excused or unexcused members	**Yes**	**No**	**Abstain**	**Voting – P&T Committee Members**	**Yes**	**No**	**Abstain**
Avery, Eric, M.D.	X			Klug, Laura, Pharm.D.	X		
Bendlin, Andrew, Pharm.D. (Chair)	X			Salzbrenner, Stephen, M.D.	X		
Cowles, Cassie, APRN	X			Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley Pharm.D.	X		
Dyer, Stacie, Pharm.D.	X			Wiese, Heather, DNP	X		
Hill, Jennifer, M.D.	X						

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2. **Public Testimony**

Speaker Order	DRUG CLASS	Drug Name	PDL Status	Speaker Name	Affiliation
1	Cytokine & CAM Antagonists	Icotyde	NP	Pavrithra Srinivas	Johnson & Johnson
2	Epinephrine, Self-Administered	Neffy	NP	George Dela Cerda	ARS Pharma
3	Hemophilia Treatments	SevenFact	NP	Sarah Day	HEMA Biologics
4	Immunomodulators, Asthma	Tezspire	P	Jeffrey Baldwin	Amgen
5	Immunomodulators, Asthma	Fasenra	P	Anthony Staresinic	Astra Zeneca
6	Glucocorticoids, Inhaled	Airsupra	NP	Anthony Staresinic	Astra Zeneca
7	Glucocorticoids, Inhaled	Breztri	NP	Anthony Staresinic	Astra Zeneca
8	Immunomodulators, Atopic Dermatitis	Opzelura	NP	Sam Brantman	Incyte
9	Stimulants & Related ADHD Drugs	Jornay PM	NP	Teresa Kelley	Collegium Pharmaceutical

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. Rick Melbye for Bimzelx

ii. Linly Stevens for Adbry and Anzupgo

3. **Committee Closed Session**

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

4. **Resume Open Session**

(1st) Motion: Avery	**(2nd) Motion:** Dolter
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.

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a. Consent Agenda

Consent Agenda
(1st) Motion: Avery
(2nd) Motion: Klug
Discussion: Cowles motioned to remove the Epinephrine, Self-Administered class from the consent agenda, Hill seconded that motion. The Committee approved the amended Consent Agenda.

Voting – P&T Committee Members **Does not include excused or unexcused members**	**Yes**	**No**	**Abstain**	**Voting – P&T Committee Members**	**Yes**	**No**	**Abstain**
Avery, Eric, M.D.	X			Klug, Laura, Pharm.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Salzbrenner, Stephen, M.D.	X		
Cowles, Cassie, APRN	X			Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley Pharm.D.	X		
Dyer, Stacie, Pharm.D.	X			Wiese, Heather, DNP	X		
Hill, Jennifer, M.D.	X						

Consent Agenda: Therapeutic categories (TC) with unchanged recommendations unless otherwise indicated.	
ANTHELMINTICS	INTRANASAL RHINITIS AGENTS
ANTI-ALLERGENS, ORAL	LEUKOTRIENE MODIFIERS
ANTIHYPERURICEMICS	METHOTREXATE
ANTIPSORIATICS, ORAL	MOVEMENT DISORDERS
ANTIPSORIATICS, TOPICAL	ONCOLOGY, ORAL - PROSTATE
ANXIOLYTICS	ONCOLOGY, ORAL - SKIN
BRONCHODILATORS, BETA AGONIST	OPHTHALMIC ANTIBIOTIC-STEROID COMBINATIONS
COUGH AND COLD, NARCOTIC	OTIC ANTI-INFECTIVES & ANESTHETICS
ENZYME REPLACEMENT, GAUCHERS DISEASE	SEDATIVE HYPNOTICS
EPINEPHRINE, SELF-ADMINISTERED **(REMOVED)**	SICKLE CELL ANEMIA TREATMENTS
ERYTHROPOIESIS STIMULATING PROTEINS	STEROIDS, HIGH
HISTAMINE II RECEPTOR BLOCKER	STEROIDS, LOW
IMMUNOMODULATORS, TOPICAL	STEROIDS, MEDIUM

b. Therapeutic Class Reviews

Review Agenda – ALZHEIMER'S AGENTS							
(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			Klug, Laura, Pharm.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Salzbrenner, Stephen, M.D.	X		
Cowles, Cassie, APRN	X			Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley Pharm.D.	X		
Dyer, Stacie, Pharm.D.	X			Wiese, Heather, DNP	X		
Hill, Jennifer, M.D.	X						

Review Agenda – ANTIHISTAMINES, MINIMALLY SEDATING							
(1st) Motion: Avery							
(2nd) Motion: Dolter							
Discussion: Approved as written.							
Voting – P&T Committee Members Does not include excused or unexcused members	**Yes**	**No**	**Abstain**	**Voting – P&T Committee Members**	**Yes**	**No**	**Abstain**
Avery, Eric, M.D.	X			Klug, Laura, Pharm.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Salzbrenner, Stephen, M.D.	X		
Cowles, Cassie, APRN	X			Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley Pharm.D.	X		
Dyer, Stacie, Pharm.D.	X			Wiese, Heather, DNP	X		
Hill, Jennifer, M.D.	X						

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Review Agenda – ANTIHYPERTENSIVES, SYMPATHOLYTICS							
(1st) Motion: Hill							
(2nd) Motion: Wiese							
Discussion: Approved as written.							
Voting – P&T Committee Members Does not include excused or unexcused members	**Yes**	**No**	**Abstain**	**Voting – P&T Committee Members**	**Yes**	**No**	**Abstain**
Avery, Eric, M.D.	X			Klug, Laura, Pharm.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Salzbrenner, Stephen, M.D.	X		
Cowles, Cassie, APRN	X			Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley Pharm.D.	X		
Dyer, Stacie, Pharm.D.	X			Wiese, Heather, DNP	X		
Hill, Jennifer, M.D.	X						

Review Agenda – ANTIPARKINSON'S AGENTS							
(1st) Motion: Cowles							
(2nd) Motion: Dolter							
Discussion: Approved as written.							
Voting – P&T Committee Members Does not include excused or unexcused members	**Yes**	**No**	**Abstain**	**Voting – P&T Committee Members**	**Yes**	**No**	**Abstain**
Avery, Eric, M.D.	X			Klug, Laura, Pharm.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Salzbrenner, Stephen, M.D.	X		
Cowles, Cassie, APRN	X			Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley Pharm.D.	X		
Dyer, Stacie, Pharm.D.	X			Wiese, Heather, DNP	X		
Hill, Jennifer, M.D.	X						

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Review Agenda – BILE SALTS

(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			Klug, Laura, Pharm.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Salzbrenner, Stephen, M.D.	X		
Cowles, Cassie, APRN	X			Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley Pharm.D.	X		
Dyer, Stacie, Pharm.D.	X			Wiese, Heather, DNP	X		
Hill, Jennifer, M.D.	X						

Review Agenda – COLONY STIMULATING FACTORS

(1st) Motion: Avery

(2nd) Motion: Klug

Discussion: Approved as written.

Voting – P&T Committee Members Does not include excused or unexcused members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D.	X			Klug, Laura, Pharm.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Salzbrenner, Stephen, M.D.	X		
Cowles, Cassie, APRN	X			Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley Pharm.D.	X		
Dyer, Stacie, Pharm.D.	X			Wiese, Heather, DNP	X		
Hill, Jennifer, M.D.	X						

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Review Agenda – COPD AGENTS

(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			Klug, Laura, Pharm.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Salzbrenner, Stephen, M.D.	X		
Cowles, Cassie, APRN	X			Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley Pharm.D.	X		
Dyer, Stacie, Pharm.D.	X			Wiese, Heather, DNP	X		
Hill, Jennifer, M.D.	X						

Review Agenda – CYTOKINE AND CAM ANTAGONISTS

(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			Klug, Laura, Pharm.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Salzbrenner, Stephen, M.D.	X		
Cowles, Cassie, APRN	X			Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley Pharm.D.	X		
Dyer, Stacie, Pharm.D.	X			Wiese, Heather, DNP	X		
Hill, Jennifer, M.D.	X						

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Review Agenda – EPINEPHRINE, SELF-ADMINISTERED

(1st) Motion: Salzbrenner

(2nd) Motion: Cowles

Discussion: The committee discussed advantages of using Neffy nasal spray and recommended moving it from NP to P.

Voting – P&T Committee Members Does not include excused or unexcused members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D.	X			Klug, Laura, Pharm.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Salzbrenner, Stephen, M.D.	X		
Cowles, Cassie, APRN	X			Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley Pharm.D.	X		
Dyer, Stacie, Pharm.D.	X			Wiese, Heather, DNP	X		
Hill, Jennifer, M.D.	X						

Review Agenda – GLUCOCORTICOIDS, INHALED

(1st) Motion: Dolter

(2nd) Motion: Cowles

Discussion: Approved as written.

Voting – P&T Committee Members Does not include excused or unexcused members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D.	X			Klug, Laura, Pharm.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Salzbrenner, Stephen, M.D.	X		
Cowles, Cassie, APRN	X			Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley Pharm.D.	X		
Dyer, Stacie, Pharm.D.	X			Wiese, Heather, DNP	X		
Hill, Jennifer, M.D.	X						

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Review Agenda – GLUCOCORTICOIDS, ORAL							
(1st) Motion: Dolter							
(2nd) Motion: Hill							
Discussion: Approved as written.							
Voting – P&T Committee Members Does not include excused or unexcused members	**Yes**	**No**	**Abstain**	**Voting – P&T Committee Members**	**Yes**	**No**	**Abstain**
Avery, Eric, M.D.	X			Klug, Laura, Pharm.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Salzbrenner, Stephen, M.D.	X		
Cowles, Cassie, APRN	X			Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley Pharm.D.	X		
Dyer, Stacie, Pharm.D.	X			Wiese, Heather, DNP	X		
Hill, Jennifer, M.D.	X						

Review Agenda – HEMOPHILIA TREATMENT							
(1st) Motion: Avery							
(2nd) Motion: Hill							
Discussion: The committee asked the State to further analyze for cost. Approved as written.							
Voting – P&T Committee Members Does not include excused or unexcused members	**Yes**	**No**	**Abstain**	**Voting – P&T Committee Members**	**Yes**	**No**	**Abstain**
Avery, Eric, M.D.	X			Klug, Laura, Pharm.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Salzbrenner, Stephen, M.D.	X		
Cowles, Cassie, APRN	X			Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley Pharm.D.	X		
Dyer, Stacie, Pharm.D.	X			Wiese, Heather, DNP	X		
Hill, Jennifer, M.D.	X						

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Review Agenda – IDIOPATHIC PULMONARY FIBROSIS							
(1st) Motion: Dolter							
(2nd) Motion: Wiese							
Discussion: Approved as written.							
Voting – P&T Committee Members Does not include excused or unexcused members	**Yes**	**No**	**Abstain**	**Voting – P&T Committee Members**	**Yes**	**No**	**Abstain**
Avery, Eric, M.D.	X			Klug, Laura, Pharm.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Salzbrenner, Stephen, M.D.	X		
Cowles, Cassie, APRN	X			Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley Pharm.D.	X		
Dyer, Stacie, Pharm.D.	X			Wiese, Heather, DNP	X		
Hill, Jennifer, M.D.	X						

Review Agenda – IMMUNOMODULATORS, ASTHMA							
(1st) Motion: Dolter							
(2nd) Motion: Hill							
Discussion: Approved as written.							
Voting – P&T Committee Members Does not include excused or unexcused members	**Yes**	**No**	**Abstain**	**Voting – P&T Committee Members**	**Yes**	**No**	**Abstain**
Avery, Eric, M.D.	X			Klug, Laura, Pharm.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Salzbrenner, Stephen, M.D.	X		
Cowles, Cassie, APRN	X			Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley Pharm.D.	X		
Dyer, Stacie, Pharm.D.	X			Wiese, Heather, DNP	X		
Hill, Jennifer, M.D.	X						

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Review Agenda – IMMUNOMODULATORS, ATOPIC DERMATITIS							
(1st) Motion: Avery							
(2nd) Motion: Dolter							
Discussion: Approved as written.							
Voting – P&T Committee Members Does not include excused or unexcused members	**Yes**	**No**	**Abstain**	**Voting – P&T Committee Members**	**Yes**	**No**	**Abstain**
Avery, Eric, M.D.	X			Klug, Laura, Pharm.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Salzbrenner, Stephen, M.D.	X		
Cowles, Cassie, APRN	X			Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley Pharm.D.	X		
Dyer, Stacie, Pharm.D.	X			Wiese, Heather, DNP	X		
Hill, Jennifer, M.D.	X						

Review Agenda – NSAIDs							
(1st) Motion: Dolter							
(2nd) Motion: Avery							
Discussion: Approved as written.							
Voting – P&T Committee Members Does not include excused or unexcused members	**Yes**	**No**	**Abstain**	**Voting – P&T Committee Members**	**Yes**	**No**	**Abstain**
Avery, Eric, M.D.	X			Klug, Laura, Pharm.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Salzbrenner, Stephen, M.D.	X		
Cowles, Cassie, APRN	X			Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley Pharm.D.	X		
Dyer, Stacie, Pharm.D.	X			Wiese, Heather, DNP	X		
Hill, Jennifer, M.D.	X						

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Review Agenda – ONCOLOGY, ORAL- BREAST

(1st) Motion: Avery

(2nd) Motion: Wiese

Discussion: Approved as written.

Voting – P&T Committee Members Does not include excused or unexcused members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D.	X			Klug, Laura, Pharm.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Salzbrenner, Stephen, M.D.	X		
Cowles, Cassie, APRN	X			Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley Pharm.D.	X		
Dyer, Stacie, Pharm.D.	X			Wiese, Heather, DNP	X		
Hill, Jennifer, M.D.	X						

Review Agenda – ONCOLOGY, ORAL- HEMATOLOGIC

(1st) Motion: Avery

(2nd) Motion: Wiese

Discussion: Avery proposed adding Sprycel and Tasigna to the drug-specific criteria behind Hydrea for a clinical reason why generic cannot be used. Approved as written with addition of criteria.

Voting – P&T Committee Members Does not include excused or unexcused members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D.	X			Klug, Laura, Pharm.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Salzbrenner, Stephen, M.D.	X		
Cowles, Cassie, APRN	X			Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley Pharm.D.	X		
Dyer, Stacie, Pharm.D.	X			Wiese, Heather, DNP	X		
Hill, Jennifer, M.D.	X						

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Review Agenda – ONCOLOGY, ORAL- LUNG							
(1st) Motion: Avery							
(2nd) Motion: Cowles							
Discussion: Approved as written.							
Voting – P&T Committee Members Does not include excused or unexcused members	**Yes**	**No**	**Abstain**	**Voting – P&T Committee Members**	**Yes**	**No**	**Abstain**
Avery, Eric, M.D.	X			Klug, Laura, Pharm.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Salzbrenner, Stephen, M.D.	X		
Cowles, Cassie, APRN	X			Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley Pharm.D.	X		
Dyer, Stacie, Pharm.D.	X			Wiese, Heather, DNP	X		
Hill, Jennifer, M.D.	X						

Review Agenda – ONCOLOGY, ORAL- OTHER							
(1st) Motion: Avery							
(2nd) Motion: Dolter							
Discussion: Approved as written.							
Voting – P&T Committee Members Does not include excused or unexcused members	**Yes**	**No**	**Abstain**	**Voting – P&T Committee Members**	**Yes**	**No**	**Abstain**
Avery, Eric, M.D.	X			Klug, Laura, Pharm.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Salzbrenner, Stephen, M.D.	X		
Cowles, Cassie, APRN	X			Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley Pharm.D.	X		
Dyer, Stacie, Pharm.D.	X			Wiese, Heather, DNP	X		
Hill, Jennifer, M.D.	X						

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Review Agenda – ONCOLOGY, ORAL- RENAL CELL

(1st) Motion: Avery

(2nd) Motion: Dolter

Discussion: Approved as written.

Voting – P&T Committee Members Does not include excused or unexcused members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D.	X			Klug, Laura, Pharm.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Salzbrenner, Stephen, M.D.	X		
Cowles, Cassie, APRN	X			Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley Pharm.D.	X		
Dyer, Stacie, Pharm.D.	X			Wiese, Heather, DNP	X		
Hill, Jennifer, M.D.	X						

Review Agenda – OPHTHALMIC ANTIBIOTICS

(1st) Motion: Cowles

(2nd) Motion: Avery

Discussion: Approved as written.

Voting – P&T Committee Members Does not include excused or unexcused members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D.	X			Klug, Laura, Pharm.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Salzbrenner, Stephen, M.D.	X		
Cowles, Cassie, APRN	X			Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley Pharm.D.	X		
Dyer, Stacie, Pharm.D.	X			Wiese, Heather, DNP	X		
Hill, Jennifer, M.D.	X						

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Review Agenda – OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS							
(1st) Motion: Dolter							
(2nd) Motion: Wiese							
Discussion: Approved as written.							
Voting – P&T Committee Members Does not include excused or unexcused members	**Yes**	**No**	**Abstain**	**Voting – P&T Committee Members**	**Yes**	**No**	**Abstain**
Avery, Eric, M.D.	X			Klug, Laura, Pharm.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Salzbrenner, Stephen, M.D.	X		
Cowles, Cassie, APRN	X			Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley Pharm.D.	X		
Dyer, Stacie, Pharm.D.	X			Wiese, Heather, DNP	X		
Hill, Jennifer, M.D.	X						

Review Agenda – OPHTHALMICS, ANTI-INFLAMMATORIES							
(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			Klug, Laura, Pharm.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Salzbrenner, Stephen, M.D.	X		
Cowles, Cassie, APRN	X			Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley Pharm.D.	X		
Dyer, Stacie, Pharm.D.	X			Wiese, Heather, DNP	X		
Hill, Jennifer, M.D.	X						

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Review Agenda – OPHTHALMICS, DRY EYE AGENTS

(1st) Motion: Cowles

(2nd) Motion: Dolter

Discussion: Approved as written.

Voting – P&T Committee Members Does not include excused or unexcused members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D.	X			Klug, Laura, Pharm.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Salzbrenner, Stephen, M.D.	X		
Cowles, Cassie, APRN	X			Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley Pharm.D.	X		
Dyer, Stacie, Pharm.D.	X			Wiese, Heather, DNP	X		
Hill, Jennifer, M.D.	X						

Review Agenda – OPHTHALMICS, GLAUCOMA AGENTS

(1st) Motion: Avery

(2nd) Motion: Dolter

Discussion: Approved as written.

Voting – P&T Committee Members Does not include excused or unexcused members	Yes	No	Abstain	Voting – P&T Committee Members	Yes	No	Abstain
Avery, Eric, M.D.	X			Klug, Laura, Pharm.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Salzbrenner, Stephen, M.D.	X		
Cowles, Cassie, APRN	X			Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley Pharm.D.	X		
Dyer, Stacie, Pharm.D.	X			Wiese, Heather, DNP	X		
Hill, Jennifer, M.D.	X						

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Review Agenda – OTIC ANTIBIOTICS							
(1st) Motion: Dolter							
(2nd) Motion: Hill							
Discussion: Approved as written.							
Voting – P&T Committee Members Does not include excused or unexcused members	**Yes**	**No**	**Abstain**	**Voting – P&T Committee Members**	**Yes**	**No**	**Abstain**
Avery, Eric, M.D.	X			Klug, Laura, Pharm.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Salzbrenner, Stephen, M.D.	X		
Cowles, Cassie, APRN	X			Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley Pharm.D.	X		
Dyer, Stacie, Pharm.D.	X			Wiese, Heather, DNP	X		
Hill, Jennifer, M.D.	X						

Review Agenda – STEROIDS, VERY HIGH							
(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			Klug, Laura, Pharm.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Salzbrenner, Stephen, M.D.	X		
Cowles, Cassie, APRN	X			Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley Pharm.D.	X		
Dyer, Stacie, Pharm.D.	X			Wiese, Heather, DNP	X		
Hill, Jennifer, M.D.	X						

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Review Agenda – STIMULANTS AND RELATED AGENTS							
(1st) Motion: Dolter							
(2nd) Motion: Wiese							
Discussion: The committee recommended adding drug-specific criteria to Jornay PM to be approved after trial and failure of one extended-release agent in its subclass.							
Voting – P&T Committee Members Does not include excused or unexcused members	**Yes**	**No**	**Abstain**	**Voting – P&T Committee Members**	**Yes**	**No**	**Abstain**
Avery, Eric, M.D.	X			Klug, Laura, Pharm.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Salzbrenner, Stephen, M.D.	X		
Cowles, Cassie, APRN	X			Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley Pharm.D.	X		
Dyer, Stacie, Pharm.D.	X			Wiese, Heather, DNP	X		
Hill, Jennifer, M.D.	X						

Review Agenda – THROMBOPOIESIS STIMULATING PROTEINS							
(1st) Motion: Avery							
(2nd) Motion: Cowles							
Discussion: Approved as written.							
Voting – P&T Committee Members Does not include excused or unexcused members	**Yes**	**No**	**Abstain**	**Voting – P&T Committee Members**	**Yes**	**No**	**Abstain**
Avery, Eric, M.D.	X			Klug, Laura, Pharm.D.	X		
Bendlin, Andrew, Pharm.D. (Chair) ***Votes only in the event of a tie***				Salzbrenner, Stephen, M.D.	X		
Cowles, Cassie, APRN	X			Stewart-Bouckaert, Sarah, Pharm.D.	X		
Dolter, Stephen, M.D.	X			Sundsboe, Bradley Pharm.D.	X		
Dyer, Stacie, Pharm.D.	X			Wiese, Heather, DNP	X		
Hill, Jennifer, M.D.	X						

c. Complete Copy of Proposed PDL

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

Jim Pillen, Governor

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

October 2026 P&T Proposed PDL
In Red Font are the changes that become effective January 22, 2027

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

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ALZHEIMER'S AGENTS

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

ANTHELMINTICS

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

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ANTI-ALLERGENS, ORAL

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

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ANTIHISTAMINES, MINIMALLY SEDATING

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

ANTIHYPERTENSIVES, SYMPATHOLYTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
clonidine TAB (generic Catapres) clonidine **TRANSDERMAL** guanfacine (generic Tenex)	clonidine 0.05mg[NR] clonidine ER (generic Nexiclon)[CL] JAVADIN (clonidine)[NR] **SOLN** methyldopa[CL] methyldopa/hydrochlorothiazide NEXICLON XR (clonidine ER)[CL] **TAB**	▪ Non-preferred agents will be approved for patients who have failed a 30-day trial with ONE preferred agent within this drug class Drug Specific Criteria ▪ **Nexiclon/ clonidine ER:** Clinical reason why the preferred clonidine tablet or transdermal cannot be used ▪ **methyldopa:** May be approved without trial of a preferred agent in pregnancy.

ANTIHYPERURICEMICS

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

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ANTIPARKINSON'S AGENTS, ORAL

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

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ANTIPSORIATICS, ORAL

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

ANTIPSORIATICS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
calcipotriene **CREAM, OINT, SOLN**	calcitriol (generic Vectical)[AL] **OINT** calcipotriene **FOAM** (generic Sorilux) calcipotriene/betamethasone **OINT** (generic Taclonex) calcipotriene/betamethasone **SUSP** (generic Taclonex Scalp) ENSTILAR (calcipotriene/betamethasone) SORILUX (calcipotriene) ZORYVE 0.3% (roflumilast)[AL] **CREAM** ZORYVE 0.3% (roflumilast)[AL,CL] **FOAM**	▪ Non-preferred agents will be approved for patients who have failed a trial with a preferred agent within this drug class Drug-Specific Criteria • **Zoryve Foam**- For diagnosis of Seborrheic Dermatitis, requires trial and failure of a topical steroid or a topical calcineurin inhibitor AND trial of a topical antifungal.

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ANXIOLYTICS

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

BILE SALTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ursodiol **CAPSULE** 300 mg (generic Actigall) ursodiol 250 mg **TABLET** (generic URSO) ursodiol 500 mg **TABLET** (generic URSO FORTE)	CHENODAL (chenodiol) CHOLBAM (cholic acid) CTEXLI (chenodiol) **TAB** IQIRVO (elafibranor)[AL,CL,QL] **TAB** LIVDELZI (seladelpar)[AL,CL,QL] **CAP** LYNAVOY (linerixibat)[NR] **TAB** RELTONE (ursodiol 200mg,400mg) **CAP** URSOLIGN (ursodiol)[NR] **CAP**	▪ Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class Drug-specific criteria: • **Iqirvo /Livdelzi:** ○ Requires ≥ 12-month trial and failure (ALP ≥ 1.67 times upper limit of normal) of ursodiol, unless contraindicated, or experienced clinically significant adverse effects; ○ AND must be used in combination with ursodiol unless contraindicated or clinically significant adverse effects experienced

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BRONCHODILATORS, BETA AGONIST

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

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COLONY STIMULATING FACTORS

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

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COPD (CHRONIC OBSTRUCTIVE PULMONARY DISEASE) AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
INHALERS		▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within the same subclass OR Patient specific documentation of inability to use traditional inhaler device. Drug-specific criteria: ▪ **Daliresp/roflumilast:** Covered for diagnosis of severe COPD associated with chronic bronchitis Requires trial of a bronchodilator Requires documentation of one exacerbation in last year upon initial review ▪ **Dupixent** (For other indications, see Immunomodulators, Atopic Dermatitis and Asthma therapeutic classes)**:** For COPD and an Eosinophilic Phenotype: Requires documentation of inadequately controlled COPD with eosinophils ≥ 300 cells/microliter AND two exacerbations OR one exacerbation that led to hospitalization while on and adherent to a ≥ 90-day trial of triple therapy (LABA + LAMA + ICS). Prescribed by, or in consultation with a pulmonologist, immunologist, or an allergist.
ANORO ELLIPTA (umeclidinium/vilanterol) COMBIVENT RESPIMAT (albuterol/ ipratropium) INCRUSE ELLIPTA (umeclidnium) ipratropium bromide HFA (Atrovent)[NR] SPIRIVA (tiotropium) SPIRIVA RESPIMAT (tiotropium) STIOLTO RESPIMAT (tiotropium/olodaterol)	ATROVENT HFA (ipratropium) BEVESPI AEROSPHERE (glycopyrolate/formoterol) DUAKLIR PRESSAIR (aclidinium br and formoterol fum) tiotropium (generic Spiriva) TUDORZA PRESSAIR (aclidinium br) umeclidinium ellipta (generic Incruse)[NR] umeclidinium/vilanterol (generic Anoro Ellipta)	
INHALATION SOLUTION		
albuterol/ipratropium (generic Duoneb) ipratropium **SOLN** (generic Atrovent)	OHTUVAYRE (ensifentrine) inhalation suspension YUPELRI (revefenacin)	
ORAL AGENT		
roflumilast (generic Daliresp)[CL,QL]	DALIRESP (roflumilast)[CL, QL]	

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COUGH AND COLD, OPIATE COMBINATION

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

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CYTOKINE & CAM ANTAGONISTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
IL-6 ANTAGONISTS		▪ Preferred agents will be approved with FDA-approved indication – ICD-10 diagnosis code is required. ▪ Non-preferred agents will be approved for FDA-approved indications in patients who have failed a trial of TWO preferred agents within this entire drug class, or upon diagnosis for non-preferred agent with FDA-approved indication if no preferred agent has FDA approval for diagnosis.
	ACTEMRA (tocilizumab) **PEN,SYR** AVTOZMA (tocilizumab-anoh) **AUTOINJ, SYR** AL,NR ENSPRYNG (satralizumab-mwge) **SYR** KEVZARA (sarilumab) **PEN, SYR** TYENNE (tocilizumab-aazg)AL	
IL-17 ANTAGONISTS		
TALTZ (ixekizumab)AL **AUTOINJ, SYR**	BIMZELX (bimekizumab-bkzx)AL **PEN, SYR** COSENTYX (secukinumab)AL,QL **PEN, SYR**	
IL-23 ANTAGONISTS		
PYZCHIVA (ustekinumab-ttwe, Stelara biosimilar)AL,CL **SYR** PYZCHIVA (ustekinumab-ttwe, Stelara biosimilar)AL,CL **VIAL** STARJEMZA (ustekinumab-hmny)AL,NR **SYR** STARJEMZA (ustekinumab-hmny)AL,NR 45mg **VIAL** STEQEYMA (ustekinumab-stba)AL,CL **SYR**	ICOTYDE (icotrokinra)AL, NR, QL **TAB** ILUMYA (tildrakizumab) SUB-Q IMULDOSA (ustekinumab-srlf)AL **SYR** OMVOH (mirikizumab-mrkz)AL OTULFI (ustekinumab-aauz)AL **SYR** 100mg, 200mg,300mg **PEN,SYR** SELARSDI (ustekinumab-aekn)AL **SYR, VIAL** SKYRIZI (risankizamab-rzaa) **SYR** SKYRIZI (risankizamab-rzaa)QL **ON-BODY** SKYRIZI (risankizamab-rzaa)QL **PEN** STELARA (ustekinumab)AL **SYR** STELARA (ustekinumab)AL **VIAL** STEQEYMA (ustekinumab-stba)AL,CL,NR **VIAL** TREMFYA (guselkumab) **AUTOINJ** AL,QL, **PEN**AL**SYR**AL USTEKINUMABAL **SYR, VIAL** USTEKINUMAB-AAUZ **SYR** (Otulfi biosimilar)AL,NR USTEKINUMAB-AEKN (biosimilar to Stelara)AL **SYR** USTEKINUMAB-TTWEAL **SYR** USTEKINUMAB-TTWEAL **VIAL**NR YESINTEK (ustekinumab -kfce)AL **SYR, VIAL**	Drug-specific criteria: • **Cibinqo/Rinvoq/RinvoqER:** For diagnois of moderate to severe Atopic Dermatitis requires treatment failure of TWO preferred systemic drug products, including biologics, within this entire drug class or the Immunomodulators, Atopic Dermatitis therapeutic class. • **JAK-Inhibitors**: For FDA approved indications that require a patient to have had an inadequate response to a TNF blocker, documentation of an inadequate response to TWO preferred TNF blockers of different active ingredients is required unless preferred products don't have the appropriate indication. • ~~**Pyzchiva/Steqeyma:** Requires a trial and failure of a preferred TNF blocker with the same indication.~~

CYTOKINE & CAM ANTAGONISTS, continued

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
JAK-INHIBITORS[CL]		▪ Preferred agents will be approved with FDA-approved indication – ICD-10 diagnosis code is required. ▪ Non-preferred agents will be approved for FDA-approved indications in patients who have failed a trial of TWO preferred agents within this entire drug class, or upon diagnosis for non-preferred agent with FDA-approved indication if no preferred agent has FDA approval for diagnosis. Drug-specific criteria: • **Cibinqo/Rinvoq/RinvoqER:** For diagnois of moderate to severe Atopic Dermatitis requires treatment failure of TWO preferred systemic drug products, including biologics, within this entire drug class or the Immunomodulators, Atopic Dermatitis therapeutic class. • **JAK-Inhibitors**: For FDA approved indications that require a patient to have had an inadequate response to a TNF blocker, documentation of an inadequate response to TWO preferred TNF blockers of different active ingredients is required unless preferred products don't have the appropriate indication. • ~~**Pyzchiva/Steqeyma:** Requires a trial and failure of a preferred TNF blocker with the same indication.~~
tofacitinib (generic Xeljanz)[NR,QL] **TAB** tofacitinib ER (generic Xeljanz XR)[NR,QL]	CIBINQO (abrocitinib)[AL,CL,QL] **TAB** LEQSELVI (deuruxolitinib) **TAB** LITFULO (ritlecitinib)[AL] **CAPS** OLUMIANT (baricitinib) [QL] **TAB** RINVOQ ER (upadacitinib)[CL,QL] **TAB** RINVOQ (upadacitinib)[AL,CL,QL] LQ **SOLN** tofacitinib (generic Xeljanz)[NR,QL] **SOLN** XELJANZ (tofacitinib) **SOLN[QL]** XELJANZ (tofacitinib) **TAB[QL]** XELJANZ XR (tofacitinib) **TAB**[QL]	
TNF-BLOCKERS		
ADALIMUMAB-ADBM(CF)[AL] 50mg/mL **KIT, PEN-KIT** ADALIMUMAB-ADBM(CF)[AL]100mg/mL KIT, PEN-KIT ENBREL (etanercept) **KIT, MINI CART, PEN, SYR, VIAL**[QL] HADLIMA (adalimumab- bwwd)[AL] **PUSHTOUCH**, **SYR** HADLIMA (CF) (adalimumab- bwwd)[AL] **PUSHTOUCH, SYR** SIMLANDI (CF) (adalimumab-ryvk)[AL] **PEN KIT**	ABRILADA (adalimumab-afzb)[AL] (CF) **KIT, PEN-KIT** ADALIMUMAB-AACF (CF)[AL] **PEN* KIT, SYR-KIT** ADALIMUMAB-AATY (CF)[AL] **PEN KIT** ADALIMUMAB-ADAZ(CF)(biosim for Hyrimoz)[AL] KIT,**PEN,SYR** ADALIMUMAB-ADBM(CF)[AL] 50mg/mL **KIT, PEN-KIT** (Quallent) ADALIMUMAB-ADBM(CF)[AL] 100mg/mL **KIT, PEN-KIT** (Quallent) ADALIMUMAB-FKJP (biosim for Hulio)[AL] **PEN, SYR** ADALIMUMAB-RYVK[AL] (biosim for Simlandi) **KIT, PEN-KIT** AMJEVITA (adalimumab-atto)[AL] **AUTOINJ, SYR** AMJEVITA(adalimumab-atto)[AL] **KIT, PEN-KIT** CIMZIA (certolizumab pegol)[QL] CYLTEZO (adalimumab-adbm)[AL] 50mg/mL**KIT, PEN-KIT** CYLTEZO (adalimumab-adbm)[AL] 100mg/mL **KIT, PEN-KIT**	

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CYTOKINE & CAM ANTAGONISTS, continued

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	HULIO (adalimumab-fkjp)[AL] **PEN, SYR** HUMIRA (adalimumab)[QL] HYRIMOZ(CF) (adalimumab-adaz)[AL] **PEN, SYR** IDACIO (adalimumab-aacf)[AL] **PE**N, **SYR** SIMLANDI (CF) (adalimumab-ryvk)[AL] **KIT** SIMPONI (golimumab) YUFLYMA 100mg/mL (CF) (adalimumab-aaty)[AL] **KIT,PEN-KIT** YUFLYMA 80mg/mL (CF) (adalimumab- aaty)[AL] **AUTOINJ, PEN, KIT** YUSIMRY (CF) (adalimumab-aqvh)[AL] **PEN KIT** ZYMFENTRA (infliximab-dyyb) **PEN, SYR**	▪ Preferred agents will be approved with FDA-approved indication – ICD-10 diagnosis code is required. ▪ Non-preferred agents will be approved for FDA-approved indications in patients who have failed a trial of TWO preferred agents within this entire drug class, or upon diagnosis for non-preferred agent with FDA-approved indication if no preferred agent has FDA approval for diagnosis. **JAK-Inhibitors:** For FDA approved indications that require a patient to have had an inadequate response to a TNF blocker, documentation of an inadequate response to TWO preferred TNF blockers of different active ingredients is required unless preferred products don't have the appropriate indication. Drug-specific criteria:. • **Cibinqo/Rinvoq/RinvoqER:** For diagnois of moderate to severe Atopic Dermatitis requires treatment failure of TWO preferred systemic drug products, including biologics, within this entire drug class or the Immunomodulators, Atopic Dermatitis therapeutic class. • ~~**Pyzchiva/Steqeyma:** Requires a trial and failure of a preferred TNF blocker with the same indication.~~

CYTOKINE & CAM ANTAGONISTS, continued

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
MISCELLANEOUS MECHANISM OF ACTION		▪ Preferred agents will be approved with FDA-approved indication – ICD-10 diagnosis code is required. ▪ Non-preferred agents will be approved for FDA-approved indications in patients who have failed a trial of TWO preferred agents within this entire drug class, or upon diagnosis for non-preferred agent with FDA-approved indication if no preferred agent has FDA approval for diagnosis. Drug-specific criteria: • **Cibinqo/Rinvoq/RinvoqER:** For diagnois of moderate to severe Atopic Dermatitis requires treatment failure of TWO preferred systemic drug products, including biologics, within this entire drug class or the Immunomodulators, Atopic Dermatitis therapeutic class. • **JAK-Inhibitors**: For FDA approved indications that require a patient to have had an inadequate response to a TNF blocker, documentation of an inadequate response to TWO preferred TNF blockers of different active ingredients is required unless preferred products don't have the appropriate indication. • ~~**Pyzchiva/Stoqeyma:** Requires a trial and failure of a preferred TNF blocker with the same indication.~~
OTEZLA (apremilast) **TAB**[QL]	ARCALYST (nilonacept) KINERET (anakinra) ENTYVIO (vedolizumab)[AL] **PEN** ORENCIA (abatacept**) CLICKJET** ORENCIA (abatacept**) SYR** OTEZLA XR (apremilast) **TAB** SOTYKTU (deucravacitinib) **TAB** SPEVIGO (spesolimab-sbzo)[AL]**SYR** VELSIPITY (etrasimod)[QL] **TAB**	

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ENZYME REPLACEMENT, GAUCHER'S DISEASE

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

EPINEPHRINE, SELF-ADMINISTERED [QL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
AUVI-Q 0.1mg (epinephrine) epinephrine (AUTHORIZED GENERIC Epipen/ Epipen Jr.) **AUTOINJ** EPIPEN (epinephrine) **AUTOINJ** EPIPEN JR. (epinephrine) **AUTOINJ**	AUVI-Q 0.15mg (epinephrine) AUVI-Q 0.3mg (epinephrine) epinephrine (generic Adrenaclick) epinephrine (generic Epipen/ Epipen Jr.) **AUTOINJ** NEFFY (epinephrine) **NASAL** [AL,QL]	▪ Non-preferred agents require clinical documentation why the preferred products within this drug class are not appropriate

ERYTHROPOIESIS STIMULATING PROTEINS

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

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GLUCOCORTICOIDS, INHALED

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

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GLUCOCORTICOIDS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
budesonide EC **CAPS** (generic Entocort EC) dexamethasone **ELIXIR, SOLN** dexamethasone **TAB** hydrocortisone **TAB** methylprednisolone tablet (generic Medrol) prednisolone **SOLN** prednisolone sodium phosphate prednisone **DOSE PAK** prednisone **TAB**	ALKINDI (hydrocortisone) **GRANULES**[AL] CORTEF (hydrocortisone) cortisone **TAB** dexamethasone[CL] **INTENSOL** DEXLYT (dexamethasone)[NR] **TAB** EOHILIA (budesonide)[AL,QL] **SUSP** HEMADY (dexamethasone) KHINDIVI (hydrocortisone)[AL] **SOLN** methylprednisolone 8mg, 16mg, 32mg prednisolone sodium phosphate (generic Millipred/Veripred) prednisolone sodium phosphate **ODT** prednisone **SOLN** prednisone[CL] **INTENSOL** prednisone DR[NR] **TAB** RAYOS DR (prednisone) **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 Drug-specific criteria: ▪ **Intensol Products:** Patient specific documentation of why the less concentrated solution is not appropriate for the patient ▪ **Dexlyt:** Requires a clinical reason why the preferred liquid dosage form, or the preferred dexamethasone 0.5mg scored tablet can not be used.

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HEMOPHILIA TREATMENTS

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

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HISTAMINE II RECEPTOR BLOCKERS

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

IDIOPATHIC PULMONARY FIBROSIS

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

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IMMUNOMODULATORS, ASTHMA [CL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
FASENRA (benralizumab)[AL] **PEN** TEZSPIRE (tezepelumab-ekko)[AL,CL] **PEN** XOLAIR (omalizumab) **AUTO-INJ**[AL,QL], **SYR**[AL,QL]	EXDENSUR (depemokimab-ulaa)[AL,NR] **SYR** NUCALA (mepolizumab)[AL] **AUTO-INJ, SYR** OMLYCLO (omalizumab-igec)[AL,NR,QL] **SYR**	Immunomodulators Self-Injectable PA Form Immunomodulators: Self-Administered Injectables Criteria ▪ All agents require prior authorization AND an FDA-approved diagnosis for approval ▪ Non-preferred agents require a trial of a preferred agent within this drug class with the same indication ▪ For asthma indications: All agents must be prescribed by or in consultation with an allergist, immunologist, or pulmonologist ▪ Agents listed may have other FDA approved indications, and will be subject to prior authorization (see links above) **Drug Specific Criteria:** ▪ **Dupixent**: (For other indications, see Immunomodulators, Atopic Dermatitis and COPD therapeutic classes). For Eosinophilic Asthma or Corticosteroid Dependent Asthma: Patients must be ages 6 and older. Documentation of moderate to severe asthma with either eosinophils >/= 150 + 1 exacerbation OR oral corticosteroid dependency AND prior drug therapy of med-high or max-tolerated inhaled corticosteroid + controller OR max-tolerated inhaled corticosteroid / long-acting beta agonist combo ~~**Tezspire Pen:** Does not require a trial of a preferred agent for severe asthma that is non-Type 2 (EOS and IgE asthma). Prior authorization still applies for approval (see links above).~~

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IMMUNOMODULATORS, ATOPIC DERMATITIS [AL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ADBRY (tralokinumab-ldrm) [AL,CL,QL] **SUB-Q** ADBRY 300mg/2mL (tralokinumab-ldrm) [AL,CL,QL] **AUTOINJ** DUPIXENT (dupilumab)[AL,CL] **PEN,SYR** EBGLYSS (lebrikizumab-lbkz)[AL,CLQL] **PEN, SYRINGE** ELIDEL (pimecrolimus) EUCRISA (crisaborole)[CL,QL] tacrolimus (generic Protopic)	ANZUPGO (delgocitinib)[QL] **CREAM** NEMLUVIO (nemolizumab-ilto)[AL] OPZELURA (ruxolitinib phosphate) **CREAM**[AL,CL,QL] pimecrolimus (generic Elidel) VTAMA (tapinarof)[AL] **CREAM** ZORYVE 0.15% (roflumilast)[AL] **CREAM** ZORYVE 0.05% (roflumilast)[AL,NR] **CREAM**	Immunomodulators Self-Injectable PA Form Immunomodulators: Self-Administered Injectables Criteria • Non-preferred agents require: Trial of a topical steroid AND Trial of one preferred product within this drug class with same indication. Non-preferred biologics also require treatment failure of a preferred biologic with the same indication. Drug-specific criteria: • **Adbry/Ebglyss:** May be approved after a trial or failure of a topical corticosteroid AND a topical calcineurin inhibitor • **Dupixent**: (For other indications, see Immunomodulators, Asthma and COPD therapeutic classes, and links above): ○ **Atopic Dermatitis**: May be approved after a minimum of a 14-day trial of a topical corticosteroid AND a 6-week topical calcineurin inhibitor • **Eucrisa**: May be approved after a 30 day trial failure of a preferred topical corticosteroid (TCS) or topical calcineurin inhibitor (TCI) within the past 180 days; Maximum of 300 grams per year • **Opzelura**: May be approved for a diagnosis of Atopic Dermatitis and after a trial/failure of a topical steroid and trial of a preferred agent

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IMMUNOMODULATORS, TOPICAL

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

INTRANASAL RHINITIS AGENTS

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

LEUKOTRIENE MODIFIERS

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

METHOTREXATE

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

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MOVEMENT DISORDERS[CL]

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

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NSAIDs, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
COX-I SELECTIVE		▪ Non-preferred agents within COX-1 SELECTIVE subclass will be approved for patients who have failed no less than 30-day trial of TWO preferred agents within the same subclass. Drug-specific criteria: ▪ **meclofenamate**: Approvable without trial of preferred agents for menorrhagia ▪ **Sprix/ketoralac Nasal:** Approved for patients unable to tolerate, swallow OR absorb oral NSAIDs OR contraindication OR trial of TWO preferred oral NSAIDs
diclofenac sodium (generic Voltaren) ibuprofen OTC, Rx (generic Advil, Motrin) **CHEW, DROPS, SUSP**, **TAB** ibuprofen OTC (generic Advil, Motrin) **CAPS** indomethacin (generic Indocin) **CAPS** ketorolac (generic Toradol) meloxicam (generic Mobic) **TAB** nabumetone (generic Relafen) naproxen Rx, OTC (generic Naprosyn) sulindac (generic Clinoril)	diclofenac potassium (generic Cataflam, Zipsor) diclofenac SR (generic Voltaren-XR) diflunisal (generic Dolobid) etodolac & SR (generic Lodine/XL) fenoprofen (generic Nalfon) flurbiprofen (generic Ansaid) ibuprofen/famotidine (generic Duexis) ibuprofen 300mg **TAB** indomethacin ER (generic Indocin) ketoprofen & ER (generic Orudis) ketorolac (generic Sprix Nasal)CL,QL **NASAL** meclofenamate (generic Meclomen)CL mefenamic acid (generic Ponstel) meloxicam (generic Vivlodex)QL **CAP** meloxicam (generic Mobic) **SUSP** naproxen CR (generic Naprelan) naproxen enteric coated naproxen (generic Naprosyn) **SUSP** naproxen sodium (generic Anaprox) naproxen-esomeprazole (generic Vimovo) ORUDIS (ketoprofen) NR **CAP** oxaprozin (generic Daypro) piroxicam (generic Feldene) tolmetin (generic Tolectin)	

NSAIDs, ORAL (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
COX-I SELECTIVE (continued)		▪ All combination agents require a clinical reason why individual agents can't be used separately
	ALL BRAND NAME NSAIDs including: DOLOBID (diflunisal) [AL] 250mg **TAB** DUEXIS (ibuprofen/famotidine)[CL] NALFON (fenoprofen) RELAFEN DS (nabumetone)	
NSAID/GI PROTECTANT COMBINATIONS[CL]		
	diclofenac/misoprostol (generic Arthrotec)	
COX-II SELECTIVE		
celecoxib (generic Celebrex)		

NSAIDs, TOPICAL

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

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

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ONCOLOGY AGENTS, ORAL, BREAST

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

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

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ONCOLOGY AGENTS, ORAL, HEMATOLOGIC

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ALL		▪ Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines
mercaptopurine	PURIXAN (mercaptopurine)[AL,CL] mercaptopurine (generic Purixan)[AL,CL] **SUSP**	
AML		▪ Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy
	DAURISMO (glasdegib maleate)[QL] IDHIFA (enasidenib) REZLIDHIA (olutasidenib)[QL] RYDAPT (midostaurin) TIBSOVO (ivosidenib)[QL] VANFLYTA (quizartinib) XOSPATA (gilteritinib) [QL]	Drug-specific critera ▪ **Hydrea®:** Requires clinical reason why generic cannot be used ▪ **Purixan/ mercaptopurine:** Prior authorization not required for age ≤12 or for documented swallowing disorder ▪ **Xpovio:** Indicated for relapsed or refractory multiple myeloma. Requires concomitant therapy with dexamethasone
CLL		
	COPIKTRA (duvelisib) [QL] IMBRUVICA (ibrutinib) VENCLEXTA (venetoclax) ZYDELIG (idelalisib)	
CML		
hydroxyurea (generic Hydrea) imatinib (generic Gleevec)	BOSULIF (bosutinib) bosutinib (generic Bosulif) **TAB**[NR] CAVHANZA ODT (nilotinib)[NR] DANZITEN (nilotinib) dasatinib (generic Sprycel) GLEEVEC (imatinib) HYDREA (hydroxyurea)[CL] ICLUSIG (ponatinib) IMKELDI (imatinib) nilotinib HCL (generic Tasigna) nilotinib TARTRATE (generic Dansiten) nilotinib TARTRATE[NR] (AG) **CAPS** PHYRAGO (dasatinib)[NR] SCEMBLIX (asciminib) SPRYCEL (dasatinib) TASIGNA (nilotinib)	

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

ONCOLOGY AGENTS, ORAL, HEMATOLOGIC, continued

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
MPN		▪ Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines ▪ Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy Drug-specific critera ▪ **Hydrea®:** Requires clinical reason why generic cannot be used ▪ **Purixan/ mercaptopurine:** Prior authorization not required for age ≤12 or for documented swallowing disorder ▪ **Xpovio:** Indicated for relapsed or refractory multiple myeloma. Requires concomitant therapy with dexamethasone
	JAKAFI (ruxolitinib)[AL] JAKAFI XR (ruxolitinib)[AL,NR]	
MYELOMA		
REVLIMID[QL] (lenalidomide)	lenalidomide[QL] (generic Revlimid) NINLARO (ixazomib) pomalidomide (generic Pomalyst)[NR] POMALYST (pomalidomide) THALOMID (thalidomide) XPOVIO (49envatini) [CL]	
OTHER		
MATULANE (procarbazine) tretinoin (generic Vesanoid)[AL]	BRUKINSA (zanubrutinib[QL] CALQUENCE (acalabrutinib)[QL] INREBIC (fedratinib dihydrochloride)[QL] INQOVI (decitabine/cedazuridine) OJJAARA (momelotinib) REVUFORJ (revumenib) **TAB** VONJO (pacritinib)[QL] ZOLINZA (vorinostat)	

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

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ONCOLOGY AGENTS, ORAL, LUNG

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ALK		▪ Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines ▪ Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy
	ALECENSA (alectinib) ALUNBRIG (brigatinib)QL ENSACOVE (ensartinib)NR LORBRENA (lorlatinib) QL ZYKADIA (ceritinib) **CAPS, TAB**	
ALK / ROS1 / NTRK		
	AUGTYRO (repotrectinib) **CAPS** ROZLYTREK (entrectinib)QL**CAPS, PELLETS** XALKORI (crizotinib) **CAPS, PELLETS**	
EGFR		
erlotinib (generic Tarceva)	gefitinib (generic Iressa) GILOTRIF (afatinib) IRESSA (gefitinib) LAZCLUZE (50envatinib) TAGRISSO (50envatinib50) TARCEVA (erlotinib) VIZIMPRO (dacomitinib)QL	
HER2/ TKD		
	HERNEXEOS (zongertinib)NR HYRNUO (sevabertinib)NR	
OTHER		
	GAVRETO (pralsetinib)QL HYCAMTIN (topotecan) KRAZATI (adagrasib) LUMAKRAS (sotrasib)QL RETEVMO (selpercatinib)AL TABRECTA (capmatinib)QL TEPMETKO (tepotinib) QL	

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

ONCOLOGY AGENTS, ORAL, OTHER

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
temozolomide (generic Temodar)	AVMAPKI-FAKZYNJA (avutometinib/ defactinib) **Combo-Pack** AYVAKIT (avapritinib)[AL,QL] BALVERSA (erdafitinib) CAPRELSA (vandetanib) COMETRIQ (cabozantinib) FRUZAQLA (fruquintinib) CAPS GOMEKLI (mirdametinib)[AL] **CAPS, TABS FOR ORAL SUSP** IWILFIN (eflornithine) JAYPIRCA (pirtobrutinib) KOSELUGO (selumetinib)[AL] LIFYORLI (relacorilant)[NR] **CAPS** LONSURF (trifluridine/tipiracil) LYNPARZA (olaparib) LYTGOBI (futibatinib) MODEYSO (dordaviprone)[NR] OGSIVEO (nirogacestat) **TAB** PEMAZYRE (pemigatinib)[QL] QINLOCK (ripretinib) ROMVIMZA (vimseltinib) **CAPS** RUBRACA (rucaparib) STIVARGA (regorafenib) TAZVERIK (tazemetostat)[AL] TURALIO (pexidartinib)[QL] VITRAKVI (51envatinib51ib) **CAPS, SOLN** VORANIGO (vorasidenib)[AL] **TAB** ZEJULA (niraparib) **TAB**	▪ Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines ▪ Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy

ONCOLOGY AGENTS, ORAL, PROSTATE

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

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

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ONCOLOGY AGENTS, ORAL, RENAL

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

ONCOLOGY AGENTS, ORAL, SKIN

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

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OPHTHALMICS, ALLERGIC CONJUNCTIVITIS

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

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OPHTHALMICS, ANTIBIOTICS

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

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OPHTHALMICS, ANTIBIOTIC-STEROID COMBINATIONS

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

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OPHTHALMICS, ANTI-INFLAMMATORIES

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

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OPHTHALMICS, DRY EYE AGENTS

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

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OPHTHALMICS, GLAUCOMA

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
MIOTICS		▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within the same subclass. Drug-specific criteria: ▪ **Rhopressa and Rocklatan:** Electronically approved for patients who have a trial of ONE generic agent, within ophthalmic – glaucoma within 180 days
pilocarpine	VUITY (pilocarpine)	
SYMPATHOMIMETICS		
ALPHAGAN P (brimonidine 0.15%) brimonidine 0.2% (generic Alphagan)	ALPHAGAN P (brimonidine 0.1%) apraclonidine (generic Iopidine) brimonidine P 0.15% (generic Alphagan P 0.15%) brimonidine 0.1% (generic Alphagan P 0.1%)	
BETA BLOCKERS		
levobunolol (generic Betagan) timolol (generic Timoptic)	betaxolol (generic Betoptic) BETIMOL (timolol) BETOPTIC S (betaxolol) carteolol (generic Ocupress) timolol (generic Betimol) timolol (generic Istalol) timolol (generic Timoptic Ocudose) TIMOPTIC (timolol) OCUDOSE	
CARBONIC ANHYDRASE INHIBITORS		
dorzolamide (generic Trusopt)	AZOPT (brinzolamide) brinzolamide (generic Azopt)	
PROSTAGLANDIN ANALOGS		
latanoprost (generic Xalatan) travoprost 2.5 ML (generic Travatan Z)	bimatoprost (generic Lumigan)[NR] 0.01% bimatoprost (generic Lumigan) 0.03% IYUZEH (latanoprost) tafluprost (generic Zioptan) TRAVATAN Z (travoprost) travoprost 5 mL (generic Travatan Z) VYZULTA (latanoprostene) XALATAN (latanoprost) ZIOPTAN (tafluprost) ZOLYMBUS GEL (bimatoprost)[NR]	
COMBINATION DRUGS		
COMBIGAN (brimonidine/timolol) dorzolamide/timolol (generic Cosopt)	brimonidine/timolol (generic Combigan) COSOPT (dorzolamide/timolol) dorzolamide/timolol PF (generic Cosopt PF) SIMBRINZA (brinzolamide/brimonidine) YUVEZZI (carbachol/brimonidine tartrate)[NR]	

OPHTHALMICS, GLAUCOMA (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
OTHER		▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within the same subclass. Drug-specific criteria: ▪ **Rhopressa and Rocklatan:** Electronically approved for patients who have a trial of ONE generic agent, within the ophthalmic - glaucoma class within 180 days
RHOPRESSA (netarsudil)[CL] ROCKLATAN (netarsudil and latanoprost) [CL]		

OTIC ANTIBIOTICS

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

OTIC ANTI-INFECTIVES & ANESTHETICS

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

Additional covered agents can be looked up using the Drug Look-up Tool at:
https://ne.primetherapeutics.com/drug-lookup

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SEDATIVE HYPNOTICS

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

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SICKLE CELL ANEMIA TREATMENT [AL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ENDARI (L-glutamine)[CL]	GLUTAMINE POWD PACK (generic Endari) OXBRYTA (voxelotor)[CL] SIKLOS (hydroxyurea)[CL] **TAB** XROMI (hydroxyurea)[CL] **SOLN**	Drug-Specific Criteria ▪ **Endari:** Patient must have documented two or more hospital admissions per year due to sickle cell crisis despite maximum hydroxyurea dosage. ▪ **Oxbryta**: Not inidcated for sickle cell crisis. Patient must have had at least one sickle cell-related vaso-occlusive event within the past 12 months; AND baseline hemoglobin is 5.5 g/dL ≤ 10.5 g/dL; AND patient is not receiving concomitant, prophylactic blood tranfusion therapy ▪ **Siklos**: May be approved for use in patients ages 2 to 17 years old. ▪ **Xromi** solution: May be approved for use in patients ages 6 months to 2 years old.

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STEROIDS, TOPICAL

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

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STEROIDS, TOPICAL (Continued)

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

STIMULANTS AND RELATED ADHD DRUGS [AL]

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

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STIMULANTS AND RELATED ADHD DRUGS (Continued)[AL]

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

STIMULANTS AND RELATED ADHD DRUGS (Continued)[AL]

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

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THROMBOPOIESIS STIMULATING PROTEINS [CL]

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

5. **Adjournment / Old Business**

   a. No old business topics were discussed by the committee.
   b. A vote to conclude the meeting was made at 11:50 AM CDT.

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

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

Date:
Wednesday, May 12th, 2027

Time:
9:00 AM – 5:00 PM CST

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

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

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