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

Pete Ricketts, Governor

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

May 2022 P&T Proposed Changes

Highlights indicate proposed changes

For the most up to date list of covered drugs consult the Drug Lookup on the Nebraska Medicaid Website at https://druglookup.fhsc.com/druglookupweb/?client=nestate

- **PDMP Check Requirements**- Nebraska Medicaid providers are required to check the prescription drug history in the statewide PDMP before prescribing CII controlled substances to certain Medicaid beneficiaries. (Exemption to this requirement are for beneficiaries receiving cancer treatment, hospice/palliative care, or in long-term care facilities). If not able to check the PDMP, then provider is required to document good faith effort, including reasons why unable to conduct the check and may be required to submit documentation to the State upon request.
    - PDMP check requirements are under Section 5042 of the SUPPORT for Patients and Communities Act, consistent with section 1944 of the Social Security Act [42 U.S.C. 1396w-3a], beginning October 1, 2021.
- **Opioids**- The maximum opioid dose covered will decrease from 120 Morphine Milligram Equivalents (MME) per day to 90 Morphine Milligram Equivalents (MME) per day. (beginning December 1, 2020)

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

- Asthma Immunomodulator PA Form
- Buprenorphine Products PA Form
- Buprenorphine Products 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

For a complete list of Claims Limitations visit:
https://nebraska.fhsc.com/Downloads/neclaimlimitations.pdf

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ACNE AGENTS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
benzoyl peroxide (BPO) **WASH, LOTION** clindamycin/BPO (generic Benzaclin) **PUMP** clindamycin phosphate **PLEDGET** clindamycin phosphate **SOLUTION** DIFFERIN **LOTION, CREAM, Rx-GEL** (adapalene) DIFFERIN **GEL** (adapalene) OTC erythromycin **GEL** erythromycin **SOLUTION** erythromycin-BPO (generic for Benzamycin) RETIN-A (tretinoin)[AL] **CREAM**, **GEL**	adapalene (generic differin) adapalene/BPO (generic Epiduo) adapalene/BPO (generic Epiduo Forte)[NR] *AKLIEF (trifarotene)* [AL] ALTRENO (tretinoin)[AL] *AMZEEQ (minocycline)* *ARAZLO (tazarotene)*[AL] ATRALIN (tretinoin) AVAR (sulfacetamide sodium/sulfur) AVITA (tretinoin) AZELEX (azelaic acid) BENZACLIN **PUMP** (clindamycin/BPO) BENZEFOAM (benzoyl peroxide) benzoyl peroxide **CLEANSER**, **CLEANSING BAR** OTC benzoyl peroxide **FOAM** (generic Benzepro) benzoyl peroxide **GEL** OTC benzoyl peroxide **GEL** Rx *benzoyl peroxide **TOWELETTE** OTC* clindamycin **FOAM, LOTION** clindamycin phosphate **GEL** clindamycin phosphate (generic for Clindagel)[NR] **GEL** clindamycin/BPO (generic Acanya) **GEL** clindamycin/BPO (generic Duac) clindamycin/tretinoin (generic Veltin, Ziana) dapsone (generic Aczone) EPIDUO FORTE **GEL PUMP** (adapalene/BPO) erythromycin **GEL, PLEDGET** erythromycin-BPO (generic for Benzamycin) EVOCLIN (clindamycin) FABIOR (tazarotene foam) NEUAC (clindamycin/BPO) ONEXTON (clindamycin/BPO) OVACE PLUS (sulfacetamide sodium) PLIXDA (adapalene) SWAB *RETIN-A*[AL] ***GEL, CREAM*** *(tretinoin)* sulfacetamide sulfacetamide/sulfur SUMADAN (sulfacetamide/sulfur) tazarotene **CREAM** (generic Tazorac) tazarotene FOAM (generic Fabior)[NR] TRETIN-X (tretinoin) tretinoin CREAM, GELAL (generic Avita, Retin-A) tretinoin microspheres (generic for Retin-A Micro) [AL]	• Non-preferred agents will be approved for patients who have failed THREE preferred agents within this drug class

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ANALGESICS, OPIOID LONG-ACTING

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

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

CL – Prior Authorization / Class Criteria apply QL – Quantity/Duration Limit AL – Age Limit

NR – Product was not reviewed - New Drug criteria will apply

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ANALGESICS, OPIOID SHORT-ACTING[QL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ORAL		
acetaminophen/codeine **ELIXIR, TABLET** codeine **TABLET** hydrocodone/APAP **SOLUTION, TABLET** hydrocodone/ibuprofen hydromorphone **TABLET** morphine **CONC SOLUTION**, **SOLUTION, TABLET** oxycodone **TABLET, SOLUTION** oxycodone/APAP Tramadol 50 **TABLET**[AL] (generic Ultram) tramadol/APAP (generic Ultracet)	APADAZ (benzhydrocodone/APAP)[CL] benzhydrocodone/APAP (generic Apadaz)[CL] butalbital/caffeine/APAP/codeine butalbital compound w/codeine (butalbital/ASA/caffeine/codeine) carisoprodol compound-codeine (carisoprodol/ASA/codeine) dihydrocodeine/APAP/caffeine dihydrocodeine/aspirin/caffeine FIORINAL/CODEINE (butalbital/ASA/codeine/caffeine) hydromorphone **LIQUID, SUPPOSITORY** (generic Dilaudid) IBUDONE (hydrocodone/ibuprofen) levorphanol meperidine (generic Demerol) morphine **SUPPOSITORIES** NALOCET (oxycodone/APAP) NUCYNTA (tapentadol)[CL] OXAYDO (oxycodone)[CL] oxycodone **CAPSULE** oxycodone/APAP **SOLUTION** oxycodone/aspirin oxycodone **CONCENTRATE** oxycodone/ibuprofen oxymorphone IR (generic Opana) pentazocine/naloxone ROXICODONE **TABLET** (oxycodone) ROXYBOND (oxycodone) SEGLENTIS (celecoxib/tramadol)[AL,NR] tramadol 100mg **TABLET**(generic Ultram)[AL] tramadol (generic Qdolo)[AL,NR,QL] **SOLN** ZAMICET (hydrocodone/APAP)	• Non-preferred agents will be approved for patients who have failed THREE preferred agents within this drug class within the last 12 months • Note: for short acting opiate tablets and capsules there is a maximum quantity limit of #150 per 30 days. • Beginning Oct. 11, 2018: Opiate limits for opiate naïve patients will consist of -prescriptions limited to a 7 day supply, AND -initial opiate prescription fill limited to maximum of 50 Morphine Milligram Equivalents (MME) per day These limits may only be exceeded with patient specific documentation of medical necessity, with examples such as, cancer diagnosis, end-of-life care, palliative care, Sickle Cell Anemia, or prescriber attestation that patient is not recently opiate naive Drug-specific criteria: • **Apadaz:** Approval for 14 days or less • **Nucynta®:** Approved only for diagnosis of acute pain, for 30 days or less

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

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

ANDROGENIC AGENTS (Topical)[CL]

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

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ANGIOTENSIN MODULATORS

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

ANGIOTENSIN MODULATORS (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ANGIOTENSIN RECEPTOR BLOCKER/DIURETIC COMBINATIONS		• Non-preferred agents will be approved for patients who have failed TWO preferred agents within this drug class within the last 12 months • Non-preferred combination products may be covered as individual prescriptions without prior authorization
irbesartan/HCTZ (generic Avalide) losartan/HCTZ (generic Hyzaar) olmesartan/HCTZ (generic Benicar-HCT) valsartan/HCTZ (generic Diovan-HCT)	candesartan/HCTZ (generic Atacand-HCT) EDARBYCLOR (azilsartan/chlorthalidone) telmisartan/HCTZ (generic Micardis-HCT)	
ANGIOTENSIN MODULATOR/ CALCIUM CHANNEL BLOCKER COMBINATIONS		• **Angiotensin Modulator/Calcium Channel Blocker Combinations**: Combination agents may be approved if there has been a trial and failure of preferred agent
amlodipine/benazepril (generic Lotrel) amlodipine/olmesartan (generic Azor) amlodipine/valsartan (generic Exforge)	amlodipine/olmesartan/HCTZ (generic Tribenzor) amlodipine/telmisartan (generic Twynsta) *amlodipine/valsartan/HCTZ (generic Exforge HCT)* PRESTALIA (perindopril/amlodipine) trandolapril/verapamil (generic Tarka)	
DIRECT RENIN INHIBITORS		• **Direct Renin Inhibitors/Direct Renin Inhibitor Combinations:** May be approved witha history of TWO preferred ACE Inhibitors or Angiotensin Receptor Blockers within the last 12 months
	aliskiren (generic Tekturna)[QL]	
DIRECT RENIN INHIBITOR COMBINATIONS		Drug Specific Criteria • **Entresto:** May be approved with a diagnosis of heart failure ~~AND ≥ 18 years old~~
	TEKTURNA/HCT (aliskiren/HCTZ)	
NEPRILYSIN INHIBITOR COMBINATION		
ENTRESTO (sacubitril/valsartan)[AL,QL]		
ANGIOTENSIN RECEPTOR BLOCKER/BETA-BLOCKER COMBINATIONS		
	BYVALSON (nevibolol/valsartan)	

ANTIBIOTICS, GASTROINTESTINAL

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

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ANTIBIOTICS, INHALED

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

ANTIBIOTICS, TOPICAL

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

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ANTIBIOTICS, VAGINAL

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

ANTICOAGULANTS

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

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ANTIEMETICS/ANTIVERTIGO AGENTS

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

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ANTIFUNGALS, ORAL

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

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

CL – Prior Authorization / Class Criteria apply QL – Quantity/Duration Limit AL – Age Limit

NR – Product was not reviewed - New Drug criteria will apply

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ANTIFUNGALS, TOPICAL

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

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ANTIMIGRAINE AGENTS, OTHER

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
AJOVY (fremanezumab-vfrm) CL, QL **PEN, Autoinjector** AJOVY (fremanezumab-vfrm) CL, NR,QL **Autoinjector 3-pack** EMGALITY 120 mg/mL (galcanezumab-gnlm) CL, QL **PEN, SYRINGE** NURTEC ODT (rimegepant)AL,CL,QL UBRELVY (ubrogepant)AL,CL, QL **TABLET**	AIMOVIG (erenumab-aooe) CL,QL CAFERGOT (ergotamine/caffeine) CAMBIA (diclofenac potassium) dihydroergotamine mesylate **NASAL** ELYXYB (celecoxib)AL,NR,QL **SOLN** EMGALITY 100 mg (galcanezumab-gnlm) CL,QL **SYRINGE** ERGOMAR **SUBLINGUAL** (ergotamine tartrate) MIGERGOT (ergotamine/caffeine) **RECTAL** MIGRANAL (dihydroergotamine) **NASAL** QULIPTA (atogepant)AL,NR,QL REYVOW (lasmiditan)AL, CL,QL **TABLET** TRUDHESA (dihydroergotamine mesylate)AL,NR,QL **NASAL**	• All acute treatment agents will be approved for patients who have a failed trial or a contraindication to a triptan. • In addition, all non-preferred agents will require a failed trial or contraindication of a preferred agent of the same indication Drug-specific criteria: • **Cambia®**: Requires diagnosis of migraine and documentation of why solid dosing forms not appropriate • ***Emgality 120mg*** *is recommended ~~dosing~~ for preventative treatment of Migraine,* ***Emgaility 100mg*** *is recommended ~~dosing~~ for treatment of Episodic Cluster Headache* • **Aimovig, Ajovy, Emgality 120mg, Nurtec ODT (prophylaxis), and Qulipta**: Require ≥ 4 migraines per month for ≥ 3 months and has tried and failed a ≥ 1 month trial of two medications listed in the 2012 American Academy of Neurology/American Headache Society guidelines (examples include: antidepressants (amitriptyline, venlafaxine), Beta blockers (propranolol, metroprolol, timolol, atenolol), anti-epileptics (valproate, topiramate), ACE/ARB (lisinopril, candesartan) • In addition, **Aimovig and Qulipta** require a trial of ~~Emgality 120mg or Ajovy or clinical~~ two preferred prophylactic agents or patient specific reason that a preferred agent cannot be used

ANTIMIGRAINE AGENTS, TRIPTANS[QL]

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

ANTIPARASITICS, TOPICAL

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

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ANTIVIRALS, ORAL

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

ANTIVIRALS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
acyclovir **OINTMENT**	acyclovir CREAM, (generic Zovirax) DENAVIR (penciclovir) XERESE (acyclovir/hydrocortisone)	• Non-preferred agents will be approved for patients who have failed a trial with ONE preferred ORAL Antiviral agent

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BETA BLOCKERS, ORAL

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

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BLADDER RELAXANT PREPARATIONS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Oxybutynin IR, ER (generic Ditropan/Ditropan XL) solifenacin (generic Vesicare) TOVIAZ (fesoterodine ER)	darifenacin ER (generic Enablex) flavoxate GELNIQUE (oxybutynin) GEMTESA (vibegron)[AL,NR,QL] MYRBETRIQ **TAB** (mirabegron) MYRBETRIQ (mirabegron) **SUSP**[AL,CL,NR,QL] OXYTROL (oxybutynin) tolterodine IR, ER (generic Detrol/ Detrol LA) trospium IR, ER (generic Sanctura/ Sanctura XR) VESICARE (solifenacin) VESICARE LS **SUSP** (solifenacin succinate) [AL]	• Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class Drug-specific criteria: • **Myrbetriq® tablets:** Covered without trial in contraindication to anticholinergic agents • **Myrbetriq suspension:** Covered for pediatric patients ≥ 3 years old with a diagnosis of Neurogenic Detrusor Overactivity (NDO)

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BONE RESORPTION SUPRESSION AND RELATED DRUGS

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

BPH (BENIGN PROSTATIC HYPERPLASIA) TREATMENTS

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

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CALCIUM CHANNEL BLOCKERS, ORAL

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

CEPHALOSPORINS AND RELATED ANTIBIOTICS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BETA LACTAM/BETA-LACTAMASE INHIBITOR COMBINATIONS		• Non-preferred agents will be approved for patients who have failed a 3-day trial of ONE preferred agent within the same group
amoxicillin/clavulanate **TABLETS, SUSPENSION**	amoxicillin/clavulanate **CHEWABLE** amoxicillin/clavulanate ER (generic Augmentin XR) AUGMENTIN (amoxicillin/clavulanate) **SUSPENSION**, **TABLET**	
CEPHALOSPORINS – First Generation		
cefadroxil **CAPSULE, SUSPENSION** (generic Duricef) cephalexin **CAPSULE, SUSPENSION** (generic Keflex)	cefadroxil **TABLET** (generic Duricef) cephalexin **TABLET**	
CEPHALOSPORINS – Second Generation		
cefprozil (generic Cefzil) cefuroxime **TABLET** (generic Ceftin)	cefaclor (generic Ceclor) CEFTIN (cefuroxime) **TABLET, SUSPENSION**	
CEPHALOSPORINS – Third Generation		
cefdinir (generic Omnicef)	cefixime **CAPSULE**, **SUSPENSION** (generic Suprax) cefpodoxime (generic Vantin) SUPRAX **CAPSULE, CHEWABLE TAB, SUSPENSION, TABLET** (cefixime)	

CONTRACEPTIVES, ORAL

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

CYSTIC FIBROSIS, ORAL

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

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DIURETICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
SINGLE-AGENT PRODUCTS		• Non-preferred agents will be approved for patients who have failed a trial of **TWO** preferred agents within this drug class
amiloride **TABLET** bumetanide **TABLET** chlorothiazide **TABLET** chlorthalidone **TABLET** (generic Diuril) furosemide **SOLUTION, TABLET** (generic Lasix) hydrochlorothiazide **CAPSULE, TABLET** (generic Microzide) indapamide **TABLET** metolazone **TABLET** spironolactone **TABLET** (generic Aldactone) torsemide **TABLET**	CAROSPIR (spironolactone) **SUSPENSION** eplerenone **TABLET** (generic Inspra) ethacrynic acid **CAPSULE** (generic Edecrin) KERENDIA (finerenone) **TABLET** NR,QL methyclothiazide **TABLET** THALITONE (chlorthalidone) **TABLET**NR triamterene (generic Dyrenium)	
COMBINATION PRODUCTS		
amiloride/HCTZ **TABLET** spironolactone/HCTZ **TABLET** (generic Aldactazide) triamterene/HCTZ **CAPSULE, TABLET** (generic Dyazide, Maxzide)		

FLUOROQUINOLONES, ORAL

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

GI MOTILITY, CHRONIC

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

GLUCAGON AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BAQSIMI (glucagon)[AL,QL] **NASAL** GLUCAGON EMERGENCY (glucagon)[QL] **INJ KIT** (Lilly) glucagon[QL] **INJECTION** PROGLYCEM (diazoxide) **SUSP**	diazoxide **SUSP** (generic Proglycem) GLUCAGON EMERGENCY (glucagon)[QL] **INJ KIT** (Fresenius) GVOKE (glucagon)[AL,QL]**PEN**, S**YR** GVOKE (glucagon)[AL,QL] **KIT**[NR] **VIAL**[NR] ZEGALOGUE (dasiglucagon)[AL,NR, QL] **AUTO-INJECTOR, SYRINGE**	▪ 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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GROWTH HORMONES

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

H. PYLORI TREATMENTS

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

HAE TREATMENTS[CL]

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

HEPATITIS B TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
entecavir **TABLET**	adefovir dipivoxil BARACLUDE (entecavir) SOLUTION, **TABLET** EPIVIR HBV (lamivudine) **TABLET, SOLUTION** HEPSERA (adefovir dipivoxil) lamivudine hbv **TABLET** VEMLIDY (tenofovir alafenamide fumarate)	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

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HEPATITIS C TREATMENTS

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

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HIV / AIDS[CL]

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

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.

CL – Prior Authorization / Class Criteria apply QL – Quantity/Duration Limit AL – Age Limit

NR – Product was not reviewed - New Drug criteria will apply

HIV / AIDS[CL] (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
PROTEASE INHIBITORS		
atazanavir **CAPSULE** (generic Reyataz) ritonavir **TABLET** (generic Norvir)	APTIVUS **CAPSULE, SOLN** (tipranavir) CRIXIVAN (indinavir) fosamprenavir **TAB** (generic Lexiva) INVIRASE (saquinavir) LEXIVA **SUSP** (fosamprenavir) LEXIVA **TABLET** (fosamprenavir) NORVIR **POWDER, SOLN** (ritonavir) NORVIR (ritonavir) **TAB** PREZISTA (darunavir) **SUSP, TABLET** REYATAZ **POWDER** (atazanavir) VIRACEPT (nelfinavir)	▪ Non-preferred agents will be approved for patients who have a diagnosis of HIV/AIDS and patient specific documentation of why the preferred products within this drug class are not appropriate for patient, including, but not limited to, drug resistance or concomitant conditions not recommended with preferred agents ▪ Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy ▪ Diagnosis of HIV/AIDS required OR ▪ Pre and Post Exposure Prophylaxis

HIV / AIDS[CL] (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
COMBINATION PROTEASE INHIBITORS (PIs) or PIs plus PHARMACOKINETIC ENHANCER		▪ Non-preferred agents will be approved for patients who have a diagnosis of HIV/AIDS and patient specific documentation of why the preferred products within this drug class are not appropriate for patient, including, but not limited to, drug resistance or concomitant conditions not recommended with preferred agents ▪ Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy ▪ Diagnosis of HIV/AIDS required OR ▪ Pre and Post Exposure Prophylaxis
EVOTAZ (atazanavir/cobicistat)[QL] lopinavir/ritonavir **SOLN** (generic Kaletra)	KALETRA **SOLN** (lopinavir/ritonavir) KALETRA **TAB** (lopinavir/ritonavir) lopinavir/ritonavir **TAB** (generic Kaletra)[NR] PREZCOBIX (darunavir/cobicistat)[QL]	
COMBINATION NUCLEOS(T)IDE REVERSE TRANSCRIPTASE INHIBITORS		
abacavir/lamivudine (generic Epzicom) CIMDUO (lamivudine/tenofovir)[QL] DESCOVY (emtricitabine/tenofovir)[QL, CL] emtricitabine/tenofovir (generic Truvada)[CL] lamivudine/zidovudine (generic Combivir)	abacavir/lamivudine/zidovudine (generic Trizivir) COMBIVIR (lamivudine/zidovudine) EPZICOM (abacavir sulfate/lamivudine) TEMIXYS (lamivudine/tenofovir)[QL] TRIZIVIR (abacavir/lamivudine/zidovudine) TRUVADA (emtricitabine/tenofovir)	Drug-Specific Criteria **Descovy**: • Approval will be granted for a diagnosis of HIV/AIDS • For PrEP use: Will require documentation of a clinical reason why generic Truvada cannot be used.

HIV / AIDS[CL] (Continued)

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

HYPOGLYCEMICS, ALPHA-GLUCOSIDASE INHIBITORS

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

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HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS

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

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HYPOGLYCEMICS, INSULIN AND RELATED DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria

HUMALOG (insulin lispro) U-100 **CARTRIDGE, PEN, VIAL**
HUMALOG JR. (insulin lispro) U-100 **KWIKPEN**
HUMALOG MIX **VIAL** (insulin lispro/lispro protamine)
HUMALOG MIX **KWIKPEN** (insulin lispro/lispro protamine)
HUMULIN (insulin) **VIAL**
HUMULIN 70/30 **VIAL**
HUMULIN U-500 **VIAL**
HUMULIN R U-500 **KWIKPEN**CL
HUMULIN OTC **PEN**
HUMULIN 70/30 OTC **PEN**
insulin aspart (generic for Novolog)
insulin aspart/insulin aspart protamine **PEN, VIAL**(generic for Novolog Mix)
insulin lispro (generic for Humalog) **PEN, VIAL, JR KWIKPEN**
insulin lispro/lispro protamine **KWIKPEN** (Humalog Mix Kwikpen)
LANTUS SOLOSTAR **PEN** (insulin glargine)
LANTUS (insulin glargine) **VIAL**
LEVEMIR (insulin detemir) **PEN, VIAL**
NOVOLIN (insulin) **PEN**
NOVOLOG (insulin aspart) **CARTRIDGE, FLEXPEN, VIAL**
NOVOLOG MIX **FLEXPEN** (insulin aspart/aspart protamine)
	ADMELOG (insulin lispro) **PEN, VIAL**
	AFREZZA (regular insulin) **INHALATION**
	APIDRA (insulin glulisine)
	BASAGLAR (insulin glargine, rec) **PEN**
	FIASP (insulin aspart) **CARTRIDGE, PEN, VIAL**
	HUMALOG (insulin lispro) U-200 **KWIKPEN**
	insulin Glargine-YFGN **PEN, VIAL** (generic for Semglee-YFGN)NR
	LYUMJEV **KWIKPEN, VIAL**(insulin lispro-aabc)
	NOVOLIN (insulin)
	NOVOLIN 70/30 **VIAL**(insulin)
	NOVOLOG MIX (insulin aspart/aspart protamine) **VIAL**
	TOUJEO SOLOSTAR (insulin glargine)
	SEMGLEE (insulin glargine) **PEN, VIAL**
	SEMGLEE YFGN (insulin glargine) **PEN, VIAL**NR
	TRESIBA (insulin degludec)
		• Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class
		
		Drug-specific criteria:
		• **Afrezza®:** Approved for T1DM on long-acting insulin with no current history of smoking or chronic lung disease
		• **Humulin® R U-500 Kwikpen:** Approved for physical reasons – such as dexterity problems and vision impairment
		  • Usage must be for self-administration, not only convenience
		  • Patient requires >200 units/day
		  • Safety reason patient can't use vial/syringe

HYPOGLYCEMICS, MEGLITINIDES

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

HYPOGLYCEMICS, METFORMINS

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

HYPOGLYCEMICS, SGLT2

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
FARXIGA (dapagliflozin)[QL,CL] INVOKAMET (canagliflozin/metformin)[QL, CL] INVOKANA (canagliflozin)[CL] JARDIANCE (empagliflozin)[QL, CL] SYNJARDY (empagliflozin/metformin)[AL,CL,QL] XIGDUO XR (dapagliflozin/metformin)[QL,CL]	INVOKAMET XR (canagliflozin/metformin)[QL] SEGLUROMET (ertugliflozin/metformin) [QL] STEGLATRO (ertugliflozin)[QL] SYNJARDY XR (empagliflozin/ metformin)[AL,QL]	▪ Preferred agents are Approved for diagnosis of diabetes AND a trial of metformin • Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class Drug Specific Criteria: **Farxiga and Jardiance:** - Approved for a diagnosis of heart failure with reduced ejection fraction (NYHA class II-IV)

HYPOGLYCEMICS, SULFONYLUREAS

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

HYPOGLYCEMICS, TZD

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

IMMUNOSUPPRESSIVES, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
azathioprine (generic Azasan, Imuran) cyclosporine, modified **CAPSULE** (generic Gengraf, Neoral) everolimus (generic for Zortress)[AL] mycophenolate **CAPSULE, TABLET** (generic Cellcept) RAPAMUNE (sirolimus) **SOLUTION** RAPAMUNE (sirolimus) **TABLET** tacrolimus	ASTAGRAF XL (tacrolimus) AZASAN (azathioprine) cyclosporine **CAPSULE**, **SOFTGEL** cyclosporine, modified **SOLUTION** (generic Neoral) ENVARSUS XR (tacrolimus) cyclosporine, modified **SOLUTION** mycophenolate **SUSPENSION** (generic Cellcept) mycophenolic acid MYFORTIC (mycophenolate sodium) PROGRAF (tacrolimus) **CAPSULE, PACKET** REZUROCK (belumosudil)[AL,NR,QL] **TAB** SANDIMMUNE (cyclosporine) **CAPSULE, SOLUTION** sirolimus **SOLUTION, TABLET** (generic Rapamune) TAVNEOS (avacopan)[NR,QL] **CAPSULE** ZORTRESS (everolimus) [AL]	Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class ▪ Patients established on existing therapy will be allowed to continue

LINCOSAMIDES / OXAZOLIDINONES / STREPTOGRAMINS

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

LIPOTROPICS, OTHER

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BILE ACID SEQUESTRANTS		▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: ▪ **Colesevelam**: Trial not required for diabetes control and monotherapy with metformin, sulfonylurea, or insulin has been inadequate ▪ **Juxtapid®/ Kynamro®:** ○ Approved for diagnosis of homozygous familial hypercholesterolemia (HoFH) OR ○ Treatment failure/maximized dosing/contraindication to ALL the following: statins, ezetimibe, niacin, fibric acid derivatives, omega-3 agents, bile acid sequestrants ○ Require faxed copy of REMS PA form ▪ **Vascepa®:** Approved for TG ≥ 500
cholestyramine (generic Questran) colestipol **TABLETS** (generic Colestid)	colesevelam (generic Welchol) **TABLET, PACKET** colestipol **GRANULES** (generic Colestid) QUESTRAN LIGHT (cholestyramine)	
TREATMENT OF HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA		
	JUXTAPID (lomitapide)[CL] KYNAMRO (mipomersen)[CL]	
FIBRIC ACID DERIVATIVES		
fenofibrate (generic Tricor) fenofibrate (generic Lofibra) gemfibrozil (generic Lopid)	fenofibric acid (generic Fibricor/Trilipix) fenofibrate (generic Antara/Fenoglide/ Lipofen/Triglide)	
NIACIN		
niacin ER (generic for Niaspan)	NIACOR (niacin IR) NIASPAN (niacin ER)	
OMEGA-3 FATTY ACIDS		
omega-3 fatty acids (generic for Lovaza)	icosapent (generic for Vascepa)[CL] omega-3 OTC VASCEPA (icosapent)[CL]	
CHOLESTEROL ABSORPTION INHIBITORS		
ezetimibe (generic for Zetia)	NEXLIZET (bempedoic acid/ ezetimibe)[QL]	

LIPOTROPICS, OTHER (continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
PROPROTEIN CONVERTASE SUBTILISIN/KEXIN TYPE 9 (PCSK9) INHIBITORS		
	PRALUENT (alorocumab)[CL] REPATHA (evolocumab)[CL]	▪ **Praluent®:** Approved for diagnoses of: • atherosclerotic cardiovascular disease (ASCVD) • heterozygous familial hypercholesterolemia (HeFH) • Homozygous familial hypercholesterolemia (HoFH) as an adjunct to other LDL-C lowering therapies • AND • Maximized high-intensity statin WITH ezetimibe for at 3 continuous months • Failure to reach target LDL-C levels: ASCVD - < 70 mg/dL, HeFH - < 100 mg/dL ▪ **Repatha®:** Approved for: • adult diagnoses of atherosclerotic cardiovascular disease (ASCVD) • heterozygous familial hypercholesterolemia (HeFH) • homozygous familial hypercholesterolemia (HoFH) in age ≥ 13 • statin-induce rhabdomyolysis AND • Maximized high-intensity statin WITH ezetimibe for 3+ continuous months • Failure to reach target LDL-C levels: ASCVD - < 70 mg/dL, HeFH - < 100 mg/dL • Concurrent use of maximally-tolerated statin must continue, except for statin-induced rhabdomyolysis or a contraindication to a statin

LIPOTROPICS, STATINS

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

MACROLIDES AND KETOLIDES, ORAL

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

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MULTIPLE SCLEROSIS DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
AVONEX (interferon beta-1a)[QL] BETASERON (interferon beta-1b)[QL] COPAXONE 20mg (glatiramer)[QL] dimethyl fumarate (generic for Tecfidera) KESIMPTA (Ofatumumab)[CL,QL]	AUBAGIO (teriflunomide) BAFIERTAM (monomethyl fumarate)[QL] dalfampridine (generic Ampyra)[QL] EXTAVIA (interferon beta-1b)[QL] GILENYA (fingolimod)[QL] glatiramer (generic Copaxone)[QL] MAVENCLAD (cladribine) MAYZENT (siponimod)[QL] PLEGRIDY (peginterferon beta-1a)[QL] PONVORY (ponesimod)[NR] REBIF (interferon beta-1a)[QL] TECFIDERA (dimethyl fumarate) VUMERITY (diroximel)[QL] ZEPOSIA (ozanimod)[AL,QL]	• Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: • **Ampyra®:** Approved for diagnosis of gait disorder associated with MS AND EDSS score ≤ 7 • **Plegridy:** Approved for diagnosis of relapsing MS • **Kesimpta:** Approved for patients who have failed a trial of a preferred injectable agent within this class

NITROFURAN DERIVATIVES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
nitrofurantoin macrocrystals **CAPSULE** (generic for Macrodantin) nitrofurantoin monohydrate-macrocrystals **CAPSULE** (generic for Macrobid)	nitrofurantoin **SUSPENSION** (generic for Furadantin)	• 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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OPIOID DEPENDENCE TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
buprenorphine **SL** buprenorphine/naloxone **TAB (SL)** SUBOXONE **FILM** (buprenorphine/ naloxone)	buprenorphine/naloxone **FILM** LUCEMYRA (lofexidine)[CL,QL] ZUBSOLV (buprenorphine/naloxone)	Non-Preferred agents require prior authorization Buprenorphine PA Form Buprenorphine Informed Consent ~~Non-Preferred buprenorphine and buprenorphine /naloxone agents:~~ ~~▪ Diagnosis of Opioid Use Disorder, NOT approved for pain management~~ ~~▪ Verification of "X" DEA license number of prescriber~~ ~~▪ No concomitant opioids~~ ▪ Non-Preferred agents also require a treatment failure of a preferred drug or patient-specific documentation of why a preferred product is not appropiate for patient Drug-specific criteria: ▪ **Lucemyra**: Approved for FDA approved indication and dosing per label. Trial of preferred product not required.

OPIOID-REVERSAL TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
naloxone **SYRINGE, VIAL** naltrexone **TABLET** NARCAN (naloxone) **SPRAY**	KLOXXADO (naloxone)[NR] **NASAL** naloxone **SPRAY** (generic for Narcan)[NR] ZIMHI (naloxone)[AL,NR] **SYRINGE**	▪ Non-preferred agents will be approved with documentation of why preferred products within this drug class are not appropriate for the patient

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PAH (PULMONARY ARTERIAL HYPERTENSION AGENTS), ORAL AND INHALED

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

PANCREATIC ENZYMES

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

PEDIATRIC VITAMIN PREPARATIONS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CHILD CHEW + IRON **CHEW** CHILDREN'S CHEWABLES MULTIVIT-FLUOR **CHEW, DROP** MULTIVIT-IRON-FLUOR POLY-VI-SOL WITH IRON **DROPS** TRI-VI-SOL **DROP**S TRI-VITE-FLUORIDE	**DEKAs PLUS** FLORIVA **CHEW DROPS** FLORIVA PLUS **DROP** MULTI-VIT-FLOR **CHEW** POLY-VI-FLOR **CHEW, DROPS** POLY-VI-FLOR /IRON POLY-VI-SOL **DROP** QUFLORA **GUMMIES** QUFLORA FE **CHEW, DROP** QUFLORA PED **CHEW, DROP** TRI-VI-FLOR **DROPS**	▪ Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class Drug specific criteria: ▪ **DEKAs Plus**: Approved for diagnosis of Cystic Fibrosis

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PENICILLINS

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

PHOSPHATE BINDERS

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

PLATELET AGGREGATION INHIBITORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
AGGRENOX (dipyridamole/aspirin) aspirin BRILINTA (ticagrelor) clopidogrel (generic Plavix) dipyridamole (generic Persantine) prasugrel (generic Effient)	aspirin/dipyridamole (generic Aggrenox) ticlopidine (generic Ticlid) YOSPRALA (aspirin/omeprazole) ZONTIVITY (vorapaxar)[CL]	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class OR documented clopidogrel resistance Drug-specific criteria: ▪ **Zontivity®:** Approved for reduction of thrombotic cardiovascular events in history of MI or with peripheral artery disease (PAD) Use with aspirin and/or clopidogrel

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

May 2022 P&T Proposed Changes Red Highlights indicate proposed changes

PRENATAL VITAMINS

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

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
COMPLETENATE TABLET CHEW EXPECTA PRENATAL **OTC** FE C/FA (Elite-OB) FOLIVANE-OB CAPSULE (onv no.15/iron fum & ps cmp/folic acid) IRON 100 PLUS TABLET (FE C/VIT C/VIT B12/FA) **OTC** MARNATAL-F **CAPSULE** M-NATAL PLUS TABLET NIVA-PLUS TABLET O-CAL FA TABLET PNV 11/IRON FUM/FOLIC ACID/OM3 (VIRT-NATE DHA SOFTGEL) pnv2/iron B-G SUC/FA/omeg3 (complete natal DHA, Trust natal DHA) PNV-DHA SOFTGEL pnv w-CA no.40/iron fum/folic acid cmb no.1 PRENATAL 118/IRON/FOLATE 6/DHA (PRIMACARE SOFTGEL) PRENATAL NO.137/IRON/FOLIC ACD (Prenatal Vitamin OTC) **OTC** PRENATAL VIT,CALC76/IRON/FOLIC (PNV 29-1 TABLET PRENATAL VIT68/IRON/FA NO6/DHA (PRENATE ENHANCE SOFTGEL) pnv w/CA, No. 72/iron/FA) **CHEW, TAB** PNV119/IRON FUMARATE/FA/DSS PRENATE ESSENTIAL SOFTGEL PREPLUS CA-FE 27 MG-FA 1 MG TB PRETAB (prenatal vit no.78/iron/folic acid) PUREFE OB PLUS **CAPSULE** PUREFE PLUS **CAPSULE** STUART ONE **CAPSULE** TARON-C DHA CAPSULE (pnv #16/iron fum & ps folic acid/omega 3 THRIVITE RX(prenatal VIT,CALC76/IRON/folic acid) TRINATAL RX 1 TABLET VIRT-C DHA SOFTGEL VIRT-PN DHA SOFTGEL VITAFOL **CHEW** VITAFOL ULTRA SOFTGEL VP-PNV-DHA **SOFTGEL** ZATEAN-PN DHA CAPSULE	CITRANATAL B-CALM COMBO C-NATE DHA SOFTGEL COMPLETE NATAL DHA DERMACINRX PRENATRIX CAPLET DERMACINRX PRETRATE CAPLET[NR] ENBRACE HR SOFTGEL NESTABS ABC PRENATAL combo NESTABS DHA COMBO PACK NESTABS ONE SOFTGEL NESTABS TABLET OB COMPLETE CAPLET OB COMPLETE ONE SOFTGEL OB COMPLETE PETITE SOFTGEL OB COMPLETE PREMIER TABLET OB COMPLETE WITH DHA SOFTGEL PNV-OMEGA SOFTGEL PRENATAL VITAMINS TABLET PRENATAL VITAMINS TABLET PRENATE AM TABLET PRENATE CHEWABLE TABLET PRENATE DHA SOFTGEL PRENATE ELITE TABLET PRENATE MINI SOFTGEL PRENATE PIXIE SOFTGEL PRENATE RESTORE SOFTGEL PRENATE STAR TABLET SELECT-OB + DHA PACK SELECT-OB CHEWABLE CAPLET TRICARE PRENATAL TABLET TRISTART DHA SOFTGEL VIRT-PN PLUS SOFTGEL VITAFOL FE PLUS SOFTGEL VITAFOL-OB CAPLET VITAFOL-OB+DHA COMBO PACK VITAFOL-ONE CAPSULE WESTGEL DHA SOFTGEL ZATEAN-PN PLUS SOFTGEL VITAFOL NANO TABLET SELECT-OB CHEWABLE	▪ Non-preferred agents will be approved for patients who have failed a trial of or are intolerant to TWO preferred agents within this drug class

Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
CL – Prior Authorization / Class Criteria apply QL – Quantity/Duration Limit AL – Age Limit
NR – Product was not reviewed - New Drug criteria will apply

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

May 2022 P&T Proposed Changes Red Highlights indicate proposed changes

PROTON PUMP INHIBITORS

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

SINUS NODE INHIBITORS

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

SKELETAL MUSCLE RELAXANTS

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

TETRACYCLINES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
doxycycline hyclate IR (generic Vibramycin) doxycycline monohydrate **50MG, 100MG CAPSULE** doxycycline monohydrate **SUSP, TABLET** (generic Vibramycin) minocycline HCl **CAPSULE, TABLET** (generic Dynacin/ Minocin/Myrac)	demeclocycline (generic Declomycin)CL DORYX MPC DR (doxycycline pelletized) doxycycline hyclate DR (generic Doryx) doxycycline monohydrate 40MG, 75MG and 150MG **CAPSULES** (generic for Adoxa/Monodox/ Oracea) minocycline HCl ER (generic Solodyn) NUZYRA (omadacycline) tetracycline VIBRAMYCIN **SUSP** (doxycycline) XIMINO (minocycline ER)QL	▪ Non-preferred agents will be approved for patients who have failed a 3-day trial of TWO preferred agents within this drug class Drug-specific criteria: ▪ **Demeclocycline:** Approved for diagnosis of SIADH ~~▪ **Doryx®/doxycycline hyclate DR/ Dynacin®/Oracea®/Solodyn®:** Requires clinical reason why generic doxycycline, minocycline or tetracycline cannot be used~~ ▪ **doxycycline suspension:** May be approved with documented swallowing difficulty

THYROID HORMONES

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

ULCERATIVE COLITIS

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

UTERINE DISORDER TREATMENT[CL]

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

VASODILATORS, CORONARY

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