NEBRASKA
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DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

PDL Updated July 20, 2017 *Highlights* indicated change from previous posting.

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

Non-Preferred Drug Coverage
Class and drug-specific therapeutic trial and failure requirements are found within this document. Examples of non-preferred exception critera include:

- Adverse reaction to preferred drugs
- Allergy to preferred drugs
- Contraindication to preferred drugs

Specific Class Prior Authorization forms can be found within the PDL class listings and at: https://nebraska.fhsc.com/priorauth/paforms.asp

- Amylinomimetic Agents PA Form
- Buprenorphine Products PA Form
- Buprenorphine Products Informed Consent
- GLP-1 Receptor Agonists PA Form
- Growth Hormone 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
- Documentation of Medical Necessity for Quantity Limit or High Dose Override 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
AZELEX (azelaic acid) BENZACLIN **W/PUMP** (clindamycin/benzoyl peroxide) benzoxyl peroxide **GEL, CREAM, WASH, LOTION** OTC clindamcyin phosphate **SOLUTION** DIFFERIN **LOTION, CREAM, GEL** (adapalene) erythromycin **SOLUTION** PANOXYL (benzoyl peroxide) OTC RETIN-A **GEL, CREAM**[AL]	ACANYA (clindamycin and benzoyl peroxide) ACZONE (dapsone) adapalene **CREAM, GEL, GEL W/PUMP** (generic Differin) ATRALIN (tretinoin) AVITA (tretinoin) BENZACLIN **GEL** (clindamycin/ benzoyl peroxide) BENZAPRO (benzoyl peroxide) benzoyl peroxide **FOAM** (generic for Benzepro Foam) benzoyl peroxide **GEL** Rx *clindamycin* **GEL, FOAM , *LOTION*** clindamycin/benzoyl peroxide (generic for Benzaclin) *clindamycin/benzoyl peroxide (generic for Duac)* clindamycin/tretinoin (generic for Veltin & Ziana) EPIDUO (adapalene/benzoyl peroxide) EPIDUO FORTE **GEL W/PUMP** erythromycin **GEL** erythromycin-benzoyl peroxide (generic for Benzamycin) EVOCLIN (clindamycin) FABIOR (tazarotene foam) *ONEXTON (clindamycin/benzoyl peroxide)* RETIN-A MICRO (tretinoin microspheres) [AL] sulfacetamide sulfacetamide/sulfur SUMADAN (sulfacetamide/sulfur) TAZORAC (tazarotene) tretinoin **CREAM, GEL**[AL] tretinoin microspheres (generic for Retin-A Micro) [AL]	▪ Non-preferred agents will be approved for patients who have failed THREE preferred agents

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ALZHEIMER'S DRUGS

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 for Aricept) donepezil ODT (generic for Aricept ODT) EXELON Transdermal (rivastigmine)	donepezil 23 (generic for Aricept 23) galantamine (generic for Razadyne) galantamine ER (generic for Razadyne ER) rivastigmine (generic for Exelon)	
NMDA RECEPTOR ANTAGONIST		
memantine (generic for Namenda) NAMENDA **SOLUTION**	NAMENDA (memantine) NAMENDA XR (memantine ER) NAMZARIC (memantine/donepezil) memantine soln (generic for Namenda)	

ANALGESICS, OPIATE LONG-ACTING

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BUTRANS (buprenorphine, transdermal) fentanyl 25, 50, 75, 100 mcg **PATCH** HYSINGLA ER (hydrocodone, extended release) morphine ER **TABLET** (generic for MS Contin, Oramorph SR) OXYCONTIN (oxycodone ER)	*ARYMO ER (morphine sulfate ER)*[QL] BELBUCA (buprenorphine, buccal)[CL] *buprenorphine TRANSDERMAL (generic for Butrans)*[NR] DURAGESIC MATRIX (fentanyl) EMBEDA (morphine sulfate+naltrexone) fentanyl 37.5, 62.5, 87.5 mcg **PATCH**[CL] hydromorphone ER (generic for Exalgo)[CL] *KADIAN (morphine ER capsule)* methadone [CL] *MORPHABOND (morphine sulfate)*[NR] morphine ER **CAPSULE** (generic for Avinza, Kadian) NUCYNTA ER (tapentadol)[CL] oxycodone ER (generic for re-formulated Oxycontin) oxymorphone ER (generic for Opana ER) tramadol extended release (generic for Ultram ER & CONZIP)[CL] *XTAMPZA ER (oxycodone myristate)*[QL] ZOHYDRO ER (hydrocodone bitartrate ER)	▪ Non-preferred agents will be approved for patients who have failed no less than 30-day trial of TWO preferred agents within the last 6 months Drug-specific criteria: ▪ **Exalgo®/Exalgo ER®:** Clinical reason why IR hydromorphone can't be used ▪ **Methadone:** Trial of preferred drug not required for end of life care ▪ **Oxycontin®:** Pain contract required for maximum quantity authorization ▪ **Ultram ER®:** Clinical reason why IR tramadol can't be used ▪ **Zohydro ER®:** Clinical reason why IR hydrocodone can't be used

ANALGESICS, OPIATE SHORT-ACTING[QL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ORAL		▪ Non-preferred agents will be approved for patients who have failed THREE preferred agents within the last 12 months ▪ *Note: for short acting opiate tablets and capsules there is a maximum quantity limit of #150 per 30 days.* Drug-specific criteria: ▪ **Abstral®/Actiq®/Fentora®/ Onsolis®/ Subsys® (fentanyl):** Approved only for diagnosis of cancer AND current use of long-acting opiate ▪ **Nucynta®:** Approved only for diagnosis of acute pain, for 30 days or less ▪ **Tramadol/APAP:** Clinical reason why individual ingredients can't be used ▪ **Xartemis XR®:** Approved only for diagnosis of acute pain
acetaminophen/codeine **ELIXIR, TABLET**	dihydrocodeine/acetamin/caffeine	
codeine **ORAL**	dihydrocodeine/aspirin/caffeine (generic for Synalgos DC)	
hydrocodone/APAP **SOLUTION, TABLET**	hydromorphone **ORAL LIQUID, TABLET, SUPPOSITORY** (generic for Dilaudid)	
hydrocodone/ibuprofen	IBUDONE (hydrocodone/ibuprofen)	
hydromorphone **TABLET**	levorphanol	
morphine **ORAL**	meperidine (generic for Demerol)	
oxycodone **TABLET, SOLUTION**	morphine **SUPPOSITORIES**	
oxycodone/APAP	NUCYNTA (tapentadol)[CL]	
tramadol	*OXAYDO (oxycodone)[NR, CL]*	
	oxycodone **CAPSULE**	
	*oxycodone/acetaminophen **SOLUTION***	
	oxycodone/aspirin	
	oxycodone **CONCENTRATE**	
	oxycodone/ibuprofen (generic for Combunox)	
	oxymorphone (generic for Opana)	
	pentazocine/naloxone	
	PRIMLEV (oxycodone/acetaminophen)	
	REPREXAIN (hydrocodone/ibuprofen)	
	ROXICODONE **TABLET** (oxycodone)	
	tramadol/APAP –generic for Ultracet	
	TREZIX (dihydrocodeine/ acetaminophen/caffeine)[NR]	
	XARTEMIS XR (oxycodone/ acetaminophen)	
	ZAMICET (hydrocodone/ acetaminophen)	
NASAL		
	butorphanol **NASAL SPRAY**[QL]	
	LAZANDA (fentanyl citrate)	
BUCCAL/TRANSMUCOSAL		
	ABSTRAL (fentanyl)[CL]	
	fentanyl **TRANSMUCOSAL** (generic for Actiq)[CL]	
	FENTORA (fentanyl)[CL]	
	SUBSYS (fentanyl spray)[CL]	

ANDROGENIC DRUGS (Topical)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ANDROGEL (testosterone)	ANDRODERM (testosterone) AXIRON (testosterone) NATESTO (testosterone) testosterone gel **PACKET, PUMP** (generic for Androgel) testosterone (generic for Fortesta) testosterone (generics for Testim) testosterone (generic for Vogelxo)	▪ Non-preferred agents will be approved for patients who have failed ONE preferred agent 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)

ANGIOTENSIN MODULATORS

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

ANGIOTENSIN MODULATORS (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ANGIOTENSIN RECEPTOR BLOCKER/DIURETIC COMBINATIONS		▪ Non-preferred agents will be approved for patients who have failed TWO preferred agents within the last 12 months ▪ Non-preferred combination products may be covered as individual prescriptions without prior authorization
irbesartan/HCTZ (generic for Avalide) losartan/HCTZ (generic for Hyzaar) valsartan-HCTZ (generic for Diovan-HCT)	candesartan/HCTZ (generic for Atacand-HCT) olmesartan/HCTZ (generic for Benicar-HCT) telmisartan/HCTZ (generic for 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 with both preferred agents ▪ **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
benazepril/amlodipine (generic for Lotrel)	amlodipine/olmesartan/HCTZ (generic for Tribenzor) PRESTALIA (perindopril/amlodipine) TEKAMLO (aliskiren/amlodipine) olmesartan/amlodipine (generic for Azor) telmisartan/amlodipine (generic for Twynsta) trandolapril/verapamil (generic for Tarka) valsartan/amlodipine (generic for Exforge) valsartan/amlodipine/HCTZ (generic for Exforge HCT)	
DIRECT RENIN INHIBITORS		
	TEKTURNA (aliskiren)	
DIRECT RENIN INHIBITOR COMBINATIONS		
	TEKTURNA/HCT (aliskiren/HCTZ)	
NEPRILYSIN INHIBITOR COMBINATION		▪ **Entresto®:** Approved only for NYHA Class II-IV Heart Failure with reduced ejection fraction **Does NOT require class criteria**
ENTRESTO (sacubitril/valsartan)[CL]		
ANGIOTENSIN RECEPTOR BLOCKER/BETA-BLOCKER COMBINATIONS		▪ ***Byvalson®:*** *Approved for hypertension in those patients not adequately controlled on valsartan 80mg or nebivolol up to 10mg*
	BYVALSON (nevibolol/valsartan)	

ANTIBIOITICS, GASTROINTESTINAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
metronidazole **TABLET** neomycin vancomycin **COMPOUNDED ORAL SOLUTION**	ALINIA (nitazoxanide) DIFICID (fidaxomicin) FLAGYL ER (metronidazole) metronidazole **CAPSULE** tinidazole (generic for Tindamax) vancomycin **CAPSULE** (generic for Vancocin) XIFAXAN (rifaximin)	▪ Note: Although azithromycin, ciprofloxacin, and trimethoprim/ sulfmethoxazole are not included in this review, they are available without prior authorization Drug-specific criteria: ▪ **Alinia®:** Trial and failure with metronidazole is required for a diagnosis of giardiasis ▪ **Dificid®:** Trial and failure with oral vancomycin OR metronidazole 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:** Trial and failure/ contraindication to metronidazole required Approvable diagnoses include: Giardia Amebiasis intestinal or liver abscess Bacterial vaginosis or trichomoniasis ▪ **Vancomycin capsules:** Trial and failure with metronidazole Trial may be bypassed if initial or recurrent episode of SEVERE C. difficile colitis SEVERE C. difficile colitis: Leukocytosis w/WBC ≥ 15,000 cells/microliter, OR Serum creatinine ≥ 1.5 times premorbid level Provider to provide labs for documentation ▪ **Xifaxan®:** Approvable diagnoses include: Travelers diarrhea resistant to quinolones Hepatic encephalopathy with treatment failure of lactulose or neomcin Diarrhea-Predominant IBS (IBS-D) 550mg strength only with treatment failure of Lomotil® AND Imodium®

ANTIBIOTICS, INHALED

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BETHKIS (tobramycin)[CL] KITABIS PAK (tobramycin)[CL] TOBI-PODHALER (tobramycin)[CL,QL]	CAYSTON (aztreonam lysine)[QL,CL] tobramycin (generic for Tobi)	▪ 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: ▪ **Tobi Podhaler®:** Requires trial on inhaled solution or documentation why solution cannot be used ▪ **Cayston®:** Trial of tobramycin via nebulizer and demonstration of TOBI® compliance required

ANTIBIOTICS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
bacitracin **OINTMENT** bacitracin/polymyxin (generic for Polysporin) mupirocin **OINTMENT** (generic for Bactroban) neomycin/polymyxin/bacitracin (generic for Neosporin, Triple AB) neomycin/polymyxin/pramoxine	ALTABAX (retapamulin) CENTANY (mupirocin) gentamicin **OINTMENT, CREAM** mupirocin **CREAM** (generic for Bactroban)	▪ Non-preferred agents will be approved for patients who have failed ALL preferred agents within the last 12 months Drug-specific criteria: ▪ **Altabax®:** Approvable diagnoses of impetigo due to *S. Aureus* OR *S. pyogenes* with clinical reason mupirocin ointment cannot be used ▪ **Mupirocin® Cream:** Clinical reason the ointment cannot be used

ANTIBIOTICS, VAGINAL

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

ANTICOAGULANTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ELIQUIS (apixaban) enoxaparin (generic for Lovenox) PRADAXA (dabigatran) warfarin (generic for Coumadin) XARELTO (rivaroxaban)[QL]	fondaparinux (generic for Arixtra) FRAGMIN (dalteparin) SAVAYSA (edoxaban)[QL]	▪ Non-preferred agents will be approved for patients who have failed ONE preferred agents 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 anticoagulent therapy

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 agents within the same group
dronabinol (generic for Marinol)[AL]	CESAMET (nabilone) *SYNDROS (dronabinol)[NR]*	
5HT3 RECEPTOR BLOCKERS		Drug-specific criteria:
ondansetron (generic for Zofran)[QL] ondansetron ODT (generic for Zofran)[QL]	ANZEMET (dolasetron) granisetron (generic for Kytril) SANCUSO (granisetron)[CL] ZUPLENZ (ondansetron)	▪ **Akynzeo®/Emend®/Varubi®:** Approved for Moderately/Highly emetogenic chemotherapy with dexamethasone and a 5-HT3 antagonist WITHOUT trial of preferred agents 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®:** Approved only for treatment of nausea and vomiting of pregnancy in females only ▪ **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		
	aprepitant (generic for Emend) [QL,CL] AKYNZEO (netupitant/palonosetron)[CL] VARUBI (rolapitant)[CL]	
TRADITIONAL ANTIEMETICS		
DICLEGIS (doxylamine/pyridoxine)[CL] dimenhydrinate (generic for Dramamine) hydroxyzine (generic for Vistaril) meclizine (generic for Antivert) metoclopramide (generic for Reglan) phosphoric acid/dextrose/fructose **SOLUTION** (generic for Emetrol) prochlorperazine, oral (generic for Compazine) promethazine, oral (generic for Phenergan) promethazine **SUPPOSITORIES** 12.5mg, 25mg TRANSDERM-SCOP (scopolamine)	COMPRO (prochlorperazine rectal) metoclopramide ODT(generic for Metozolv ODT) prochlorperazine **SUPPOSITORIES** (generic for Compazine) promethazine **SUPPOSITORIES** 50mg trimethobenzamide, oral (generic for Tigan)	

ANTIFUNGALS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
clotrimazole (mucous membrane, troche) fluconazole (generic for Diflucan) griseofulvin **SUSPENSION** *griseofulvin microsized **TABLET*** nystatin **TABLET**, **SUSPENSION** terbinafine (generic for Lamisil)	CRESEMBA (isavuconazonium)[CL] flucytosine (generic for Ancobon)[CL] *griseofulvin ultramicrosize (generic for GRIS-PEG)* itraconazole (generic for Sporanox)[CL] ketoconazole (generic for Nizoral) NOXAFIL (posaconazole)[CL,AL] nystatin **POWDER,** oral ONMEL (itraconazole) ORAVIG (miconazole) SPORANOX (itraconazole)[CL] voriconazole (generic for VFEND)[CL]	Non-preferred agents will be approved for patients who have failed TWO diagnosis-appropriate preferred agents 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 ▪ **Ommel®:** 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 oral cannot be used ▪ **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

ANTIFUNGALS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ANTIFUNGAL		▪ Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within the last 6 months Drug-specific criteria: ▪ **Extina®:** Requires trial and failure or contraindication to other ketoconazole forms ▪ **Jublia®:** Approved diagnoses include Onychomycosis of the toenails due to *T. rubrum* OR *T. mentagrophytes* ▪ **Nystatin/Triamcinolone:** individual ingredients available without prior authorization ▪ **Ciclopirox nail lacquer:** No trial required in diabetes, peripheral vascular disease (PVD), immunocompromised OR contraindication to oral terbinafine
clotrimazole (generic for Lotrimin) RX, OTC ketoconazole **CREAM, SHAMPOO** (generic for Nizoral) LAMISIL AT **CREAM** (terbinafine) OTC miconazole **OTC CREAM, SPRAY, POWDER** nystatin selenium sulfide 2.5% terbinafine OTC (generic for Lamisil AT) tolnaftate OTC (generic for Tinactin)	ALEVAZOL (clotrimazole) OTC BENSAL HP (salicylic acid) ciclopirox **CREAM, GEL, SUSPENSION** (generic for Ciclodan, Loprox) ciclopirox **NAIL LACQUER** (generic for Penlac) ciclopirox **SHAMPOO** (generic for Loprox) clotrimazole **SOLUTION** RX (generic for Lotrimin) DESENEX AERO **POWDER** OTC (miconazole) econazole (generic for Spectazole) ERTACZO (sertaconazole) EXELDERM (sulconazole) EXTINA (ketoconazole) FUNGOID OTC JUBLIA (efinaconazole) ketoconazole **FOAM** (generic for Ketodan) *LAMISIL AT **GEL, SPRAY** (terbinafine) OTC* *LOPROX (ciclopirox) **SUSPENSION*** LOTRIMIN AF **CREAM** OTC (clotrimazole) LOTRIMIN ULTRA (bufenafine) LUZU (luliconazole) MENTAX (butenafine) miconazole OTC **OINTMENT** naftifine (generic for Naftin) oxiconazole (generic for Oxistat) selenium sulfide 2.25% tolnaftate **POWDER** OTC (generic for Tinactin Aero) VUSION (miconazole/ zinc oxide)	
ANTIFUNGAL/STEROID COMBINATIONS		
clotrimazole/betamethasone **CREAM** (generic for Lotrisone)	clotrimazole/betamethasone **LOTION** (generic for Lotrisone) nystatin/triamcinolone (generic for Mycolog)	

ANTIHISTAMINES, MINIMALLY SEDATING

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
cetirizine **TABLET, SOLUTION** (generic for Zyrtec) loratadine **TABLET, SOLUTION** (generic for Claritin) levocetirizine **TABLET** (generic for Xyzal)	cetirizine **CHEWABLE** (generic for Zyrtec) desloratadine (generic for Clarinex) desloratadine ODT (generic for Clarinex Reditabs) fexofenadine (generic for Allegra) levocetirzine (generic for Xyzal) **SOLUTION** loratadine **DISPERSABLE TABLET** (generic for Claritin Reditabs)	▪ Non-preferred agents will be approved for patients who have failed TWO preferred agents ▪ Combination products not covered – individual products may be covered

ANTIHYPERTENSIVES, SYMPATHOLYTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CATAPRES-TTS (clonidine) clonidine **TABLET** (generic for Catapres) guanfacine (generic for Tenex) methyldopa	clonidine **TRANSDERMAL** CLORPRES (chlorthalidone/clonidine) methyldopa/hydrochlorothiazide reserpine	▪ Non-preferred agents will be approved for patients who have failed a 30-day trial with ONE preferred agent

ANTIHYPERURICEMICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
allopurinol (generic for Zyloprim) probenecid probenecid/colchicine (generic for Col-Probenecid)	colchicine (generic for Colcrys)[CL] colchicine **CAPSULE**(generic for Mitigare) ULORIC (febuxostat)[CL] ZURAMPIC (lesinurad)[CL]	▪ Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent ▪ **colchicine tablet®:** Approved without trial for familial Mediterranean fever OR pericarditis ▪ **Uloric®:** Clinical reason why allopurinol cannot be used ▪ ***Zurampic®:*** *Requires trial of allopurinol and Uloric®*

ANTIMIGRAINE AGENTS, OTHER

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	CAFERGOT (ergotamine/caffeine) CAMBIA (diclofenac potassium) dihydroergotamine mesylate **NASAL** *ERGOMAR **SUBLINGUAL** (ergotamine tartrate)* MIGERGOT (ergotamine/caffeine) **RECTAL** MIGRANAL (dihydroergotamine) **NASAL**	▪ Non-preferred agents will be approved for patients who have a contraindication OR trial failure of a triptan Drug-specific criteria: ▪ *Cambia®: Requires diagnosis of migraine and documentation of why solid dosing forms not appropriate*

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 Drug-specific criteria: ▪ **Sumavel® Dosepro:** Requires clinical reason sumatriptan injection cannot be used ▪ ***Onzetra, Zembrace:** approved for patients who have failed ALL preferred agents*
RELPAX (eletriptan) rizatriptan (generic for Maxalt) rizatriptan ODT (generic for Maxalt MLT) sumatriptan	almotriptan (generic for Axert) frovatriptan (generic for Frova) IMITREX (sumatriptan) naratriptan (generic for Amerge) TREXIMET (sumatriptan/naproxen) zolmitriptan (generic for Zomig/Zomig ZMT)	
NASAL		
sumatriptan	*IMITREX (sumatriptan)* *ONZETRA XSAIL (sumatriptan)* ZOMIG (zolmitriptan)	
INJECTABLE		
*sumatriptan **KIT, SYRINGE**,* **VIAL**	ALSUMA (sumatriptan) *IMITREX (sumatriptan) **INJECTION*** *sumatriptan **KIT (mfr SUN)*** SUMAVEL DOSEPRO (sumatriptan) *ZEMBRACE SYMTOUCH (sumatriptan)*	

ANTIPARASITICS, TOPICAL

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

ANTIPARKINSON'S DRUGS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ANTICHOLINERGICS		▪ Non-preferred agents will be approved for patients who have failed ONE preferred agents within the same group Drug-specific criteria: ▪ **Carbidopa/Levodopa ODT:** Approved for documented swallowing disorder ▪ **COMT Inhibitors:** Approved if using as add-on therapy with levodopa-containing drug ▪ **Neupro®:** For Parkinsons: Clinical reason required why preferred agent cannot be used For Restless Leg (RLS): Requires trial OR Contraindication to ropinirole AND pramipexole ▪ **Pramipexole ER:** Required diagnosis of Parkinson's along with preferred agent trial ▪ **Ropinerole ER:** Required diagnosis of Parkinson's along with preferred agent trial ▪ **Zelapar®:** Approved for documented swallowing disorder
benztropine (generic for Cogentin) trihexyphenidyl (generic for Artane)		
COMT INHIBITORS		
	entacapone (generic for Comtan) TASMAR (tolcapone) tolcapone (generic for Tasmar)	
DOPAMINE AGONISTS		
bromocriptine (generic for Parlodel) pramipexole (generic for Mirapex) ropinirole (generic for Requip)	NEUPRO (rotigotine)CL pramipexole ER (generic for Mirapex ER)CL ropinirole ER (generic for REQUIP XL)CL	
MAO-B INHIBITORS		
selegiline **TABLET** (generic for Eldepryl)	rasagilineQL (generic for Azilect) selegiline **CAPSULE** (gen. for Eldepryl) *XADAGO (safinamide)NR* ZELAPAR (selegiline)CL	
OTHER ANTIPARKINSON'S DRUGS		
amantadine **CAPSULE, SYRUP** (generic for Symmetrel) carbidopa/levodopa (generic for Sinemet) carbidopa/levodopa ER (generic for Sinemet CR) levodopa/carbidopa/entacapone (generic for Stalevo)	amantadine **TABLET** carbidopa (generic for Lodosyn) carbidopa/levodopa ODT (generic for Parcopa) DUOPA (carbidopa/levadopa) RYTARY (carbidopa/levodopa) STALEVO (levodopa/carbidopa/entacapone)	

ANTIPSORIATICS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
SORIATANE (acitretin)	acitretin (generic for Soriatane) methoxsalen (generic for Oxsoralen-Ultra) OXSORALEN-ULTRA (methoxsalen) 8-MOP (methoxsalen)	▪ Non-preferred agents will be approved for patients who have failed a trial with THE preferred agent ▪ 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** calcipotriene **SOLUTION**	calcipotriene **OINTMENT** calcitriol (generic for Vectical) calcipotriene/betamethasone (generic for Taclonex) CALCITRENE (calcipotriene) DOVONEX **CREAM** (calcipotriene) ENSTILAR (calcipotriene/betamethasone) SORILUX (calcipotriene) TACLONEX SCALP (calcipotriene/betamethasone)	▪ Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent

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
acyclovir (generic for Zovirax) famciclovir (generic for Famvir) valacyclovir (generic for Valtrex)	SITAVIG (acyclovir buccal)	
ANTI-INFLUENZA DRUGS		Drug-specific criteria: ▪ **Sitavig®:** Approved for recurrent herpes labialis (cold sores) in immunocompetent adults
RELENZA (zanamivir)QL rimantadine (generic for Flumadine) TAMIFLU (oseltamivir) QL	*oseltamivir (generic for Tamiflu)QL*	

ANTIVIRALS, TOPICAL

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

ANXIOLYTICS

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

BENIGN PROSTATIC HYPERPLASIA (BPH) TREATMENTS

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

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 preferred agents within the last 12 months 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 for Tenormin)	acebutolol (generic for Sectral)	
atenolol/chlorthalidone(generic for Tenoretic)	betaxolol (generic for Kerlone)	
bisoprolol/HCTZ (generic for Ziac)	bisoprolol (generic for Zebeta)	
metoprolol (generic for Lopressor)	BYSTOLIC (nebivolol)	
metoprolol XL (generic for Toprol XL)	DUTOPROL (metoprolol XR and HCTZ)	
propranolol (generic for Inderal)	HEMANGEOL (propranolol) oral solution	
propranolol extended release (generic for Inderal LA)	INDERAL XL (propranolol)	
	INNOPRAN XL (propranolol)	
	LEVATOL (penbutolol)	
	metoprolol/HCTZ (generic for Lopressor HCT)	
	nadolol (generic for Corgard)	
	nadolol/bendroflumethiazide (generic for Corzide)	
	pindolol (generic for Viskin)	
	propranolol/hydrochlorothiazide (generic for Inderide)	
	timolol (generic for Blocadren)	
	TOPROL XL (metoprolol)	
BETA- AND ALPHA-BLOCKERS		
carvedilol (generic for Coreg)	COREG CR (carvedilol)	
labetalol (generic for Trandate)		
ANTIARRHYTHMIC		
sotalol (generic for Betapace)	SOTYLIZE (sotalol)	

BILE SALTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ursodiol 250mg **TABLET** (generic for URSO)	CHENODAL (chenodiol)	▪ Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent
ursodiol 500mg **TABLET** (generic for URSO FORTE)	CHOLBAM (cholic acid)	
	OCALIVA (obeticholic acid)	
	ursodiol **CAPSULE** 300mg (generic for Actigall)	

BLADDER RELAXANT PREPARATIONS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
oxybutynin & ER (generic for Ditropan/XL) TOVIAZ (fesoterodine ER) VESICARE (solifenacin)	darifenacin ER (generic for Enablex) GELNIQUE (oxybutynin) MYRBETRIQ (mirabegron) OXYTROL (oxybutynin) tolterodine & ER (generic for Detrol/LA) trospium & ER (generic for Sanctura/XR)	▪ Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent Drug-specific criteria: ▪ **Myrbetriq®:** Covered without trial in contraindication to anticholinergic agents

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 Miacalcin not required
alendronate (generic for Fosamax) (daily and weekly formulations)	alendronate **SOLUTION** (generic for Fosamax)QL ATELVIA DR (risedronate) BINOSTO (alendronate) etidronate disodium (generic for Didronel) FOSAMAX PLUS DQL ibandronate (generic for Boniva)QL risedronate (generic for Actonel)QL	
OTHER BONE RESORPTION SUPPRESSION AND RELATED DRUGS		
calcitonin-salmon **NASAL** raloxifene (generic for Evista)	EVISTA (raloxifene) FORTEO (teriparatide)QL FORTICAL (calcitonin) **NASAL** *TYMLOS (abaloparatide)NR*	

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 group Drug-specific criteria: ▪ **Albuterol low dose:** May be approved if parent/caregiver is not capable/reliable to measure/dilute preferred agent OR patient <15kg ▪ **Ventolin HFA®:** Requires trial and failure on Proventil HFA® AND Proair HFA® OR allergy/ contraindication/side effect to BOTH ▪ **Xopenex®:** Covered for cardiac diagnoses or side effect of tachycardia with albuterol product
PROAIR HFA (albuterol) PROVENTIL HFA (albuterol)	PROAIR RESPICLICK (albuterol) VENTOLIN HFA (albuterol) XOPENEX HFA (levalbuterol)	
INHALERS – Long Acting		
FORADIL (formoterol) SEREVENT (salmeterol)	ARCAPTA NEOHALER (indacaterol) STRIVERDI RESPIMAT (olodaterol)	
INHALATION SOLUTION		
albuterol (2.5mg/3ml premix or 2.5mg/0.5ml)	albuterol low dose (0.63mg/3ml & 1.25mg/3ml) BROVANA (arformoterol) levalbuterol (generic for Xopenex) PERFOROMIST (formoterol)	
ORAL		
albuterol **SYRUP** albuterol ER (generic for Vospire ER) terbutaline (generic for Brethine)	albuterol **TABLET** metaproterenol (formerly generic for Alupent)	

CALCIUM CHANNEL BLOCKERS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
SHORT-ACTING		▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within the same group Drug-specific criteria: ▪ **Nimodipine:** Covered without trial for diagnosis of subarachnoid hemorrhage
Dihydropyridines		
nifedipine (generic for Procardia)	isradipine (generic for Dynacirc) nicardipine (generic for Cardene) nimodipine (generic for Nimotop) NYMALIZE (nimodipine solution)	
Non-dihydropyridines		
diltiazem (generic for Cardizem) verapamil (generic for Calan, Isoptin)		
LONG-ACTING		
Dihydropyridines		
amlodipine (generic for Norvasc) nifedipine ER (generic for Procardia XL/Adalat CC)	felodipine ER (generic for Plendil) nisoldipine (generic for Sular)	
Non-dihydropyridines		
diltiazem ER (generic for Cardizem CD) verapamil ER **TABLET**	CALAN SR (verapamil) diltiazem LA (generic for Cardizem LA) MATZIM LA (diltiazem) TIAZAC (diltiazem) verapamil ER **CAPSULE** verapamil 360mg **CAPSULE** *verapamil ER PM (generic for 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 Drug-specific criteria: ▪ **Suprax® Tablet/Chewable/ Suspension:** Requires clinical reason why capsule or generic suspension cannot be used
amoxicillin/clavulanate **TABLETS, CHEWABLE, SUSPENSION**	amoxicillin/clavulanate XR (generic for Augmentin XR) *AUGMENTIN **SUSPENSION***, **TABLET** (amoxicillin/clavulanate)	
CEPHALOSPORINS – First Generation		
cefadroxil **CAPSULE, SUSPENSION** (generic for Duricef) cephalexin **CAPSULE, SUSPENSION** (generic for Keflex)	cefadroxil **TABLET** (generic for Duricef) cephalexin **TABLET**	
CEPHALOSPORINS – Second Generation		
cefprozil (generic for Cefzil) cefuroxime **TABLET** (generic for Ceftin)	cefaclor (generic for Ceclor) CEFTIN (cefuroxime) **TABLET, SUSPENSION**	
CEPHALOSPORINS – Third Generation		
cefdinir (generic for Omnicef) cefixime **SUSPENSION** (generic for Suprax) SUPRAX **CAPSULE** (cefixime)	ceftibuten (generic for Cedax) cefpodoxime (generic for Vantin) SUPRAX **CHEWABLE TABLET, SUSPENSION, TABLET** (cefixime)	

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) 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 in the same group Drug-specific criteria: ▪ **Daliresp®:** 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
ATROVENT HFA (ipratropium) COMBIVENT RESPIMAT (albuterol/ ipratropium) SPIRIVA (tiotropium)	ANORO ELLIPTA (umeclidinium/vilanterol) BEVESPI AEROSPHERE (glycopyrolate/formoterol) INCRUSE ELIPTA (umeclidnium) SEEBRI NEOHALER (glycopyrolate) SPIRIVA RESPIMAT (tiotropium) STIOLTO RESPIMAT (tiotropium/olodaterol) TUDORZA PRESSAIR (aclidinium br) UTIBRON NEOHALER (indacaterol/glycopyrolate)	
INHALATION SOLUTION		
albuterol/ipratropium (generic for Duoneb) ipratropium **SOLUTION** (generic for Atrovent)		
ORAL AGENT		
	DALIRESP (roflumilast)[CL]	

COLONY STIMULATING FACTORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
NEUPOGEN (filgrastim) **VIAL**	GRANIX (tbo-filgrastim) NEUPOGEN (filgrastim) **DISP SYR** ZARXIO (filgrastim-sndz)	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent

CONTRACEPTIVES, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
All agents are recommended preferred at this time *Brand name products may be subject to Maximum Allowable Cost (MAC) pricing* *Specific agents can be looked up using the Drug Look-up Tool at:*		

https://druglookup.fhsc.com/druglookupweb/?client=nestate

CYSTIC FIBROSIS, ORAL

Preferred Agents	*Non-Preferred Agents*	*Prior Authorization/Class Criteria*
	*KALYDECO **PACKET, TABLET** (ivacaftor)* *ORKAMBI (lumacaftor/ivacaftor)*	*Drug-specific criteria:* ▪ ***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*

CYTOKINE & CAM ANTAGONISTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ENBREL (etanercept) HUMIRA (adalimumab)	ACTEMRA subcutaneous (tocilizumab) ARCALYST (nilonacept) CIMZIA (certolizumab pegol) COSENTYX (secukinumab) *KEVZARA (sarilumab)NR* KINERET (anakinra) ORENCIA (abatacept**) SUB-Q** OTEZLA (apremilast, oral) *SILIQ (brodalumab)NR* SIMPONI (golimumab) *STELARA (ustekinumab) **SUB-Q**NR* TALTZ (ixekizumab) XELJANZ (tofacitinib, oral)	▪ Non-preferred agents will be approved for FDA-approved indications in patients who have failed a trial of ONE preferred agent

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 agent within the same group*
*amiloride **TABLET*** *bumetanide **TABLET*** *chlorothiazide **TABLET*** *chlorthalidone **TABLET*** *furosemide **SOLUTION, TABLET*** *hydrochlorothiazide **CAPSULE, TABLET*** *indapamide **TABLET*** *metolazone **TABLET*** *methyclothiazide **TABLET*** *spironolactone **TABLET*** *torsemide **TABLET***	*ALDACTONE TABLET (spironolactone)* *DIURIL **TABLET** (chlorothiazide)* *DYRENIUM **TABLET** (triamterene)* *eplerenone **TABLET** (generic for INSPRA)* *ethacrynic acid **CAPSULE** (generic for EDECRIN)* *LASIX **TABLET** (furosemide)* *MICROZIDE **TABLET** (hydrochlorothiazide)*	
COMBINATION PRODUCTS		
*amiloride/HCTZ **TABLET*** *spironolactone/HCTZ **TABLET*** *triamterene/HCTZ **CAPSULE, TABLET***	*ALDACTAZIDE **TABLET** (spironolactone/HCTZ)* *DYAZIDE **CAPSULE** (triamterene/HCTZ)* *MAXZIDE **TABLET** (triamterene/HCTZ)* *MAXZIDE-25 **TABLET** (triamterene/HCTZ)*	

EPINEPHRINE, SELF-INJECTED

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
epinephrine (generic for Adrenaclick) EPIPEN EPIPEN JR.	ADRENACLICK *epinephrine (generic for Epipen/Jr.)*[NR]	▪ Non-preferred agents require clinical documentation why the preferred product is not appropriate

ERYTHROPOIESIS STIMULATING PROTEINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
EPOGEN (rHuEPO) PROCRIT (rHuEPO)	*MIRCERA*[NR]	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent

FLUOROQUINOLONES, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ciprofloxacin (generic for Cipro) levofloxacin **TABLET** (generic for Levaquin)	ciprofloxacin ER ciprofloxacin **SUSPENSION** (generic for Cipro) levofloxacin **SOLUTION** moxifloxacin (generic for Avelox) ofloxacin	▪ Non-preferred agents will be approved for patients who have failed a 3-day trial of ONE preferred agent Drug-specific criteria: ▪ **Ciprofloxacin Suspension:** Coverable with documented swallowing disorders ▪ **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)QL LINZESS (linaclotide)QL	alosetron (generic for Lotronex) MOVANTIK (naloxegol oxalate) *RELISTOR (methylnaltrexone) **TABLET**QL* *TRULANCE (plecanatide)QL* VIBERZI (eluxodoline)	▪ Non-preferred agents will be approved for patients who have failed a 30-day trial of ONE preferred agent Drug-specific criteria: ▪ **Lotronex®:** Covered for diagnosis of IBS Diarrhea Predominant type with trial and failure of loperamide AND diphenoxylate ▪ **Movantik®:** Covered for diagnosis of opioid-induced constipation in adult patients with chronic non-cancer pain after trial on at least TWO OTC laxatives ▪ ***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.)* ▪ ***Trulance®**: Covered for diagnosis of chronic idiopathic 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

GLUCOCORTICOIDS, INHALED

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
GLUCOCORTICOIDS		▪ Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within the last 6 months Drug-specific criteria: ▪ **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
ASMANEX (mometasone)[QL,AL]	AEROSPAN (flunisolide)	
QVAR (beclomethasone)	ALVESCO (ciclesonide)[AL,CL]	
	ARNUITY ELLIPTA (fluticasone)	
	ASMANEX HFA (mometasone)[AL,QL]	
	FLOVENT DISKUS (fluticasone)	
	FLOVENT HFA (fluticasone)	
	PULMICORT FLEXHALER (budesonide)	
GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS		
ADVAIR DISKUS (fluticasone/ salmeterol)[QL]	ADVAIR HFA[QL]	
DULERA (mometasone/formoterol)	*AIRDUO RESPICLICK (fluticasone/salmeterol)[NR]*	
SYMBICORT (budesonide/ formoterol)	BREO ELLIPTA (fluticasone/vilanterol)	
INHALATION SOLUTION		
	budesonide **RESPULES** (generic for Pulmicort)	

GROWTH HORMONE

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
GENOTROPIN (somatropin)	HUMATROPE (somatropin)	Growth Hormone PA Form Growth Hormone Criteria
NORDITROPIN (somatropin)	OMNITROPE (somatropin)	
NUTROPIN AQ (somatropin)	*SAIZEN (somatropin)*	
	SEROSTIM (somatropin)	
	ZOMACTON (somatropin)	
	ZORBTIVE (somatropin)	

H. PYLORI TREATMENTS

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

HEPATITIS C TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
DIRECT ACTING ANTI-VIRAL		Hepatitis C Treatments PA Form Hepatitis C Criteria
EPCLUSA (sofosbuvir/velpatasvir)[CL] (genotype 2,3) HARVONI (sofosbuvir/ledipasvir)[CL] (genotype1,5,6) TECHNIVIE (ombitasvir, paritaprevir, ritonavir) [CL] (genotype 4) VIEKIRA PAK/XR[CL] (genotype 1) (ombitasvir/paritaprevir/ritonavir/ dasabuvir)	DAKLINZA (daclatasvir) [CL] OLYSIO (simeprevir)[CL] SOVALDI (sofosbuvir)[CL] ZEPATIER (elbasvir/grazoprevir)[CL]	
RIBAVIRIN		
ribavirin 200mg **TABLET, CAPSULE**	REBETOL (ribavirin)	
INTERFERON		
PEGASYS (pegylated interferon alfa-2a) [CL] PEG-INTRON (pegylated interferon alfa-2b) [CL]		

HISTAMINE II RECEPTOR BLOCKERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
famotidine **TABLET** (generic for Pepcid) ranitidine **TABLET, SYRUP** (generic for Zantac)	cimetidine **TABLET, SOLUTION** (generic for Tagamet) famotidine **SUSPENSION** nizatidine (generic for Axid) ranitidine **CAPSULE**	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent Drug-specific criteria: ▪ **Cimetidine:** Approved for viral *M. contagiosum* or common wart *V.* Vulgaris treatment ▪ **Nizatadine/Cimetidine Solution/ Famotidine Suspension:** Requires clinical reason why ranitidine syrup cannot be used

HYPOGLYCEMICS, ALPHA-GLUCOSIDASE INHIBITORS

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

HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS

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

HYPOGLYCEMICS, INSULIN AND RELATED DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
HUMALOG (insulin lispro) U-100 **CARTRIDGE, PEN, VIAL** HUMALOG MIX **VIAL** (insulin lispro/lispro protamine) HUMULIN (insulin) **VIAL** HUMULIN 70/30 **VIAL** HUMULIN U-500 **VIAL** LANTUS SOLOSTAR **PEN** (insulin glargine) LANTUS (insulin glargine) **VIAL** LEVEMIR (insulin detemir) **PEN, VIAL** NOVOLOG (insulin aspart) **CARTRIDGE, PEN, VIAL** NOVOLOG MIX **PEN, VIAL** (insulin aspart/aspart protamine)	AFREZZA (insul reg, inhaled) APIDRA (insulin glulisine) *BASAGLAR (insulin glargine, rec) **PEN*** HUMALOG (insulin lispro) U-200 **PEN** *HUMALOG MIX **PEN** (insulin lispro/lispro protamine)* HUMULIN 70/30 **PEN** HUMULIN U-500 **PEN** HUMULIN OTC **PEN** NOVOLIN (insulin) NOVOLIN 70/30 **VIAL** TOUJEO SOLOSTAR (insulin glargine) TRESIBA (Insulin degludec)	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent Drug-specific criteria: ▪ **Afrezza®:** Approved for T1DM on long-acting insulin with no current history of smoking or chronic lung disease ▪ ***Humulin® U-500:*** *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) repaglinide/metformin (generic for Prandimet)	▪ Non-preferred agents will be approved for patients with: Failure of a trial of ONE preferred agent in another class OR T2DM and inadequate glycemic control

HYPOGLYCEMICS, METFORMINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
glipizide/metformin glyburide/metformin (generic for Glucovance) metformin & ER (generic for Glucophage/XR)	metformin ER (generic for Fortamet) metformin ER (generic for Glumetza) RIOMET (metformin)	▪ **Metformin ER (generic Fortamet®)/Glumetza®:** Requires clinical reason why generic Glucophage XR® cannot be used ▪ **Riomet®:** Prior authorization not required for age <7 years

HYPOGLYCEMICS, SGLT2

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
FARXIGA (dapagliflozin)[QL,CL] INVOKANA (canagliflozin)[CL]	*INVOKAMET & XR (canagliflozin/metformin)*[QL] JARDIANCE (empagliflozin)[QL] SYNJARDY (empagliflozin/metformin) *SYNJARDY XR (empagliflozin/ metformin)*[NR,QL] XIGDUO XR (dapagliflozin/metformin)[QL]	▪ Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent ▪ **Invokana®/Farxiga®:** Approved for diagnosis of diabetes AND a trial of metformin

HYPOGLYCEMICS, SULFONYLUREAS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
glimepiride (generic for Amaryl) glipizide & ER (generic for Glucotrol/XL) glyburide & micronized (generic for Diabeta, Glynase)	chlorpropamide tolazamide tolbutamide	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent

HYPOGLYCEMICS, TZD

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

IDIOPATHIC PULMONARY FIBROSIS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	ESBRIET (pirfenidone) OFEV (nintedanib esylate)	▪ Non-preferred agents require: Use limited to FDA-approved indications

IMMUNOMODULATORS, ATOPIC DERMATITIS[AL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ELIDEL (pimecrolimus)	tacrolimus (generic for Protopic)[CL] *DUPIXENT (dupilumab)*[NR] *EUCRISA (crisaborole)*[NR]	▪ Non-preferred agents require:Trial of a topical steroid AND Trial of one preferred product

IMMUNOMODULATORS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
imiquimod (generic for Aldara)	ALDARA (imiquimod) ZYCLARA (imiquimod)	▪ Non-preferred agents require clinical reason why preferred agent cannot be used

INTRANASAL RHINITIS DRUGS

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 group Drug-specific criteria: ▪ **Mometasone:** Prior authorization NOT required for children ≤ 12 years ▪ **Budesonide:** Approved for use in Pregnancy (Pregnancy Category B) ▪ **Veramyst®:** Prior authorization NOT required for children ≤ 12 years
ipratropium (generic for Atrovent)		
ANTIHISTAMINES		
PATANASE (olopatadine)	azelastine (generic for Astelin) azelastine (generic for Astepro) DYMISTA (azelastine/fluticasone) olopatadine (generic for Patanase)	
CORTICOSTEROIDS		
fluticasone (generic for Flonase)	BECONASE AQ (beclomethasone) budesonide Rx (generic for Rhinocort) flunisolide (generic for Nasalide) mometasone (generic for Nasonex) OMNARIS (ciclesonide) QNASL 40 & 80 (beclomethasone) TICANASE (fluticasone) VERAMYST (fluticasone) ZETONNA (ciclesonide)	

LEUKOTRIENE MODIFIERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
montelukast **TABLET/CHEWABLE** (generic for Singulair)	montelukast **GRANULES** (generic for Singulair) zafirlukast (generic for Accolate) ZYFLO (zileuton) ZYFLO CR (zileuton)	▪ Non-preferred agents will be approved for patients who have failed a 30-day trial of THE preferred agent Drug-specific criteria: ▪ **Montelukast granules:** PA not required for age < 2 years

LIPOTROPICS, OTHER

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BILE ACID SEQUESTRANTS		▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within the same group Drug-specific criteria: ▪ **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 ▪ **Lovaza®:** Approved for TG ≥ 500 ▪ **Praluent®:** Approved for diagnoses of: • atherosclerotic cardiovascular disease (ASCVD) • heterozygous familial hypercholesterolemia (HeFH) 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 ▪ **Vascepa®:** Approved for TG ≥ 500 ▪ **WelChol®:** Trial not required for diabetes control and monotherapy with metformin, sulfonylurea, or insulin has been inadequate ▪ **Zetia®:** Approvd for diagnosis of hypercholesterolemia AND failed statin monotherapy OR statin intolerance/contraindication
cholestyramine (generic for Questran) colestipol **TABLETS** (generic for Colestid)	colestipol **GRANULES** (generic for Colestid) QUESTRAN LIGHT (cholestyramine) WELCHOL (colesevalam)	
TREATMENT OF HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA		
	JUXTAPID (lomitapide)CL KYNAMRO (mipomersen)CL	
FIBRIC ACID DERIVATIVES		
fenofibrate (generic for Tricor) *fenofibric acid (generic for Trilipix)* gemfibrozil (generic for Lopid)	fenofibrate (generic for Antara, Fenoglide, Lipofen, Lofibra) fenofibric acid (generic for Fibricor) TRICOR (fenofibrate) TRIGLIDE (fenofibrate) *TRILIPIX (fenofibric acid)*	
NIACIN		
niacin ER (generic for Niaspan)	NIACOR (niacin IR) NIASPAN (niacin ER)	
Several other forms of OTC Niacin and fish oil are also covered without prior authorization under Medicaid with a prescription		
OMEGA-3 FATTY ACIDS		
	omega-3 fatty acids (generic for Lovaza)CL VASCEPA (icosapent)CL	
CHOLESTEROL ABSORPTION INHIBITORS		
	ezetimibe (generic for Zetia)	
PROPROTEIN CONVERTASE SUBTILISIN/KEXIN TYPE 9 (PCSK9) INHIBITORS		
	PRALUENT (alorocumab)CL REPATHA (evolocumab)CL	

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

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 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 ▪ **Lescol XL®:** Requires trial of TWO preferred agents AND trial of IR fluvastatin OR clinical reason IR cannot be used ▪ **Vytorin®:** Approved for 3-month continuous trial of ONE standard dose statin
atorvastatin (generic for Lipitor)	ALTOPREV (lovastatin)	
lovastatin (generic for Mevacor)	*CRESTOR (rosuvastatin)*	
pravastatin (generic for Pravachol)	fluvastatin (generic for Lescol)	
rosuvastatin (generic for Crestor)	LESCOL & XL (fluvastatin & ER)	
simvastatin (generic for Zocor)	LIVALO (pitavastatin)	
STATIN COMBINATIONS		
	atorvastatin/amlodiine (generic for CADUET)	
	VYTORIN (simvastatin/ezetimibe)	

MACROLIDES AND KETOLIDES, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
KETOLIDES		▪ **Ketek®:** Requires clinical resaon why patient cannot use preferred macrolide ▪ **Macrolides:** Require clinical reason why preferred products cannot be used AND ≥ 3-day trial on a preferred macrolide
	KETEK (telithromycin)	
MACROLIDES		
azithromycin (generic for Zithromax)	clarithromycin ER (generic for Biaxin XL)	
clarithromycin **TABLET, SUSPENSION** (generic for Biaxin)	*EES **SUSPENSION, TABLET***	
	ERY-TAB	
	ERYPED 200 **SUSPENSION**	
	ERYTHROCIN	
	erythromycin base **TABLET, CAPSULE**	
	PCE (erythromycin)	
	ZMAX (azithromycin ER)	
	ZITHROMAX (azithromycin)	

MULTIPLE SCLEROSIS DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
AVONEX (interferon beta-1a)[QL] BETASERON (interferon beta-1b)[QL] COPAXONE **20mg** Syringe Kit (glatiramer)[QL] GILENYA (fingolimod)[QL,CL] REBIF (interferon beta-1a)[QL]	AMPYRA (dalfampridine)[QL] AUBAGIO (teriflunomide) COPAXONE **40mg** Syringe (glatiramer)[QL] EXTAVIA (interferon beta-1b)[QL] *glatiramer 20 mg/mL (generic for Copaxone)* PLEGRIDY (peginterferon beta-1a)[QL] TECFIDERA (dimethyl fumarate) *ZINBRYTA (daclizumab)*	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent Drug-specific criteria: ▪ **Ampyra®:** Approved for diagnosis of gait disorder associated with MS AND EDSS score ≤ 7 ▪ **Gilenya®:** Requires trial of preferred injectable agent (Avonex®, Betaseron®, Copaxone®, Rebif®) ▪ **Plegridy®:** Approved for diagnosis of relapsing MS

NITROFURAN DERIVATIVES

Preferred Agents	*Non-Preferred Agents*	*Prior Authorization/Class Criteria*
*nitrofurantoin **SUSPENSION** (generic for Furadantin)* *nitrofurantoin macrocrystals **CAPSULE** (generic for Macrodantin)* *nitrofurantoin monohydrate-macrocrystals **CAPSULE** (generic for Macrobid)*	*MACROBID **CAPSULE** (nitrofurantoin monohydrate macrocrystals)* *MACRODANTIN **CAPSULE** (nitrofurantoin macrocrystals)* *FURADANTIN **SUSPENSION** (nitrofurantoin)*	▪ *Non-preferred agents will be approved for patients who have failed a trial of **ONE** preferred agent*

NSAIDS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
COX-I SELECTIVE		▪ Non-preferred agents will be approved for patients who have failed no less than 30-day trial of TWO preferred agents Drug-specific criteria: ▪ **Arthrotec®:** Requires clinical reason why individual ingredients cannot be used ▪ **Duexis®/Vimovo®:** Requires clinical reason why individual agents cannot be used ▪ **Meclofenamate:** Approvable without trial of preferred agents for menorrhagia ▪ **Meloxicam suspension:** Approved for age ≤ 11 years
diclofenac sodium (generic for Voltaren)	diclofenac potassium (generic for Cataflam)	
diclofenac SR (generic for Voltaren-XR)	diflunisal (generic for Dolobid)	
ibuprofen OTC, Rx (generic for Advil, Motrin)	etodolac & sr (generic for Lodine/XL)	
indomethacin **CAPSULE** (generic for Indocin)	fenoprofen (generic for Nalfon)	
ketorolac (generic for Toradol)	flurbiprofen (generic for Ansaid)	
meloxicam **TABLET** (generic for Mobic)	ibuprofen OTC (generic for Advil, Motrin) **CAPSULE**	
nabumetone (generic for Relafen)	indomethacin ER (generic for Indocin)	
naproxen Rx, OTC (generic for Naprosyn)	INDOCIN **RECTAL, SUSPENSION**	
naproxen **SUSPENSION** (Naprosyn)	Ketoprofen & ER (generic for Orudis)	
sulindac (generic for Clinoril)	meclofenamate (generic for Meclomen)	
	mefenamic acid (generic for Ponstel)	
	meloxicam **SUSPENSION** (generic Mobic)	
	naproxen CR (generic for Naprelan)	
	naproxen enteric coated	
	naproxen sodium (generic for Anaprox)	
	oxaprozin (generic for Daypro)	
	piroxicam (generic for Feldene)	
	tolmetin (generic for Tolectin)	

NSAID (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
COX-I SELECTIVE (continued)		▪ Non-preferred agents will be approved for patients who have failed no less than 30-day trial of TWO preferred agents Drug-specific criteria: ▪ **Sprix®:** Approved for patients unable to tolerate, swallow OR absorb oral NSAIDs OR contraindication OR trial of TWO preferred oral NSAIDs ▪ **Tivorbex®:** Requires clinical reason why indomethacin capsules cannot be used ▪ **Zorvolex®:** Requires trial of oral diclofenac OR clinical reason why diclofenac potassium/sodium cannot be used ▪ **Celebrex®:** Rheumatoid Arthritis (RA) and Juvenile RA AND Osteoarthritis with at least ONE risk factor: Approvable with history of GI bleed/ulcer, active peptic ulcer disease, current daily/every other day use of oral corticosteroids, current use of anticoagulents, coronary artery or cerebral vascular disease requiring daily aspirin and a trial of meloxicam Approved for age ≥ 65 years and NOT taking another NSAID (other than daily aspirin)
	ALL BRAND NAME NSAIDs including: CAMBIA (diclofenac oral solution) DUEXIS (ibuprofen/famotidine) SPRIX (ketorolac)[QL] TIVORBEX (indomethacin) VIMOVO (naprosyn/esomeprazole) VIVLODEX (meloxican submicronized) ZIPSOR (diclofenac) ZORVOLEX (diclofenac)	
NSAID/GI PROTECTANT COMBINATIONS		
	diclofenac/misoprostol (generic for Arthrotec)	
COX-II SELECTIVE		
	celecoxib (generic for Celebrex)[CL]	

NSAIDS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	diclofenac (generic for Pennsaid Solution) FLECTOR **PATCH** (diclofenac) *PENNSAID* ***PACKET*** [NR]**, PUMP** (diclofenac) VOLTAREN **GEL** (diclofenac)	▪ **Flector®:** Approved for diagnosis of acute pain due to sprain/strain/contusion AND trial of oral diclofenac OR clinical reason patient cannot use oral dosage form ▪ **Pennsaid®:** Approved for osteoarthritis of the knees AND trial of oral diclofenac OR clinical reason patient cannot use oral dosage form ▪ **Pennsaid® Pump:** Requires clinical reason why 1.5% solution cannot be used ▪ **Voltaren®:** Approved for diagnosis of osteoarthritis AND trial of oral diclofenac OR clinical resaon patient cannot use oral dosage form

ONCOLOGY AGENTS, ORAL, BREAST CANCER

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
anastrozole (generic for Arimidex) cyclophosphamide (generic for Cytoxan) exemestane (generic for Aromasin) letrozole (generic for Femara) tamoxifen citrate	FARESTON (toremifene) capecitabine (generic for Xeloda) IBRANCE (palbociclib) *KISQALI (ribociclib)NR* *KISQALI FEMARA CO-PACKNR* TYKERB (lapatinib	▪ 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 Drug-specific critera ▪ **Anastrazole:** May be approved for malignant neoplasm of male breast (male breast cancer) ▪ **Fareston®:** 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

ONCOLOGY AGENTS, ORAL, HEMATOLOGIC

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ALKERAN (melphalan) GLEEVEC (imatinib) hydroxyurea (generic for Hydrea) IMBRUVICA (irutinib) JAKAFI (ruxolitinib) LEUKERAN (chlorambucil) MATULANE (procarbazine) mercaptopurine MYLERAN (busulfan) REVLIMID (lenalidomide) SPRYCEL (dasatinib) TASIGNA (nilotinib)	BOSULIF (bosutinib) FARYDAK (panobinostat) HYDREA (hydroxyurea) ICLUSIG (ponatinib) imatinib (generic for Gleevec) NINLARO (ixazomib) POMALYST (pomalidomide) PURIXAN (mercaptopurine) *RYDAPT (midostaurin)NR* TABLOID (thioguanine) THALOMID (thalidomide) tretinoin (generic for Vesanoid) VENCLEXTA (venetoclax) ZOLINZA (vorinostat) ZYDELIG (idelalisib)	▪ 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 Drug-specific critera ▪ **Hydrea®:** Requires clinical reason why generic cannot be used

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

ONCOLOGY AGENTS, ORAL, LUNG

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
GILOTRIF (afatinib) HYCAMTIN (topotecan) IRESSA (gefitinib) TARCEVA (erlotinib) XALKORI (crizotinib)	ALECENSA (alectinib) *ALUNBRIG (brigatinib)*[NR] TAGRISSO (osimertinib) ZYKADIA (ceritinib)	▪ 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

ONCOLOGY AGENTS, ORAL, OTHER

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CAPRELSA (vandetanib) GLEOSTINE (lomustine) temozolomide (generic for Temodar)	COMETRIQ (cabozantinib) HEXALEN (altretamine) LONSURF (trifluridine/tipiracil) LYNPARZA (olaparib) RUBRACA (rucaparib) STIVARGA (regorafenib) *ZEJULA (niraparib)*[NR]	▪ 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

ONCOLOGY AGENTS, ORAL, PROSTATE

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
bicalutamide (generic for Casodex) flutamide	CASODEX (bicalutamide) EMCYT (estramustine) nilutamide (generic for Nilandron) XTANDI (enzalutamide) ZYTIGA (abiraterone)	▪ 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 ▪ **Nilandron®:** Approved for males only for metastatic prostate cancer

ONCOLOGY AGENTS, ORAL, RENAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
AFINITOR (everolimus) INLYTA (axitinib) NEXAVAR (sorafenib) SUTENT (sunitinib) VOTRIENT (pazopanib)	AFINITOR **DISPERZ**[CL] CABOMETYX (cabozantinib) LENVIMA (lenvatinib)	▪ 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 Drug-specific critera ▪ **Afinitor Disperz®:** Requires clinical reason why Afinitor® cannot be used

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

ONCOLOGY AGENTS, ORAL, SKIN

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
COTELLIC (cobimetinib) ERIVEDGE (vismodegib) MEKINIST (trametinib) ODOMZO (sonidegib) TAFINLAR (dabrafenib) ZELBORAF (vemurafenib)		▪ 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

OPHTHALMICS, ANTIBIOTICS

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

OPHTHALMICS, ANTIBIOTIC-STEROID COMBINATIONS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
neomycin/polymyxin/dexamethasone (generic for Maxitrol) PRED-G **SUSPENSION, OINTMENT** (prednisolone/gentamicin) sulfacetamide/prednisolone TOBRADEX **SUSPENSION, OINTMENT** (tobramycin and dexamethasone)	BLEPHAMIDE (prednisolone and sulfacetamide) BLEPHAMIDE S.O.P. neomyxin/polymyxin/HC neomycin/bacitracin/poly/HC tobramycin/dexamethasone **SUSPENSION** (generic for Tobradex) 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

OPHTHALMICS, ALLERGIC CONJUNCTIVITIS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ALREX (loteprednol 0.2%) cromolyn (generic for Opticrom) ketotifen OTC (generic for Zaditor) PATADAY (olopatadine 0.2%) PAZEO (olopatadine)	ALOCRIL (nedocromil) ALOMIDE (lodoxamide) azelastine (generic for Optivar) BEPREVE (bepotastine besilate) EMADINE (emedastine) epinastine (generic for Elestat) LASTACAFT (alcaftadine) olopatadine 0.1% (generic for Patanol)	▪ Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents

OPHTHALMICS, ANTI-INFLAMMATORIES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CORTICOSTEROIDS		▪ Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents ▪ **NSAID class:** Non-preferred agents will be approved for patients whohave failed a trial of ONE preferred agent
dexamethasone (generic for Maxidex)	FML (fluorometholone 0.1% **SOLUT.**)	
DUREZOL (difluprednate)	FML FORTE (fluorometholone 0.25%)	
FLAREX (fluorometholone)	FML S.O.P. (fluorometholone 0.1%)	
fluorometholone 0.1% (generic for FML) **OINTMENT**)	LOTEMAX **OINTMENT, GEL** (loteprednol)	
LOTEMAX **SOLUTION** (loteprednol 0.5%)	prednisolone acetate 1% (gen. for Omnipred, Pred Forte)	
MAXIDEX (dexamethasone)	prednisolone sodium phosphate 1%	
PRED MILD (prednisolone 0.12%)	VEXOL (rimexolone)	
NSAID		
diclofenac (generic for Voltaren)	ACUVAIL (ketorolac 0.45%)	
flurbiprofen (generic for Ocufen)	*BROMSITE (bromfenac)*^{NR}	
	bromfenac 0.09% (generic for Bromday)	
	ILEVRO (nepafenac 0.3%)	
	ketorolac LS 0.4% (generic for Acular LS)	
	ketorolac 0.5% (generic for Acular)	
	NEVANAC (nepafenac)	
	PROLENSA (bromfenac 0.07%)	

OPHTHALMICS, IMMUNOMODULATORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
RESTASIS (cyclosporine)	XIIDRA (lifitegrast)	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent
	RESTASIS MULTIDOSE (cyclosporine)^{NR}	

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 group
Pilocarpine	PHOSPHOLINE IODIDE (echothiophate iodide)	
SYMPATHOMIMETICS		
Alphagan P (brimonidine 0.15%) brimonidine 0.2% (generic for Alphagan)	Alphagan P (brimonidine 0.1%) apraclonidine (generic for Iopidine) brimonidine P 0.15%	
BETA BLOCKERS		
carteolol (generic for Ocupress) levobunolol (generic for Betagan) metipranolol (generic for Optipranolol) timolol (generic for Timoptic)	betaxolol (generic for Betoptic) BETOPTIC S (betaxolol) ISTALOL (timolol) TIMOPTIC OCUDOSE TIMOPTIC XE (timolol gel forming solution)	
CARBONIC ANHYDRASE INHIBITORS		
AZOPT (brinzolamide) dorzolamide (generic for Trusopt)	TRUSOPT (dorzolamide)	
PROSTAGLANDIN ANALOGS		
latanoprost (generic for Xalatan) TRAVATAN Z (travoprost)	bimatoprost (generic for Lumigan) travoprost (generic for Travatan) XALATAN (latanoprost) ZIOPTAN (tafluprost)	
COMBINATION DRUGS		
COMBIGAN (brimonidine/timolol) dorzolamide/timolol (generic for Cosopt) SIMBRINZA (brinzolamide/brimonidine)	COSOPT (dorzolamide/timolol)	

OPIATE DEPENDENCE TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
SUBOXONE **FILM** (buprenorphine/ naloxone)[CL]	BUNAVAIL (buprenorphine/naloxone) buprenorphine **SL** buprenorphine/naloxone **SL** ZUBSOLV (buprenorphine/naloxone)	Buprenorphine PA Form Buprenorphine Informed Consent *Preferred:* ▪ *Diagnosis of Opioid Use Disorder, NOT approved for pain management* ▪ *Verification of "X" DEA license number of prescriber* ▪ *No concomitant opioids* *Non-preferred:* ▪ *Criteria same as preferred agent, PLUS* ▪ *Failed trial of preferred drug or patient-specific documentation of why preferred product not appropiriate for patient*

OPIATE-REVERSAL TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
naloxone **SYRINGE, VIAL** naltrexone **TABLET** NARCAN (naloxone) **SPRAY**		▪ Non-preferred agents will be approved with documentation of why preferred products are not appropriate for the patient

OTIC ANTIBIOTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CIPRODEX (ciprofloxacin/dexamethasone) ciprofloxacin neomycin/polymyxin/hydrocortisone (generic for Cortisporin) ofloxacin (generic for Floxin)	CIPRO HC (ciprofloxacin/ hydrocortisone) COLY-MYCIN S(neomycin/ hydrocortisone/colistin) CORTISPORIN-TC (neomycin/ hydrocortisone/colistin) OTOVEL (ciprofloxacin/fluocinolone)	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent

OTIC ANTI-INFECTIVES & ANESTHETICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
acetic acid (generic for Vosol)	acetic acid/aluminum (generic for Otic Domeboro) acetic acid/hydrocortisone (generic for Vosol HC)	▪ Non-preferred agents will be approved for patients who have failed a trial of BOTH preferred agents

PANCREATIC ENZYMES

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

PENICLLINS

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

PHOSPHATE BINDERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
calcium acetate **TABLET, CAPSULE** CALPHRON OTC (calcium acetate) PHOSLYRA (calcium acetate) RENAGEL (sevelamer HCl)	AURYXIA (ferric citrate) calcium acetate **CAPSULE** ELIPHOS (calcium acetate) FOSRENOL (lanthanum) PHOSLO (calcium acetate) sevelamer carbonate (generic for Renvela) VELPHORO (sucroferric oxyhydroxide)	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent 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 for Plavix) dipyridamole (generic for Persantine)	aspirin/dipyridamole (generic for Aggrenox) DURLAZA (aspirin) *EFFIENT (prasugrel)* ticlopidine (generic for Ticlid) *YOSPRALA (aspirin/omeprazole)* ZONTIVITY (vorapaxar)^{CL}	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent 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

PRENATAL VITAMINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
COMPLETE NATAL DHA *COMPLETENATE **CHEWABLE*** *CONCEPT DHA **CAPSULE*** *CONCEPT OB **CAPSULE*** *DOTHELLE DHA **SOFTGEL*** *EXPECTA PRENATAL COMBO PACK* *FOLIVANE-OB **CAPSULE*** *NIVA-PLUS **TABLET*** *OB COMPLETE/DHA **SOFTGEL*** *PNV PRENATAL PLUS MVI **TABLET*** *PNV-DHA* *PNV-SELECT **TABLET*** *PRENATAL **CHEWABLE*** *PRENATAL FORMULA **TABLET*** *PRENATAL VITAMIN PLUS LOW IRON* *PREPLUS CA-FE 27MG-FA 1MG* *RULAVITE DHA **SOFTGEL*** *TARON PRENATAL DHA **CAPSULE*** *TARON-C DHA **CAPSULE*** *TRUST NATAL DHA* *VIRT-ADVANCE **TABLET*** *VIRT-C DHA **SOFTGEL*** *VIRT-PN DHA **SOFTGEL*** *VIRT-VITE GT **TABLET*** *VOL-PLUS **TABLET*** *ZATEAN-PN DHA **CAPSULE***		*Additional covered agents can be looked up using the Drug Look-up Tool at:* https://druglookup.fhsc.com/druglookupweb/?client=nestate

PROTON PUMP INHIBITORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
omeprazole (generic for Prilosec) **RX** pantoprazole (generic for Protonix)	DEXILANT (dexlansoprazole) esomeprazole magnesium (generic for Nexium) esomeprazole strontium lansoprazole (generic for Prevacid) NEXIUM SUSPENSION (esomeprazole) omeprazole/sodium bicarbonate (generic for Zegerid RX) PREVACID Rx, SOLU-TAB (lansoprazole) PRILOSEC (omeprazole) rabeprazole (generic for Aciphex)	▪ Non-preferred agents will be approved for patients who have failed an 8-week trial of BOTH preferred agents ***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 if 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.*

PULMONARY ARTERIAL HYPERTENSION AGENTS, ORAL AND INHALED

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ADCIRCA (tadalafil) (for PAH only)[CL] LETAIRIS (ambrisentan) sildenafil (generic for Revatio) (for PAH only) TRACLEER (bosentan) TYVASO **INHALATION** (treprostinil) VENTAVIS **INHALATION** (iloprost)	ADEMPAS (riociguat) OPSUMIT (macitentan) ORENITRAM ER (treprostinil) REVATIO **SUSPENSION** (for PAH only) UPTRAVI (selexipag)	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent 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 ▪ **Revatio® suspension:** Requires clinical reason why sildenafil tablets cannot be used

SEDATIVE HYPNOTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BENZODIAZEPINES		▪ **Lunesta®/ Rozerem®/Zolpidem ER:** Requires a trial with generic zolpidem within the last 12 months AND Trial OR Clinical reason why zaleplon and preferred benzodiapines cannot be used ▪ **Ativan®/Klonopin®/Valium®:** Requires trial of generic Approvable for seizure diagnosis and documentation of seizure activity on generic therapy ▪ **Edluar®:** Requires a trial with generic zolpidem within the last 12 months AND Trial OR Clinical reason why zaleplon and preferred benzodiapines cannot be used Requires documentation of swallowing disorder ▪ **Flurazepam/Triazolam:** Requirestrial of BOTH preferred benzodiazepines ▪ **Hetlioz®:** Requires trial with generic zolpidem within last 12 months AND clinical reason why zaleplon AND preferred benzodiazepines cannot be used ▪ **Silenor®:** Requires clinical reason why generic doxepin cannot be used ▪ **Temazepam 7.5mg/22.5mg:** Requires clinical reason why 15mg/30mg cannot be used ▪ **Zolpidem/Zolpidem ER:** Maximum daily dose for females: Zolpidem 5mg; Zolpidem ER® 6.25mg ▪ **Zolpidem SL:** Requires clinical reason why half of zolpidem tablet cannot be used ▪ **Zolpimist®:** Requires documentation of swallowing disorder
temazepam 15mg, 30mg (generic for Restoril)	estazolam (generic for ProSom) flurazepam (generic for Dalmane) temazepam 7.5mg, 22.5mg triazolam (generic for Halcion)	
OTHERS		
zaleplon (generic for Sonata) zolpidem (generic for Ambien)	BELSOMRA (suvorexant) EDLUAR (zolpidem sublingual) eszopiclone (generic for Lunesta) HETLIOZ (tasimelteon)CL ROZEREM (ramelteon) SILENOR (doxepin) zolpidem ER (generic for Ambien CR) zolpidem SL (generic for Intermezzo) ZOLPIMIST (zolpidem oral spray)	

SINUS NODE INHIBITORS

Preferred Agents	*Non-Preferred Agents*	*Prior Authorization/Class Criteria*
	CORLANOR (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 for Lioresal) chlorzoxazone (generic for Parafon) cyclobenzaprine (generic for Flexeril) methocarbamol (generic for Robaxin) tizanidine **TABLET** (generic for Zanaflex)	AMRIX (cyclobenzaprine)CL carisoprodol (generic for Soma) carisoprodol compound dantrolene (generic for Dantrium) FEXMID (cyclobenzaprine) LORZONE (chlorzoxazone)CL metaxalone (generic for Skelaxin) orphenadrine ER SOMA (carisoprodol) CL 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 Drug-specific criteria: ▪ **Amrix®/Fexmid®:** Requires clinical reason why IR cyclobenzaprine 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

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 agents
hydrocortisone **CREAM , OINTMENT** (generic for Cortaid)	alclometasone dipropionate (generic for Aclovate)	
hydrocortisone **OTC LOTION**	CAPEX **SHAMPOO** (fluocinolone)	
hydrocortisone **RX LOTION**	DESONATE (desonide **GEL**)	
hydrocortisone/aloe **OINTMENT, CREAM**	desonide **LOTION** (generic for Desowen)	
	desonide **CREAM, OINTMENT** (generic for former products Desowen, Tridesilon)	
	fluocinolone 0.01% **OIL** (generic for DERMA-SMOOTHE-FS)	
	MICORT-HC (hydrocortisone)[NR]	
	TEXACORT (hydrocortisone)	

STEROIDS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
MEDIUM POTENCY		▪ Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents
fluticasone propionate **CREAM, OINTMENT** (generic for Cutivate) mometasone furoate **CREAM, OINTMENT, SOLUTION** (generic for Elocon)	betamethasone valerate (generic for Luxiq) clocortolone (generic for Cloderm) fluocinolone acetonide (generic for Synalar) flurandrenolide (generic for Cordran) fluticasone propionate **LOTION** (generic for Cutivate) hydrocortisone butyrate (generic for Locoid) hydrocortisone butyrate/emoll (generic for Locoid Lipocream) hydrocortisone valerate (generic for Westcort) PANDEL (hydrocortisone probutate 0.1%) prednicarbate (generic for Dermatop)	
HIGH POTENCY		
betamethasone valerate (generic for Beta-Val) triamcinolone acetonide **OINTMENT, CREAM** (generic for Kenalog) triamcinolone **LOTION**	amcinonide **CREAM, LOTION, OINTMENT** betamethasone dipropionate (generic for Diprolene) betamethasone dipro/prop gly (augmented) DERMACINRX SILAPAK (triamcinolone/dimethicone) DERMACINRX SILAZONE (triamcinolone)[NR] DERMASORB TA (triamcinolone)[NR] desoximetasone (generic for Topicort) diflorasone diacetate fluocinonide **SOLUTION** fluocinonide **CREAM, GEL, OINTMENT** fluocinonide emollient HALOG (halcinonide) KENALOG AEROSOL (triamcinolone) SERNIVO (betamethasone dipropionate) triamcinolone **SPRAY** (generic for Kenalog spray) TRIANEX **OINTMENT** (triamcinolone) VANOS (fluocinonide)	

STEROIDS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
VERY HIGH POTENCY		▪ Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents
clobetasol emollient (generic for Temovate-E) clobetasol propionate (generic for Temovate) halobetasol propionate (generic for Ultravate)	APEXICON-E (diflorasone) clobetasol **SHAMPOO, LOTION** clobetasol propionate **FOAM, SPRAY** CLOBEX (clobetasol) OLUX-E /OLUX/OLUX-E CP (clobetasol)	

STIMULANTS AND RELATED ADHD DRUGS

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 the same group Drug-specific criteria: ▪ **Procentra®:** May be approved with documentation of swallowing disorder ▪ **Zenzedi®:** Requires clinical reason generic dextroamphetamine IR cannot be used
Amphetamine type		
ADDERALL XR (amphetamine salt combo) amphetamine salt combination IR VYVANSE (lisdexamfetamine)	ADZENYS XR (amphetamine) amphetamine salt combination ER (generic for Adderall XR) dextroamphetamine (generic for Dexedrine) dextroamphetamine **SOLUTION** (generic for Procentra) dextroamphetamine ER (generic for Dexedrine ER) DYANAVEL XR (amphetamine) *MYDAYIS (amphetamine salt combo)*^{NR,QL} EVEKEO (amphetamine sulfate) methamphetamine (generic for Desoxyn) ZENZEDI (dextroamphetamine)	

STIMULANTS AND RELATED ADHD DRUGS (Continued)

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 Drug-specific criteria: ▪ **Daytrana®:** May be approved in history of substance abuse by parent/caregiver or patient May be approved with documentation of difficulty swallowing
FOCALIN (dexmethylphenidate) FOCALIN XR (dexmethylphenidate) --- METHYLIN **CHEWABLE** (methylphenidate) methylphenidate (generic for Ritalin) --- methylphenidate ER 10mg, 20mg (generic for Ritalin SR, Metadate ER) --- *QUILLICHEW ER (methylphenidate)* QUILLIVANT XR (methylphenidate suspension)	APTENSIO XR[NR] (methylphenidate) dexmethylphenidate (generic for Focalin) dexmethylphenidate XR (generic for Focalin XR) --- APTENSIO XR (methylphenidate) methylphenidate **CHEWABLE, SOLUTION** (generic for Methylin) RITALIN (methylphenidate) --- DAYTRANA (methylphenidate) methylphenidate 30/70 (generic for Metadate CD) methylphenidate 50/50 (generic for RITALIN LA) methylphenidate ER (generic for Ritalin SR) --- CONCERTA (methylphenidate ER) 18mg, 27mg, 36mg, 54mg methylphenidate ER 18mg, 27mg, 36mg, 54mg (generic Concerta)	
MISCELLANEOUS		
guanfacine ER (generic for Intuniv) STRATTERA (atomoxetine)	*Atomoxetine (generic for Strattera)[NR]* clonidine ER (generic for Kapvay)[CL]	**Note: generic IR guanfacine and Clonidine ER/Guanfacine IR are available without prior authorization**
ANALEPTICS		
	modafanil (generic for Provigil)[CL] armodafinil (generic for Nuvigil)[CL]	▪ **Armodafinil:** Requires trial of Provigil Approved ONLY for: Sleep Apnea, Narcolepsy, Shift Work Sleep disorder ▪ **Modafinil:** Approved ONLY for: Sleep Apnea, Narcolepsy, Shift Work Sleep disorder

TETRACYCLINES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
doxycycline hyclate IR (generic for Vibramycin) doxycycline monohydrate **50MG, 100MG CAPSULE** minocycline HCl **CAPSULE** (generic for Minocin, Dynacin)	*ACTICLATE (doxycycline hyclate)* NR demeclocycline CL DORYX (doxycycline pelletized) doxycycline hyclate DR (generic for Vibratabs) doxycycline monohydrate **TABLET, SUSPENSION, 40mg, 75MG and 150MG CAPSULES** (Monodox, Adoxa) doxycycline monohydrate (generic for Oracea) minocycline HCl **TABLET** (generic for Dynacin, Murac) minocycline HCl ER (generic for Solodyn) SOLODYN (minocycline HCl) tetracycline HCl (generic for Sumycin) VIBRAMYCIN **SUSPENSION** (doxycycline)	▪ Non-preferred agents will be approved for patients who have failed an 3-day trial of TWO preferred agents 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 ▪ **Vibramycin® suspension:** May be approved with documented swallowing difficulty

THYROID HORMONES

Preferred Agents	*Non-Preferred Agents*	*Prior Authorization/Class Criteria*
*levothyroxine **TABLET** (generic for Synthroid)* *liothyronine **TABLET** (generic for Cytomel)* *thyroid, pork **TABLET***	*CYTOMEL **TABLET** (liothyronine)* *SYNTHROID **TABLET** (levothyroxine)* *THYROLAR **TABLET** (liotrix)* *TIROSINT **TABLET** (levothyroxine)*	▪ *Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent*

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 Drug-specific criteria: ▪ **Asacol HD®/Delzicol DR®/ Lialda®/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) balsalazide (generic for Colazal) sulfasalazine / DR (generic for Azulfidine)	DELZICOL DR (mesalamine) DIPENTUM (olsalazine) GIAZO (balsalazide) LIALDA (mesalamine) mesalamine (generic for Asacol HD) PENTASA (mesalamine) UCERIS (budesonide)	
RECTAL		
CANASA (mesalamine)	mesalamine sf ROWASA (mesalamine)	

VASODILATORS, CORONARY

Preferred Agents	*Non-Preferred Agents*	*Prior Authorization/Class Criteria*
*isosorbide dinitrate **TABLET*** *isosorbide dinitrate ER **TABLET*** *isosorbide mononitrate **TABLET*** *isosorbide mononitrate SR **TABLET*** *nitroglycerin **SUBLINGUAL, TRANSDERMAL*** *nitroglycerin ER **TABLET*** *NITROSTAT **SUBLINGUAL** (nitroglycerin)*	*BIDIL (isosorbide dinitrate/hydralazine)* *DILATRATE-SR (isosorbide dinitrate)* *GONITRO (nitroglycerin)* *ISORDIL (isosorbide dinitrate)* *NITRO-BID **OINTMENT** (nitroglycerin)* *NITRO-DUR (nitroglycerin)* *nitroglycerin **TRANSLINGUAL** (generic for Nitrolingual)* *NITROMIST (nitroglycerin)*	▪ *Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent*