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 December 1, 2018 *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 criteria include:

- Adverse reaction to preferred drugs
- Allergy to preferred drugs
- Contraindication to preferred drugs
- Documentation of inability to swallow solid dosage forms

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

- Buprenorphine Products PA Form
- Buprenorphine Products Informed Consent
- 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

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

ACNE AGENTS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
AZELEX (azelaic acid) benzoyl peroxide **GEL, WASH, LOTION** OTC clindamycin/benzoyl peroxide (generic for Duac) clindamcyin phosphate **PLEDGET, SOLUTION** DIFFERIN **LOTION, CREAM, GEL RX** (adapalene) erythromycin **SOLUTION** PANOXYL 10% ACNE FOAMING WASH (benzoyl peroxide) OTC RETIN-A **GEL, CREAM**[AL]	adapalene **CREAM, GEL, GEL W/PUMP** (generic Differin) adapalene **SOLUTION** adapalene/benzoyl peroxide (generic EPIDUO) *ALTRENO (tretinoin)*[NR, AL] ATRALIN (tretinoin) AVAR (sulfacetamine sodium/sulfur) AVITA (tretinoin) BENZACLIN **GEL** (clindamycin/ benzoyl peroxide) BENZACLIN **W/PUMP** (clindamycin/benzoyl peroxide) BENZAPRO (benzoyl peroxide) benzoxyl peroxide **CLEANSER**, **CLEANSING BAR**, OTC benzoyl peroxide **FOAM** (generic for Benzepro Foam) benzoyl peroxide **GEL** Rx clindamycin **GEL, FOAM , LOTION** clindamycin/benzoyl peroxide (generic for Acanya) clindamycin/benzoyl peroxide (generic for Benzaclin) clindamycin/tretinoin (generic for Veltin & Ziana) dapsone (generic for ACZONE) DIFFERIN **GEL OTC** EPIDUO FORTE **GEL W/PUMP** erythromycin **GEL** erythromycin-benzoyl peroxide (generic for Benzamycin) EVOCLIN (clindamycin) FABIOR (tazarotene foam) NEUAC (clindamycin/benzoyl peroxide) ONEXTON (clindamycin/benzoyl peroxide) OVACE PLUS (sulfacetamind sodium) *PLIXDA (adapalene) SWAB*[NR] 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

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 with the same group 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)	memantine ER (generic for Namenda XR) memantine soln (generic for Namenda) NAMENDA (memantine) NAMENDA **SOLUTION** NAMZARIC (memantine/donepezil)	

ANALGESICS, OPIOID LONG-ACTING

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BUTRANS (buprenorphine, transdermal)[QL] EMBEDA (morphine sulfate/ naltrexone) 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)[QL] DURAGESIC MATRIX (fentanyl) 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) 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 with failure on, or intolerance to TWO preferred agents 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, OPIOID SHORT-ACTING[QL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ORAL		▪ Non-preferred agents will be approved for patients who have failed THREE preferred agents within the last 12 months
acetaminophen/codeine **ELIXIR, TABLET**	butalbital/caffeine/APAP w/codeine	▪ Note: for short acting opiate tablets and capsules there is a maximum quantity limit of #150 per 30 days.
codeine **ORAL**	butalbital compound w/codeine (butalbital/ASA/caffeine/codeine)	▪ Beginning Oct. 11, 2018: Opiate limits for opiate naïve patients will consist of -prescriptions limited to a 7 day supply, AND -initial opiate prescription fill limited to maximum of 50 Morphine Milligram Equivalents (MME) per day These limits may only be exceeded with patient specific documentation of medical necessity, with examples such as, cancer diagnosis, end-of-life care, palliative care, Sickle Cell Anemia, or prescriber attestation that patient is not recently opiate naive
hydrocodone/APAP **SOLUTION, TABLET**	carisoprodol compound-codeine (carisoprodol/ASA/codeine)	
hydrocodone/ibuprofen	dihydrocodeine/acetamin/caffeine	
hydromorphone **TABLET**	dihydrocodeine/aspirin/caffeine (generic for Synalgos DC)	
morphine **ORAL**	FIORINAL/CODEINE (butalbital/ ASA/codeine/caffeine)	
oxycodone **TABLET, SOLUTION**	hydromorphone **ORAL LIQUID, TABLET, SUPPOSITORY** (generic for Dilaudid)	
oxycodone/APAP	IBUDONE (hydrocodone/ibuprofen)	
tramadol	levorphanol	
	meperidine (generic for Demerol)	
	morphine **SUPPOSITORIES**	
	NALOCET (oxycodone/APAP)[NR]	
	NUCYNTA (tapentadol)[CL]	
	OXAYDO (oxycodone)[CL]	
	oxycodone **CAPSULE**	
	oxycodone/acetaminophen **SOLUTION**	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
	oxycodone/aspirin	
	oxycodone **CONCENTRATE**	
	oxycodone/ibuprofen (generic for Combunox)	
	oxymorphone (generic for Opana)	
	pentazocine/naloxone	
	PANLOR (dihydrocodeine/ acetaminophen/caffeine) [NR]	
	PRIMLEV (oxycodone/acetaminophen)	
	REPREXAIN (hydrocodone/ibuprofen)	
	ROXICODONE **TABLET** (oxycodone)	
	ROXYBOND (oxycodone)[NR]	
	tramadol/APAP –generic for Ultracet	
	XARTEMIS XR (oxycodone/ acetaminophen)	
	ZAMICET (hydrocodone/ acetaminophen)	

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

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
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) NATESTO (testosterone) testosterone gel **PACKET, PUMP** (generic for Androgel) testosterone (generic for Axiron) 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 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) 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) EDARBYCLOR (azilsartan/ chlorthalidone) olmesartan/HCTZ (generic for Benicar-HCT)	
ANGIOTENSIN MODULATOR/ CALCIUM CHANNEL BLOCKER COMBINATIONS		▪ **Angiotensin Modulator/Calcium Channel Blocker Combinations**: Combination agents may be approved if there has been a trial and failure of preferred agent
benazepril/amlodipine (generic for Lotrel)	amlodipine/olmesartan/HCTZ (generic for Tribenzor) PRESTALIA (perindopril/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		▪ **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
	TEKTURNA (aliskiren)	
DIRECT RENIN INHIBITOR COMBINATIONS		
	TEKTURNA/HCT (aliskiren/HCTZ)	
NEPRILYSIN INHIBITOR COMBINATION		
ENTRESTO (sacubitril/valsartan)CL		
ANGIOTENSIN RECEPTOR BLOCKER/BETA-BLOCKER COMBINATIONS		
	BYVALSON (nevibolol/valsartan)	

ANTHELMINITICS

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

ANTI-ALLERGENS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	ORALAIR (sweet vernal/orchard/rye/ timothy/kentucky blue grass mixed pollen allergen extract)	Class Criteria: ▪ Approved for immunotherapy for the treatment of grass pollen-induced allergic rhinitis with or without conjunctivitis. ▪ Patient has had treatment failure with or contraindication to: antihistamines AND montelukast ▪ Clinical reason as to why allergy shots cannot be used. Drug-specific criteria: **ORALAIR** ▪ Confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for Sweet Vernal, Orchard, Perennial Rye, Timothy, and Kentucky Blue Grass Mixed Pollens. ▪ For use in patients 10 through 65 years of age.

ANTIBIOTICS, GASTROINTESTINAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
metronidazole **TABLET** neomycin vancomycin **COMPOUNDED ORAL SOLUTION**	ALINIA (nitazoxanide) **SUSPENSION** DIFICID (fidaxomicin) *FIRVANQ (vancomycin) **SOLUTION**NR* FLAGYL ER (metronidazole) metronidazole **CAPSULE** paromomycin SOLOSEC (secnidazole) 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 is required for a diagnosis of C. difficile diarrhea (pseudomembranous colitis) ▪ **Firvanq:** Requires patient specific documentation of why the compounded product is not appropriate for patient ▪ **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	ANon-Preferred Agents	Prior Authorization/Class Criteria
BETHKIS (tobramycin)[CL] KITABIS PAK (tobramycin)[CL] TOBI-PODHALER (tobramycin)[CL,QL]	*ARIKAYCE (amikacin liposomal inh susp)[NR]* 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: ▪ ***Arikayce:*** *Requires diagnosis of refractory MAC lung disease defined as patients who did not achieve negative sputum cultures after a minimum of 6 consecutive months of a multidrug background regimen therapy* ▪ **Cayston®:** Trial of tobramycin via nebulizer and demonstration of TOBI® compliance required ▪ **Tobi Podhaler®:** Requires trial of tobramycin via nebulizer or documentation why nebulized tobramycin cannot be used

ANTIBIOTICS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
bacitracin **OINTMENT** bacitracin/polymyxin (generic for Polysporin) mupirocin **OINTMENT** (generic for Bactroban) neomycin/polymyxin/bacitracin (generic for Neosporin, Triple AB) neomycin/polymyxin/pramoxine	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 ▪ SYNDROS – documentation of inability to swallow solid dosage forms. Drug-specific criteria: ▪ **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®/Bonjesta:** Approved only for treatment of nausea and vomiting of pregnancy ▪ **Metozolv ODT®:** Documentation of inability to swallow or Clinical reason oral liquid cannot be used ▪ **Sancuso®/Zuplenz®:** Documentation of oral dosage form intolerance
dronabinol (generic for Marinol)[AL]	CESAMET (nabilone) SYNDROS (dronabinol)[AL, CL]	
5HT3 RECEPTOR BLOCKERS		
ondansetron (generic for Zofran)[QL] ondansetron ODT (generic for Zofran)[QL]	ANZEMET (dolasetron) granisetron (generic for Kytril) SANCUSO (granisetron)[CL] ZUPLENZ (ondansetron)	
NK-1 RECEPTOR ANTAGONIST		
	aprepitant (generic for Emend) [QL,CL] AKYNZEO (netupitant/palonosetron)[CL] VARUBI (rolapitant) **TABLET**[CL]	
TRADITIONAL ANTIEMETICS		
DICLEGIS (doxylamine/pyridoxine)[CL,QL] 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)	BONJESTA (doxylamine/pyridoxine)[CL,QL] COMPRO (prochlorperazine rectal) metoclopramide ODT(generic for Metozolv ODT) prochlorperazine **SUPPOSITORIES** (generic for Compazine) promethazine **SUPPOSITORIES** 50mg scopolamine transdermal 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 a trial of 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 ▪ **Onmel®:** Requires trial and failure or contraindication to terbinafine ▪ **Sporanox®/Itraconazole:** Approved for diagnosis of Aspergillosis, Blastomycosis, Histoplasmosis, Onychomycosis due to terbinafine-resistant dermatophytes, Oropharyngeal/ esophageal candidiasis refractory to fluconazole ▪ **Sporanox®:** Requires trial and failure of generic itraconazole ▪ **Sporanox® Liquid:** Clinical reason 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 **CREAM** (generic for Lotrimin) RX, OTC ketoconazole **CREAM, SHAMPOO** (generic for Nizoral) LAMISIL AT **CREAM** (terbinafine) OTC miconazole **OTC CREAM, POWDER** nystatin selenium sulfide 2.5% terbinafine OTC (generic for Lamisil AT) tolnaftate AERO POWDER, CREAM, POWDER,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) KERIDYN (tavaborole) ketoconazole **FOAM** (generic for Ketodan) LAMISIL AT **GEL, SPRAY** (terbinafine) OTC LOPROX (ciclopirox) **SUSPENSION, SHAMPOO, CREAM** LOTRIMIN AF **CREAM** OTC (clotrimazole) LOTRIMIN ULTRA (bufenafine) luliconazole (generic for Luzu) MENTAX (butenafine) miconazole OTC **OINTMENT, SPRAY** *miconazole/zinc oxide/petrolatum (generic for Vusion)* naftifine (generic for Naftin) oxiconazole (generic for Oxistat) selenium sulfide 2.25% TINACTIN AERO POWDER OTC tolnaftate **SPRAY,** OTC	
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) *fexofenadine 180mg (generic for Allegra 180mg)*[QL] levocetirzine (generic for Xyzal) **SOLUTION** loratadine **CHEWABLE,**	▪ 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) colchicine **CAPSULE** (generic for Mitigare) probenecid probenecid/colchicine (generic for Col-Probenecid)	colchicine **TABLET** (generic for Colcrys)[CL] *DUZALLO (allopurinol/lesinurad)*[NR] 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
	AJOVY (fremanezumab-vfrm)[NR, QL, CL] *AIMOVIG AUTOINJECTOR (erenumab-aooe)*[NR, QL,CL] CAFERGOT (ergotamine/caffeine) CAMBIA (diclofenac potassium) dihydroergotamine mesylate **NASAL** *EMGALITY (galcanezumab-gnlm)*[NR,CL] 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 ▪ Aimovig, Ajovy, and Emgality: Require ≥ 4 migraines per month for ≥ 3 months and has tried and failed a ≥ 1 month trial of two medications listed in the 2012 American Academy of Neurology/American Headache Society guidelines (examples include: antidepressants (amitriptyline, venlafaxine), Beta blockers (propranolol, metroprolol, timolol, atenolol), anti-epileptics (valproate, topiramate), ACE/ARB (lisinopril, candesartan)

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) eletriptan (generic Relpax) 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** sumatriptan **KIT (mfr SUN)**	IMITREX (sumatriptan) **INJECTION** SUMAVEL DOSEPRO (sumatriptan) ZEMBRACE SYMTOUCH (sumatriptan)	

ANTIPARASITICS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
NATROBA (spinosad) permethrin 1% OTC (generic for Nix) permethrin 5% RX (generic for Elimite) pyrethrin/piperonyl butoxide (generic for RID, A-200) SKLICE (ivermectin)	*CROTAN (crotamiton) LOTION*[NR] EURAX (crotamiton) **CREAM, LOTION** lindane malathion (generic for Ovide) spinosad (generic for Natroba) *VANALICE (piperonyl butoxide/pyrethrins)*[NR]	▪ 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) 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)	rasagiline[QL] (generic for Azilect) selegiline **CAPSULE** (gen. for Eldepryl) XADAGO (safinamide) 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) *GOCOVRI (amantadine)*[NR, QL] *OSMOLEX ER (amantadine)*[NR, QL] RYTARY (carbidopa/levodopa) STALEVO (levodopa/carbidopa/entacapone)	

ANTIPSORIATICS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
acitretin (generic for Soriatane)	methoxsalen (generic for Oxsoralen-Ultra) OXSORALEN-ULTRA (methoxsalen) SORIATANE (acitretin)	▪ 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 within the same group Drug-specific criteria: ▪ **Sitavig®:** Approved for recurrent herpes labialis (cold sores) in immunocompetent adults ▪ **Xofluza:** Requires clinical, patient specific reason that a preferred agent cannot be used
acyclovir (generic for Zovirax) famciclovir (generic for Famvir) valacyclovir (generic for Valtrex)	SITAVIG (acyclovir buccal)	
ANTI-INFLUENZA DRUGS		
RELENZA (zanamivir)[QL] TAMIFLU (oseltamivir) [QL]	oseltamivir (generic for Tamiflu)[QL] rimantadine (generic for Flumadine) *XOFLUZA (baloxavir marboxil)*[NR,QL,AL]	

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®

BETA BLOCKERS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BETA BLOCKERS		▪ Non-preferred agents will be approved for patients who have failed TWO diagnosis-appropriate preferred agents Drug-specific criteria: ▪ **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) atenolol/chlorthalidone(generic for Tenoretic) bisoprolol (generic for Zebeta) bisoprolol/HCTZ (generic for Ziac) metoprolol (generic for Lopressor) metoprolol XL (generic for Toprol XL) propranolol (generic for Inderal) propranolol extended release (generic for Inderal LA)	acebutolol (generic for Sectral) betaxolol (generic for Kerlone) BYSTOLIC (nebivolol) DUTOPROL (metoprolol XR and HCTZ) HEMANGEOL (propranolol) oral solution INDERAL XL (propranolol) INNOPRAN XL (propranolol) *KAPSPARGO SPRINKLE (metoprolol ER)NR* 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)	
BETA- AND ALPHA-BLOCKERS		
carvedilol (generic for Coreg) labetalol (generic for Trandate)	carvedilol ER (generic for Coreg CR)	
ANTIARRHYTHMIC		
sotalol (generic for Betapace)	SOTYLIZE (sotalol)	

BILE SALTS

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

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) flavoxate 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 D[QL] 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] TYMLOS (abaloparatide)	

BPH (BENIGN PROSTATIC HYPERPLASIA TREATMENTS)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ALPHA BLOCKERS		▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within the same 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)	

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: ▪ **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		
SEREVENT (salmeterol)	ARCAPTA NEOHALER (indacaterol) STRIVERDI RESPIMAT (olodaterol)	
INHALATION SOLUTION		
albuterol (2.5mg/3ml premix or 2.5mg/0.5ml) albuterol 100 mg/20 mL albuterol low dose (0.63mg/3ml & 1.25mg/3ml)	BROVANA (arformoterol) levalbuterol (generic for Xopenex) PERFOROMIST (formoterol)	
ORAL		
albuterol **SYRUP** terbutaline (generic for Brethine)	albuterol **TABLET** albuterol ER (generic for Vospire ER) 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: ▪ **Nifedipine:** May be approved without trial for diagnosis of Preterm Labor or Pregnancy Induced Hypertension (PIH) ▪ **Nimodipine:** Covered without trial for diagnosis of subarachnoid hemorrhage
Dihydropyridines		
	isradipine (generic for Dynacirc) nicardipine (generic for Cardene) nifedipine (generic for Procardia) 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 within the same group Drug-specific criteria: ▪ **Suprax® Tablet / Suspension:** Requires clinical reason why capsule or generic suspension cannot be used
amoxicillin/clavulanate **TABLETS, SUSPENSION**	amoxicillin/clavulanate, CHEWABLE 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** **DAXBIA (cephalexin)**	
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) SUPRAX **CAPSULE**, **CHEWABLE TABLET** (cefixime)	cefixime **SUSPENSION** (generic for Suprax) cefpodoxime (generic for Vantin) SUPRAX **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 OR Patient specific documentation of inability to use traditional inhaler device. 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) BEVESPI AEROSPHERE (glycopyrolate/formoterol) SPIRIVA (tiotropium)	ANORO ELLIPTA (umeclidinium/vilanterol) COMBIVENT RESPIMAT (albuterol/ ipratropium) 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)	*LONHALA (glycopyrrolate inhalation soln)*[NR] *YUPELRI (revefenacin)*[NR]	
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** *NIVESTYM (filgrastim-aafi)* ***SYR***[NR] 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 reviewed 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

COUGH AND COLD, OPIATE COMBINATION

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
guaifenesin/codeine **SOLUTION** promethazine/codeine **SOLUTION**	hydrocodone/homatropine LORTUSS EX (pseudoephedrine/ codeine/guaifenesin promethazine/phenylephrine/codeine PROMETHAZINE VC-CODEINE (promethazine/phenylephrine/ codeine) TUSNEL C (pseudoephedrine/ codeine/guaifenesin) VIRTUSSIN DAC (pseudoephedrine/ codeine/guaifenesin)	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent

CYSTIC FIBROSIS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	KALYDECO **PACKET, TABLET** (ivacaftor)QL, AL ORKAMBI (lumacaftor/ivacaftor) PACKET, TABLETQL, AL SYMDEKO (tezacaftor/ivacaftor)QL, AL	Drug-specific criteria: ▪ **Kalydeco®:** Diagnosis of CF and documentation of the drug-specific, FDA-approved mutation of CFTR gene • Minimum age: 2 years ▪ **Orkambi®:** Diagnosis of CF and documentation of presence of two copies of the F580del mutation (homozygous) of CFTR gene • Minimum age: 6 years for tablet • *Minimum age: 2 years for packet* ▪ **Symdeko:** Diagnosis of CF and documentation of the drug specific, FDA approved mutation of CFTR gene**.** • Minimum age: 12 years

CYTOKINE & CAM ANTAGONISTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
COSENTYX (secukinumab)[CL] ENBREL (etanercept)[QL] HUMIRA (adalimumab)[QL]	ACTEMRA (tocilizumab) **SUB-Q** ARCALYST (nilonacept) CIMZIA (certolizumab pegol)[QL] *ILUMYA (tildrakizumab) SUB-Q*[NR] KEVZARA (sarilumab) **SUB-Q, PEN, SYRINGE** KINERET (anakinra) *OLUMIANT (baricitinib)* ***ORAL***[NR,QL] ORENCIA (abatacept**) SUB-Q** OTEZLA (apremilast) **ORAL** [QL] SILIQ (brodalumab) SIMPONI (golimumab) STELARA (ustekinumab) **SUB-Q** TALTZ (ixekizumab)[AL] TREMFYA (guselkumab)[QL] XELJANZ (tofacitinib) **ORAL**[QL] XELJANZ XR (tofacitinib) **ORAL**[QL]	▪ Non-preferred agents will be approved for FDA-approved indications in patients who have failed a trial of ONE preferred agent Drug-specific criteria: ▪ **Cosentyx**: Requires trial of Humira

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** spironolactone **TABLET** torsemide **TABLET**	ALDACTONE TABLET (spironolactone) CAROSPIR (spironolactone) **SUSPENSION** DIURIL **TABLET** (chlorothiazide) DYRENIUM **TABLET** (triamterene) eplerenone **TABLET** (generic for INSPRA) ethacrynic acid **CAPSULE** (generic for EDECRIN) LASIX **TABLET** (furosemide) methyclothiazide **TABLET** MICROZIDE (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)	

ENZYME REPLACEMENT, GAUCHERS DISEASE

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
No preferred agents	CERDELGA (eliglustat) miglustat (generic Zavesca)	▪ Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication

EPINEPHRINE, SELF-INJECTED

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
epinephrine (generic for Epipen/ Epipen Jr.)	epinephrine (generic for Adrenaclick) EPIPEN EPIPEN JR.	▪ Non-preferred agents require clinical documentation why the preferred product is not appropriate Brand name product may be authorized in event of documented national shortage of generic product.

ERYTHROPOIESIS STIMULATING PROTEINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
EPOGEN (rHuEPO) PROCRIT (rHuEPO)	*RETACRIT (EPOETIN ALFA-EPBX)*[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)	BAXDELA (delafloxacin) 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: ▪ **Baxdela:** Coverable with documented intolerance or failure of preferred MRSA agents (clindamycin, doxycycline, linezolid, sulfamethoxazole/trimethoprim) ▪ **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] MOVANTIK (naloxegol oxalate)[QL]	alosetron (generic for Lotronex) RELISTOR (methylnaltrexone) **TABLET**[QL] SYMPROIC (naldemedine) TRULANCE (plecanatide)[QL] VIBERZI (eluxodoline)	▪ Non-preferred agents will be approved for patients who have failed a 30-day trial of ONE preferred agent Drug-specific criteria: ▪ **Lotronex®:** Covered for diagnosis of IBS Diarrhea Predominant type with trial and failure of loperamide AND diphenoxylate ▪ **Relistor®**: Covered for diagnosis of opioid-induced constipation in adults with chronic, non-cancer pain after trial of at least TWO OTC laxatives (senna, bisacodyl, etc.) and failure of Movantik ▪ **Symproic**: Covered for diagnosis of opioid-induced constipation in adult patients with chronic non-cancer pain after trial on at least TWO OTC laxatives and failure of Movantik ▪ **Trulance®:** Covered for diagnosis of either chronic idiopathic constipation or IBS with constipation after trial of at least TWO OTC laxatives (senna, bisacodyl, etc.) ▪ **Viberzi®:** Covered for diagnosis of IBS Diarrhea Predominant type with trial and failure of loperamide AND diphenoxylate

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 within the same group 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)	
FLOVENT HFA (fluticasone)	ALVESCO (ciclesonide)[AL,CL]	
PULMICORT FLEXHALER (budesonide)	ARMONAIR RESPICLICK (fluticasone)[AL]	
	ARNUITY ELLIPTA (fluticasone)	
	ASMANEX HFA (mometasone)[AL,QL]	
	FLOVENT DISKUS (fluticasone)	
	QVAR (beclomethasone)	
	QVAR Redihaler (beclomethasone)[NR]	
GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS		
ADVAIR DISKUS (fluticasone/ salmeterol)[QL]	ADVAIR HFA (fluticasone/salmeterol)[QL]	
DULERA (mometasone/formoterol)	AIRDUO RESPICLICK (fluticasone/salmeterol)	
SYMBICORT (budesonide/ formoterol)	BREO ELLIPTA (fluticasone/vilanterol)	
	TRELEGY ELLIPTA (fluticasone/ umeclidinium/vilanterol)[NR]	
INHALATION SOLUTION		
	budesonide **RESPULES** (generic for Pulmicort)	

GLUCOCORTICOIDS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
budesonide EC **CAPSULE** (generic for Entocort EC)	CORTEF (hydrocortisone)	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agents within the last 6 months Drug-specific criteria: ▪ **Emflaza:** Indicated for the treatment of Duchenne muscular dystrophy (DMD) in patients 5 years of age and older ▪ Approved after trial/failure with prednisone ▪ **Intensol Products:** Patient specific documentation of why the less concentrated solution is not appropriate for the patient
dexamethasone **SOLN, TABLET**	cortisone **TABLET**	
dexamethasone **ELIXIR**	dexamethasone **INTENSOL**	
hydrocortisone **TABLET**	DEXPAK (dexamethasone)	
methylprednisolone **DOSE PAK**	EMFLAZA (deflazacort) **SUSPENSION, TABLET**[CL]	
methylprednisolone tablet (generic for Medrol)	ENTOCORT EC (budesonide)	
prednisolone **SOLUTION**	methylprednisolone (generic for Medrol)	
prednisolone sodium phosphate	ORAPRED ODT (prednisolone sodium phosphate)	
prednisone **DOSE PAK, SOLUTION**	PEDIAPRED (prednisolone sodium phosphate)	
prednisone **TABLET**	prednisolone sodium phosphate (generic for Millipred/Veripred)	
	prednisolone sodium phosphate **ODT**	
	prednisone **INTENSOL**	
	RAYOS DR (prednisone) **TABLET**	

GROWTH HORMONE

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

H. PYLORI TREATMENTS

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

HEMOPHILIA TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
FACTOR VIII		▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent
ADVATE ADYNOVATE ALPHANATE ELOCTATE HELIXATE FS HEMOFIL-M HUMATE-P KOATE-DVI **KIT, VIAL** KOGENATE FS KOVALTRY MONOCLATE-P NOVOEIGHT NUWIQ RECOMBINATE XYNTHA **KIT, SOLOFUSE**	AFSTYLA *JIVI*[NR,AL] OBIZUR	

HEMOPHILIA TREATMENTS (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
FACTOR IX		
ALPHANINE SD	IDELVION	
ALPROLIX	*REBINYN*[NR]	
BEBULIN		
BENEFIX		
IXINITY		
MONONINE		
PROFILNINE SD		
RIXUBIS		
FACTOR VIIa AND PROTHROMBIN COMPLEX-PLASMA DERIVED		
FEIBA NF		
NOVOSEVEN RT		
FACTOR X AND XIII PRODUCTS		
	COAGADEX[CL]	
	CORIFACT[CL]	
	TRETTEN[CL]	
VON WILLEBRAND PRODUCTS		
WILATE	VONVENDI[CL]	
BISPECIFIC FACTORS		
	HEMLIBRA[CL,NR]	

HEPATITIS B TREATMENTS

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

HEPATITIS C TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
DIRECT ACTING ANTI-VIRAL		Hepatitis C Treatments PA Form Hepatitis C Criteria ▪ Non-preferred products require trial of preferred agents within the same group and will only be considered with documentation of why the preferred product is not appropriate for patient ▪ Patients undergoing treatment at the time of preferred status change (January 2018) will be allowed to complete treatment with same drug as started on ▪ Patients newly eligible for Medicaid will be allowed to complete treatment with the original that treatment was initially authorized by another payor Drug-specific criteria:Trial with Mavyret not required in the following: ▪ **Epclusa**: For genotype 1-6 with decompensated cirrhosis along with ribavirin ▪ **Harvoni**: ○ For genotype 1 with decompensated cirrhosis along with ribavirin ○ For use in children ages 12 to 17 ○ Post liver transplant for genotype 1 or 4 ▪ **Vosevi:** Requires documentation of non-response after previous treatment course of Direct Acting Anti-viral agent (DAA) for genotype 1-6 without cirrhosis or with compensated cirrhosis
MAVYRET (glecaprevir/pibrentasvir)CL VOSEVI (sofosbuvir/velpatasvir/ voxilaprev)CL	DAKLINZA (daclatasvir) CL EPCLUSA (sofosbuvir/velpatasvir)CL HARVONI (sofosbuvir/ledipasvir)CL OLYSIO (simeprevir)CL SOVALDI (sofosbuvir)CL TECHNIVIE (ombitasvir/paritaprevir/ ritonavir) CL VIEKIRA PAK/XR (ombitasvir/ paritaprevir/ritonavir/dasabuvir)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

HIV / AIDS[CL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
HIV CCR5 ANTAGONISTS		▪ Non-preferred agents will be approved for patients who have a diagnosis of HIV/AIDS and patient specific documentation of why the preferred products are not appropriate for patient ▪ Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy ▪ Diagnosis of HIV/AIDS ▪ Prophylaxis, both pre and post exposure covered
SELZENTRY **SOLN, TAB** (maraviroc)		
CYTOCHROME P450 INHIBITORS		
TYBOST (cobicistat)[QL]		
FUSION INHIBITORS		
FUZEON **SUB-Q** (enfuvirtide)[QL]		
INTEGRASE INHIBITORS		
GENVOYA (elvitegravier/cobicistat/emtricitabine/tenofovir alafenamide)[QL, AL] ISENTRESS **CHEW TAB, POWDER PACK, TAB** (raltegravir)[QL] ISENTRESS HD (raltegravir) JULUCA (dolutegravir/rilpivirine)[QL] TIVICAY (dolutegravir)		
NNRTIs		
EDURANT (rilpivirine) INTELENCE (etravirine)[QL] nevirapine **TAB** (generic for Viramune) nevirapine er (generic for Viramune XR) RESCRIPTOR (delavirdine) SUSTIVA **CAP, TAB** (efavirenz) VIRAMUNE **SUSP** (nevirapine)	efavirenz (generic for Sustiva) *PIFELTRO (doravirine)[NR,QL]* VIRAMUNE **TAB** (nevirapine) VIRAMUNE XR (nevirapine extended release)	

HIV / AIDS[CL] (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
NRTIs		
abacavir **SOLN, TAB** (generic for Ziagen) didanosine **CAP** DR (generic for Videx EC) EMTRIVA **CAP, SOLN** (emtricitabine) lamivudine **SOLN, TAB** (generic for Epivir) stavudine **CAP, SOLN** (generic for Zerit) VIDEX **SOLN** (didanosine) VIREAD (tenofovir disoproxil fumarate) zidovudine **CAP, SYRUP, TAB** (generic for Retrovir)	EPIVIR (lamivudine) RETROVIR (zidovudine) tenofovir disoproxil fumarate **TAB** (generic for Viread) VIDEX EC (didanosine) ZERIT **CAP**, **SOLN** (stavudine) ZIAGEN (abacavir)	
PROTEASE INHIBITORS		
APTIVUS **CAP, SOLN** (tipranavir) CRIXIVAN (indinavir) EVOTAZ(atazanavir sulfate/cobicistat)[QL] INVIRASE (saquinavir) KALETRA **TAB** (lopinavir/ritonavir) LEXIVA **SUSP, TAB** (fosamprenavir) lopinavir/ritonavir **SOLN** (generic for Kaletra) NORVIR **SOLN, TAB** (ritonavir) PREZCOBIX (darunavir/cobicistat)[QL] PREZISTA **SUSP, TAB** darunavir) REYATAZ **CAP, POWDER PACK** (atazanavir) VIRACEPT (nelfinavir)	atazanavir **CAP** (generic for Reyataz) fosamprenavir **TAB**(generic for Lexiva) ritonavir **TAB** (generic for Norvir) KALETRA **SOLN** (lopinavir/ritonavir) NORVIR **POWDER PACK**[NR]	

HIV / AIDS[CL] CONTINUED

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
COMBINATIONS		
abacavir/lamivudine (generic for EPZICOM) abacavir/lamivudine/zidovudine (generic for Trizivir) ATRIPLA (tenofovir disoproxil fumarate/ emtricitabine/efavirenz) BIKTARVY (bictegravir/emtricitabine/ tenofovir alafenamide)[QL] COMPLERA (rilpivirine/emtricitabine/tenofovir disoproxil fumarate) DESCOVY (emtricitabine/tenofovir alafenamide)[QL] lamivudine/zidovudine (generic for COMBIVIR) ODEFSEY (emtricitabine/rilpivirine/tenofovir alafenamide)[QL] STRIBILD (elvitegravir/cobicistat/emtricitabine/tenofovir disoproxil fumarate)[QL] TRIUMEQ (dolutegravir/abacavir/lamivudine) TRUVADA (tenofovir disoproxil fumarate/emtricitabine)	CIMDUO (lamivudine/tenofovir disoproxil fumarate)[NR,QL] COMBIVIR (zidovudine/lamivudine) *DELSTRIGO (doravirine/lamivudine/tenofovir disoproxil fumarate)[NR,QL]* EPZICOM (abacavir sulfate/lamivudine) SYMFI (efavirenz/lamivudine/tenofovir disoproxil fumarate)[NR,QL] SYMFI LO (efavirenz/lamivudine/ tenofovir disoproxil fumarate)[NR,QL] *SYMTUZA (darunavir, cobicistat, emtricitabine, tenofovir alafenamide)[NR,QL]* TRIZIVIR (abacavir/zidovudine/lamivudine)	

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

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** HUMALOG MIX **PEN** (insulin lispro/lispro protamine) 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)	ADMELOG (insulin lispro) **PEN, VIAL** AFREZZA (regular insulin, inhaled) APIDRA (insulin glulisine) BASAGLAR (insulin glargine, rec) **PEN** FIASP (insulin aspart)**PEN, VIAL** HUMALOG JR. (insulin lispro) U-100 **PEN** HUMALOG (insulin lispro) U-200 **PEN** HUMULIN 70/30 **PEN** HUMULIN R U-500 **KWIKPEN**CL 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® R U-500 Kwikpen:** Approved for physical reasons – such as dexterity problems and vision impairment • Usage must be for self-administration, not only convenience • Patient requires >200 units/day • Safety reason patient can't use vial/syringe

HYPOGLYCEMICS, MEGLITINIDES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
repaglinide (generic for Prandin)	nateglinide (generic for Starlix) 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] JARDIANCE (empagliflozin)[QL, CL]	INVOKAMET & XR (canagliflozin/metformin)[QL] SEGLUROMET (ertugliflozin/metformin) [QL] STEGLATRO (ertugliflozin)[QL] SYNJARDY (empagliflozin/metformin) SYNJARDY XR (empagliflozin/ metformin)[QL] XIGDUO XR (dapagliflozin/metformin)[QL]	▪ Preferred agents are Approved for diagnosis of diabetes AND a trial of metformin ▪ Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent

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 ▪ **Combination products:** Require clinical reason why individual ingredients cannot be used
pioglitazone (generic for Actos)	AVANDIA (rosiglitazone)	
TZD COMBINATIONS		
	pioglitazone/glimepiride (generic for Duetact) pioglitazone/metformin (generic for Actoplus Met)	

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)[CL] EUCRISA (crisaborole)	▪ Non-preferred agents require:Trial of a topical steroid AND Trial of one preferred product Drug-specific criteria: ▪ **Dupixent:** For atopic dermatitis, must follow non-preferred drug criteria; For moderate to severe asthma, must have eosinophilic phenotype or oral corticosteroid dependent asthma uncontrolled with maintenance controller medication

IMMUNOMODULATORS, TOPICAL

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

IMMUNOSUPPRESSIVES, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
azathiaprine cyclosporine **CAPSULE,** cyclosporine, modified **CAPSULE** mycophenolate mofetil **CAPSULE, TABLET** RAPAMUNE (sirolimus) **SOLUTION** Sirolimus **TABLET** tacrolimus	ASTAGRAF XL (tacrolimus) AZASAN (azathioprine) CELLCEPT (mycophenolate mofetil) **CAPSULE, SUSPENSION, TABLET** cyclosporine **SOFTGEL** cyclosporine, modified **SOLUTION** ENVARSUS XR (tacrolimus) GENGRAF (cyclosporine, modified) **CAPSULE, SOLUTION** IMURAN (azathioprine) mycophenolate mofetil **SUSPENSION** mycophenolic acid (mycophenolate sodium) MYFORTIC (mycophenolate sodium) NEORAL (cyclosporine, modified) **CAPSULE, SOLUTION** PROGRAF (tacrolimus) RAPAMUNE (sirolimus) **TABLET** SANDIMMUNE (cyclosporine) **CAPSULE, SOLUTION** ZORTRESS (everolimus)	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent ▪ Patients established on existing therapy will be allowed to continue

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		
azelastine 0.1% (generic for Astelin)	DYMISTA (azelastine/fluticasone)	
azelastine 0.15% (generic for Astepro)	PATANASE (olopatadine)	
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

LINCOSAMIDES / OXAZOLIDINONES / STREPTOGRAMINS

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

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
cholestyramine (generic for Questran) colestipol **TABLETS** (generic for Colestid)	colesevelam (generic for Welchol) **TABLET, PACKET** colestipol **GRANULES** (generic for Colestid) QUESTRAN LIGHT (cholestyramine)	
TREATMENT OF HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA		
	JUXTAPID (lomitapide)CL KYNAMRO (mipomersen)CL	
FIBRIC ACID DERIVATIVES		
fenofibrate (generic for Tricor) gemfibrozil (generic for Lopid)	*fenofibrate* (generic for Antara, Fenoglide, Lipofen, Lofibra, *Triglide*) fenofibric acid (generic for Fibricor) fenofibric acid (generic for Trilipix) TRICOR (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	

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)QL lovastatin (generic for Mevacor) pravastatin (generic for Pravachol) rosuvastatin (generic for Crestor) simvastatin (generic for Zocor)	ALTOPREV (lovastatin) CRESTOR (rosuvastatin) fluvastatin (generic for Lescol) LESCOL & XL (fluvastatin & ER) LIVALO (pitavastatin) *ZYPITAMAG (pitavastatin)NR*	
STATIN COMBINATIONS		
	atorvastatin/amlodiine (generic for CADUET) simvastatin/ezetimibe (generic for Vytorin)	

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 **TABLET, SUSPENSION** (generic for Biaxin)	clarithromycin ER (generic for Biaxin XL) EES **SUSPENSION, TABLET** ERY-TAB ERYPED **SUSPENSION** ERYTHROCIN erythromycin base **TABLET, CAPSULE** PCE (erythromycin) ZMAX (azithromycin ER) ZITHROMAX (azithromycin)	

METHOTREXATE

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
methotrexate **PF VIAL, TABLET, VIAL**	OTREXUP (methotrexate) **SUB-Q** RASUVO (methotrexate) **SUB-Q** TREXALL (methotrexate) **TABLET** XATMEP (methotrexate) **SOLUTION**	▪ Non-preferred agents will be approved for FDA-approved indications Drug-specific criteria: ▪ **Xatmep™**:Indicated for pediatric patients only

MOVEMENT DISORDERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
No preferred agents	AUSTEDO (deutetrabenazine)CL INGREZZA (valbenazine)CL tetrabenazine (generic for Xenazine)CL	Drug-specific criteria: ▪ **Austedo:** Diagnosis of chorea associated with Huntington's Disease OR Tardive Dyskinesia ▪ **Ingrezza:** Diagnosis of Tardive Dyskinesia in adults ▪ **Tetrabenazine:**Diagnosis of chorea with Huntington Disease

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 REBIF (interferon beta-1a)QL	AUBAGIO (teriflunomide) dalfampridine (generic to Ampyra)QL EXTAVIA (interferon beta-1b)QL glatiramer 20 mg/mL (generic for Copaxone) glatiramer 40 mg/mL (generic for Copaxone)QL 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 ▪ **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 within COX-I SELECTIVE group will be approved for patients who have failed no less than 30-day trial of TWO preferred agents within same group 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 SR (generic for Voltaren-XR) ibuprofen **TABLET** OTC, Rx (generic for Advil, Motrin) indomethacin **CAPSULE** (generic for Indocin) ketorolac (generic for Toradol) meloxicam **TABLET** (generic for Mobic) nabumetone (generic for Relafen) naproxen Rx, OTC (generic for Naprosyn) naproxen enteric coated sulindac (generic for Clinoril)	diclofenac potassium (generic for Cataflam) diflunisal (generic for Dolobid) etodolac & sr (generic for Lodine/XL) fenoprofen (generic for Nalfon) flurbiprofen (generic for Ansaid) ibuprofen OTC (generic for Advil, Motrin) **CAPSULE** indomethacin ER (generic for Indocin) INDOCIN **RECTAL, SUSPENSION** Ketoprofen & ER (generic for Orudis) meclofenamate (generic for Meclomen) mefenamic acid (generic for Ponstel) meloxicam **SUSPENSION** (generic Mobic) naproxen CR (generic for Naprelan) naproxen **SUSPENSION** (generic for Naprosyn) 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 within NSAID 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
	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)		

NSAIDS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	diclofenac (generic for Pennsaid Solution) FLECTOR **PATCH** (diclofenac) PENNSAID **PACKET, 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

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

PDL Updated December 1, 2018 *Highlights* indicated change from previous posting

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

ONCOLOGY AGENTS, ORAL, BREAST CANCER

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
anastrozole (generic for Arimidex) exemestane (generic for Aromasin) letrozole (generic for Femara) tamoxifen citrate XELODA (capecitabine)	capecitabine (generic for Xeloda) FARESTON (toremifene) IBRANCE (palbociclib) KISQALI (ribociclib) KISQALI FEMARA **CO-PACK** NERLYNX (neratinib) *TALZENNA (talazoparib tosylate)*[NR,QL] TYKERB (lapatinib) VERZENIO (abemaciclib)[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 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) *CALQUENCE (acalabrutinib)*[NR,QL] *COPIKTRA (duvelisib)*[NR,QL] FARYDAK (panobinostat) HYDREA (hydroxyurea) ICLUSIG (ponatinib) IDHIFA (enasidenib) imatinib (generic for Gleevec) melphalan (generic for Alkeran) NINLARO (ixazomib) POMALYST (pomalidomide) PURIXAN (mercaptopurine) RYDAPT (midostaurin) TABLOID (thioguanine) THALOMID (thalidomide) *TIBSOVO (ivosidenib)*[NR,QL] tretinoin (generic for Vesanoid) VENCLEXTA (venetoclax) ZOLINZA (vorinostat)	▪ 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 ▪ **Tabloid (thioguanine):** Prior authorization not required for age < 19

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

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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) *LORBRENA (lorlatinib)*[NR,QL] TAGRISSO (osimertinib) *VIZIMPRO (dacomitinib)*[NR,QL] 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) cyclophosphamide (generic for Cytoxan) GLEOSTINE (lomustine) temozolomide (generic for Temodar)	COMETRIQ (cabozantinib) HEXALEN (altretamine) LONSURF (trifluridine/tipiracil) LYNPARZA (olaparib) RUBRACA (rucaparib) STIVARGA (regorafenib) ZEJULA (niraparib)	▪ 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) *ERLEADA (apalutamide)*[NR, QL] nilutamide (generic for Nilandron) XTANDI (enzalutamide) ZYTIGA (abiraterone) *YONSA (abiraterone acet, submicronized)*[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 ▪ **Nilandron®:** Approved for males only for metastatic prostate cancer

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

ONCOLOGY AGENTS, ORAL, RENAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
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

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)	*BRAFTOVI (encorafenib)*[NR] *MEKTOVI (binimetinib)*[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

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 moxifloxacin (generic for Vigamox)	
MACROLIDES		
erythromycin	AZASITE (azithromycin)	
AMINOGLYCOSIDES		
gentamicin **SOLUTION, OINTMENT** tobramycin (generic for Tobrex drops) TOBREX **OINTMENT** (tobramycin)		
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 NEOSPORIN (neomycin/polymyxin B/gramcidin) 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) PAZEO (olopatadine 0.7%)	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) olopatadine 0.2% (generic for Pataday) PATADAY (olopatadine 0.2%)	▪ 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 within the same group ▪ **NSAID class:** Non-preferred agents will be approved for patients whohave failed a trial of ONE preferred agent
DUREZOL (difluprednate) FLAREX (fluorometholone) fluorometholone 0.1% (generic for FML) **OINTMENT**) LOTEMAX **SOLUTION** (loteprednol 0.5%) MAXIDEX (dexamethasone) PRED MILD (prednisolone 0.12%)	dexamethasone (generic for Maxidex) FML (fluorometholone 0.1% **SOLUT.**) FML FORTE (fluorometholone 0.25%) FML S.O.P. (fluorometholone 0.1%) LOTEMAX **OINTMENT, GEL** (loteprednol) prednisolone acetate 1% (gen. for Omnipred, Pred Forte) prednisolone sodium phosphate 1%	
NSAID		
diclofenac (generic for Voltaren) flurbiprofen (generic for Ocufen)	ACUVAIL (ketorolac 0.45%) BROMSITE (bromfenac) 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, ANTI-INFLAMMATORY/IMMUNOMODULATORS

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

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) BETIMOL (timolol) BETOPTIC S (betaxolol) timolol (generic for Istalol) 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) *VYZULTA (latanoprostene)*[NR] XALATAN (latanoprost) ZIOPTAN (tafluprost)	
COMBINATION DRUGS		
COMBIGAN (brimonidine/timolol) dorzolamide/timolol/PF (generic for Cosopt) SIMBRINZA (brinzolamide/brimonidine)	COSOPT/PF (dorzolamide/timolol)	
OTHER		
	RHOPRESSA (netarsudil mesylate)[NR]	

OPIOID DEPENDENCE TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
SUBOXONE **FILM** (buprenorphine/ naloxone)	BUNAVAIL (buprenorphine/naloxone) buprenorphine **SL** buprenorphine/naloxone **SL** *LUCEMYRA (lofexidine)*[NR, QL] ZUBSOLV (buprenorphine/naloxone)	Buprenorphine PA Form Buprenorphine Informed Consent Non-Preferred: Bunavail, buprenorphine SL, Buprenorphine/naloxone SL, Zubsolv: ▪ Diagnosis of Opioid Use Disorder, NOT approved for pain management ▪ Verification of "X" DEA license number of prescriber ▪ No concomitant opioids ▪ Failed trial of preferred drug or patient-specific documentation of why preferred product not appropiriate for patient Drug-specific criteria: ▪ **Lucemyra**: Approved for FDA approved indication and dosing per label. Trial of preferred product not required.

OPIOID-REVERSAL TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
naloxone **SYRINGE, VIAL** naltrexone **TABLET** NARCAN (naloxone) **SPRAY**		▪ 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) neomycin/polymyxin/hydrocortisone (generic for Cortisporin) ofloxacin (generic for Floxin)	CIPRO HC (ciprofloxacin/ hydrocortisone) ciprofloxacin COLY-MYCIN S(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 the preferred agent

PAH (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)[CL] TRACLEER (bosentan) TYVASO **INHALATION** (treprostinil) VENTAVIS **INHALATION** (iloprost)	ADEMPAS (riociguat) OPSUMIT (macitentan) ORENITRAM ER (treprostinil) REVATIO **SUSPENSION** (for PAH only)[CL] tadalafil (generic for Adcirca)[CL] TRACLEER **TABLETS FOR SUSPENSION** (bosentan) UPTRAVI (selexipag)	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within 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

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

PEDIATRIC VITAMIN PREPARATIONS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CHILD LITTLE ANIMALS VITAMINS CHEW OTC (pedi multivit 91/iron fum) **CHEW** child multivitamins chew otc (pedi multivit 19/folic acid) **CHEW** CHILDREN'S CHEW MULTIVIT-IRON OTC (pedi multivit 91/iron fum) **CHEW** children's chewables otc (pedi multivit 23/folic acid) **CHEW** children's vitamins with iron otc (pedi multivit/iron) fluoride/vitamins A,C,AND D (ped multivit A,C,D3, 21/fluoride) **DROPS** multivitamins with fluoride (pedi multivit 2/fluoride) **DROPS** multivits with iron and fluoride (pedi multivit 45/fluoride/iron) **DROPS** MVC-FLUORIDE (pedi multivit 12/fluoride) **CHEW TAB** ped mvit A,C,D3,No 21/fluoride **DROPS** pedi mvi no. 16 with fluoride **CHEW** pedi mvi 17 with fluoride **CHEW** POLY-VI-SOL OTC (pedi multivit 81) **DROPS** POLY-VI-SOL WITH IRON (pedi multivit 80/ferrous sulfate) **DROPS** TRI-VI-SOL OTC (vit A palmitate/vit C/Vit D3) **DROPS** VITALETS OTC (pedi multivit 36/iron) **CHEW**	AQUADEKS (pedi multivit 40/phytonadione) ESCAVITE (pedi multivit 47/iron/fluoride) ESCAVITE D (pedi multivit 78/iron/fluoride) **CHEW** ESCAVITE LQ (pedi multivit 86/iron/fluoride) FLORIVA (pedi multivit 85/fluoride) **CHEW** FLORIVA PLUS (pedi multivit 130/fluoride) **DROPS** multivit A, B, D, E, K, ZN (pediatric multivit 153/D3/K) POLY-VI-FLOR (pedi multivit 33/fluoride) **CHEW** POLY-VI-FLOR (pedi multivit 37/fluoride) **DROPS** POLY-VI-FLOR w/IRON (pedi multivit 33/fluoride/iron) **CHEW** POLY-VI-FLOR w/IRON (pedi multivit 37/fluoride/iron) **DROPS** QUFLORA (pedi multivit 84/fluoride) QUFLORA FE (pedi multivit 142/iron/fluoride) TRI-VI-FLORO (ped multivit A, C, D3, 38/fluoride)	▪ Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents Drug specific criteria: ▪ **Aquadeks**: Approved for diagnosis of Cystic Fibrosis

PENICILLINS

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

PHOSPHATE BINDERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
calcium acetate **TABLET, CAPSULE** CALPHRON OTC (calcium acetate) RENAGEL (sevelamer HCl)	AURYXIA (ferric citrate) calcium acetate **CAPSULE** ELIPHOS (calcium acetate) lanthanum (generic for FOSRENOL) PHOSLO (calcium acetate) PHOSLYRA (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) prasugrel (generic for Effient) 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
COMPLETENATE **CHEWABLE** CONCEPT DHA **CAPSULE** CONCEPT OB **CAPSULE** PRENATA TAB **CHEW** pnv #15/iron fum & ps cmp/fa pnv #16/iron fum & ps/fa/om-3 pnv combo #47/iron/fa #1/dha pnv with ca, #72/iron/fa pnv with ca, #74/iron/fa TARON-PREX PRENATAL VOL-PLUS **TABLET**		▪ Non-preferred agents will be approved for patients who have failed a trial of or are intolerant to TWO preferred agents Additional covered agents can be looked up using the Drug Look-up Tool at: https://druglookup.fhsc.com/druglookupweb/?client=nestate

PROGESTERONE (hydroxyprogesterone caproate)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
MAKENA ***AUTO INJECTOR***[NR], **MDV, SDV (hydroxyprogesterone caproate)**	hydroxyprogesterone caproate (generic Makena) **SDV**	▪ When filled as outpatient prescription, use limited to: ▪ Singleton pregnancy AND ▪ Previous Pre-term delivery AND ▪ No more than 20 doses (administered between 16 -36 weeks gestation) ▪ Maximum of 30 days per dispensing

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

SEDATIVE HYPNOTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BENZODIAZEPINES		
temazepam 15mg, 30mg (generic for Restoril)	estazolam (generic for ProSom) flurazepam (generic for Dalmane) temazepam (generic for Restoril) 7.5mg, 22.5mg triazolam (generic for Halcion)	▪ **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®:** Must meet one of the following: ○ Contraindication to preferred oral sedative hypnotics ○ Medical necessity for doxepin dose < 10mg ○ Age greater than 65 years old or hepatic impairment (3mg dose will be approved if this criteria is met) ▪ **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
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)[QL] 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 PARAFON FORTE (chlorzoxazone) 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 agent within the same group
hydrocortisone **CREAM, GEL, OINTMENT** (generic for Cortaid) hydrocortisone **OTC LOTION** hydrocortisone **RX LOTION** hydrocortisone/aloe **OINTMENT, CREAM**	alclometasone dipropionate (generic for Aclovate) CAPEX **SHAMPOO** (fluocinolone) DESONATE (desonide **GEL**) 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) TEXACORT (hydrocortisone)	
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)	

STEROIDS, TOPICAL (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
HIGH POTENCY		▪ Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents
triamcinolone acetonide **OINTMENT, CREAM** (generic for Kenalog) triamcinolone **LOTION**	amcinonide **CREAM, LOTION, OINTMENT** betamethasone dipropionate (generic for Diprolene) betamethasone dipro/prop gly (augmented) betamethasone valerate (generic for Beta-Val) 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)	
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) *BRYHALI (halobetasol prop) LOTION*[NR] clobetasol **SHAMPOO, LOTION** clobetasol propionate **FOAM, SPRAY** CLOBEX (clobetasol) OLUX-E /OLUX/OLUX-E CP (clobetasol)	

STIMULANTS AND RELATED ADHD DRUGS[AL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CNS STIMULANTS		▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within 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) **CAPSULE, CHEWABLE**	*ADZENYS ER (amphetamine)* ***SUSPENSION***[NR] ADZENYS XR (amphetamine) amphetamine salt combination ER (generic for Adderall XR) amphetamine sulfate (generic for Evekeo) dextroamphetamine (generic for Dexedrine) dextroamphetamine **SOLUTION** (generic for Procentra) dextroamphetamine ER (generic for Dexedrine ER) DYANAVEL XR (amphetamine) MYDAYIS (amphetamine salt combo)[QL] methamphetamine (generic for Desoxyn) ZENZEDI (dextroamphetamine)	

STIMULANTS AND RELATED ADHD DRUGS (Continued)[AL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Methylphenidate type		▪ Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents 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) --- APTENSIO XR (methylphenidate) methylphenidate (generic for Ritalin) --- methylphenidate ER 10mg, 20mg (generic for Ritalin SR, Metadate ER) --- QUILLICHEW ER (methylphenidate) QUILLIVANT XR (methylphenidate suspension)	dexmethylphenidate (generic for Focalin) dexmethylphenidate XR (generic for Focalin XR) --- COTEMPLA XR-ODT (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) methylphenidate ER 72mg (generic for RELEXXI)[QL]	
MISCELLANEOUS		**Note: generic IR guanfacine and Clonidine ER/Guanfacine IR are available without prior authorization**
atomoxetine (generic for Strattera) guanfacine ER (generic for Intuniv)	clonidine ER (generic for Kapvay)[CL] STRATTERA (atomoxetine)	
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)	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) XIMINO (minocycline ER) **CAPSULE**[QL]	▪ 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) LEVO-T (levothyroxine) 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)	budesonide ER (generic Uceris) DELZICOL DR (mesalamine) DIPENTUM (olsalazine) GIAZO (balsalazide) mesalamine (generic for Lialda) mesalamine (generic for Asacol HD) PENTASA (mesalamine)	
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) NITROLINGUAL SPRAY NITROMIST (nitroglycerin)	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent