



Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

Contains May 2019 P&T Changes

Noted in Red Font that Become Effective July 18, 2019

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>

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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) clindamycin 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) <i>ALTRENO (tretinoin)^{AL}</i> ATRALIN (tretinoin) AVAR (sulfacetamine sodium/sulfur) AVITA (tretinoin) BENZACLIN GEL (clindamycin/benzoyl peroxide) BENZACLIN W/PUMP (clindamycin/benzoyl peroxide) BENZAPRO (benzoyl peroxide) benzoyl peroxide CLEANSER, CLEANSING BAR , OTC benzoyl peroxide FOAM (generic for Benzepro Foam) benzoyl peroxide GEL Rx clindamycin FOAM, LOTION clindamycin GEL clindamycin/benzoyl peroxide (generic for Acanya) clindamycin/benzoyl peroxide (generic for Benzacilin) clindamycin/tretinoin (generic for Veltin & Ziana) dapsone (generic for ACZONE) DIFFERIN GEL OTC EPIDUO FORTE GEL W/PUMP erythromycin GEL, PLEDGET erythromycin-benzoyl peroxide (generic for Benzamycin) EVOCLIN (clindamycin) FABIOR (tazarotene foam) NEUAC (clindamycin/benzoyl peroxide) ONEXTON (clindamycin/benzoyl peroxide) OVACE PLUS (sulfacetamind sodium) <i>PLIXDA (adapalene) SWAB</i> RETIN-A MICRO (tretinoin microspheres) ^{AL} sulfacetamide sulfacetamide/sulfur SUMADAN (sulfacetamide/sulfur) tazarotene CREAM TAZORAC (tazarotene) TRETIN-X (tretinoin) tretinoin CREAM, GEL ^{AL} tretinoin microspheres (generic for Retin-A Micro) ^{AL}	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed THREE preferred agents within this drug class

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

CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

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ALZHEIMER'S DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CHOLINESTERASE INHIBITORS		<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a 120-day trial of ONE preferred agent within this drug class within the last 6 months OR Current, stabilized therapy of the non-preferred agent within the previous 45 days
donepezil (generic for Aricept) donepezil ODT (generic for Aricept ODT) EXELON Transdermal (rivastigmine)	donepezil 23 (generic for Aricept 23) galantamine (generic for Razadyne) SOLUTION, TABLET galantamine ER (generic for Razadyne ER) rivastigmine (generic for Exelon)	
NMDA RECEPTOR ANTAGONIST		Drug-specific criteria: <ul style="list-style-type: none"> 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)
memantine (generic for Namenda)	memantine ER (generic for Namenda XR) memantine soln (generic for Namenda) NAMENDA (memantine) NAMENDA SOLUTION NAMZARIC (memantine/donepezil)	

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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 ^{QL} 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) ^{QL} fentanyl 37.5, 62.5, 87.5 mcg PATCH ^{QL} hydromorphone ER (generic for Exalgo) ^{CL} <i>HYSINGLA ER (hydrocodone, extended release)</i> KADIAN (morphine ER capsule) methadone ^{CL} MORPHABOND ER (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 Conzip, Ryzolt, Ultram ER) ^{CL} XTAMPZA ER (oxycodone myristate) ^{QL} ZOHYDRO ER (hydrocodone bitartrate ER)	The Center for Disease Control (CDC) does not recommend long acting opioids when beginning opioid treatment. <ul style="list-style-type: none"> Preferred agents require previous use of a long acting opioid or documentation of a trial on a short acting agent within 90 days Non-preferred agents will be approved with failure on, or intolerance to TWO preferred agents within this drug class Drug-specific criteria: <ul style="list-style-type: none"> <i>Methadone:</i> <i>Will only be approved for use in pain control or end of life care. Trial of preferred agent not required for end of life care</i> Oxycontin®: Pain contract required for maximum quantity authorization

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ANALGESICS, OPIOID SHORT-ACTING^{QL}

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ORAL		
acetaminophen/codeine ELIXIR, TABLET codeine ORAL hydrocodone/APAP SOLUTION, TABLET hydrocodone/ibuprofen hydromorphone TABLET morphine CONC SOLUTION, SOLUTION, TABLET oxycodone TABLET, SOLUTION oxycodone/APAP tramadol	<i>APADAZ (benzhydrocodone/APAP)^{CL}</i> <i>benzhydrocodone/APAP (generic for Apadaz)^{CL}</i> butalbital/cafeine/APAP w/codeine butalbital compound w/codeine (butalbital/ASA/cafeine/codeine) carisoprodol compound-codeine (carisoprodol/ASA/codeine) dihydrocodeine/acetamin/cafeine dihydrocodeine/aspirin/cafeine (generic for Synalgos DC) FIORINAL/CODEINE (butalbital/ASA/codeine/cafeine) hydromorphone ORAL LIQUID, TABLET, SUPPOSITORY (generic for Dilaudid) IBUDONE (hydrocodone/ibuprofen) levorphanol meperidine (generic for Demerol) morphine SUPPOSITORIES <i>NALOCET (oxycodone/APAP)</i> NUCYNTA (tapentadol) ^{CL} OXAYDO (oxycodone) ^{CL} oxycodone CAPSULE oxycodone/acetaminophen SOLUTION oxycodone/aspirin oxycodone CONCENTRATE oxycodone/ibuprofen (generic for Combunox) oxymorphone (generic for Opana) pentazocine/naloxone PRIMLEV (oxycodone/acetaminophen) ROXICODONE TABLET (oxycodone) <i>ROXYBOND (oxycodone)</i> tramadol/APAP (generic for Ultracet) XARTEMIS XR (oxycodone/acetaminophen) ZAMICET (hydrocodone/acetaminophen)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed THREE preferred agents within this drug class within the last 12 months Note: for short acting opiate tablets and capsules there is a maximum quantity limit of #150 per 30 days. Beginning Oct. 11, 2018: Opiate limits for opiate naïve patients will consist of <ul style="list-style-type: none"> -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 naïve <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Abstral®/Actiq®/Fentora®/Onsolis®/ Subsys® (fentanyl): Approved only for diagnosis of cancer AND current use of long-acting opiate Apadaz: Approval for 14 days or less 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

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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
<i>testosterone gel PACKET, PUMP (generic for Vogelxo)^{CL}</i>	ANDRODERM (testosterone) <i>ANDROGEL 1% GEL PACKET, 1.62% GEL PUMP and PACKET (testosterone)</i> NATESTO (testosterone) testosterone gel PACKET, PUMP (generic for Androgel) testosterone (generic for Axiron) testosterone (generic for Fortesta) testosterone (generics for Testim)	<ul style="list-style-type: none"> <i>Preferred agents approved for diagnosis of Primary hypogonadism (congenital or acquired) or Hypogonadotropic hypogonadism. Off label use for the following will be considered with documentation of necessity: female to male transsexual – gender dysphoria, weight gain, male osteoporosis, delayed puberty in males, corticosteroid-induced hypogonadism and osteoporosis, inoperable carcinoma of the breast, postpartum breast pain and engorgement, and menopause</i> <i>In addition, non-preferred agents will be approved for patients who have failed ONE preferred agent within this drug class within the last 6 months</i> <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Androderm®/Androgel®: Approved for Males only Natesto®: Approved for Males only with diagnosis of: Primary hypogonadism (congenital or acquired) OR Hypogonadotropic hypogonadism (congenital or acquired)

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ANGIOTENSIN MODULATORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ACE INHIBITORS		<ul style="list-style-type: none">Non-preferred agents will be approved for patients who have failed TWO preferred agents within this drug class within the last 12 monthsNon-preferred combination products may be covered as individual prescriptions without prior authorization <p>Drug-specific criteria:</p> <ul style="list-style-type: none">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) moexepiril (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 Vasoretic) lisinopril/HCTZ (generic Prinzide/Zestoretic)	captopril/HCTZ (generic for Capozide) fosinopril/HCTZ (generic for Monopril HCT) moexepiril/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)	

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ANGIOTENSIN MODULATORS (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ANGIOTENSIN RECEPTOR BLOCKER/DIURETIC COMBINATIONS		<ul style="list-style-type: none">Non-preferred agents will be approved for patients who have failed TWO preferred agents within this drug class within the last 12 monthsNon-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		<ul style="list-style-type: none">Angiotensin Modulator/Calcium Channel Blocker Combinations: Combination agents may be approved if there has been a trial and failure of preferred agent
amlodipine/benazepril (generic for Lotrel) <i>amlodipine/valsartan (generic for Exforge)</i> <i>amlodipine/valsartan/HCTZ (generic for Exforge HCT)</i>	amlodipine/olmesartan (generic for Azor) amlodipine/olmesartan/HCTZ (generic for Tribenzor) amlodipine/telmisartan (generic for Twynsta) PRESTALIA (perindopril/amlodipine) trandolapril/verapamil (generic for Tarka)	
DIRECT RENIN INHIBITORS		<ul style="list-style-type: none">Direct Renin Inhibitors/Direct Renin Inhibitor Combinations: May be approved with history of TWO preferred ACE Inhibitors or Angiotensin Receptor Blockers within the last 12 months
	aliskiren (generic for Tekturna) ^{QL}	
DIRECT RENIN INHIBITOR COMBINATIONS		
	TEKTURNA/HCT (aliskiren/HCTZ)	
NEPRILYSIN INHIBITOR COMBINATION		
ENTRESTO (sacubitril/valsartan) ^{CL}		
ANGIOTENSIN RECEPTOR BLOCKER/BETA-BLOCKER COMBINATIONS		
	BYVALSON (nevigolol/valsartan)	

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ANTHELMINTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ALBENZA (albendazole) BILTRICIDE (praziquantel) ivermectin STROMEKTOL (ivermectin)	<i>EGATEN (triclabendazole)^{NR,AL}</i> EMVERM (mebendazole) praziquantel (generic for Biltricide)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agents within this drug class within the last 6 months <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> 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)	<p>Class Criteria:</p> <ul style="list-style-type: none"> 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. <p>Drug-specific criteria:</p> <p>ORALAIR</p> <ul style="list-style-type: none"> 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.

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ANTIBIOTICS, GASTROINTESTINAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<i>FIRVANQ (vancomycin) SOLUTION</i> metronidazole TABLET neomycin	ALINIA (nitazoxanide) SUSPENSION DIFICID (fidaxomicin) FLAGYL ER (metronidazole) metronidazole CAPSULE paromomycin SOLOSEC (secnidazole) tinidazole (generic for Tindamax) vancomycin CAPSULE (generic for Vancocin) XIFAXAN (rifaximin)	<ul style="list-style-type: none"> Note: Although azithromycin, ciprofloxacin, and trimethoprim/ sulfmethoxazole are not included in this review, they are available without prior authorization <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Alinia®: Trial and failure with metronidazole is required for a diagnosis of giardiasis Dificid®: Trial and failure with oral vancomycin is required for a diagnosis of C. difficile diarrhea (pseudomembranous colitis) Flagyl ER®: Trial and failure with metronidazole is required Flagyl®/Metronidazole 375mg capsules and Flagyl ER®/ Metronidazole 750mg ER tabs: Clinical reason why the generic regular-release cannot be used tinidazole: Trial and failure/ contraindication to metronidazole required Approvable diagnoses include: Giardia Amebiasis intestinal or liver abscess Bacterial vaginosis or trichomoniasis vancomycin capsules: <i>Requires patient specific documentation of why the Firvanq/vancomycin solution is not appropriate for patient</i> Xifaxan®: Approvable diagnoses include: Travelers diarrhea resistant to quinolones Hepatic encephalopathy with treatment failure of lactulose or neomycin Diarrhea-Predominant IBS (IBS-D) 550mg strength only with treatment failure of Lomotil® AND Imodium®

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ANTIBIOTICS, INHALED

Preferred Agents	ANon-Preferred Agents	Prior Authorization/Class Criteria
BETHKIS (tobramycin) ^{CL} KITABIS PAK (tobramycin) ^{CL} TOBI-PODHALER (tobramycin) ^{CL,QL}	<i>ARIKAYCE (amikacin liposomal inh susp)^{CL}</i> CAYSTON (aztreonam lysine) ^{QL,CL} tobramycin (generic for Tobii)	<ul style="list-style-type: none"> Diagnosis of Cystic Fibrosis is required for all agents ICD10 Group = E84, ICD9 = 277.00, 277.01, 277.02, 277.03, 277.09 <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> 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 neomycin/polymyxin/bacitracin/pramoxine	CENTANY (mupirocin) gentamicin OINTMENT, CREAM mupirocin CREAM (generic for Bactroban)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed ALL preferred agents within this drug class within the last 12 months <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Altabax®: Approvable diagnoses of impetigo due to <i>S. Aureus</i> OR <i>S. pyogenes</i> with clinical reason mupirocin ointment cannot be used Mupirocin® Cream: Clinical reason the ointment cannot be used

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ANTIBIOTICS, VAGINAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CLEOCIN OVULES (clindamycin) clindamycin CREAM (generic for Cleocin) CLINDESSE (clindamycin, vaginal) metronidazole, vaginal <i>NUVESSA (metronidazole, vaginal)</i> <i>VANDAZOLE (metronidazole, vaginal)</i>	CLEOCIN CREAM (clindamycin) METROGEL (metronidazole, vaginal)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a therapeutic trial (duration = 3 days) with ONE preferred agent within this drug class within the last 6 months

ANTICOAGULANTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ELIQUIS (apixaban) enoxaparin (generic for Lovenox) PRADAXA (dabigatran) warfarin (generic for Coumadin) XARELTO (rivaroxaban) ^{CLon2.5mg,QL}	BEVYXXA (<i>betrixaban maleate</i>) ^{NR,QL} fondaparinux (generic for Arixtra) FRAGMIN (dalteparin) SAVAYSA (edoxaban) ^{QL}	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed ONE preferred agent within this drug class within the last 12 months <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Coumadin®: Clinical reason generic warfarin cannot be used Savaysa®: Approved diagnoses include: Stroke and systemic embolism (SE) risk reduction in nonvalvular atrial fibrillation (NVAf) OR Treatment of deep vein thrombosis (DVT) and pulmonary embolism (PE) following 5-10 days of parenteral anticoagulant therapy <i>Xarelto 2.5mg: Use limited to reduction of risk of major cardiovascular events (cardiovascular death, myocardial infarction, and stroke) in patients with chronic coronary artery disease or peripheral artery disease</i>

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ANTIEMETICS/ANTIVERTIGO AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CANNABINOIDS		<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed ONE preferred agent within this drug class within the same group
dronabinol (generic for Marinol) ^{AL}	CESAMET (nabilone) SYNDROS (dronabinol) ^{AL, CL}	
5HT3 RECEPTOR BLOCKERS		<ul style="list-style-type: none"> SYNDROS – documentation of inability to swallow solid dosage forms.
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		<ul style="list-style-type: none"> Drug-specific criteria:
	aprepitant (generic for Emend) ^{QL, CL} AKYNZEO (netupitant/palonosetron) ^{CL} VARUBI (rolapitant) TABLET ^{CL}	
TRADITIONAL ANTIEMETICS		<ul style="list-style-type: none"> Akynzeo®/Emend®/Varubi®: Approved for Moderately/Highly emetogenic chemotherapy with dexamethasone and a 5-HT3 antagonist WITHOUT trial of preferred agents <u>Regimens include:</u> AC combination (Doxorubicin or Epirubicin with Cyclophosphamide), Aldesleukin, Amifostine, Arsenic trioxide, Azacitidine, Bendamustine, Busulfan, Carmustine, Carboplatin, 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
DICLEGIS (doxylamine/pyridoxine) ^{CL, QL} dimenhydrinate (generic for Dramamine) 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) doxylamine/pyridoxine (generic for Diclegis) ^{CL, QL} metoclopramide ODT (generic for Metozolv ODT) prochlorperazine SUPPOSITORIES (generic for Compazine) promethazine SUPPOSITORIES 50mg scopolamine transdermal trimethobenzamide, oral (generic for Tigan)	

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ANTIFUNGALS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
clotrimazole (mucous membrane, troche) fluconazole SUSPENSION, TABLET (generic for Diflucan) griseofulvin SUSPENSION griseofulvin microsize TABLET nystatin SUSPENSION, TABLET 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) <i>TOLSURA (itraconazole)^{CL}</i> voriconazole (generic for VFEND) ^{CL}	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of TWO diagnosis-appropriate preferred agents within this drug class <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Cresemba®: Approved for diagnosis of invasive aspergillosis or invasive mucormycosis Flucytosine: Approved for diagnosis of: Candida: Septicemia, endocarditis, UTIs Cryptococcus: Meningitis, pulmonary infections Noxafil®: No trial for diagnosis of Neutropenia Myelodysplastic Syndrome (MDS), Neutropenic Acute Myeloid Leukemia (AML), Neutropenic hematologic malignancies, Graft vs. Host disease (GVHD), Immunosuppression secondary to hematopoietic stem cell transplant Noxafil® Suspension: Oropharyngeal/esophageal candidiasis refractory to itraconazole and/or fluconazole Onmel®: Requires trial and failure or contraindication to terbinafine Sporanox®/itraconazole: Approved for diagnosis of Aspergillosis, Blastomycosis, Histoplasmosis, Onychomycosis due to terbinafine-resistant dermatophytes, Oropharyngeal/ esophageal candidiasis refractory to fluconazole Sporanox®: Requires trial and failure of generic itraconazole Sporanox® Liquid: Clinical reason solid oral cannot be used <i>Tolsura: Approved for diagnosis of Aspergillosis, Blastomycosis, and Histoplasmosis and requires a trial and failure of generic itraconazole</i> 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, <i>S. apiospermum</i> and <i>Fusarium spp.</i>, Oropharyngeal/esophageal candidiasis refractory to fluconazole

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ANTIFUNGALS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ANTIFUNGAL		
clotrimazole CREAM (generic for Lotrimin) RX, OTC clotrimazole SOLN OTC ketoconazole CREAM, SHAMPOO (generic for Nizoral) LAMISIL (terbinafine) SPRAY OTC LAMISIL AT CREAM (terbinafine) OTC miconazole CREAM, POWDER OTC nystatin terbinafine OTC (generic for Lamisil AT) tolnaftate AERO POWDER, CREAM, POWDER, OTC (generic for Tinactin)	ALEVAZOL (clotrimazole) OTC 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) FUNGOID OTC JUBLIA (efinaconazole) KERIDYN (tavaborole) ketoconazole FOAM (generic for Extina, 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 CREAM, GEL (generic for Naftin) oxiconazole (generic for Oxistat) salicylic acid (generic Bensal HP) tolnaftate SPRAY , OTC	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class within the last 6 months Drug-specific criteria: <ul style="list-style-type: none"> Extina: Requires trial and failure or contraindication to other ketoconazole forms Jublia: Approved diagnoses include Onychomycosis of the toenails due to <i>T. rubrum</i> OR <i>T. Mentagrophytes</i> 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
ANTIFUNGAL/STEROID COMBINATIONS		
clotrimazole/betamethasone CREAM (generic for Lotrisone)	clotrimazole/betamethasone LOTION (generic for Lotrisone) nystatin/triamcinolone (generic for Mycolog)	

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ANTI-HISTAMINES, 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} levocetirizine (generic for Xyzal) SOLUTION loratadine CAPSULE, CHEWABLE, DISPERSABLE TABLET (generic for Claritin Reditabs)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed TWO preferred agents within this drug class Combination products not covered – individual products may be covered

ANTI-HYPERTENSIVES, 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 methyldopa/hydrochlorothiazide	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a 30-day trial with ONE preferred agent within this drug class

ANTI-HYPERURICEMICS

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} ULORIC (febuxostat) ^{CL}	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class colchicine tablet®: Approved without trial for familial Mediterranean fever OR pericarditis Uloric®: Clinical reason why allopurinol cannot be used

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ANTIMIGRAINE AGENTS, OTHER

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
EMGALITY (galcanezumab-gnlm) ^{CL, QL} PEN, SYR	AIMOVIG AUTOINJECTOR <i>(erenumab-aooe)^{CL, QL}</i> AJOVY (fremanezumab-vfrm) ^{CL, QL} CAFERGOT (ergotamine/cafeine) CAMBIA (diclofenac potassium) dihydroergotamine mesylate NASAL ERGOMAR SUBLINGUAL (ergotamine tartrate) MIGERGOT (ergotamine/cafeine) RECTAL MIGRANAL (dihydroergotamine) NASAL	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have a contraindication OR trial failure of a triptan <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Cambia®: Requires diagnosis of migraine and documentation of why solid dosing forms not appropriate Emgality indicated for treatment of episodic cluster headaches <i>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, metoprolol, timolol, atenolol), anti-epileptics (valproate, topiramate), ACE/ARB (lisinopril, candesartan)</i> <i>In addition, Aimovig and Ajovy require a trial of Emgality or patient specific documentation of why Emgality is not appropriate for patient</i>

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ANTIMIGRAINE AGENTS, TRIPTANS^{QL}

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ORAL		<ul style="list-style-type: none">Non-preferred agents will be approved for patients who have failed ALL preferred agents within this drug class <p>Drug-specific criteria:</p> <ul style="list-style-type: none">Sumavel® Dosepro: Requires clinical reason sumatriptan injection cannot be usedOnzetra, Zembrace: approved for patients who have failed ALL preferred agents
RELPAx (eletriptan) ^{QL} 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) sumatriptan/naproxen (generic for Treximet) 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)	<i>CROTAN (crotamiton) LOTION</i> EURAX (crotamiton) CREAM, LOTION lindane malathion (generic for Ovide) spinosad (generic for Natroba) <i>VANALICE (piperonyl butoxide/pyrethrins)</i>	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class

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ANTIPARKINSON'S DRUGS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ANTICHOLINERGICS		<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed ONE preferred agents within this drug class
benztropine (generic for Cogentin)		
trihexyphenidyl (generic for Artane)		
COMT INHIBITORS		Drug-specific criteria: <ul style="list-style-type: none"> Carbidopa/Levodopa ODT: Approved for documented swallowing disorder COMT Inhibitors: Approved if using as add-on therapy with levodopa-containing drug Gocovri: Required diagnosis of Parkinson's disease and had trial of or is intolerant to amantadine AND must be used as an add-on therapy with levodopa-containing drug Inbrija: Approval upon diagnosis of Parkinson's disease and concurrent treatment with carbidopa/levodopa agent Neupro®: <ul style="list-style-type: none"> For Parkinsons: Clinical reason required why preferred agent cannot be used For Restless Leg (RLS): Requires trial OR Contraindication to ropinirole AND pramipexole Osmolex ER: Required diagnosis of Parkinson's disease or drug-induced extrapyramidal reactions and had trial of or is intolerant to amantadine IR Pramipexole ER: Required diagnosis of Parkinson's along with preferred agent trial Ropinerole ER: Required diagnosis of Parkinson's along with preferred agent trial Zelapar®: Approved for documented swallowing disorder
	entacapone (generic for Comtan)	
	tolcapone (generic for Tasmar)	
DOPAMINE AGONISTS		
bromocriptine (generic for Parlodel)	NEUPRO (rotigotine) ^{CL}	
pramipexole (generic for Mirapex)	pramipexole ER (generic for Mirapex ER) ^{CL}	
ropinirole (generic for Requip)	ropinirole ER (generic for Requip XL) ^{CL}	
MAO-B INHIBITORS		
selegiline TABLET (generic for Eldepryl)	rasagiline (generic for Azilect) ^{QL}	
	selegiline CAPSULE (gen. for Eldepryl)	
	XADAGO (safinamide)	
	ZELAPAR (selegiline) ^{CL}	
OTHER ANTIPARKINSON'S DRUGS		
amantadine CAPSULE, SYRUP (generic for Symmetrel)	amantadine TABLET	
carbidopa/levodopa (generic for Sinemet)	carbidopa (generic for Lodosyn)	
carbidopa/levodopa ER (generic for Sinemet CR)	carbidopa/levodopa ODT (generic for Parcopa)	
levodopa/carbidopa/entacapone (generic for Stalevo)	DUOPA (carbidopa/levadopa)	
	GOCOVRI (amantadine) ^{QL}	
	INBRIJA (levodopa) INHALER ^{NR, CL, QL}	
	OSMOLEX ER (amantadine) ^{QL}	
	RYTARY (carbidopa/levodopa)	
	STALEVO (levodopa/carbidopa/entacapone)	

ANTIPSORIATICS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
acitretin (generic for Soriatane)	DUOBRII (halobetasol propionate/tazarotene) ^{NR}	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial with THE preferred agent within this drug class Trial of acitretin (Pregnancy category X) not required in pregnancy or while attempting or planning pregnancy
	methoxsalen (generic for Oxsoalene-Ultra)	
	SORIATANE (acitretin)	

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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	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial with TWO preferred agents within this drug class <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> 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		<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed TWO diagnosis-appropriate preferred agents within this drug class <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> 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) HEMANGEOL (propranolol) oral solution INDERAL XL (propranolol) INNOPRAN XL (propranolol) KAPSPARGO SPRINKLE (metoprolol ER) LEVATOL (penbutolol) metoprolol/HCTZ (generic for Lopressor HCT) nadolol (generic for Corgard) nadolol/bendroflumethiazide (generic for Corzide) pindolol (generic for Viskin) propranolol/hydrochlorothiazide (generic for Inderide) timolol (generic for Blocadren) TOPROL XL (metoprolol)	
BETA- AND ALPHA-BLOCKERS		
carvedilol (generic for Coreg) labetalol (generic for Trandate)	carvedilol ER (generic for Coreg CR)	
ANTIARRHYTHMIC		
sotalol (generic for Betapace)	SOTYLIZE (sotalol)	

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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)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class

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) solifenacin (generic for Vesicare) tolterodine & ER (generic for Detrol/LA) trospium & ER (generic for Sanctura/XR)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Myrbetriq®: Covered without trial in contraindication to anticholinergic agents

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BONE RESORPTION SUPPRESSION AND RELATED DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BISPHOSPHONATES		<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within the same group
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		<ul style="list-style-type: none"> 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 heterotrophic ossification Forteo®: Covered for high risk of fracture <ul style="list-style-type: none"> 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
calcitonin-salmon NASAL raloxifene (generic for Evista)	EVISTA (raloxifene) FORTEO (teriparatide) ^{QL} TYMLOS (abaloparatide)	

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BPH (BENIGN PROSTATIC HYPERPLASIA TREATMENTS)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ALPHA BLOCKERS		<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class
alfuzosin (generic for Uroxatral) doxazosin (generic for Cardura) tamsulosin (generic for Flomax) terazosin (generic for Hytrin)	CARDURA XL (doxazosin) silodosin (generic for Rapaflo)	
5-ALPHA-REDUCTASE (5AR) INHIBITORS		Drug-specific criteria: <ul style="list-style-type: none"> Avodart®: Covered for males only Cardura XL®: Requires clinical reason generic IR form cannot be used Flomax®: Females covered for a 7 day supply with diagnosis of acute kidney stones Jalyn®: Requires clinical reason why individual agents cannot be used Proscar®: Covered for males only Uroxatral®: Covered for males only
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		<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class
PROAIR HFA (albuterol) PROVENTIL HFA (albuterol)	albuterol sul. HFA (generic for ProAir HFA, <i>Proventil HFA</i> , Ventolin HFA) PROAIR RESPICLICK (albuterol) levalbuterol HFA (generic for Xopenex HFA)	
INHALERS – Long Acting		Drug-specific criteria: <ul style="list-style-type: none"> 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
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)	

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CALCIUM CHANNEL BLOCKERS, ORAL

Preferred Agents		Non-Preferred Agents	Prior Authorization/Class Criteria
SHORT-ACTING			<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> 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)	felodipine ER (generic for Plendil)		
nifedipine ER (generic for Procardia XL/Adalat CC)	nisoldipine (generic for Sular)		
Non-dihydropyridines			
diltiazem ER (generic for Cardizem CD)	CALAN SR (verapamil)		
verapamil ER TABLET	diltiazem LA (generic for Cardizem LA)		
	MATZIM LA (diltiazem)		
	TIAZAC (diltiazem)		
	verapamil ER CAPSULE		
	verapamil 360mg CAPSULE		
	verapamil ER PM (generic for Verelan PM)		

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CEPHALOSPORINS AND RELATED ANTIBIOTICS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BETA LACTAM/BETA-LACTAMASE INHIBITOR COMBINATIONS		Non-preferred agents will be approved for patients who have failed a 3-day trial of ONE preferred agent within the same group
amoxicillin/clavulanate TABLETS, SUSPENSION	amoxicillin/clavulanate, CHEWABLE amoxicillin/clavulanate 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)	cefixime CAPSULE, SUSPENSION (generic for Suprax) cefpodoxime (generic for Vantin) SUPRAX CAPSULE, CHEWABLE TAB, SUSPENSION, TABLET (cefixime)	

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, VIAL ZARXIO (filgrastim-sndz)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

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CONTRACEPTIVES, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<p>All reviewed agents are recommended preferred at this time</p> <p>Brand name products may be subject to Maximum Allowable Cost (MAC) pricing or require substitution with a generic equivalent</p> <p>Specific agents can be looked up using the Drug Look-up Tool at:</p>		

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

COPD (CHRONIC OBSTRUCTIVE PULMONARY DISEASE) AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
INHALERS		<ul style="list-style-type: none">Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class OR Patient specific documentation of inability to use traditional inhaler device. <p>Drug-specific criteria:</p> <ul style="list-style-type: none">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)	ANORO ELLIPTA (umeclidinium/vilanterol)	
BEVESPI AEROSPHERE (glycopyrolate/formoterol)	INCRUSE ELIPTA (umeclidinium)	
COMBIVENT RESPIMAT (albuterol/ ipratropium)	SEEBRI NEOHALER (glycopyrolate)	
STIOLTO RESPIMAT (tiotropium/olodaterol)	SPIRIVA RESPIMAT (tiotropium)	
SPIRIVA (tiotropium)	TUDORZA PRESSAIR (aclidinium br)	
	UTIBRON NEOHALER (indacaterol/glycopyrolate)	
INHALATION SOLUTION		
albuterol/ipratropium (generic for Duoneb)	LONHALA (glycopyrrolate inhalation soln)	
ipratropium SOLUTION (generic for Atrovent)	YUPELRI (revefenacin) ^{NR}	
ORAL AGENT		
	DALIRESP (roflumilast) ^{CL}	

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COUGH AND COLD, OPIATE COMBINATION

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
guaifenesin/codeine LIQUID promethazine/codeine SYRUP	hydrocodone/homatropine SYRUP promethazine/phenylephrine/codeine SYRUP pseudoephedrine/codeine/ guaifenesin (generic for Lortuss EX, Tusnel C, Virtussin DAC)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class All codeine or hydrocodone containing cough and cold combinations are limited to ≥ 18 years of age

CYSTIC FIBROSIS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	KALYDECO PACKET, TABLET (ivacaftor) ^{QL, AL} ORKAMBI (lumacaftor/ivacaftor) PACKET, TABLET ^{QL, AL} SYMDEKO (tezacaftor/ivacaftor) ^{QL, AL}	<p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Kalydeco®: Diagnosis of CF and documentation of the drug-specific, FDA-approved mutation of CFTR gene <ul style="list-style-type: none"> Minimum age: 6 months Orkambi®: Diagnosis of CF and documentation of presence of two copies of the F580del mutation (homozygous) of CFTR gene <ul style="list-style-type: none"> 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. <ul style="list-style-type: none"> Minimum age: 6 years

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CYTOKINE & CAM ANTAGONISTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
COSENTYX (secukinumab) ^{CL} ENBREL (etanercept) KIT, MINI CART, PEN^{QL} HUMIRA (adalimumab) ^{QL}	ACTEMRA (tocilizumab) SUB-Q ARCALYST (niloncept) CIMZIA (certolizumab pegol) ^{QL} ILUMYA (tildrakizumab) SUB-Q KEVZARA (sarilumab) SUB-Q, PEN, SYRINGE KINERET (anakinra) OLUMIANT (baricitinib) ORAL^{QL} ORENCIA (abatacept) SUB-Q OTEZLA (apremilast) ORAL^{QL} SILIQ (brodalumab) SIMPONI (golimumab) SKYRIZI (<i>risankizumab-rzaa</i>) ^{NR} STELARA (ustekinumab) SUB-Q TALTZ (ixekizumab) ^{AL} TREMFYA (guselkumab) ^{QL} XELJANZ (tofacitinib) ORAL^{QL} XELJANZ XR (tofacitinib) ORAL^{QL}	<ul style="list-style-type: none"> Preferred agents will be approved with FDA-approved indication – ICD-10 diagnosis code is required. Non-preferred agents will be approved for FDA-approved indications in patients who have failed a trial of ONE preferred agent within this drug class, or upon diagnosis for non-preferred agent with FDA-approved indication if no preferred agent has FDA approval for diagnosis. <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Cosentyx: Requires trial of Humira

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DIURETICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
SINGLE-AGENT PRODUCTS		• Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class
amiloride TABLET bumetanide TABLET chlorothiazide TABLET chlorthalidone TABLET (generic for Diuril) furosemide SOLUTION, TABLET (generic for Lasix) hydrochlorothiazide CAPSULE, TABLET (generic for Microzide) indapamide TABLET metolazone TABLET spironolactone TABLET (generic for Aldactone) torsemide TABLET	CAROSPIR (spironolactone) SUSPENSION eplerenone TABLET (generic for Inspra) ethacrynic acid CAPSULE (generic for Edecrin)) methyclothiazide TABLET	
COMBINATION PRODUCTS		
amiloride/HCTZ TABLET spironolactone/HCTZ TABLET (generic for Aldactazide) triamterene/HCTZ CAPSULE, TABLET (generic for Dyazide, Maxzide (25))		

ENZYME REPLACEMENT, GAUCHERS DISEASE

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ZAVESCA (miglustat) ^{CL}	CERDELGA (eliglustat) miglustat (generic Zavesca)	<ul style="list-style-type: none"> Non-preferred agents require clinical documentation why the preferred product within this drug class is not appropriate <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Zavesca: Approved for mild to moderate type 1 Gaucher disease for whom enzyme replacement therapy is not a therapeutic option

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EPINEPHRINE, SELF-INJECTED^{QL}

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
epinephrine (generic for Epipen/ Epipen Jr.)	epinephrine (generic for Adrenaclick) EPIPEN EPIPEN JR. SYMJEPI ^{NR}	<ul style="list-style-type: none"> Non-preferred agents require clinical documentation why the preferred product within this drug class is not appropriate <p>Brand name product may be authorized in event of documented national shortage of generic product.</p>

ERYTHROPOIESIS STIMULATING PROTEINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
RETACRIT (EPOETIN ALFA- EPBX)	EPOGEN (rHuEPO) PROCRT (rHuEPO)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

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	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a 3-day trial of ONE preferred agent within this drug class <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> 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)

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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) <i>MOTEGRITY (prucalopride succinate)</i> RELISTOR (methylnaltrexone) TABLET^{QL} SYMPROIC (naldemedine) TRULANCE (plecanatide) ^{QL} VIBERZI (eluxodoline)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a 30-day trial of ONE preferred agent within this drug class <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> 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

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GLUCOCORTICIDS, INHALED

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
GLUCOCORTICIDS		<ul style="list-style-type: none"> Non-preferred agents within the Glucocorticoids and Glucocorticoid/Bronchodilator Combo groups will be approved for patients who have failed a trial of TWO preferred agents within this drug class within the last 6 months
ASMANEX (mometasone) ^{QL,AL} FLOVENT HFA (fluticasone) PULMICORT FLEXHALER (budesonide)	AEROSPAN (flunisolide) ALVESCO (ciclesonide) ^{AL,CL} ARMONAIR RESPICLICK (fluticasone) ^{AL} ARNUITY ELLIPTA (fluticasone) ASMANEX HFA (mometasone) ^{AL,QL} FLOVENT DISKUS (fluticasone) QVAR (beclomethasone) QVAR Redihaler (beclomethasone)	
GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS		Drug-specific criteria: <ul style="list-style-type: none"> budesonide respules: Covered without PA for age ≤ 8 years OR for diagnosis of eosinophilic esophagitis in patients ≥ 9 years, by GI biopsy or upper endoscopy. For other indications, must have failed a trial of two preferred agents within this drug class, within the last 6 months.
ADVAIR DISKUS (fluticasone/salmeterol) ^{QL} DULERA (mometasone/formoterol) SYMBICORT (budesonide/ formoterol)	ADVAIR HFA (fluticasone/salmeterol) ^{QL} BREO ELLIPTA (fluticasone/vilanterol) fluticasone/salmeterol (generic for Advair Diskus) fluticasone/salmeterol (generic for Airduo Respiclick) TRELEGY ELLIPTA (fluticasone/umeclidinium/vilanterol) WIXELA INHUB (generic for Advair Diskus)	
INHALATION SOLUTION		
	budesonide RESPULES (generic for Pulmicort)	

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GLUCOCORTICOIDS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
budesonide EC CAPSULE (generic for Entocort EC) dexamethasone SOLN, TABLET dexamethasone ELIXIR hydrocortisone TABLET methylprednisolone DOSE PAK methylprednisolone tablet (generic for Medrol) prednisolone SOLUTION prednisolone sodium phosphate prednisone DOSE PAK prednisone TABLET	CORTEF (hydrocortisone) cortisone TABLET dexamethasone INTENSOL DEXPAK (dexamethasone) DXEVO (<i>dexamethasone</i>) ^{NR} EMFLAZA (deflazacort) SUSPENSION, TABLET ^{CL} ENTOCORT EC (budesonide) methylprednisolone 8mg, 16mg PEDIAPRED (prednisolone sodium phosphate) prednisolone sodium phosphate (generic for Millipred/Veripred) prednisolone sodium phosphate ODT prednisone SOLUTION prednisone INTENSOL RAYOS DR (prednisone) TABLET	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agents within this drug class within the last 6 months Drug-specific criteria: <ul style="list-style-type: none"> Emflaza: Indicated for the treatment of Duchenne muscular dystrophy (DMD) in patients 5 years of age and older <ul style="list-style-type: none"> Approved after trial/failure with prednisone Intensol Products: Patient specific documentation of why the less concentrated solution is not appropriate for the patient

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) ZORBIVE (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}	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

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HEMOPHILIA TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
FACTOR VIII		<ul style="list-style-type: none">Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug classPatients receiving a hemophilia agent which moved from preferred to non-preferred status on 1-17-19 will be allowed to continue same therapy
ADVATE ALPHANATE HUMATE-P MONOCLATE-P NOVOEIGHT NUWIQ RECOMBIMATE XYNTHA KIT, SOLOFUSE	ADYNOVATE AFSTYLA ELOCTATE HELIXATE FS HEMOFIL-M JIVI ^{AL} KOATE-DVI KIT, VIAL KOGENATE FS KOVALTRY OBIZUR	
FACTOR IX		
BENEFIX MONONINE PROFILNINE SD	ALPHANINE SD ALPROLIX BEBULIN IDELVION IXINITY REBINYN RIXUBIS	
FACTOR VIIa AND PROTHROMBIN COMPLEX-PLASMA DERIVED		
NOVOSEVEN RT	FEIBA NF	
FACTOR X AND XIII PRODUCTS		
CORIFACT ^{CL}	COAGADEX ^{CL} TRETTE ^{CL}	
VON WILLEBRAND PRODUCTS		
WILATE	VONVENDI ^{CL}	
BISPECIFIC FACTORS		
	HEMLIBRA ^{CL}	

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)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

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HEPATITIS C TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
DIRECT ACTING ANTI-VIRAL		Hepatitis C Treatments PA Form Hepatitis C Criteria
MAVYRET (glecaprevir/pibrentasvir) ^{CL} VOSEVI (sofosbuvir/velpatasvir/ voxilaprev) ^{CL}	DAKLINZA (daclatasvir) ^{CL} OLYSIO (simeprevir) ^{CL} sofosbuvir/ledipasvir (generic for Harvoni) ^{CL} sofosbuvir/velpatasvir (generic for Epclusa) ^{CL} SOVALDI (sofosbuvir) ^{CL} TECHNIVIE (ombitasvir/paritaprevir/ ritonavir) ^{CL} VIEKIRA PAK (ombitasvir/ paritaprevir/ritonavir/dasabuvir) ^{CL} ZEPATIER (elbasvir/grazoprevir) ^{CL}	<ul style="list-style-type: none"> Non-preferred products require trial of preferred agents within the same group and will only be considered with documentation of why the preferred product within this drug class 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
RIBAVIRIN		
ribavirin 200mg TABLET, CAPSULE	REBETOL (ribavirin)	
INTERFERON		
PEGASYS (pegylated interferon alfa-2a) ^{CL} PEG-INTRON (pegylated interferon alfa-2b) ^{CL}		<p>Drug-specific criteria: Trial with Mavyret not required in the following:</p> <ul style="list-style-type: none"> Epclusa: For genotype 1-6 with decompensated cirrhosis along with ribavirin Harvoni: <ul style="list-style-type: none"> 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

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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	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> cimetidine: Approved for viral <i>M. contagiosum</i> or common wart <i>V. Vulgaris</i> treatment nizatadine/cimetidine solution/ famotidine suspension: Requires clinical reason why ranitidine syrup cannot be used

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HIV / AIDS^{CL}

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CCR5 ANTAGONISTS		<ul style="list-style-type: none">Non-preferred agents will be approved for patients who have a diagnosis of HIV/AIDS and patient specific documentation of why the preferred products within this drug class are not appropriate for patient, <i>including, but not limited to, drug resistance or concomitant conditions not recommended with preferred agents</i>Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapyDiagnosis of HIV/AIDS required OR <ul style="list-style-type: none">Pre and Post Exposure Prophylaxis
SELZENTRY SOLN, TAB (maraviroc)		
FUSION INHIBITORS		
FUZEON SUB-Q (enfuvirtide) ^{QL}		
INTEGRASE STRAND TRANSFER INHIBITORS (INSTIs)		
ISENTRESS CHEW TAB, POWDER PACK, TAB (raltegravir) ^{QL}		
ISENTRESS HD (raltegravir)		
TIVICAY (dolutegravir)		
NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NNRTIs)		
EDURANT (rilpivirine)	efavirenz (generic for Sustiva)	
INTELENCE (etravirine) ^{QL}	nevirapine TAB (generic for Viramune)	
PIFELTRO (doravirine) ^{QL}	nevirapine er (generic for Viramune XR)	
SUSTIVA CAP, TAB (efavirenz)	RESCRIPTOR (delavirdine)	
	VIRAMUNE SUSP, TAB (nevirapine)	
	VIRAMUNE XR (nevirapine extended release)	
NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTIs)		
abacavir SOLN, TAB (generic for Ziagen)	didanosine CAP DR (generic for Videx EC)	
EMTRIVA CAP, SOLN (emtricitabine)	EPIVIR (lamivudine)	
lamivudine SOLN, TAB (generic for Epivir)	RETROVIR (zidovudine)	
zidovudine CAP, SYRUP, TAB (generic for Retrovir)	stavudine CAP (generic for Zerit)	
	VIDEX SOLN (didanosine)	
	VIDEX EC (didanosine)	
	ZIAGEN (abacavir)	

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HIV / AIDS^{CL} (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTIs)		
<i>tenofovir disoproxil fumarate</i> TAB (generic for Viread)	<i>VIREAD (tenofovir disoproxil fumarate)</i>	
PHARMACOKINETIC ENHANCER		
TYBOST (cobicistat) ^{QL}		
PROTEASE INHIBITORS		
<i>atazanavir CAP</i> (generic for Reyataz) LEXIVA SUSP, TAB (fosamprenavir) NORVIR TAB (ritonavir) PREZISTA SUSP, TAB darunavir)	<i>APTIVUS CAP, SOLN</i> (tipranavir) <i>CRIXIVAN</i> (indinavir) fosamprenavir TAB (generic for Lexiva) <i>INVIRASE</i> (saquinavir) <i>NORVIR POWDER PACK</i> <i>NORVIR SOLN</i> (ritonavir) <i>REYATAZ CAP, POWDER PACK</i> (atazanavir) ritonavir TAB (generic for Norvir) <i>VIRACEPT</i> (nelfinavir)	
COMBINATION NUCLEOS(T)IDE REVERSE TRANSCRIPTASE INHIBITORS		
abacavir/lamivudine (generic for Epzicom) abacavir/lamivudine/zidovudine (generic for Trizivir) <i>CIMDUO (lamivudine/tenofovir disoproxil fumarate)</i> ^{QL} DESCOVY (emtricitabine/tenofovir alafenamide) ^{QL} lamivudine/zidovudine (generic for Combivir) TRUVADA (emtricitabine/tenofovir disoproxil fumarate)	COMBIVIR (lamivudine/zidovudine) EPZICOM (abacavir sulfate/lamivudine) TRIZIVIR (abacavir/ lamivudine/zidovudine)	

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HIV / AIDS^{CL} (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
COMBINATION PROTEASE INHIBITORS (PIs) or PIs plus PHARMACOKINETIC ENHANCER		
EVOTAZ (atazanavir sulfate/cobicistat) ^{QL} KALETRA TAB (lopinavir/ritonavir) PREZCOBIX (darunavir/cobicistat) ^{QL} lopinavir/ritonavir SOLN (generic for Kaletra)	KALETRA SOLN (lopinavir/ritonavir)	
COMBINATION PRODUCTS – MULTIPLE CLASSES		
ATRIPLA (tenofovir disoproxil fumarate/ emtricitabine/efavirenz) BIKTARVY (bictegravir/emtricitabine/ tenofovir alafenamide) ^{QL} COMPLERA (rilpivirine/emtricitabine/tenofovir disoproxil fumarate) <i>DELSTRIGO</i> <i>(doravirine/lamivudine/tenofovir disoproxil fumarate)^{QL}</i> GENVOYA (elvitegravir/cobicistat/emtricitabi ne/tenofovir alafenamide) ^{QL, AL} ODEFSEY (emtricitabine/rilpivirine/tenofovir alafenamide) ^{QL} STRIBILD (elvitegravir/cobicistat/emtricitabin e/tenofovir disoproxil fumarate) ^{QL} <i>SYMFI (efavirenz/lamivudine/tenofovir disoproxil fumarate)^{QL}</i> <i>SYMFI LO (efavirenz/lamivudine/ tenofovir disoproxil fumarate)^{QL}</i> <i>SYMTUZA (darunavir, cobicistat, emtricitabine, tenofovir alafenamide)^{QL}</i> TRIUMEQ (dolutegravir/abacavir/lamivudine)	<i>DOVATO (dolutegravir/lamifudine)^{NR, QL}</i> <i>JULUCA (dolutegravir/rilpivirine)^{QL}</i>	

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HYPOGLYCEMICS, ALPHA-GLUCOSIDASE INHIBITORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
acarbose (generic for Precose) Glyset (miglitol)	miglitol (generic for Glyset)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
GLUCAGON-LIKE PEPTIDE-1 RECEPTOR AGONIST (GLP-1 RA)^{CL}		Preferred agents require metformin trial and diagnosis of diabetes
BYDUREON (exenatide ER) subcutaneous	ADLYXIN (lixisenatide)	Non-preferred agents will be approved for patients who have: <ul style="list-style-type: none"> Failed a trial of TWO preferred agents within GLP-1 RA AND <ul style="list-style-type: none"> Diagnosis of diabetes with HbA1C ≥ 7 AND Trial of metformin, or contraindication or intolerance to metformin
BYDUREON PEN (exenatide ER) subcutaneous	BYDUREON BCISE PEN (exenatide) ^{QL}	
BYETTA (exenatide) subcutaneous	OZEMPIC (semaglutide)	
VICTOZA (liraglutide) subcutaneous	TANZEUM (albiglutide)	
	TRULICITY (dulaglutide)	
INSULIN/GLP-1 RA COMBINATIONS		
	SOLIQUA (insulin glargine/lixisenatide)	
	XULTOPHY (insulin degludec/liraglutide)	
AMYLIN ANALOG		
	SYMLIN (pramlintide) subcutaneous	ALL criteria must be met <ul style="list-style-type: none"> Concurrent use of short-acting mealtime insulin Current therapy compliance No diagnosis of gastroparesis HbA1C $\leq 9\%$ within last 90 days Fingerstick monitoring of glucose during <u>initiation</u> of therapy
DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITOR		
GLYXAMBI (empagliflozin/linagliptin) ^{QL}	alogliptin (generic for Nesina) ^{QL}	Non-preferred agents within DPP-4 will be approved for patients who have failed a trial of ONE preferred agent within DPP-4
JANUMET (sitagliptin/metformin) ^{QL}	alogliptin/metformin (generic for Kazano) ^{QL}	
JANUMET XR(sitagliptin/metformin) ^{QL}	JENTADUETO XR (linagliptin/metformin) ^{QL}	
JANUVIA (sitagliptin) ^{QL}	KOMBIGLYZE XR (saxagliptin/metformin) ^{QL}	
JENTADUETO (linagliptin/metformin) ^{QL}	ONGLYZA (saxagliptin) ^{QL}	
TRADJENTA (linagliptin) ^{QL}	alogliptin/pioglitazone (generic for Oseni) ^{QL}	
	QTERN (dapagliflozin/saxagliptin) ^{QL}	
	STEGLUJAN (ertugliflozin/sitagliptin) ^{QL}	

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HYPOGLYCEMICS, INSULIN AND RELATED DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
HUMALOG (insulin lispro) U-100 CARTRIDGE, PEN, VIAL HUMALOG 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 insulin lispro (generic for Humalog) PEN, VIAL NOVOLIN (insulin) NOVOLIN 70/30 VIAL TOUJEO SOLOSTAR (insulin glargine) TRESIBA (insulin degludec)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients with: Failure of a trial of ONE preferred agent in another Hypoglycemic class OR T2DM and inadequate glycemic control

HYPOGLYCEMICS, METFORMINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
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)	<ul style="list-style-type: none"> Metformin ER (generic Fortamet[®])/Glumetza[®]: Requires clinical reason why generic Glucophage XR[®] cannot be used Riomet[®]: Prior authorization not required for age <7 years

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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} SEGLUOMET (ertugliflozin/metformin) ^{QL} STEGLATRO (ertugliflozin) ^{QL} SYNJARDY (empagliflozin/metformin) SYNJARDY XR (empagliflozin/ metformin) ^{QL} XIGDUO XR (dapagliflozin/metformin) ^{QL}	<ul style="list-style-type: none"> Preferred agents are Approved for diagnosis of diabetes AND a trial of metformin Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class

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	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

HYPOGLYCEMICS, TZD

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
THIAOLIDINEDIONES (TZDs)		<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of THE preferred agent within this drug class
pioglitazone (generic for Actos)	AVANDIA (rosiglitazone)	
TZD COMBINATIONS		<ul style="list-style-type: none"> Combination products: Require clinical reason why individual ingredients cannot be used
	pioglitazone/glimepiride (generic for Duetact) pioglitazone/metformin (generic for Actoplus Met)	

IDIOPATHIC PULMONARY FIBROSIS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	ESBRIET (pirfenidone) OFEV (nintedanib esylate)	<ul style="list-style-type: none"> Non-preferred agents require: Use limited to FDA-approved indications

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IMMUNOMODULATORS, ATOPIC DERMATITIS^{AL}

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ELIDEL (pimecrolimus)	DUPIXENT (dupilumab) ^{CL} EUCRISA (crisaborole) pimecrolimus (generic for Elidel) tacrolimus (generic for Protopic) ^{CL}	<ul style="list-style-type: none"> Non-preferred agents require: Trial of a topical steroid AND Trial of one preferred product within this drug class Drug-specific criteria: <ul style="list-style-type: none"> Dupixent: For atopic dermatitis, must have trial of Eucrisa; For moderate to severe asthma, must have eosinophilic phenotype or oral corticosteroid dependent asthma uncontrolled with maintenance controller medication; <i>For adults with chronic rhinosinusitis with nasal polyps, must document inadequate control on current treatment regimen and be used as add-on maintenance treatment with intranasal steroid</i>

IMMUNOMODULATORS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
imiquimod (generic for Aldara)	ALDARA (imiquimod) imiquimod (generic for Zyclara) podofilox (generic for Condyllox) VEREGEN (sinecatechins) ZYCLARA (imiquimod)	<ul style="list-style-type: none"> Non-preferred agents require clinical reason why preferred agent within this drug class cannot be used

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IMMUNOSUPPRESSIVES, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
azathiaprine (generic Imuran) cyclosporine, modified CAPSULE (generic for Neoral) mycophenolate mofetil CAPSULE, TABLET (generic for Cellcept) RAPAMUNE (sirolimus) SOLUTION tacrolimus	ASTAGRAF XL (tacrolimus) AZASAN (azathioprine) <i>cyclosporine CAPSULE, SOFTGEL</i> cyclosporine, modified SOLUTION (generic for Neoral) ENVARSUS XR (tacrolimus) GENGRAF (cyclosporine, modified) CAPSULE, SOLUTION mycophenolate mofetil SUSPENSION (generic for Cellcept) mycophenolic acid (mycophenolate sodium) MYFORTIC (mycophenolate sodium) PROGRAF (tacrolimus) CAPSULE, PACKET^{NR} RAPAMUNE (sirolimus) TABLET SANDIMMUNE (cyclosporine) CAPSULE, SOLUTION <i>sirolimus</i> (generic for Rapamune) SOLUTION, TABLET ZORTRESS (everolimus)	Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class <ul style="list-style-type: none"> 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 this drug class
ipratropium (generic for Atrovent)		
ANTI HISTAMINES		Drug-specific criteria: <ul style="list-style-type: none"> 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 Xhance: Indicated for treatment of nasal polyps in ≥ 18 years only
azelastine 0.1% (generic for Astelin)	azelastine 0.15% (generic for Astepro) DYMISTA (azelastine/fluticasone) olopatadine (generic for Patanase)	
CORTICOSTEROIDS		
fluticasone (generic for Flonase)	BECONASE AQ (beclomethasone) budesonide Rx (generic for Rhinocort) flunisolide (generic for Nasalide) mometasone (generic for Nasonex) OMNARIS (ciclesonide) QNASL 40 & 80 (beclomethasone) TICANASE (fluticasone) VERAMYST (fluticasone) XHANCE (fluticasone) ZETONNA (ciclesonide)	

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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) zileuton ER (generic for Zyflo CR) ZYFLO (zileuton)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a 30-day trial of THE preferred agent within this drug class <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

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LIPOTROPICS, OTHER

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BILE ACID SEQUESTRANTS		<ul style="list-style-type: none">Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: <ul style="list-style-type: none">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 formLovaza®: Approved for TG ≥ 500Praluent®: Approved for diagnoses of:<ul style="list-style-type: none">atherosclerotic cardiovascular disease (ASCVD)heterozygous familial hypercholesterolemia (HeFH) AND <ul style="list-style-type: none">Maximized high-intensity statin WITH ezetimibe for at 3 continuous monthsFailure to reach target LDL-C levels: ASCVD - < 70 mg/dL, HeFH - < 100 mg/dL <ul style="list-style-type: none">Repatha®: Approved for:<ul style="list-style-type: none">adult diagnoses of atherosclerotic cardiovascular disease (ASCVD)heterozygous familial hypercholesterolemia (HeFH)homozygous familial hypercholesterolemia (HoFH) in age ≥ 13statin-induce rhabdomyolysis AND <ul style="list-style-type: none">Maximized high-intensity statin WITH ezetimibe for 3+ continuous monthsFailure to reach target LDL-C levels: ASCVD - < 70 mg/dL, HeFH - < 100 mg/dLConcurrent use of maximally-tolerated statin must continue <ul style="list-style-type: none">Vascepa®: Approved for TG ≥ 500WelChol®: Trial not required for diabetes control and monotherapy with metformin, sulfonylurea, or insulin has been inadequate
cholestyramine (generic for Questran)	colesevelam (generic for Welchol)	
colestipol TABLETS (generic for Colestid)	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)	fenofibrate (generic for Antara, Fenoglide, Lipofen, Lofibra, Triglide)	
gemfibrozil (generic for Lopid)	fenofibric acid (generic for Fibracor) fenofibric acid (generic for Trilipix)	
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}	

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LIPOTROPICS, STATINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
STATINS		<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agent within this drug class, within the last 12 months
atorvastatin (generic for Lipitor) ^{QL} lovastatin (generic for Altoprev) pravastatin (generic for Pravachol) rosuvastatin (generic for Crestor) simvastatin (generic for Zocor)	EZALLOR SPRINKLE (rosuvastatin) ^{NR, QL} fluvastatin/ER (generic for Lescol/XL) LIVALO (pitavastatin) ZYPITAMAG (pitavastatin)	
STATIN COMBINATIONS		Drug-specific criteria: <ul style="list-style-type: none"> 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/amlodipine (generic for Caduet) simvastatin/ezetimibe (generic for Vytorin)	

MACROLIDES AND KETOLIDES, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
KETOLIDES		<ul style="list-style-type: none"> Ketek®: Requires clinical reason why patient cannot use preferred macrolide
	KETEK (telithromycin)	
MACROLIDES		<ul style="list-style-type: none"> Macrolides: Require clinical reason why preferred products within this drug class cannot be used AND ≥ 3-day trial on a preferred macrolide
azithromycin (generic for Zithromax) clarithromycin TABLET, SUSPENSION (generic for Biaxin)	clarithromycin ER (generic for Biaxin XL) E.E.S. SUSPENSION, TABLET ERY-TAB ERYPED SUSPENSION ERYTHROCIN erythromycin base TABLET, CAPSULE erythromycin ethylsuccinate SUSPENSION ZITHROMAX (azithromycin)	

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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	<ul style="list-style-type: none"> Non-preferred agents will be approved for FDA-approved indications <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> 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} CAP, INITIATION PACK tetrabenazine (generic for Xenazine) ^{CL}	<p>Drug-specific criteria:</p> <ul style="list-style-type: none"> 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} TECFIDERA (dimethyl fumarate)	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} MAVENCLAD (cladiribine) ^{NR} MAYZENT (siponimod) ^{NR, QL} PLEGRIDY (peginterferon beta-1a) ^{QL}	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> 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 Macrochantin) nitrofurantoin monohydrate-macrocrystals CAPSULE (generic for Macrobid)		<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

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NSAID

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
COX-I SELECTIVE		<ul style="list-style-type: none"> Non-preferred agents within COX-1 SELECTIVE group will be approved for patients who have failed no less than 30-day trial of TWO preferred agents within this drug class <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> 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 OTC, Rx (generic for Advil, Motrin) CHEW, DROPS, SUSPENSION, TABLET 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, Zipsor) 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) <i>QMIIZ ODT (meloxicam)^{NR, QL}</i> tolmetin (generic for Tolectin)	

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CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

AL – Age Limit

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NSAID (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
COX-I SELECTIVE (continued)		Drug-specific criteria: <ul style="list-style-type: none">▪ 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 (meloxicam 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)	<ul style="list-style-type: none"> ▪ 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 reason patient cannot use oral dosage form

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ONCOLOGY AGENTS, ORAL, BREAST CANCER

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CDK 4/6 INHIBITOR		<ul style="list-style-type: none">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
IBRANCE (palbociclib)	KISQALI (ribociclib) KISQALI FEMARA CO-PACK VERZENIO (abemaciclib)	
CHEMOTHERAPY		<p>Drug-specific criteria</p> <ul style="list-style-type: none">anastrozole: May be approved for malignant neoplasm of male breast (male breast cancer)capecitabine: Requires trial of Xeloda or clinical reason Xeloda cannot be usedFareston®: Require clinical reason why tamoxifen cannot be usedletrozole: Approved for diagnosis of breast cancer with day supply greater than 12 – NOT approved for short term use
cyclophosphamide XELODA (capecitabine)	capecitabine (generic for Xeloda) ^{CL}	
HORMONE BLOCKADE		
anastrozole (generic for Arimidex) exemestane (generic for Aromasin) letrozole (generic for Femara) tamoxifen citrate (generic for Nolvadex)	toremifene (generic for Fareston) ^{CL}	
OTHER		
	NERLYNX (neratinib) PIQRAY (<i>alpelisib</i>) ^{NR} TYKERB (lapatinib) TALZENNA (<i>talazoparib tosylate</i>) ^{NR, QL}	

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CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

AL – Age Limit

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ONCOLOGY AGENTS, ORAL, HEMATOLOGIC

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ALL		<ul style="list-style-type: none">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 criteria <ul style="list-style-type: none">Hydrea®: Requires clinical reason why generic cannot be usedimatinib: Requires trial of Gleevec or clinical reason Gleevec cannot be usedmelphalan: Requires trial of Alkeran or clinical reason Alkeran cannot be usedTabloid: Prior authorization not required for age <19Tasigna: Patients receiving Tasigna, which changed from preferred to non-preferred on 1-17-19 will be allowed to continue therapy
mercaptopurine	PURIXAN (mercaptopurine)	
AML		
	DAURISMO (glasdegib maleate) ^{NR, QL} IDHIFA (enasidenib) RYDAPT (midostaurin) TIBSOVO (ivosidenib) ^{QL} XOSPATA (gilteritinib) ^{NR, QL}	
CLL		
IMBRUVICA (irutinib) LEUKERAN (chlorambucil)	COPIKTRA (duvelisib) ^{NR, QL} VENCLEXTA (venetoclax) ZYDELIG (idelalisib)	
CML		
GLEEVEC (imatinib) hydroxyurea (generic for Hydrea) MYLERAN (busulfan) SPRYCEL (dasatinib)	BOSULIF (bosutinib) HYDREA (hydroxyurea) ICLUSIG (ponatinib) imatinib (generic for Gleevec) ^{CL} TASIGNA (nilotinib) ^{CL}	
MPN		
JAKAFI (ruxolitinib)		
MYELOMA		
ALKERAN (melphalan) REVLIMID (lenalidomide)	FARYDAK (panobinostat) melphalan (generic for Alkeran) NINLARO (ixazomib) POMALYST (pomalidomide) THALOMID (thalidomide)	
OTHER		
MATULANE (procarbazine)	CALQUENCE (acalabrutinib) ^{QL} TABLOID (thioguanine) tretinoin (generic for Vesanoid) ZOLINZA (vorinostat)	

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QL – Quantity/Duration Limit

AL – Age Limit

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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
ALK		▪ Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines
ALECENSA (alectinib)	ALUNBRIG (brigatinib) LORBRENA (lorlatinib) ^{NR, QL} ZYKADIA (ceritinib) CAPSULE, TABLET	
ALK / ROS1		
XALKORI (crizotinib)		
EGFR		
GILOTRIF (afatinib) IRESSA (gefitinib) TAGRISSO (osimertinib) TARCEVA (erlotinib)	erlotinib (generic for Tarceva) VIZIMPRO (dacomitinib) ^{NR, QL}	
OTHER		
HYCAMTIN (topotecan)		

ONCOLOGY AGENTS, ORAL, OTHER

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CAPRELSA (vandetanib) GLEOSTINE (lomustine) temozolomide (generic for Temodar)	BALVERSA (erdafitinib) ^{NR} COMETRIQ (cabozantinib) HEXALEN (altretamine) LONSURF (trifluridine/tipiracil) LYNPARZA (olaparib) RUBRACA (rucaparib) STIVARGA (regorafenib) VITRAKVI (larotrectinib) CAPSULE, SOLUTION ^{NR, QL} ZEJULA (niraparib)	<ul style="list-style-type: none"> 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	abiraterone (generic for Zytiga) EMCYT (estramustine) ERLEADA (apalutamide) ^{QL} nilutamide (generic for Nilandron) XTANDI (enzalutamide) YONSA (abiraterone acet, submicronized)	<ul style="list-style-type: none"> 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

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QL – Quantity/Duration Limit

AL – Age Limit

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

Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

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ONCOLOGY AGENTS, ORAL, RENAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
INLYTA (axitinib) LENVIMA (lenvatinib) NEXAVAR (sorafenib) SUTENT (sunitinib) VOTRIENT (pazopanib)	AFINITOR (everolimus) AFINITOR DISPERZ (everolimus) CABOMETYX (cabozantinib)	<ul style="list-style-type: none"> 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 <p>Drug-specific criteria</p> <ul style="list-style-type: none"> Afinitor: Patients receiving Afinitor, which changed from preferred to non-preferred on 1-17-19 will be allowed to continue therapy

ONCOLOGY AGENTS, ORAL, SKIN

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BASAL CELL		<ul style="list-style-type: none"> 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
ERIVEDGE (vismodegib)	ODOMZO (sonidegib)	
BRAF MUTATION		<p>Drug-specific criteria</p> <ul style="list-style-type: none"> Odomzo: Patients receiving Odomzo, which changed from preferred to non-preferred on 1-17-19 will be allowed to continue therapy
BRAFTOVI (encorafenib) COTELLIC (cobimetinib) MEKINIST (trametinib) MEKTOVI (binimetinib) TAFINLAR (dabrafenib) ZELBORAF (vemurafenib)		

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QL – Quantity/Duration Limit

AL – Age Limit

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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%)	ALOCRIIL (nedocromil) ALOMIDE (lodoxamide) azelastine (generic for Optivar) BEPREVE (bepotastine besilate) EMADINE (emedastine) epinastine (generic for Elestat) LASTACRAFT (alcaftadine) olopatadine 0.1% (generic for Patanol) olopatadine 0.2% (generic for Pataday) PATADAY (olopatadine 0.2%)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class

OPHTHALMICS, ANTIBIOTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
FLUOROQUINOLONES		<ul style="list-style-type: none">Non-preferred agents will be approved for patients who have failed a one month trial of TWO preferred agent within this drug classAzasite®: Approval only requires trial of erythromycin <p>Drug-specific criteria:</p> <ul style="list-style-type: none">Natacyn®: Approved for documented fungal infection
ciprofloxacin SOLUTION (generic for Ciloxan) MOXEZA (moxifloxacin) ofloxacin (generic for Ocuflox)	BESIVANCE (besifloxacin) CILOXAN (ciprofloxacin) gatifloxacin 0.5% (generic for Zymaxid) levofloxacin moxifloxacin (generic for Vigamox) VIGAMOX (moxifloxacin)	
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/gramicidin) sulfacetamide SOLUTION (generic for Bleph-10) sulfacetamide OINTMENT	

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OPHTHALMICS, ANTIBIOTIC-STEROID COMBINATIONS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
neomycin/polymyxin/dexamethasone (generic for Maxitrol) sulfacetamide/prednisolone TOBRADEX SUSPENSION, OINTMENT (tobramycin and dexamethasone)	BLEPHAMIDE (prednisolone and sulfacetamide) BLEPHAMIDE S.O.P. neomycin/polymyxin/HC neomycin/bacitracin/poly/HC PRED-G SUSPENSION, OINTMENT (prednisolone/gentamicin) tobramycin/dexamethasone SUSPENSION (generic for Tobradex) TOBRADEX S.T. (tobramycin and dexamethasone) ZYLET (loteprednol, tobramycin)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class

OPHTHALMICS, ANTI-INFLAMMATORIES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CORTICOSTEROIDS		<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class NSAID class: Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent
DUREZOL (difluprednate) fluorometholone 0.1% (generic for FML) OINTMENT LOTEMAX SOLUTION (loteprednol 0.5%) MAXIDEX (dexamethasone) PRED MILD (prednisolone 0.12%)	dexamethasone (generic for Maxidex) FLAREX (fluorometholone) FML (fluorometholone 0.1% SOLUT.) FML FORTE (fluorometholone 0.25%) FML S.O.P. (fluorometholone 0.1%) LOTEMAX OINTMENT, GEL (loteprednol) loteprednol 0.5% SOLUTION (generic for Lotemax SOLUTION) prednisolone acetate 1% (gen. for Omnipred, Pred Forte) prednisolone sodium phosphate prednisolone sodium phosphate 1%	
NSAID		
diclofenac (generic for Voltaren) flurbiprofen (generic for Ocufen) ketorolac 0.5% (generic for Acular)	ACUVAIL (ketorolac 0.45%) BROMSITE (bromfenac) bromfenac 0.09% (generic for Bromday) ILEVRO (nepafenac 0.3%) ketorolac LS 0.4% (generic for Acular LS) NEVANAC (nepafenac) PROLENSA (bromfenac 0.07%)	

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OPHTHALMICS, ANTI-INFLAMMATORY / IMMUNOMODULATORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
RESTASIS (cyclosporine) RESTASIS MULTIDOSE (cyclosporine)	CEQUA (cyclosporine) ^{NR, QL} XIIDRA (lifitegrast)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

OPHTHALMICS, GLAUCOMA

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
MIOTICS		<ul style="list-style-type: none">Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: <ul style="list-style-type: none">Rhopressa: Electronically approved for patients who have a trial of ONE generic agent, within ophthalmics- glaucoma within 60 days
pilocarpine	PHOSPHOLINE IODIDE (echothiophate iodide)	
SYMPATHOMIMETICS		
brimonidine 0.2% (generic for Alphagan)	Alphagan P (brimonidine 0.1%) Alphagan P (brimonidine 0.15%) apraclonidine (generic for Iopidine)	
BETA BLOCKERS		
levobunolol (generic for Betagan) timolol (generic for Timoptic)	betaxolol (generic for Betoptic) BETIMOL (timolol) BETOPTIC S (betaxolol) carteolol (generic for Ocupress) timolol (generic for Istalol) TIMOPTIC OCUDOSE TIMOPTIC XE (timolol gel forming solution)	
CARBONIC ANHYDRASE INHIBITORS		
AZOPT (brinzolamide) dorzolamide (generic for Trusopt)		
PROSTAGLANDIN ANALOGS		
latanoprost (generic for Xalatan) TRAVATAN Z (travoprost)	bimatoprost (generic for Lumigan) VYZULTA (latanoprostene) XALATAN (latanoprost) ZIOPTAN (tafluprost)	
COMBINATION DRUGS		
COMBIGAN (brimonidine/timolol) dorzolamide/timolol (generic for Cosopt) SIMBRINZA (brinzolamide/brimonidine)	dorzolamide/timolol PF (generic for Cosopt PF)	
OTHER		
RHOPRESSA (netarsudil) ^{CL}	ROCKLATAN (netarsudil and latanoprost) ^{NR}	

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^{CL} – Prior Authorization / Class Criteria apply

^{QL} – Quantity/Duration Limit

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OPIOID DEPENDENCE TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
SUBOXONE FILM (buprenorphine/naloxone)	BUNAVAIL (buprenorphine/naloxone) buprenorphine SL buprenorphine/naloxone FILM, TAB, SL <i>LUCEMYRA (lofexidine)^{QL}</i> ZUBSOLV (buprenorphine/naloxone)	Buprenorphine PA Form Buprenorphine Informed Consent Non-Preferred: Bunavail, buprenorphine SL, Buprenorphine/naloxone SL, Zubsolv: <ul style="list-style-type: none"> 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 appropriate for patient Drug-specific criteria: <ul style="list-style-type: none"> <i>Lucemyra: Approved for FDA approved indication and dosing per label. Trial of preferred product not required.</i>

OPIOID-REVERSAL TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
naloxone SYRINGE, VIAL naltrexone TABLET NARCAN (naloxone) SPRAY		<ul style="list-style-type: none"> Non-preferred agents will be approved with documentation of why preferred products within this drug class are not appropriate for the patient

OTIC ANTI-INFECTIVES & ANESTHETICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
acetic acid (generic for Vosol)	acetic acid/hydrocortisone (generic for Vosol HC)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of the preferred agent within this drug class

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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)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

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 TABLET (generic for Revatio) (for PAH only) ^{CL} TRACLEER TABLET (bosentan) TYVASO INHALATION (treprostinil) VENTAVIS INHALATION (iloprost)	ADEMPAS (riociguat) ambrisentan (generic for Letairis) bosentan TABLET (generic for Tracleer) OPSUMIT (macitentan) ORENITRAM ER (treprostinil) sildenafil SUSPENSION (generic for Revatio) (for PAH only) ^{CL} tadalafil (generic for Adcirca) ^{CL} TRACLEER TABLETS FOR SUSPENSION (bosentan) UPTRAVI (selexipag)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class within the last 6 months <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Adcirca®/Revatio®: Approved for diagnosis of Pulmonary Arterial Hypertension (PAH) Adempas®: PAH: Requires clinical reason preferred agent cannot be used CTEPH: Approved for persistent/recurrent diagnosis after surgical treatment or inoperable CTEPH NOT for use in Pregnancy sildenafil suspension: Requires clinical reason why sildenafil tablets cannot be used

PANCREATIC ENZYMES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CREON ZENPEP (pancrelipase)	PANCREAZE (pancrelipase) PERTZYE (pancrelipase) VIOKACE (pancrelipase)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class

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PEDIATRIC VITAMIN PREPARATIONS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<p>CHILD LITTLE ANIMALS VITAMINS CHEW OTC (pedi multivit 91/iron fum) CHEW</p> <p>child multivitamins chew otc (pedi multivit 19/folic acid) CHEW</p> <p>CHILDREN'S CHEW MULTIVIT-IRON OTC (pedi multivit 91/iron fum) CHEW</p> <p>children's chewables otc (pedi multivit 23/folic acid) CHEW</p> <p>children's vitamins with iron otc (pedi multivit/iron)</p> <p>fluoride/vitamins A,C,AND D (pedi multivit A,C,D3, 21/fluoride) DROPS</p> <p>infant-toddler multivit drop OTC (pediatric multivit no. 165 drops)</p> <p>infant-toddler multivit-iron OTC (pedi mv no.164/ferrous sulfate drops)</p> <p>infant-toddler tri-vit drop (vit a pamintate/vit c/vit d3 drops)</p> <p>multivitamins with fluoride (pedi multivit 2/fluoride) DROPS</p> <p>multivits with iron and fluoride (pedi multivit 45/fluoride/iron) DROPS</p> <p>MVC-FLUORIDE (pedi multivit 12/fluoride) CHEW TAB</p> <p>ped mvit A,C,D3,No 21/fluoride DROPS</p> <p>pedi mvi no. 16 with fluoride CHEW</p> <p>pedi mvi 17 with fluoride CHEW</p> <p>POLY-VI-SOL OTC (pedi multivit 81) DROPS</p> <p>POLY-VI-SOL WITH IRON (pedi multivit 80/ferrous sulfate) DROPS</p> <p>TRI-VI-SOL OTC (vit A palmitate/vit C/Vit D3) DROPS</p> <p>tri-vite-fluoride 0.25 mg/ml, and 0.5 mg/ml</p> <p>VITALETS OTC (pedi multivit 36/iron) CHEW</p>	<p>AQUADEKS (pedi multivit 40/phytonadione)</p> <p>ESCAVITE (pedi multivit 47/iron/fluoride)</p> <p>ESCAVITE D (pedi multivit 78/iron/fluoride) CHEW</p> <p>ESCAVITE LQ (pedi multivit 86/iron/fluoride)</p> <p>FLORIVA (pedi multivit 85/fluoride) CHEW</p> <p>FLORIVA PLUS OTC and Rx (pedi multivit 130/fluoride) DROPS</p> <p>multivit A, B, D, E, K, ZN (pediatric multivit 153/D3/K)</p> <p>POLY-VI-FLOR (pedi multivit 33/fluoride) CHEW</p> <p>POLY-VI-FLOR (pedi multivit 37/fluoride) DROPS</p> <p>POLY-VI-FLOR w/IRON (pedi multivit 33/fluoride/iron) CHEW</p> <p>POLY-VI-FLOR w/IRON (pedi multivit 37/fluoride/iron) DROPS</p> <p>QUFLORA OTC and Rx (pedi multivit 84/fluoride)</p> <p>QUFLORA FE (pedi multivit 142/iron/fluoride)</p> <p>TRI-VI-FLORO (pedi multivit A, C, D3, 38/fluoride)</p>	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class <p>Drug specific criteria:</p> <ul style="list-style-type: none"> Aquadeks: Approved for diagnosis of Cystic Fibrosis

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PENICILLINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
amoxicillin CAPSULE, CHEWABLE TABLET, SUSP, TABLET ampicillin CAPSULE dicloxacillin penicillin VK		<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a 3-day trial of ONE preferred agent within this drug class

PHOSPHATE BINDERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
calcium acetate TABLET, CAPSULE CALPHRON OTC (calcium acetate) RENAGEL (sevelamer HCl)	AURYXIA (ferric citrate) ELIPHOS (calcium acetate) lanthanum (generic for FOSRENOL) PHOSLO (calcium acetate) PHOSLYRA (calcium acetate) sevelamer carbonate (generic for Renvela) sevelamer hcl (generic for Renagel) VELPHORO (sucroferric oxyhydroxide)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class within the last 6 months

PLATELET AGGREGATION INHIBITORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
AGGRENOLX (dipyridamole/aspirin) aspirin BRILINTA (ticagrelor) clopidogrel (generic for Plavix) dipyridamole (generic for Persantine) <i>prasugrel (generic for Effient)</i>	aspirin/dipyridamole (generic for Aggrenolx) ticlopidine (generic for Ticlid) YOSPRALA (aspirin/omeprazole) ZONTIVITY (vorapaxar) ^{CL}	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class OR documented clopidogrel resistance <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Zontivity®: Approved for reduction of thrombotic cardiovascular events in history of MI or with peripheral artery disease (PAD) Use with aspirin and/or clopidogrel

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PRENATAL VITAMINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
c-nate dha SOFTGEL complete natal dha (pnv2/iron b-g suc-p/fa/omega-3) calcium-pnv 28-1-250mg SOFTGEL classic prenatal TABLET (prenatal vit/fe fum/fa) COMPLETENATE CHEWABLE CONCEPT DHA CAPSULE CONCEPT OB CAPSULE elite-ob CAPLET (fe c/fa) folivane-ob CAPSULE (pnv#15/iron fum & ps cmp/fa) MARNATAL-F CAPSULE niva-plus TABLET (pnv with ca,no.74/iron/fa) PRENATA TAB CHEW pnv with ca, #72/iron/fa pnv-dha SOFTGEL (pnv combo#47/iron/fa #1/dha) pnv-ob+dha combo pack (pnv22/iron cbn&gluc/fa/dss/dha) pnv-vp-u CAPSULE prenaissance CAPSULE (pnv80/iron fum/fa/dss/dha) prenaissance plus SOFTGEL (pnv69/iron/fa/dss/dha) prenatal vitamin TABLET (pnv#124/iron/fa) prenatal no.137/iron/fa OTC pretab 29mg-1 TABLET (pnv#78/iron/fa) PUREFE PLUS PUREFE OB PLUS taron-c dha CAPSULE (pnv#16/iron fum &ps/fa/om-3) TARON-PREX PRENATAL TRINATAL RX 1 triveen-duo dha combo pack (pnv53/iron b-g hcl-p/fa/omega3) trust natal dha (pnv2/iron b-g suc-p/fa/omega-3) virtprex CAPSULE (pnv66/iron fum/fa/dss/dha) virt-c dha SOFTGEL (pnv#16/iron fum &ps/fa/om-3) virt-nate dha SOFTGEL (pnv 11-iron fum-fa-om3) virt-pm dha SOFTGEL (pnv combo#47/iron/fa #1/dha) virt-pn TABLET (pnv w-ca no.40/iron fum/fa cmb no.1) virt-pn plus SOFTGEL (pnv/ca no.68/iron/fa1/dha) virt-select CAPSULE (pnv80/iron fum/fa/dss/dha) virt-vite gt TABLET (prenatal vit 16/iron cb/fa/dss) VOL-PLUS TABLET vp-ch-pnv prenatal SOFTGEL vp-heme ob TABLET (pnv#21/iron/ps& heme polyp/fa) zatean-pn dha CAPSULE (pnv #47/iron/fa #1/dha) zatean-pn plus SOFTGEL (pnv/ca no.68/iron/fa1/dha)		<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of or are intolerant to TWO preferred agents within this drug class <p>Additional covered agents can be looked up using the Drug Look-up Tool at: https://druglookup.fhsc.com/druglookupweb/?client=nestate</p>

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PROGESTERONE (hydroxyprogesterone caproate)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
MAKENA AUTO INJECTOR (hydroxyprogesterone caproate) MAKENA MDV, SDV (hydroxyprogesterone caproate)	hydroxyprogesterone caproate (generic Makena)	<ul style="list-style-type: none"> When filled as outpatient prescription, use limited to: <ul style="list-style-type: none"> 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) rabeprazole (generic for Aciphex)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed an 8-week trial of BOTH preferred agents within this drug class <p>Pediatric Patients: Patients ≤ 4 years of age – No PA required for Prevacid 30mg or omeprazole 20mg capsules (used to compound suspensions).</p> <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> Child can not swallow whole generic omeprazole capsules OR, Documentation that contents of capsule may not be sprinkled in applesauce

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SEDATIVE HYPNOTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BENZODIAZEPINES		<ul style="list-style-type: none"> ▪ Lunesta®/ Rozerem®/zolpidem ER: Requires a trial with generic zolpidem within the last 12 months AND Trial OR Clinical reason why zaleplon and preferred benzodiazepine 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 benzodiazepine cannot be used and Requires documentation of swallowing disorder ▪ flurazepam/triazolam: Requires trial of preferred benzodiazepine ▪ Hetlioz®: Requires trial with generic zolpidem within last 12 months AND clinical reason why zaleplon AND preferred benzodiazepine cannot be used ▪ Silenor®: Must meet ONE of the following: <ul style="list-style-type: none"> ○ 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
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)	
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)	

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SINUS NODE INHIBITORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	CORLANOR (ivabradine)	<ul style="list-style-type: none"> 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 Forte) cyclobenzaprine (generic for Flexeril) ^{QL} methocarbamol (generic for Robaxin) tizanidine TABLET (generic for Zanaflex)	carisoprodol (generic for Soma) ^{CL} carisoprodol compound cyclobenzaprine ER (generic for AMRIX) ^{CL} dantrolene (generic for Dantrium) FEXMID (cyclobenzaprine) LORZONE (chlorzoxazone) ^{CL} metaxalone (generic for Skelaxin) NORGESIC FORTE (orphenadrine/ASA/caffeine) orphenadrine ER PARAFON FORTE (chlorzoxazone) tizanidine CAPSULE ZANAFLEX (tizanidine) CAPSULE, TABLET	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a 1-week trial of TWO preferred agents within this drug class <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> 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 day of previous course of therapy Dantrolene: Trial NOT required for treatment of spasticity from spinal cord injury Lorzone®: Requires clinical reason why chlorzoxazone cannot be used Soma® 250mg: Requires clinical reason why 350mg generic strength cannot be used Zanaflex® Capsules: Requires clinical reason generic cannot be used

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STERIODS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
LOW POTENCY		<ul style="list-style-type: none"> Low Potency Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class
hydrocortisone OTC & RX CREAM, LOTION, OINTMENT hydrocortisone/aloe OINTMENT, CREAM SCALPICIN OTC (hydrocortisone)	ALA-CORT (hydrocortisone) CREAM ALA-SCALP HP (hydrocortisone) 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-SMOOTHIE-FS) MICORT-HC (hydrocortisone) TEXACORT (hydrocortisone)	
MEDIUM POTENCY		<ul style="list-style-type: none"> Medium Potency Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class
fluticasone propionate CREAM, 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)	

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STEROIDS, TOPICAL (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
HIGH POTENCY		<ul style="list-style-type: none"> High Potency Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class
triamcinolone acetonide OINTMENT, CREAM triamcinolone LOTION	amcinonide CREAM, LOTION, OINTMENT betamethasone dipropionate betamethasone / propylene glyc betamethasone valerate desoximetasone 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		<ul style="list-style-type: none"> Very High Potency Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class
clobetasol emollient (generic for Temovate-E) clobetasol propionate (generic for Temovate) halobetasol propionate (generic for Ultravate)	APEXICON-E (diflorasone) BRYHALI (<i>halobetasol prop</i>) LOTION ^{NR} clobetasol SHAMPOO, LOTION clobetasol propionate FOAM, SPRAY CLOBEX (clobetasol) <i>halobetasol propionate FOAM</i> ^{NR,AL,QL} OLUX-E /OLUX/OLUX-E CP (clobetasol)	

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STIMULANTS AND RELATED ADHD DRUGS^{AL}

Preferred Agents		Non-Preferred Agents	Prior Authorization/Class Criteria
CNS STIMULANTS			<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class
Amphetamine type			
ADDERALL XR (amphetamine salt combo) amphetamine salt combination IR VYVANSE (lisdexamfetamine) CAPSULE, CHEWABLE	ADZENYS ER (amphetamine) SUSPENSION 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)		Drug-specific criteria: <ul style="list-style-type: none"> Procentra®: May be approved with documentation of swallowing disorder Zenzedi®: Requires clinical reason generic dextroamphetamine IR cannot be used

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STIMULANTS AND RELATED ADHD DRUGS (Continued)^{AL}

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Methylphenidate type		<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class
FOCALIN (dexamethylphenidate) FOCALIN XR (dexamethylphenidate)	dexamethylphenidate (generic for Focalin) dexamethylphenidate XR (generic for Focalin XR)	
APTENSIO XR (methylphenidate) methylphenidate (generic for Ritalin)	COTEMPLA XR-ODT (methylphenidate) methylphenidate CHEWABLE, SOLUTION (generic for Methylin) RITALIN (methylphenidate)	Drug-specific criteria: <ul style="list-style-type: none"> Daytrana®: May be approved in history of substance abuse by parent/caregiver or patient May be approved with documentation of difficulty swallowing
methylphenidate ER 10mg, 20mg (generic for Ritalin SR, Metadate ER)	DAYTRANA (methylphenidate) methylphenidate 30/70 (generic for Metadate CD) methylphenidate 50/50 (generic for RITALIN LA) methylphenidate ER (generic for Ritalin SR)	
QUILLICHEW ER (methylphenidate) QUILLIVANT XR (methylphenidate suspension)	CONCERTA (methylphenidate ER) 18mg, 27mg, 36mg, 54mg methylphenidate ER 18mg, 27mg, 36mg, 54mg (generic Concerta) methylphenidate ER 72mg (generic for RELEXXI) ^{QL} <i>JORNAY PM (methylphenidate)^{NR, QL}</i>	
MISCELLANEOUS		Note: generic guanfacine IR and clonidine IR are available without prior authorization
atomoxetine (generic for Strattera) guanfacine ER (generic for Intuniv) ^{QL}	clonidine ER (generic for Kapvay) ^{CL} STRATTERA (atomoxetine)	
ANALEPTICS		<ul style="list-style-type: none"> 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
	modafinil (generic for Provigil) ^{CL} armodafinil (generic for Nuvigil) ^{CL}	

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TETRACYCLINES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
doxycycline hyclate IR (generic for Vibramycin) doxycycline monohydrate 50MG, 100MG CAPSULE <i>doxycycline monohydrate SUSP (generic for Vibramycin 25MG)</i> <i>doxycycline monohydrate TAB</i> minocycline HCL CAPSULE (generic for Minocin, Dynacin) <i>minocycline HCL TABLET (generic for Dynacin, Myrac)</i>	demeclocycline (generic for Declomycin) ^{CL} DORYX MPC DR (doxycycline pelletized) doxycycline hyclate DR (generic for Doryx) doxycycline monohydrate 40MG, 75MG and 150MG CAPSULES (generic for Adoxa, Monodox, Oracea) minocycline HCL ER (generic for Solodyn) <i>NUZYRA (omadacycline)</i> tetracycline HCl (generic for Sumycin) VIBRAMYCIN SUSP (doxycycline) XIMINO (minocycline ER) CAPSULE ^{QL}	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed an 3-day trial of TWO preferred agents within this drug class Drug-specific criteria: <ul style="list-style-type: none"> 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	<i>EUTHYROX (levothyroxine)^{NR}</i> LEVO-T (levothyroxine) THYROLAR TABLET (liotrix) TIROSINT TABLET (levothyroxine) <i>TIROSINT-SOL (LIQUID) (levothyroxine)^{CL}</i>	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: <ul style="list-style-type: none"> Tirosint-Sol: May be approved with documented swallowing difficulty

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ULCERATIVE COLITIS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ORAL		<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> 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 DR (generic Uceris) DIPENTUM (olsalazine) GIAZO (balsalazide) mesalamine (generic for Lialda) mesalamine (generic for Asacol HD) mesalamine (generic for Delzicol) PENTASA (mesalamine)	
RECTAL		
CANASA (mesalamine) <i>mesalamine ENEMA (generic Rowasa)</i>	sf ROWASA (mesalamine) mesalamine SUPPOSITORY (generic for Canasa) UCERIS (budesonide)	

UTERINE DISORDER TREATMENT - ENDOMETRIOSIS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<i>ORILISSA (elagolix sodium)^{QL,CL} (must have an FDA approved indication, must follow FDA dosing guidelines, and have had a trial and failure of an NSAID and oral contraceptive before approval)</i>		<p>Drug-specific criteria:</p> <p><i>Orilissa: Requires an FDA approved indication, must follow FDA dosing guidelines, and have had a trial and failure of an NSAID and oral contraceptive</i></p>

VASODILATORS, CORONARY

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
isosorbide dinitrate TABLET isosorbide dinitrate ER, SA TABLET (generic Dilatrate-SR and Isordil) isosorbide mononitrate TABLET isosorbide mononitrate SR TABLET nitroglycerin SUBLINGUAL, TRANSDERMAL nitroglycerin ER TABLET	BIDIL (isosorbide dinitrate/hydralazine) ^{CL} GONITRO (nitroglycerin) NITRO-BID OINTMENT (nitroglycerin) NITRO-DUR (nitroglycerin) nitroglycerin TRANSLINGUAL (generic for Nitrolingual) NITROMIST (nitroglycerin) <i>NITROSTAT SUBLINGUAL (nitroglycerin)</i>	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> <i>BiDil: Approved for the treatment of heart failure as an adjunct therapy to standard therapy in self-identified black patients</i>

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

CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

AL – Age Limit

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