NEBRASKA
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DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

PDL Updated December 1, 2019 *Highlights* indicated change from previous posting

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

Non-Preferred Drug Coverage

Class and drug-specific therapeutic trial and failure requirements are found within this document. Examples of non-preferred exception criteria include:

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

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

- Buprenorphine Products PA Form
- Buprenorphine Products Informed Consent
- Growth Hormone PA Form
- Hepatitis C PA Form

For all other class medically-necessary coverage, quantity, and high dose requests use the following:

- Documentation of Medical Necessity PA Form

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

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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) clindamcyin phosphate **PLEDGET, SOLUTION** DIFFERIN **LOTION, CREAM, GEL RX** (adapalene) erythromycin **SOLUTION** PANOXYL 10% ACNE FOAMING WASH (benzoyl peroxide) OTC RETIN-A **GEL, CREAM**[AL]	adapalene **CREAM, GEL, GEL W/PUMP** (generic Differin) adapalene **SOLUTION** adapalene/benzoyl peroxide (generic EPIDUO) *AKLIEF (trifarotene)*[NR, AL] ALTRENO (tretinoin)[AL] 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 Benzaclin) 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) PLIXDA (adapalene) SWAB 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]	▪ 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 AL – Age Limit

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

ALZHEIMER'S DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CHOLINESTERASE INHIBITORS		▪ Non-preferred agents will be approved for patients who have failed a 120-day trial of ONE preferred agent within this drug class within the last 6 months **OR** ▪ Current, stabilized therapy of the non-preferred agent within the previous 45 days Drug-specific criteria: ▪ **Donepezil 23:** Requires donepezil 10mg/day for at least 3 months AND clinical reason as to why 5mg or 10mg tablets can't be used (to deliver 20mg or 25mg)
donepezil (generic for Aricept) donepezil ODT (generic for Aricept ODT) EXELON Transdermal (rivastigmine)	donepezil 23 (generic for Aricept 23) galantamine (generic for Razadyne) **SOLUTION, TABLET** galantamine ER (generic for Razadyne ER) rivastigmine (generic for Exelon)	
NMDA RECEPTOR ANTAGONIST		
memantine (generic for Namenda)	memantine ER (generic for Namenda XR) memantine soln (generic for Namenda) NAMENDA (memantine) NAMENDA **SOLUTION** NAMZARIC (memantine/donepezil)	

ANALGESICS, OPIOID LONG-ACTING

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BUTRANS (buprenorphine, transdermal)[QL] EMBEDA (morphine sulfate/ naltrexone) fentanyl 25, 50, 75, 100 mcg **PATCH**[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] HYSINGLA ER (hydrocodone, extended release) 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. ▪ Preferred agents require previous use of a long acting opioid or documentation of a trial on a short acting agent within 90 days ▪ Non-preferred agents will be approved with failure on, or intolerance to TWO preferred agents within this drug class Drug-specific criteria: ▪ **Methadone:** Will only be approved for use in pain control or end of life care. Trial of preferred agent not required for end of life care ▪ **Oxycontin®:** Pain contract required for maximum quantity authorization

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

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

ANGIOTENSIN MODULATORS

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

ANGIOTENSIN MODULATORS (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ANGIOTENSIN RECEPTOR BLOCKER/DIURETIC COMBINATIONS		▪ Non-preferred agents will be approved for patients who have failed TWO preferred agents within this drug class within the last 12 months ▪ Non-preferred combination products may be covered as individual prescriptions without prior authorization
irbesartan/HCTZ (generic for Avalide) losartan/HCTZ (generic for Hyzaar) valsartan-HCTZ (generic for Diovan-HCT)	candesartan/HCTZ (generic for Atacand-HCT) EDARBYCLOR (azilsartan/ chlorthalidone) olmesartan/HCTZ (generic for Benicar-HCT)	
ANGIOTENSIN MODULATOR/ CALCIUM CHANNEL BLOCKER COMBINATIONS		▪ **Angiotensin Modulator/Calcium Channel Blocker Combinations**: Combination agents may be approved if there has been a trial and failure of preferred agent
amlodipine/benazepril (generic for Lotrel) amlodipine/valsartan (generic for Exforge) amlodipine/valsartan/HCTZ (generic for Exforge HCT)	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		▪ **Direct Renin Inhibitors/Direct Renin Inhibitor Combinations:** May be approved witha history of TWO preferred ACE Inhibitors or Angiotensin Receptor Blockers within the last 12 months
	aliskiren (generic 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 (nevibolol/valsartan)	

ANTHELMINTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ALBENZA (albendazole) BILTRICIDE (praziquantel) ivermectin STROMECTOL (ivermectin)	*EGATEN (triclabendazole)*[NR,AL] EMVERM (mebendazole) praziquantel (generic for Biltricide)	▪ 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: ▪ **Emverm**: Approval will be considered for indications not covered by preferred agents

ANTI-ALLERGENS, ORAL

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

ANTIBIOTICS, GASTROINTESTINAL

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

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

ANTIBIOTICS, TOPICAL

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

ANTIBIOTICS, VAGINAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CLEOCIN **OVULES** (clindamycin) clindamycin **CREAM** (generic for Cleocin) CLINDESSE (clindamycin, vaginal) metronidazole, vaginal NUVESSA (metronidazole, vaginal) VANDAZOLE (metronidazole, vaginal)	CLEOCIN **CREAM** (clindamycin) METROGEL (metronidazole, vaginal)	▪ 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 (betrixaban maleate)*^{NR,QL} fondaparinux (generic for Arixtra) FRAGMIN (dalteparin) SAVAYSA (edoxaban)^{QL}	▪ Non-preferred agents will be approved for patients who have failed ONE preferred agent within this drug class within the last 12 months Drug-specific criteria: ▪ **Coumadin®:** Clinical reason generic warfarin cannot be used ▪ **Savaysa®:** Approved diagnoses include: Stroke and systemic embolism (SE) risk reduction in nonvalvular atrial fibrillation (NVAF) OR Treatment of deep vein thrombosis (DVT) and pulmonary embolism (PE) following 5-10 days of parenteral anticoagulent therapy ▪ **Xarelto 2.5mg:** Use limited to reduction of risk of major cardiovascular events (cardiovascular death, myocardial infarction, and stroke) in patients with chronic coronary artery disease or peripheral artery disease

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ANTIEMETICS/ANTIVERTIGO AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CANNABINOIDS		▪ Non-preferred agents will be approved for patients who have failed ONE preferred agent within this drug class within the same group ▪ ~~SYNDROS – documentation of inability to swallow solid dosage forms.~~
dronabinol (generic for Marinol)[AL]	CESAMET (nabilone) ~~SYNDROS (dronabinol)[AL, CL]~~	
5HT3 RECEPTOR BLOCKERS		
ondansetron (generic for Zofran)[QL] ondansetron ODT (generic for Zofran)[QL]	ANZEMET (dolasetron) granisetron (generic for Kytril) SANCUSO (granisetron)[CL] ZUPLENZ (ondansetron)	
NK-1 RECEPTOR ANTAGONIST		
	aprepitant (generic for Emend) [QL,CL] AKYNZEO (netupitant/palonosetron)[CL] VARUBI (rolapitant) **TABLET**[CL]	
TRADITIONAL ANTIEMETICS		
DICLEGIS (doxylamine/pyridoxine)[CL,QL] dimenhydrinate (generic for Dramamine) 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)	Drug-specific criteria: ▪ **Akynzeo®/Emend®/Varubi®:** Approved for Moderately/Highly emetogenic chemotherapy with dexamethasone and a 5-HT3 antagonist WITHOUT trial of preferred agents Regimens include: AC combination (Doxorubicin or Epirubicin with Cyclophosphamide), Aldesleukin, Amifostine, Arsenic trioxide, Azacitidine, Bendamustine, Busulfan, Carmustine, Carbplatin, Cisplatin, Clofarabine, Cyclophosphamide, Cytarabine, Dacarbazine, Dactinomycin, Daunorubicin, Epirubicin, Etoposide, Hexamethylmelamine, Idarubicin, Ifosfamide, Imatinib, Interferon α, Irinotecan, Mechlorethamine, Melphalan, Methotrexate, Oxaliplatin, Procarbazine, Streptozotocin, Temozolomide ▪ **Diclegis®/Bonjesta:** Approved only for treatment of nausea and vomiting of pregnancy ▪ **Metozolv ODT®:** Documentation of inability to swallow or Clinical reason oral liquid cannot be used ▪ **Sancuso®/Zuplenz®:** Documentation of oral dosage form intolerance

ANTIFUNGALS, ORAL

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

ANTIFUNGALS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ANTIFUNGAL		▪ Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class within the last 6 months Drug-specific criteria: ▪ **Extina:** Requires trial and failure or contraindication to other ketoconazole forms ▪ **Jublia:** Approved diagnoses includ Onychomycosis of the toenails due to *T.rubrum OR T. Mentagrophytes* ▪ **nystatin/triamcinolone:** Indivudual ingredients available without prior authorization ▪ **ciclopirox nail lacquer:** No trial required in diabetes, peripheral vascular disease (PVD), immunocompromised OR contraindication to oral terbinafine
clotrimazole **CREAM** (generic for Lotrimin) RX, OTC clotrimazole **SOLN** OTC ketoconazole **CREAM, SHAMPOO** (generic for Nizoral) LAMISIL (tervinafine) **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	
ANTIFUNGAL/STEROID COMBINATIONS		
clotrimazole/betamethasone **CREAM** (generic for Lotrisone)	clotrimazole/betamethasone **LOTION** (generic for Lotrisone) nystatin/triamcinolone (generic for Mycolog)	

ANTIHISTAMINES, MINIMALLY SEDATING

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

ANTIHYPERTENSIVES, SYMPATHOLYTICS

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

ANTIHYPERURICEMICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
allopurinol (generic for Zyloprim) colchicine **CAPSULE** (generic for Mitigare) probenecid probenecid/colchicine (generic for Col-Probenecid)	colchicine **TABLET** (generic for Colcrys)CL febuxostat (generic for Uloric)CL *GLOPERBA **SOLN** (colchicine)NR,QL*	▪ 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

ANTIMIGRAINE AGENTS, OTHER

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
EMGALITY (galcanezumab-gnlm)[CL,QL] **PEN, SYR**	AIMOVIG AUTOINJECTOR (erenumab-aooe)[CL,QL] AJOVY (fremanezumab-vfrm)[CL,QL] CAFERGOT (ergotamine/caffeine) CAMBIA (diclofenac potassium) dihydroergotamine mesylate **NASAL** ERGOMAR **SUBLINGUAL** (ergotamine tartrate) MIGERGOT (ergotamine/caffeine) **RECTAL** MIGRANAL (dihydroergotamine) **NASAL**	▪ Non-preferred agents will be approved for patients who have a contraindication OR trial failure of a triptan Drug-specific criteria: ▪ Cambia®: Requires diagnosis of migraine and documentation of why solid dosing forms not appropriate ▪ Emgality indicated for treatment of episodic cluster headaches ▪ Aimovig, Ajovy, and Emgality: Require ≥ 4 migraines per month for ≥ 3 months and has tried and failed a ≥ 1 month trial of two medications listed in the 2012 American Academy of Neurology/American Headache Society guidelines (examples include: antidepressants (amitriptyline, venlafaxine), Beta blockers (propranolol, metroprolol, timolol, atenolol), anti-epileptics (valproate, topiramate), ACE/ARB (lisinopril, candesartan) ▪ In addition, Aimovig and Ajovy require a trial of Emgality or patient specific documentation of why Emgality is not appropriate for patient

ANTIMIGRAINE AGENTS, TRIPTANS[QL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ORAL		▪ Non-preferred agents will be approved for patients who have failed ALL preferred agents within this drug class Drug-specific criteria: ▪ **Sumavel® Dosepro:** Requires clinical reason sumatriptan injection cannot be used ▪ **Onzetra, Zembrace:** approved for patients who have failed ALL preferred agents
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) *TOSYMRA (sumatriptan)[NR]* ZOMIG (zolmitriptan)	
INJECTABLE		
sumatriptan **KIT, SYRINGE, VIAL** sumatriptan **KIT (mfr SUN)**	IMITREX (sumatriptan) **INJECTION** SUMAVEL DOSEPRO (sumatriptan) ZEMBRACE SYMTOUCH (sumatriptan)	

ANTIPARASITICS, TOPICAL

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

ANTIPARKINSON'S DRUGS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ANTICHOLINERGICS		▪ Non-preferred agents will be approved for patients who have failed ONE preferred agents within this drug class
benztropine (generic for Cogentin) trihexyphenidyl (generic for Artane)		
COMT INHIBITORS		Drug-specific criteria:
	entacapone (generic for Comtan) tolcapone (generic for Tasmar)	▪ **Carbidopa/Levodopa ODT:** Approved for documented swallowing disorder ▪ **COMT Inhibitors:** Approved if using as add-on therapy with levodopa-containing drug
DOPAMINE AGONISTS		▪ **Gocovri:** Required diagnosis of Parkinson's disease and had trial of or is intolerant to amantadine AND must be used as an add-on therapy with levodopa-containing drug
bromocriptine (generic for Parlodel) pramipexole (generic for Mirapex) ropinirole (generic for Requip)	NEUPRO (rotigotine)CL pramipexole ER (generic for Mirapex ER)CL ropinirole ER (generic for Requip XL)CL	▪ ***Inbrija:*** *Approval upon diagnosis of Parkinson's disease and concurrent treatment with carbidopa/levodopa agent* ▪ **Neupro®:** For Parkinsons: Clinical reason required why preferred agent cannot be used For Restless Leg (RLS): Requires trial OR Contraindication to ropinirole AND pramipexole
MAO-B INHIBITORS		▪ **Nourianz**: *Approval upon diagnosis of Parkinson's disease and concurrent treatment with carbidopa/levodopa agent* ▪ **Osmolex ER:** Required diagnosis of Parkinson's disease or drug-induced extrapyramidal reactions and had trial of or is intolerant to amantadine IR ▪ **Pramipexole ER:** Required diagnosis of Parkinson's along with preferred agent trial ▪ **Ropinerole ER:** Required diagnosis of Parkinson's along with preferred agent trial ▪ **Zelapar®:** Approved for documented swallowing disorder
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) carbidopa/levodopa (generic for Sinemet) carbidopa/levodopa ER (generic for Sinemet CR) levodopa/carbidopa/entacapone (generic for Stalevo)	amantadine **TABLET** carbidopa (generic for Lodosyn) carbidopa/levodopa ODT (generic for Parcopa) DUOPA (carbidopa/levadopa) GOCOVRI (amantadine)QL *INBRIJA (levodopa) INHALERNR,CL,QL* *NOURIANZ (istradefylline)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)	methoxsalen (generic for Oxsoralen-Ultra) SORIATANE (acitretin)	▪ Non-preferred agents will be approved for patients who have failed a trial with THE preferred agent within this drug class ▪ Trial of acitretin (Pregnancy category X) not required in pregnancy or while attempting or planning pregnancy

ANTIPSORIATICS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
calcipotriene **CREAM, OINTMENT, SOLUTION,**	calcitriol (generic for Vectical) calcipotriene/betamethasone (generic for Taclonex) CALCITRENE (calcipotriene) DOVONEX **CREAM** (calcipotriene) *DUOBRII (halobetasol proprionate/tazarotene)*[NR] ENSTILAR (calcipotriene/betamethasone) SORILUX (calcipotriene)	▪ Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class

ANTIVIRALS, ORAL

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

ANTIVIRALS, TOPICAL

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

ANXIOLYTICS

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

BETA BLOCKERS, ORAL

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

BILE SALTS

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

BLADDER RELAXANT PREPARATIONS

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

BONE RESORPTION SUPRESSION AND RELATED DRUGS

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

BPH (BENIGN PROSTATIC HYPERPLASIA TREATMENTS)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ALPHA BLOCKERS		▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: ▪ **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
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		
dutasteride (generic for Avodart) finasteride (generic for Proscar)	dutasteride/tamsulosin (generic for Jalyn)	

BRONCHODILATORS, BETA AGONIST

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
INHALERS – Short Acting		▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: ▪ **Ventolin HFA®:** Requires trial and failure on Proventil HFA® AND Proair HFA® OR allergy/ contraindication/side effect to BOTH ▪ **Xopenex®:** Covered for cardiac diagnoses or side effect of tachycardia with albuterol product
PROAIR HFA (albuterol) PROVENTIL HFA (albuterol)	albuterol sul. HFA (generic for ProAir HFA, *Proventil HFA*, Ventolin HFA) PROAIR DIGIHALER (albuterol)[NR] PROAIR RESPICLICK (albuterol) levalbuterol HFA (generic for Xopenex HFA)	
INHALERS – Long Acting		
SEREVENT (salmeterol)	ARCAPTA NEOHALER (indacaterol) STRIVERDI RESPIMAT (olodaterol)	
INHALATION SOLUTION		
albuterol (2.5mg/3ml premix or 2.5mg/0.5ml) albuterol 100 mg/20 mL albuterol low dose (0.63mg/3ml & 1.25mg/3ml)	BROVANA (arformoterol) levalbuterol (generic for Xopenex) PERFOROMIST (formoterol)	
ORAL		
albuterol **SYRUP** terbutaline (generic for Brethine)	albuterol **TABLET** albuterol ER (generic for Vospire ER) metaproterenol (formerly generic for Alupent)	

CALCIUM CHANNEL BLOCKERS, ORAL

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

CEPHALOSPORINS AND RELATED ANTIBIOTICS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BETA LACTAM/BETA-LACTAMASE INHIBITOR COMBINATIONS		▪ Non-preferred agents will be approved for patients who have failed a 3-day trial of ONE preferred agent within the same group
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) *ZIEXTENZO **SYR** (pegfilgrastim-bmez)*^{NR}	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

CONTRACEPTIVES, ORAL

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

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

COPD (CHRONIC OBSTRUCTIVE PULMONARY DISEASE) AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
INHALERS		▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class OR Patient specific documentation of inability to use traditional inhaler device. Drug-specific criteria: ▪ **Daliresp®:** Covered for diagnosis of severe COPD associated with chronic bronchitis Requires trial of a bronchodilator Requires documentation of one exacerbation in last year upon initial review
ATROVENT HFA (ipratropium) BEVESPI AEROSPHERE (glycopyrolate/formoterol) COMBIVENT RESPIMAT (albuterol/ ipratropium) STIOLTO RESPIMAT (tiotropium/olodaterol) SPIRIVA (tiotropium)	ANORO ELLIPTA (umeclidinium/vilanterol) *DUAKLIR PRESSAIR (aclidinium br and formoterol fum)*[NR] INCRUSE ELIPTA (umeclidnium) SEEBRI NEOHALER (glycopyrolate) SPIRIVA RESPIMAT (tiotropium) TUDORZA PRESSAIR (aclidinium br) UTIBRON NEOHALER (indacaterol/glycopyrolate)	
INHALATION SOLUTION		
albuterol/ipratropium (generic for Duoneb) ipratropium **SOLUTION** (generic for Atrovent)	LONHALA (glycopyrrolate inhalation soln) *YUPELRI (revefenacin)*[NR]	
ORAL AGENT		
	DALIRESP (roflumilast)[CL]	

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)	▪ 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] *TRIKAFTA (elexacaftor, tezacaftor, ivacaftor)[NR,AL]*	Drug-specific criteria: ▪ **Kalydeco®:** Diagnosis of CF and documentation of the drug-specific, FDA-approved mutation of CFTR gene • Minimum age: 6 months ▪ **Orkambi®:** Diagnosis of CF and documentation of presence of two copies of the F580del mutation (homozygous) of CFTR gene • Minimum age: 6 years for tablet • Minimum age: 2 years for packet ▪ **Symdeko:** Diagnosis of CF and documentation of the drug specific, FDA approved mutation of CFTR gene. • Minimum age: 6 years ▪ ***Trikafta:*** *Diagnosis of CF and documentation of at least one F508del mutation in the CFTR gene* • *Minimum age: 12*

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 (nilonacept) 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] *RINVOQ ER (upadacitinib)*[NR,CL,QL] SILIQ (brodalumab) SIMPONI (golimumab) *SKYRIZI (risankizamab-rzaa)*[NR] STELARA (ustekinumab) **SUB-Q** TALTZ (ixekizumab)[AL] TREMFYA (guselkumab)[QL] XELJANZ (tofacitinib) **ORAL**[QL] XELJANZ XR (tofacitinib) **ORAL**[QL]	▪ 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. Drug-specific criteria: ▪ **Cosentyx**: Requires trial of Humira ▪ **Rinvoq ER**: Requires documentation of inadequate response or intolerance to methotrexate

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** triamterene (generic for Dyrenium)	
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)	▪ Non-preferred agents require clinical documentation why the preferred product within this drug class is not appropriate Drug-specific criteria: ▪ **Zavesca:** Approved for mild to moderate type 1 Gaucher disease for whom enzyme replacement therapy is not a therapeutic option

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]	▪ Non-preferred agents require clinical documentation why the preferred product within this drug class is not appropriate Brand name product may be authorized in event of documented national shortage of generic product.

ERYTHROPOIESIS STIMULATING PROTEINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
RETACRIT (EPOETIN ALFA-EPBX)	EPOGEN (rHuEPO) PROCRIT (rHuEPO)	▪ 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	▪ Non-preferred agents will be approved for patients who have failed a 3-day trial of ONE preferred agent within this drug class Drug-specific criteria: ▪ **Baxdela:** Coverable with documented intolerance or failure of preferred MRSA agents (clindamycin, doxycycline, linezolid, sulfamethoxazole/trimethoprim) ▪ **Ciprofloxacin Suspension:** Coverable with documented swallowing disorders ▪ **Levofloxacin Suspension:** Coverable with documented swallowing disorders ▪ **Ofloxacin:** Trial of preferred not required for diagnoses of Pelvic Inflammatory Disease OR Acute Epididymitis (non-gonorrhea)

GI MOTILITY, CHRONIC

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

GLUCOCORTICOIDS, INHALED

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

GLUCOCORTICOIDS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
budesonide EC **CAPSULE** (generic for Entocort EC) dexamethasone **SOLN, TABLET** dexamethasone **ELIXIR,SYRUP** 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 (dexamethasone)*[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**	▪ 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: ▪ **Emflaza:** Indicated for the treatment of Duchenne muscular dystrophy (DMD) in patients 5 years of age and older ▪ Approved after trial/failure with prednisone ▪ **Intensol Products:** Patient specific documentation of why the less concentrated solution is not appropriate for the patient

GROWTH HORMONE

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

H. PYLORI TREATMENTS

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

HEMOPHILIA TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
FACTOR VIII		▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class ▪ Patients 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 RECOMBINATE 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] TRETTEN[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)	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

HEPATITIS C TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
DIRECT ACTING ANTI-VIRAL		Hepatitis C Treatments PA Form Hepatitis C Criteria ▪ Non-preferred products require trial of preferred agents within the same group and will only be considered with documentation of why the preferred product within this drug class is not appropriate for patient ▪ Patients newly eligible for Medicaid will be allowed to complete treatment with the original that treatment was initially authorized by another payor Drug-specific criteria:Trial with Mavyret not required in the following: ▪ **Epclusa**: For genotype 1-6 with decompensated cirrhosis along with ribavirin ▪ **Harvoni**: ○ For genotype 1 with decompensated cirrhosis along with ribavirin ○ Post liver transplant for genotype 1 or 4 ○ For pediatric patients ages 3 to 11 years old with FDA indications ▪ Sovaldi: ○ For pediatric patients ages 3 to 11 years old with genotype 2 or 3 chronic HCV infection without cirrhosis or with compensated cirrhosis in combination with ribavirin ▪ **Vosevi:** Requires documentation of non-response after previous treatment course of Direct Acting Anti-viral agent (DAA) for genotype 1-6 without cirrhosis or with compensated cirrhosis
MAVYRET (glecaprevir/pibrentasvir)CL VOSEVI (sofosbuvir/velpatasvir/ voxilaprev)CL	DAKLINZA (daclatasvir) CL *HARVONI* 200/45MG, **TABLET** (sofosbuvir/ledipasvir)CL OLYSIO (simeprevir)CL sofosbuvir/ledipasvir **TABLET** (generic for Harvoni 400/90)CL sofosbuvir/velpatasvir (generic for Epclusa)CL SOVALDI TABLET (sofosbuvir)CL TECHNIVIE (ombitasvir/paritaprevir/ ritonavir) CL VIEKIRA PAK (ombitasvir/ paritaprevir/ritonavir/dasabuvir)CL ZEPATIER (elbasvir/grazoprevir)CL	
RIBAVIRIN		
ribavirin 200mg **TABLET, CAPSULE**	REBETOL (ribavirin)	
INTERFERON		
PEGASYS (pegylated interferon alfa-2a) CL PEG-INTRON (pegylated interferon alfa-2b) CL		

HISTAMINE II RECEPTOR BLOCKERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
famotidine **TABLET** (generic for Pepcid) ranitidine **TABLET, SYRUP** (generic for Zantac)	cimetidine **TABLET, SOLUTION** (generic for Tagamet) famotidine **SUSPENSION** nizatidine (generic for Axid) ranitidine **CAPSULE**	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: ▪ **cimetidine:** Approved for viral *M. contagiosum* or common wart *V.* Vulgaris treatment ▪ **nizatadine/cimetidine solution/ famotidine suspension:** Requires clinical reason why ranitidine syrup cannot be used ******famotidine suspension is authorized during national shortage of ranitidine syrup.******

HIV / AIDS[CL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CCR5 ANTAGONISTS		▪ Non-preferred agents will be approved for patients who have a diagnosis of HIV/AIDS and patient specific documentation of why the preferred products within this drug class are not appropriate for patient, including, but not limited to, drug resistance or concomitant conditions not recommended with preferred agents ▪ Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy ▪ Diagnosis of HIV/AIDS required OR ▪ Pre and Post Exposure Prophylaxis
SELZENTRY **SOLN, TAB** (maraviroc)		
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) INTELENCE (etravirine)[QL] PIFELTRO (doravirine)[QL] SUSTIVA CAP, TAB (efavirenz)	efavirenz (generic for Sustiva) nevirapine **TAB** (generic for Viramune) nevirapine er (generic for Viramune XR) RESCRIPTOR (delavirdine) VIRAMUNE **SUSP** (nevirapine)	
NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTIs)		
abacavir **SOLN, TAB** (generic for Ziagen) EMTRIVA **CAP, SOLN** (emtricitabine) lamivudine **SOLN, TAB** (generic for Epivir) zidovudine **CAP, SYRUP, TAB** (generic for Retrovir)	didanosine **CAP** DR (generic for Videx EC) EPIVIR (lamivudine) RETROVIR (zidovudine) stavudine **CAP** (generic for Zerit) VIDEX **SOLN** (didanosine) ZIAGEN (abacavir)	

HIV / AIDS[CL] (Continued)

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

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) DELSTRIGO (doravirine/lamivudine/tenofovir disoproxil fumarate)[QL] GENVOYA (elvitegravier/cobicistat/emtricitabine/tenofovir alafenamide)[QL, AL] ODEFSEY (emtricitabine/rilpivirine/tenofovir alafenamide)[QL] STRIBILD (elvitegravir/cobicistat/emtricitabine/tenofovir disoproxil fumarate)[QL] SYMFI (efavirenz/lamivudine/tenofovir disoproxil fumarate)[QL] SYMFI LO (efavirenz/lamivudine/ tenofovir disoproxil fumarate)[QL] SYMTUZA (darunavir, cobicistat, emtricitabine, tenofovir alafenamide)[QL] TRIUMEQ (dolutegravir/abacavir/lamivudine)	*DOVATO (dolutegravir/lamifudine)[NR,QL]* JULUCA (dolutegravir/rilpivirine)[QL]	

HYPOGLYCEMICS, ALPHA-GLUCOSIDASE INHIBITORS

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

HYPOGLYCEMICS, INSULIN AND RELATED DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
HUMALOG (insulin lispro) U-100 **CARTRIDGE, PEN, VIAL** HUMALOG MIX **VIAL** (insulin lispro/lispro protamine) HUMULIN (insulin) **VIAL** HUMULIN 70/30 **VIAL** HUMULIN U-500 **VIAL** HUMALOG MIX **PEN** (insulin lispro/lispro protamine) LANTUS SOLOSTAR **PEN** (insulin glargine) LANTUS (insulin glargine) **VIAL** LEVEMIR (insulin detemir) **PEN, VIAL** NOVOLOG (insulin aspart) **CARTRIDGE, PEN, VIAL** NOVOLOG MIX **PEN, VIAL** (insulin aspart/aspart protamine)	ADMELOG (insulin lispro) **PEN, VIAL** AFREZZA (regular insulin, inhaled) APIDRA (insulin glulisine) BASAGLAR (insulin glargine, rec) **PEN** FIASP (insulin aspart) **CARTRIDGE, 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)	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: ▪ **Afrezza®:** Approved for T1DM on long-acting insulin with no current history of smoking or chronic lung disease ▪ **Humulin® R U-500 Kwikpen:** Approved for physical reasons – such as dexterity problems and vision impairment • Usage must be for self-administration, not only convenience • Patient requires >200 units/day • Safety reason patient can't use vial/syringe

HYPOGLYCEMICS, MEGLITINIDES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
repaglinide (generic for Prandin)	nateglinide (generic for Starlix) repaglinide/metformin (generic for Prandimet)	▪ 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)	▪ **Metformin ER (generic Fortamet®)/Glumetza®:** Requires clinical reason why generic Glucophage XR® cannot be used ▪ **Riomet®:** Prior authorization not required for age <7 years

HYPOGLYCEMICS, SGLT2

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
FARXIGA (dapagliflozin)[QL,CL] INVOKANA (canagliflozin)[CL] JARDIANCE (empagliflozin)[QL, CL]	INVOKAMET & XR (canagliflozin/metformin)[QL] SEGLUROMET (ertugliflozin/metformin) [QL] STEGLATRO (ertugliflozin)[QL] SYNJARDY (empagliflozin/metformin) SYNJARDY XR (empagliflozin/ metformin)[QL] XIGDUO XR (dapagliflozin/metformin)[QL]	▪ Preferred agents are Approved for diagnosis of diabetes AND a trial of metformin ▪ Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent 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	▪ 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
THIZAOLIDINEDIONES (TZDs)		▪ Non-preferred agents will be approved for patients who have failed a trial of THE preferred agent within this drug class ▪ **Combination products:** Require clinical reason why individual ingredients cannot be used
pioglitazone (generic for Actos)	AVANDIA (rosiglitazone)	
TZD COMBINATIONS		
	pioglitazone/glimepiride (generic for Duetact) pioglitazone/metformin (generic for Actoplus Met)	

IDIOPATHIC PULMONARY FIBROSIS

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

IMMUNOMODULATORS, ATOPIC DERMATITIS[AL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ELIDEL (pimecrolimus)	DUPIXENT (dupilumab)[CL] EUCRISA (crisaborole) pimecrolimus (generic for Elidel) tacrolimus (generic for Protopic)[CL]	▪ Non-preferred agents require:Trial of a topical steroid AND Trial of one preferred product within this drug class Drug-specific criteria: ▪ **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; For adults with chronic rhinosinusitis with nasal polyposis, must document inadequate control on current treatment regimen and be used as add-on maintenance treatment with intranasal steroid

IMMUNOMODULATORS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
imiquimod (generic for Aldara)	ALDARA (imiquimod) imiquimod (generic for Zyclara) podofilox (generic for Condylox) VEREGEN (sinecatechins) ZYCLARA (imiquimod)	▪ Non-preferred agents require clinical reason why preferred agent within this drug class cannot be used

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) cyclosporine **CAPSULE**, **SOFTGEL** 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** sirolimus (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 ▪ 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 Drug-specific criteria: ▪ **mometasone:** Prior authorization NOT required for children ≤ 12 years ▪ **budesonide:** Approved for use in Pregnancy (Pregnancy Category B) ▪ **Veramyst®:** Prior authorization NOT required for children ≤ 12 years ▪ **Xhance:** Indicated for treatment of nasal polyps in ≥ 18 years only
ipratropium (generic for Atrovent)		
ANTIHISTAMINES		
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)	

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)	▪ Non-preferred agents will be approved for patients who have failed a 30-day trial of THE preferred agent within this drug class Drug-specific criteria: ▪ **montelukast granules:** PA not required for age < 2 years

LINCOSAMIDES / OXAZOLIDINONES / STREPTOGRAMINS

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

LIPOTROPICS, OTHER

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BILE ACID SEQUESTRANTS		▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: ▪ **Juxtapid®/ Kynamro®:** Approved for diagnosis of homozygous familial hypercholesterolemia (HoFH) OR Treatment failure/maximized dosing/contraindication to ALL the following: statins, ezetimibe, niacin, fibric acid derivatives, omega-3 agents, bile acid sequestrants Require faxed copy of REMS PA form ▪ **Lovaza®:** Approved for TG ≥ 500 ▪ **Praluent®:** Approved for diagnoses of: • atherosclerotic cardiovascular disease (ASCVD) • heterozygous familial hypercholesterolemia (HeFH) AND • Maximized high-intensity statin WITH ezetimibe for at 3 continuous months • Failure to reach target LDL-C levels: ASCVD - < 70 mg/dL, HeFH - < 100 mg/dL ▪ **Repatha®:** Approved for: • adult diagnoses of atherosclerotic cardiovascular disease (ASCVD) • heterozygous familial hypercholesterolemia (HeFH) • homozygous familial hypercholesterolemia (HoFH) in age ≥ 13 • statin-induce rhabdomyolysis AND • Maximized high-intensity statin WITH ezetimibe for 3+ continuous months • Failure to reach target LDL-C levels: ASCVD - < 70 mg/dL, HeFH - < 100 mg/dL • Concurrent use of maximally-tolerated statin must continue ▪ **Vascepa®:** Approved for TG ≥ 500 ▪ **WelChol®:** Trial not required for diabetes control and monotherapy with metformin, sulfonylurea, or insulin has been inadequate
cholestyramine (generic for Questran) colestipol **TABLETS** (generic for Colestid)	colesevelam (generic for Welchol) **TABLET, PACKET** colestipol **GRANULES** (generic for Colestid) QUESTRAN LIGHT (cholestyramine)	
TREATMENT OF HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA		
	JUXTAPID (lomitapide)CL KYNAMRO (mipomersen)CL	
FIBRIC ACID DERIVATIVES		
fenofibrate (generic for Tricor) gemfibrozil (generic for Lopid)	fenofibrate (generic for Antara, Fenoglide, Lipofen, Lofibra, Triglide) fenofibric acid (generic for Fibricor) fenofibric acid (generic for Trilipix)	
NIACIN		
niacin ER (generic for Niaspan)	NIACOR (niacin IR) NIASPAN (niacin ER)	
Several other forms of OTC Niacin and fish oil are also covered without prior authorization under Medicaid with a prescription		
OMEGA-3 FATTY ACIDS		
	omega-3 fatty acids (generic for Lovaza)CL VASCEPA (icosapent)CL	
CHOLESTEROL ABSORPTION INHIBITORS		
ezetimibe (generic for Zetia)		
PROPROTEIN CONVERTASE SUBTILISIN/KEXIN TYPE 9 (PCSK9) INHIBITORS		
	PRALUENT (alorocumab)CL REPATHA (evolocumab)CL	

LIPOTROPICS, STATINS

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

MACROLIDES AND KETOLIDES, ORAL

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

METHOTREXATE

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

MOVEMENT DISORDERS

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

MULTIPLE SCLEROSIS DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
AVONEX (interferon beta-1a)QL BETASERON (interferon beta-1b)QL COPAXONE **20mg** Syringe Kit (glatiramer)QL GILENYA (fingolimod)QL REBIF (interferon beta-1a)QL 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 *VUMERITY (diroximel)NR,QL*	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: ▪ **Ampyra®:** Approved for diagnosis of gait disorder associated with MS AND EDSS score ≤ 7 ▪ **Plegridy:** Approved for diagnosis of relapsing MS

NITROFURAN DERIVATIVES

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

NSAID

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
COX-I SELECTIVE		▪ 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 Drug-specific criteria: ▪ **Arthrotec®:** Requires clinical reason why individual ingredients cannot be used ▪ **Duexis®/Vimovo®:** Requires clinical reason why individual agents cannot be used ▪ **meclofenamate:** Approvable without trial of preferred agents for menorrhagia ▪ **meloxicam suspension:** Approved for age≤ 11 years
diclofenac sodium (generic for Voltaren) diclofenac SR (generic for Voltaren-XR) ibuprofen 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) *QMIIZ ODT (meloxicam)*^{NR,QL} RELAFEN DS (nabumetone) tolmetin (generic for Tolectin)	

NSAID (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
COX-I SELECTIVE (continued)		
	ALL BRAND NAME NSAIDs including: CAMBIA (diclofenac oral solution) DUEXIS (ibuprofen/famotidine) SPRIX (ketorolac)QL TIVORBEX (indomethacin) VIMOVO (naprosyn/esomeprazole) VIVLODEX (meloxican submicronized) ZIPSOR (diclofenac) ZORVOLEX (diclofenac)	Drug-specific criteria: ▪ **Sprix®:** Approved for patients unable to tolerate, swallow OR absorb oral NSAIDs OR contraindication OR trial of TWO preferred oral NSAIDs ▪ **Tivorbex®:** Requires clinical reason why indomethacin capsules cannot be used ▪ **Zorvolex®:** Requires trial of oral diclofenac OR clinical reason why diclofenac potassium/sodium cannot be used
NSAID/GI PROTECTANT COMBINATIONS		▪
	diclofenac/misoprostol (generic for Arthrotec)	
COX-II SELECTIVE		
celecoxib (generic for Celebrex)		

NSAIDS, TOPICAL

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

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

PDL Update December 1, 2019 *Highlights* indicated change from previous posting

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

ONCOLOGY AGENTS, ORAL, BREAST CANCER

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CDK 4/6 INHIBITOR		▪ Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines Drug-specific critera ▪ **anastrazole:** May be approved for malignant neoplasm of male breast (male breast cancer) ▪ **capecitabine:** Requires trial of Xeloda or clinical reason Xeloda cannot be used ▪ **Fareston®:** Require clinical reason why tamoxifen cannot be used ▪ **letrozole:** Approved for diagnosis of breast cancer with day supply greater than 12 – NOT approved for short term use
IBRANCE (palbociclib)	KISQALI (ribociclib) KISQALI FEMARA **CO-PACK** VERZENIO (abemaciclib)	
CHEMOTHERAPY		
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 (alpelisib)*[NR] TYKERB (lapatinib) *TALZENNA (talazoparib tosylate)*[NR, QL]	

Nebraska Medicaid
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ONCOLOGY AGENTS, ORAL, HEMATOLOGIC

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ALL		▪ Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines Drug-specific critera ▪ **Hydrea®:** Requires clinical reason why generic cannot be used ▪ **imatinib:** Requires trial of Gleevec or clinical reason Gleevec cannot be used ▪ **melphalan:** Requires trial of Alkeran or clinical reason Alkeran cannot be used ▪ **Tabloid:** Prior authorization not required for age <19 ▪ **Tasigna:** Patients receiving Tasigna, which changed from preferred to non-preferred on 1-17-19 will be allowed to continue therapy ▪ **Xpovio:** Indicated for relapsed or refractory multiple myeloma. Requires concomitant therapy with dexamethasone
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) *XPOVIO (selinexor)*[NR, CL]	
OTHER		
MATULANE (procarbazine)	*BRUKINSA (zanubrutinib)*[NR,QL] CALQUENCE (acalabrutinib)[QL] *INREBIC (fedratinib dihydrochloride)*[NR,QL] TABLOID (thioguanine) tretinoin (generic for Vesanoid)	

Nebraska Medicaid
Preferred Drug List
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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 / NTRK		
XALKORI (crizotinib)	*ROZLYTREK (entrectinib)*[NR,AL,QL]	
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) *TURALIO (pexidartinib)*[NR,QL] *VITRAKVI (larotrectinib) **CAPSULE, SOLUTION***[NR,QL] ZEJULA (niraparib)	▪ Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines

ONCOLOGY AGENTS, ORAL, PROSTATE

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
bicalutamide (generic for Casodex) flutamide	abiraterone (generic for Zytiga) EMCYT (estramustine) ERLEADA (apalutamide)[QL] nilutamide (generic for Nilandron) *NUBEQA (darolutamide)*[NR,QL] XTANDI (enzalutamide) YONSA (abiraterone acet, submicronized)	▪ 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

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

PDL Update December 1, 2019 *Highlights* indicated change from previous posting

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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)	▪ Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines Drug-specific critera ▪ **Afinitor:** Patients receiving Affinitor, 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		▪ Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines Drug-specific critera ▪ **Odomzo:** Patients receiving Odomzo, which changed from preferred to non-preferred on 1-17-19 will be allowed to continue therapy
ERIVEDGE (vismodegib)	ODOMZO (sonidegib)	
BRAF MUTATION		
BRAFTOVI (encorafenib) COTELLIC (cobimetinib) MEKINIST (trametinib) MEKTOVI (binimetinib) TAFINLAR (dabrafenib) ZELBORAF (vemurafenib)		

OPHTHALMICS, ALLERGIC CONJUNCTIVITIS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ALREX (loteprednol 0.2%) cromolyn (generic for Opticrom) ketotifen OTC (generic for Zaditor) PAZEO (olopatadine 0.7%)	ALOCRIL (nedocromil) ALOMIDE (lodoxamide) azelastine (generic for Optivar) BEPREVE (bepotastine besilate) EMADINE (emedastine) epinastine (generic for Elestat) LASTACAFT (alcaftadine) olopatadine 0.1% (generic for Patanol) olopatadine 0.2% (generic for Pataday) PATADAY (olopatadine 0.2%)	▪ Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class

OPHTHALMICS, ANTIBIOTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
FLUOROQUINOLONES		▪ Non-preferred agents will be approved for patients who have failed a one month trial of TWO preferred agent within this drug class ▪ **Azasite®:** Approval only requires trial of erythromycin Drug-specific criteria: ▪ **Natacyn®:** Approved for documented fungal infection
ciprofloxacin **SOLUTION** (generic for Ciloxan) MOXEZA (moxifloxacin) ofloxacin (generic for Ocuflox)	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/gramcidin) sulfacetamide **SOLUTION** (generic for Bleph-10) sulfacetamide **OINTMENT**	

OPHTHALMICS, ANTIBIOTIC-STEROID COMBINATIONS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
neomycin/polymyxin/dexamethasone (generic for Maxitrol) sulfacetamide/prednisolone TOBRADEX **SUSPENSION, OINTMENT** (tobramycin and dexamethasone)	BLEPHAMIDE (prednisolone and sulfacetamide) BLEPHAMIDE S.O.P. neomyxin/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)	▪ 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		▪ 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 whohave 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%)	

OPHTHALMICS, ANTI-INFLAMMATORY / IMMUNOMODULATORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
RESTASIS (cyclosporine) RESTASIS MULTIDOSE (cyclosporine)	*CEQUA (cyclosporine)*[NR,QL] XIIDRA (lifitegrast)	▪ 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		▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: ▪ **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]	

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

OPIOID-REVERSAL TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
naloxone **SYRINGE, VIAL** naltrexone **TABLET** NARCAN (naloxone) **SPRAY**		▪ Non-preferred agents will be approved with documentation of why preferred products 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)	▪ Non-preferred agents will be approved for patients who have failed a trial of the preferred agent within this drug class

OTIC ANTIBIOTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CIPRODEX (ciprofloxacin/dexamethasone) neomycin/polymyxin/hydrocortisone (generic for Cortisporin) ofloxacin (generic for Floxin)	CIPRO HC (ciprofloxacin/ hydrocortisone) ciprofloxacin COLY-MYCIN S(neomycin/ hydrocortisone/colistin) OTOVEL (ciprofloxacin/fluocinolone)	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent 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)	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class within the last 6 months Drug-specific criteria: ▪ **Adcirca®/Revatio®:** Approved for diagnosis of Pulmonary Arterial Hypertension (PAH) ▪ **Adempas®:** PAH: Requires clinical reason preferred agent cannot be used CTEPH: Approved for persistent/recurrent diagnosis after surgical treatment or inoperable CTEPH NOT for use in Pregnancy ▪ **sildenafil suspension:** Requires clinical reason why sildenafil tablets cannot be used

PANCREATIC ENZYMES

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

PEDIATRIC VITAMIN PREPARATIONS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CHILD LITTLE ANIMALS VITAMINS CHEW OTC (pedi multivit 91/iron fum) **CHEW** child multivitamins chew otc (pedi multivit 19/folic acid) **CHEW** CHILDREN'S CHEW MULTIVIT-IRON OTC (pedi multivit 91/iron fum) **CHEW** children's chewables otc (pedi multivit 23/folic acid) **CHEW** children's vitamins with iron otc (pedi multivit/iron) fluoride/vitamins A,C,AND D (ped multivit A,C,D3, 21/fluoride) **DROPS** infant-toddler multivit drop OTC (pediatric multivit no. 165 drops) infant-toddler multivit-iron OTC (pedi mv no.164/ferrous sulfate drops) infant-toddler tri-vit drop (vit a pamintate/vit c/vit d3 drops) multivitamins with fluoride (pedi multivit 2/fluoride) **DROPS** multivits with iron and fluoride (pedi multivit 45/fluoride/iron) **DROPS** MVC-FLUORIDE (pedi multivit 12/fluoride) **CHEW TAB** ped mvit A,C,D3,No 21/fluoride **DROPS** pedi mvi no. 16 with fluoride **CHEW** pedi mvi 17 with fluoride **CHEW** POLY-VI-SOL OTC (pedi multivit 81) **DROPS** POLY-VI-SOL WITH IRON (pedi multivit 80/ferrous sulfate) **DROPS** TRI-VI-SOL OTC (vit A palmitate/vit C/Vit D3) **DROPS** tri-vite-fluoride 0.25 mg/ml, and 0.5 mg/ml VITALETS OTC (pedi multivit 36/iron) **CHEW**	AQUADEKS (pedi multivit 40/phytonadione) ESCAVITE (pedi multivit 47/iron/fluoride) ESCAVITE D (pedi multivit 78/iron/fluoride) **CHEW** ESCAVITE LQ (pedi multivit 86/iron/fluoride) FLORIVA (pedi multivit 85/fluoride) **CHEW** FLORIVA PLUS OTC and Rx (pedi multivit 130/fluoride) **DROPS** multivit A, B, D, E, K, ZN (pediatric multivit 153/D3/K) POLY-VI-FLOR (pedi multivit 33/fluoride) **CHEW** POLY-VI-FLOR (pedi multivit 37/fluoride) **DROPS** POLY-VI-FLOR w/IRON (pedi multivit 33/fluoride/iron) **CHEW** POLY-VI-FLOR w/IRON (pedi multivit 37/fluoride/iron) **DROPS** QUFLORA OTC and Rx (pedi multivit 84/fluoride) QUFLORA FE (pedi multivit 142/iron/fluoride) TRI-VI-FLORO (ped multivit A, C, D3, 38/fluoride)	▪ Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class Drug specific criteria: ▪ **Aquadeks**: Approved for diagnosis of Cystic Fibrosis

PENICILLINS

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

PHOSPHATE BINDERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
calcium acetate **TABLET, 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)	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class within the last 6 months

PLATELET AGGREGATION INHIBITORS

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

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

PROGESTERONE (hydroxyprogesterone caproate)

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

PROTON PUMP INHIBITORS

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

SEDATIVE HYPNOTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BENZODIAZEPINES		
temazepam 15mg, 30mg (generic for Restoril)	estazolam (generic for ProSom) flurazepam (generic for Dalmane) temazepam (generic for Restoril) 7.5mg, 22.5mg triazolam (generic for Halcion)	▪ **Lunesta®/ Rozerem®/zolpidem ER:** Requires a trial with generic zolpidem within the last 12 months AND Trial OR Clinical reason why zaleplon and preferred benzodiapine 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 benzodiapine 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: ○ Contraindication to preferred oral sedative hypnotics ○ Medical necessity for doxepin dose < 10mg ○ Age greater than 65 years old or hepatic impairment (3mg dose will be approved if this criteria is met) ▪ **temazepam 7.5mg/22.5mg:** Requires clinical reason why 15mg/30mg cannot be used ▪ **zolpidem/zolpidem ER:** Maximum daily dose for females: Zolpidem 5mg; Zolpidem ER® 6.25mg ▪ **zolpidem SL:** Requires clinical reason why half of zolpidem tablet cannot be used ▪ **Zolpimist®:** Requires documentation of swallowing disorder
OTHERS		
zaleplon (generic for Sonata) zolpidem (generic for Ambien)	BELSOMRA (suvorexant) EDLUAR (zolpidem sublingual) eszopiclone (generic for Lunesta) HETLIOZ (tasimelteon)CL ramelteon (generic for Rozerem) SILENOR (doxepin) zolpidem ER (generic for Ambien CR) zolpidem SL (generic for Intermezzo) ZOLPIMIST (zolpidem oral spray)	

SINUS NODE INHIBITORS

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

SKELETAL MUSCLE RELAXANTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
baclofen (generic 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,QL] 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**	▪ Non-preferred agents will be approved for patients who have failed a 1-week trial of TWO preferred agents within this drug class Drug-specific criteria: ▪ **Amrix®/Fexmid®:** Requires clinical reason why IR cyclobenzaprine cannot be used Approved only for acute muscle spasms NOT approved for chronic use ▪ **carisoprodol:** Approved for Acute, musculoskeletal pain - NOT for chronic pain Use is limited to no more than 30 days Additional authorizations will not be granted for at least 6 months following the last dayy of previous course of therapy ▪ **Dantrolene:** Trial NOT required for treatment of spasticity from spinal cord injury ▪ **Lorzone®:** Requires clinical reason why chlorzoxazone cannot be used ▪ **Soma® 250mg:** Requires clinical reason why 350mg generic strength cannot be used ▪ **Zanaflex® Capsules:** Requires clinical reason generic cannot be used

STEROIDS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
LOW POTENCY		▪ Low Potency Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within 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-SMOOTHE-FS) MICORT-HC (hydrocortisone) TEXACORT (hydrocortisone)	
MEDIUM POTENCY		▪ Medium Potency Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class
fluticasone propionate **CREAM, OINTMENT** (generic for Cutivate) mometasone furoate **CREAM, OINTMENT, SOLUTION** (generic for Elocon)	betamethasone valerate (generic for Luxiq) clocortolone (generic for Cloderm) fluocinolone acetonide (generic for Synalar) flurandrenolide (generic for Cordran) fluticasone propionate **LOTION** (generic for Cutivate) hydrocortisone butyrate (generic for Locoid) hydrocortisone butyrate/emoll (generic for Locoid Lipocream) hydrocortisone valerate (generic for Westcort) PANDEL (hydrocortisone probutate 0.1%) prednicarbate (generic for Dermatop)	

STEROIDS, TOPICAL (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
HIGH POTENCY		▪ 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 halcinonide **CREAM** (generic for Halog) HALOG (halcinonide) KENALOG AEROSOL (triamcinolone) SERNIVO (betamethasone dipropionate) triamcinolone **SPRAY** (generic for Kenalog spray) TRIANEX **OINTMENT** (triamcinolone) VANOS (fluocinonide)	
VERY HIGH POTENCY		▪ Very High Potency Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class
clobetasol emollient (generic for Temovate-E) clobetasol propionate **CREAM**, **GEL, OINTMENT, SOLUTION** halobetasol propionate (generic for Ultravate)	APEXICON-E (diflorasone) *BRYHALI (halobetasol prop) **LOTION**NR* clobetasol **SHAMPOO, LOTION** clobetasol propionate **FOAM, SPRAY** CLOBEX (clobetasol) *halobetasol propionate **FOAM**NR,AL,QL* OLUX-E /OLUX/OLUX-E CP (clobetasol)	

STIMULANTS AND RELATED ADHD DRUGS[AL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CNS STIMULANTS		▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: ▪ **Procentra®:** May be approved with documentation of swallowing disorder ▪ **Zenzedi®:** Requires clinical reason generic dextroamphetamine IR cannot be used
Amphetamine type		
ADDERALL XR (amphetamine salt combo) amphetamine salt combination IR VYVANSE (lisdexamfetamine) **CAPSULE, CHEWABLE**	ADZENYS ER (amphetamine) **SUSPENSION** 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) *EVEKEO ODT (amphetamine sulfate)*[NR] MYDAYIS (amphetamine salt combo)[QL] methamphetamine (generic for Desoxyn) ZENZEDI (dextroamphetamine)	

STIMULANTS AND RELATED ADHD DRUGS (Continued)[AL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Methylphenidate type		▪ Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class Drug-specific criteria: ▪ **Daytrana®:** May be approved in history of substance abuse by parent/caregiver or patient May be approved with documentation of difficulty swallowing
FOCALIN (dexmethylphenidate) FOCALIN XR (dexmethylphenidate) --- APTENSIO XR (methylphenidate) methylphenidate (generic for Ritalin) --- methylphenidate ER 10mg, 20mg (generic for Ritalin SR, Metadate ER) --- QUILLICHEW ER (methylphenidate) QUILLIVANT XR (methylphenidate suspension)	dexmethylphenidate (generic for Focalin) dexmethylphenidate XR (generic for Focalin XR) --- COTEMPLA XR-ODT (methylphenidate) methylphenidate **CHEWABLE, SOLUTION** (generic for Methylin) RITALIN (methylphenidate) --- DAYTRANA (methylphenidate) methylphenidate 30/70 (generic for Metadate CD) methylphenidate 50/50 (generic for RITALIN LA) methylphenidate ER (generic for Ritalin SR) --- CONCERTA (methylphenidate ER) 18mg, 27mg, 36mg, 54mg methylphenidate ER 18mg, 27mg, 36mg, 54mg (generic Concerta) methylphenidate ER 72mg (generic for RELEXXI)[QL] --- *ADHANSIA XR (methylphenidate)[NR, QL]* *JORNAY PM (methylphenidate)[NR,QL]*	

STIMULANTS AND RELATED ADHD DRUGS (Continued)[AL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
MISCELLANEOUS		**Note: generic guanfacine IR and clonidine IR are available without prior authorization**
atomoxetine (generic for Strattera) guanfacine ER (generic for Intuniv)[QL]	clonidine ER (generic for Kapvay)[CL] STRATTERA (atomoxetine)	
ANALEPTICS		▪ **Armodafinil, *Sunosi, and Wakix*:** Require trial of modafinil ▪ **armodafinil and modafinil:** approved only for: ○ Sleep Apnea with documentation/confirmation via sleep study and documentation that C-PAP has been maxed ○ Narcolepsy with documentation of diagnosis via sleep study ○ Shift Work Sleep Disorder (only approvable for 6 months) with work schedule verified and documented. Shift work is defined as working the all night shift ▪ ***Sunosi*** approved only for: ○ Sleep Apnea with documentation/confirmation via sleep study and documentation that C-PAP has been maxed ○ Narcolepsy with documentation of diagnosis via sleep study ▪ ***Wakix:*** *approved only for excessive daytime sleepiness in adults with narcolepsy with documentation of narcolepsy diagnosis via sleep study*
	armodafinil (generic for Nuvigil)[CL] modafanil (generic for Provigil)[CL] *SUNOSI (solriamfetol)[NR,CL,QL]* *WAKIX (pitolisant)[NR,CL,QL]*	

TETRACYCLINES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
doxycycline hyclate IR (generic for Vibramycin) doxycycline monohydrate **50MG, 100MG CAPSULE** doxycycline monohydrate **SUSP** (generic for Vibramycin 25MG) doxycycline monohydrate **TAB** minocycline HCL **CAPSULE** (generic for Minocin, Dynacin) minocycline HCL **TABLET** (generic for Dynacin, Myrac)	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) NUZYRA (omadacycline) tetracycline HCl (generic for Sumycin) VIBRAMYCIN **SUSP** (doxycycline) XIMINO (minocycline ER) **CAPSULE**[QL]	▪ Non-preferred agents will be approved for patients who have failed an 3-day trial of TWO preferred agents within this drug class Drug-specific criteria: ▪ **Demeclocycline:** Approved for diagnosis of SIADH ▪ **Doryx®/doxycycline hyclate DR/ Dynacin®/Oracea®/Solodyn®:** Requires clinical reason why generic doxycycline, minocycline or tetracycline cannot be used ▪ **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**	*EUTHYROX (levothyroxine)*[NR] LEVO-T (levothyroxine) THYROLAR **TABLET** (liotrix) TIROSINT **TABLET** (levothyroxine) TIROSINT-SOL (LIQUID) (levothyroxine)[CL]	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: ▪ Tirosint-Sol: May be approved with documented swallowing difficulty

ULCERATIVE COLITIS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ORAL		▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: ▪ **Asacol HD®/Delzicol DR®/ 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) mesalamine **ENEMA** (generic Rowasa)	mesalamine **SUPPOSITORY** (generic for Canasa) UCERIS (budesonide)	

UTERINE DISORDER TREATMENT - ENDOMETRIOSIS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
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)		Drug-specific criteria: **Orilissa:** Requires an FDA approved indication, must follow FDA dosing guidelines, and have had a trial and failure of an NSAID and oral contraceptive

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)	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: ▪ **BiDil:** Approved for the treatment of heart failure as an adjunct therapy to standard therapy in self-identified black patients