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

Pete Ricketts, Governor

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

Contains November 2021 P&T Proposed Changes
Noted in Red Font that Become Effective January 21, 2022

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

- **Opioids**- The maximum opioid dose covered will decrease from 120 Morphine Milligram Equivalents (MME) per day to 90 Morphine Milligram Equivalents (MME) per day. (beginning December 1, 2020)

Non-Preferred Drug Coverage

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

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

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

- Asthma Immunomodulator PA Form
- Buprenorphine Products PA Form
- Buprenorphine Products Informed Consent
- Growth Hormone PA Form
- HAE Treatments PA Form
- Hepatitis C PA Form

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

- Documentation of Medical Necessity PA Form

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

ALZHEIMER'S AGENTS

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
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 **SOLUTION** (generic for Namenda) NAMENDA (memantine) NAMZARIC (memantine/donepezil)	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)

ANTHELMINTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
albendazole (generic for Albenza) BILTRICIDE (praziquantel) ivermectin (generic for Stromectol)	ALBENZA (albendazole) EMVERM (mebendazole)[CL] praziquantel (generic for Biltricide) STROMECTOL (ivermectin)	• 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: ▪ **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) *PALFORZIA [AL,CL] (peanut allergen powder-dnfp)*	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. ***PALFORZIA*** • *Confirmed diagnosis of peanut allergy by allergist* • *For use in patients ages 4 to 17; it may be continued in patients 18 years and older with documentation of previous use within the past 90 days* • *Initial dose and increase titration doses should be given in a healthcare setting* • *Should not be used in patients with uncontrolled asthma or concurrently on a NSAID*

ANTIHISTAMINES, MINIMALLY SEDATING

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
cetirizine **TABLET, SOLUTION (Rx only)** (generic for Zyrtec) loratadine **TABLET, SOLUTION** (generic for Claritin) levocetirizine **TABLET** (generic for Xyzal)	cetirizine **CHEWABLE** (generic for Zyrtec) cetirizine **SOLUTION (OTC)** desloratadine (generic for Clarinex) desloratadine ODT (generic for Clarinex Reditabs) fexofenadine (generic for Allegra) fexofenadine 180mg (generic for Allegra 180mg)[QL] levocetirizine (generic for Xyzal) **SOLUTION** loratadine **CAPSULE, CHEWABLE, ODT** (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) MITIGARE (colchicine) probenecid probenecid/colchicine (generic for Col-Probenecid)	colchicine **TABLET** (generic for Colcrys)[CL] colchicine **CAPSULE** (generic for Mitigare) febuxostat (generic for Uloric)[CL] *GLOPERBA **SOLN** (colchicine)*[CL, 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 • ***Gloperba:*** *Approved for documented swallowing disorder* • **Uloric®:** Clinical reason why allopurinol cannot be used

ANTIPARKINSON'S AGENTS, 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
pramipexole (generic for Mirapex) ropinirole (generic for Requip)	bromocriptine (generic for Parlodel) ropinirole ER (generic for Requip ER)[CL] 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*
selegiline **CAPSULE, TABLET** (generic for Eldepryl)	rasagiline (generic for Azilect) [QL] XADAGO (safinamide) ZELAPAR (selegiline)[CL]	• **Osmolex ER:** Required diagnosis of Parkinson's disease or drug-induced extrapyramidal reactions and had trial of or is intolerant to amantadine IR
OTHER ANTIPARKINSON'S DRUGS		• **Pramipexole ER:** Required diagnosis of Parkinson's along with preferred agent trial
amantadine **CAPSULE, SYRUP TABLET** (generic for Symmetrel) carbidopa/levodopa (generic for Sinemet) carbidopa/levodopa ER (generic for Sinemet CR) levodopa/carbidopa/entacapone (generic for Stalevo)	APOKYN (apomorphine) **SUB-Q** carbidopa (generic for Lodosyn) carbidopa/levodopa ODT (generic for Parcopa) DUOPA (carbidopa/levodopa) GOCOVRI (amantadine)[QL] INBRIJA (levodopa) INHALER[CL, QL] *KYNMOBI (apomorphine)[QL,* ***KIT, SUBLINGUAL*** *NOURIANZ (istradefylline)[CL, QL]* OSMOLEX ER (amantadine)[QL] RYTARY (carbidopa/levodopa) STALEVO (ledopa/carbidopa/entacapone)	• **Ropinerole ER:** Required diagnosis of Parkinson's along with preferred agent trial • **Zelapar®:** Approved for documented swallowing disorder

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 **OINTMENT(**generic for Taclonex) *calcipotriene/betamethasone **SUSP** (generic for Taclonex Scalp)* CALCITRENE (calcipotriene) DOVONEX **CREAM** (calcipotriene) DUOBRII (halobetasol prop/tazarotene 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

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**[CL] clorazepate (generic for Tranxene-T) diazepam **INTENSOL**[CL] 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 criteria: • **Diazepam Intensol®:** Requires clinical reason why diazepam solution cannot be used • **Alprazolam Intensol®:** Requires trial of diazepam solution OR lorazepam Intensol®

BILE SALTS

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

BRONCHODILATORS, BETA AGONIST

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class
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: • **Xopenex®:** Covered for cardiac diagnoses or side effect of tachycardia with albuterol product
PROAIR HFA (albuterol) albuterol HFA (generic for ProAir HFA)	albuterol HFA (Proventil HFA, Ventolin HFA) levalbuterol HFA (generic for Xopenex HFA) *PROAIR DIGIHALER (albuterol)* PROAIR RESPICLICK (albuterol) PROVENTIL HFA (albuterol)	
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)	arformoterol tartrate (generic Brovana) BROVANA (arformoterol) formoterol fumarate (generic Perforomist) levalbuterol (generic for Xopenex) PERFOROMIST (formoterol)	
ORAL		
albuterol **SYRUP**	albuterol **TABLET** albuterol ER (generic for Vospire ER) metaproterenol (formerly generic for Alupent) terbutaline (generic for Brethine)	

COLONY STIMULATING FACTORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
NEUPOGEN (filgrastim) **VIAL**	GRANIX (tbo-filgrastim) NEUPOGEN **DISP SYR** (filgrastim) NIVESTYM **SYR,VIAL** (filgrastim-aafi) Nyvepria (pegfilgrastim-apgf) ZARXIO (filgrastim-sndz) *ZIEXTENZO **SYR** (pegfilgrastim-bmez)*	• Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

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
ANORO ELLIPTA (umeclidinium/vilanterol) ATROVENT HFA (ipratropium) COMBIVENT RESPIMAT (albuterol/ipratropium) SPIRIVA (tiotropium) STIOLTO RESPIMAT (tiotropium/olodaterol)	BEVESPI AEROSPHERE (glycopyrolate/formoterol) DUAKLIR PRESSAIR (aclidinium br and formoterol fum) 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)	
ORAL AGENT		
	DALIRESP (roflumilast)[CL, QL]	

COUGH AND COLD, OPIATE COMBINATION

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	guaifenesin/codeine **LIQUID** hydrocodone/homatropine SYRUP promethazine/codeine **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 dextromethorphan product • All codeine or hydrocodone containing cough and cold combinations are limited to ≥ 18 years of age

CYTOKINE & CAM ANTAGONISTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ENBREL (etanercept) **KIT, MINI CART, PEN**[QL] HUMIRA (adalimumab)[QL] ENBREL (etanercept) **VIAL**[QL] OTEZLA (apremilast) **ORAL**[CL,QL]	ACTEMRA (tocilizumab) **SUB-Q** ARCALYST (nilonacept) CIMZIA (certolizumab pegol)[QL] COSENTYX (secukinumab) ENSPRYNG (satralizumab-mwge) **SUB-Q** ILUMYA (tildrakizumab) SUB-Q KEVZARA (sarilumab) **SUB-Q, PEN, SYRINGE** KINERET (anakinra) OLUMIANT (baricitinib) **ORAL**[CL,QL] ORENCIA (abatacept**) SUB-Q** RINVOQ ER (upadacitinib)[CL,QL] SILIQ (brodalumab) SIMPONI (golimumab) SKYRIZI (risankizamab-rzaa) SKYRIZI **PEN** (risankizamab-rzaa)[QL] STELARA (ustekinumab) **SUB-Q** TALTZ (ixekizumab)[AL] TREMFYA (guselkumab)[QL] XELJANZ (tofacitinib) **ORAL, *SOLN***[CL,QL] XELJANZ XR (tofacitinib) **ORAL**[CL,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: • ***Otezla****: Requires a trial of Humira* • ***Olumiant:*** *Requires documentation of inadequate response or intolerance to methotrexate and an inadequate response to one or more TNF antagonist therapies.* • ***Rinvoq:*** *Requires documentation of inadequate response or intolerance to methotrexate* • ***Xeljanz, Xeljanz XR****: Requires documentation of inadequate response or intolerance to Tumor Necrosis Factor (TNF).*

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 (AUTHORIZED GENERIC for Epipen/ Epipen Jr.) **AUTOINJECTOR**	epinephrine (generic for Adrenaclick) epinephrine (generic for Epipen/ Epipen Jr.) **AUTOINJECTOR** EPIPEN (epinephrine) **AUTOINJ** EPIPEN JR. (epinephrine) **AUTOINJ** SYMJEPI (epinephrine) **PFS**	• 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

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] FLOVENT HFA (fluticasone) PULMICORT FLEXHALER (budesonide)	AEROSPAN (flunisolide) ALVESCO (ciclesonide)[AL,CL] *ARMONAIR DIGIHALER (fluticasone)[AL,QL]* ARMONAIR RESPICLICK (fluticasone)[AL] ARNUITY ELLIPTA (fluticasone) ASMANEX HFA (mometasone)[CL,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) SYMBICORT (budesonide/ formoterol)	*AIRDUO DIGIHALER (fluticasone/salmeterol)[AL,QL]* BREO ELLIPTA (fluticasone/vilanterol) *BREZTRI (budesonide/formoterol/ glycopyrrolate)[QL]* Budesonide/formoterol (generic for Symbicort) 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 **ELIXIR, SOLN** dexamethasone **TABLET** hydrocortisone **TABLET** methylprednisolone tablet (generic for Medrol) prednisolone **SOLUTION** prednisolone sodium phosphate prednisone **DOSE PAK** prednisone **TABLET**	*ALKINDI (hydrocortisone)* ***GRANULES***[AL] CORTEF (hydrocortisone) cortisone **TABLET** dexamethasone **INTENSOL** DEXPAK (dexamethasone) DXEVO (dexamethasone) EMFLAZA (deflazacort) **SUSPENSION, TABLET**[CL] ENTOCORT EC (budesonide) methylprednisolone 8mg, 16mg, 32mg *ORTIKOS ER (budesonide)*[AL,QL] 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 2 years of age and older • **Intensol Products:** Patient specific documentation of why the less concentrated solution is not appropriate for the patient

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 1-21-21 will be allowed to continue same therapy*
ALPHANATE HELIXATE FS HUMATE-P NOVOEIGHT NUWIQ XYNTHA **KIT, SOLOFUSE**	ADVATE ADYNOVATE AFSTYLA ELOCTATE ESPEROCT HEMOFIL-M JIVI[AL] KOATE-DVI **KIT** KOATE-DVI **VIAL** KOGENATE FS KOVALTRY OBIZUR RECOMBINATE	
FACTOR IX		
ALPROLIX BENEFIX	ALPHANINE SD IDELVION IXINITY MONONINE PROFILNINE SD REBINYN RIXUBIS	
FACTOR VIIa AND PROTHROMBIN COMPLEX-PLASMA DERIVED		
NOVOSEVEN RT	FEIBA NF SEVENFACT[AL]	
FACTOR X AND XIII PRODUCTS		
COAGADEX CORIFACT	TRETTEN	
VON WILLEBRAND PRODUCTS		
WILATE	VONVENDI	
BISPECIFIC FACTORS		
HEMLIBRA		

HISTAMINE II RECEPTOR BLOCKERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
famotidine **TABLET** (generic for Pepcid) nizatidine **SOLUTION** (generic for Axid)	cimetidine **TABLET, SOLUTION**[CL] (generic for Tagamet) famotidine **SUSPENSION** nizatidine **CAP** (generic for Axid) ranitidine **CAPSULE,** (generic for Zantac) ranitidine OTC, SYRUP, TABLET (generic for Zantac)	• 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 • ***cimetidine solution/ famotidine suspension/ranitidine syrup:*** *Requires clinical reason why nizatidine syrup cannot be used* ******famotidine suspension is authorized during shortage of nizatidine syrup.******

IDIOPATHIC PULMONARY FIBROSIS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
OFEV (nintedanib esylate)[CL]	ESBRIET (pirfenidone)	• Non-preferred agent requires trial of preferred agent within this drug class • FDA approved indication required – ICD-10 diagnosis code

IMMUNOMODULATORS, ASTHMA[CL]

Preferred Agents	*Non-Preferred Agents*	*Prior Authorization/Class Criteria*
FASENRA (benralizumab)[AL] ***PEN*** *XOLAIR (omalizumab)* ***SYR***[AL,QL]	*NUCALA (mepolizumab)*[AL] ***AUTO-INJ, SYR,***	Asthma Immunomodulator PA Form Non-preferred agents requires trial of a preferred agent within this drug class with the same indication Drug Specific Criteria: **Dupixent**: is indicated for - Patients 6 years and older as an add-on maintenance treatment in patients with moderate-to-severe asthma with an eosinophilic phenotype or with oral corticosteroid dependent asthma - For other indications, see Immunomodulators, Atopic Dermatitis **Fasenra**: is indicated for patient 12 years and older for add on maintenance treatment of severe asthma, and with an eosinophilic phenotype **Nucala**: is indicated for -Patients 6 years and older for add on maintenance treatment of severe asthma, and with an eosinophilic phenotype -Patients 12 years and older with hypereosinophilic syndrome (HES) for ≥6 months without identifiable non-hematologic secondary cause -Patients 18 years and older for add-on maintenance treatment of chronic rhinosinusitis with nasal polyps (CRWSwNP) with inadequate response to nasal corticosteroids. -Adult patients with eosinophilic granulomatosis with polyangiitis **Xolair:** is indicated for - Moderate to severe persistent asthma in adults and pediatric patients 6 years of age and older with a positive skin test or in vitro reactivity to a perennial aeroallergen and symptoms that are inadequately controlled with inhaled corticosteroids -Nasal polyps in adult patients 18 years of age and older with inadequate response to nasal corticosteroids, as add-on maintenance treatment -Chronic spontaneous urticaria (CSU) in adults and adolescents 12 years of age and older who remain symptomatic despite H1 antihistamine treatment

IMMUNOMODULATORS, ATOPIC DERMATITIS[AL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ELIDEL (pimecrolimus) EUCRISA (crisaborole)[CL,QL]	DUPIXENT (dupilumab)[AL,CL] DUPIXENT **PEN**[AL] 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:** Indicated for - for the treatment of patients aged 6 years and older with moderate-to-severe atopic dermatitis whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable. DUPIXENT can be used with or without topical corticosteroids. - as an add-on maintenance treatment in patients with moderate-to-severe asthma aged 6 years and older with an eosinophilic phenotype or with oral corticosteroid dependent asthma - as an add-on maintenance treatment in adult patients with inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP) **Eucrisa:** Requires use and failure of 1 topical steroid or Elidel.

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

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) *azelastine/fluticasone (generic for Dymista)* 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)[AL]	montelukast **GRANULES** (generic for Singulair)[CL, AL] 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

METHOTREXATE

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
methotrexate **PF VIAL, TABLET, VIAL**	OTREXUP (methotrexate) **SUB-Q** RASUVO (methotrexate) **SUB-Q** REDITREX (methotrexate) **SUB-Q** AL 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
AUSTEDO (deutetrabenazine)CL INGREZZA (valbenazine)CL **CAP** tetrabenazine (generic for Xenazine)CL	INGREZZA (valbenazine)CL **INITIATION PACK** XENAZINE (tetrabenazine)CL	Non-preferred agent requires trial of Austedo All drugs require an FDA approved indication – ICD-10 diagnosis code required. Drug-specific criteria: • **Austedo:** Diagnosis of Tardive Dyskinesia or chorea associated with Huntington's Disease; Requires a Step through tetrabenazine with the diagnosis of chorea associated with Huntington's Disease • **Ingrezza:** Diagnosis of Tardive Dyskinesia in adults • **tetrabenazine:**Diagnosis of chorea with Huntington's Disease

NSAIDs, ORAL

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
diclofenac sodium (generic for Voltaren) 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) diclofenac SR (generic for Voltaren-XR) 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 **CAP** (generic Vivlodex)[CL, QL] naproxen CR (generic for Naprelan) naproxen **SUSPENSION** (generic for Naprosyn) naproxen sodium (generic for Anaprox) *naproxen-esomeprazole (generic for Vimovo)* oxaprozin (generic for Daypro) piroxicam (generic for Feldene) QMIIZ ODT (meloxicam) [QL] RELAFEN DS (nabumetone) tolmetin (generic for Tolectin) Ketorolac Nasal (generic for Sprix)[QL]	

NSAIDs, ORAL (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)CL ibuprofen/famotidine (generic Duexis)CL SPRIX (ketorolac nasal spray) **NASAL**QL, CL TIVORBEX (indomethacin) VIVLODEX (meloxicam 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 sodium **GEL (OTC only)**	diclofenac (generic for Pennsaid Solution)[CL] FLECTOR **PATCH** (diclofenac)[CL] LICART **PATCH** (diclofenac)[CL] PENNSAID **PACKET, PUMP** (diclofenac)[CL] VOLTAREN **GEL** (diclofenac)[CL]	Non-preferred agents will be approved for patients who have failed ONE preferred agent within this drug class Drug Specific Criteria • **Flector®/Licart:** 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

November 2021 P&T Proposed Changes Highlighted in Red Font become effective January 21, 2022

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

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 ▪ **anastrozole:** 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 ▪ **Soltamox:** May be approved with documented swallowing difficulty
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)	SOLTAMOX **SOLN** (tamoxifen)[CL] toremifene (generic for Fareston)[CL]	
OTHER		
	NERLYNX (neratinib) PIQRAY (alpelisib) *lapatinib (generic Tykerb)[CL]* TALZENNA (talazoparib tosylate)[QL] TUKYSA(tucatinib)[QL]	

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

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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 ▪ **Melphalan:** Requires trial of Alkeran or clinical reason Alkeran cannot be used ▪ **Purixan:** Prior authorization not required for age ≤12 or for documented swallowing disorder ▪ **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)[AL]	
AML		
	DAURISMO (glasdegib maleate)[QL] IDHIFA (enasidenib) RYDAPT (midostaurin) TIBSOVO (ivosidenib)[QL] XOSPATA (gilteritinib) [QL]	
CLL		
IMBRUVICA (ibrutinib) LEUKERAN (chlorambucil) VENCLEXTA (venetoclax)	COPIKTRA (duvelisib) [QL] ZYDELIG (idelalisib)	
CML		
hydroxyurea (generic for Hydrea) imatinib (generic for Gleevec) MYLERAN (busulfan) SPRYCEL (dasatinib)	BOSULIF (bosutinib) GLEEVEC (imatinib) HYDREA (hydroxyurea) ICLUSIG (ponatinib) 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) [CL]	
OTHER		
MATULANE (procarbazine) TABLOID (thioguanine) tretinoin (generic for Vesanoid)	BRUKINSA (zanubrutinib[QL] CALQUENCE (acalabrutinib)[QL] INREBIC (fedratinib dihydrochloride)[QL] INQOVI (decitabine/cedazuridine) ZOLINZA (vorinostat)	

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

November 2021 P&T Proposed Changes Highlighted in Red Font become effective January 21, 2022

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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 Drug-Specific Criteria ▪ **Iressa/ Xalkori**: Patients receiving Iressa or Xalkori prior to 1/21/21 (which changed from preferred to non-preferred) will be allowed to continue current treatment
ALECENSA (alectinib)	ALUNBRIG (brigatinib) LORBRENA (lorlatinib) QL ZYKADIA (ceritinib) **CAPSULE, *TABLET***	
ALK / ROS1 / NTRK		
	ROZLYTREK (entrectinib) AL,QL XALKORI (crizotinib)	
EGFR		
TAGRISSO (osimertinib)	erlotinib (generic for Tarceva) GILOTRIF (afatinib) IRESSA (gefitinib) TARCEVA (erlotinib) VIZIMPRO (dacomitinib) QL	
OTHER		
	GAVRETO (pralsetinib) QL HYCAMTIN (topotecan) *LUMAKRAS (sotrasib* QL *RETEVMO (selpercatinib)* AL *TABRECTA (capmatinib)* QL *TEPMETKO (tepotinib)* QL	

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, OTHER

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CAPRELSA (vandetanib) GLEOSTINE (lomustine) LYNPARZA (olaparib) temozolomide (generic for Temodar) ZEJULA (niraparib)	BALVERSA (erdafitinib) COMETRIQ (cabozantinib) HEXALEN (altretamine) KOSELUGO (selumetinib)[AL] LONSURF (trifluridine/tipiracil) PEMAZYRE (pemigatinib)[QL] RUBRACA (rucaparib) STIVARGA (regorafenib) TAZVERIK (tazemetostat)[AL] TURALIO (pexidartinib)[QL] TRUSELTIQ (infigratinib) **CAPSULE** VITRAKVI (larotrectinib) **CAPSULE, SOLUTION**[QL]	• 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

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, PROSTATE

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
abiraterone (generic for Zytiga)CL bicalutamide (generic for Casodex) flutamide XTANDI (enzalutamide)AL,QL ZYTIGA (abiraterone)CL	EMCYT (estramustine) ERLEADA (apalutamide)QL nilutamide (generic for Nilandron) NUBEQA (darolutamide) QL YONSA (abiraterone acetonide, 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

ONCOLOGY AGENTS, ORAL, RENAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
INLYTA (axitinib) LENVIMA (lenvatinib) SUTENT (sunitinib) VOTRIENT (pazopanib	AFINITOR DISPERZ (everolimus)CL CABOMETYX (cabozantinib) everolimus (generic for Afinitor) NEXAVAR (sorafenib) sunitinib malate (generic for Sutent)	• 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 Afinitor, which changed from preferred to non-preferred on 1-17-19 will be allowed to continue therapy

ONCOLOGY AGENTS, ORAL, SKIN

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

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) olapatadine OTC (generic Pataday once daily, Pataday twice daily) olopatadine 0.1% (generic for Patanol)	ALOCRIL (nedocromil) ALOMIDE (lodoxamide) azelastine (generic for Optivar) BEPREVE (bepotastine besilate) bepotastine besilate (generic for Bepreve) EMADINE (emedastine) epinastine (generic for Elestat) LASTACAFT (alcaftadine) olopatadine 0.2% (generic for Pataday) PATADAY **XS** (olopatadine 0.7%) PATADAY OTC (olopatadine 0.2%) PAZEO (olopatadine 0.7%) ZERVIATE (certirizine)[AL]	▪ 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) ofloxacin (generic for Ocuflox)	BESIVANCE (besifloxacin) CILOXAN (ciprofloxacin) gatifloxacin 0.5% (generic for Zymaxid) levofloxacin MOXEZA (moxifloxacin) moxifloxacin (generic for Vigamox) moxifloxacin (generic for Moxeza) VIGAMOX (moxifloxacin)	
MACROLIDES		
erythromycin	AZASITE (azithromycin)[CL]	
AMINOGLYCOSIDES		
gentamicin **OINTMENT** gentamicin **SOLUTION** tobramycin (generic for Tobrex drops)	TOBREX **OINTMENT** (tobramycin)	
OTHER OPHTHALMIC AGENTS		
bacitracin/polymyxin B (generic Polysporin) polymyxin B/trimethoprim (generic for Polytrim)	bacitracin 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. neomycin/polymyxin/HC neomycin/bacitracin/poly/HC PRED-G **SUSPENSION, OINTMENT** (prednisolone/gentamicin) tobramycin/dexamethasone **SUSPENSION** (generic for Tobradex) TOBRADEX S.T. (tobramycin and dexamethasone) ZYLET (loteprednol, tobramycin)	▪ 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 who have failed a trial of ONE preferred agent
fluorometholone 0.1% (generic for FML) **OINTMENT** LOTEMAX **SOLUTION** (loteprednol 0.5%) MAXIDEX (dexamethasone) PRED MILD (prednisolone 0.12%)	dexamethasone (generic for Maxidex) DUREZOL (difluprednate) FLAREX (fluorometholone) FML (fluorometholone 0.1% **SOLUT.**) FML FORTE (fluorometholone 0.25%) FML S.O.P. (fluorometholone 0.1%) INVELTYS (loteprednol etabonate) LOTEMAX **OINTMENT, GEL** (loteprednol) loteprednol **GEL** (generic for Lotemax Gel) 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) ketorolac 0.5% (generic for Acular)	ACUVAIL (ketorolac 0.45%) BROMSITE (bromfenac) bromfenac 0.09% (generic for Bromday) flurbiprofen (generic for Ocufen) 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) XIIDRA (lifitegrast)	CEQUA (cyclosporine) QL EYSUVIS (loteprednol etabonate) QL	▪ 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
pilocarpine	PHOSPHOLINE IODIDE (echothiophate iodide)	
SYMPATHOMIMETICS		
Alphagan P (brimonidine 0.15%) brimonidine 0.2% (generic for Alphagan)	Alphagan P (brimonidine 0.1%) apraclonidine (generic for Iopidine) brimonidine P 0.15%	
BETA BLOCKERS		
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) timolol (generic for Timoptic Ocudose) TIMOPTIC OCUDOSE TIMOPTIC XE (timolol gel forming solution)	
CARBONIC ANHYDRASE INHIBITORS		
dorzolamide (generic for Trusopt)	AZOPT (brinzolamide) brinzolamide (generic for Azopt)	
PROSTAGLANDIN ANALOGS		
latanoprost (generic for Xalatan) TRAVATAN Z (travoprost)	bimatoprost (generic for Lumigan) travoprost (generic for Travatan Z) VYZULTA (latanoprostene) XALATAN (latanoprost) ZIOPTAN (tafluprost)	
COMBINATION DRUGS		
COMBIGAN (brimonidine/timolol) dorzolamide/timolol (generic for Cosopt)	dorzolamide/timolol PF (generic for Cosopt PF) SIMBRINZA (brinzolamide/brimonidine	
OTHER		
RHOPRESSA (netarsudil)[CL] ROCKLATAN (netarsudil and latanoprost)[CL]		Drug-specific criteria: ▪ **Rhopressa and Rocklatan:** Electronically approved for patients who have a trial of ONE generic agent, within ophthalmics-glaucoma within 60 days

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 ciprofloxacin/dexamethasone (generic for CIPRODEX) 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

PROGESTERONE (hydroxyprogesterone caproate)

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

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 ▪ **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
OTHERS		
zaleplon (generic for Sonata) zolpidem (generic for Ambien)	BELSOMRA (suvorexant)[AL,QL] DAYVIGO (lemborexant)[AL,QL] doxepin (generic for Silenor) EDLUAR (zolpidem sublingual) eszopiclone (generic for Lunesta) HETLIOZ (tasimelteon)[CL] HETLIOZ LQ (tasimelteon) **SUSP** [AL,QL] ramelteon (generic for Rozerem) zolpidem ER (generic for Ambien CR) zolpidem SL (generic for Intermezzo)	

SICKLE CELL ANEMIA TREATMENT[AL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
DROXIA (hydroxyurea)	*ENDARI (L-glutamine)*[CL] *OXBRYTA (voxelotor)*[CL] *SIKLOS (hydroxyurea)*	Drug-Specific Criteria ▪ **Endari:** Patient must have documented two or more hospital admissions per year due to sickle cell crisis despite maximum hydroxyurea dosage. ▪ **Oxbryta**: Not inidcated for sickle cell crisis. Patient must have had at least one sickle cell-related vaso-occlusive event within the past 12 months; AND baseline hemoglobin is 5.5 g/dL ≤ 10.5 g/dL; AND patient is not receiving concomitant, prophylactic blood tranfusion therapy ▪ **Siklos**: Approved for use in patients ages 2 to 17 years old

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 (Rx only)** hydrocortisone/aloe **OINTMENT** 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) hydrocortisone/aloe **CREAM** hydrocortisone **OTC OINTMENT** 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 glycol betamethasone valerate desoximetasone diflorasone diacetate fluocinonide **SOLUTION** fluocinonide **CREAM, GEL, OINTMENT** fluocinonide emollient halcinonide **CREAM** (generic for Halog) HALOG (halcinonide) **CREAM**, **OINT, SOLN** 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** clobetasol **SHAMPOO, LOTION** clobetasol propionate **FOAM, SPRAY** CLOBEX (clobetasol) halobetasol propionate **FOAM** (generic for Lexette) AL,QL IMPEKLO (clobetasol) LOTION AL LEXETTE(halobetasol propionate) AL,QL OLUX-E /OLUX/OLUX-E CP (clobetasol)	

STIMULANTS AND RELATED AGENTS[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 XR (amphetamine) amphetamine ER (generic for Adzenys ER) **SUSPENSION** amphetamine salt combination ER (generic for Adderall XR) amphetamine sulfate (generic for Evekeo) AZSTARYS (serdexmethylphenidate and dexmethylphenidate)[AL,QL] dextroamphetamine (generic for Dexedrine) dextroamphetamine **SOLUTION** (generic for Procentra) dextroamphetamine ER (generic for Dexedrine ER) DYANAVEL XR (amphetamine) EVEKEO ODT (amphetamine sulfate) 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 ▪ Maximum accumulated dose of 108mg per day for ages < 18 ▪ Maximum accumulated dose of 72mg per day for ages > 19 Drug-specific criteria: ▪ **Daytrana®:** May be approved in history of substance use disorder by parent, caregiver, or patient. May be approved with documentation of difficulty swallowing
CONCERTA (methylphenidate ER)[QL] 18mg, 27mg, 36mg, 54mg dexmethylphenidate (generic for Focalin IR) FOCALIN XR (dexmethylphenidate) METHYLIN **SOLUTION** (methylphenidate) methylphenidate (generic for Ritalin) methylphenidate **SOLUTION** (generic for Methylin) QUILLICHEW ER **CHEWTAB** (methylphenidate)	ADHANSIA XR (methylphenidate) [QL] APTENSIO XR (methylphenidate) COTEMPLA XR-ODT (methylphenidate)[QL] DAYTRANA **PATCH** (methylphenidate)[QL] dexmethylphenidate XR (generic for Focalin XR) FOCALIN IR (dexmethylphenidate) JORNAY PM (methylphenidate) [QL] methylphenidate 50/50 (generic for Ritalin LA) *methylphenidate* 30/70 (generic for Metadate CD) methylphenidate ER 18mg, 27mg, 36mg, 54mg (generic Concerta)[QL] methylphenidate ER **CAP** (generic for Aptensio XR)[QL] Methylphenidate ER (generic for Metadate ER) methylphenidate ER 72mg (generic for RELEXXII)[QL] methylphenidate ER (generic for Ritalin SR) QUILLIVANT XR **SUSP** (methylphenidate) RITALIN (methylphenidate)	

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)[QL] guanfacine ER (generic for Intuniv)[QL]	clonidine ER (generic for Kapvay)[QL] QELBREE (viloxazine)[QL] STRATTERA (atomoxetine)	Drug-specific criteria: ▪ **armodafinil and *Sunosi*:** 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*
ANALEPTICS		
	armodafinil (generic for Nuvigil)[CL] modafanil (generic for Provigil)[CL] SUNOSI (solriamfetol) [CL,QL] WAKIX (pitolisant)[CL,QL]	

THROMBOPOIESIS STIMULATING PROTEINS[CL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
PROMACTA (eltrombopag) ***TABLET***[CL]	*DOPTELET (avatrombopag)* *MULPLETA (lusutrombopag)* *PROMACTA (eltrombopag)* ***SUSP*** *TAVALISSE (fostamatinib)*	▪ All agents will be approved with FDA-approved indication, ICD-10 code is required. ▪ Non-preferred agents require a trial of a preferred agent with the same indication or a contraindication. Drug-Specific Criteria ▪ **Doptelet/Mulpleta**: Approved for one course of therapy for a scheduled procedure with a risk of bleeding for treatment of thrombocytopenia in adult patients with chronic liver disease