



Jim Pillen, Governor

Nebraska Medicaid Preferred Drug List with Prior Authorization Criteria

February 2026 PDL

PDL updated February 2, 2026, **Highlights** indicate 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://ne.primetherapeutics.com/drug-lookup>.

- **PDMP Check Requirements** – Nebraska Medicaid providers are required to check the prescription drug history in the statewide PDMP before prescribing CII controlled substances to certain Medicaid beneficiaries (exemption to this requirement are for beneficiaries receiving cancer treatment, hospice/palliative care, or in long-term care facilities). If not able to check the PDMP, then provider is required to document good faith effort, including reasons why unable to conduct the check and may be required to submit documentation to the State upon request.
 - PDMP check requirements are under Section 5042 of the SUPPORT for Patients and Communities Act, consistent with section 1944 of the Social Security Act [42 U.S.C. 1396w-3a].
- **Opioids** – The maximum opioid dose covered is 90 Morphine Milligram Equivalents (MME) per day.

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>

- [Immunomodulators Self-Injectable PA Form](#)
- [Opioid Dependence Treatment PA Form](#)
- [Opioid Dependence Treatment 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](#)

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ACNE AGENTS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
adapalene (generic Differin) ^{CL} GEL (OTC/Rx), GEL PUMP adapalene/BPO (generic Epiduo) ^{CL} benzoyl peroxide (BPO) WASH, LOTION benzoyl peroxide GEL OTC clindamycin/BPO (generic BenzaClin) GEL, PUMP clindamycin/BPO (generic Duac) clindamycin phosphate PLEGET clindamycin phosphate SOLUTION erythromycin GEL erythromycin SOLN erythromycin-BPO (generic for Benzamycin) tretinoin (generic Avita, Retin-A) ^{AL, CL} CREAM, GEL	adapalene (generic Differin) ^{CL} CREAM adapalene/BPO (generic Epiduo Forte) ^{CL} ALTRENO (tretinoin) ^{AL, CL} AMZEEQ (minocycline) ATRALIN (tretinoin) ^{CL} AVAR (sulfacetamide sodium/sulfur) AVITA (tretinoin) ^{CL} AZELEX (azelaic acid) BENZEFOAM (benzoyl peroxide) benzoyl peroxide CLEANSE, CLEANSING BAR OTC benzoyl peroxide FOAM (generic BenzePro) benzoyl peroxide GEL Rx benzoyl peroxide TOWELETTE OTC clindamycin FOAM, LOTION clindamycin GEL clindamycin phosphate (generic Clindagel) GEL clindamycin/BPO (generic Acanya) GEL clindamycin/BPO PUMP (generic Onexton) ^{AL} clindamycin/tretinoin (generic Veltin, Ziana) dapsose (generic Aczone) DIFFERIN (adapalene) CREAM, GEL-OTC, GEL PUMP, LOTION erythromycin PLEGET EVOCLIN (clindamycin) FOAM	<ul style="list-style-type: none"> ▪ Non-preferred agents will be approved for patients who have failed THREE preferred agents within this drug class ▪ All retinoid products have a maximum age limit of 20 without a diagnosis of acne

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

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ACNE AGENTS, TOPICAL (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	<p>FABIOR (tazarotene) FOAM NEUAC (clindamycin/BPO) OVACE PLUS (sulfacetamide sodium) RETIN-A MICRO (tretinoin) sulfacetamide sulfacetamide/sulfur sulfacetamide sodium/ sulfur CLEANER SUMADAN (sulfacetamide/sulfur) tazarotene (generic Tazorac) CREAM tazarotene FOAM (generic Fabior) tazarotene GEL (generic Tazorac) TRETIN-X (tretinoin) tretinoin (generic Atralin) ^{AL}GEL tretinoin microspheres (generic Retin-A Micro) ^{AL}GEL, GEL PUMP WINLEVI (clascoterone)^{AL}</p>	<ul style="list-style-type: none">Non-preferred agents will be approved for patients who have failed THREE preferred agents within this drug classAll retinoid products have a maximum age limit of 20 without a diagnosis of acne

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ALZHEIMER'S AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CHOLINESTERASE INHIBITORS		
donepezil (generic Aricept) donepezil ODT (generic Aricept ODT) rivastigmine PATCH (generic for Exelon Patch)	ADLARITY (donepezil) PATCH ARICEPT (donepezil) donepezil 23 (generic Aricept 23) ^{CL} EXELON (rivastigmine) PATCH galantamine (generic Razadyne) SOLN , TAB galantamine ER (generic Razadyne ER) rivastigmine CAPS (generic Exelon) ZUNVEYL DR (benzgalantamine)	<ul style="list-style-type: none"> ▪ Non-preferred agents will be approved for patients who have failed a 120-day trial of ONE preferred agent within the last 6 months; ▪ OR ▪ Current, stabilized therapy of the non-preferred agent within the previous 45 days <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> ▪ Donepezil 23: Requires donepezil 10mg/day for at least 3 months AND clinical reason as to why 5mg or 10mg tablets can't be used (to deliver 20mg or 25mg)
NMDA RECEPTOR ANTAGONIST		
memantine (generic Namenda)	memantine ER (generic Namenda XR) memantine SOLN (generic Namenda) memantine/donepezil (generic Namzaric) NAMENDA (memantine) NAMZARIC (memantine/donepezil)	

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ANALGESICS, OPIOID LONG-ACTING

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BUTRANS (buprenorphine) ^{QL} PATCH fentanyl 25, 50, 75, 100 mcg PATCH ^{QL} morphine ER TABLET (generic MS Contin, Oramorph SR) OXYCONTIN ^{CL} (oxycodone ER) tramadol ER (generic Ultram ER) ^{CL}	BELBUCA (buprenorphine) \ ^{AL,QL} BUCCAL buprenorphine PATCH (generic Butrans) ^{QL} fentanyl 37.5/62.5/87.5 mcg PATCH ^{QL} hydrocodone ER (generic Hysingla ER) ^{QL} hydrocodone bitartrate ER (generic Zohydro ER) hydromorphone ER (generic Exalgo) ^{CL} HYSINGLA ER (hydrocodone ER) methadone TABLET ^{CL} methadone ORAL SYR ^{CL} methadone SOL TABLET ^{CL} morphine ER (generic Avinza, Kadian) CAPS NUCYNTA ER (tapentadol) ^{CL} oxycodone ER (generic Oxycontin) oxymorphone ER (generic Opana ER) tramadol ER (generic ConZip) ^{CL}	<p>The Center for Disease Control (CDC) does not recommend long-acting opioids when beginning opioid treatment.</p> <ul style="list-style-type: none"> ▪ Preferred agents require previous use of a long-acting opioid or documentation of a trial on a short acting agent within 90 days ▪ Non-preferred agents will be approved with failure on, or intolerance to TWO preferred agents within this drug class <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> ▪ 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, TAB codeine TAB hydrocodone/APAP SOLN, TAB hydrocodone/ibuprofen hydromorphone TAB morphine CONC SOLN, SOLN, TAB oxycodone TAB, SOLN oxycodone/APAP tramadol 50 TAB^{AL} (generic Ultram)	butalbital/caffeine/APAP/codeine butalbital compound w/codeine (butalbital/ASA/caffeine/codeine) carisoprodol compound-codeine (carisoprodol/ASA/codeine) dihydrocodeine/APAP/caffeine hydrocodone/APAP SOLN (generic Zolvit) ^{NR} hydromorphone LIQUID, SUPPOSITORY (generic Dilaudid) levorphanol meperidine (generic Demerol) morphine SUPPOSITORIES NALOCET (oxycodone/APAP) NUCYNTA (tapentadol) ^{CL} oxycodone CAPS oxycodone/APAP SOLN oxycodone CONCENTRATE oxymorphone IR (generic Opana) pentazocine/naloxone ROXICODONE (oxycodone) ROXYBOND (oxycodone) SEGLENTIS (celecoxib/tramadol) ^{AL} tramadol 25mg tramadol 75mg tramadol 100mg (generic Ultram) ^{AL} tramadol (generic Qdolo) ^{AL, QL} SOLN tramadol/APAP (generic Ultracet)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed THREE preferred agents within this drug class within the last 12 months Note: for short acting opiate tablets and capsules there is a maximum quantity limit of #150 per 30 days. Opiate limits for opiate naïve patients will consist of: <ul style="list-style-type: none"> -prescriptions limited to a 7 day supply, AND -initial opiate prescription fill limited to maximum of 50 Morphine Milligram Equivalents (MME) per day These limits may only be exceeded with patient specific documentation of medical necessity, with examples such as, cancer diagnosis, end-of-life care, palliative care, Sickle Cell Anemia, or prescriber attestation that patient is not recently opiate naive <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Nucynta®: Approved only for diagnosis of acute pain, for 30 days or less

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ANALGESICS, OPIOID SHORT-ACTING ^{QL} (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	NASAL butorphanol SPRAY^{QL}	Drug-specific criteria: ▪ Actiq®/Fentora®/ fentanyl transmucosal/Onsolis: Approved only for diagnosis of cancer AND current use of long-acting opiate
	BUCCAL/TRANSMUCOSAL ^{CL} fentanyl TRANSMUCOSAL (generic Actiq) ^{CL} FENTORA (fentanyl) ^{CL}	

ANDROGENIC AGENTS (TOPICAL) ^{CL}

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ANDROGEL (testosterone) PUMP ^{CL} testosterone PUMP (generic Androgel) ^{CL} TESTIM (testosterone) TRANSDERMAL	NATESTO (testosterone) ^{CL} testosterone PACKET (generic Androgel) ^{CL} testosterone GEL, PACKET, PUMP (generic Vogelxo) testosterone (generic Axiron) testosterone (generic Fortesta) testosterone (generic 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: ▪ Androgel®: Approved for Males only ▪ Natesto®: Approved for Males only with diagnosis of: Primary hypogonadism (congenital or acquired) OR Hypogonadotropic hypogonadism (congenital or acquired)

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ANGIOTENSIN MODULATORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ACE INHIBITORS		
benazepril (generic Lotensin) enalapril (generic Vasotec) lisinopril (generic Prinivil, Zestril) ramipril (generic Altace)	captopril (generic Capoten) EPANED (enalapril) ^{CL} ORAL SOLN enalapril (generic for Epaned) ^{CL} ORAL SOLN fosinopril (generic Monopril) moexepril (generic Univasc) perindopril (generic Aceon) QBRELIS (lisinopril) ^{CL} ORAL SOLN quinapril (generic Accupril) trandolapril (generic Mavik)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed TWO preferred agents within the last 12 months Non-preferred combination products may be covered as individual prescriptions without prior authorization <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Epaned/enalapril oral solution/Qbrelis oral solution: Clinical reason why oral tablet is not appropriate
ACE INHIBITOR/DIURETIC COMBINATIONS		
enalapril/HCTZ (generic Vaseretic) lisinopril/HCTZ (generic Prinzide, Zestoretic)	benazepril/HCTZ (generic Lotensin HCT) captopril/HCTZ (generic Capozide) fosinopril/HCTZ (generic Monopril HCT) moexipril/HCTZ (generic Uniretic) quinapril/HCTZ (generic Accuretic)	
ANGIOTENSIN RECEPTOR BLOCKERS		
irbesartan (generic Avapro) losartan (generic Cozaar) olmesartan (generic Benicar) valsartan (generic Diovan)	candesartan (generic Atacand) EDARBI (azilsartan) eprosartan (generic Teveten) telmisartan (generic Micardis)	

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ANGIOTENSIN MODULATORS (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ANGIOTENSIN RECEPTOR BLOCKER/DIURETIC COMBINATIONS		
irbesartan/HCTZ (generic Avalide) losartan/HCTZ (generic Hyzaar) olmesartan/HCTZ (generic Benicar-HCT) valsartan/HCTZ (generic Diovan-HCT)	candesartan/HCTZ (generic Atacand-HCT) EDARBYCLOR (azilsartan/chlorthalidone) telmisartan/HCTZ (generic Micardis-HCT)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed TWO preferred agents within the last 12 months Non-preferred combination products may be covered as individual prescriptions without prior authorization
ANGIOTENSIN MODULATOR/CALCIUM CHANNEL BLOCKER COMBINATIONS		
amlodipine/benazepril (generic Lotrel) amlodipine/olmesartan (generic Azor) amlodipine/valsartan (generic Exforge)	amlodipine/olmesartan/HCTZ (generic Tribenzor) amlodipine/telmisartan (generic Twynsta) amlodipine/valsartan/HCTZ (generic Exforge HCT) PRESTALIA (perindopril/amlodipine) trandolapril/verapamil (generic Tarka)	
DIRECT RENIN INHIBITORS		
	aliskiren (generic Tekturna) ^{QL}	
DIRECT RENIN INHIBITOR COMBINATIONS		
	TEKTURNIA/HCTZ (aliskiren/HCTZ)	
NEPRILYSIN INHIBITOR COMBINATION		
ENTRESTO (sacubitril/valsartan) ^{CL,QL}	ENTRESTO (sacubitril/valsartan) ^{CL,QL} SPRINKLE CAP sacubitril/valsartan (generic Entresto) ^{CL,NR,QL}	<p>Direct Renin Inhibitors/Direct Renin Inhibitor Combinations: May be approved with a history of TWO preferred ACE Inhibitors or Angiotensin Receptor Blockers within the last 12 months</p> <p>Drug Specific Criteria</p> <ul style="list-style-type: none"> Entresto/ sacubitril-valsartan: May be approved in patients ages ≥ 1 years old and with a diagnosis of heart failure

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ANTHELMINTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
albendazole (generic Albenza) BILTRICIDE (praziquantel) ivermectin (generic Stromectol)	EMVERM (mebendazole) ^{CL} praziquantel (generic Biltricide) STROMECTOL (ivermectin)	<ul style="list-style-type: none">Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class within the last 6 months <p>Drug-specific criteria:</p> <ul style="list-style-type: none">Emverm: Approval will be considered for indications not covered by preferred agents

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ANTI-ALLERGENS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	<p>GRASTEK (timothy grass pollen allergen)^{AL,CL,QL}</p> <p>ODACTRA (Dermatophagoides farinae and Dermatophagoides pteronyssinus)^{AL,CL,QL}</p> <p>ORALAIR (sweet vernal/orchard/rye/timothy/kentucky blue grass mixed pollen allergen extract)^{CL}</p> <p>PALFORZIA (peanut allergen powder-dnfp)^{AL,CL}</p> <p>RAGWITEK (weed pollen-short ragweed)^{AL,CL,QL}</p>	<p>All agents require initial dose to be given in a healthcare setting</p> <p>Drug-specific criteria:</p> <p>GRASTEK</p> <ul style="list-style-type: none"> Confirmed by positive skin test or in vitro testing for pollen specific IgE antibodies for Timothy grass or cross-reactive grass pollens. For use in persons 5 through 65 years of age. <p>ODACTRA</p> <ul style="list-style-type: none"> Confirmed by positive skin test to licensed house dust mite allergen extracts or in vitro testing for IgE antibodies to Dermatophagoides farinae and Dermatophagoides pteronyssinus house dust mite For use in persons 5 through 65 years of age <p>ORALAIR</p> <ul style="list-style-type: none"> Confirmed by positive skin test or in vitro testing for pollen specific IgE antibodies for Sweet Vernal, Orchard, Perennial Rye, Timothy, and Kentucky Blue Grass Mixed Pollens. For use in patients 5 through 65 years of age. <p>PALFORZIA</p> <ul style="list-style-type: none"> 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 <p>RAGWITEK</p> <ul style="list-style-type: none"> Confirmed by positive skin test or in vitro testing for pollen specific IgE antibodies for short ragweed pollen. For use in patients 5 through 65 years of age.

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ANTIBIOTICS, GASTROINTESTINAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
metronidazole TABLET neomycin tinidazole (generic Tindamax) ^{CL} vancomycin (generic Firvanq) ^{QL} SOLN	AEMCOLO (rifamycin) TAB DIFICID (fidaxomicin) ^{CL} TAB, SUSP fidaxomicin (generic Dificid) ^{CL,NR} TAB FIRVANQ (vancomycin) ^{QL} SOLN LIKMEZ (metronidazole) SUSP metronidazole ^{CL} CAPS metronidazole 125mg TAB nitazoxanide (generic Alinia) TAB^{AL, CL, QL} paromomycin SOLOSEC (secnidazole) vancomycin CAPS (generic Vancocin) ^{CL} VOWST (fecal microbiota spores) ^{AL,QL}	<ul style="list-style-type: none"> Note: Although azithromycin, ciprofloxacin, and trimethoprim/ sulfmethoxazole are not included in this review, they are available without prior authorization <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Alinia /nitazoxanide tablet: Trial and failure with metronidazole is required for a diagnosis of giardiasis Dificid®/ fidaxomicin: For diagnosis of C. difficile diarrhea (pseudomembranous colitis), trial and failure or intolerance to oral vancomycin is required. For diagnosis of relapsed or recurrent C. difficile, an appropriate ICD-10 diagnosis code must be submitted for coverage. Flagyl®/Metronidazole 375mg capsules and / Metronidazole 750mg ER tabs: Clinical reason why the generic regular release cannot be used tinidazole: 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

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ANTIBIOTICS, INHALED CL

Preferred Agents CL	Non-Preferred Agents	Prior Authorization/Class Criteria
BETHKIS (tobramycin) KITABIS PAK (tobramycin) tobramycin (generic Tobi) TOBI-PODHALER (tobramycin) ^{CL,QL}	ARIKAYCE (amikacin liposomal inh) ^{CL} SUSP CAYSTON (aztreonam lysine) ^{CL,QL} tobramycin (generic Bethkis)	<ul style="list-style-type: none"> ▪ Diagnosis of Cystic Fibrosis is required for all agents ICD10 Group = E84, ICD9 = 277.00, 277.01, 277.02, 277.03, 277.09 <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> ▪ Arikayce: Requires diagnosis of refractory MAC lung disease defined as patients who did not achieve negative sputum cultures after a minimum of 6 consecutive months of a multidrug background regimen therapy ▪ Cayston®: Trial of tobramycin via nebulizer and demonstration of TOBI® compliance required ▪ Tobi Podhaler®: Requires trial of tobramycin via nebulizer or documentation of why nebulized tobramycin cannot be used

ANTIBIOTICS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
bacitracin OINT bacitracin OINT OTC bacitracin/polymyxin (generic Polysporin) mupirocin OINT (generic Bactroban) neomycin/polymyxin/bacitracin (generic Neosporin, Triple AB) neomycin/polymyxin/pramoxine neomycin/polymyxin/bacitracin/pramoxine	bacitracin PCKT-OTC CENTANY (mupirocin) gentamicin OINT, CREAM mupirocin CREAM (generic Bactroban) ^{CL}	<ul style="list-style-type: none"> ▪ Non-preferred agents will be approved for patients who have failed ALL preferred agents within this drug class within the last 12 months <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> ▪ Mupirocin® Cream: Clinical reason the ointment cannot be used

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ANTIBIOTICS, VAGINAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CLEOCIN CREAM (clindamycin) CLEOCIN OVULES (clindamycin) metronidazole, vaginal NUVESSA (metronidazole)	clindamycin CREAM (generic Cleocin) ▪ CLINDESSE (clindamycin) metronidazole (generic Nuvessa) ^{NR} VANDAZOLE (metronidazole) XACIATO (clindamycin phosphate) ^{AL} GEL	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
dabigatran etexilate (generic Pradaxa) CAPS ELIQUIS (apixaban) TAB enoxaparin (generic Lovenox) INJ warfarin (generic Coumadin) TAB XARELTO (rivaroxaban) 10 mg, 15 mg, 20 mg TAB XARELTO (rivaroxaban) 2.5 mg ^{CL,QL} TAB XARELTO DOSE PACK (rivaroxaban)	fondaparinux (generic Arixtra) INJ FRAGMIN (dalteparin) INJ PRADAXA (dabigatran) CAPS , PELLETS rivaroxaban (generic Xarelto) ^{NR} TAB rivaroxaban (generic Xarelto) ^{AL,CL,NR} SUSP SAVAYSA (edoxaban) ^{CL,QL} TAB XARELTO (rivaroxaban) ^{CL} SUSP	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed ONE preferred agent within this drug class within the last 12 months <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Coumadin®: Clinical reason generic warfarin cannot be used Savaysa®: Approved diagnoses include: Stroke and systemic embolism (SE) risk reduction in nonvalvular atrial fibrillation (NVAF) OR Treatment of deep vein thrombosis (DVT) and pulmonary embolism (PE) following 5-10 days of parenteral anticoagulant therapy 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 Xarelto/ rivaroxaban Suspension: Approved for patients \leq12 years of age or if there is a clinical reason why a preferred solid dosage form cannot be used.

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ANTIEMETICS/ANTIVERTIGO AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CANNABINOIDs		
dronabinol (generic Marinol) ^{AL}		<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed ONE preferred agent within this drug class within the same subclass
5HT3 RECEPTOR BLOCKERS		
ondansetron (generic Zofran/Zofran ODT) ^{QL}	ANZEMET (dolasetron) granisetron (generic Kytril) ondansetron 16mg ODT (generic Zofran ODT) SANCUSO (granisetron) ^{CL}	<ul style="list-style-type: none"> Drug-specific criteria: <ul style="list-style-type: none"> Akynzeo®: Approved for Moderately/Highly emetogenic chemotherapy with dexamethasone and a 5-HT3 antagonist Regimens include: AC combination (Doxorubicin or Epirubicin with Cyclophosphamide), Aldesleukin, Amifostine, Arsenic trioxide, Azacitidine, Bendamustine, Busulfan, Carmustine, Carboplatin, Cisplatin, Clofarabine, Cyclophosphamide, Cytarabine, Dacarbazine, Dactinomycin, Daunorubicin, Epirubicin, Etoposide, Hexamethylmelamine, Idarubicin, Ifosfamide, Imatinib, Interferon α, Irinotecan, Mechlorethamine, Melphalan, Methotrexate, Oxaliplatin, Procarbazine, Streptozotocin, Temozolomide
NK-1 RECEPTOR ANTAGONIST		
aprepitant (generic Emend) CAPS ^{QL}	AKYNZEO (netupitant/palonosetron) ^{CL} aprepitant (generic Emend) PACK EMEND (aprepitant) CAPS, PACK, POWDER ^{QL}	<ul style="list-style-type: none"> Drug-specific criteria: <ul style="list-style-type: none"> Akynzeo®: Approved for Moderately/Highly emetogenic chemotherapy with dexamethasone and a 5-HT3 antagonist Regimens include: AC combination (Doxorubicin or Epirubicin with Cyclophosphamide), Aldesleukin, Amifostine, Arsenic trioxide, Azacitidine, Bendamustine, Busulfan, Carmustine, Carboplatin, Cisplatin, Clofarabine, Cyclophosphamide, Cytarabine, Dacarbazine, Dactinomycin, Daunorubicin, Epirubicin, Etoposide, Hexamethylmelamine, Idarubicin, Ifosfamide, Imatinib, Interferon α, Irinotecan, Mechlorethamine, Melphalan, Methotrexate, Oxaliplatin, Procarbazine, Streptozotocin, Temozolomide
TRADITIONAL ANTIEMETICS		
DICLEGIS (doxylamine/pyridoxine) ^{CL,QL} dimenhydrinate (generic Dramamine) OTC meclizine (generic Antivert) metoclopramide (generic Reglan) phosphoric acid/dextrose/fructose (generic Emetrol) SOLN prochlorperazine(generic Compazine) promethazine (generic Phenergan) SYRUP, TAB promethazine 12.5mg, 25mg SUPPOSITORY scopolamine TRANSDERMAL TRANSDERM-SCOP (scopolamine)	BONJESTA (doxylamine/pyridoxine) ^{CL,QL} COMPROM (prochlorperazine) doxylamine/pyridoxine (generic Diclegis) ^{CL,QL} prochlorperazine SUPPOSITORY (generic Compazine) promethazine SUPPOSITORY 50mg trimethobenzamide TAB (generic Tigan)	<ul style="list-style-type: none"> Diclegis/doxylamine-pyridoxine)/ Bonjesta: Approved only for treatment of nausea and vomiting of pregnancy Sancuso®: Documentation of oral dosage form intolerance

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ANTIFUNGALS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
clotrimazole (mucous membrane, troche) fluconazole SUSP, TAB (generic Diflucan) griseofulvin SUSP griseofulvin microsized TAB nystatin SUSP terbinafine (generic Lamisil)	BREXAFEMME (ibrexafungerp) ^{QL} CRESEMBA (isavuconazonium) ^{CL} flucytosine (generic Ancobon) ^{CL} griseofulvin ultramicrosize (generic GRIS-PEG) itraconazole (generic Sporanox) ^{CL} ketoconazole (generic Nizoral) ORAVIG (miconazole) ^{QL} BUCCAL NOXAFL (posaconazole) ^{AL,CL} SUSP, TAB NOXAFL (posaconazole) ^{AL,CL} POWDERMIX nystatin TAB posaconazole (generic Noxafl) ^{AL,CL} TOLSURA (itraconazole) ^{CL} VIVJOA (oteseconazole) CAPS voriconazole (generic VFEND) ^{CL}	<ul style="list-style-type: none"> ▪ Non-preferred agents will be approved for patients who have failed a trial of TWO diagnosis-appropriate preferred agents within this drug class <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> ▪ Cresemba[®]: Approved for diagnosis of invasive aspergillosis or invasive mucormycosis ▪ Flucytosine: Approved for diagnosis of: <u>Candida</u>: Septicemia, endocarditis, UTIs <u>Cryptococcus</u>: Meningitis, pulmonary infections ▪ Noxafl/ posaconazole DR tablets, oral suspension, PowderMix[®] for delayed oral suspension: For prophylaxis of invasive Aspergillus and Candida infections, no preferred agent trial is required in severely immunocompromised patients (i.e., Neutropenia Myelodysplastic Syndrome (MDS), Neutropenic Acute Myeloid Leukemia (AML), Neutropenic hematologic malignancies, Graft vs. Host disease(GVHD), Immunosuppression secondary to hematopoietic stem cell transplant ▪ Noxafl[®] Powdermix: pediatric patients 2 years of age and older who weigh 40 kg or less ▪ Noxafl/ posaconazole Suspension: Oropharyngeal/esophageal candidiasis refractory to itraconazole and/or fluconazole and; Prophylaxis of invasive Aspergillus and Candida infections ▪ Sporanox[®]/Itraconazole: Approved for diagnosis of Aspergillosis, Blastomycosis, Histoplasmosis, Onychomycosis due to terbinafine-resistant dermatophytes, Oropharyngeal/ esophageal candidiasis refractory to fluconazole ▪ 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/voriconazole: No trial for diagnosis of Myelodysplastic Syndrome (MDS), Neutropenic Acute Myeloid Leukemia (AML), Graft vs. Host disease (GVHD), Candidemia (candida krusei), Esophageal Candidiasis, Blastomycosis, <i>S. apiospermum</i> and <i>Fusarium</i> spp., Oropharyngeal/esophageal candidiasis refractory to fluconazole

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ANTIFUNGALS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ANTIFUNGAL		
clotrimazole CREAM (generic Lotrimin) RX, OTC clotrimazole (generic Lotrimin) SOLN -Rx ketoconazole CREAM, SHAMPOO (generic Nizoral) miconazole CREAM, POWDER OTC nystatin terbinafine OTC (generic Lamisil AT) tolnaftate AERO-POWDER OTC, CREAM-OTC, SOLN-OTC (generic Tinactin)	ALEVAZOL (clotrimazole) OTC ciclopirox CREAM, GEL, SUSP (generic Ciclodan, Loprox) ciclopirox SHAMPOO (generic Loprox) clotrimazole SOLN OTC DESENEX POWDER OTC (miconazole) econazole (generic Spectazole) ERTACZO (sertaconazole) FUNGOID (miconazole) OTC ketoconazole FOAM^{CL} (generic Extina, Ketodan) LASOLEX AG 2% (miconazole nitrate 2%) GEL^{NR, AL} LOPROX (ciclopirox) SUSP, SHAMPOO, CREAM LOTRIMIN AF CREAM OTC (clotrimazole) LOTRIMIN ULTRA (butenafine) miconazole OTC OINT, SPRAY, SOLN miconazole/zinc oxide/petrolatum (generic Vusion) naftifine CREAM, GEL (generic Naftin) oxiconazole (generic Oxistat) tavaborole SOLN^{CL} (generic Kerydin) tolnaftate POWDER OTC TRIPENICOL (undecylenic acid) CREAM-OTC VOTRIZA-AL (clotrimazole) LOTION OTC	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within the last 6 months <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Extina/ Ketodan/ ketoconazole foam: Requires trial and failure or contraindication to other ketoconazole forms tavaborole: Approved diagnoses include Onychomycosis of the toenails due to <i>T. rubrum</i> OR <i>T. Mentagrophytes</i> ciclopirox nail lacquer: No trial required in diabetes, peripheral vascular disease (PWD), immunocompromised OR contraindication to oral terbinafine
ANTIFUNGAL/STEROID COMBINATIONS		
clotrimazole/betamethasone CREAM (generic Lotrisone) nystatin/triamcinolone (generic Mycolog) CREAM, OINT	clotrimazole/betamethasone LOTION (generic Lotrisone)	

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ANTIHISTAMINES, MINIMALLY SEDATING

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
cetirizine TAB (generic Zyrtec) cetirizine SOLN (OTC) (generic Zyrtec) levocetirizine TAB (generic Xyzal) loratadine TAB, SOLN (generic Claritin)	cetirizine CHEWABLE (generic Zyrtec) cetirizine SOLN (Rx) (generic Zyrtec) desloratadine (generic Clarinex) desloratadine ODT (generic Clarinex Reditabs) desloratadine ^{NR} SOLN fexofenadine (generic Allegra) fexofenadine 180mg (generic Allegra 180mg) ^{QL} levocetirizine (generic Xyzal) SOLN loratadine CAPS, CHEWABLE, ODT (generic Claritin Reditabs)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed TWO preferred agents within this drug class Combination products not covered – individual products may be covered

ANTIHYPERTENSIVES, SYMPATHOLYTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
clonidine TAB (generic Catapres) clonidine TRANSDERMAL guanfacine (generic Tenex) methyldopa	clonidine ER (generic NEXICLON) ^{CL} JAVADIN (clonidine) ^{NR} SOLN methyldopa/hydrochlorothiazide NEXICLON XR (clonidine ER) ^{CL} TAB	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a 30-day trial with ONE preferred agent within this drug class <p>Drug Specific Criteria</p> <ul style="list-style-type: none"> NEXICLON/ clonidine ER: Clinical reason why the preferred clonidine tablet or transdermal cannot be used

ANTIHYPERURICEMICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
allopurinol (generic Zyloprim) colchicine TAB (generic Colcrys) probenecid	allopurinol 200mg colchicine CAPS (generic Mitigare) febuxostat (generic Uloric) ^{CL} GLOPERBA SOLN (colchicine) ^{CL,QL} MITIGARE (colchicine) probenecid/colchicine (generic Col-Probenecid)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class Gloperba: Approved for documented swallowing disorder Uloric/febuxostat: Clinical reason why allopurinol cannot be used

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ANTIMIGRAINE AGENTS, OTHER

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
AIMOVIG (erenumab-aooe) ^{CL,QL} AJOVY (fremanezumab-vfrm) ^{CL, QL} PEN, Autoinjector	BREKIYA (dihydroergotamine mesylate) ^{NR} diclofenac (generic Cambia) POWDER dihydroergotamine mesylate NASAL ELYXYB (celecoxib) ^{AL,QL} SOLN	<ul style="list-style-type: none"> All non-preferred agents will require a failed trial or contraindication of a preferred agent of the same indication
AJOVY (fremanezumab-vfrm) Autoinjector 3-pack^{CL,QL}	EMGALITY 100 mg (galcanezumab-gnlm) ^{CL,QL} SYR	<ul style="list-style-type: none"> For Acute Treatment: agents will be approved for patients who have a failed trial or a contraindication to two triptans.
EMGALITY 120 mg/mL (galcanezumab-gnlm) ^{CL, QL} PEN, SYRINGE	MIGERGOT (ergotamine/caffeine) RECTAL	<ul style="list-style-type: none"> For Prophylactic Treatment: Require ≥ 4 migraines per month for ≥ 3 months and has tried and failed a ≥ 1 month trial of two medications: antidepressants (amitriptyline, venlafaxine), Beta blockers (propranolol, metoprolol, atenolol), anti-epileptics (divalproex, valproate, topiramate)
NURTEC ODT (rimegepant) ^{AL,CL,QL} QULIPTA (atogepant) ^{AL,CL,QL} UBRELVY (ubrogepant) ^{AL,CL, QL} TAB	MIGRANAL (dihydroergotamine) NASAL REYVOW (lasmiditan) ^{AL, CL,QL} TAB ZAVZPRET (zavegepant) ^{AL,QL} NASAL	<p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Emgality 100mg will only be approved for treatment of Episodic Cluster Headache Nurtec ODT: for use in acute treatment, will be approved for patients who have a failed trial or a contraindication to two triptans. For use in preventative treatment, will be approved for patients who have a failed trial of ONE preferred injectable CGRP. Qulipta: May be approved for patients who have a failed trial of ONE preferred injectable CGRP CGRP Antagonists: Use will be limited to one CGRP for acute use and one CGRP for prophylactic use.

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ANTIMIGRAINE AGENTS, TRIPTANS^{QL}

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ORAL		
rizatriptan (generic Maxalt) rizatriptan ODT (generic Maxalt MLT) sumatriptan	almotriptan (generic Axert) eletriptan (generic Relpax) frovatriptan (generic Frova) IMITREX (sumatriptan) naratriptan (generic Amerge) RELPAX (eletriptan) ^{QL} sumatriptan/naproxen (generic Treximet) SYMBRAVO (rizatriptan benzoate/meloxicam) ^{AL,NR} TAB zolmitriptan (generic Zomig)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed ALL preferred agents within this drug class <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Zembrace: approved for patients who have failed ALL preferred agents
NASAL		
IMITREX (sumatriptan) sumatriptan (generic Imitrex Nasal)	TOSYMRA (sumatriptan) zolmitriptan (generic Zomig) ZOMIG (zolmitriptan)	
INJECTABLE		
sumatriptan SYRINGE, VIAL	sumatriptan KIT ZEMBRACE SYMTOUCH (sumatriptan) ^{CL}	

ANTIPARASITICS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
NATROBA (spinosad) permethrin 1% OTC (generic Nix) permethrin 5% RX (generic Elimite) pyrethrin/piperonyl butoxide (generic RID, A-200)	CROTAN (crotamiton) LOTION EURAX (crotamiton) CREAM, LOTION ivermectin (generic Sklice) LOTION malathion (generic Ovide) PRURADIK (cromtamiton) ^{NR} LOTION spinosad (generic Natroba) VANALICE (piperonyl butoxide/pyrethrins)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class within the past 6 months

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ANTIPARKINSON'S AGENTS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ANTICHOLINERGICS		
benztropine (generic Cogentin) trihexyphenidyl (generic Artane)		<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed ONE preferred agent within the same subclass
COMT INHIBITORS		
entacapone (generic Comtan)	ONGENTYS (opicapone) tolcapone (generic Tasmar)	<p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Carbidopa/Levodopa ODT: Approved for documented swallowing disorder COMT Inhibitors: Approved if using as add-on therapy with levodopa-containing drug
DOPAMINE AGONISTS		
pramipexole (generic Mirapex) ropinirole (generic Requip)	bromocriptine (generic Parlodel) NEUPRO (rotigotine) ^{CL} pramipexole ER (generic Mirapex ER) ^{CL} ropinirole ER (generic Requip XL) ^{CL}	<ul style="list-style-type: none"> Gocovri: Required diagnosis of Parkinson's disease and had trial of or is intolerant to amantadine AND must be used as an add-on therapy with levodopa-containing drug Inbrija: Approval upon diagnosis of Parkinson's disease and concurrent treatment with carbidopa/levodopa agent Neupro®: 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		
selegiline CAPS, TABLET (generic Eldepryl)	rasagiline (generic Azilect) ^{QL} XADAGO (safinamide)	<ul style="list-style-type: none"> Nourianz: Approval upon diagnosis of Parkinson's disease and concurrent treatment with carbidopa/levodopa agent
OTHER ANTIPARKINSON'S DRUGS		
amantadine CAPS, SYRUP TABLET (generic Symmetrel) carbidopa/levodopa (generic Sinemet) carbidopa/levodopa ER (generic Sinemet CR)	carbidopa (generic Lodosyn) carbidopa/levodopa ODT (generic Parcopa) ^{CL} carbidopa/levodopa ER (generic Rytary) ^{NR} CREXONT (carbidopa and levodopa ER.) ^{QL} CAPS DHIVY (carbidopa/levodopa) ^{QL} DUOPA (carbidopa/levodopa) GOCOVRI (amantadine) ^{CL,QL} INBRIJA (levodopa) ^{CL,QL} INHALER levodopa/carbidopa/entacapone (generic Stalevo) NOURIANZ (istradefylline) ^{CL,QL} OSMOLEX ER (amantadine) ^{CL,QL} RYTARY (carbidopa/levodopa)	<ul style="list-style-type: none"> 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

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ANTIPSORIATICS, ORAL

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

ANTIPSORIATICS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
calcipotriene CREAM, OINT, SOLN	calcitriol (generic Vectical) ^{AL} OINT calcipotriene FOAM (generic Sorilux) calcipotriene/betamethasone OINT (generic Taclonex) calcipotriene/betamethasone SUSP (generic Taclonex Scalp) ENSTILAR (calcipotriene/betamethasone) SORILUX (calcipotriene) ZORYVE 0.3% (roflumilast)^{AL} CREAM ZORYVE 0.3% (roflumilast)^{AL,CL} FOAM	<ul style="list-style-type: none"> ▪ Non-preferred agents will be approved for patients who have failed a trial with a preferred agent within this drug class <p>Drug-Specific Criteria</p> <ul style="list-style-type: none"> • Zoryve Foam- For diagnosis of Seborrheic Dermatitis, requires trial of a topical steroid or a topical calcineurin inhibitor AND trial of a topical antifungal.

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ANTIVIRALS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ANTI-COVID-19 DRUGS		
PAXLOVID (nirmatrelvir/ritonavir) ^{CL,QL}		<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a 10-day trial of ONE preferred agent within the same subclass
ANTI-HERPETIC DRUGS		
acyclovir (generic Zovirax) famciclovir (generic Famvir) valacyclovir (generic Valtrex)	acyclovir (generic Zovirax) ^{CL} SUSP	<ul style="list-style-type: none"> Drug-specific criteria: Acyclovir Susp: Prior authorization NOT required for children \leq 12 years old
ANTI-INFLUENZA DRUGS		
oseltamivir (generic Tamiflu) ^{QL} CAPS, SUSP	rimantadine (generic Flumadine) RELENZA (zanamivir) ^{QL} TAMIFLU (oseltamivir) ^{QL} CAPS, SUSP XOFLUZA (baloxavir marboxil) ^{AL,CL,QL}	<ul style="list-style-type: none"> Paxlovid: Requires a diagnosis of COVID-19 and is limited to 1 dose pack per 30 days Xofluza: Requires clinical, patient specific reason that a preferred agent cannot be used

ANTIVIRALS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
acyclovir OINT docosanol OTC	acyclovir CREAM, (generic Zovirax) DENAVIR (penciclovir) ^{AL} penciclovir (generic Denavir) ^{AL}	<ul style="list-style-type: none"> 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 (generic Xanax) TAB buspirone (generic Buspar) chlordiazepoxide diazepam (generic Valium) TAB, SOLN lorazepam (generic Ativan) INTENSOL, TAB	alprazolam ER (generic Xanax XR) alprazolam INTENSOL ^{CL} alprazolam ODT BUCAPSOL (buspirone hcl) ^{CL} CAP clorazepate (generic Tranxene-T) diazepam INTENSOL ^{CL} LOREEV XR (lorazepam) ^{AL} meprobamate oxazepam	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial with TWO preferred agents within this drug class <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Alprazolam Intensol®: Requires trial of diazepam solution OR lorazepam Intensol® Bucapsol: Requires clinical reason why preferred buspirone can't be used. Diazepam Intensol®: Requires clinical reason why diazepam solution cannot be used

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BETA BLOCKERS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BETA BLOCKERS		
atenolol (generic Tenormin) atenolol/chlorthalidone (generic Tenoretic) bisoprolol (generic Zebeta) bisoprolol/HCTZ (generic Ziac) HEMANGEOL (propranolol) ^{AL,CL} SOLN metoprolol (generic Lopressor) metoprolol ER (generic Toprol XL) nebivolol (generic Bystolic) propranolol (generic Inderal) propranolol ER (generic Inderal LA)	acebutolol (generic Sectral) betaxolol (generic Kerlone) BYSTOLIC (nebivolol) INDERAL/INNOPRAN XL (propranolol ER) KAPSPARGO SPRINKLE (metoprolol ER) LOPRESSOR (metoprolol tartrate) ^{NR} SOLN metoprolol/HCTZ (generic Lopressor HCT) nadolol (generic Corgard) pindolol (generic Viskin) propranolol/HCTZ (generic Inderide) timolol (generic Blocadren) TOPROL XL (metoprolol ER)	<p>Non-preferred agents will be approved for patients who have failed TWO diagnosis-appropriate preferred agents .</p> <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Coreg CR/carvedilol ER: Requires clinical reason generic IR product cannot be used Hemangeol®: Covered for diagnosis of Proliferating Infantile Hemangioma Sotylyze®: Covered for diagnosis of life –threatening ventricular arrhythmias OR maintenance of normal sinus rhythm in highly symptomatic atrial fibrillation/flutter (AFIB/AFL) <p>Requires clinical reason generic sotalol cannot be used</p>
BETA- AND ALPHA-BLOCKERS		
carvedilol (generic Coreg) labetalol (generic Trandate)	carvedilol ER ^{CL} (generic Coreg CR)	
ANTIARRHYTHMIC		
sotalol (generic Betapace)	SOTYLIZE (sotalol) ^{CL}	

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BILE SALTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ursodiol CAPSULE 300 mg (generic Actigall)	BYLVAY (odevixibat) CAP, PELLET	
ursodiol 250 mg TABLET (generic URSO)	CHENODAL (chenodiol)	
ursodiol 500 mg TABLET (generic URSO FORTE)	CHOLBAM (cholic acid)	
	CTEXLI (chenodiol) TAB	
	IQIRVO (elafibranor) ^{QL} TAB	
	LIVDELZI (seladelpar) CAP	
	LIVMARLI (maralixibat) SOLN^{AL}TABLET	
	OCALIVA (obeticholic acid)	
	RELTONE (ursodiol 200mg,400mg) CAP	

BLADDER RELAXANT PREPARATIONS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
fesoterodine (generic Toviaz) MYRBETRIQ (mirabegron) ^{AL} TAB oxybutynin IR, ER (generic Ditropan/Ditropan XL)	darifenacin ER (generic Enablex) flavoxate HCL GEMTESA (vibegron) ^{AL,QL} mirabegron ER TAB (generic Myrbetriq) MYRBETRIQ (mirabegron) SUSP^{AL,CL,QL} oxybutynin 2.5mg OXYTROL (oxybutynin) solifenacina (generic Vesicare) tolterodine IR, ER (generic Detrol/ Detrol LA) TOVIAZ (fesoterodine ER) trospium IR, ER (generic Sanctura/ Sanctura XR) VESICARE (solifenacina) VESICARE LS SUSP (solifenacina) ^{AL}	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Myrbetriq suspension: Covered for pediatric patients \geq 3 years old with a diagnosis of Neurogenic Detrusor Overactivity (NDO)

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BONE RESORPTION SUPPRESSION AND RELATED DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BISPHOSPHONATES		
alendronate (generic Fosamax) TAB ibandronate (generic Boniva) ^{QL}	alendronate SOLN (generic Fosamax) ^{QL} ATELVIA DR (risedronate) ^{CL} BINOSTO (alendronate) ^{CL} FOSAMAX PLUS D (alendronate sodium/ cholecalciferol) ^{QL} risedronate (generic Actonel) ^{QL}	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within the same subclass <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> 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 Forsteo/ teriparatide: Covered for high risk of fracture <p>High risk of fracture:</p> <ul style="list-style-type: none"> BMD -3 or worse Postmenopausal women with history of non-traumatic fractures Postmenopausal women with 2 or more clinical risk factors <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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 calcitonin-salmon not required Maximum of 24 months treatment per lifetime
OTHER BONE RESORPTION SUPPRESSION AND RELATED DRUGS		
calcitonin-salmon NASAL FORTEO (teriparatide) ^{CL,QL} raloxifene (generic Evista)	BONSITY (teriparatide) ^{QL,NR} EVISTA (raloxifene) teriparatide (generic Forteo) ^{CL,QL} TYMLOS (abaloparatide)	

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BPH (BENIGN PROSTATIC HYPERPLASIA) TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ALPHA BLOCKERS		
alfuzosin (generic Uroxatral) ^{CL} doxazosin (generic Cardura) tamsulosin (generic Flomax) ^{CL} terazosin (generic Hytrin)	CARDURA XL (doxazosin) ^{CL} silodosin (generic Rapaflo) TEZRULY (terazosin) ^{CL,NR} SOLN	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within the same subclass.
5-ALPHA-REDUCTASE (5AR) INHIBITORS		
dutasteride (generic Avodart) ^{CL} finasteride (generic Proscar) ^{CL}	dutasteride/tamsulosin (generic Jalyn) ^{CL} ENTADFI (finasteride/tadalafil) finasteride/tadalafil (generic Entadfi) ^{NR}	<p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Alfuzosin/dutasteride/finasteride <ul style="list-style-type: none"> Covered for males only Cardura XL®: Requires clinical reason generic IR form cannot be used Flomax/ tamsulosin: Covered for males and may be covered for females for a 7-day supply with diagnosis of acute kidney stones Jalyn/ dutasteride-tamsulosin: Requires clinical reason why individual agents cannot be used Tezruly: Clinical reason why oral tablet is not appropriate

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BRONCHODILATORS, BETA AGONIST

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
INHALERS – Short Acting		
albuterol HFA (generic Proventil HFA) VENTOLIN HFA (albuterol) XOPENEX HFA (levalbuterol HFA)	albuterol HFA (generic ProAir HFA and Ventolin HFA) levalbuterol HFA (generic Xopenex HFA) PROAIR DIGIHALER (albuterol) PROAIR RESPICLICK (albuterol)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within the same subclass.
INHALERS – Long Acting		
SEREVENT (salmeterol)	STRIVERDI RESPIMAT (olodaterol)	<p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Xopenex/levalbuterol solution: Covered for cardiac diagnoses or side effect of tachycardia with albuterol product
INHALATION SOLUTION		
albuterol (2.5mg/3ml premix or 2.5mg/0.5ml) albuterol low dose (0.63mg/3ml & 1.25mg/3ml)	arformoterol tartrate (generic Brovana) BROVANA (arformoterol) formoterol fumarate (generic Perforomist) levalbuterol (generic Xopenex) ^{CL} PERFOROMIST (formoterol)	
ORAL		
albuterol SYRUP	albuterol TAB albuterol ER (generic Vospire ER) terbutaline (generic Brethine)	

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CALCIUM CHANNEL BLOCKERS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	SHORT-ACTING	
	Dihydropyridines	
	isradipine (generic Dynacirc) nicardipine (generic Cardene) nifedipine (generic Procardia) ^{CL} nimodipine (generic Nimotop) ^{CL} nimodipine (generic Nymalize) ^{CL} SOLN NYMALIZE (nimodipine) SOLN	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within the same subclass. <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Katerzia/ Norliqva: May be approved with documented swallowing difficulty 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 Nimodipine solution: Covered without trial for diagnosis of subarachnoid hemorrhage and documented swallowing difficulty
	Non-dihydropyridines	
diltiazem (generic Cardizem) verapamil (generic Calan/Isoptin)		
	LONG-ACTING	
	Dihydropyridines	
amlodipine (generic Norvasc) nifedipine ER (generic Procardia XL/ Adalat CC)	felodipine ER (generic Plendil) KATERZIA (amlodipine) ^{CL,QL} SUSP levamlodipine (generic ConjuPRI) nisoldipine (generic Sular) NORLIQVA (amlodipine) ^{AL,CL,QL} SOLN SDAMLO (amlodipine) ^{NR,AL} SOLN	
	Non-dihydropyridines	
diltiazem ER (generic Cardizem CD) verapamil ER TAB	diltiazem ER (generic Cardizem LA) MATZIM LA (diltiazem ER) TIAZAC (diltiazem) verapamil ER CAPS verapamil 360mg CAPS verapamil ER (generic Verelan PM) verapamil SR (generic Verelan) CAPS	

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CEPHALOSPORINS AND RELATED ANTIBIOTICS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BETA LACTAM/BETA-LACTAMASE INHIBITOR COMBINATIONS		
amoxicillin/clavulanate TAB, SUSP	amoxicillin/clavulanate CHEWABLE amoxicillin/clavulanate ER (generic Augmentin XR) AUGMENTIN (amoxicillin/clavulanate) SUSP, TAB	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a 3-day trial of ONE preferred agent within the same subclass
CEPHALOSPORINS – First Generation		
cefadroxil CAPS, SUSP (generic Duricef) cephalexin CAPS, SUSP (generic Keflex)	cefadroxil TAB (generic Duricef) cephalexin TAB	<p>Drug Specific Criteria</p> <ul style="list-style-type: none"> Cefixime- May be approved for a diagnosis of gonorrhea, with an appropriate ICD-10 diagnosis code without a 3-day trial of a preferred agent Cefpodoxime- May be approved for a diagnosis of pyelonephritis, with an appropriate ICD-10 diagnosis code without a 3-day trial of a preferred agent
CEPHALOSPORINS – Second Generation		
cefprozil (generic Cefzil) cefuroxime TAB (generic Ceftin)	cefaclor (generic Ceclor)	
CEPHALOSPORINS – Third Generation		
cefdinir (generic Omnicef)	cefixime (generic Suprax) ^{CL} CAPS, SUSP, TAB cefpodoxime (generic Vantin) ^{CL}	

COLONY STIMULATING FACTORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
FULPHILA (pegfilgrastim-jmdb) SUB-Q FYLNETRA (pegfilgrastim-pbbk) NEUPOGEN DISP SYR NEUPOGEN (filgrastim) VIAL	GRANIX (tbo-filgrastim) LEUKINE (sargramostim) NEULASTA (pegfilgrastim) SYR NIVESTYLM (filgrastim-aafi) SYR, VIAL NYVEPRIA (pegfilgrastim-apgf) RELEUKO (filgrastim-ayow) SYR ROLVEDON (eflapegrastim-xnst) SYR STIMUFEND (pegfilgrastim-fpgk) UDENYCA (pegfilgrastim-cbqv) AUTOINJ UDENYCA (pegfilgrastim-cbqv) SUB-Q ZARXIO (filgrastim-sndz) ZIEXTENZO SYR (pegfilgrastim-bmez)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

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CONTRACEPTIVES, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<p>All reviewed agents are recommended preferred at this time <i>Only those products for review are listed.</i> Brand name products may be subject to Maximum Allowable Cost (MAC) pricing or require substitution with a generic equivalent</p> <p>Specific agents can be looked up using the Drug Look-up Tool at: https://ne.primetherapeutics.com/drug-lookup</p>	<p>AVERI (desogestrel and ethinyl estradiol kit)^{NR}</p> <p>GALBRIELA (norethindrone/ethinyl estradiol/ferrous fumarate)^{NR} CHEW</p> <p>LUIZZA (norethindrone ac/eth estradiol)^{NR}</p> <p>MELEYA (norethindrone)^{NR}</p> <p>ORQUIDEA (norethindrone)^{NR}</p> <p>ROSYRAH (levonorgestrel/ ethinyl estradiol/ ethinyl estradiol kit)^{NR}</p> <p>XARAH FE (norethindrone acetate and ethinyl estradiol and ferrous fumarate)^{NR}</p> <p>XELRIA FE (norethindrone and ethinyl estradiol and ferrous fumarate)^{NR}</p>	

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COPD (CHRONIC OBSTRUCTIVE PULMONARY DISEASE) AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
INHALERS		
ANORO ELLIPTA (umeclidinium/vilanterol) ATROVENT HFA (ipratropium) COMBIVENT RESPIMAT (albuterol/ ipratropium) SPIRIVA (tiotropium) SPIRIVA RESPIMAT (tiotropium) STIOLTO RESPIMAT (tiotropium/olodaterol)	BEVESPI AEROSPHERE (glycopyrrolate/formoterol) DUAKLIR PRESSAIR (aclidinium br and formoterol fum) INCRUSE ELLIPTA (umeclidinium) tiotropium (generic Spiriva) TUDORZA PRESSAIR (aclidinium br) umeclidinium/vilanterol (generic Anoro Ellipta)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within the same subclass OR Patient specific documentation of inability to use traditional inhaler device. <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Daliresp/roflumilast: 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
INHALATION SOLUTION		
albuterol/ipratropium (generic Duoneb) ipratropium SOLN (generic Atrovent)	OHTUVAYRE (ensifentrine) inhalation suspension YUPELRI (revefenacin)	<ul style="list-style-type: none"> Dupixent (For other indications, see Immunomodulators, Atopic Dermatitis and Asthma therapeutic classes): For COPD and an Eosinophilic Phenotype: Requires documentation of inadequately controlled COPD with eosinophils ≥ 300 cells/microliter AND two exacerbations OR one exacerbation that led to hospitalization while on and adherent to a ≥ 90-day trial of triple therapy (LABA + LAMA + ICS). Prescribed by, or in consultation with a pulmonologist, immunologist, or an allergist.
ORAL AGENT		
roflumilast (generic Daliresp) ^{CL, QL}	DALIRESP (roflumilast) ^{CL, QL}	

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COUGH AND COLD, OPIATE COMBINATION

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	guaiifenesin/codeine LIQUID hydrocodone/homatropine SYRUP promethazine/codeine SYRUP promethazine/phenylephrine/codeine SYRUP	<ul style="list-style-type: none"> 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 \geq 18 years of age

CYSTIC FIBROSIS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	ALYFTREK (vanzacaftor; tezacaftor; deutivacaftor) ^{AL,CL} TAB BRONCHITOL (mannitol) ^{AL,CL,QL} Kalydeco PACKET, TAB (ivacaftor) ^{AL,CL,QL} ORKAMBI (lumacaftor/ivacaftor) PACKET, TAB ^{AL,CL,QL} SYMDEKO (tezacaftor/ivacaftor) ^{AL,CL,QL} TRIKAFTA (elexacaftor, tezacaftor, ivacaftor) ^{AL, CL} PACKET^{CL}, TAB	<p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Alyfrek: Diagnosis of CF and documentation of at least one F508del mutation or another responsive mutation in the CFTR gene. Bronchitol: Approved for diagnosis of CF and documentation that the patient has passed the BRONCHITOL Tolerance Test Kalydeco®: Diagnosis of CF and documentation of the drug-specific, FDA-approved mutation of CFTR gene Orkambi®: Diagnosis of CF and documentation of presence of two copies of the F580del mutation (homozygous) of CFTR gene Symdeko: Diagnosis of CF and documentation of the drug specific, FDA approved mutation of CFTR gene. Trikafta: Diagnosis of CF and documentation of at least one F508del mutation in the CFTR gene or a mutation that is responsive to Trikafta based on clinical and/or in vitro data

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CYTOKINE & CAM ANTAGONISTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	IL-6 ANTAGONISTS ACTEMRA (tocilizumab) PEN,SYR ENSPRYNG (satralizumab-mwge) SYR KEVZARA (sarilumab) PEN, SYR TYENNE (tocilizumab-aaazg) ^{AL} AUTOINJ, SYR	<ul style="list-style-type: none"> Preferred agents will be approved with FDA-approved indication – ICD-10 diagnosis code is required. Non-preferred agents will be approved for FDA-approved indications in patients who have failed a trial of TWO preferred agents within this entire drug class, or upon diagnosis for non-preferred agent with FDA-approved indication if no preferred agent has FDA approval for diagnosis.
	IL-17 ANTAGONISTS TALTZ (ixekizumab) ^{AL} AUTOINJ, SYR BIMZELX (bimekizumab-bkzx) ^{AL} PEN, SYR COSENTYX (secukinumab) ^{AL,QL} PEN, SYR	
PYZCHIVA (ustekinumab-ttwe, Stelara biosimilar) ^{AL,CL} SYR STEQEYMA (ustekinumab-stba) ^{AL,CL} SYR	IL-23 ANTAGONISTS ILUMYA (tildrakizumab) SUB-Q IMULDOSA (ustekinumab-srlf) ^{AL} SYR OMVOH (mirikizumab-mrkz) ^{AL} OTULFI (ustekinumab-aaaz) ^{AL,SYR} 100mg, 200mg,300mg PEN,SYR SELARSDI (ustekinumab-aekn) ^{AL} SYR, VIAL SKYRIZI (risankizumab-rzaa) SYR SKYRIZI (risankizumab-rzaa) ^{QL} ON-BODY SKYRIZI (risankizumab-rzaa) ^{QL} PEN STARJEMZA (ustekinumab-hmny) ^{AL,NR} SYR STARJEMZA (ustekinumab-hmny) ^{AL,NR} 45mg VIAL STELARA (ustekinumab) ^{AL} SYR STELARA (ustekinumab) ^{AL} VIAL TREMFYA (guselkumab) AUTOINJ AL,QL, PEN AL,SYR AL USTEKINUMAB ^{AL} SYR, VIAL USTEKINUMAB-AAUZ SYR (Otulsi biosimilar) ^{AL,NR} USTEKINUMAB-AEKN (biosimilar to Stelara) ^{AL} SYR USTEKINUMAB-TTWE ^{AL} SYR YESINTEK (ustekinumab -kfce) ^{AL} SYR, VIAL	<p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Cibinqo/Rinvoq/RinvoqER: For diagnosis of moderate to severe Atopic Dermatitis requires treatment failure of TWO preferred systemic drug products, including biologics, within this entire drug class or the Immunomodulators, Atopic Dermatitis therapeutic class. JAK-Inhibitors: For FDA approved indications that require a patient to have had an inadequate response to a TNF blocker, documentation of an inadequate response to TWO preferred TNF blockers of different active ingredients is required unless preferred products don't have the appropriate indication. Pyzchiva/Steqeyma: Requires a trial and failure of a preferred TNF blocker with the same indication.

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CYTOKINE & CAM ANTAGONISTS, continued

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	JAK-INHIBITORS^{CL}	<ul style="list-style-type: none"> ▪ Preferred agents will be approved with FDA-approved indication – ICD-10 diagnosis code is required. ▪ Non-preferred agents will be approved for FDA-approved indications in patients who have failed a trial of TWO preferred agents within this entire drug class, or upon diagnosis for non-preferred agent with FDA-approved indication if no preferred agent has FDA approval for diagnosis.
	CIBINQO (abrocitinib) ^{AL,CL,QL} TAB LEQSELVI (deuruxolitinib) TAB LITFULO (ritlecitinib) ^{AL} CAPS OLUMIANT (baricitinib) ^{QL} TAB RINVOQ ER (upadacitinib) ^{CL,QL} TAB RINVOQ (upadacitinib) ^{AL,CL,QL} LQ SOLN XELJANZ (tofacitinib) SOLN^{QL} XELJANZ (tofacitinib) TAB^{QL} XELJANZ XR (tofacitinib) TAB^{QL}	
	TNF-BLOCKERS	<p>Drug-specific criteria:</p> <ul style="list-style-type: none"> • Cibinqo/Rinvoq/RinvoqER: For diagnosis of moderate to severe Atopic Dermatitis requires treatment failure of TWO preferred systemic drug products, including biologics, within this entire drug class or the Immunomodulators, Atopic Dermatitis therapeutic class. • JAK-Inhibitors: For FDA approved indications that require a patient to have had an inadequate response to a TNF blocker, documentation of an inadequate response to TWO preferred TNF blockers of different active ingredients is required unless preferred products don't have the appropriate indication. • Pyzchiva/Steqeyma: Requires a trial and failure of a preferred TNF blocker with the same indication.
ADALIMUMAB-ADBM(CF) ^{AL} 50mg/mL KIT, PEN-KIT ADALIMUMAB-ADBM(CF) ^{AL} 100mg/mL KIT, PEN-KIT ENBREL (etanercept) KIT, MINI CART, PEN, SYR, VIAL^{QL} HADLIMA (adalimumab- bwwd) ^{AL} PUSHTOUCH, SYR HADLIMA (CF) (adalimumab- bwwd) ^{AL} PUSHTOUCH, SYR SIMLANDI (CF) (adalimumab-ryvk) ^{AL} PEN KIT	ABRILADA (adalimumab-afzb) ^{AL} (CF) KIT, PEN-KIT ADALIMUMAB-AACF (CF) ^{AL} PEN* KIT, SYR-KIT ADALIMUMAB-AATY (CF) ^{AL} PEN KIT ADALIMUMAB-ADAZ(CF)(biosim for Hyrimoz) ^{AL} KIT, PEN, SYR ADALIMUMAB-ADBM(CF) ^{AL} 50mg/mL KIT, PEN-KIT (Quallent) ADALIMUMAB-ADBM(CF) ^{AL} 100mg/mL KIT, PEN-KIT (Quallent) ADALIMUMAB-FKJP (biosim for Hulio) ^{AL} PEN, SYR ADALIMUMAB-RYVK ^{AL} (biosim for Simlandi) KIT, PEN-KIT AMJEVITA (adalimumab-atto) ^{AL} AUTOINJ, SYR AMJEVITA(adalimumab-atto) ^{AL} KIT, PEN-KIT CIMZIA (certolizumab pegol) ^{QL} CYLTEZO (adalimumab-adbm) ^{AL} 50mg/mL KIT, PEN-KIT CYLTEZO (adalimumab-adbm) ^{AL} 100mg/mL KIT, PEN-KIT	

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CYTOKINE & CAM ANTAGONISTS, continued

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	<p>TNF-BLOCKERS (continued)</p> <p>HULIO (adalimumab-fkjp)^{AL} PEN, SYR HUMIRA (adalimumab)^{QL} HYRIMOZ(CF) (adalimumab-adaz)^{AL} PEN, SYR IDACIO (adalimumab-aacf)^{AL} PEN, SYR SIMLANDI (CF) (adalimumab-ryvk)^{AL} KIT SIMPONI (golimumab) YUFLYMA 100mg/mL (CF) (adalimumab-aaty)^{AL} KIT,PEN-KIT YUFLYMA 80mg/mL (CF) (adalimumab- aaty)^{AL} AUTOINJ, PEN, KIT YUSIMRY (CF) (adalimumab-aqvh)^{AL} PEN KIT ZYMFENTRA (infliximab-dyyb) PEN, SYR</p>	<ul style="list-style-type: none"> ▪ Preferred agents will be approved with FDA-approved indication – ICD-10 diagnosis code is required. ▪ Non-preferred agents will be approved for FDA-approved indications in patients who have failed a trial of TWO preferred agents within this entire drug class, or upon diagnosis for non-preferred agent with FDA-approved indication if no preferred agent has FDA approval for diagnosis. <p>JAK-Inhibitors: For FDA approved indications that require a patient to have had an inadequate response to a TNF blocker, documentation of an inadequate response to TWO preferred TNF blockers of different active ingredients is required unless preferred products don't have the appropriate indication.</p> <p>Drug-specific criteria:.</p> <ul style="list-style-type: none"> • Pyzchiva/Steqeyma: Requires a trial and failure of a preferred TNF blocker with the same indication. • Cibinqo/Rinvoq/RinvoqER: For diagnosis of moderate to severe Atopic Dermatitis requires treatment failure of TWO preferred systemic drug products, including biologics, within this entire drug class or the Immunomodulators, Atopic Dermatitis therapeutic class.

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CYTOKINE & CAM ANTAGONISTS, continued

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
MISCELLANEOUS MECHANISM OF ACTION		
OTEZLA (apremilast) TAB^{QL}	ARCALYST (nilonacept) KINERET (anakinra) ENTYVIO (vedolizumab) ^{AL} PEN ORENCIA (abatacept) CLICKJET ORENCIA (abatacept) SYR SOTYKTU (deucravacitinib) TAB SPEVIGO (spesolimab-sbzo) ^{AL} SYR VELSIPITY (etrasimod) ^{QL} TAB	<ul style="list-style-type: none"> ▪ Preferred agents will be approved with FDA-approved indication – ICD-10 diagnosis code is required. ▪ Non-preferred agents will be approved for FDA-approved indications in patients who have failed a trial of TWO preferred agents within this entire drug class, or upon diagnosis for non-preferred agent with FDA-approved indication if no preferred agent has FDA approval for diagnosis. <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> • Cibinqo/Rinvoq/RinvoqER: For diagnosis of moderate to severe Atopic Dermatitis requires treatment failure of TWO preferred systemic drug products, including biologics, within this entire drug class or the Immunomodulators, Atopic Dermatitis therapeutic class. • JAK-Inhibitors: For FDA approved indications that require a patient to have had an inadequate response to a TNF blocker, documentation of an inadequate response to TWO preferred TNF blockers of different active ingredients is required unless preferred products don't have the appropriate indication. • Pyzchiva/Steqeyma: Requires a trial and failure of a preferred TNF blocker with the same indication.

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DIURETICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
SINGLE-AGENT PRODUCTS		
amiloride TAB bumetanide TAB chlorthalidone (generic Diuril) TAB furosemide (generic Lasix) SOLN, TAB hydrochlorothiazide (generic Microzide) CAPS, TAB indapamide TAB KERENDIA (finerenone) TAB CL,QL metolazone TAB spironolactone (generic Aldactone) ^{AL} TAB torsemide TAB	CAROSPIR (spironolactone) ^{AL} SUSP eplerenone (generic Inspira) ^{CL} TAB ethacrynic acid (generic Edecrin) CAPS HEMICLOR (chlorthalidone) ^{NR} TAB INZIRQQ (hydrochlorothiazide) ^{NR,QL} SUSP spironolactone (generic Carospir) ^{AL,CL} SUSP THALITONE (chlorthalidone) TAB triamterene (generic Dyrenium)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class. <p>Drug Specific Criteria:</p> <ul style="list-style-type: none"> eplerenone: Will be approved with a failed trial or intolerance to spironolactone, a trial with two preferred agents is not required. Kerendia: For diagnosis of chronic kidney disease associated with Type-II diabetes in adults. Also for diagnosis of heart failure in adults with LVEF of 40% or greater. spironolactone suspension: May be approved without trial of a preferred agent if there is a clinical reason why preferred spironolactone solid dosage form cannot be used.
COMBINATION PRODUCTS		
amiloride/HCTZ TAB spironolactone/HCTZ TAB (generic Aldactazide) triamterene/HCTZ CAPS, TAB (generic Dyazide, Maxzide)		

ENZYME REPLACEMENT, GAUCHER'S DISEASE

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

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EPINEPHRINE, SELF-ADMINISTERED QL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
AUVI-Q 0.1mg (epinephrine) epinephrine (AUTHORIZED GENERIC Epipen/ Epipen Jr.) AUTOINJ EPIPEN (epinephrine) AUTOINJ EPIPEN JR. (epinephrine) AUTOINJ	AUVI-Q 0.15mg (epinephrine) AUVI-Q 0.3mg (epinephrine) epinephrine (generic Adrenaclick) epinephrine (generic Epipen/ Epipen Jr.) AUTOINJ NEFFY (epinephrine) NASAL AL,QL	<ul style="list-style-type: none"> Non-preferred agents require clinical documentation why the preferred products within this drug class are not appropriate

ERYTHROPOIESIS STIMULATING PROTEINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ARANESP (darbopoetin alfa) DISP SYR, VIAL EPOGEN (rHuEPO) RETACRIT (epoetin alfa-epbx) <i>Pfizer manufacturer only</i>	PROCRIT (rHuEPO) RETACRIT (epoetin alfa-epbx) <i>Vifor manufacturer only</i> VAFSEO (vadadustat) TAB	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

FLUOROQUINOLONES, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ciprofloxacin TAB (generic Cipro) levofloxacin TAB (generic Levaquin) moxifloxacin (generic Avelox)	BAXDELA (delafloxacin) ^{CL} ciprofloxacin ER ciprofloxacin SUSP (generic Cipro) ^{CL} levofloxacin SOLN ^{CL} ofloxacin ^{CL}	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a 3-day trial of ONE preferred agent within this drug class <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Baxdela: Coverable with documented intolerance or failure of preferred MRSA agents (clindamycin, doxycycline, linezolid, sulfamethoxazole/trimethoprim) Ciprofloxacin/Levofloxacin Suspension: Coverable with documented swallowing disorders Ofloxacin: Trial of preferred not required for diagnoses of Pelvic Inflammatory Disease OR Acute Epididymitis (non-gonorrhea)

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GI MOTILITY, CHRONIC

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<p>LINZESS (linaclotide)^{AL,QL} lubiprostone (generic Amitiza)^{AL,QL}</p>	<p>alosetron (generic Lotronex)^{CL} AMITIZA (lubiprostone)^{AL, QL} IBSRELA (tenapanor)^{AL,CL,QL} MOTEGRITY (prucalopride succinate) MOVANTIK (naloxegol oxalate)^{QL} prucalopride (generic Motegrity) SYMPROIC (naldemedine)^{CL} VIBERZI (eluxodoline)^{CL}</p>	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a 30-day trial of ONE preferred agent within this drug class with the same indication <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Ibsrela: May be approved for diagnosis of IBS with constipation after trial of at least TWO OTC laxatives (senna, bisacodyl, etc.) Lotronex/ alosetron: Covered for diagnosis of IBS Diarrhea Predominant type with trial and failure of loperamide AND diphenoxylate 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 Viberzi®: Covered for diagnosis of IBS Diarrhea Predominant type with trial and failure of loperamide AND diphenoxylate

GLUCAGON AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<p>BAQSIMI (glucagon)^{AL,QL} NASAL GLUCAGON EMERGENCY (glucagon)^{QL} INJ KIT (Fresenius) GLUCAGON EMERGENCY (glucagon)^{QL} INJ KIT (Lilly) glucagon^{QL} INJ GVOKE (glucagon)^{AL,QL} PEN, SYR PROGLYCEM (diazoxide) SUSP ZEGALOGUE (dasiglucagon)^{AL, QL} AUTO-INJ</p>	<p>diazoxide SUSP (generic Proglycem) GLUCAGON EMERGENCY (glucagon)^{NR} INJ KIT (Lupin) GVOKE (glucagon)^{AL,QL} VIAL ZEGALOGUE (dasiglucagon)^{AL, QL} SYR</p>	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

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GLUCOCORTICOIDS, INHALED

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
GLUCOCORTICOIDS		
ARNUITY ELLIPTA (fluticasone) ASMANEX (mometasone) ^{QL,AL} ASMANEX HFA (mometasone) ^{QL} fluticasone HFA (generic Flovent HFA) PULMICORT FLEXHALER (budesonide)	ALVESCO (ciclesonide) ^{AL,CL} ARMONAIR DIGIHALER (fluticasone) ^{AL,QL} fluticasone (generic Flovent Diskus) fluticasone furoate (generic Arnuity Ellipta) ^{AL} QVAR Redihaler (beclomethasone)	<ul style="list-style-type: none"> Non-preferred agents within the Glucocorticoids and Glucocorticoid/Bronchodilator Combo groups will be approved for patients who have failed a trial of TWO preferred agents within the last 6 months <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> budesonide respules: Covered without PA for age \leq 8 years OR for diagnosis of eosinophilic esophagitis in patients \geq 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.
GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS		
ADVAIR DISKUS (fluticasone/ salmeterol) ^{QL} ADVAIR HFA (fluticasone/salmeterol) ^{QL} DULERA (mometasone/formoterol) SYMBICORT (budesonide/ formoterol) TRELEGY ELLIPTA (fluticasone/ umeclidinium/vilanterol)	AIRDUO DIGIHALER (fluticasone/salmeterol) ^{AL,QL} AIRSUPRA HFA (albuterol and budesonide) ^{AL} 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 Advair HFA) ^{QL} fluticasone/salmeterol (generic for Airduo Respiclick) fluticasone/vilanterol (Breo Ellipta)	
INHALATION SOLUTION		
	budesonide RESPULES (generic Pulmicort) ^{CL}	

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GLUCOCORTICOIDS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
budesonide EC CAPS (generic Entocort EC) dexamethasone ELIXIR, SOLN dexamethasone TAB hydrocortisone TAB methylprednisolone tablet (generic Medrol) prednisolone SOLN prednisolone sodium phosphate prednisone DOSE PAK prednisone TAB	ALKINDI (hydrocortisone) GRANULES^{AL} CORTEF (hydrocortisone) cortisone TAB dexamethasone ^{CL} INTENSOL EOHILIA (budesonide) ^{AL, QL} SUSP HEMADY (dexamethasone) KHINDIVI (hydrocortisone) ^{AL} SOLN methylprednisolone 8mg, 16mg, 32mg prednisolone sodium phosphate (generic Millipred/Veripred) prednisolone sodium phosphate ODT prednisone SOLN prednisone ^{CL} INTENSOL prednisone DR^{NR} TAB RAYOS DR (prednisone) TAB TARPEYO (budesonide) ^{CL} CAPS	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class within the last 6 months <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Intensol Products: Patient specific documentation of why the less concentrated solution is not appropriate for the patient Tarpeyo: Indicated for the treatment of primary immunoglobulin A nephropathy (IgAN)

GROWTH HORMONES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
GENOTROPIN (somatropin) NORDITROPIN (somatropin)	HUMATROPE (somatropin) NGENLA (somatropin-ghla) ^{AL} NUTROPIN AQ (somatropin) OMNITROPE (somatropin) SEROSTIM (somatropin) SKYTROFA (lonapegsomatropin-tcgd) SOGROYA (smapacitan-beco) ZOMACTON (somatropin)	Growth Hormone PA Form Growth Hormone Criteria

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H. PYLORI TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
PYLERA (bismuth, metronidazole, tetracycline) ^{QL}	bismuth,metronidazole,tetracycline (generic Pylera) ^{QL} lansoprazole/amoxicillin/clarithromycin (generic Prevpac) ^{QL} OMECLAMOX-PAK (omeprazole, clarithromycin, amoxicillin) ^{QL} TALICIA (omeprazole/amoxicillin/rifaxitin) VOQUEZNA (vonoprazan) ^{CL,QL}	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class <p>Drug-Specific Criteria</p> <ul style="list-style-type: none"> Voquezna: For the diagnosis of erosive esophagitis or heartburn associated with non-erosive GERD, will require confirmation by initial endoscopy and a trial/failure or a contraindication of two different PPIs (8 weeks each) up to maximally indicated doses in the past 180 days. Length of therapy for erosive esophagitis is 240 days max per calendar year and 4 weeks for heartburn associated with non-erosive GERD.

HAE TREATMENTS^{CL}

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BERINERT (C1 esterase inhibitor, human) INTRAVENOUS HAEGARD (C1 esterase inhibitor, human) ^{AL,CL} SUB-Q icatibant acetate (generic for FIRAZYR) ^{AL} SUB-Q TAKHZYRO (lanadelumab-flyo) ^{AL,CL} SYRINGE	ANDEMORY (garadacimab) ^{AL,NR} AUTOINJECTOR CINRYZE (C1 esterase inhibitor, human) ^{AL,CL} INTRAVENOUS DAWNZERA ^{AL,NR} (donidolersen) FIRAZYR (icatibant acetate) ^{AL} SUB-Q ORLADEYO (berotralstat) CAP ^{AL,CL,QL} RUCONEST (recombinant human C1 inhibitor) ^{AL} INTRAVENOUS TAKHZYRO (lanadelumab-flyo) ^{AL,CL} VIAL	<p>HAE Treatments PA Form</p> <ul style="list-style-type: none"> All agents require documentation of diagnosis of Type I or Type II HAE and deficient or dysfunctional C1 esterase inhibitor enzyme. Concomitant use with ACE inhibitors, NSAIDs, or estrogen-containing products is contraindicated Non-preferred agents will be approved for patients who have a failed trial or a contraindication to ONE preferred agent within this drug class with the same indication. <p>Drug-Specific Criteria</p> <ul style="list-style-type: none"> Cinryze, Haegarda, Orladeyo, and Takhzyro, require a history of two or more HAE attacks monthly

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HEMOPHILIA TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BISPECIFIC FACTORS		
HEMLIBRA		<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this entire drug class and with the same indication.
FACTOR VIII		
ALPHANATE HUMATE-P KOVALTRY NOVOEIGHT NUWIQ XYNTHA KIT, SOLOFUSE	ADVATE ADYNOVATE AFSTYLA ALTUVIIO ELOCTATE ESPEROCT HEMOFIL-M JIVI ^{AL} KOATE-DVI KIT KOATE-DVI VIAL KOGENATE FS OBIZUR RECOMBINATE	
FACTOR IX		
ALPROLIX BENEFIX	ALPHANINE SD IDELVION IXINITY PROFILNINE SD REBINYN RIXUBIS	
FACTOR VIIa AND PROTHROMBIN COMPLEX-PLASMA DERIVED		
NOVOSEVEN RT	FEIBA NF SEVENFACT ^{AL}	
FACTOR X AND XIII PRODUCTS		
COAGADEX CORIFACT	TRETEN	
TISSUE FACTOR PATHWAY INHIBITOR/ ANTITHROMBIN INHIBITORS		
	ALHEMO ^{AL} HYMPAVZ ^{AL} QFITLIA (fitusiran) ^{AL} PEN, VIAL	
VON WILLEBRAND PRODUCTS		
WILATE	VONVENDI	

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HEPATITIS B TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
entecavir TAB	adefovir dipivoxil BARACLUDE (entecavir) SOLN, TAB lamivudine hbv TAB VEMLIDY (tenofovir alafenamide fumarate)	<ul style="list-style-type: none">▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class <p>Drug Specific Criteria</p> <ul style="list-style-type: none">▪ tenofovir disoproxil fumarate (generic Viread) tablet: Diagnosis for use required. May be indicated for chronic hepatitis B or HIV-1 infection.<ul style="list-style-type: none">○ See HIV/AIDS class for drug listing and placement

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HEPATITIS C TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
DIRECT ACTING ANTI-VIRAL		
MAVYRET (glecaprevir/pibrentasvir) TAB^{CL}, PELLET^{AL,CL} sofosbuvir/velpatasvir (generic Epclusa) ^{CL} VOSEVI (sofosbuvir/velpatasvir/ voxilaprevir) ^{CL}	HARVONI 200/45MG, TAB (ledipasvir/sofosbuvir) ^{CL} HARVONI (ledipasvir/sofosbuvir) ^{CL} PELLET ledipasvir/sofosbuvir (generic Harvoni) ^{CL} SOVALDI (sofosbuvir) ^{CL} PELLET SOVALDI TAB (sofosbuvir) ^{CL} ZEPATIER (elbasvir/grazoprevir) ^{CL}	<p>Hepatitis C Treatments PA Form Hepatitis C Criteria</p> <ul style="list-style-type: none"> Non-preferred products require trial of preferred agents within the same subclass and/or 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 <p>Drug-specific criteria: Trial with with a preferred agent not required in the following:</p> <ul style="list-style-type: none"> Harvoni/ ledipasvir- sofosbuvir: <ul style="list-style-type: none"> Post liver transplant for genotype 1 or 4 Vosevi: Requires documentation of non-response after previous treatment course of Direct Acting Anti-viral agent (DAA) for genotype 1-6 without cirrhosis or with compensated cirrhosis
RIBAVIRIN		
ribavirin 200mg CAPSULE, TAB		
INTERFERON		
PEGASYS (pegylated interferon alfa-2a) ^{CL}		

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HISTAMINE II RECEPTOR BLOCKERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
famotidine TAB (generic for Pepcid) famotidine SUSP	cimetidine TAB , SOLN^{CL} (generic Tagamet) famotidine CHEW-TAB nizatidine CAPS (generic for Axit)	<ul style="list-style-type: none">▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class <p>Drug-specific criteria:</p> <ul style="list-style-type: none">▪ Cimetidine: Approved for viral M. contagiosum or common wart V. Vulgaris treatment

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HIV / AIDS^{CL}

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CAPSID INHIBITOR		
	SUNLENCA (lenacapavir) ^{QL} YEZTUGO (lenacapavir) ^{NR,QL} TAB	
CCR5 ANTAGONISTS		
SELZENTRY SOLN, TAB (maraviroc)	maraviroc (generic Selzentry)	
FUSION INHIBITORS		
FUZEON SUB-Q (enfuvirtide) ^{QL}		
HIV-1 ATTACHMENT INHIBITOR		
	RUKOBIA ER (fostemsavir) ^{AL,QL}	
INTEGRASE STRAND TRANSFER INHIBITORS (INSTIs)		
ISENTRESS (raltegravir) ^{QL} ISENTRESS HD (raltegravir) TIVICAY (dolutegravir)	TIVICAY PD (dolutegravir)	
NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NNRTIs)		
EDURANT (rilpivirine) efavirenz CAPS, TABLET (generic Sustiva)	etravirine (generic Intelence) ^{QL} nevirapine IR, ER (generic Viramune/Viramune XR)	
INTELENCE (etravirine) ^{QL} PIFELTRO (doravirine) ^{QL}	SUSTIVA CAPS, TABLET (efavirenz) VIRAMUNE (nevirapine) SUSP	
NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTIs)		
abacavir SOLN, TABLET (generic Ziagen) EMTRIVA CAPS, SOLN (emtricitabine)	didanosine DR (generic Videx EC) emtricitabine CAPS (generic for Emtriva)	
lamivudine SOLN, TABLET (generic Epivir)	EPIVIR (lamivudine)	
zidovudine CAPS, SYRUP, TABLET (generic Retrovir)	RETROVIR (zidovudine) stavudine CAPS (generic Zerit) ZIAGEN (abacavir)	
NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTIs)		
tenofovir TABLET (generic Viread)	VIREAD (tenofovir) POWDER	
PHARMACOKINETIC ENHANCER		
	TYBOST (cobicistat) ^{QL}	

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HIV / AIDS CL (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
PROTEASE INHIBITORS		
atazanavir CAPS (generic Reyataz) NORVIR (ritonavir) TAB PREZISTA (darunavir) TAB ritonavir TAB (generic Norvir)	APTIVUS CAPS, SOLN (tipranavir) CRIXIVAN (indinavir) DARUNAVIR PROPYLENE GLYCOLATE ^{AL} TAB darunavir ethanolate (generic Prezista) ^{AL} TAB fosamprenavir TAB (generic Lexiva) LEXIVA SUSP (fosamprenavir) LEXIVA TAB (fosamprenavir) NORVIR POWDER, SOLN (ritonavir) PREZISTA (darunavir) SUSP REYATAZ POWDER (atazanavir) VIRACEPT (nelfinavir)	<ul style="list-style-type: none"> ▪ All agents require: <ul style="list-style-type: none"> ○ Diagnosis of HIV/AIDS required, OR ○ Diagnosis of Pre and Post Exposure Prophylaxis ▪ 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 patients, 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.
COMBINATION PROTEASE INHIBITORS (PIs) or PIs plus PHARMACOKINETIC ENHANCER		
EVOTAZ (atazanavir/cobicistat) ^{QL} lopinavir/ritonavir SOLN, TAB (generic Kaletra)	KALETRA SOLN (lopinavir/ritonavir) KALETRA TAB (lopinavir/ritonavir) PREZCOBIX (darunavir/cobicistat) ^{QL}	
COMBINATION NUCLEOS(T)IDE REVERSE TRANSCRIPTASE INHIBITORS		
abacavir/lamivudine (generic Epzicom) CIMDUO (lamivudine/tenofovir) ^{QL} DESCOVY (emtricitabine/tenofovir) ^{QL} emtricitabine/tenofovir (generic Truvada) lamivudine/zidovudine (generic Combivir)	abacavir/lamivudine/zidovudine (generic Trizivir) COMBIVIR (lamivudine/zidovudine) EPZICOM (abacavir sulfate/lamivudine) TRIZIVIR (abacavir/lamivudine/zidovudine) TRUVADA (emtricitabine/tenofovir)	

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HIV / AIDS CL (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
COMBINATION PRODUCTS – MULTIPLE CLASSES		
BIKTARVY (bictegravir/emtricitabine/tenofovir) ^{QL}	efavirenz/lamivudine/tenofovir (generic for Symfi) ^{QL}	
COMPLERA (rilpivirine/emtricitabine/tenofovir)	efavirenz/lamivudine/tenofovir (generic for Symfi Lo) ^{QL}	
DELSTRIGO (doravirine/lamivudine/tenofovir) ^{QL}	rilpivirine/emtricitabine/tenofovir (Complera) ^{NR}	
DOVATO (dolutegravir/lamivudine) ^{QL}	TRIUMEQ PD (abacavir/dolutegravir/lamivudine) SUSP	
efavirenz/emtricitabine/tenofovir (generic Atripla) ^{CL}		
GENVOYA (elvitegravir/cobicistat/emtricitabine/tenofovir) ^{QL, AL}		
JULUCA (dolutegravir/rilpivirine) ^{QL}		
ODEFSEY (emtricitabine/rilpivirine/tenofovir) ^{QL}		
STRIBILD (elvitegravir/cobicistat/emtricitabine/tenofovir) ^{QL}		
SYMF1 (efavirenz/lamivudine/tenofovir) ^{QL}		
SYMF1 LO (efavirenz/lamivudine/tenofovir) ^{QL}		
SYMTUZA (darunavir/cobicistat/emtricitabine/tenofovir) ^{QL}		
TRIUMEQ (dolutegravir/abacavir/lamivudine)		

HYPOGLYCEMICS, ALPHA-GLUCOSIDASE INHIBITORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
acarbose (generic Precose)	miglitol (generic Glyset)	

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HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
GLUCAGON-LIKE PEPTIDE-1 RECEPTOR AGONIST (GLP-1 RA)^{AL,CL,QL}		
OZEMPIC (semaglutide) ^{AL,QL} TRULICITY (dulaglutide) ^{AL,QL} VICTOZA (liraglutide) ^{AL,QL} subcutaneous	BYDUREON BCISE PEN (exenatide) ^{AL,QL} BYETTA (exenatide) ^{AL,QL} subcutaneous exenatide (generic Byetta) ^{AL,QL} liraglutide (generic Victoza) ^{AL,QL} MOUNJARO (tirzepatide) ^{AL,QL} PEN RYBELSUS (semaglutide) ^{AL,QL} 1.5mg ^{NR} , 3mg, 4mg ^{NR} , 7mg, 9mg ^{NR} , 14mg TAB	<p>GLP-1 RA Criteria</p> <p>Preferred agents require a diagnosis of Type II diabetes AND a trial and failure or intolerance to metformin OR A diagnosis of ASCVD associated with a diagnosis of Type II diabetes (no metformin trial required)</p> <p>Non-preferred agents will be approved for patients who have:</p> <ul style="list-style-type: none"> 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
INSULIN/GLP-1 RA COMBINATIONS		
	SOLIQUA (insulin glargine/lixisenatide) XULTOPHY (insulin degludec/liraglutide)	
AMYLIN ANALOG^{CL}		
	SYMLIN (pramlintide) subcutaneous	<p>Amylin Analog Criteria</p> <p>ALL criteria must be met</p> <ul style="list-style-type: none"> Concurrent use of short-acting mealtime insulin Current therapy compliance No diagnosis of gastroparesis HbA1C $\leq 9\%$ within last 90 days Monitoring of glucose during initiation of therapy
DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITOR^{AL,CL,QL}		
JANUMET (sitagliptin/metformin) JANUMET XR (sitagliptin/metformin) JANUVIA (sitagliptin) JENTADUETO (linagliptin/metformin) TRADJENTA (linagliptin)	alogliptin (generic Nesina) alogliptin/metformin (generic Kazano) alogliptin/pioglitazone (generic Oseni) BRYNOVIN (sitagliptin) ^{NR,QL} SOLN GLYXAMBI (empagliflozin/linagliptin) JENTADUETO XR (linagliptin/metformin) KOMBIGLYZE XR (saxagliptin/metformin) linagliptin (generic Tradjenta)^{NR} ONGLYZA (saxagliptin) QTERN (dapagliflozin/saxagliptin)	<p>DPP-4 Inhibitor Criteria</p> <p>Preferred agents require a diagnosis of Type II diabetes AND a trial and failure or intolerance to metformin.</p> <p>Non-preferred DPP-4s will be approved for patients who have failed a trial of ONE preferred agent within the DPP-4 inhibitor class</p>

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HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	Dipeptidyl Peptidase-4 (DPP-4) Inhibitor^{AL,CL,QL} saxagliptin (generic Onglyza) saxagliptin/metformin ER (generic Kombiglyze ER) sitagliptin (generic Zituvio) sitagliptin/ metformin (Zituvimet) sitagliptin/ metformin ER (Zituvimet XR) ^{NR} STEGLUJAN (ertugliflozin/sitagliptin) TRIJARDY XR (empagliflozin/linagliptin/metformin) ZITUVIMET (sitagliptin/metformin) TAB^{QL} ZITUVIMET XR (sitagliptin/ metformin ER) TAB^{QL} ZITUVIO (sitagliptin)	

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HYPOLYCEMICS, INSULIN AND RELATED DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<p>HUMULIN (insulin) VIAL HUMULIN 70/30 VIAL HUMULIN U-500 VIAL HUMULIN U-500 PEN^{CL} HUMULIN OTC PEN HUMULIN 70/30 OTC PEN insulin aspart/insulin aspart protamine PEN, VIAL(generic for Novolog Mix) insulin lispro (generic for Humalog) PEN, VIAL, JR KWIKPEN insulin lispro/lispro protamine KWIKPEN (Humalog Mix Kwikpen) LANTUS SOLOSTAR PEN (insulin glargine) LANTUS (insulin glargine) VIAL</p>	<p>ADMELOG (insulin lispro) PEN, VIAL AFREZZA (regular insulin)^{CL} INHALATION APIDRA (insulin glulisine) SOLOSTAR, VIAL BASAGLAR (insulin glargine, rec) PEN, TEMPO PEN FIASP (insulin aspart) CARTRIDGE, PEN, VIAL HUMALOG U-100 TEMPO PEN HUMALOG (insulin lispro)^{CL} U-200 KWIKPEN HUMALOG (insulin lispro) U-100 CARTRIDGE, PEN, VIAL HUMALOG JR. (insulin lispro) U-100 KWIKPEN HUMALOG MIX VIAL (insulin lispro/lispro protamine) HUMALOG MIX KWIKPEN (insulin lispro/lispro protamine) insulin degludec (generic Tresiba) 100U/mL PEN, VIAL insulin degludec (generic Tresiba) 200U/mL PEN insulin glargine PEN, VIAL insulin glargine (Toujeo) insulin glargine max (Toujeo Max) insulin glargine-YFGN PEN, VIAL (generic for Semglee-YFGN) LEVEMIR (insulin detemir) PEN, VIAL LYUMJEV KWIKPEN, VIAL(insulin lispro-aabc) LYUMJEV (insulin lispro-aabc) TEMPO PEN</p>	<p>Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class</p> <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> ▪ Afrezza®: Approved for T1DM on long-acting insulin with no current history of smoking or chronic lung disease ▪ Humulin® R U-500 Kwikpen: May be approved for patients who require >200 units/day ▪ Humalog U-200 Pen: May be approved for patients who require > 100 units/day

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HYPOGLYCEMICS, INSULIN AND RELATED DRUGS, continued

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	MERILOG (insulin aspart-szjj) ^{NR} SOLOSTAR PEN MERILOG (insulin aspart-szjj) ^{NR} VIAL NOVOLIN (insulin) PEN-OTC, VIAL-OTC NOVOLIN 70/30 VIAL (insulin) NOVOLOG (insulin aspart) CARTRIDGE, PEN, VIAL NOVOLOG MIX (insulin aspart/aspart protamine) PEN, VIAL REZVOGLAR (insulin glargine-aglr) KWIKPEN SEMLEE (insulin glargine) PEN, VIAL SEMLEE YFGN (insulin glargine) PEN, VIAL TOUJEO SOLOSTAR (insulin glargine)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

HYPOGLYCEMICS, MEGLITINIDES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
repaglinide (generic Prandin)	nateglinide (generic Starlix) ^{CL}	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients with: Failure of a trial of ONE preferred agent in another Hypoglycemic class OR T2DM and inadequate glycemic control

HYPOGLYCEMICS, METFORMINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
metformin IR & ER (generic Glucophage/Glucophage XR)	metformin IR 750 mg metformin ER (generic Fortamet/Glumetza) ^{CL} metformin SOLN (generic Riomet) ^{CL} RIOMET ER (metformin ER) ^{AL}	<ul style="list-style-type: none"> Metformin ER (generic Fortamet[®])/Glumetza[®]: Requires clinical reason why generic Glucophage XR[®] cannot be used Metformin solution: Prior authorization not required for age <7 years

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HYPOGLYCEMICS, SGLT2^{CL}

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
FARXIGA (dapagliflozin) ^{QL} JARDIANCE (empagliflozin) ^{QL} SYNJARDY (empagliflozin/metformin) ^{AL,QL} XIGDUO XR (dapagliflozin/metformin) ^{QL}	BRENZAVVY (bexagliflozin) ^{NR} dapagliflozin ^{CL,NR,QL} (generic Farxiga) dapagliflozin/metformin ^{QL} (generic Xigduo) INPEFA (sotagliflozin) ^{QL TAB} INVOKAMET (canagliflozin/ metformin) ^{QL} INVOKAMET XR (canagliflozin/metformin) ^{QL} INVOKANA (canagliflozin) SEGLUROMET (ertugliflozin/metformin) ^{QL} STEGLATRO (ertugliflozin) ^{QL} SYNJARDY XR (empagliflozin/ metformin) ^{AL,QL}	<p>Preferred agents require a diagnosis of Type II diabetes AND a trial and failure or intolerance to metformin,</p> <p>OR</p> <p>A diagnosis of ASCVD or Heart Failure, or Chronic Kidney Disease associated with a diagnosis of Type II diabetes (no metformin trial required)</p> <ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class <p>Drug Specific Criteria:</p> <ul style="list-style-type: none"> Farxiga/ dapagliflozin: May be approved for a diagnosis of Heart Failure without a diagnosis of diabetes May be approved for a diagnosis of chronic kidney disease at risk of progression without a diagnosis of diabetes Jardiance: May be approved for a diagnosis of Heart Failure without a diagnosis of diabetes

HYPOGLYCEMICS, SULFONYLUREAS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
glimepiride 1mg, 2mg, 4mg, 6mg, 8mg (generic Amaryl) glipizide IR & ER (generic Glucotrol/ Glucotrol XL) glyburide (generic Diabeta/Glynase)	chlorpropamide glimepiride 3mg (generic Amaryl) tolazamide tolbutamide	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

SULFONYLUREA COMBINATIONS

glipizide/metformin
glyburide/metformin (generic Glucovance)

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HYPOGLYCEMICS, TZD

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

IDIOPATHIC PULMONARY FIBROSIS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
pirfenidone (generic Esbriet) ^{QL}	ESBRIET (pirfenidone) ^{QL} JASCAYD (nerandomilast) ^{NR} OFEV (nintedanib esylate) ^{CL}	<ul style="list-style-type: none"> ▪ Non-preferred agent requires trial of preferred agent within this drug class with the same indication ▪ FDA approved indication required – ICD-10 diagnosis code

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IMMUNOMODULATORS, ASTHMA ^{CL}

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
FASENRA (benralizumab) ^{AL} PEN XOLAIR (omalizumab) AUTO-INJ^{AL,QL}, SYR^{AL,QL}	EXDENSUR (depemokimab-ulaa) ^{AL,NR} SYR NUCALA (mepolizumab) ^{AL} AUTO-INJ, SYR TEZSPIRE (tezepelumab-ekko) ^{AL,CL} PEN	<p>Immunomodulators Self-Injectable PA Form</p> <ul style="list-style-type: none"> ▪ All agents require prior authorization AND an FDA-approved diagnosis for approval ▪ Non-preferred agents require a trial of a preferred agent within this drug class with the same indication ▪ For asthma indications: All agents must be prescribed by or in consultation with an allergist, immunologist, or pulmonologist ▪ Agents listed may have other FDA approved indications, and will be subject to prior authorization <p>Drug Specific Criteria:</p> <ul style="list-style-type: none"> ▪ Dupixent: (For other indications, see Immunomodulators, Atopic Dermatitis and COPD therapeutic classes). For Eosinophilic Asthma or Corticosteroid Dependent Asthma: Patients must be ages 6 and older. Documentation of moderate to severe asthma with either eosinophils ≥ 150 + 1 exacerbation OR oral corticosteroid dependency AND prior drug therapy of med-high or max-tolerated inhaled corticosteroid + controller OR max-tolerated inhaled corticosteroid / long-acting beta agonist combo ▪ Tezspire Pen: Does not require a trial of a preferred agent for severe asthma that is non-Type 2 (EOS and IgE asthma). Prior authorization still applies for approval (see also Immunomodulators Self-Injectable PA Form)

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IMMUNOMODULATORS, ATOPIC DERMATITIS^{AL}

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
<p>ADBRY (tralokinumab-ldrm) <small>AL,CL,QL</small> SUB-Q ADBRY 300mg/2mL <small>(tralokinumab-ldrm)</small> <small>AL,CL,QL</small> AUTOINJ</p> <p>DUPIXENT (dupilumab) <small>AL,CL</small> PEN,SYR</p> <p>EBGLYSS (lebrikizumab-lbkz) <small>AL,CL,QL</small> PEN, SYRINGE</p> <p>ELIDEL (pimecrolimus)</p> <p>EUCRISA (crisaborole) <small>CL,QL</small></p> <p>pimecrolimus (generic Elidel)</p> <p>tacrolimus (generic Protopic)</p>	<p>ANZUPGO (delgocitinib) <small>QL</small> CREAM</p> <p>NEMLUVIO (nemolizumab-ilt) <small>AL</small></p> <p>OPZELURA (ruxolitinib phosphate) <small>CL,QL</small> CREAM</p> <p>VTAMA (tapinarof) <small>AL</small> CREAM</p> <p>ZORYVE 0.15% (roflumilast) <small>AL</small> CREAM</p> <p>ZORYVE 0.05% (roflumilast) <small>AL,NR</small> CREAM</p>	<p>Immunomodulators_Self-Injectable PA Form</p> <ul style="list-style-type: none"> Non-preferred agents require: Trial of a topical steroid AND Trial of one preferred product within this drug class with same indication. Non-preferred biologics also require treatment failure of a preferred biologic with the same indication. <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Adbry/Ebglyss: May be approved after a trial or failure of a topical corticosteroid AND a topical calcineurin inhibitor Dupixent: (For other indications, see Immunomodulators, Asthma and COPD therapeutic classes):1. Atopic Dermatitis: May be approved after a minimum of a 14-day trial of a topical corticosteroid AND a 6-week topical calcineurin inhibitor 2. Eosinophilic Esophagitis: Trial, failure, or technique difficulty to a swallowed topical corticosteroid or treatment failure of a proton pump inhibitor. Prescribed by, or in consultation with an allergist, gastroenterologist, or immunologist. Documentation that the Patient has a confirmed diagnosis of eosinophilic esophagitis with ≥ 15 eosinophils/high-power field.3. Nasal Polyps: May be approved with documentation of treatment failure or contraindication within the previous year to an intranasal corticosteroid OR systemic corticosteroid therapy OR prior nasal surgery. Prescribed by, or in consultation with an allergist, pulmonologist, or otolaryngologist [ENT].4. Prurigo Nodularis: Patient must have a diagnosis of Prurigo Nodularis with provider attestation of ≥ 20 nodular lesions. Trial and failure of a topical corticosteroid. Prescribed by, or in consultation with an allergist, dermatologist, or immunologist. Eucrisa: May be approved after a 30 day trial failure of a preferred topical corticosteroid (TCS) or topical calcineurin inhibitor (TCI) within the past 180 days; Maximum of 300 grams per year Opzelura: May be approved for a diagnosis of Atopic Dermatitis and after a trial/failure of a topical steroid and trial of a preferred agent

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IMMUNOMODULATORS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
imiquimod (generic for Aldara)	HYFTOR (sirolimus) ^{AL} GEL imiquimod (generic Zyclara) podofilox (generic Condylox) GEL, SOLN VEREGEN (sinecatechins)	<ul style="list-style-type: none"> 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
azathioprine (generic Imuran) azathioprine (generic Azasan) ^{NR} cyclosporine, modified (generic Neoral) CAPS everolimus (generic for Zortress) ^{AL} mycophenolate (generic Cellcept) CAPS, TAB mycophenolic acid RAPAMUNE (sirolimus) SOLN RAPAMUNE (sirolimus) TAB sirolimus (generic Rapamune) SOLN, TAB tacrolimus	ASTAGRAF XL (tacrolimus) AZASAN (azathioprine) cyclosporine CAP, SOFTGEL cyclosporine, modified (generic Neoral) SOLN ENVARSUS XR (tacrolimus) GENGRAF (cyclosporine, modified) CAP, SOLN mycophenolate (generic Cellcept) SUSP MYFORTIC (mycophenolate sodium) MYHIBBIN (mycophenolate) ^{AL} SUSP PROGRAF (tacrolimus) CAPS, PACKET REZUROCK (belumosudil) ^{AL,QL} TAB SANDIMMUNE (cyclosporine) CAPS, SOLN TAVNEOS (avacopan) ^{CL,QL} CAPS ZORTRESS (everolimus) ^{AL}	<p>Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class</p> <ul style="list-style-type: none"> Patients established on existing therapy will be allowed to continue <p>Drug Specific Criteria</p> <ul style="list-style-type: none"> Tavneos (avacopan) <ul style="list-style-type: none"> No trial of a preferred agent required with appropriate FDA indications with concurrent use of standard therapy, including glucocorticoids

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CL – Prior Authorization / Class Criteria apply

QL – Quantity/Duration Limit

AL – Age Limit

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INTRANASAL RHINITIS AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ANTICHOLINERGICS		
ipratropium (generic for Atrovent)		Non-preferred agents will be approved for patients who have failed a 30-day trial of ONE preferred agent within the same subclass.
ANTIHISTAMINES		
azelastine 0.1% (generic for Astelin)	azelastine 0.15% (generic for Astepro) azelastine/fluticasone (generic for Dymista) olopatadine (generic for Patanase) RYALTRIS (olopatadine/mometasone) ^{AL}	Drug-specific criteria: <ul style="list-style-type: none">▪ mometasone: Prior authorization NOT required for children ≤ 12 years▪ budesonide: Approved for use in Pregnancy (Pregnancy Category B)▪ Xhance: Indicated for treatment of nasal polyps in ≥ 18 years only
CORTICOSTEROIDS		
fluticasone Rx (generic Flonase)	BECONASE AQ (beclomethasone) budesonide (Rhinocort) ^{CL} OTC flunisolide (generic Nasalide) fluticasone (generic Flonase) OTC mometasone (generic Nasonex) ^{CL} OTC, RX NASONEX (mometasone) OTC OMNARIS (ciclesonide) QNASL 40 & 80 (beclomethasone) triamcinolone (generic Nasacort) OTC XHANCE (fluticasone) ^{CL} ZETONNA (ciclesonide)	

LEUKOTRIENE MODIFIERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
montelukast (generic Singulair) TAB^{QL}/CHEWABLE^{AL}	montelukast GRANULES (generic Singulair) ^{CL, AL} zafirlukast (generic Accolate) zileuton ER (generic 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: <ul style="list-style-type: none">▪ montelukast granules: PA not required for age < 2 years

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LINCOSAMIDES / OXAZOLIDINONES / STREPTOGRAMINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
clindamycin CAPS clindamycin palmitate SOLN linezolid TAB	CLEOCIN (clindamycin) CAPS CLEOCIN PALMITATE (clindamycin) CLEOCIN PEDIATRIC (clindamycin) ^{NR} SOLN linezolid SUSP SIVEXTRO (tedizolid phosphate) ZYVOX (linezolid) SUSP, TAB	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

LIPOTROPICS, OTHER

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BILE ACID SEQUESTRANTS		
cholestyramine (generic Questran) colestipol TAB (generic Colestid)	colesevelam (generic Welchol) ^{CL} TAB, PACKET colestipol (generic Colestid) GRANULES QUESTRAN LIGHT (cholestyramine)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within the same subclass.
TREATMENT OF HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA		
	JUXTAPID (lomitapide) ^{CL} KYNAMRO (mipomersen) ^{CL}	<p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Colesevelam: Trial not required for diabetes control and monotherapy with metformin, sulfonylurea, or insulin has been inadequate
TREATMENT OF FAMILIAL CHYLOMICRONEMIA SYNDROME (FCS)		
	TRYNGOLZA (olezarsen) ^{AL,CL,QL} INJ	<ul style="list-style-type: none"> Juxtapid/ Kynamro: <ul style="list-style-type: none"> 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
FIBRIC ACID DERIVATIVES		
fenofibrate (generic Tricor) fenofibrate (generic Lofibra) gemfibrozil (generic Lopid)	fenofibric acid (generic Fibrincor/Trilipix) fenofibrate (generic Antara/Fenoglide/ Lipofen/Triglide)	
NIACIN		
niacin ER (generic Niaspan)	NIACOR (niacin IR)	
OMEGA-3 FATTY ACIDS		
omega-3 fatty acids (generic Lovaza)	icosapent (generic Vascepa) ^{CL} omega-3 OTC	
CHOLESTEROL ABSORPTION INHIBITORS		
ezetimibe (generic Zetia)	NEXLETOL (bempedoic acid) NEXLIZET (bempedoic acid/ ezetimibe) ^{QL}	<ul style="list-style-type: none"> Tryngolza: Approved for diagnosis of familial chylomicronemia syndrome and fasting triglycerides equal to or greater than 880 mg/dL within the past 90 days and used in combination with a low-fat diet of 20 gm or less of fat per day

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LIPOTROPICS, OTHER (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
PROPROTEIN CONVERTASE SUBTILISIN/KEXIN TYPE 9 (PCSK9) INHIBITORS <p>PRALUENT (alorocumab)^{CL} REPATHA (evolocumab)^{CL} SURECLICK, SYR</p>	REPATHA (evolocumab)^{CL} PUSHTRONEX	<p>Drug-Specific Criteria</p> <p>Praluent and Repatha: May be approved for diagnoses of:</p> <ul style="list-style-type: none"> • Atherosclerotic cardiovascular disease (ASCVD) in adults • Heterozygous familial hypercholesterolemia (HeFH) <ul style="list-style-type: none"> ◦ Praluent \geq 8 years of age ◦ Repatha \geq 10 years of age • Homozygous familial hypercholesterolemia (HoFH) <ul style="list-style-type: none"> ◦ Praluent \geq 18 years of age ◦ Repatha \geq 10 years of age <p>AND</p> <ul style="list-style-type: none"> • Trial and failure or intolerance to a statin for 8 continuous weeks • Concurrent use of a maximally tolerated statin must continue, except for statin-induced rhabdomyolysis or a contraindication to a statin • Failure to reach target LDL-C levels: <ul style="list-style-type: none"> ◦ ASCVD – $<$ 70 mg/dL ◦ Very high risk ASCVD – $<$ 55mg/dL ◦ HeFH – $<$ 100 mg/dL

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LIPOTROPICS, STATINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
STATINS		
atorvastatin (generic Lipitor) ^{QL} lovastatin (generic Mevacor) pravastatin (generic Pravachol) rosuvastatin (generic Crestor) simvastatin (generic Zocor)	ALTOPREV (lovastatin ER) ^{CL} ATORVALIQ (atorvastatin) ^{QL} SUSP EZALLOR SPRINKLE (rosuvastatin) ^{QL} fluvastatin ER (generic Lescol XL) ^{CL} fluvastatin IR (generic Lescol) LIVALO (pitavastatin) ^{AL,QL} pitavastatin (generic Livalo) ^{AL,QL} ZYPITAMAG (pitavastatin)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class, within the last 12 months <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Altoprev®: One of the TWO trials must be IR lovastatin Combination products: Require clinical reason why individual ingredients cannot be used fluvastatin ER: Requires trial of TWO preferred agents AND trial of IR fluvastatin OR clinical reason IR cannot be used simvastatin/ezetimibe: Approved for 3-month continuous trial of ONE standard dose statin
STATIN COMBINATIONS^{CL}		
	atorvastatin/amlodipine (generic Caduet) simvastatin/ezetimibe (generic Vytorin)	

MACROLIDES AND KETOLIDES, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
MACROLIDES		
azithromycin (generic Zithromax) clarithromycin SUSP, TAB (generic Biaxin) E.E.S. SUSP (erythromycin ethylsuccinate)	clarithromycin ER (generic Biaxin XL) E.E.S. TAB (erythromycin ethylsuccinate) ERY-TAB (erythromycin) ERYPED SUSP (erythromycin) erythromycin ethylsuccinate SUSP ERYTHROCIN (erythromycin) erythromycin base CAPS, TAB	<ul style="list-style-type: none"> Non-preferred agents require clinical reason why preferred products within this drug class cannot be used AND \geq 3-day trial on a preferred product

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METHOTREXATE

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
methotrexate PF VIAL, TABLET, VIAL	JYLAMVO (methotrexate) SOLN OTREXUP (methotrexate) SUB-Q RASUVO (methotrexate) SUB-Q TREXALL (methotrexate) TAB XATMEP (methotrexate) ^{CL} SOLN	<p>Non-preferred agents require a trial of the preferred agent AND will be approved for an FDA-approved indication</p> <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> ▪ XatmepTM: Indicated for pediatric patients only

MOVEMENT DISORDERS^{CL}

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
AUSTEDO (deutetrabenazine) ^{AL,CL,QL} AUSTEDO XR (deutetrabenazine) ^{AL,CL,QL} AUSTEDO XR Titration Pack (deutetrabenazine) ^{AL,CL} INGREZZA (valbenazine) ^{AL,CL,QL} CAPS, SPRINKLES tetabenazine (generic for Xenazine) ^{CL}	INGREZZA (valbenazine) ^{AL,CL} INITIATION PACK XENAZINE (tetrabenazine) ^{CL}	<p>All drugs require an FDA approved indication – ICD-10 diagnosis code required.</p> <p>Non-preferred agents require a trial and failure of a preferred agent with the same indication or a clinical reason why a preferred agent in this class cannot be used.</p> <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> ▪ Austedo/Austedo XR/Ingrezza: 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 ▪ tetabenazine: Diagnosis of chorea with Huntington's Disease

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MULTIPLE SCLEROSIS DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
AVONEX (interferon beta-1a) ^{QL} COPAXONE 20mg (glatiramer) ^{QL} dimethyl fumarate (generic Tecfidera) fingolimod (generic Gilenya) ^{QL} KESIMPTA (Ofatumumab) ^{CL,QL} teriflunomide (generic Aubagio) ^{QL}	AUBAGIO (teriflunomide) ^{QL} BAFIERTAM (monomethyl fumarate) ^{QL} BETASERON (interferon β -1b) ^{QL} cladribine (generic Mavenclad) ^{NR} dalfampridine (generic Ampyra) ^{CL,QL} dimethyl fumarate (generic Tecfidera Starter Pack) Starter Pack EXTAVIA (interferon β -1b) ^{QL} GILENYA (fingolimod) ^{QL} glatiramer (generic Copaxone) ^{QL} MAVENCLAD (cladribine) TAB MAYZENT (siponimod) ^{QL} PLEGRIDY (peginterferon β-1a) ^{CL,QL} PONVORY (ponesimod) REBIF (interferon β -1a) ^{QL} TASCENSO ODT (fingolimod) TAB^{AL} TECFIDERA (dimethyl fumarate) VUMERTY (diroximel) ^{QL} ZEPOSIA (ozanimod) ^{AL,CL,QL}	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Ampyra/ dalfampridine: Approved for diagnosis of gait disorder associated with MS AND EDSS score ≤ 7 Kesimpta: Approved for patients who have failed a trial of a preferred injectable agent within this class Plegridy: Approved for diagnosis of relapsing MS Zeosia: Approved for a diagnosis of relapsing forms of multiple sclerosis (MS) with trial of ONE preferred agent OR a diagnosis of moderately to severely active ulcerative colitis and treatment failure of a preferred adalimumab product.

NITROFURAN DERIVATIVES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
nitrofurantoin macrocrystals CAPS (generic Macrodantin) nitrofurantoin monohydrate- macrocrystals CAPS (generic Macrobid)	nitrofurantoin SUSP (generic Furadantin)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

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NSAIDs, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
COX-I SELECTIVE		
diclofenac sodium (generic Voltaren) ibuprofen OTC, Rx (generic Advil, Motrin) CHEW, DROPS, SUSP, TAB ibuprofen OTC (generic Advil, Motrin) CAPS indomethacin (generic Indocin) CAPS ketorolac (generic Toradol) meloxicam (generic Mobic) TAB nabumetone (generic Relafen) naproxen Rx, OTC (generic Naprosyn) naproxen enteric coated sulindac (generic Clinoril)	diclofenac potassium (generic Cataflam, Zipsor) diclofenac SR (generic Voltaren-XR) diflunisal (generic Dolobid) etodolac & SR (generic Lodine/XL) fenoprofen (generic Nalfon) flurbiprofen (generic Ansaid) ibuprofen/famotidine (generic Duexis) ^{CL} ibuprofen 300mg TAB indomethacin ER (generic Indocin) ketoprofen & ER (generic Orudis) ketorolac (generic Sprix Nasal) ^{CL,QL} NASAL meclofenamate (generic Meclofen) ^{CL} mefenamic acid (generic Ponstel) meloxicam (generic Vivlodex) ^{CL,QL} CAP meloxicam (generic Mobic) SUSP naproxen CR (generic Naprelan) naproxen (generic Naprosyn) SUSP naproxen sodium (generic Anaprox) naproxen-esomeprazole (generic Vimovo) ORUDIS (ketoprofen) ^{NR} CAP oxaprozin (generic Daypro) piroxicam (generic Feldene) tolmetin (generic Tolectin) ZYBIC (meloxicam) ^{NR, AL} SUSP	<ul style="list-style-type: none"> Non-preferred agents within COX-1 SELECTIVE subclass will be approved for patients who have failed no less than 30-day trial of TWO preferred agents within the same subclass. <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> meclofenamate: Approvable without trial of preferred agents for menorrhagia Sprix/ketorolac Nasal: Approved for patients unable to tolerate, swallow OR absorb oral NSAIDs OR contraindication OR trial of TWO preferred oral NSAIDs

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NSAIDs, ORAL (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	COX-I SELECTIVE (continued)	
	ALL BRAND NAME NSAIDs including: DOLOBID (diflunisal) ^{AL} 250mg TAB DUEXIS (ibuprofen/famotidine) ^{CL} NALFON (fenoprofen) RELAFEN DS (nabumetone)	<ul style="list-style-type: none"> All combination agents require a clinical reason why individual agents can't be used separately
	NSAID/GI PROTECTANT COMBINATIONS^{CL} diclofenac/misoprostol (generic Arthrotec)	
	COX-II SELECTIVE celecoxib (generic Celebrex)	VYSCOXA SUSP (celecoxib) ^{AL,NR}

NSAIDs, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
diclofenac sodium GEL (OTC only)	diclofenac PUMP (generic Pennsaid) ^{CL} diclofenac SOLN (generic Pennsaid) FLECTOR PATCH (diclofenac) ^{CL} LICART PATCH (diclofenac) ^{CL}	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed ONE preferred agent within this drug class AND a clinical reason why patient cannot use oral dosage form.

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ONCOLOGY AGENTS, ORAL, BREAST

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	CDK 4/6 INHIBITOR	
	IBRANCE (palbociclib) KISQALI (ribociclib) KISQALI FEMARA CO-PACK VERZENIO (abemaciclib)	<ul style="list-style-type: none"> ▪ Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines ▪ Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy
	CHEMOTHERAPY	
capecitabine (generic Xeloda) cyclophosphamide	XELODA (capecitabine)	Drug-specific criteria
		<ul style="list-style-type: none"> ▪ anastrozole: May be approved for malignant neoplasm of male breast (male breast cancer) ▪ Fareston/toremifene: 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
	HORMONE BLOCKADE	
anastrozole (generic Arimidex) ^{CL} exemestane (generic Aromasin) letrozole (generic Femara) ^{CL} tamoxifen citrate (generic Nolvadex)	INLURIYO (imlunestrant) ^{NR} ORSERDU (elacestrant) SOLTAMOX SOLN (tamoxifen) ^{CL} toremifene (generic Fareston) ^{CL}	
	OTHER	
	ITOVEBI (inavolisib) NERLYNX (neratinib) PIQRAY (alpelisib) lapatinib (generic Tykerb) TALZENNA (talazoparib tosylate) ^{QL} TUKYSA (tucatinib) ^{QL} TRUQAP (capivasertib)	

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ONCOLOGY AGENTS, ORAL, HEMATOLOGIC

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	ALL	
mercaptopurine	PURIXAN (mercaptopurine) ^{AL,CL} mercaptopurine (generic Purixan) ^{AL,CL} SUSP	<ul style="list-style-type: none"> Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines
	AML	
	DAURISMO (glasdegib maleate) ^{QL} IDHIFA (enasidenib) REZLIDHIA (olutasidenib) ^{QL} RYDAPT (midostaurin) TIBSOVO (ivosidenib) ^{QL} VANFLYTA (quizartinib) XOSPATA (gilteritinib) ^{QL}	<ul style="list-style-type: none"> Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy <p>Drug-specific criteria</p> <ul style="list-style-type: none"> Hydrea®: Requires clinical reason why generic cannot be used Purixan/ mercaptopurine: Prior authorization not required for age ≤ 12 or for documented swallowing disorder Xpovio: Indicated for relapsed or refractory multiple myeloma. Requires concomitant therapy with dexamethasone
	CLL	
	COPIKTRA (duvelisib) ^{QL} IMBRUVICA (ibrutinib) VENCLEXTA (venetoclax) ZYDELIG (idelalisib)	
	CML	
hydroxyurea (generic Hydrea) imatinib (generic Gleevec)	BOSULIF (bosutinib) DANZITEN (nilotinib) dasatinib (generic Sprycel) GLEEVEC (imatinib) HYDREA (hydroxyurea) ^{CL} ICLUSIG (ponatinib) IMKELDI (imatinib) nilotinib HCL (generic Tasigna) nilotinib TARTRATE (generic Dansiten) nilotinib TARTRATE ^{NR} (AG) CAPS PHYRAGO (dasatinib) ^{NR} SCEMBLIX (asciminib) SPRYCEL (dasatinib) TASIGNA (nilotinib)	

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ONCOLOGY AGENTS, ORAL, HEMATOLOGIC, continued

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	MPN JAKAFI (ruxolitinib)	<ul style="list-style-type: none"> Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines
	MYELOMA REVLIMID ^{QL} (lenalidomide)	<ul style="list-style-type: none"> Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy
MATULANE (procarbazine) tretinoin (generic for Vesano ^{AL} id)	lenalidomide ^{QL} (generic Revlimid) NINLARO (ixazomib) POMALYST (pomalidomide) THALOMID (thalidomide) XPOVIO (selinexor) ^{CL}	<p>Drug-specific criteria</p> <ul style="list-style-type: none"> Hydrea®: Requires clinical reason why generic cannot be used Purixan/ mercaptopurine: Prior authorization not required for age ≤ 12 or for documented swallowing disorder Xpovio: Indicated for relapsed or refractory multiple myeloma. Requires concomitant therapy with dexamethasone
	BRUKINSA (zanubrutinib) ^{QL} CALQUENCE (acalabrutinib) ^{QL} INREBIC (federatinib dihydrochloride) ^{QL} INQOVI (decitabine/cedazuridine) OJJAARA (momelotinib) REVUFORJ (revumenib) TAB VONJO (pacritinib) ^{QL} ZOLINZA (vorinostat)	

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ONCOLOGY AGENTS, ORAL, LUNG

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	ALK	
	ALECENSA (alectinib) ALUNBRIG (brigatinib) ^{QL} LORBRENA (lorlatinib) ^{QL} ZYKADIA (ceritinib) CAPS, TAB	<ul style="list-style-type: none"> ▪ Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines
	ALK / ROS1 / NTRK	
	AUGTYRO (repotrectinib) CAPS ROZLYTREK (entrectinib) ^{QL} CAPS, PELLETS XALKORI (crizotinib) CAPS, PELLETS	<ul style="list-style-type: none"> ▪ Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy
	EGFR	
erlotinib (generic for Tarceva)	gefitinib (generic Iressa) GILOTTRIF (afatinib) IRESSA (gefitinib) LAZCLUZE (lazertinib) TAGRISSO (osimertinib) TARCEVA (erlotinib) VIZIMPRO (dacomitinib) ^{QL}	
	HER2/ TKD	
	HERNEXEOS (zongertinib) ^{NR} HYRNUO (sevabertinib) ^{NR}	
	OTHER	
	GAVRETO (pralsetinib) ^{QL} HYCAMTIN (topotecan) KRAZATI (adagrasib) LUMAKRAS (sotrasib) ^{QL} RETEVMO (selpercatinib) ^{AL} TABRECTA (capmatinib) ^{QL} TEPMETKO (tepotinib) ^{QL}	

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ONCOLOGY AGENTS, ORAL, OTHER

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
temozolomide (generic Temodar)	AVMAPKI-FAKZYNJA (avutometinib/defactinib) Combo-Pack AYVAKIT (avapritinib) ^{AL,QL} BALVERSA (erdafitinib) CAPRELSA (vandetanib) COMETRIQ (cabozantinib) FRUZAQLA (fruquintinib) CAPS GOMEKLI (mirdametinib) ^{AL} CAPS, TABS FOR ORAL SUSP IWILFIN (eflornithine) JAYPIRCA (pirtobrutinib) KOSELUGO (selumetinib) ^{AL} LONSURF (trifluridine/tipiracil) LYNPARZA (olaparib) LYTGOBI (futibatinib) MODEYSO (dordaviprone) ^{NR} OGSIVEO (nirogacestat) TAB PEMAZYRE (pemigatinib) ^{QL} QINLOCK (ripretinib) ROMVIMZA (vimseltinib) CAPS RUBRACA (rucaparib) STIVARGA (regorafenib) TAZVERIK (tazemetostat) ^{AL} TURALIO (pexidartinib) ^{QL} VITRAKVI (larotrectinib) CAPS, SOLN VORANIGO (vorasidenib) ^{AL} TAB ZEJULA (niraparib) TAB	<ul style="list-style-type: none"> ▪ Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines ▪ Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy

ONCOLOGY AGENTS, ORAL, PROSTATE

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
abiraterone (generic Zytiga) ^{AL,QL} bicalutamide (generic Casodex)	AKEEGA (niraparib/abiraterone) ERLEADA (apalutamide) ^{QL} nilutamide (generic Nilandron) NUBEQA (darolutamide) ^{QL} ORGOVYX (relugolix) ^{AL} XTANDI (enzalutamide) ^{AL,QL} YONSA (abiraterone acetone, submicronized) ZYTIGA (abiraterone) ^{AL,QL}	<ul style="list-style-type: none"> ▪ Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines ▪ Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy

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ONCOLOGY AGENTS, ORAL, RENAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
everolimus (generic Afinitor) TAB sunitinib malate (generic Sutent) CAPS VOTRIENT (pazopanib)	AFINITOR DISPERZ (everolimus) ^{CL} CABOMETYX (cabozantinib) everolimus SUSP (generic Afinitor Disperz) FOTIVDA (tivozanib) INLYTA (axitinib) LENVIMA (lenvatinib) NEXAVAR (sorafenib) pazopanib (generic Votrient) TAB sorafenib (generic Nexavar) SUTENT (sunitinib) CAPS TORPENZ (generic everolimus) TAB WELIREG (belzutifan) ^{QL}	<ul style="list-style-type: none"> Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy

ONCOLOGY AGENTS, ORAL, SKIN

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	BASAL CELL ERIVEDGE (vismodegib) ODOMZO (sonidegib) ^{CL}	<ul style="list-style-type: none"> Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines
MEKINIST (trametinib) TAFINLAR (dabrafenib)	BRAF MUTATION BRAFTOVI (encorafenib) COTELLIC (cobimetinib) MEKINIST (trametinib) SOLN MEKTOVI (binimatinib) OJEMDA (tovorafenib) SUSP^{AL}, TAB TAFINLAR (dabrafenib) SUSP ZELBORAF (vemurafenib)	<ul style="list-style-type: none"> Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy

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OPHTHALMICS, ALLERGIC CONJUNCTIVITIS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ALREX (loteprednol 0.2%) ketotifen OTC (generic Zaditor) olopatadine OTC (Pataday once daily) olopatadine OTC (Pataday twice daily)	ALOCRIL (nedocromil) ALOMIDE (lodoxamide) azelastine (generic Optivar) BEPREVE (bepotastine besilate) bepotastine besilate (generic Bepreve) epinastine (generic Elestat) LASTACAFT (alcaftadine) OTC loteprednol 0.2% (generic Alrex) olopatadine DROPS (generic Pataday) olopatadine 0.1% (generic Patanol) PATADAY OTC (olopatadine 0.2%) PATADAY XS (olopatadine 0.7%) ZERVIATE (certirizine) ^{AL}	<ul style="list-style-type: none">Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class

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OPHTHALMICS, ANTIBIOTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
FLUOROQUINOLONES		
ciprofloxacin SOLN (generic Ciloxan) ofloxacin (generic Ocuflor)	besifloxacin (generic Besivance)^{NR} BESIVANCE (besifloxacin) CILOXAN (ciprofloxacin) gatifloxacin 0.5% (generic Zymaxid) moxifloxacin (generic Vigamox) moxifloxacin (generic Moxeza) VIGAMOX (moxifloxacin)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a one-month trial of TWO preferred agents within the same subclass <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Azasite®: Approval only requires trial of erythromycin Natacyn®: Approved for documented fungal infection
MACROLIDES		
erythromycin	AZASITE (azithromycin) ^{CL}	
AMINOGLYCOSIDES		
gentamicin SOLN tobramycin (generic Tobrex drops)	TOBREX OINT (tobramycin)	
OTHER OPHTHALMIC AGENTS		
bacitracin/polymyxin B (generic Polysporin) polymyxin B/trimethoprim (generic Polytrim)	bacitracin NATACYN (natamycin) ^{CL} neomycin/bacitracin/polymyxin B OINT neomycin/polymyxin B/gramicidin sulfacetamide SOLN (generic Bleph-10) sulfacetamide OINT	

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OPHTHALMICS, ANTIBIOTIC-STEROID COMBINATIONS

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

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OPHTHALMICS, ANTI-INFLAMMATORIES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CORTICOSTEROIDS		
fluorometholone 0.1% (generic FML) OINT LOTEMAX SOLN (loteprednol 0.5%) MAXIDEX (dexamethasone) PRED MILD (prednisolone 0.12%) prednisolone acetate 1% (generic Omnipred, Pred Forte)	dexamethasone (generic Maxidex) difluprednate (generic Durezol) DUREZOL (difluprednate) FLAREX (fluorometholone) FML (fluorometholone 0.1% SOLN) FML FORTE (fluorometholone 0.25%) INVELTYS (loteprednol etabonate) LOTEMAX OINT, GEL (loteprednol) loteprednol GEL (generic Lotemax Gel) loteprednol 0.5% SOLN (generic Lotemax SOLN) prednisolone sodium phosphate prednisolone sodium phosphate 1%	<ul style="list-style-type: none"> ▪ ALL sub-classes unless listed below: 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 within the same sub-class
NSAID		
diclofenac (generic Voltaren) ketorolac 0.5% (generic Acular)	ACUVAIL (ketorolac 0.45%) bromfenac 0.09% (generic Bromday) bromfenac (generic Bromsite) bromfenac 0.07% (generic Prolensa) BROMSITE (bromfenac) flurbiprofen (generic Ocufen) ILEVRO (nepafenac 0.3%) ketorolac LS 0.4% (generic Acular LS) NEVANAC (nepafenac) PROLENSA (bromfenac 0.07%)	

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OPHTHALMICS, DRY EYE AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
RESTASIS (cyclosporine) RESTASIS MULTIDOSE (cyclosporine) XIIDRA (lifitegrast)	CEQUA (cyclosporine) ^{QL} cyclosporine (generic Restasis) EYSUVIS (loteprednol etabonate) ^{QL} MIEBO (perfluorohexyloctane) TRYPTYR (acoltremon) SOLN TYRVAYA (varenicline tartrate) ^{QL} VERKAZIA (cyclosporine emulsion) VEVYE (cyclosporine)	<ul style="list-style-type: none">Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

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OPHTHALMICS, GLAUCOMA

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
MIOTICS		
pilocarpine	VURITY (pilocarpine)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within the same subclass.
SYMPATHOMIMETICS		
ALPHAGAN P (brimonidine 0.15%) brimonidine 0.2% (generic Alphagan)	ALPHAGAN P (brimonidine 0.1%) apraclonidine (generic lopidine) brimonidine P 0.15% (generic Alphagan P 0.15%) brimonidine 0.1% (generic Alphagan P 0.1%)	<p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Rhopressa and Rocklatan: Electronically approved for patients who have a trial of ONE generic agent, within ophthalmic - glaucoma within 180 days
BETA BLOCKERS		
levobunolol (generic Betagan) timolol (generic Timoptic)	betaxolol (generic Betoptic) BETIMOL (timolol) BETOPTIC S (betaxolol) carteolol (generic Ocupress) timolol (generic Betimol) timolol (generic Istalol) timolol (generic Timoptic Ocudose) TIMOPTIC (timolol) OCUDOSE	
CARBONIC ANHYDRASE INHIBITORS		
dorzolamide (generic for Trusopt)	AZOPT (brinzolamide) brinzolamide (generic Azopt)	
PROSTAGLANDIN ANALOGS		
latanoprost (generic for Xalatan) TRAVATAN Z (travoprost)	bimatoprost (generic Lumigan) IYZEH (latanoprost) OMLONTI (omidenepag isopropyl) ^{NR} tafluprost (generic Zioptan) travoprost (generic Travatan Z) VYZULTA (latanoprostene) XALATAN (latanoprost) ZIOPTAN (tafluprost)	
COMBINATION DRUGS		
COMBIGAN (brimonidine/timolol) dorzolamide/timolol (generic Cosopt)	brimonidine/timolol (generic Combigan) COSOPT (dorzolamide/timolol) dorzolamide/timolol PF (generic Cosopt PF) SIMBRINZA (brinzolamide/brimonidine)	

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OPHTHALMICS, GLAUCOMA (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
OTHER		<ul style="list-style-type: none"> ▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within the same subclass. <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> ▪ Rhopressa and Rocklatan: Electronically approved for patients who have a trial of ONE generic agent, within the ophthalmic - glaucoma class within 180 days

OPIOID DEPENDENCE TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
buprenorphine ^{AL,QL} SL buprenorphine/naloxone ^{AL,QL} TAB (SL) naltrexone TAB SUBOXONE (buprenorphine/naloxone) ^{AL,QL} FILM	buprenorphine/naloxone ^{AL,QL} FILM lofexidine (generic Lucemyra) ^{CL,QL} LUCEMYRA (lofexidine) ^{CL,QL} ZUBSOLV (buprenorphine/naloxone) ^{AL,QL}	<p>Opioid Dependence Treatment PA Form</p> <p>Opioid Dependence Treatment Informed Consent</p> <ul style="list-style-type: none"> ▪ Non-preferred agents require a treatment failure of a preferred drug or patient-specific documentation of why a preferred product is not appropriate for the patient. <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> ▪ Lucemyra/ lofexidine: Approved for FDA approved indication and dosing per label. Trial of preferred product not required.

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OPIOID-REVERSAL TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
naloxone NASAL(Rx), VIAL NARCAN (naloxone) NASAL (OTC)	KLOXXADO (naloxone) NASAL naloxone (generic Narcan) OTC NASAL naloxone (generic Narcan) (Rx) SYR NARCAN (naloxone) NASAL (Rx) OPVEE (nalmefene) ^{AL} NASAL REXTOVY (naloxone) NASAL ZIMHI (naloxone) SYR ZURNAL (nalmefene injection) ^{NR}	<ul style="list-style-type: none"> Non-preferred agents will be approved with documentation of why preferred products within this drug class are not appropriate for the patient

OTIC ANTI-INFECTIVES & ANESTHETICS

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

OTIC ANTIBIOTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CIPRO HC (ciprofloxacin/ hydrocortisone) ciprofloxacin/dexamethasone (generic Ciprodex) neomycin/polymyxin/hydrocortisone (generic Cortisporin) ofloxacin (generic Floxin)	ciprofloxacin ciprofloxacin/fluocinolone (generic Otovel) ciprofloxacin/ hydrocortisone (generic Cipro HC) ^{NR} CORTISPORIN TC (colistin/neomycin thonzonium/hydrocortisone OTOVEL (ciprofloxacin/fluocinolone)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

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PAH (PULMONARY ARTERIAL HYPERTENSION AGENTS), ORAL AND INHALED

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ambrisentan (generic Letairis) REVATIO (sildenafil) ^{CL,QL} TAB sildenafil (generic Revatio) ^{CL} SUSP tadalafil (generic for Adcirca) ^{CL} TRACLEER (bosentan) TAB	ADEMPAS (riociguat) ^{CL} ADCIRCA (tadalafil) ^{CL} bosentan (generic Tracleer) TAB, TAB for SUSPENSION ^{NR} LETAIRIS (ambrisentan) LIQREV (sildenafil) ^{CL} SUSP OPSUMIT (macitentan) OPSYNVI (macitentan and tadalafil) TAB ORENITRAM ER (treprostинil) REVATIO (sildenafil) ^{CL} SUSP sildenafil (generic Revatio) ^{CL} TAB TADLIQ (tadalafil) ^{CL} SUSP TRACLEER (bosentan) TAB FOR SUSPENSION TYVASO DPI (treprostинil) INHL TYVASO (treprostинil) INHL PWDR UPTRAVI (selexipag) VENTAVIS (iloprost) INHALATION YUTREPIA (treprostинil) ^{NR} INHAL CAP	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class within the last 6 months <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Adcirca/Liqrev/ Revatio/sildenafil tablets and suspension/tadalafil: 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 Liqrev/ Revatio suspension: Requires clinical reason why preferred sildenafil suspension cannot be used

PANCREATIC ENZYMES

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

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PEDIATRIC VITAMIN PREPARATIONS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CHILD MVI (mvi, ped mvi no. 19/FA, ped mvi no. 17) OTC CHEW	DEKAs PLUS ^{AL, CL}	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class
CHILDREN'S MVI-IRON OTC CHEW (ped mvi no. 91/iron fum)	FLORAFOL(mvi and fluoride) CHEW OTC, DROPS-OTC	Drug specific criteria:
CHILDREN'S CHEWABLES OTC (ped mvi no. 25/FA, ped mvi no. 31 /iron/FA, ped mvi no.17/iron sulf)	FLORAFOL FE PEDIATRIC DROPS OTC	<ul style="list-style-type: none"> DEKAs Plus: Approved for diagnosis of Cystic Fibrosis and does not require a trial of a preferred agent
CHILDREN'S VITAMINS W/ IRON CHEW OTC (mvi with iron)	FLORIVA (ped mvi no.85/fluoride) CHEW	
FLUORIDE/VITAMINS A,C,AND D DROPS (ped mvi A,C,D3 no.21/ fluoride)	FLORIVA PLUS (ped mvi no.161/fluoride) OTC-DROPS	
MULTIVITAMINS W/ FLUORIDE (PEDI MVI NO.2 W-FLUORIDE) DROPS	MULTI-VIT-FLOR (ped mvi no.205/fluoride) CHEW	
MULTIVITS W/ IRON & FLUORIDE DROPS (ped mvi no. 45/fluoride/iron)	PEDI MULTIVIT A,C,AND D3 NO.21 DROPS OTC	
PED MVI NO.17 W/ FLUORIDE CHEW	PEDI MVI NO.22 WITH FLUORIDE ^{NR} DROPS-OTC	
POLY-VITAMIN (ped mvi no. 212) DROPS OTC	PEDI MVI NO.242/FLUORIDE CHEW-OTC	
POLY-VITAMIN W/ IRON (ped mvi no. 207 w/ferrous sulf) DROPS OTC	POLY-VI-FLOR (ped mvi no.217/fluoride, ped mvi no. 205/fluoride) CHEW	
TRI-VITAMIN W/ FLUORIDE (ped mvi A,C, D3 no. 21/fluoride)	POLY-VI-FLOR (ped mvi no.213 w/fluoride) DROPS	
	POLY-VI-FLOR W/ IRON (ped mvi no. 205/fluoride/iron) CHEW	
	POLY-VI-FLOR W/ IRON (ped mvi no. 214/fluoride/iron) DROPS	

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PEDIATRIC VITAMIN PREPARATIONS, continued

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	<p>QUFLORA (ped mvi no.84/fluoride, ped mvi no. 63/fluoride, ped mvi no. 83/fluoride)</p> <p>QUFLORA FE (ped mvi 142/iron/fluoride, ped mvi no. 151/iron/fluoride) CHEW</p> <p>QUFLORA (ped mvi no.157/ fluoride OTC</p> <p>SOLUVITA A,C,D WITH FLUORIDE DROPS OTC</p> <p>TRI-VI-FLOR (ped mvi A,C,D3 no.38/fluoride) DROPS</p>	<ul style="list-style-type: none">Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class <p>Drug specific criteria:</p> <ul style="list-style-type: none">DEKAs Plus: Approved for diagnosis of Cystic Fibrosis and does not require a trial of a preferred agent

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PENICILLINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
amoxicillin CAPS, CHEWABLE TAB, SUSP, TAB ampicillin CAPS dicloxacillin penicillin VK	PIVYA (pivmecillinam) ^{CL,NR} TAB	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a 3-day trial of ONE preferred agent within this drug class <p>Drug Specific Criteria</p> <ul style="list-style-type: none"> Pivya tablets: Approved for treatment of female patients 18 years of age and older with uncomplicated urinary tract infections (uUTI) caused by <i>E. coli</i>, <i>Proteus mirabilis</i> and <i>Staphylococcus saprophyticus</i>.

PHOSPHATE BINDERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
calcium acetate TAB sevelamer carbonate (generic Renvela) PWD PACK, TAB	AURYXIA (ferric citrate) calcium acetate CAPS CALPHRON OTC (calcium acetate) ferric citrate (generic Auryxia) ^{NR} lanthanum (generic FOSRENOL) PHOSLYRA (calcium acetate) RENAGEL (sevelamer HCl) RENVELA (sevelamer carbonate) PWD PACK, TAB sevelamer HCl (generic Renagel) VELPHORO (sucroferric oxyhydroxide) XPHOZAH (tenapanor) TAB	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class within the last 6 months

PLATELET AGGREGATION INHIBITORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
aspirin BRILINTA (ticagrelor) clopidogrel (generic Plavix) dipyridamole (generic Persantine) prasugrel (generic Effient)	aspirin/dipyridamole (generic Aggrenox) ticlopidine (generic Ticlid) ticagrelor (generic Brilinta) ^{NR} YOSPRALA (aspirin/omeprazole)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class OR documented clopidogrel resistance

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Additional covered agents can be looked up using the Drug Look-up Tool at:

<https://ne.primetherapeutics.com/drug-lookup>

PRENATAL VITAMINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
FE C/FA PNV 2/IRON B-G SUC-P/FA/OMEGA-3 PNV NO.118/IRON FUMARATE/FA CHEW TAB PNV NO.15/IRON FUM & PS CMP/FA PNV WITH CA, NO.72/IRON/FA PNV WITH CA, NO.74/IRON/FA OTC PNV#16/IRON FUM & PS/FA/OM-3 PNV119/IRON FUMARATE/FA/DSS PRENATAL MULTI OTC PRENATAL VIT #76/IRON, CARB/FA PRENATAL VIT/FE FUMARATE/FA OTC SELECT-OB + DHA STUART ONE OTC TENDER-OB OTC TRICARE TRINATAL RX 1 VITAFOL CHEW TAB VITAFOL FE+ VITAFOL ULTRA VITAFOL-OB VITAFOL-OB+DHA VITAFOL-ONE	ALTRIXA OB ^{NR} OTC CITRANATAL B-CALM COMPLETENATE CHEW TAB ENBRACE HR MARNATAL-F MULTI-MAC OTC NATAL PNV (pnv no.164/iron/folate no.6) NEO-VITAL RX TAB OTC NESTABS NESTABS ABC NESTABS DHA NESTABS ONE OB COMPLETE ONE OB COMPLETE PETITE OB COMPLETE PREMIER OB COMPLETE TAB OB COMPLETE WITH DHA OTC ONE NATAL RX TAB OTC^{NR} PNV 11-IRON FUM-FOLIC ACID-OM3 PNV COMBO#47/IRON/FA #1/DHA PNV W-CA NO.40/IRON FUM/FA CMB NO.1 PNV WITH CA NO.68/IRON/FA NO.1/DHA PRENATAL + DHA OTC PRENATE AM PRENATE CHEW TAB PRENATE DHA PRENATE ELITE PRENATE ENHANCE PRENATE ESSENTIAL PRENATE MINI PRENATE PIXIE PRENATE RESTORE PRENATE STAR PRIMACARE SELECT-OB CHEW TAB TRISTART DHA VITAFOL NANO WESTGEL DHA	<ul style="list-style-type: none"> ▪ Non-preferred agents will be approved for patients who have failed a trial of or are intolerant to TWO preferred agents within this drug class

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PROTON PUMP INHIBITORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
esomeprazole magnesium (generic Nexium) RX^{QL} omeprazole (generic Prilosec) RX pantoprazole (generic Protonix) QL PROTONIX SUSP (pantoprazole)	DEXILANT (dexlansoprazole) dexlansoprazole (generic Dexilant) esomeprazole magnesium (generic Nexium) OTC^{QL} esomeprazole strontium KONVOMEП (omeprazole/sodium bicarb) SUSP lansoprazole (generic Prevacid) QL NEXIUM SUSP (esomeprazole) omeprazole/sodium bicarbonate (generic Zegerid RX) pantoprazole GRANULES^{QL} rabeprazole (generic Aciphex)	<ul style="list-style-type: none"> ▪ Non-preferred agents will be approved for patients who have failed an 8-week trial of THREE preferred agents. <p>Pediatric Patients: Patients \leq 4 years of age – No PA required for Prevacid 30mg/ lansoprazole 30mg capsules (used to compound suspensions).</p> <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> ▪ Omeprazole OTC/ Prilosec[®]OTC: EXCLUDED from coverage Acceptable as trial instead of Omeprazole 20mg ▪ Prevacid (lansoprazole) Solutab: may be approved after trial of compounded suspension. Patients \geq 5 years of age- Only approve non-preferred for GI diagnosis if: <ul style="list-style-type: none"> ▪ Child can not swallow whole generic omeprazole capsules OR, ▪ Documentation that contents of capsule may not be sprinkled in applesauce

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SEDATIVE HYPNOTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BENZODIAZEPINES		
temazepam 15 mg, 30 mg (generic Restoril)	estazolam (generic ProSom) quazepam (generic Doral) temazepam (generic Restoril) ^{CL} 7.5 mg, 22.5 mg triazolam (generic Halcion)	<p>Benzodiazepines Criteria</p> <ul style="list-style-type: none"> Non-preferred agents require a trial of the preferred benzodiazepine agent temazepam 7.5/22.5 mg: Requires clinical reason why 15 mg/30 mg cannot be used
OTHERS		
eszopiclone (generic Lunesta) ^{AL} zaleplon (generic Sonata) zolpidem (generic Ambien) ^{CL}	BELSOMRA (suvorexant) ^{AL,QL} DAYVIGO (lemborexant) ^{AL,QL} doxepin (generic for Silenor) ^{CL} EDLUAR (zolpidem sublingual) HETLIOZ (tasimelteon) ^{AL,CL} HETLIOZ LQ (tasimelteon) SUSP ^{AL,QL} QUVIVIQ (daridorexant) ^{QL} ramelteon (generic Rozerem) ^{AL} tasimelteon (generic Hetlioz) ^{AL,CL} zolpidem ^{QL} CAP zolpidem ER (generic Ambien CR) ^{CL} zolpidem SL (generic Intermezzo) ^{CL}	<p>Others Criteria</p> <ul style="list-style-type: none"> Non-preferred agents require a trial of TWO preferred agents in the OTHERS sub-category Silenor/doxepin Tablet: Must meet ONE of the following: <ul style="list-style-type: none"> Contraindication to all of the preferred oral sedative hypnotics agents in the OTHERS sub-category Medical necessity for doxepin dose < 10 mg Age greater than 65 years old or hepatic impairment (3 mg dose will be approved if this criterion is met) zolpidem/zolpidem ER: Maximum daily dose for females: zolpidem 5 mg; zolpidem ER 6.25 mg zolpidem SL: Requires clinical reason why half of zolpidem tablet cannot be used or documented swallowing disorder

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SICKLE CELL ANEMIA TREATMENT^{AL}

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
DROXIA (hydroxyurea) CAPS ENDARI (L-glutamine) ^{CL}	GLUTAMINE POWD PACK (generic Endari) OXBRYTA (voxelotor) ^{CL} SIKLOS (hydroxyurea) ^{CL} TAB XROMI (hydroxyurea) ^{CL} SOLN	<p>Drug-Specific Criteria</p> <ul style="list-style-type: none"> ▪ Endari: Patient must have documented two or more hospital admissions per year due to sickle cell crisis despite maximum hydroxyurea dosage. ▪ Oxbryta: Not indicated 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 $5.5 \text{ g/dL} \leq 10.5 \text{ g/dL}$; AND patient is not receiving concomitant, prophylactic blood transfusion therapy ▪ Siklos: May be approved for use in patients ages 2 to 17 years old without a trial of Droxia ▪ Xromi solution: May be approved for use in patients ages 6 months to 2 years old without a trial of Droxia.

SINUS NODE INHIBITORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	CORLANOR SOLN, TAB (ivabradine) ivabradine (generic Corlanor) TAB	<ul style="list-style-type: none"> ▪ Diagnosis of Chronic Heart Failure with left ventricular ejection fraction less than or equal to 35%, AND ▪ Sinus rhythm with resting heart rate greater than or equal to 70 beats per minute, AND ▪ On maximally tolerated doses of beta-blockers OR have a contraindication to beta-blocker use

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SKELETAL MUSCLE RELAXANTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
baclofen (generic Lioresal) chlorzoxazone (generic Parafon Forte) cyclobenzaprine (generic Flexeril) ^{QL} methocarbamol (generic Robaxin) tizanidine TAB (generic Zanaflex)	baclofen (generic Fleqsuvy) ^{QL} SUSP baclofen (generic Ozobax) ^{QL} SOLN baclofen (generic Ozobax DS) SUSP carisoprodol (generic Soma) ^{CL,QL} carisoprodol compound cyclobenzaprine ER (generic Amrix) ^{CL} dantrolene (generic Dantrium) ^{CL} FEXMID (cyclobenzaprine ER) FLEQSUVY (baclofen) ^{QL} SUSP LORZONE (chlorzoxazone) ^{CL} LYVISPAN (baclofen) ^{QL} GRANULES metaxalone (generic Skelaxin) NORGESIC FORTE (orphenadrine/ASA/caffeine) orphenadrine ER PARAFON FORTE (chlorzoxazone) TANLOR (methocarbamol) TAB tizanidine CAPS ZANAFLEX (tizanidine) ^{CL} CAPS, TAB	<ul style="list-style-type: none"> ▪ Non-preferred agents will be approved for patients who have failed a 1-week trial of TWO preferred agents within this drug class <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> ▪ cyclobenzaprine ER: <ul style="list-style-type: none"> ○ Requires clinical reason why IR cannot be used ○ Approved only for acute muscle spasms ○ NOT approved for chronic use ▪ carisoprodol: <ul style="list-style-type: none"> ○ Approved for Acute, musculoskeletal pain - NOT for chronic pain ○ Use is limited to no more than 30 days ○ Additional authorizations will not be granted for at least 6 months following the last day of previous course of therapy ▪ dantrolene: Trial NOT required for treatment of spasticity from spinal cord injury ▪ Lorzone®: Requires clinical reason why chlorzoxazone cannot be used ▪ Soma® 250 mg: Requires clinical reason why 350 mg generic strength cannot be used ▪ Zanaflex® Capsules: Requires clinical reason generic cannot be used

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STEROIDS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
LOW POTENCY		
DERMA-SMOOTH FS (fluocinolone) hydrocortisone OTC & RX CREAM, LOTION, OINT (Rx only)	alclometasone dipropionate (generic for Aclovate) desonide LOTION (generic for Desowen) desonide CREAM, OINT (generic Desowen, Tridesilon) fluocinolone 0.01% OIL (generic DERMA-SMOOTH-FS) hydrocortisone/aloe CREAM hydrocortisone OTC OINT hydrocortisone SOLN (generic Texacort) HYDROXYM (hydrocortisone) GEL TEXACORT (hydrocortisone)	<ul style="list-style-type: none"> ▪ Low Potency Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class
MEDIUM POTENCY		
fluticasone propionate CREAM, OINT (generic for Cutivate) mometasone furoate CREAM, OINT, SOLN (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/emol (generic for Locoid Lipocream) hydrocortisone valerate (generic for Westcort) PANDEL (hydrocortisone probutate 0.1%)	<ul style="list-style-type: none"> ▪ Medium Potency Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class

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STEROIDS, TOPICAL (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	HIGH POTENCY	
triamcinolone acetonide OINTMENT, CREAM triamcinolone LOTION	amcinonide CREAM betamethasone dipropionate betamethasone / propylene glycol betamethasone valerate clobetasol propionate (generic Impoyz) CREAM desoximetasone diflorasone diacetate fluocinonide CREAM, GEL, OINT fluocinonide emollient fluocinonide SOLN halcinonide CREAM, SOLN (generic Halog) HALOG (halcinonide) CREAM, OINT, SOLN KENALOG AEROSOL (triamcinolone) triamcinolone SPRAY (generic Kenalog spray) VANOS (fluocinonide)	<ul style="list-style-type: none"> ▪ High Potency Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class
	VERY HIGH POTENCY	
clobetasol emollient (generic Temovate-E) clobetasol propionate CREAM, OINT, SOLN halobetasol propionate (generic Ultravate)	APEXICON-E (diflorasone) clobetasol LOTION, SHAMPOO clobetasol propionate GEL, FOAM, SPRAY halobetasol propionate FOAM (generic Lexette) ^{AL,QL}	<ul style="list-style-type: none"> ▪ Very High Potency Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class

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STIMULANTS AND RELATED ADHD DRUGS ^{AL}

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CNS STIMULANTS		
Amphetamine type		
amphetamine salt combination ER (generic Adderall XR)	ADDERALL XR (amphetamine salt combo) ADZENYS XR (amphetamine) ODT amphetamine salt combination ER (generic Mydayis) CAP amphetamine ER ODT ^{AL, NR} (generic Adzenys XR ODT)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this subclass.
amphetamine salt combination IR	amphetamine sulfate (generic Evekeo) dextroamphetamine (generic Dexedrine) TAB dextroamphetamine (generic Procentra) ^{CL} SOLN	Drug-specific criteria:
DYANAVEL XR (amphetamine) ^{QL}	dextroamphetamine ER (generic Dexedrine ER Spansule) CAPS EVEKEO ODT (amphetamine sulfate) methamphetamine (generic Desoxyn)	<ul style="list-style-type: none"> Procentra/ dextroamphetamine soln: May be approved with documentation of swallowing disorder
lisdexamfetamine (generic Vyvanse Chew) ^{QL} CHEW	MYDAYIS (amphetamine salt combo) ^{QL} XELTRYM (dextroamphetamine) ^{QL} PATCH ZENZEDI (dextroamphetamine) ^{CL}	<ul style="list-style-type: none"> Zenzedi®: Requires clinical reason generic dextroamphetamine IR cannot be used
lisdexamfetamine (generic Vyvanse) ^{QL} CAP		
VYVANSE (lisdexamfetamine) ^{QL} CAPS, CHEWABLE		

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

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Methylphenidate type		
CONCERTA (methylphenidate ER) ^{QL} 18 mg, 27 mg, 36 mg, 54 mg	APTENSIO XR (methylphenidate) AZSTARYS (serdexmethylphenidate and dexmethylphenidate) ^{QL} COTEMPLA XR-ODT (methylphenidate) ^{QL} FOCALIN IR (dexmethylphenidate) FOCALIN XR (dexmethylphenidate) JORNAY PM (methylphenidate) ^{QL} methylphenidate CHEW methylphenidate ER (45 mg and 63 mg) ^{QL} methylphenidate 50/50 (generic Ritalin LA) methylphenidate 30/70 (generic Metadate CD) methylphenidate ER 18 mg, 27 mg, 36 mg, 54 mg (generic Concerta) ^{QL} methylphenidate ER CAP (generic Aptensio XR) ^{QL} methylphenidate ER (generic Metadate ER) methylphenidate ER 72 mg (generic RELEXXII) ^{QL} methylphenidate ER (generic Ritalin LA) methylphenidate TD24 ^{AL,CL} PATCH (generic Daytrana) RELEXXII ER (methylphenidate 45mg and 63mg) ^{AL,QL} TAB RITALIN (methylphenidate)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this subclass. Maximum accumulated dose of 108mg per day for ages < 18 Maximum accumulated dose of 72mg per day for ages > 19 <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Daytrana/methylphenidate patch: May be approved in history of substance use disorder by parent, caregiver, or patient. May be approved with documentation of difficulty swallowing QuilliChew ER: May be approved for children \leq 12 years of age OR with documentation of difficulty swallowing
DAYTRANA PATCH (methylphenidate) ^{CL,QL} dexmethylphenidate (generic for Focalin IR) dexmethylphenidate ER (generic Focalin XR) METHYLIN SOLN (methylphenidate) methylphenidate (generic Ritalin) methylphenidate SOLN (generic Methylin) QUILLICHEW ER CHEWTAB (methylphenidate) ^{CL} QUILLIVANT XR (methylphenidate) SUSP		

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

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
MISCELLANEOUS		
atomoxetine (generic Straterra) ^{QL} guanfacine ER (generic Intuniv) ^{QL} QUELBREE (viloxazine) ^{QL}	clonidine ER (generic Kapvay) ^{QL} INTUNIV (guanfacine) Onyda XR (clonidine suspension, extended release) ^{QL} STRATTERA (atomoxetine)	<p>Note: generic guanfacine IR and clonidine IR are available without prior authorization</p> <ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this subclass <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Wakix and Sunosi: Require trial of armodafinil or modafinil armodafinil and modafinil: approved only for: <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> 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 Nuvigil) ^{CL} modafanil (generic Provigil) ^{CL} SUNOSI (solriamfetol) ^{CL,QL} WAKIX (pitolisant) ^{CL,QL}	

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TETRACYCLINES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
doxycycline hyclate IR (generic Vibramycin) CAPS doxycycline monohydrate (generic Vibramycin) ^{CL} SUSP doxycycline monohydrate TAB (generic Vibramycin) minocycline HCl (generic Dynacin/Myrac) TAB tetracycline	demeclocycline (generic Declomycin) ^{CL} DORYX MPC DR (doxycycline pelletized) doxycycline hyclate IR TAB (generic Vibramycin) doxycycline hyclate DR (generic Doryx) doxycycline monohydrate 50MG, 100MG CAPS doxycycline monohydrate 40MG, 75MG and 150MG CAP (generic Adoxa/Monodox/ Oracea) minocycline HCl CAPS (generic Dynacin/ Minocin/Myrac) minocycline HCl ER (generic Solodyn) NUZYRA (omadacycline)	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a sequential 3-day trial of TWO preferred agents within this drug class <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> demeclocycline: Approved for diagnosis of SIADH doxycycline suspension: May be approved with documented swallowing difficulty

THROMBOPOEISIS STIMULATING PROTEINS ^{CL}

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
PROMACTA (eltrombopag) TAB	ALVAIZ (eltrombopag choline) ^{AL} DOPTELET (avatrombopag) ^{AL} TAB, SPRINKLES eltrombopag (generic Promacta) SUSP, TAB MULPLETA (lusutrombopag) ^{CL} PROMACTA (eltrombopag) SUSP TAVALISSE (fostamatinib) WAYRILZ (rilzabrutinib) ^{NR}	<ul style="list-style-type: none"> 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. <p>Drug-Specific Criteria</p> <ul style="list-style-type: none"> 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

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THYROID HORMONES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
levothyroxine (generic Synthroid) TAB liothyronine (generic Cytomel) TAB thyroid, pork TAB UNITHROID (levothyroxine)	ADTHYZA (thyroid, pork) ERMEZA (levothyroxine) SOLN EUTHYROX (levothyroxine) LEVO-T (levothyroxine) levothyroxine CAPS (generic Tirosint) RENTHYROID (thyroid;pork)^{NR} TAB SYNTHROID (levothyroxine) TAB THYQUIDITY (levothyroxine) SOLN	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

ULCERATIVE COLITIS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ORAL		
APRISO (mesalamine) PENTASA (mesalamine) mesalamine (generic Lialda) sulfasalazine IR, DR (generic Azulfidine)	balsalazide (generic Colazal) budesonide DR (generic Uceris) DIPENTUM (olsalazine) LIALDA (mesalamine) mesalamine ER (generic Apriso) mesalamine ER (generic Pentasa) mesalamine (generic Asacol HD/ Delzicol) ^{CL}	<ul style="list-style-type: none"> Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class <p>Drug-specific criteria:</p> <ul style="list-style-type: none"> Asacol HD®/Delzicol DR®: Requires clinical reason why preferred mesalamine products cannot be used
RECTAL		
mesalamine (generic Canasa) SUPPOSITORY Sulfite-Free ROWASA (mesalamine) ENEMA	CANASA (mesalamine) mesalamine (generic Rowasa) ENEMA UCERIS (budesonide)	

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

**Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria**

PDL updated February 2, 2026, **Highlights** indicate change from previous posting

<https://nebraska.fhsc.com/PDL/PDListings.asp>

UTERINE DISORDER TREATMENT

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
MYFEMBREE (relugolix/ estradiol/norethindrone acetate) ^{AL, CL, QL} ORIAHNN (elagolix/ estradiol/norethindrone) ^{AL, CL} ORILISSA (elagolix sodium) ^{QL, CL}		Drug-specific criteria: <ul style="list-style-type: none"> • Myfembree, Orilissa, and Oriahnn: Requires an FDA approved indication, must follow FDA dosing guidelines, and have had a trial and failure of an NSAID and oral contraceptive <ul style="list-style-type: none"> ○ Total duration of treatment is max of 24 months

VASODILATORS, CORONARY

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
isosorbide dinitrate TAB isosorbide dinitrate/hydralazine (Bidil) ^{CL} isosorbide mono IR/SR TAB nitroglycerin SUBLINGUAL, TRANSDERMAL nitroglycerin ER TAB	BIDIL (isosorbide dinitrate/hydralazine) ^{CL} GONITRO (nitroglycerin) isosorbide dinitrate TAB (Oceanside Pharm MFR only) NITRO-BID OINT (nitroglycerin) NITRO-DUR (nitroglycerin) nitroglycerin TRANSLINGUAL (generic Nitrolingual) VERQUVO (vericiguat) ^{AL, CL, QL}	<ul style="list-style-type: none"> ▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: <ul style="list-style-type: none"> ▪ BiDil/ isosorbide dinitrate-hydralazine: Approved for the treatment of heart failure as an adjunct therapy to standard therapy in self-identified black patients ▪ Verquvo: Approved for use in patients following a recent hospitalization for HF within the past 6 months OR need for outpatient IV diuretics, in adults with symptomatic chronic HF and EF less than 45%

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

AL – Age Limit

QL – Quantity/Duration Limit

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

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