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

Jim Pillen, Governor

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

November 2026 PDL
PDL updated November 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

Prior Authorization (PA) Renewal Requests:
All PAs require a positive clinical outcome for PA reauthorization approval

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

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

PDL Update November 2, 2026, *Highlights* indicate change from previous posting

https://nebraska.fhsc.com/PDL/PDLlistings.asp

ACNE AGENTS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
adapalene (generic Differin) **GEL (OTC/Rx), GEL PUMP** adapalene/BPO (generic Epiduo) benzoyl peroxide (BPO) **WASH, LOTION** benzoyl peroxide **GEL** OTC clindamycin/BPO (generic BenzaClin) **GEL, PUMP** clindamycin/BPO (generic Duac) clindamycin phosphate **PLEDGET** clindamycin phosphate **SOLUTION** erythromycin **GEL** erythromycin **SOLN** erythromycin-BPO (generic Benzamycin) tretinoin (generic Avita, Retin-A) AL, **CREAM, GEL**	adapalene (generic Differin) **CREAM** adapalene/BPO (generic Epiduo Forte) ALTRENO (tretinoin)AL AMZEEQ (minocycline) ATRALIN (tretinoin)AL AVAR (sulfacetamide sodium/sulfur) AVITA (tretinoin)AL AZELEX (azelaic acid) BENZEFOAM (benzoyl peroxide) benzoyl peroxide **CLEANSER**, **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) dapsone (generic Aczone) DIFFERIN (adapalene) **CREAM, GEL-OTC, GEL PUMP, LOTION** erythromycin **PLEDGET** EVOCLIN (clindamycin) **FOAM** TRETINOIN MICROSPHERES GEL 0.06% PUMP AL,NR	▪ 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**

ACNE AGENTS, TOPICAL (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	FABIOR (tazarotene) **FOAM** NEUAC (clindamycin/BPO) OVACE PLUS (sulfacetamide sodium) RETIN-A MICRO (tretinoin)[AL] sulfacetamide sulfacetamide/sulfur sulfacetamide sodium/ sulfur **CLEANSER** SUMADAN (sulfacetamide/sulfur) tazarotene (generic Tazorac) **CREAM** tazarotene **FOAM** (generic Fabior) tazarotene **GEL** (generic Tazorac) TRETIN-X (tretinoin)[AL] tretinoin (generic Atralin) [AL]**GEL** tretinoin microspheres (generic Retin-A Micro) [AL] **GEL, GEL PUMP** WINLEVI (clascoterone)[AL]	▪ 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

ALZHEIMER'S AGENTS

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

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)	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) HYSINGLA ER (hydrocodone ER) methadone **TABLET** [CL] methadone **ORAL SYR** [CL] methadone **SOL TABLET**[CL] morphine ER (generic Avinza, Kadian) **CAPS** NUCYNTA ER (tapentadol) oxycodone ER (generic Oxycontin)[CL] oxymorphone ER (generic Opana ER) tapentadol ER (Generic Nucynta ER)[NR] tramadol ER (generic ConZip)	The Center for Disease Control (CDC) does not recommend long-acting opioids when beginning opioid treatment. ▪ Preferred agents require previous use of a long-acting opioid or documentation of a trial on a short acting agent within 90 days ▪ Non-preferred agents will be approved with failure on, or intolerance to TWO preferred agents within this drug class Drug-specific criteria: ▪ **Methadone (all formulations):** 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/ oxycodone ER:** Pain contract required for maximum quantity authorization

ANALGESICS, OPIOID SHORT-ACTING [QL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ORAL		▪ Non-preferred agents will be approved for patients who have failed THREE preferred agents within 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: -prescriptions limited to a 7 day supply, AND -initial opiate prescription fill limited to maximum of 50 Morphine Milligram Equivalents (MME) per day These limits may only be exceeded with patient specific documentation of medical necessity, with examples such as, cancer diagnosis, end-of-life care, palliative care, Sickle Cell Anemia, or prescriber attestation that patient is not recently opiate naive Drug-specific criteria: ▪ **Nucynta/ tapentadol:** Approved only for diagnosis of acute pain, for 30 days or less
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) hydromorphone **LIQUID, SUPPOSITORY** (generic Dilaudid) levorphanol (generic Xyvona) 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] tapentadol (generic Nucynta) [CL] tapentadol **SOLN**[NR] tramadol 25mg tramadol 75mg tramadol 100mg (generic Ultram)[AL] tramadol (generic Qdolo)[AL] **SOLN** tramadol/APAP (generic Ultracet)	

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

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
NASAL		Drug-specific criteria: ▪ **Actiq®/Fentora®/ fentanyl transmucosal/Onsolis:** Approved only for diagnosis of cancer AND current use of long-acting opiate
	butorphanol **SPRAY**[QL]	
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) [CL] **PUMP** testosterone **PUMP** (generic Androgel)[CL] TESTIM (testosterone) **TRANSDERMAL** testosterone **GEL-PACKET** (generic Vogelxo)	NATESTO (testosterone)[CL] testosterone PACKET (generic Androgel)[CL] testosterone **GEL**, **GEL-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: 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)

ANGIOTENSIN MODULATORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ACE INHIBITORS		▪ Non-preferred agents will be approved for patients who have failed TWO preferred agents within the last 12 months ▪ Non-preferred combination products may be covered as individual prescriptions without prior authorization Drug-specific criteria: ▪ **Epaned/enalapril oral solution/Qbrelis oral solution:** Clinical reason why oral tablet is not appropriate
benazepril (generic Lotensin) enalapril (generic Vasotec) lisinopril (generic Prinivil, Zestril) ramipril (generic Altace)	captopril (generic Capoten) EPANED (enalapril)[CL] **ORAL SOLN** enalapril (generic Epaned)[CL] **ORAL SOLN** fosinopril (generic Monopril) moexepril (generic Univasc) perindopril (generic Aceon) QBRELIS (lisinopril)[CL] **ORAL SOLN** quinapril (generic Accupril) trandolapril (generic Mavik)	
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)	azilsartan medoxomil (generic Edarbi)[NR] candesartan (generic Atacand) EDARBI (azilsartan) eprosartan (generic Teveten) telmisartan (generic Micardis)	

ANGIOTENSIN MODULATORS (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ANGIOTENSIN RECEPTOR BLOCKER/DIURETIC COMBINATIONS		▪ Non-preferred agents will be approved for patients who have failed TWO preferred agents within the last 12 months ▪ Non-preferred combination products may be covered as individual prescriptions without prior authorization
irbesartan/HCTZ (generic 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)	
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) WIDAPLIK NR, QL (telmisartan/amlodipine/indapamide)	
DIRECT RENIN INHIBITORS		▪ **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
	aliskiren (generic Tekturna)QL	
DIRECT RENIN INHIBITOR COMBINATIONS		
	TEKTURNA/HCTZ (aliskiren/HCTZ)	
NEPRILYSIN INHIBITOR COMBINATION		Drug Specific Criteria • **Entresto/ sacubitril-valsartan:** May be approved in patients ages ≥1 years old and with a diagnosis of heart failure
sacubitril/valsartan (generic Entresto)CL,QL	ENTRESTO (sacubitril/valsartan)CL,QL ENTRESTO (sacubitril/valsartan)CL,QL **SPRINKLE CAP**	

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)	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class within the last 6 months Drug-specific criteria: • **Emverm**: Approval will be considered for indications not covered by preferred agents

ANTI-ALLERGENS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	GRASTEK (timothy grass pollen allergen) AL,CL,QL ODACTRA (Dermatophagoides farinae and Dermatophagoides pteronyssinus)AL,CL,QL ORALAIR (sweet vernal/orchard/rye/ timothy/kentucky blue grass mixed pollen allergen extract)CL PALFORZIA (peanut allergen powder-dnfp) AL,CL RAGWITEK (weed pollen-short ragweed)AL,CL,QL	**All agents require initial dose to be given in a healthcare setting** Drug-specific criteria: **GRASTEK** • 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. **ODACTRA** • 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 **ORALAIR** • Confirmed by positive skin test or in vitro testing for pollen specific IgE antibodies for Sweet Vernal, Orchard, Perennial Rye, Timothy, and Kentucky Blue Grass Mixed Pollens. • For use in patients 5 through 65 years of age. **PALFORZIA** • Confirmed diagnosis of peanut allergy by allergist • For use in patients ages 4 to 17; it may be continued in patients 18 years and older with documentation of previous use within the past 90 days • Initial dose and increase titration doses should be given in a healthcare setting • Should not be used in patients with uncontrolled asthma or concurrently on a NSAID **RAGWITEK** • 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.

ANTIBIOTICS, GASTROINTESTINAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
metronidazole **TAB** neomycin tinidazole (generic Tindamax) vancomycin (generic Firvanq)[QL] **SOLN** vancomycin **CAPS** (generic Vancocin)[CL]	AEMCOLO (rifamycin) **TAB** DIFICID (fidaxomicin) [CL] **TAB, SUSP** fidaxomicin (generic Dificid)[CL] **TAB** FIRVANQ (vancomycin)[QL] **SOLN** LIKMEZ (metronidazole) **SUSP** metronidazole **CAPS** metronidazole 125mg **TAB** nitazoxanide (generic Alinia) **TAB**[AL, CL, QL] paromomycin SOLOSEC (secnidazole) VOWST (fecal microbiota spores)[AL,QL]	▪ Note: Although azithromycin, ciprofloxacin, and trimethoprim/ sulfmethoxazole are not included in this review, they are available without prior authorization Drug-specific criteria: ▪ **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: No trial required for diagnosis of relapsed or recurrent C. difficile with an appropriate ICD-10 diagnosis code or if immunocompromised; additionally, generic fidaxomicin tablets require a clinical reason why brand Dificid tablets can't be used. ▪ **metronidazole CAPS/ metronidazole 125mg TAB**: requires a clinical reason why preferred metronidazole tablet cannot be used

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)	▪ Diagnosis of Cystic Fibrosis is required for all agents ICD10 Group = E84, ICD9 = 277.00, 277.01, 277.02, 277.03, 277.09 Drug-specific criteria: ▪ **Arikayce:** Requires diagnosis of refractory MAC lung disease defined as patients who did not achieve negative sputum cultures after a minimum of 6 consecutive months of a multidrug background regimen therapy ▪ **Cayston®:** Trial of tobramycin via nebulizer and demonstration of TOBI® compliance required ▪ **Tobi Podhaler®:** Requires trial of tobramycin via nebulizer or documentation 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] XEPI (ozenoxacin)	▪ Non-preferred agents will be approved for patients who have failed ALL preferred agents within this drug class within the last 12 months Drug-specific criteria: ▪ **Mupirocin® Cream:** Clinical reason the ointment cannot be used

ANTIBIOTICS, VAGINAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CLEOCIN **OVULES** (clindamycin) clindamycin **CREAM** (generic Cleocin) metronidazole, vaginal NUVESSA (metronidazole)	CLEOCIN **CREAM** (clindamycin) 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
ELIQUIS (apixaban) **DOSE PACK, TAB** ELIQUIS (apixaban) **SPRINKLE, SUSP** 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)	dabigatran etexilate (generic Pradaxa) **CAPS** fondaparinux (generic Arixtra) **INJ** FRAGMIN (dalteparin) **INJ** PRADAXA (dabigatran) **CAPS, PELLETS** rivaroxaban (generic Xarelto) **TAB** rivaroxaban (generic Xarelto)[AL,CL] **SUSP** SAVAYSA (edoxaban)[CL,QL] **TAB** XARELTO (rivaroxaban)[CL] **SUSP**	▪ Non-preferred agents will be approved for patients who have failed ONE preferred agent within this drug class within the last 12 months Drug-specific criteria: ▪ **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/ rivaroxaban Suspension**: Approved for patients ≤12 years of age or if there is a clinical reason why a preferred solid dosage form cannot be used.

ANTIEMETICS/ANTIVERTIGO AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CANNABINOIDS		▪ Non-preferred agents will be approved for patients who have failed ONE preferred agent within this drug class within the same subclass Drug-specific criteria: ▪ **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, Carbplatin, Cisplatin, Clofarabine, Cyclophosphamide, Cytarabine, Dacarbazine, Dactinomycin, Daunorubicin, Epirubicin, Etoposide, Hexamethylmelamine, Idarubicin, Ifosfamide, Imatinib, Interferon α, Irinotecan, Mechlorethamine, Melphalan, Methotrexate, Oxaliplatin, Procarbazine, Streptozotocin, Temozolomide ▪ **Diclegis/doxylamine-pyridoxine)/ Bonjesta:** Approved only for treatment of nausea and vomiting of pregnancy ▪ **Sancuso®:** Documentation of oral dosage form intolerance
dronabinol (generic Marinol)[AL]	dronabinol (generic Syndros)[AL, NR,QL] **SOLN**	
5HT3 RECEPTOR BLOCKERS		
ondansetron (generic Zofran/Zofran ODT)[QL]	ANZEMET (dolasetron) granisetron (generic Kytril) Nereus (tradipatant) [NR. QL] **CAPS** ondansetron 16mg **ODT (generic** Zofran ODT) SANCUSO (granisetron)[CL]	
NK-1 RECEPTOR ANTAGONIST		
aprepitant (generic Emend) **CAPS** [QL]	AKYNZEO (netupitant/palonosetron)[CL] aprepitant (generic Emend) **PACK** EMEND (aprepitant) **CAPS, PACK, POWDER** [QL]	
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] COMPRO (prochlorperazine) doxylamine/pyridoxine (generic Diclegis)[CL,QL] prochlorperazine **SUPPOSITOR**Y (generic Compazine) promethazine **SUPPOSITORY** 50mg trimethobenzamide **TAB** (generic Tigan)	

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** NOXAFIL (posaconazole)[AL,CL] **SUSP, TAB** NOXAFIL (posaconazole) [AL,CL] **POWDERMIX** nystatin **TAB** posaconazole (generic Noxafil)[AL,CL] TOLSURA (itraconazole)[CL] VIVJOA (oteseconazole) **CAPS** voriconazole (generic VFEND)[CL]	▪ Non-preferred agents will be approved for patients who have failed a trial of TWO diagnosis-appropriate preferred agents within this drug class Drug-specific criteria: ▪ **Cresemba®:** Approved for diagnosis of invasive aspergillosis or invasive mucormycosis ▪ **Flucytosine:** Approved for diagnosis of: Candida: Septicemia, endocarditis, UTIs Cryptococcus: Meningitis, pulmonary infections ▪ **Noxafil/ 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 ▪ **Noxafil® Powdermix:** pediatric patients 2 years of age and older who weigh 40 kg or less ▪ **Noxafil/ 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, *S. apiospermum* and *Fusarium spp.*, Oropharyngeal/esophageal candidiasis refractory to fluconazole

ANTIFUNGALS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ANTIFUNGAL		▪ Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within the last 6 months Drug-specific criteria: ▪ **Extina/ Ketodan/ ketoconazole foam:** Requires trial and failure or contraindication to other ketoconazole forms ▪ **tavaborole:** Approved diagnoses include Onychomycosis of the toenails due to *T.rubrum OR T. Mentagrophytes* ▪ **ciclopirox nail lacquer:** No trial required in diabetes, peripheral vascular disease (PVD), immunocompromised OR contraindication to oral terbinafine
clotrimazole **CREAM** (generic Lotrimin) RX, OTC clotrimazole (generic Lotrimin)**SOLN**-Rx ketoconazole **CREAM, SHAMPOO** (generic Nizoral) miconazole **CREAM, POWDER** OTC nystatin **CREAM, POWDER** terbinafine OTC (generic Lamisil AT) tolnaftate **AERO-POWDER OTC, CREAM-OTC, SOLN-OTC (generic Tinactin)** tolnaftate **POWDER OTC** tolnaftate **SPRAY OTC**	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] LASOLEX (clotrimazole)[NR] **SOLN (OTC)** LOPROX (ciclopirox) **SUSP, SHAMPOO, CREAM** LOTRIMIN AF **CREAM** OTC (clotrimazole) LOTRIMIN ULTRA (butenafine) MICOCLEAR (clotrimazole)[NR] **CREAM** 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 **SPRAY**[NR] TRIPENICOL (undecylenic acid) **CREAM-OTC** VOTRIZA-AL (clotrimazole) **LOTION OTC**	
ANTIFUNGAL/STEROID COMBINATIONS		
clotrimazole/betamethasone **CREAM** (generic Lotrisone) nystatin/triamcinolone (generic Mycolog) **CREAM, OINT**	clotrimazole/betamethasone **LOTION** (generic Lotrisone)	

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

PDL Update November 2, 2026, *Highlights* indicate change from previous posting

https://nebraska.fhsc.com/PDL/PDLlistings.asp

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)	▪ 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 0.05mg[NR] clonidine ER (generic Nexiclon)[CL] JAVADIN (clonidine)[NR] **SOLN** methyldopa/hydrochlorothiazide NEXICLON XR (clonidine ER)[CL] **TAB**	▪ Non-preferred agents will be approved for patients who have failed a 30-day trial with ONE preferred agent within this drug class Drug Specific Criteria ▪ **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)	▪ 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

ANTIMIGRAINE AGENTS, OTHER

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
AIMOVIG (erenumab-aooe) CL,QL AJOVY (fremanezumab-vfrm) CL, QL **PEN, Autoinjector** AJOVY (fremanezumab-vfrm) **Autoinjector 3-pack**CL,QL EMGALITY 120 mg/mL (galcanezumab-gnlm) CL, QL **PEN, SYRINGE** NURTEC ODT (rimegepant)AL,CL,QL QULIPTA (atogepant)AL,CL,QL UBRELVY (ubrogepant)AL,CL, QL **TAB**	BREKIYA (dihydroergotamine mesylate) diclofenac (generic Cambia) **POWDER** dihydroergotamine mesylate **NASAL** ELYXYB (celecoxib)AL,QL **SOLN** EMGALITY 100 mg (galcanezumab-gnlm) CL,QL **SYR** MIGERGOT (ergotamine/caffeine) **RECTAL** MIGRANAL (dihydroergotamine) **NASAL** REYVOW (lasmiditan)AL, CL,QL **TAB** ZAVZPRET (zavegepant)AL,CL,QL **NASAL**	▪ All non-preferred agents will require a failed trial or contraindication of a preferred agent of the same indication ▪ **For Acute Treatment**: agents will be approved for patients who have a failed trial or a contraindication to two triptans. ▪ **For Prophylactic Treatment**: Require ≥ 4 migraines days per month for ≥ 3 months and has tried and failed a ≥ 1 month trial of two medications: antidepressants (amitriptyline, venlafaxine), Beta blockers (propranolol, metroprolol, atenolol), anti-epileptics (divalproex, valproate, topiramate) Drug-specific criteria: ▪ **Emgaility 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.

ANTIMIGRAINE AGENTS, TRIPTANS [QL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ORAL		▪ Non-preferred agents will be approved for patients who have failed ALL preferred agents within this drug class Drug-specific criteria: ▪ **Zembrace:** approved for patients who have failed ALL preferred agents
naratriptan (generic Amerge) rizatriptan (generic Maxalt) rizatriptan ODT (generic Maxalt MLT) sumatriptan	almotriptan (generic Axert) eletriptan (generic Relpax) frovatriptan (generic Frova) IMITREX (sumatriptan) RELPAX (eletriptan)[QL] sumatriptan/naproxen (generic Treximet) SYMBRAVO (rizatriptan benzoate/meloxicam)[AL] **TAB** zolmitriptan (generic Zomig)	
NASAL		
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) spinosad (generic Natroba)	CROTAN (crotamiton) **LOTION** EURAX (crotamiton) **CREAM, LOTION** ivermectin (generic Sklice) **LOTION** malathion (generic Ovide) PRURADIK (cromtamiton) **LOTION** VANALICE (piperonyl butoxide/pyrethrins)	▪ Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class within the past 6 months

ANTIPARKINSON'S AGENTS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ANTICHOLINERGICS		▪ Non-preferred agents will be approved for patients who have failed ONE preferred agent within the same subclass
benztropine (generic Cogentin) trihexyphenidyl (generic Artane)		
COMT INHIBITORS		Drug-specific criteria:
entacapone (generic Comtan)	ONGENTYS (opicapone) tolcapone (generic Tasmar)	▪ **Carbidopa/Levodopa ODT:** Approved for documented swallowing disorder ▪ **COMT Inhibitors:** Approved if using as add-on therapy with levodopa-containing drug
DOPAMINE AGONISTS		▪ **Gocovri:** Required diagnosis of Parkinson's disease and had trial of or is intolerant to amantadine AND must be used as an add-on therapy with levodopa-containing drug
pramipexole (generic Mirapex) ropinirole (generic Requip)	bromocriptine (generic Parlodel) JUVMO TABLET, TITRATION PACK (tavapadon)[NR] NEUPRO (rotigotine)[CL] pramipexole ER (generic Mirapex ER)[CL] ropinirole ER (generic Requip XL)[CL]	▪ **Inbrija:** Approval upon diagnosis of Parkinson's disease and concurrent treatment with carbidopa/levodopa agent ▪ **Neupro®:** For Parkinsons: Clinical reason required why preferred agent cannot be used For Restless Leg (RLS): Requires trial OR Contraindication to ropinirole AND pramipexole
MAO-B INHIBITORS		▪ **Nourianz**: *Approval upon diagnosis of Parkinson's disease and concurrent treatment with carbidopa/levodopa agent*
selegiline **CAPS, TABLET** (generic Eldepryl)	rasagiline (generic Azilect) [QL] XADAGO (safinamide)	▪ **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
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)	

ANTIPSORIATICS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
acitretin (generic Soriatane)	methoxsalen (generic Oxsoralen-Ultra)	▪ 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**	▪ Non-preferred agents will be approved for patients who have failed a trial with a preferred agent within this drug class Drug-Specific Criteria • **Zoryve Foam**- For diagnosis of Seborrheic Dermatitis, requires trial of a topical steroid or a topical calcineurin inhibitor AND trial of a topical antifungal.

ANTIVIRALS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ANTI-COVID-19 DRUGS		▪ Non-preferred agents will be approved for patients who have failed a 10-day trial of ONE preferred agent within the same subclass Drug-specific criteria: ▪ **Acyclovir Susp:** Prior authorization NOT required for children ≤ 12 years old ▪ **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
PAXLOVID (nirmatrelvir/ritonavir)[CL,QL]		
ANTI-HERPETIC DRUGS		
acyclovir (generic Zovirax) famciclovir (generic Famvir) valacyclovir (generic Valtrex)	acyclovir (generic Zovirax)[CL] **SUSP**	
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]	

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]	▪ 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	▪ Non-preferred agents will be approved for patients who have failed a trial with TWO preferred agents within this drug class Drug-specific criteria: ▪ **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

BETA BLOCKERS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BETA BLOCKERS		Non-preferred agents will be approved for patients who have failed TWO diagnosis-appropriate preferred agents . Drug-specific criteria: ▪ **Coreg CR/carvedilol ER:** Requires clinical reason generic IR product cannot be used ▪ **Hemangeol®:** Covered for diagnosis of Proliferating Infantile Hemangioma ▪ **Sotylize®:** Covered for diagnosis of life –threatening ventricular arrhythmias OR maintenance of normal sinus rhythm in highly symptomatic atrial fibrillation/flutter (AFIB/AFL) Requires clinical reason generic sotalol cannot be used
atenolol (generic Tenormin)	acebutolol (generic Sectral)	
atenolol/chlorthalidone (generic Tenoretic)	betaxolol (generic Kerlone)	
bisoprolol (generic Zebeta)	BYSTOLIC (nebivolol)	
bisoprolol/HCTZ (generic Ziac)	HEMANGEOL (propranolol)[AL,CL] **SOLN**	
metoprolol (generic Lopressor)	INDERAL/INNOPRAN XL (propranolol ER)	
metoprolol ER (generic Toprol XL)	KAPSPARGO SPRINKLE (metoprolol ER)	
nebivolol (generic Bystolic)	LOPRESSOR (metoprolol tartrate) **SOLN**	
propranolol (generic Inderal)	metoprolol/HCTZ (generic Lopressor HCT)	
propranolol ER (generic Inderal LA)	nadolol (generic Corgard)	
	pindolol (generic Viskin)	
	propranolol/HCTZ (generic Inderide)	
	timolol (generic Blocadren)	
	TOPROL XL (metoprolol ER)	
BETA- AND ALPHA-BLOCKERS		
carvedilol (generic Coreg)	carvedilol ER [CL] (generic Coreg CR)	
labetalol (generic Trandate)		
ANTIARRHYTHMIC		
sotalol (generic Betapace)	SOTYLIZE (sotalol)[CL]	

BILE SALTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ursodiol **CAPSULE** 300 mg (generic Actigall) ursodiol 250 mg **TABLET** (generic URSO) ursodiol 500 mg **TABLET** (generic URSO FORTE)	CHENODAL (chenodiol) CHOLBAM (cholic acid) CTEXLI (chenodiol) **TAB** IQIRVO (elafibranor)AL,CL,QL **TAB** LIVDELZI (seladelpar)AL,CL,QL **CAP** LYNAVOY (linerixibat)NR **TAB** RELTONE (ursodiol 200mg,400mg) **CAP** URSOLIGN (ursodiol)NR **CAP**	▪ Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class Drug-specific criteria: • **Iqirvo /Livdelzi:** ○ Requires ≥ 12-month trial and failure (ALP ≥ 1.67 times upper limit of normal) of ursodiol, unless contraindicated, or experienced clinically significant adverse effects; ○ AND must be used in combination with ursodiol unless contraindicated or clinically significant adverse effects experienced

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 (generic Myrbetriq) **TAB** mirabegron ER (generic Myrbetriq) **SUSP**NR MYRBETRIQ (mirabegron) **SUSP**AL,CL,QL oxybutynin 2.5mg OXYTROL (oxybutynin) solifenacin (generic Vesicare) tolterodine IR, ER (generic Detrol/ Detrol LA) TOVIAZ (fesoterodine ER) trospium IR, ER (generic Sanctura/ Sanctura XR) VESICARE (solifenacin) VESICARE LS **SUSP** (solifenacin) AL	▪ Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class Drug-specific criteria: ▪ **Myrbetriq suspension:** Covered for pediatric patients ≥ 3 years old with a diagnosis of Neurogenic Detrusor Overactivity (NDO)

BONE RESORPTION SUPPRESSION AND RELATED DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BISPHOSPHONATES		▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within the same subclass Drug-specific criteria: ▪ **Atelvia DR®:** Requires clinical reason a preferred product cannot be taken on an empty stomach ▪ **Binosto®:** Requires clinical reason why alendronate tablets OR Fosamax® solution cannot be used ▪ **BONSITY**: Requires clinical reason why preferred Forteo cannot be used ▪ **Forteo/ teriparatide:** Covered for high risk of fracture High risk of fracture: • BMD -3 or worse • Postmenopausal women with history of non-traumatic fractures • Postmenopausal women with 2 or more clinical risk factors ○ Family history of non-traumatic fractures ○ DXA BMD T-score ≤ -2.5 at any site ○ Glucocorticoid use ≥ 6 months at 7.5 dose of prednisolone equivalent ○ Rheumatoid Arthritis • Postmenopausal women with BMD T-score ≤ -2.5 at any site with any clinical risk factors ○ More than 2 units of alcohol per day ○ Current smoker • Men with primary or hypogonadal osteoporosis • Osteoporosis associated with sustained systemic glucocorticoid therapy • Trial of calcitonin-salmon not required • Maximum of 24 months treatment per lifetime
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]	
OTHER BONE RESORPTION SUPPRESSION AND RELATED DRUGS		
calcitonin-salmon **NASAL** FORTEO (teriparatide)[CL,QL] raloxifene (generic Evista)	BONSITY (teriparatide)[QL] EVISTA (raloxifene) teriparatide (generic Forteo) [CL,QL] TYMLOS (abaloparatide)	

BPH (BENIGN PROSTATIC HYPERPLASIA) TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ALPHA BLOCKERS		▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within the same subclass. Drug-specific criteria: ▪ **Alfuzosin/dutasteride/finasteride** • 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 (terazosin) solution**: Clinical reason why oral capsule is not appropriate
alfuzosin (generic Uroxatral)[CL] doxazosin (generic Cardura) tamsulosin (generic Flomax)[CL] terazosin (generic Hytrin)	CARDURA XL (doxazosin)[CL] silodosin (generic Rapaflo) TEZRULY (terazosin)[CL] **SOLN**	
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]	

BRONCHODILATORS, BETA AGONIST

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
INHALERS – Short Acting		• Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within the same subclass. Drug-specific criteria: • **Xopenex/levalbuterol solution:** Covered for cardiac diagnoses or side effect of tachycardia with albuterol product
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)	
INHALERS – Long Acting		
SEREVENT (salmeterol)	STRIVERDI RESPIMAT (olodaterol)	
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)	

CALCIUM CHANNEL BLOCKERS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
SHORT-ACTING		▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within the same subclass. Drug-specific criteria: ▪ **Katerzia/ Norliqva/ Sdamlo:** May be approved with documented swallowing difficulty. Katerzia and Sdamlo also require a clinical reason why Norliqva cannot be used. ▪ **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
Dihydropyridines		
	isradipine (generic Dynacirc) nicardipine (generic Cardene) nifedipine (generic Procardia)CL nimodipine (generic Nimotop)CL nimodipine (generic Nymalize)CL **SOLN** NYMALIZE (nimodipine) **SOLN**	
Non-dihydropyridines		
diltiazem (generic Cardizem) verapamil (generic Calan/Isoptin)		
LONG-ACTING		
Dihydropyridines		
amlodipine (generic Norvasc) nifedipine ER (generic Procardia XL/ Adalat CC) NORLIQVA (amlodipine)AL,CL,QL **SOLN**	felodipine ER (generic Plendil) KATERZIA (amlodipine)CL,QL **SUSP** levamlodipine (generic Conjupri) nisoldipine (generic Sular) SDAMLO (amlodipine)AL,CL **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**	

CEPHALOSPORINS AND RELATED ANTIBIOTICS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BETA LACTAM/BETA-LACTAMASE INHIBITOR COMBINATIONS		▪ Non-preferred agents will be approved for patients who have failed a 3-day trial of ONE preferred agent within the same subclass Drug Specific Criteria • **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
amoxicillin/clavulanate **TAB, SUSP**	amoxicillin/clavulanate **CHEWABLE** amoxicillin/clavulanate ER (generic Augmentin XR) AUGMENTIN (amoxicillin/clavulanate) **SUSP, TAB**	
CEPHALOSPORINS – First Generation		
cefadroxil **CAPS, SUSP** (generic Duricef) cephalexin **CAPS, SUSP** (generic Keflex)	cefadroxil **TAB** (generic Duricef) cephalexin **TAB**	
CEPHALOSPORINS – Second Generation		
cefprozil (generic Cefzil) cefuroxime **TAB** (generic Ceftin)	cefaclor (generic Ceclor)	
CEPHALOSPORINS – Third Generation		
cefdinir (generic Omnicef) cefpodoxime (generic Vantin)	cefixime (generic Suprax)[CL] **CAPS, SUSP, TAB**	

COLONY STIMULATING FACTORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
FULPHILA (pegfilgrastim-jmdb) **SUB-Q** FYLNETRA (pegfilgrastim-pbbk) **SUB-Q** NEUPOGEN **DISP SYR (SUB-Q)** NEUPOGEN (filgrastim) **VIAL (IV)**	ARMLUPEG (pegfilgrastim-unne) **SYR**[NR] FILKRI (filgrastim-laha) **SYR**[NR] GRANIX (tbo-filgrastim) **SUB-Q** LEUKINE (sargramostim) **INTRAVENOUS** NEULASTA (pegfilgrastim) **SYR, VIAL**[NR] NIVESTYM (filgrastim-aafi) **SYR,VIAL** NYVEPRIA (pegfilgrastim-apgf) RELEUKO (filgrastim-ayow) **SYR** ROLVEDON (eflapegrastim-xnst) **SYR** STIMUFEND (pegfilgrastim-fpgk) **SUB-Q** UDENYCA (pegfilgrastim-cbqv) **AUTOINJ** UDENYCA (pegfilgrastim-cbqv) **SUB-Q** ZARXIO (filgrastim-sndz) **IV, SUB-Q** ZIEXTENZO (pegfilgrastim-bmez) **SUB-Q**	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

CONTRACEPTIVES, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
All reviewed agents are recommended preferred at this time *Only those products for review are listed.* Brand name products may be subject to Maximum Allowable Cost (MAC) pricing or require substitution with a generic equivalent Specific agents can be looked up using the Drug Look-up Tool at: https://ne.primetherapeutics.com/drug-lookup		

COPD (CHRONIC OBSTRUCTIVE PULMONARY DISEASE) AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
INHALERS		▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within the same subclass OR Patient specific documentation of inability to use traditional inhaler device. Drug-specific criteria: ▪ **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 ▪ **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.
ANORO ELLIPTA (umeclidinium/vilanterol) ATROVENT HFA (ipratropium) COMBIVENT RESPIMAT (albuterol/ ipratropium) SPIRIVA (tiotropium) SPIRIVA RESPIMAT (tiotropium) STIOLTO RESPIMAT (tiotropium/olodaterol)	BEVESPI AEROSPHERE (glycopyrolate/formoterol) DUAKLIR PRESSAIR (aclidinium br and formoterol fum) INCRUSE ELLIPTA (umeclidnium) tiotropium (generic Spiriva) TUDORZA PRESSAIR (aclidinium br) umeclidinium ellipta (generic Incruse)NR umeclidinium/vilanterol (generic Anoro Ellipta) ipratropium bromide HFA (Atrovent)NR	
INHALATION SOLUTION		
albuterol/ipratropium (generic Duoneb) ipratropium **SOLN** (generic Atrovent)	OHTUVAYRE (ensifentrine) inhalation suspension YUPELRI (revefenacin)	
ORAL AGENT		
roflumilast (generic Daliresp)CL,QL	DALIRESP (roflumilast)CL, QL	

COUGH AND COLD, OPIATE COMBINATION

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	guaifenesin/codeine **LIQUID** hydrocodone/homatropine **SYRUP** promethazine/codeine **SYRUP** promethazine/phenylephrine/codeine **SYRUP**	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE dextromethorphan product ▪ All codeine or hydrocodone containing cough and cold combinations are limited to ≥ 18 years of age

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, TAB**	Drug-specific criteria: ▪ **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

CYTOKINE & CAM ANTAGONISTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
IL-6 ANTAGONISTS		▪ 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. Drug-specific criteria: • **Cibinqo/Rinvoq/RinvoqER:** For diagnois 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.
	ACTEMRA (tocilizumab) **PEN,SYR** AVTOZMA (tocilizumab-anoh) **AUTOINJ, SYR** AL,NR ENSPRYNG (satralizumab-mwge) **SYR** KEVZARA (sarilumab) **PEN, SYR** TYENNE (tocilizumab-aazg)AL	
IL-17 ANTAGONISTS		
TALTZ (ixekizumab)AL **AUTOINJ, SYR**	BIMZELX (bimekizumab-bkzx)AL **PEN, SYR** COSENTYX (secukinumab)AL,QL **PEN, SYR**	
IL-23 ANTAGONISTS		
PYZCHIVA (ustekinumab-ttwe, Stelara biosimilar)AL,CL **SYR** STEQEYMA (ustekinumab-stba)AL,CL **SYR**	ICOTYDE (icotrokinra)AL, NR, QL **TAB** ILUMYA (tildrakizumab) SUB-Q IMULDOSA (ustekinumab-srlf)AL **SYR** OMVOH (mirikizumab-mrkz)AL OTULFI (ustekinumab-aauz)AL **SYR** 100mg, 200mg,300mg **PEN**,**SYR** PYZCHIVA (ustekinumab-ttwe, Stelara biosimilar)AL,CL **VIAL** SELARSDI (ustekinumab-aekn)AL **SYR, VIAL** SKYRIZI (risankizamab-rzaa) **SYR** SKYRIZI (risankizamab-rzaa)QL **ON-BODY** SKYRIZI (risankizamab-rzaa)QL **PEN** STARJEMZA (ustekinumab-hmny)AL,NR **SYR** STARJEMZA (ustekinumab-hmny)AL,NR 45mg **VIAL** STELARA (ustekinumab)AL **SYR** STELARA (ustekinumab)AL **VIAL** STEQEYMA (ustekinumab-stba)AL,CL,NR **VIAL** TREMFYA (guselkumab) **AUTOINJ** AL,QL, **PEN**AL**SYR**AL USTEKINUMABAL **SYR, VIAL** USTEKINUMAB-AAUZ **SYR** (Otulfi biosimilar)AL,NR USTEKINUMAB-AEKN (biosimilar to Stelara)AL **SYR** USTEKINUMAB-TTWEAL **SYR, VIAL**NR YESINTEK (ustekinumab -kfce)AL **SYR, VIAL**	

CYTOKINE & CAM ANTAGONISTS, continued

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
JAK-INHIBITORS[CL]		▪ 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. Drug-specific criteria: • **Cibinqo/Rinvoq/RinvoqER:** For diagnois 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.
	CIBINQO (abrocitinib)[AL,CL,QL] **TAB** LEQSELVI (deuruxolitinib) **TAB** LISRAYA (brepocitinib)[NR] **TAB** LITFULO (ritlecitinib)[AL] **CAPS** OLUMIANT (baricitinib) [QL] **TAB** RINVOQ ER (upadacitinib)[CL,QL] **TAB** RINVOQ (upadacitinib)[AL,CL,QL] LQ **SOLN** tofacitinib (generic Xeljanz)[NR,QL] **SOLN** tofacitinib (generic Xeljanz)[NR,QL] **TAB** tofacitinib ER (generic Xeljanz XR)[NR,QL] XELJANZ (tofacitinib) **SOLN[QL]** XELJANZ (tofacitinib) **TAB[QL]** XELJANZ XR (tofacitinib) **TAB**[QL]	
TNF-BLOCKERS		
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**	

CYTOKINE & CAM ANTAGONISTS, continued

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
TNF-BLOCKERS (continued)		
	HULIO (adalimumab-fkjp)[AL] **PEN, SYR** HUMIRA (adalimumab)[QL] HYRIMOZ(CF) (adalimumab-adaz)[AL] **PEN, SYR** IDACIO (adalimumab-aacf)[AL] **PE**N, **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**	▪ 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. **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. Drug-specific criteria:. • **Pyzchiva/Steqeyma:** Requires a trial and failure of a preferred TNF blocker with the same indication. • **Cibinqo/Rinvoq/RinvoqER:** For diagnois 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.

CYTOKINE & CAM ANTAGONISTS, continued

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
MISCELLANEOUS MECHANISM OF ACTION		▪ 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. Drug-specific criteria: • **Cibinqo/Rinvoq/RinvoqER:** For diagnois 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.
OTEZLA (apremilast) **TAB**[QL]	ARCALYST (nilonacept) KINERET (anakinra) ENTYVIO (vedolizumab)[AL] **PEN** ORENCIA (abatacept**) CLICKJET** ORENCIA (abatacept**) SYR** OTEZLA XR (apremilast) **TAB** SOTYKTU (deucravacitinib) **TAB** SPEVIGO (spesolimab-sbzo)[AL]**SYR** VELSIPITY (etrasimod)[QL] **TAB**	

DIABETES MELLITUS, ALPHA-GLUCOSIDASE INHIBITORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
acarbose (generic Precose)	miglitol (generic Glyset)	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

DIABETES MELLITUS, INCRETIN MIMETICS/ENHANCERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
GLUCAGON-LIKE PEPTIDE-1 RECEPTOR AGONIST (GLP-1 RA)[AL,CL,QL]		**GLP-1 RA Criteria**
OZEMPIC (semaglutide)[AL,QL] TRULICITY (dulaglutide) [AL,QL] VICTOZA (liraglutide)[AL,QL]	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** OZEMPIC (semaglutide)[AL, NR, QL] **TAB**	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) Non-preferred agents will be approved for patients who have: • Failed a trial of TWO preferred agents within GLP-1 RA AND • Diagnosis of diabetes with HbA1C ≥ 7 AND • Trial of metformin, or contraindication or intolerance to metformin
INSULIN/GLP-1 RA COMBINATIONS		
	SOLIQUA (insulin glargine/lixisenatide) XULTOPHY (insulin degludec/liraglutide)	
AMYLIN ANALOG[CL]		**Amylin Analog Criteria**
	SYMLIN (pramlintide) subcutaneous	ALL criteria must be met ▪ Concurrent use of short-acting mealtime insulin ▪ Current therapy compliance ▪ No diagnosis of gastroparesis ▪ HbA1C ≤ 9% within last 90 days ▪ Monitoring of glucose during initiation of therapy
DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITOR[AL,CL,QL]		**DPP-4 Inhibitor Criteria**
JANUMET (sitagliptin/metformin) JANUVIA (sitagliptin) JENTADUETO (linagliptin/metformin) TRADJENTA (linagliptin)	alogliptin (generic Nesina) alogliptin/metformin (generic Kazano) alogliptin/pioglitazone (generic Oseni) BRYNOVIN (sitagliptin) **SOLN** dapagliflozin/saxagliptin (generic Qtern)[NR] GLYXAMBI (empagliflozin/linagliptin) JANUMET XR (sitagliptin/metformin) JENTADUETO XR (linagliptin/metformin) KOMBIGLYZE XR (saxagliptin/metformin) linagliptin (generic Tradjenta)[NR] ONGLYZA (saxagliptin) QTERN (dapagliflozin/saxagliptin) sitagliptin (generic Januvia)[NR]	Preferred agents require a diagnosis of Type II diabetes AND a trial and failure or intolerance to metformin. Non-preferred DPP-4s will be approved for patients who have failed a trial of ONE preferred agent within the DPP-4 inhibitor class

DIABETES MELLITUS, 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 phos/metformin (generic Janumet)[NR] sitagliptin phos-metformin er (generic Janumet XR)[AL,NR, QL] sitagliptin/ metformin (Zituvimet) sitagliptin/ metformin ER (generic Zituvimet XR) STEGLUJAN (ertugliflozin/sitagliptin) TRIJARDY XR (empagliflozin/linagliptin/metformin) ZITUVIMET (sitagliptin/metformin) **TAB**[QL] ZITUVIMET XR (sitagliptin/ metformin ER) **TAB**[QL] ZITUVIO (sitagliptin)	

DIABETES MELLITUS, INSULIN AND RELATED DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
HUMALOG U-100 **CARTRIDGE, PEN, VIAL** HUMALOG JR. (insulin lispro) U-100 **KWIKPEN** HUMALOG MIX **PEN** (insulin lispro protamine/lispro) 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 Novolog Mix) insulin lispro (generic Humalog) **PEN, VIAL, JR KWIKPEN** insulin lispro/lispro protamine **KWIKPEN** (Humalog Mix Kwikpen) LANTUS SOLOSTAR **PEN** (insulin glargine) LANTUS (insulin glargine) **VIAL**	ADMELOG (insulin lispro) **PEN, VIAL** AFREZZA (regular insulin)CL **INHALATION** APIDRA (insulin glulisine) **SOLOSTAR, VIAL** AWIQLI (insulin icodec-abae) FLEXTOUCH **PEN**NR BASAGLAR (insulin glargine, rec) **PEN** FIASP (insulin aspart) **CARTRIDGE, PEN, VIAL** HUMALOG U-100 **TEMPO PEN** HUMALOG (insulin lispro)CL U-200 **PEN** HUMALOG MIX **VIAL** (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 Semglee-YFGN) LEVEMIR (insulin detemir) **PEN, VIAL** LYUMJEV **KWIKPEN, VIAL**(insulin lispro-aabc) LYUMJEV (insulin lispro-aabc) **TEMPO PEN**	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: ▪ **Afrezza®:** Approved for T1DM on long-acting insulin with no current history of smoking or chronic lung disease • **Humulin® R U-500 Kwikpen:** May be approved for patients who require >200 units/day ▪ **Humalog U-200 Pen:** May be approved for patients who require > 100 units/day

DIABETES MELLITUS, INSULIN AND RELATED DRUGS, continued

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	MERILOG (insulin aspart-szjj) **SOLOSTAR PEN** MERILOG (insulin aspart-szjj) **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** SEMGLEE (insulin glargine) **PEN, VIAL** SEMGLEE YFGN (insulin glargine) **PEN, VIAL** TOUJEO SOLOSTAR (insulin glargine)	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

DIABETES MELLITUS, MEGLITINIDES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
repaglinide (generic Prandin)	nateglinide (generic Starlix)	▪ 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

DIABETES MELLITUS, 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}	▪ **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

DIABETES MELLITUS, SGLT2[CL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
dapagliflozin (generic Farxiga)[CL,QL] JARDIANCE (empagliflozin) [QL] SYNJARDY (empagliflozin/metformin)[AL,QL] XIGDUO XR (dapagliflozin/metformin)[QL]	BRENZAVVY (bexagliflozin)[NR] dapagliflozin (AG) (generic Farxiga)[CL,QL] dapagliflozin/metformin (generic Xigduo)[QL] FARXIGA (dapagliflozin)[QL] 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]	Preferred agents require a diagnosis of Type II diabetes AND a trial and failure or intolerance to metformin, **OR** A diagnosis of ASCVD or Heart Failure, or Chronic Kidney Disease associated with a diagnosis of Type II diabetes (no metformin trial required) ▪ Non-preferred agents will be approved for patients who have failed a trial with ONE preferred agent within this drug class Drug Specific Criteria: • **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

DIABETES MELLITUS, 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) glipizide 15mg[NR] tolazamide tolbutamide	▪ 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)		

DIABETES MELLITUS, TZD

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
THIAZOLIDINEDIONES (TZDs)		▪ Non-preferred agents will be approved for patients who have failed a trial of the preferred agent within this drug class
pioglitazone (generic Actos)		
TZD COMBINATIONS[CL]		
	pioglitazone/glimepiride (generic Duetact) pioglitazone/metformin (generic Actoplus Met)	▪ **Combination products:** Require clinical reason why individual ingredients cannot be used

DIURETICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
SINGLE-AGENT PRODUCTS		▪ Non-preferred agents will be approved for patients who have failed a trial of **TWO** preferred agents within this drug class. Drug Specific Criteria: ▪ **eplerenone**: Will be approved with a failed trial or intolerance to spironolactone, a trial with two preferred agents is not required. ▪ **Kerendia**: Approved for a diagnosis of chronic kidney disease associated with Type-I or 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.
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**	BAXFENDY (baxdrostat) **TAB** NR,AL,QL CAROSPIR (spironolactone)AL **SUSP** ENBUMYST (bumetanide)NR **NASAL SPRAY** eplerenone (generic Inspra)CL **TAB** ethacrynic acid (generic Edecrin) **CAPS** HEMICLOR (chlorthalidone) **TAB** INZIRQO (hydrochlorothiazide)QL **SUSP** spironolactone (generic Carospir)AL,CL **SUSP** THALITONE (chlorthalidone) **TAB** triamterene (generic Dyrenium)	
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	▪ Non-preferred agents require clinical documentation on why the preferred product within this drug class is not appropriate Drug-specific criteria: ▪ **Zavesca/miglustat:** Approved for mild to moderate type 1 Gaucher disease for whom enzyme replacement therapy is not a therapeutic option

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]	▪ 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 (darbopoetine alfa) **DISP SYR, VIAL** EPOGEN (rHuEPO) RETACRIT (epoetin alfa-epbx) *Pfizer manufacturer only*	PROCRIT (rHuEPO) RETACRIT (epoetin alfa-epbx) *Vifor manufacturer only* VAFSEO (vadadustat) **TAB**	▪ 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]	▪ Non-preferred agents will be approved for patients who have failed a 3-day trial of ONE preferred agent within this drug class Drug-specific criteria: ▪ **Baxdela:** Coverable with documented intolerance or failure of preferred MRSA agents (clindamycin, doxycycline, linezolid, sulfamethoxazole/trimethoprim) ▪ **Ciprofloxacin/Levofloxacin Suspension:** Coverable with documented swallowing disorders ▪ **Ofloxacin:** Trial of preferred not required for diagnoses of Pelvic Inflammatory Disease OR Acute Epididymitis (non-gonorrhea)

GI MOTILITY, CHRONIC

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
LINZESS (linaclotide)[AL,QL] lubiprostone (generic Amitiza)[AL,QL]	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]	▪ 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 Drug-specific criteria: ▪ **Lotronex/ alosetron:** Covered for diagnosis of IBS Diarrhea Predominant type with trial and failure of loperamide AND diphenoxylate ▪ **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
BAQSIMI (glucagon)[AL,QL] **NASAL** GLUCAGON EMERGENCY (glucagon)[QL] **INJ KIT** (Amphastar) GLUCAGON EMERGENCY (glucagon)[QL] **INJ KIT** (Fresenius) glucagon[QL] **INJ** GVOKE (glucagon)[AL,QL] **PEN**, **SYR** GVOKE (glucagon)[AL,QL] **VIAL** PROGLYCEM (diazoxide) **SUSP** ZEGALOGUE (dasiglucagon)[AL, QL] **AUTO-INJ**	diazoxide **SUSP** (generic Proglycem) GLUCAGON EMERGENCY (glucagon) **INJ KIT** (Lupin)[QL] GLUCAGON EMERGENCY (glucagon)[QL] **INJ KIT** (Mylan) ZEGALOGUE (dasiglucagon)[AL, QL] **SYR**	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

GLUCOCORTICOIDS, INHALED

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
GLUCOCORTICOIDS		▪ Non-preferred agents within the Glucocorticoids and Glucocorticoid/Bronchodilator Combo groups will be approved for patients who have failed a trial of TWO preferred agents within the last 6 months Drug-specific criteria: ▪ **budesonide respules:** Covered without PA for age ≤ 8 years OR for diagnosis of eosinophilic esophagitis in patients ≥ 9 years, by GI biopsy or upper endoscopy. For other indications, must have failed a trial of two preferred agents within this drug class, within the last 6 months.
ARNUITY ELLIPTA (fluticasone) ASMANEX (mometasone)[QL,AL] ASMANEX HFA (mometasone)[QL] fluticasone HFA (generic Flovent HFA)	ALVESCO (ciclesonide)[AL] ARMONAIR DIGIHALER (fluticasone)[AL,QL] beclomethasone (generic Qvar)[NR] fluticasone (generic Flovent Diskus) fluticasone furoate (generic Arnuity Ellipta) [AL] QVAR Redihaler (beclomethasone)	
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 Symbicort) fluticasone/salmeterol (generic Advair Diskus)[QL] fluticasone/salmeterol (generic Advair HFA)[QL] fluticasone/salmeterol (generic Airduo Respiclick) fluticasone/vilanterol (Breo Ellipta)	
INHALATION SOLUTION		
	budesonide **RESPULES** (generic Pulmicort)[CL]	

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** DEXLYT (dexamethasone)[NR] **TAB** 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**	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class within the last 6 months Drug-specific criteria: ▪ **Intensol Products:** Patient specific documentation of why the less concentrated solution is not appropriate for the patient

GROWTH HORMONES

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

H. PYLORI TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
PYLERA (bismuth, metronidazole, tetracycline)[QL]	bismuth,metronidazole,tetracycline (generic Pylera)[QL] lansoprazole/amoxicillin/clarithromycin (generic Prevpac)[QL] OMECLAMOX-PAK (omeprazole, clarithromycin, amoxicillin)[QL] TALICIA (omeprazole/amoxicillin/rifabutin) VOQUEZNA (vonoprazan)[CL,QL]	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-Specific Criteria • **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 180days. 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** HAEGARDA (C1 esterase inhibitor, human)[AL,CL] **SUB-Q** icatibant acetate (generic FIRAZYR)[AL] **SUB-Q** TAKHZYRO (lanadelumab-flyo)[AL,CL,QL] **SYRINGE**	ANDEMBRY (garadacimab)[AL,NR.QL] **AUTOINJECTOR** CINRYZE (C1 esterase inhibitor, human)[AL,CL,QL] **INTRAVENOUS** DAWNZERA [AL,QL] (donidalorsen) EKTERLY (sebetralstat)[AL] **TAB** FIRAZYR (icatibant acetate)[AL]**SUB-Q** ORLADEYO (berotralstat) **CAP**[AL,CL,QL] **PELLET**[AL,CL,QL] RUCONEST (recombinant human C1 inhibitor)[AL] **INTRAVENOUS** SAJAZIR (icatibant) [AL] **SUB-Q**	HAE Treatments PA Form • 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. Drug-Specific Criteria • **Andembry, Cinryze, Dawnzera, Haegarda, Orladeyo, and Takhzyro,** require a history of two or more HAE attacks monthly

HEMOPHILIA TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BISPECIFIC FACTORS		▪ 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.
HEMLIBRA		
FACTOR VIII		
ALPHANATE HUMATE-P KOVALTRY NOVOEIGHT NUWIQ XYNTHA **KIT, SOLOFUSE**	ADVATE ADYNOVATE AFSTYLA ALTUVIIIO 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	TRETTEN	
TISSUE FACTOR PATHWAY INHIBITOR/ ANTITHROMBIN INHIBITORS		
	ALHEMO[AL] HYMPAVZI[AL] QFITLIA (fitusiran)[AL] **PEN, VIAL**	
VON WILLEBRAND PRODUCTS		
WILATE	VONVENDI	

HEPATITIS B AND RELATED AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
entecavir **TAB**	adefovir dipivoxil BARACLUDE (entecavir) **SOLN, TAB** HEPCLUDEX (bulevirtide) **SUB-Q**NR lamivudine hbv **TAB** VEMLIDY (tenofovir alafenamide fumarate)	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug Specific Criteria ▪ **tenofovir disoproxil fumarate (generic Viread) tablet**: Diagnosis for use required. May be indicated for chronic hepatitis B or HIV-1 infection. ○ See HIV/AIDS class for drug listing and placement

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

PDL Update November 2, 2026, *Highlights* indicate change from previous posting

https://nebraska.fhsc.com/PDL/PDLlistings.asp

HEPATITIS C TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
DIRECT ACTING ANTI-VIRAL		Hepatitis C Treatments PA Form Hepatitis C Criteria ▪ Non-preferred products require trial of preferred agents within the same 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 Drug-specific criteria: Trial with with a preferred agent not required in the following: ▪ **Harvoni/ ledipasvir-sofosbuvir**: o Post liver transplant for genotype 1 or 4 ▪ **Vosevi:** Requires documentation of non-response after previous treatment course of Direct Acting Anti-viral agent (DAA) for genotype 1-6 without cirrhosis or with compensated cirrhosis
MAVYRET (glecaprevir/pibrentasvir) **TAB**[CL], **PELLET**[AL,CL] sofosbuvir/velpatasvir (generic Epclusa)[CL] VOSEVI (sofosbuvir/velpatasvir/ voxilaprevir)[CL]	HARVONI 200/45MG (ledipasvir/sofosbuvir)[CL] **TAB** HARVONI (ledipasvir/sofosbuvir)[CL] **PELLET** ledipasvir/sofosbuvir (generic Harvoni)[CL] SOVALDI (sofosbuvir)[CL] **PELLET** SOVALDI **TAB** (sofosbuvir)[CL] ZEPATIER (elbasvir/grazoprevir)[CL]	
RIBAVIRIN		
ribavirin 200mg **CAPSULE, TAB**		
INTERFERON		
PEGASYS (pegylated interferon alfa-2a) [CL]		

HISTAMINE II RECEPTOR BLOCKERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
famotidine **TAB** (generic Pepcid) famotidine **SUSP**	cimetidine (generic Tagamet)[CL] **SOLN, TAB** famotidine **CHEW-TAB** nizatidine **CAPS** (generic Axid) ranitidine **SYRUP, TAB**	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: ▪ **Cimetidine:** Approved for viral M. contagiosum or common wart V. Vulgaris treatment

HIV / AIDS [CL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CAPSID INHIBITOR		▪ All agents require: ○ 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 the patient, including, but not limited to, drug resistance or concomitant conditions not recommended with preferred agents ▪ Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy
	SUNLENCA (lenacapavir)[QL] YEZTUGO (lenacapavir)[NR,QL] **TAB**	
CCR5 ANTAGONISTS		
maraviroc (generic Selzentry) SELZENTRY (maraviroc) **SOLN**	SELZENTRY (maraviroc) **TAB**	
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) INTELENCE (etravirine)[QL] PIFELTRO (doravirine)[QL]	etravirine (generic Intelence)[QL] nevirapine IR, ER (generic Viramune/Viramune XR) rilpivirine (generic Edurant) SUSTIVA **CAPS, TABLET** (efavirenz) VIRAMUNE (nevirapine) **SUSP**	
NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTIs)		
abacavir **SOLN, TABLET** (generic Ziagen) emtricitabine **CAPS** (generic Emtriva) EMTRIVA **SOLN** (emtricitabine) lamivudine **SOLN, TABLET** (generic Epivir) zidovudine **CAPS, SYRUP, TABLET** (generic Retrovir)	didanosine DR (generic Videx EC) EMTRIVA **CAPS** (emtricitabine) EPIVIR (lamivudine) 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]	

HIV / AIDS [CL] (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
PROTEASE INHIBITORS		▪ All agents require: ○ 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.
atazanavir **CAPS** (generic Reyataz) darunavir ethanolate (generic Prezista)[AL] **TAB** ritonavir TAB (generic Norvir)	APTIVUS **CAPS, SOLN** (tipranavir) CRIXIVAN (indinavir) DARUNAVIR PROPYLENE GLYCOLATE[AL] **TAB** fosamprenavir **TAB** (generic Lexiva) LEXIVA **SUSP** (fosamprenavir) LEXIVA **TAB** (fosamprenavir) NORVIR **POWDER, SOLN** (ritonavir) NORVIR (ritonavir) **TAB** PREZISTA (darunavir) **SUSP** PREZISTA (darunavir) **TAB** REYATAZ **POWDER** (atazanavir) VIRACEPT (nelfinavir)	
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] PREZCOBIX PED **TAB for SUSP** (darunavir and cobicistat)[NR,AL,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)	

HIV / AIDS [CL] (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
COMBINATION PRODUCTS – MULTIPLE CLASSES		▪ All agents require: ○ 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
BIKTARVY (bictegravir/emtricitabine/ tenofovir)[QL] COMPLERA (rilpivirine/emtricitabine/tenofovir) DELSTRIGO (doravirine/lamivudine/tenofovir)[QL] DOVATO (dolutegravir/lamivudine)[QL] efavirenz/emtricitabine/tenofovir (generic Atripla)[CL] GENVOYA (elvitegravier/cobicistat/ emtricitabine/tenofovir)[QL, AL] JULUCA (dolutegravir/rilpivirine)[QL] ODEFSEY (emtricitabine/rilpivirine/ tenofovir)[QL] STRIBILD (elvitegravir/cobicistat/ emtricitabine/tenofovir)[QL] SYMFI (efavirenz/lamivudine/ tenofovir)[QL] SYMFI LO (efavirenz/lamivudine/ tenofovir)[QL] SYMTUZA (darunavir/cobicistat/ emtricitabine/tenofovir)[QL] TRIUMEQ (dolutegravir/abacavir/ lamivudine)	BIXLENVO (bictegravir/lenacapavir) **TAB** [NR] BIXLENVO-SUNLENCA **TAB**[NR] efavirenz/lamivudine/tenofovir (generic Symfi)[QL] efavirenz/lamivudine/tenofovir (generic Symfi Lo)[QL] IDVYNSO (doravirine/islatravir)[AL,NR] rilpivirine/emtricitabine/tenofovir (Complera)[NR] TRIUMEQ PD (abacavir/dolutegravir/lamivudine) **SUSP**	

IDIOPATHIC PULMONARY FIBROSIS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
pirfenidone (generic Esbriet)[QL]	ESBRIET (pirfenidone)[QL] JASCAYD (nerandomilast)[NR] nintedanib (generic Ofev)[NR, QL] **CAPS** OFEV (nintedanib esylate)[QL] CAPS	▪ Non-preferred agent requires trial of preferred agent within this drug class with the same indication ▪ FDA approved indication required – ICD-10 diagnosis code

IMMUNOMODULATORS, ASTHMA [CL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
FASENRA (benralizumab)[AL] **PEN** XOLAIR (omalizumab) **AUTO-INJ**[AL,QL], **SYR**[AL,QL]	EXDENSUR (depemokimab-ulaa) [AL,NR] **SYR** NUCALA (mepolizumab)[AL] **AUTO-INJ, SYR** OMLYCLO (omalizumab-igec)[AL,NR,QL] **SYR** TEZSPIRE (tezepelumab-ekko)[AL,CL] **PEN**	Immunomodulators Self-Injectable PA Form Immunomodulators: Self-Administered Injectables Criteria ▪ 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 (see links above) **Drug Specific Criteria:** ▪ **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 links above).

IMMUNOMODULATORS, ATOPIC DERMATITIS [AL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ADBRY (tralokinumab-ldrm) [AL,CL,QL] **SUB-Q** ADBRY 300mg/2mL (tralokinumab-ldrm) [AL,CL,QL] **AUTOINJ** DUPIXENT (dupilumab)[AL,CL] **PEN,SYR** EBGLYSS (lebrikizumab-lbkz)[AL,CLQL] **PEN, SYRINGE** ELIDEL (pimecrolimus) EUCRISA (crisaborole)[CL,QL] pimecrolimus (generic Elidel) tacrolimus (generic Protopic)	ADQUEY (difamilast) **OINT** [AL,NR] ANZUPGO (delgocitinib)[QL] **CREAM** NEMLUVIO (nemolizumab-ilto)[AL] OPZELURA (ruxolitinib phosphate) **CREAM**[AL,CL,QL] VTAMA (tapinarof)[AL] **CREAM** ZORYVE 0.15% (roflumilast)[AL] **CREAM** ZORYVE 0.05% (roflumilast)[AL,NR] **CREAM**	Immunomodulators Self-Injectable PA Form Immunomodulators: Self-Administered Injectables Criteria • 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. Drug-specific criteria: • **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, and links above): ○ **Atopic Dermatitis**: May be approved after a minimum of a 14-day trial of a topical corticosteroid AND a 6-week topical calcineurin inhibitor • **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

IMMUNOMODULATORS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
imiquimod (generic Aldara)	HYFTOR (sirolimus)[AL] **GEL** imiquimod (generic Zyclara) podofilox (generic Condylox) **GEL, SOLN** VEREGEN (sinecatechins)	▪ 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 Zortress)[AL] mycophenolate (generic Cellcept) **CAPS, TAB** mycophenolic acid 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]	Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class ▪ Patients established on existing therapy will be allowed to continue Drug Specific Criteria ▪ **Tavneos** (avacopan) ▪ No trial of a preferred agent required with appropriate FDA indications with concurrent use of standard therapy, including glucocorticoids

INTRANASAL RHINITIS AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ANTICHOLINERGICS		Non-preferred agents will be approved for patients who have failed a 30-day trial of ONE preferred agent within the same subclass. Drug-specific criteria: ▪ **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
ipratropium (generic Atrovent)		
ANTIHISTAMINES		
azelastine 0.1% (generic Astelin)	azelastine 0.15% (generic Astepro) azelastine/fluticasone (generic Dymista) olopatadine (generic Patanase) RYALTRIS (olopatadine/mometasone)[AL]	
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: ▪ **montelukast granules:** PA not required for age < 2 years

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) **SOLN** linezolid **SUSP** SIVEXTRO (tedizolid phosphate) ZYVOX (linezolid) **SUSP, TAB**	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

LIPOTROPICS, OTHER

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BILE ACID SEQUESTRANTS		▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within the same subclass. Drug-specific criteria: ▪ **Colesevelam**: Trial not required for diabetes control and monotherapy with metformin, sulfonylurea, or insulin has been inadequate ▪ **Juxtapid/ Kynamro:** ○ Approved for diagnosis of homozygous familial hypercholesterolemia (HoFH) OR ○ Treatment failure/maximized dosing/contraindication to ALL the following: statins, ezetimibe, niacin, fibric acid derivatives, omega-3 agents, bile acid sequestrants ○ Require faxed copy of REMS PA form ▪ **Redemplo/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
cholestyramine (generic Questran) colestipol **TAB** (generic Colestid)	colesevelam (generic Welchol)[CL] **TAB, PACKET** colestipol (generic Colestid) **GRANULES** QUESTRAN LIGHT (cholestyramine)	
TREATMENT OF HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA		
	JUXTAPID (lomitapide)[CL] KYNAMRO (mipomersen)[CL]	
TREATMENT OF FAMILIAL CHYLOMICRONEMIA SYNDROME (FCS)		
	TRYNGOLZA (olezarsen)[AL,CL,QL] **INJ** REDEMPLO (plozasiran)[CL] **SYR**	
FIBRIC ACID DERIVATIVES		
fenofibrate (generic Tricor) fenofibrate (generic Lofibra) gemfibrozil (generic Lopid)	fenofibric acid (generic Fibricor/Trilipix) fenofibrate (generic Antara/Fenoglide/ Lipofen/Triglide)	
NIACIN		
niacin ER (generic Niaspan)	NIACOR (niacin IR)	
OMEGA-3 FATTY ACIDS		
icosapent (generic Vascepa) omega-3 fatty acids (generic Lovaza)	omega-3 **OTC**	
CHOLESTEROL ABSORPTION INHIBITORS		
ezetimibe (generic Zetia)	NEXLETOL (bempedoic acid) NEXLIZET (bempedoic acid/ ezetimibe)[QL]	

LIPOTROPICS, OTHER (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
PROPROTEIN CONVERTASE SUBTILISIN/KEXIN TYPE 9 (PCSK9) INHIBITORS		**Drug-Specific Criteria** **Praluent and Repatha**: May be approved for diagnoses of: • Atherosclerotic cardiovascular disease (ASCVD) in adults • Heterozygous familial hypercholesterolemia (HeFH) ○ Praluent ≥ 8 years of age ○ Repatha ≥ 10 years of age • Homozygous familial hypercholersterolemia (HoFH) ○ Praluent ≥ 18 years of age ○ Repatha ≥ 10 years of age AND • Trial and failure or intolerance to a statin plus ezetimibe 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: ○ ASCVD – < 70 mg/dL ○ Very high risk ASCVD- < 55mg/dL ○ HeFH – < 100 mg/dL
PRALUENT (alirocumab)[CL] REPATHA (evolocumab)[CL] **SURECLICK, SYR**	LIPFENDRA (enlicitide)[NR,QL] **TAB** REPATHA (evolocumab)[CL] **PUSHTRONEX**	

LIPOTROPICS, STATINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
STATINS		▪ Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class, within the last 12 months Drug-specific criteria: ▪ **Altoprev®:** One of the TWO trials must be IR lovastatin ▪ **Combination products:** Require clinical reason why individual ingredients cannot be used ▪ **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
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)	
STATIN COMBINATIONS[CL]		
	atorvastatin/amlodipine (generic Caduet) simvastatin/ezetimibe (generic Vytorin)[CL]	

MACROLIDES AND KETOLIDES, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
MACROLIDES		▪ Non-preferred agents require clinical reason why preferred products within this drug class cannot be used AND ≥ 3-day trial on a preferred product
azithromycin (generic Zithromax) clarithromycin **SUSP, TAB** (generic Biaxin) erythromycin ethylsuccinate **SUSP**	azithromycin (generic Zithromax) **PACKET** clarithromycin ER (generic Biaxin XL) E.E.S. SUSP (erythromycin ethylsuccinate) E.E.S. TAB (erythromycin ethylsuccinate) ERY-TAB (erythromycin) ERYPED SUSP (erythromycin) ERYTHROCIN (erythromycin) erythromycin base CAPS, TAB	

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**	Non-preferred agents require a trial of the preferred agent AND will be approved for an FDA-approved indication Drug-specific criteria: ▪ **Xatmep™**: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,CLQL] **CAPS, SPRINKLES** tetrabenazine (generic Xenazine)[CL]	INGREZZA (valbenazine)[AL,CL] **INITIATION PACK** XENAZINE (tetrabenazine)[CL]	All drugs require an FDA approved indication – ICD-10 diagnosis code required. 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. Drug-specific criteria: ▪ **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 ▪ **tetrabenazine:** Diagnosis of chorea with Huntington's Disease

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)[QL] teriflunomide (generic Aubagio)[QL]	AUBAGIO (teriflunomide)[QL] BAFIERTAM (monomethyl fumarate)[QL] BETASERON (interferon β -1b)[QL] cladribine (generic Mavenclad) 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) VUMERITY (diroximel)[QL] ZEPOSIA (ozanimod)[AL,CL,QL]	▪ Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class Drug-specific criteria: ▪ **Ampyra/ dalfampridine:** Approved for diagnosis of gait disorder associated with MS AND EDSS score ≤ 7 ▪ **Zeposia:** Approved for a diagnosis of relapsing forms of multiple sclerosis (MS) with trial of TWO preferred agents 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)	▪ Non-preferred agents will be approved for patients who have failed a trial of **ONE** preferred agent within this drug class

NSAIDs, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
COX-I SELECTIVE		▪ 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. Drug-specific criteria: ▪ **meclofenamate**: Approvable without trial of preferred agents for menorrhagia ▪ **Sprix/ketoralac Nasal:** Approved for patients unable to tolerate, swallow OR absorb oral NSAIDs OR contraindication OR trial of TWO preferred oral NSAIDs
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) ibuprofen 300mg **TAB** indomethacin ER (generic Indocin) ketoprofen & ER (generic Orudis) ketorolac (generic Sprix Nasal)[CL,QL] **NASAL** meclofenamate (generic Meclomen)[CL] mefenamic acid (generic Ponstel) meloxicam (generic Vivlodex)[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**	

NSAIDs, ORAL (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
COX-I SELECTIVE (continued)		▪ All combination agents require a clinical reason why individual agents can't be used separately
	ALL BRAND NAME NSAIDs including: DOLOBID (diflunisal) AL 250mg **TAB** DUEXIS (ibuprofen/famotidine)CL NALFON (fenoprofen) RELAFEN DS (nabumetone)	
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) diclofenac **SOLN** (generic Pennsaid) FLECTOR **PATCH** (diclofenac) LICART **PATCH** (diclofenac)	▪ 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.

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

PDL Update November 2, 2026, *Highlights* indicate change from previous posting

https://nebraska.fhsc.com/PDL/PDLlistings.asp

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

ONCOLOGY AGENTS, ORAL, BREAST

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CDK 4/6 INHIBITOR		▪ Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines ▪ Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy Drug-specific critera ▪ **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
	IBRANCE (palbociclib) KISQALI (ribociclib) KISQALI FEMARA **CO-PACK** VERZENIO (abemaciclib)	
CHEMOTHERAPY		
capecitabine (generic Xeloda) cyclophosphamide	XELODA (capecitabine)	
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) VEPPANU (vepdegestrant)[NR,QL]	

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

PDL Update November 2, 2026, *Highlights* indicate change from previous posting

https://nebraska.fhsc.com/PDL/PDLlistings.asp

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

ONCOLOGY AGENTS, ORAL, HEMATOLOGIC

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ALL		▪ Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines
mercaptopurine	PURIXAN (mercaptopurine)[AL,CL] mercaptopurine (generic Purixan)[AL,CL] **SUSP**	
AML		▪ Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy
	DAURISMO (glasdegib maleate)[QL] IDHIFA (enasidenib) REZLIDHIA (olutasidenib)[QL] RYDAPT (midostaurin) TIBSOVO (ivosidenib)[QL] VANFLYTA (quizartinib) XOSPATA (gilteritinib) [QL]	Drug-specific critera ▪ **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		
	BEQALZI (sonrotoclax) **TAB, Starter Pack** [NR] COPIKTRA (duvelisib) [QL] IMBRUVICA (ibrutinib) VENCLEXTA (venetoclax) ZYDELIG (idelalisib)	
CML		
hydroxyurea (generic Hydrea) imatinib (generic Gleevec)	BOSULIF (bosutinib) bosutinib (generic Bosulif) **TAB**[NR] CAVHANZA ODT (nilotinib)[NR] 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)	

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

ONCOLOGY AGENTS, ORAL, HEMATOLOGIC, continued

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
MPN		▪ 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 Drug-specific critera ▪ **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
	JAKAFI (ruxolitinib)[AL] JAKAFI XR (ruxolitinib)[AL,NR]	
MYELOMA		
REVLIMID[QL] (lenalidomide)	lenalidomide[QL] (generic Revlimid) NINLARO (ixazomib) pomalidomide (generic Pomalyst)[NR] POMALYST (pomalidomide) THALOMID (thalidomide) XPOVIO (71envatini) [CL] ZENBEXUS (iberdomide)[NR] **CAPS**	
OTHER		
MATULANE (procarbazine) tretinoin (generic Vesanoid)[AL]	BRUKINSA (zanubrutinib[QL] CALQUENCE (acalabrutinib)[QL] INREBIC (fedratinib dihydrochloride)[QL] INQOVI (decitabine/cedazuridine) OJJAARA (momelotinib) REVUFORJ (revumenib) **TAB** VONJO (pacritinib)[QL] ZOLINZA (vorinostat)	

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

PDL Update November 2, 2026, *Highlights* indicate change from previous posting

https://nebraska.fhsc.com/PDL/PDLlistings.asp

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

ONCOLOGY AGENTS, ORAL, LUNG

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ALK		▪ Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines ▪ Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy
	ALECENSA (alectinib) ALUNBRIG (brigatinib)QL ENSACOVE (ensartinib)NR LORBRENA (lorlatinib) QL ZYKADIA (ceritinib) **CAPS, TAB**	
ALK / ROS1 / NTRK		
	AUGTYRO (repotrectinib) **CAPS** ROZLYTREK (entrectinib)QL**CAPS, PELLETS** XALKORI (crizotinib) **CAPS, PELLETS**	
EGFR		
erlotinib (generic Tarceva)	afatinib dimaleate (generic Gilotrif)NR gefitinib (generic Iressa) GILOTRIF (afatinib) IRESSA (gefitinib) LAZCLUZE (72envatinib) TAGRISSO (72envatinib72) VIZIMPRO (dacomitinib)QL	
HER2/ TKD		
	HERNEXEOS (zongertinib)NR HYRNUO (sevabertinib)NR	
OTHER		
	GAVRETO (pralsetinib)QL HYCAMTIN (topotecan) JIDEYTRO (zidesamtinib)NR KRAZATI (adagrasib) LUMAKRAS (sotrasib)QL RETEVMO (selpercatinib)AL TABRECTA (capmatinib)QL TEPMETKO (tepotinib) QL VEPESID CAPSULE (etoposide)NR	

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

ONCOLOGY AGENTS, ORAL, OTHER

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
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] LIFYORLI (relacorilant)[NR] **CAPS** LONSURF (trifluridine/tipiracil) LYNPARZA (olaparib) LYTGOBI (futibatinib) MODEYSO (dordaviprone)[NR] OGSIVEO (nirogacestat) **TAB** PEMAZYRE (pemigatinib)[QL] QINLOCK (ripretinib) RASONQUE (daraxonrasib)[NR] ROMVIMZA (vimseltinib) **CAPS** RUBRACA (rucaparib) STIVARGA (regorafenib) TAZVERIK (tazemetostat)[AL] TURALIO (pexidartinib)[QL] VITRAKVI (73envatinib73ib) **CAPS, SOLN** VORANIGO (vorasidenib)[AL] **TAB** ZEJULA (niraparib) **TAB**	▪ 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 acetonide, submicronized) ZYTIGA (abiraterone)[AL,QL]	▪ Non-preferred agents DO NOT require a trial of a preferred agent, but DO require an FDA-approved indication OR documentation submitted supporting off-label use from current treatment guidelines ▪ Patients undergoing treatment at the time of any preferred status change will be allowed to continue therapy

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

PDL Update November 2, 2026, *Highlights* indicate change from previous posting

https://nebraska.fhsc.com/PDL/PDLlistings.asp

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

ONCOLOGY AGENTS, ORAL, RENAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
everolimus (generic Afinitor) **TAB** sunitinib malate (generic Sutent) **CAPS** VOTRIENT (pazopanib)	AFINITOR DISPERZ (everolimus)[C] CABOMETYX (cabozantinib) everolimus **SUSP** (generic Afinitor Disperz) everolimus **TAB** (generic Yulithira)[NR] 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]	▪ 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		▪ 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
	ERIVEDGE (vismodegib) ODOMZO (sonidegib)	
BRAF MUTATION		
MEKINIST (trametinib) TAFINLAR (dabrafenib)	BRAFTOVI (encorafenib) COTELLIC (cobimetinib) MEKINIST (trametinib) **SOLN** MEKTOVI (binimetinib) OJEMDA (tovorafenib) **SUSP**[AL]**, TAB** TAFINLAR (dabrafenib) **SUSP** ZELBORAF (vemurafenib)	

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) olopatadine **OTC** (PATADAY XS) NR PATADAY OTC (olopatadine 0.2%) PATADAY XS (olopatadine 0.7%) ZERVIATE (certirizine) AL	▪ Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class

OPHTHALMICS, ANTIBIOTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
FLUOROQUINOLONES		▪ Non-preferred agents will be approved for patients who have failed a one-month trial of TWO preferred agents within the same subclass Drug-specific criteria: ▪ **Azasite®:** Approval only requires trial of erythromycin ▪ **Natacyn®:** Approved for documented fungal infection
ciprofloxacin **SOLN** (generic Ciloxan) ofloxacin (generic Ocuflox)	besifloxacin (generic Besivance)[NR] BESIVANCE (besifloxacin) CILOXAN (ciprofloxacin) gatifloxacin 0.5% (generic Zymaxid) moxifloxacin (generic Vigamox) moxifloxacin (generic Moxeza) VIGAMOX (moxifloxacin)	
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**	

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)	▪ Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class

OPHTHALMICS, ANTI-INFLAMMATORIES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CORTICOSTEROIDS		▪ 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
fluorometholone 0.1% (generic FML) **OINT** MAXIDEX (dexamethasone) PRED MILD (prednisolone 0.12%) prednisolone acetate 1% (generic Omnipred, Pred Forte)	BYQLOVI (clobetasol)[NR] 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%	
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%)	

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)	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

OPHTHALMICS, GLAUCOMA

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
MIOTICS		▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within the same subclass. Drug-specific criteria: ▪ **Rhopressa and Rocklatan:** Electronically approved for patients who have a trial of ONE generic agent, within ophthalmic – glaucoma within 180 days
pilocarpine	VUITY (pilocarpine)	
SYMPATHOMIMETICS		
ALPHAGAN P (brimonidine 0.15%) brimonidine 0.2% (generic Alphagan)	ALPHAGAN P (brimonidine 0.1%) apraclonidine (generic Iopidine) brimonidine P 0.15% (generic Alphagan P 0.15%) brimonidine 0.1% (generic Alphagan P 0.1%)	
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 Trusopt)	AZOPT (brinzolamide) brinzolamide (generic Azopt)	
PROSTAGLANDIN ANALOGS		
latanoprost (generic Xalatan) TRAVATAN Z (travoprost)	bimatoprost (generic Lumigan)[NR] 0.01% bimatoprost (generic Lumigan) 0.03% IYUZEH (latanoprost) OMLONTI (omidenepag isopropyl)[NR] tafluprost (generic Zioptan) travoprost (generic Travatan Z) VYZULTA (latanoprostene) XALATAN (latanoprost) ZIOPTAN (tafluprost) ZOLYMBUS GEL (bimatoprost)[NR]	
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) YUVEZZI (carbachol/brimonidine tartrate)[NR]	

OPHTHALMICS, GLAUCOMA (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
OTHER		▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within the same subclass. Drug-specific criteria: ▪ **Rhopressa and Rocklatan:** Electronically approved for patients who have a trial of ONE generic agent, within the ophthalmic - glaucoma class within 180 days
RHOPRESSA (netarsudil)[CL] ROCKLATAN (netarsudil and latanoprost) [CL]		

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]	Opioid Dependence Treatment PA Form Opioid Dependence Treatment Informed Consent ▪ 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. Drug-specific criteria: ▪ **Lucemyra/ lofexidine**: Approved for FDA approved indication and dosing per label. Trial of preferred product not required.

OPIOID-REVERSAL TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
naloxone **VIAL** naloxone (generic Narcan) **OTC NASAL** NARCAN (naloxone) **NASAL (OTC)**	KLOXXADO (naloxone) **NASAL** naloxone (generic Narcan) **(Rx) SYR** NARCAN (naloxone) **NASAL (Rx)** OPVEE (nalmefene)[AL] **NASAL** REXTOVY (naloxone) **NASAL** REZENOPY (naloxone) **NASAL**[NR] ZIMHI (naloxone) **SYR** ZURNAI (nalmefene injection)	▪ 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 Vosol)	acetic acid/hydrocortisone (generic Vosol HC) CLOTIC (clotrimazole) **SOLN**	▪ 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)	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class

PAH (PULMONARY ARTERIAL HYPERTENSION AGENTS), ORAL AND INHALED

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ambrisentan (generic Letairis) **TAB** REVATIO (sildenafil)[CL,QL] **TAB** sildenafil (generic Revatio)[CL] **SUSP** tadalafil (generic Adcirca)[CL] **TAB** TRACLEER (bosentan) **TAB**	ADEMPAS (riociguat)[CL] **TAB** ADCIRCA (tadalafil)[CL] **TAB** bosentan (generic Tracleer) **TAB, TAB for SUSPENSION** LETAIRIS (ambrisentan) **TAB** LIQREV (sildenafil)[CL] **SUSP** macitentan (generic Opsumit)[NR] **TAB** OPSUMIT (macitentan) **TAB** OPSYNVI (macitentan and tadalafil) **TAB** ORENITRAM ER (treprostinil) **TAB, TITRATION KIT** REVATIO (sildenafil)[CL] **SUSP** RIOCIGUAT TABLET (generic Adempas)[NR] sildenafil (generic Revatio)[CL] **TAB** TADLIQ (tadalafil)[CL] **SUSP** TRACLEER (bosentan) **TAB FOR SUSPENSION** TYVASO **DPI** (treprostinil) **INHL** TYVASO (treprostinil) **INHL PWDR** UPTRAVI (selexipag) **TAB** VENTAVIS (iloprost) **INHALATION**	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class within the last 6 months Drug-specific criteria: ▪ **Adcirca/Liqrev/ Revatio/sildenafil tablets and suspension/Tadliq/tadalafil:** Approved for diagnosis of Pulmonary Arterial Hypertension (PAH) ▪ **Adempas®/ riociguat:** 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/Tadliq 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)	▪ Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class

PEDIATRIC VITAMIN PREPARATIONS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CHILD MVI (mvi, ped mvi no. 19/FA, CHILD MVI (mvi, ped mvi no. 19/FA, ped mvi no. 17) **OTC CHEW** CHILDREN'S CHEWABLES **OTC** (ped mvi no. 25/FA, ped mvi no. 31 /iron/FA, ped mvi no.17/iron sulf) FLINSTONES COMPLETE CHEW[NR] **OTC** FLUORIDE/VITAMINS A,C,AND D **DROPS** (ped mvi A,C,D3 no.21/ fluoride) MULTIVITAMINS W/ FLUORIDE (PEDI MVI NO.2 W-FLUORIDE) **DROPS** MULTIVITS W/ IRON & FLUORIDE **DROPS** (ped mvi no. 45/fluoride/iron) PED MVI NO.17 W/ FLUORIDE **CHEW** POLY-VITAMIN (ped mvi no. 212) **DROPS OTC** POLY-VITAMIN W/ IRON (ped mvi no. 207 w/ferrous sulf) **DROPS OTC** TRI-VITAMIN W/ FLUORIDE (ped mvi A,C, D3 no. 21/fluoride)	DEKAs PLUS[AL, CL] FLORAFOL(pedi mv no.257/sodium fluoride) **PEDIATRIC DROPS OTC** FLORAFOL FE PEDIATRIC (ped multivit 257/fluoride/iron) **DROPS OTC** MULTI-VIT-FLOR (pedi multivit no.228/fluoride, pedi multivit no.219/fluoride) **CHEW** PEDI MULTIVIT A,C,AND D3 NO.21 **DROPS OTC** PEDI MVI NO.22 WITH FLUORIDE[NR] **DROPS-OTC** PEDI MVI NO.242/FLUORIDE **CHEW-OTC** POLY-VI-FLOR (ped mvi no.217/fluoride, ped mvi no. 205/fluoride) **CHEW** 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**	▪ Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class Drug specific criteria: ▪ **DEKAs Plus**: Approved for diagnosis of Cystic Fibrosis and does not require a trial of a preferred agent

PEDIATRIC VITAMIN PREPARATIONS, continued

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**

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
	QUFLORA (ped mvi no.84/fluoride, ped mvi no. 63/fluoride, ped mvi no. 83/fluoride) QUFLORA FE (ped mvi 142/iron/fluoride, ped mvi no. 151/iron/fluoride) **CHEW** QUFLORA (ped mvi no.157/ fluoride) **OTC** SOLUVITA A,C,D WITH FLUORIDE **DROPS OTC** SOLUVITA MULTIVITAMIN FLUORIDE **DROPS OTC** TRI-VI-FLOR (ped mvi A,C,D3 no.38/fluoride) **DROPS**	▪ Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class Drug specific criteria: ▪ **DEKAs Plus**: Approved for diagnosis of Cystic Fibrosis and does not require a trial of a preferred agent

PENICILLINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
amoxicillin **CAPS, CHEWABLE TAB, SUSP, TAB** ampicillin **CAPS** dicloxacillin penicillin VK	PIVYA (pivmecillinam)[AL,CL,] **TAB**	Drug Specific Criteria • **Pivya tablets**: Approved for treatment of female patients 18 years of age and older with uncomplicated urinary tract infections (uUTI) caused by E. coli, Proteus mirabilis and Staphylococcus saprophyticus. Also requires a trial/failure of nitrofurantoin ER, trimethoprim, or trimethoprim/sulfamthoxazole or clinical reason why they can't be used.

PHOSPHATE BINDERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
calcium acetate **TAB (OTC)** sevelamer carbonate (generic Renvela) **PWD PACK, TAB**	AURYXIA (ferric citrate) calcium acetate **CAPS** calcium acetate **TAB (Rx)** CALPHRON **OTC** (calcium acetate) ferric citrate (generic Auryxia) 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**	▪ 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 clopidogrel (generic Plavix) dipyridamole (generic Persantine) prasugrel (generic Effient) ticagrelor (generic Brilinta)	aspirin/dipyridamole (generic Aggrenox) BRILINTA (ticagrelor) ticlopidine (generic Ticlid) YOSPRALA (aspirin/omeprazole)	▪ 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

Nebraska Medicaid
Preferred Drug List
with Prior Authorization Criteria

PDL Update November 2, 2026, *Highlights* indicate change from previous posting

https://nebraska.fhsc.com/PDL/PDLlistings.asp

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
CONCEPT OB CONCEPT DHA 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** TRICARE TRINATAL RX 1 VITAFOL **CHEW TAB** VITAFOL FE+ VITAFOL ULTRA VITAFOL-OB VITAFOL-OB+DHA VITAFOL-ONE	ALTRIXA OB **OTC** AZENTRA[NR] CITRANATAL B-CALM COMPLETENATE **CHEW TAB** ENBRACE HR MARNATAL-F MATRONEX TABLET **OTC** MULTI-MAC **OTC** NATAL PNV (pnv no.164/iron/folate no.6) NATALCORE CHEW[NR] 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** 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 PRENOVA[NR] PRIMACARE PROVIDA OB SELECT-OB **CHEW TAB** TRISTART DHA VITAFOL NANO WESTGEL DHA	▪ Non-preferred agents will be approved for patients who have failed a trial of or are intolerant to TWO preferred agents within this drug class

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**

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 KONVOMEP (omeprazole/sodium bicarb) **SUSP** lansoprazole (generic Prevacid)[QL] NEXIUM **SUSP** (esomeprazole) omeprazole/sodium bicarbonate (generic Zegerid RX) pantoprazole **GRANULES** [QL] rabeprazole (generic Aciphex)	▪ Non-preferred agents will be approved for patients who have failed an 8-week trial of THREE preferred agents. **Pediatric Patients:** Patients ≤ 4 years of age – No PA required for Prevacid 30mg/ lansoprazole 30mg capsules (used to compound suspensions). Drug-specific criteria: ▪ **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 ≥ 5 years of age- Only approve non-preferred for GI diagnosis if: ▪ Child can not swallow whole generic omeprazole capsules OR, ▪ Documentation that contents of capsule may not be sprinkled in applesauce

SEDATIVE HYPNOTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BENZODIAZEPINES		**Benzodiazepines Criteria**
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)	▪ 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[CL]		**Others Criteria**
eszopiclone (generic Lunesta)[AL] zaleplon (generic Sonata) zolpidem (generic Ambien)[CL]	BELSOMRA (suvorexant) [AL,QL] DAYVIGO (lemborexant) [AL,QL] doxepin (generic Silenor)[CL] EDLUAR (zolpidem sublingual) HETLIOZ (tasimelteon)[AL] HETLIOZ LQ (tasimelteon) **SUSP** [AL,QL] QUVIVIQ (daridorexant)[QL] ramelteon (generic Rozerem)[AL] tasimelteon (generic Hetlioz) [AL] zolpidem[QL] **CAP** zolpidem ER (generic Ambien CR)[CL] zolpidem SL (generic Intermezzo)[CL]	▪ Non-preferred agents require a trial of TWO preferred agents in the OTHERS sub-category ▪ **Silenor/doxepin Tablet**: Must meet ONE of the following: ○ 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

SICKLE CELL ANEMIA TREATMENT [AL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ENDARI (L-glutamine)[CL]	GLUTAMINE POWD PACK (generic Endari) OXBRYTA (voxelotor)[CL] SIKLOS (hydroxyurea)[CL] **TAB** XROMI (hydroxyurea)[CL] **SOLN**	Drug-Specific Criteria ▪ **Endari:** Patient must have documented two or more hospital admissions per year due to sickle cell crisis despite maximum hydroxyurea dosage. ▪ **Oxbryta**: Not inidcated for sickle cell crisis. Patient must have had at least one sickle cell-related vaso-occlusive event within the past 12 months; AND baseline hemoglobin is 5.5 g/dL ≤ 10.5 g/dL; AND patient is not receiving concomitant, prophylactic blood tranfusion therapy ▪ **Siklos**: May be approved for use in patients ages 2 to 17 years old. ▪ **Xromi** solution: May be approved for use in patients ages 6 months to 2 years old.

SINUS NODE INHIBITORS

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

SKELETAL MUSCLE RELAXANTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
baclofen (generic Lioresal) cyclobenzaprine (generic Flexeril)[QL] methocarbamol (generic Robaxin) tizanidine **TAB** (generic Zanaflex)	ATMEKSI (methocarbamol)[NR, AL] **SUSP** baclofen (generic Fleqsuvy)[QL] **SUSP** baclofen (generic Ozobax)[QL] **SOLN** baclofen (generic Ozobax DS) **SUSP** carisoprodol (generic Soma)[CL,QL] carisoprodol compound chlorzoxazone (generic Parafon Forte) cyclobenzaprine ER (generic Amrix)[CL] dantrolene (generic Dantrium)[CL] FEXMID (cyclobenzaprine ER) FLEQSUVY (baclofen)[QL] **SUSP** LORZONE (chlorzoxazone)[CL] LYVISPAH (baclofen)[QL] **GRANULES** metaxalone (generic Skelaxin) NORGESIC FORTE (orphenadrine/ASA/caffeine) ONTRALFY (tizanidine) **SOLN** orphenadrine ER PARAFON FORTE (chlorzoxazone) TANLOR (methocarbamol) **TAB** tizanidine[CL] **CAPS** ZANAFLEX (tizanidine)[CL] **CAPS, TAB**	▪ Non-preferred agents will be approved for patients who have failed a 1-week trial of TWO preferred agents within this drug class Drug-specific criteria: ▪ **cyclobenzaprine ER:** ○ Requires clinical reason why IR cannot be used ○ Approved only for acute muscle spasms ○ NOT approved for chronic use ▪ **carisoprodol:** ○ Approved for Acute, musculoskeletal pain - NOT for chronic pain ○ Use is limited to no more than 30 days ○ Additional authorizations will not be granted for at least 6 months following the last day of previous course of therapy ▪ **dantrolene:** Trial NOT required for treatment of spasticity from spinal cord injury ▪ **Lorzone®:** Requires clinical reason why chlorzoxazone cannot be used ▪ **Zanaflex capsules/tablets:** Requires clinical reason generic cannot be used

STEROIDS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
LOW POTENCY		▪ Low Potency Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class
DERMA-SMOOTHE FS (fluocinolone) hydrocortisone OTC & RX **CREAM, LOTION, OINT (Rx only)**	alclometasone dipropionate (generic Aclovate) desonide **LOTION** (generic Desowen) desonide **CREAM, OINT** (generic Desowen, Tridesilon) fluocinolone 0.01% **OIL** (generic DERMA-SMOOTHE-FS) hydrocortisone/aloe **CREAM** hydrocortisone **OTC OINT** hydrocortisone **SOLN** (generic Texacort) HYDROXYM (hydrocortisone) **GEL** TEXACORT (hydrocortisone)	
MEDIUM POTENCY		▪ Medium Potency Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class
fluticasone propionate **CREAM, OINT** (generic Cutivate) mometasone furoate **CREAM, OINT, SOLN** (generic Elocon)	betamethasone valerate (generic Luxiq) clocortolone (generic Cloderm) fluocinolone acetonide (generic Synalar) flurandrenolide (generic Cordran) fluticasone propionate **LOTION** (generic Cutivate) hydrocortisone butyrate (generic Locoid) hydrocortisone butyrate/emoll (generic Locoid Lipocream) hydrocortisone valerate (generic Westcort) PANDEL (hydrocortisone probutate 0.1%)	

STEROIDS, TOPICAL (Continued)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
HIGH POTENCY		▪ High Potency Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class
triamcinolone acetonide **OINTMENT, CREAM** triamcinolone **LOTION**	amcinonide **CREAM** 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)	
VERY HIGH POTENCY		▪ Very High Potency Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this drug class
clobetasol emollient (generic Temovate-E) clobetasol propionate **CREAM**, **OINT, SOLN** halobetasol propionate (generic Ultravate) **CREAM**	APEXICON-E (diflorasone) clobetasol **LOTION, SHAMPOO** clobetasol propionate **GEL**, **FOAM, SPRAY** halobetasol propionate (generic Lexette) AL,QL **FOAM** halobetasol propionate (generic Ultravate) NR **LOTION**	

STIMULANTS AND RELATED ADHD DRUGS [AL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CNS STIMULANTS		▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this subclass. Drug-specific criteria: ▪ **Procentra/ dextroamphetamine soln:** May be approved with documentation of swallowing disorder ▪ **Zenzedi®:** Requires clinical reason generic dextroamphetamine IR cannot be used
Amphetamine type		
amphetamine salt combination ER (generic Adderall XR) amphetamine salt combination IR DYANAVEL XR (amphetamine)[QL] lisdexamfetamine (generic Vyvanse Chew)[QL] **CHEW** lisdexamfetamine (generic Vyvanse)[QL] **CAP** VYVANSE (lisdexamfetamine)[QL] **CAPS, CHEWABLE**	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) amphetamine sulfate (generic Evekeo) ARYNTA (lisdexamfetamine dimesylate)[AL,NR] **SOLN** dextroamphetamine (generic Dexedrine) **TAB** dextroamphetamine (generic Procentra)[CL] **SOLN** dextroamphetamine ER (generic Dexedrine ER Spansule) **CAPS** EVEKEO ODT (amphetamine sulfate) methamphetamine (generic Desoxyn) MYDAYIS (amphetamine salt combo)[QL] XELSTRYM (detroamphetamine)[QL] **PATCH** ZENZEDI (dextroamphetamine)[CL]	

STIMULANTS AND RELATED ADHD DRUGS (Continued)[AL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Methylphenidate type		▪ Non-preferred agents will be approved for patients who have failed a trial of TWO preferred agents within this subclass. ▪ Maximum accumulated dose of 108mg per day for ages < 18 ▪ Maximum accumulated dose of 72mg per day for ages > 19 Drug-specific criteria: ▪ **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
CONCERTA (methylphenidate ER)[QL] 18 mg, 27 mg, 36 mg, 54 mg	APTENSIO XR (methylphenidate)	
DAYTRANA **PATCH** (methylphenidate)[CL,QL]	AZSTARYS (serdexmethylphenidate and dexmethylphenidate)[QL]	
dexmethylphenidate (generic Focalin IR)	COTEMPLA XR-ODT (methylphenidate)[QL]	
dexmethylphenidate ER (generic Focalin XR)	FOCALIN IR (dexmethylphenidate)	
METHYLIN **SOLN** (methylphenidate)	FOCALIN XR (dexmethylphenidate)	
methylphenidate TD24[AL,CL] **PATCH** (generic Daytrana)	JORNAY PM (methylphenidate) [QL]	
methylphenidate (generic Ritalin)	methylphenidate **CHEW**	
methylphenidate **SOLN** (generic Methylin)	methylphenidate ER (45 mg and 63 mg)[QL]	
QUILLICHEW ER **CHEWTAB** (methylphenidate)	methylphenidate 50/50 (generic Ritalin LA)	
QUILLIVANT XR (methylphenidate)**SUSP**	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 ER ODT (generic COTEMPLA XR)[AL,NR,QL]	
	methylphenidate TD24[AL,CL] **PATCH (AG)** (generic Daytrana) ***Padagis Manf. only***	
	RELEXXII ER (methylphenidate 45mg and 63mg)[AL,QL] **TAB**	
	RITALIN (methylphenidate)	

STIMULANTS AND RELATED ADHD DRUGS (Continued)[AL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
MISCELLANEOUS		**Note:** generic guanfacine IR and clonidine IR are available without prior authorization • Non-preferred agents will be approve for patients who have failed a trial of ONE preferred agent within this subclass Drug-specific criteria: ▪ **Wakix and Sunosi:** Require trial of armodafinil or modafinil ▪ **armodafinil and modafinil:** approved only for: ○ Sleep Apnea with documentation/confirmation via sleep study and documentation that C-PAP has been maxed ○ Narcolepsy with documentation of diagnosis via sleep study ○ Shift Work Sleep Disorder (only approvable for 6 months) with work schedule verified and documented. Shift work is defined as working the all night shift ▪ **Sunosi** approved only for: ○ Sleep Apnea with documentation/confirmation via sleep study and documentation that C-PAP has been maxed ○ Narcolepsy with documentation of diagnosis via sleep study ▪ **Wakix**: approved only for excessive daytime sleepiness in adults with narcolepsy with documentation of narcolepsy diagnosis via sleep study
atomoxetine (generic Strattera) [QL] guanfacine ER (generic Intuniv)[QL] QELBREE (viloxazine)[QL]	ATONCY **SOLN** (atomoxetine)[AL, NR] atomoxetine (generic ATONCY)[AL, NR] clonidine ER (generic Kapvay)[QL] INTUNIV (guanfacine) Onyda XR (clonidine suspension, extended release) [QL] STRATTERA (atomoxetine)	
ANALEPTICS		
	armodafinil (generic Nuvigil)[CL] modafanil (generic Provigil)[CL] SUNOSI (solriamfetol) [CL,QL] WAKIX (pitolisant)[CL,QL]	

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 75MG **CAPS**[NR] 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)	▪ Non-preferred agents will be approved for patients who have failed a sequential 3-day trial of TWO preferred agents within this drug class Drug-specific criteria: ▪ **demeclocycline:** Approved for diagnosis of SIADH ▪ **doxycycline suspension:** May be approved with documented swallowing difficulty

THROMBOPOIESIS STIMULATING PROTEINS [CL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
PROMACTA (eltrombopag) **TAB**	ALVAIZ (eltrombopag choline)[AL] DOPTELET (avatrombopag)[AL] **TAB, SPRINKLES**[AL,NR] eltrombopag (generic Promacta) **SUSP, TAB** MULPLETA (lusutrombopag)[CL] PROMACTA (eltrombopag) **SUSP** TAVALISSE (fostamatinib) WAYRILZ (rilzabrutinib) [NR]	▪ All agents will be approved with FDA-approved indication, ICD-10 code is required. ▪ Non-preferred agents require a trial of a preferred agent with the same indication or a contraindication. Drug-Specific Criteria ▪ **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

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) **TAB** SYNTHROID (levothyroxine) **TAB** THYQUIDITY (levothyroxine) **SOLN**	▪ 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		▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: ▪ **Asacol HD®/Delzicol DR®:** Requires clinical reason why preferred mesalamine products cannot be used
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]	
RECTAL		
mesalamine (generic Canasa) **SUPPOSITORY** Sulfite-Free ROWASA (mesalamine) **ENEMA**	CANASA (mesalamine) mesalamine (generic Rowasa) **ENEMA** UCERIS (budesonide)	

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: • **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 ○ Total duration of treatment is max of 24 months

VASODILATORS, CORONARY

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
isosorbide dinitrate **TAB** isosorbide mono IR/SR **TAB** nitroglycerin **SUBLINGUAL, TRANSDERMAL**	BIDIL (isosorbide dinitrate/ hydralazine)[CL] GONITRO (nitroglycerin) isosorbide dinitrate **TAB (Oceanside Pharm MFR only)** isosorbide dinitrate/hydralazine (generic Bidil)[CL] NITRO-BID **OINT** (nitroglycerin) NITRO-DUR (nitroglycerin) nitroglycerin **TRANSLINGUAL** (generic Nitrolingual) VERQUVO (vericiguat)[AL,CL,QL]	▪ Non-preferred agents will be approved for patients who have failed a trial of ONE preferred agent within this drug class Drug-specific criteria: ▪ **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%