Indiana Medicaid Statewide Uniform Preferred Drug List (SUPDL)

OptumRx Call Center

For prior authorization requests, claims processing issues or questions about the SUPDL, please contact OptumRx at 855-577-6317

Or fax the prior authorization requests to 855-577-6384

Indiana Health Coverage Programs (IHCP) Drug Coverage

In accordance with 405 IAC 5-24, the IHCP covers all FDA-approved legend drugs with the exception of the following:

- Drugs designated by Centers for Medicare and Medicaid Services (CMS, formerly HCFA) as "less than effective" (DESI), or identical, related, or similar to a DESI drug
- Anorectics or any agent used to promote weight loss
- Topical minoxidil preparations
- Fertility enhancement drugs
- Drugs used primarily or solely for cosmetic purposes

Note: Inclusion of, or reference to, any given drug does not indicate market availability of the drug. Drugs that will be or have been withdrawn from the market will be removed from the SUPDL as part of routine periodic updating of the SUPDL.

Nomenclature

- **Statewide Uniform Preferred Drug List (SUPDL)** - a list of drugs within select therapeutic drug classes, developed and maintained by the Drug Utilization Review (DUR) Board, designated as *preferred* or *non-preferred* based upon clinical and financial considerations.
    - **Preferred Drug** – Covered drug designated by the DUR Board as a principle agent for use within a therapeutic class.
        - Mental health drugs are considered *preferred* (see Mental Health Drugs section below).
    - **Non-preferred Drug** – Covered drug designated by the DUR Board as secondary agent for use within a therapeutic class. Non-preferred drugs typically require prior authorization and history of trial and failure of (each of) the preferred agent(s), as confirmed by claims history, chart documentation, or provider attestation including dates of trial for each preferred agent (unless otherwise specified on the SUPDL).
        - Legacy continuation of therapy - The process whereby criteria are established exempting a drug from prior authorization, under specific conditions, when it would otherwise require prior authorization.
        - Brand name drugs, with an available substitutable generic, are *non-preferred* unless otherwise specified on the SUPDL. All preferred brand products on the SUPDL with a new available generic will list the generic agent added as non-preferred until it is financially advantageous to move to preferred (unless the product is classified as a mental health medication). Once the generic agent is financially advantageous, it will replace the brand product as preferred. All non-preferred brand products on the SUPDL with a new available generic will list the generic agent added as non-preferred until it is reviewed by the Therapeutics Committee in the product's regularly scheduled review cycle.

- Prior authorization is typically required for a prescriber's specification of "brand medically necessary".
- Certain drugs, sometimes referred to as “narrow therapeutic index” drugs, are exempt from the requirement of prior authorization for “brand medically necessary”; see information in the Pharmacy Services Module found at this link: https://www.in.gov/medicaid/files/pharmacy%20services.pdf

- **Neutral Drug** – Covered drug that is in a therapeutic class not included on the SUPDL. As such, the drug has neither *preferred* nor *non-preferred* status.
- **Line Extension Drug** – A new strength, formulation, or dosage form of a particular chemical entity for a given manufacturer that has been approved by the FDA. The SUPDL status of a line extension drug is the same as the status of the chemical entity to which it pertains unless otherwise determined by the DUR Board.
- **Point of Sale Quick Check (PSQC)** – real-time automated prior authorization system that utilizes clinical prior authorization edits supported by a member’s medical and pharmacy claims data. This process results in quicker PA determination for pharmacy claims processed by the fee-for-service (FFS) pharmacy benefit, with less intervention on the part of the pharmacy and prescribing providers.
- **Status Pending Drug –** Covered drug that is subject to the SUPDL, but for which *preferred* or *non-preferred* status has yet to be assigned.

Prior Authorization (PA)

This term is defined at 405 IAC 5-2-20. Any IHCP covered legend drug (including drugs that are or are not listed on the SUPDL) may require PA. Prior authorization is generally required in order to ensure appropriate drug utilization, conformance to established therapeutic guidelines, and fiscal reasonability.

Prior authorization request forms are located at https://www.in.gov/medicaid/providers/index.html under Pharmacy Services. Select "PA Criteria and Administrative Forms" under the "Quick Links" column on the right-hand margin. Drug specific PA criteria are attached to each associated drug class within the SUPDL document. Non-specific criteria are located at the end of the SUPDL document.

Mental Health Drugs

In accordance with Indiana law, all antianxiety, antidepressant, antipsychotic, and "cross indicated" drugs are considered as being preferred. Drugs that are (1) classified in a central nervous system drug category or classification (according to *Drug Facts and Comparisons*) created after March 12, 2002, and (2) prescribed for the treatment of a mental illness (as defined by the most recent publication of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*) are also considered as *preferred*. Please note that since these drugs/classes are *preferred*, they are not shown on the SUPDL document. ***Lack of inclusion on the SUPDL does not mean these drugs are non-covered by the IHCP.*** Click the following link for a list of utilization edits on mental health medications: Utilization Edits for Mental Health Medications.

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Effective for FFS claims submitted on or after May 1, 2025. Effective for Managed Care claims submitted on or after May 15, 2025. V1.1

Inclusion or reference to any given drug does not indicate market availability of the drug. Drugs that will be, or have been, withdrawn from the market will be removed from the SUPDL as part of routine periodic updating of the SUPDL.

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
ANTI-INFECTIVES			
Antivirals – Anti-Herpetic	• acyclovir • valacyclovir ○ ST – must have diagnosis of HIV or trial and failure of acyclovir or medical justification for use over acyclovir	• famciclovir • Sitavig	

Antivirals – Influenza and COVID-19	***Influenza***
	• amantadine
	• oseltamivir
	• Relenza
	• rimantadine
	  ○ AGE – 60 years and older
	
	COVID-19
	• Paxlovid
	  ○ AGE – 12 years of age and older
	  ○ QL – 1 therapy pack every 30 days
		Influenza
		• rimantadine
		  ○ AGE – under 60 years old
		• Rapivab
		• Xofluza
		
		COVID-19
		• N/A	

Cephalosporins – 3rd Generation	• cefdinir • cefpodoxime	• cefixime caps, susp • Suprax chew, susp	
Fluoroquinolones ***Note: All fluoroquinolones will be limited to 14 days per claim***	• ciprofloxacin • levofloxacin • moxifloxacin	• Baxdela • ofloxacin PA criteria must be met for the following: • Cipro suspension • ciprofloxacin suspension • levofloxacin solution	PA Criteria for ciprofloxacin and levofloxacin solution
Hepatitis C Agents	• Pegasys • ribavirin PA criteria must be met for the following (**note: treatment naïve patients must only meet age and quantity limits**): • Epclusa 200-50mg • Epclusa 150-37.5mg • Mavyret • sofosbuvir/velpatasvir 400-100mg • Zepatier	PA criteria must be met for the following: • Epclusa 400-100mg • Harvoni • ledipasvir/sofosbuvir • Sovaldi • Vosevi	Hepatitis C Agents PA Criteria Hepatitis C Agents PA Form

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
ANTI-INFECTIVES - Continued			

Macrolides	• azithromycin suspension
	• azithromycin 600 mg oral tablets
	  ○ QL – 1 tablet/day
	• azithromycin 500 mg oral tablets
	  ○ QL – 7 tablets/30 days
	• azithromycin 250 mg oral tablets
	  ○ QL – 6 tablets/30 days
	• clarithromycin
	• erythromycin capsules
	• erythromycin ethylsuccinate susp
	  ○ ST – must be under 12 years of age or unable to swallow tablets/capsules
		• E.E.S. Granules
		  ○ ST – must have tried and failed erythromycin ethylsuccinate suspension in the past 90 days OR member must be under 12 years of age or unable to swallow tablets/capsules and prescriber has provided valid medical justification for the use of E.E.S. Granules over preferred agents
		• E.E.S. tablets
		• erythrocin stearate
		• erythromycin tablets
		• erythromycin tablets EC
		• Zmax
		
		PA criteria must be met for the following:
		• Dificid
			Dificid PA Criteria
			
			Dificid PA Form

Ophthalmic Antibiotics	• Azasite soln • Besivance susp • Ciloxan oint • ciprofloxacin soln • erythromycin oint • gentamicin soln • moxifloxacin soln ○ AGE – 30 years of age or older; ST – patients under 30 years of age must have tried at least one preferred agent other than moxifloxacin within the past 30 days • ofloxacin soln • polymyxin B/bacitracin oint • polymyxin B/trimethoprim soln • sulfacet sod oint • tobramycin soln • Tobrex oint	• bacitracin oint • gatifloxacin soln • neomycin/bacitracin/polymyxin oint • neomycin/polymyxin B/gramicidin soln	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
ANTI-INFECTIVES - Continued			
Ophthalmic Antibiotics/ Corticosteroid Combinations	• neomycin/polymyxin B/dexamethasone oint • neomycin/polymyxin B/dexamethasone susp • sulfacetamide sodium/prednisolone soln • Tobradex oint • Tobradex ST susp • tobramycin/dexamethasone susp • Zylet susp	• neomycin/polymyxin/bacitracin/hc oint • neomycin/polymyxin/hc susp	
Otic Antibiotics	• ofloxacin otic soln ***Antibiotic/Steroid Combinations*** • ciprofloxacin-dexamethasone otic susp • Cipro HC susp • Cortisporin TC otic susp • neomycin/polymyxin B/hydrocortisone otic soln • neomycin/polymyxin B/hydrocortisone otic susp	• ciprofloxacin soln ***Antibiotic/Steroid Combinations*** • ciprofloxacin-fluocinolone PF otic susp	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
ANTI-INFECTIVES - Continued			

Systemic Antifungals	• fluconazole 50 mg tabs
	  ○ QL – 3 tabs/30 days
	• fluconazole 150 mg tabs
	  ○ QL – 4 tabs/30 days
	• fluconazole suspension
	• itraconazole
	• ketoconazole
	• terbinafine
		• Cresemba
		• itraconazole solution
		  ○ ST – must have tried and failed all preferred agents (i.e., each preferred chemical entity) or must provide medical justification as to why each preferred agent is not appropriate for use (e.g., infection being treated is not susceptible to preferred agents); must be 12 years of age and under or unable to swallow capsules/tablets
		• Noxafil PAK
		  ○ ST – must be 2 years of age or older and less than 13 years of age
		• posaconazole tablet & 200 mg/5 mL suspension
		  ○ ST – must have tried fluconazole for treatment of oropharyngeal candidiasis or must be severely immunocompromised and need prophylaxis against invasive Aspergillus or Candida infections
		• Tolsura
		• voriconazole suspension
		  ○ ST – must have tried and failed all preferred agents (i.e., each preferred chemical entity) or must provide medical justification as to why each preferred agent is not appropriate for use (e.g., infection being treated is not susceptible to preferred agents); must be 12 years of age and under or unable to swallow capsules/tablets
		• voriconazole tabs
		
		PA criteria must be met for the following:
		• Brexafemme
		• Vivjoa
			Antimicrobials for Treatment of Vaginal Infections PA Criteria
			
			Antimicrobials for Treatment of Vaginal Infections PA form

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
ANTI-INFECTIVES - Continued			
Topical Antifungals	***All generics unless otherwise specified*** • ciclopirox (cream & topical solution) • clotrimazole • Jublia • miconazole • terbinafine 1% cream • tolnaftate 1% cream, powder, spray	• ciclopirox gel, kit, topical shampoo, topical suspension • econazole • Ertaczo • ketoconazole topical foam • Loprox kit • luliconazole • Luzu • miconazole/zinc/pet oint • Mycozyl AL 1% solution • Mycozyl HC gel, liquid • naftifine 1% cream • naftifine 2% cream, gel • Naftin 1% gel • Oxistat • tavaborole solution • Vusion	
Topical Antivirals	• acyclovir cream	• acyclovir ointment • penciclovir cream • docosanol OTC cream	
Topical Antiviral and Anti-inflammatory Steroid Combinations	• Xerese ○ QL – 1 tube per claim per 90 days	N/A	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
ANTI-INFECTIVES - Continued			

Vaginal Antimicrobials	***Antibacterials – oral***
	• metronidazole
	
	Antibacterials – intravaginal
	• Cleocin 2% cream
	• metronidazole vaginal gel
	• Nuvessa
	• Xaciato
	  ○ ST – previous trial and failure of a preferred intravaginal antibacterial agent
	
	Antifungals
	• clotrimazole OTC
	  ○ QL – 2 treatment courses/month
	• miconazole cream OTC
	  ○ QL – 2 treatment courses/month
	• tioconazole OTC
	  ○ QL – 2 treatment courses/month
	• terconazole cream
		Antibacterials – oral
		• Solosec
		• tinidazole
		  ○ ST – must have tried and failed metronidazole or provide medical justification as to why metronidazole is not appropriate for use (e.g., infection being treated is not susceptible to preferred agent)
		
		Antibacterials – intravaginal
		• Cleocin Ovules
		• Clindesse
		• Vandazole
		
		Generic Medically Necessary PA criteria must be met for the following:
		• clindamycin 2% cream
		
		Antifungals
		• Gynazole-1
		• miconazole combination pack OTC
		  ○ QL – 2 treatment courses/month
		• miconazole suppositories OTC
		  ○ QL – 2 treatment courses/month
		• miconazole suppositories (Rx)
		• terconazole suppositories	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
ANTIMIGRAINE			

Antimigraine Preparations	• rizatriptan
	  ○ QL – 1 box – 12 tabs/30 days
	• rizatriptan ODT
	  ○ QL – 1 box – 12 tabs/30 days
	• sumatriptan nasal spray
	  ○ QL – 1 box – 6 inhalers/30 days
	• sumatriptan tablets
	  ○ QL – 1 box – 9 tabs/30 days
	• sumatriptan stat dose or stat dose refill package
	  ○ QL – 1 box – 2 injections/30 days
	• sumatriptan vial
	  ○ QL – 2 vials – 2 injections/30 days
	
	PSQC/PA criteria must be met for the following:
	• Elyxyb
	  ○ QL – 6 bottles/30 days
	• Nurtec ODT
	  ○ QL – 8 tabs/30 days for acute treatment;
	  ○ QL – 16 tabs/30 days for preventative treatment
	• Ubrelvy
	  ○ QL – 10 tabs/20 days
		• almotriptan
		  ○ QL – 1 box – 6 tabs/30 days
		• frovatriptan
		  ○ QL – 1 box – 9 tabs/30 days
		• naratriptan
		  ○ QL – 1 box – 9 tabs/30 days
		• Onzetra Xsail
		  ○ QL – 1 box (8 pouches)/30 days
		• Relpax
		  ○ QL – 1 box – 6 tabs/30 days
		• sumatriptan/naproxen
		  ○ QL – 1 box – 9 tabs/30 days
		• Tosymra Solution
		• Treximet
		  ○ QL – 1 box – 9 tabs/30 days
		• Zembrace SymTouch
		  ○ QL – 1 box (4 injections)/30 days
		• zolmitriptan
		  ○ QL – 1 box – 6 tabs/30 days
		• zolmitriptan nasal spray
		  ○ QL – 1 box – 6 inhalers/30 days
		• zolmitriptan ODT
		  ○ QL – 1 box – 6 tabs/30 days
		
		PSQC/PA criteria must be met for the following:
		• Reyvow
		  ○ QL – 50 mg dose – 4 (50 mg) tabs/30 days
		  ○ QL – 100 mg dose – 4 (100 mg) tabs/30 days
		  ○ QL – 200 mg dose – 8 (100 mg) tabs/30 days
		• Zavzpret
		  ○ QL – 6 devices/22 days
		
		Generic Medically Necessary PA criteria must be met for the following:
		• eletriptan
		  ○ QL – 1 box – 6 tabs/30 days
			Antimigraine PA Criteria

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
ANTIMIGRAINE - Continued			

Antimigraine Preparations - Continued	**Prophylaxis**
	PSQC/PA criteria must be met for the following:
	• Aimovig
	  ○ QL – 140 mg/month
	• Ajovy
	  ○ QL – 225 mg/month or 675 mg/3 months
	• Emgality
	  ○ QL migraine – 240 mg loading dose; then 120 mg/month
	  ○ QL cluster headache – 300mg at start of headache and once monthly thereafter until end of headache
	• Qulipta
	  ○ QL – 1 tab/day
		Prophylaxis
		PSQC/PA criteria must be met for the following:
		• Vyepti
		  ○ QL – 3 mL/90 days
			Antimigraine PA Criteria

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
CARDIOVASCULAR			

ACE Inhibitors	• benazepril
	• enalapril
	• fosinopril
	• lisinopril
	• ramipril
		• captopril
		• enalapril 1 mg/mL solution
		  ○ ST – must be under 12 years of age or unable to swallow tablets
		• moexipril
		• perindopril
		• Qbrelis
		  ○ ST – must be 6 years of age or older and less than 12 years of age OR 12 years of age and older AND unable to swallow tablets
		• quinapril
		• trandolapril	

ACE Inhibitor Combinations	***ACE Inhibitors with Calcium Channel Blockers***
	• amlodipine/benazepril
	  ○ QL – 30 caps/30 days
	
	ACE Inhibitors with Diuretics
	• benazepril/HCTZ
	• enalapril/HCTZ
	• lisinopril/HCTZ
		ACE Inhibitors with Calcium Channel Blockers
		• trandolapril/verapamil
		  ○ QL – 30 caps/30 days
		
		ACE Inhibitors with Diuretics
		• captopril/HCTZ
		• fosinopril/HCTZ
		• quinapril/HCTZ	

Angiotensin Receptor Blockers	• Edarbi
	  ○ QL – 1 tab/day
	• irbesartan
	  ○ QL – 1 tab/day
	• losartan 25 mg, 50 mg
	  ○ QL – 2 tabs/day
	• losartan 100 mg
	  ○ QL – 1 tab/day
	• olmesartan 5 mg
	  ○ QL – 3 tabs/day
	• olmesartan 20 mg, 40 mg
	  ○ QL – 1 tab/day
	• telmisartan
	  ○ QL – 1 tab/day
	• valsartan 40 mg, 80 mg, 160 mg
	  ○ QL – 2 tabs/day
	• valsartan 320 mg
	  ○ QL – 1 tab/day
		• candesartan 4 mg, 8 mg, 16 mg
		  ○ QL – 2 tabs/day
		• candesartan 32 mg
		  ○ QL – 1 tab/day
		• valsartan solution
		  ○ ST – must be unable to swallow tablets	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
CARDIOVASCULAR - Continued			
Angiotensin Receptor Blocker Combinations	***Angiotensin Receptor Blockers with Diuretics*** • Edarbyclor • losartan/HCTZ • valsartan/HCTZ ***Angiotensin Receptor Blockers with Calcium Channel Blockers*** N/A ***Angiotensin Receptor Blockers with Calcium Channel Blockers and Diuretics*** N/A	***Angiotensin Receptor Blockers with Diuretics*** • candesartan/HCTZ • irbesartan/HCTZ • olmesartan/HCTZ • telmisartan/HCTZ ***Angiotensin Receptor Blockers with Calcium Channel Blockers*** • olmesartan/amlodipine o ST – trial and failure of individual components • telmisartan/amlodipine o ST – trial and failure of individual components • valsartan/amlodipine o ST – trial and failure of individual components ***Angiotensin Receptor Blockers with Calcium Channel Blockers and Diuretics*** • amlodipine/olmesartan/HCTZ o ST – trial and failure of individual components • amlodipine/valsartan/HCTZ o ST – trial and failure of individual components	
Beta Adrenergic Blockers	• acebutolol • atenolol • bisoprolol • carvedilol • labetalol • metoprolol • metoprolol succinate ER • nadolol • nebivolol • propranolol • propranolol ER caps • sotalol	• betaxolol • carvedilol ER cap o QL – 1 cap/day • Hemangeol solution o ST – must be 5 weeks of age or older and less than or equal to 1 year of age • Kapspargo • pindolol • Sotylize oral solution o ST – must be under 12 years of age or unable to swallow capsules/tablets • timolol	
Beta Adrenergic Blockers with Diuretics	• atenolol/chlorthalidone • bisoprolol/HCTZ	• metoprolol/HCTZ	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
CARDIOVASCULAR - Continued			

Calcium Channel Blockers	***Dihydropyridine***
	• amlodipine
	• felodipine ER
	• nifedipine (short-acting)
	• nifedipine ER
	
	Non-Dihydropyridine
	• Calan SR
	• Cardizem LA
	• diltiazem (long-acting formulations)
	• diltiazem (non-time released)
	• nimodipine
	• verapamil (long-acting formulations)
	• verapamil (non-time released)
	
	Liquid Formulation
	• Norliqva
	  ○ ST – must be unable to swallow tablets
	
	Combinations
	N/A
		Dihydropyridine
		• isradipine (non-time released)
		• levamlodipine
		• nicardipine (non-time released)
		• nisoldipine
		
		Non-Dihydropyridine
		• Cardizem CD
		• Matzim LA
		• verapamil ER PM
		• Verelan PM
		
		Liquid Formulation
		• Katerzia
		  ○ ST – must be 6 years of age or older and less than 12 years of age OR 12 years of age and older and unable to swallow tablets AND previous trial and failure of Norliqva OR medical rationale for use
		• Nymalize
		  ○ ST – must be 18 years of age or older AND unable to swallow capsule formulation
		
		Combinations
		• amlodipine/atorvastatin
		  ○ ST – prescriber must provide documentation that separate components are not suitable for use	

Miscellaneous Cardiac Agents	PA criteria must be met for the following: • ivabradine • Entresto	PA criteria must be met for the following: • Camzyos • Entresto sprinkle capsules • Verquvo	Cardiac Agents PA Criteria Cardiac Agents PA Form

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
CNS AND OTHERS			

Agents for the Treatment of Opioid Use Disorder or Overdose	***Agents for Opioid Use Disorder – oral***
	• buprenorphine sublingual tablets
	  ○ AGE – 16 years of age and older
	  ○ QL – 24mg/day
	• buprenorphine/naloxone sublingual tablets
	  ○ AGE – 16 years of age and older
	  ○ QL – 24mg/day
	• Suboxone Film
	  ○ AGE – 16 years of age and older
	  ○ QL – 24mg/day
	• Zubsolv
	  ○ AGE – 16 years of age and older
	  ○ QL – 17.2mg/day
	
	Agents for Opioid Use Disorder – injectable
	PA criteria must be met for the following:
	• Sublocade
	
	Agents for Opioid Overdose
	• Kloxxado
	• nalmefene
	• naloxone injection
	• naloxone nasal spray
	• Narcan Nasal
	• Rextovy
	• Opvee
	• Zimhi
		Agents for Opioid Use Disorder – oral
		Generic Medically Necessary PA criteria must be met for the following:
		• buprenorphine/naloxone sublingual films
		  ○ AGE – 16 years of age and older
		  ○ QL – 24mg/day
		
		Agents for Opioid Use Disorder – injectable
		PA criteria must be met for the following:
		• Brixadi
		
		Agents for Opioid Overdose
		N/A
			Opioid Use Disorder Treatments

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
CNS AND OTHERS - continued			

Antiemetic/Antivertigo Agents	***Appetite Stimulant***
	N/A
	
	H1 Antagonist/Vitamin
	• Diclegis
	  ○ QL – 4 tabs/day; Max 270/365 days
	
	Selective 5-HT3 Receptor Antagonist
	• ondansetron oral tablets
	  ○ QL – 90 tabs/30 days
	• ondansetron oral disintegrating tablets (4 mg and 8 mg)
	  ○ QL – 90 tabs/30 days
	• ondansetron oral solution
	  ○ QL – 1 bottle/Rx
	• ondansetron solution for injection
		Appetite Stimulant
		PSQC criteria must be met for the following:
		• dronabinol
		
		H1 Antagonist/Vitamin
		• Bonjesta
		  ○ QL – 2 tabs/day; Max 270/365 days
		
		Generic Medically Necessary PA criteria must be met for the following:
		• doxylamine/pyridoxine oral tabs
		  ○ QL – 4 tabs/day; Max 270/365 days
		
		Selective 5-HT3 Receptor Antagonist
		• Anzemet oral tabs
		  ○ QL – 10 units/Rx
		• granisetron oral tablets
		• granisetron solution for injection
		• ondansetron 16 mg ODT
		  ○ QL – 3 tablets/30 days
		• palonosetron injection
		  ○ QL – 1 vial/Rx
		• Posfrea
		  ○ QL – 1 vial/Rx
		  ○ ST – must have previous trial of generic palonosetron within the past 90 days AND provide medical justification for use of Posfrea over generic palonosetron injection
		• Sancuso transdermal system
		  ○ ST – physician documentation required indicating oral medications are unsuitable for patient use
		• Sustol
			Dronabinol PA Criteria

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
CNS AND OTHERS - continued			

Antiemetic/Antivertigo Agents - continued	***Substance P-Neurokinin 1 Receptor Antagonist***
	• aprepitant 40 mg and 80 mg oral capsules
	  ○ QL – 6 caps/Rx
	• aprepitant 80 mg/125 mg tripack
	  ○ QL – 2 packs (6 caps)/Rx
	• fosaprepitant vials
	  ○ QL – 2 vials/Rx
	
	Substance P-NK 1 Antagonist/Selective 5-HT3 Antagonist
	N/A
		Substance P-Neurokinin 1 Receptor Antagonist
		• aprepitant 125 mg oral capsules
		  ○ QL – 6 caps/Rx
		• Cinvanti injection
		  ○ QL – 2 vials/Rx
		• Emend IV solution
		  ○ QL – 2 vials/Rx
		• Emend suspension
		  ○ QL – 3 packets /Rx
		  ○ ST – must have tried Emend oral capsules or have inability to swallow or tolerate the capsule formulation
		• Focinvez
		  ○ QL – 2 vials/Rx
		
		Substance P-NK 1 Antagonist/Selective 5-HT3 Antagonist
		• Akynzeo
		  ○ ST – must have tried and failed combination therapy with preferred agents of the same classes or provide medical justification for use of the combination product
			Dronabinol PA Criteria

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
CNS AND OTHERS – continued			

Antiseizure Agents
 	
Note: Utilization Edits may apply for mental health medications; see Utilization Edits for Mental Health Medications for associated quantity limits
	• carbamazepine IR, ER cap, chew
	• Carbatrol
	• Celontin
	• clobazam tab, susp
	• Depakote Sprinkle
	• diazepam rectal gel
	  ○ QL – 10 doses/30 days
	• Dilantin cap, chew, susp
	• divalproex DR, ER, sprinkle cap
	• Epitol
	• ethosuximide cap, soln
	• felbamate susp
	• Felbatol tablets
	• fosphenytoin
	• gabapentin cap, tab, soln
	• lacosamide tab
	• Lamictal chew
	• Lamictal XR Kit
	• lamotrigine tab, chew, ODT, ER tab
	• lamotrigine starter kit
	• lamotrigine ODT starter kit
	• levetiracetam IR, ER, soln, inj
	• Nayzilam
	  ○ QL – 10 doses/30 days
	• Neurontin cap, tab
	• oxcarbazepine tab, susp
	• Oxtellar XR
	• phenobarbital tab, soln, inj
	• phenytoin cap, chew, susp, inj
	• pregabalin
	• primidone
	• Qudexy XR
	• Roweepra
	• Subvenite
	• Subvenite starter kit
	• Sympazan
	• Tegretol IR, XR tab, susp
	• tiagabine
	• topiramate tab, IR sprinkle cap
	• Trileptal Susp
	• Trokendi XR
	• valproate inj
	• valproic acid cap, solution
	• Valtoco
	  ○ QL – 10 doses/30 days
	• zonisamide cap
		PA criteria must be met for the following:
		• Aptiom
		• Banzel 200 mg tablet
		• Briviact inj, sol, tab
		• Diacomit
		• Elepsia XR
		• Epidiolex
		• Fintepla
		• Fycompa tab, susp
		• lacosamide inj, sol
		• Libervant
		  ○ QL – 10 doses/30 days
		• Motpoly XR
		• rufinamide susp
		• rufinamide 400 mg tab
		• Spritam
		• vigabatrin
		• Vigadrone
		• Vigafyde
		• Vigpoder
		• Xcopri tab
		• Xcopri Titration Pak
		  ○ QL – 1 Pak/90 days
		• Zonisade
		• Ztalmy
		
		PA criteria AND Generic Medically Necessary PA criteria must be met for the following:
		• felbamate
		• methsuximide
		• rufinamide 200 mg tab
			Antiseizure Agents Prior Authorization Criteria
			
			Utilization Edits for Mental Health Medications

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
CNS AND OTHERS - Continued			
Antiseizure Agents - continued ***Note: Utilization Edits may apply for mental health medications; see Utilization Edits for Mental Health Medications for associated quantity limits***	PA criteria must be met for the following: • Eprontia Generic Medically Necessary PA criteria must be met for the following: • carbamazepine ER tab • carbamazepine suspension • oxcarbazepine ER tab • topiramate ER capsule • topiramate ER sprinkle capsule Brand Medically Necessary PA criteria must be met for the following: • Depakote DR, ER • Lamictal IR, ODT, XR • Lamictal IR Starter Kit • Lamictal ODT Starter Kit • Lyrica • Neurontin sol • Onfi tab, susp • Topamax IR, Sprinkle • Trileptal IR tab		Antiseizure Agents Prior Authorization Criteria Utilization Edits for Mental Health Medications

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
CNS AND OTHERS - Continued			
Gastroprotective Agents	• Celebrex • naproxen-esomeprazole magnesium	• diclofenac-misoprostol delayed release tablets • ibuprofen-famotidine Generic Medically Necessary PA criteria must be met for the following: • celecoxib	
Movement Disorder Agents	• benztropine tablet, injection • trihexyphenidyl tablet, solution PA criteria must be met for the following: • Austedo • Austedo XR • Austedo Titration Kit • Austedo XR Titration Kit • Ingrezza • Ingrezza sprinkle capsules • Ingrezza Therapy Pack • tetrabenazine	N/A	Movement Disorder Agents PA Criteria
Narcotic Antitussives and Combinations ***See Opioid Overutilization with Age and Quantity Limits PA Criteria for product-specific age and quantity limits*** ***Note: All narcotic antitussives will require PA for members under 18 years of age ***	PSQC criteria must be met for the following: • guaifenesin/codeine 100-10mg/5mL solution • hydrocodone/ homatropine syrup • hydrocodone/homatropine tab • Hydromet syrup • promethazine VC/codeine syrup • promethazine with codeine	PSQC criteria must be met for the following: • hydrocodone polst/chlorpheniramine polst ER • Tuxarin ER	Opioid Overutilization with Age and Quantity Limits PA Criteria

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
CNS AND OTHERS - Continued			
Narcotics ***See Opioid Overutilization with Age and Quantity Limits PA Criteria for product-specific age and quantity limits*** ***Note: All codeine products will require PA for members under 18 years of age***	***Short Acting*** PSQC/PA criteria must be met for the following: • apap/codeine • buprenorphine inj • butorphanol injection ○ AGE – 18 years of age and older • butorphanol 10 mg/mL nasal spray • codeine sulfate • codeine/butalbital/apap/caffeine • codeine/butalbital/asa/caffeine • hydrocodone/apap • hydrocodone/ibu • hydromorphone • levorphanol • meperidine • morphine • nalbuphine • opium tincture • oxycodone • oxycodone/apap • pentazocine/naloxone • tramadol • tramadol/APAP ***Long Acting*** PSQC criteria must be met for the following: • Butrans • fentanyl patches • morphine ER tab (MS Contin)	***Short Acting*** PA criteria must be met for the following: • fentanyl citrate lozenges • fentanyl citrate buccal tablets • Fentora buccal tablets PSQC/PA criteria must be met for the following: • Apadaz • apap/caffeine/dihydrocodeine • benzhydrocodone/APAP • belladonna and opium suppositories • Nalocet • oxycodone AD • oxymorphone IR • Prolate • Qdolo • RoxyBond • tramadol 5 mg/mL solution • Trezix ***Long Acting*** PSQC criteria must be met for the following: • Belbuca • hydrocodone ER cap (Zohydro) • Hysingla ER • hydromorphone ER tab (Exalgo) • methadone • morphine ER cap (Avinza, Kadian) • oxycodone ER tab • Oxycontin • oxymorphone ER tab (Opana) • Tramadol ER (Conzip, Ryzolt, Ultram ER) PA criteria AND Generic Medically Necessary PA criteria must be met for the following: • buprenorphine patches • hydrocodone ER tab (Hysingla ER)	APAP High Dose PA Criteria Fentanyl Citrate PA Criteria Opioid Overutilization with Age and Quantity Limits PA Criteria Opioid PA Form – Request to Exceed MME Limit Opioid with Concurrent Buprenorphine/Naloxone PA Form Benzodiazepine and Opioid Concurrent Therapy PA Form

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
CNS AND OTHERS - Continued			

Skeletal Muscle Relaxants	• baclofen
	• chlorzoxazone
	• cyclobenzaprine IR (tabs)
	• methocarbamol
	• orphenadrine citrate
	• tizanidine tablets
	
	Granules/Liquid Formulation
	• Lyvispah granules
	  ○ ST – must be unable to swallow tablets
		• Amrix
		  ○ ST – must try cyclobenzaprine tablets within the past 30 days
		• dantrolene
		• Fexmid
		• Lorzone
		• metaxalone
		• Norgesic
		• Norgesic Forte
		• Orphengesic Forte
		• orphenadrine/aspirin/caffeine
		• Tanlor
		• tizanidine capsules
		
		PA criteria must be met for the following:
		• carisoprodol
		  ○ QL – 4 tabs/day
		
		Generic Medically Necessary PA criteria must be met for the following:
		• cyclobenzaprine ER (caps)
		  ○ ST – must try cyclobenzaprine tablets within the past 30 days
		
		Granules/Liquid Formulation
		• baclofen 5 mg/5 mL sol; baclofen 10 mg/5 mL sol; baclofen 25 mg/5mL susp; Fleqsuvy susp
		  ○ ST – trial and failure of Lyvispah (baclofen) or medical rationale for use
			Carisoprodol Agents PA Criteria
			
			Carisoprodol Agents PA Form

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
CNS AND OTHERS - Continued			
Smoking Deterrent Agents	***Nicotine Replacement*** • nicotine gum ○ AGE – 10 years of age or older ○ QL – 24 pieces/day • nicotine lozenge ○ AGE – 10 years of age or older ○ QL – 20 pieces/day • nicotine patch ○ AGE – 10 years of age or older ○ QL – 1 patch/day • nicotine patch kit ○ AGE – 10 years of age or older ○ QL – 1 kit/90 days ***Other Smoking Deterrents*** • bupropion SR 150 • varenicline ○ AGE – 18 years of age or older	***Nicotine Replacement*** • Nicotrol NS ○ AGE – 10 years of age or older ○ QL – 12 bottles/30 days • Nicotrol Inhaler ○ AGE – 10 years of age or older ○ QL – 3 inhalers/31 days ***Other Smoking Deterrents*** N/A	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
DERMATOLOGIC			

Acne Agents
 	
Note: All Rx acne agents for members over the age of 25 years require step therapy with one covered OTC acne product
 	
Note: A 14-day trial each of at least 2 preferred agents is required prior to receiving a non-preferred agent.
	All legend generic products are preferred unless otherwise specified
	
	• adapalene 0.1% gel (OTC)
	  ○ AGE – 12 years and older
	• benzoyl peroxide cream, liquid, gel
	• Differin 0.1% cream
	  ○ AGE – 25 years and under – ST – must have tried a preferred topical tretinoin product
	  ○ AGE – >25 years – ST – must have tried one covered OTC acne product AND a preferred topical tretinoin product
	• Differin 0.3% gel
	  ○ AGE – 25 years and under – ST – must have tried a preferred topical tretinoin product
	  ○ AGE – >25 years – ST – must have tried one covered OTC acne product AND a preferred topical tretinoin product
	• Retin-A (all formulations except micro)
	• Ziana
	
	Oral Formulations
	• Amnesteem
	• Claravis
	• Myorisan
	• Zenatane
		All legend brand products are non-preferred unless otherwise specified
		
		• adapalene/benzoyl peroxide gel
		• Aklief
		• Avar cleanser
		• Benzepro
		• BP cleanser
		• BP 10-1 wash
		• Cabtreo
		• clindamycin foam
		• Clindacin 1% swab
		• clindamycin 1.2%/benzoyl peroxide 2.5%
		• clindamycin 1.2%/benzoyl peroxide 3.75%
		• dapsone gel
		• Erygel
		• PR benzoyl peroxide wash
		• Retin-A Micro
		• sodium sulfacetamide med pads
		• sulfacetamide sod top susp
		• sodium sulfacetamide-sulfur cleanser, cream, lotion, wash
		• sulfacetamide topical lotion
		• tretinoin gel 0.05%
		• tretinoin microsphere
		• Twyneo
		  ○ ST – trial and failure of concomitant use of individual components for at least 30 days AND rationale for use over separate individual components
		
		Generic Medically Necessary PA criteria must be met for the following:
		• adapalene 0.1% cream
		• adapalene 0.3% gel
		• clindamycin phosphate-tretinoin gel
		• tretinoin cream
		• tretinoin gel 0.01%, 0.025%
		
		Oral Formulations
		• isotretinoin	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
DERMATOLOGIC - Continued			
Antipsoriatics	• calcipotriene cream • calcipotriene topical solution • Enstilar • Taclonex scalp suspension • tazarotene 0.1% cream • Vectical ointment PA criteria must be met for the following: • acitretin	• calcipotriene 0.005% foam • calcipotriene ointment • calcipotriene/betamethasone ointment • calcitriol ointment • Duobrii • methoxsalen • Sorilux foam • tazarotene 0.05% cream, gel • tazarotene 0.1% gel • Vtama Generic Medically Necessary PA criteria must be met for the following: • calcipotriene/betamethasone suspension	Soriatane PA Criteria

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
ELECTROLYTE DEPLETERS			
Electrolyte Depleters	***Miscellaneous Agents*** N/A ***Phosphate Binders*** • calcium acetate capsules • calcium acetate tabs • calcium carbonate 500 mg • calcium carbonate 500 mg, 750 mg, 1000 mg chew • calcium carbonate 1.25 gm (500 mg elemental calcium) chew • calcium carbonate 1.25 gm (500 mg elemental calcium) tab • calcium carbonate 1250 mg/5 mL susp ○ QL – 30 mL/day • Magnebind 300 mg tab ○ QL – 2 bottles (300 tabs)/30 days • sevelamer carbonate powder • sevelamer carbonate tabs ***Potassium Binders*** • Lokelma • sodium polystyrene sulfonate powder • SPS (sodium polystyrene sulfonate) suspension • Veltassa	***Miscellaneous Agents*** • Xphozah ○ ST – must have tried and failed preferred phosphate binders OR submit medical rationale for use over ALL preferred phosphate binders ***Phosphate Binders*** • Auryxia • Fosrenol powder packet ○ ST – member must be under 18 years of age or unable to swallow tablets • lanthanum carbonate chew • sevelamer HCl tabs • Velphoro ***Potassium Binders*** • Kionex suspension	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
ENDOCRINE			
Anaphylaxis Agents	• epinephrine auto-injector	• Auvi-Q • Epipen • Neffy	
Bone Formation Stimulating Agents	PA criteria must be met for the following: • Forteo	PA criteria must be met for the following: • Evenity • teriparatide 620 mcg/2.48 mL • Tymlos PA criteria AND Generic Medically Necessary PA criteria must be met for the following: • teriparatide 560 mcg/2.24 mL (generic Forteo)	Bone Formation Stimulating Agents PA Criteria Bone Formation Stimulating Agents PA Form

Bone Resorption Inhibitors	***Bisphosphonates***
	• alendronate
	• risedronate tablets
	  ○ ST – must try alendronate within the past 90 days
	
	Bone Modifying Monoclonal Antibodies
	N/A
	
	Calcitonin
	• calcitonin-salmon nasal
	
	SERMs
	• raloxifene
		Bisphosphonates
		• alendronate oral solution 70mg/75mL
		  ○ ST – must be 5 years of age or older and less than 12 years of age OR unable to swallow tablets
		• Fosamax Plus D
		• ibandronate
		• ibandronate pre-filled syringe
		  ○ QL – one single-use, pre-filled syringe per 90 days
		• risedronate DR (generic Atelvia)
		
		Bone Modifying Monoclonal Antibodies
		PA criteria must be met for the following:
		• Prolia injection
		• Xgeva
		
		Calcitonin
		• calcitonin (salmon) injection
		  ○ ST – trial and failure of calcitonin-salmon nasal or medical justification for use over the preferred calcitonin agent
		
		SERMs
		N/A
			Bone Resorption Inhibitors PA Criteria

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
ENDOCRINE - Continued			
DPP4 Inhibitors and Combination Agents ***Note: For all DPP-4 Inhibitor and Combination Agents, the following ST applies – member must not be on concomitant GLP-1 receptor agonist and/or combination therapy (i.e., history of use of GLP-1 RA and/or combination therapy within the past 45 days)***	***DPP4-I*** • Januvia ○ ST – must have tried metformin for 90 of the past 120 days or provide medical justification for use • Tradjenta ○ ST – must have tried metformin for 90 of the past 120 days or provide medical justification for use ***DPP4-I & metformin combination*** • Janumet ○ ST – must have tried metformin for 90 of the past 120 days or provide medical justification for use • Janumet XR ○ ST – must have tried metformin for 90 of the past 120 days or provide medical justification for use • Jentadueto ○ ST – must have tried metformin for 90 of the past 120 days or provide medical justification for use • Jentadueto XR ○ ST – must have tried metformin for 90 of the past 120 days or provide medical justification for use ***DPP4-I & thiazolidinedione combination*** N/A	***DPP4-I*** • alogliptin ○ ST – must have tried a preferred agent for 90 of the past 120 days or provide medical justification for use • saxagliptin ○ ST – must have tried a preferred agent for 90 of the past 120 days or provide medical justification for use • sitagliptin (authorized generic Zituvio) ○ ST – must have tried a preferred agent for 90 of the past 120 days or provide medical justification for use • Zituvio ○ ST – must have tried a preferred agent for 90 of the past 120 days or provide medical justification for use ***DPP4-I & metformin combination*** • alogliptin/metformin ○ ST – must have tried a preferred combination agent for 90 of the past 120 days or provide medical justification for use • saxagliptin/metformin ER ○ ST – must have tried a preferred combination agent for 90 of the past 120 days or provide medical justification for use • sitagliptin free base/metformin (authorized generic Zituvimet) ○ ST – must have tried a preferred combination agent for 90 of the past 120 days or provide medical justification for use • Zituvimet ○ ST – must have tried a preferred combination agent for 90 of the past 120 days or provide medical justification for use • Zituvimet XR ○ ST – must have tried a preferred combination agent for 90 of the past 120 days or provide medical justification for use ***DPP4-I & thiazolidinedione combination*** • alogliptin/pioglitazone ○ ST – must have tried and failed combination therapy with preferred agents of the same classes for 90 of the past 120 days or provide medical justification for use	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
ENDOCRINE - Continued			
GLP-1 Receptor Agonists and Combinations	***GLP-1 RA*** PSQC criteria must be met for the following: • Byetta • exenatide (generic Byetta) • liraglutide (authorized generic and generic Victoza) • Ozempic • Trulicity • Victoza ***GIP/GLP-1 RA*** N/A ***Combination Agents*** PSQC criteria must be met for the following: • Soliqua	***GLP-1 RA*** PSQC criteria must be met for the following: • Bydureon Bcise • Rybelsus ***GIP/GLP-1 RA*** PSQC criteria must be met for the following: • Mounjaro ***Combination Agents*** PSQC criteria must be met for the following: • Xultophy	GLP-1 RA/GIP RA/Combinations PA Criteria
Glucagon Agents	• Baqsimi nasal spray • Gvoke injection • Zegalogue injection	• Glucagon Kit	
Growth Hormones	***Somatropin products*** PA criteria must be met for the following: • Genotropin • Norditropin • Serostim ***Long-acting products*** PA criteria must be met for the following: • Skytrofa • Sogroya ***Miscellaneous growth hormone products*** N/A	***Somatropin products*** PA criteria must be met for the following: • Humatrope • Nutropin AQ • Omnitrope • Zomacton ***Long-acting products*** PA criteria must be met for the following: • Ngenla ***Miscellaneous growth hormone products*** PA criteria must be met for the following: • Increlex • Voxzogo	Growth Hormone PA Criteria Growth Hormone for Adults PA Form Growth Hormone for Children PA Form

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
ENDOCRINE - Continued			
Insulins – Intermediate Acting	• Humalog Mix 50/50 • Humulin N (vials) • Humulin 50/50 • Humulin 70/30 (all formulations) • insulin lispro protamine/insulin lispro KwikPen • Novolin N • Novolin N ReliOn (vials only) • Novolin 70/30 • Novolin 70/30 ReliOn (vials only) • Novolog Mix 70/30 (all formulations)	• insulin aspart (70/30) (Novolog mix ABA) • Humalog Mix 75/25 • Humulin N KwikPen • Novolin N ReliOn (prefilled pen, innolets, syringes and cartridges) • Novolin 70/30 ReliOn (prefilled pen, innolets, syringes and cartridges) • Novolog Mix 70/30 ReliOn (all formulations)	
Insulins – Rapid Acting	• Humalog (cartridge and vials) • insulin aspart (all formulations) • insulin lispro KwikPen and Jr. KwikPen	• Admelog • Admelog Solostar • Apidra • Apidra SoloStar • Fiasp • Humalog KwikPen and Jr. KwikPen • Humalog Tempo Pen • insulin lispro (vials) • Lyumjev • Lyumjev Tempo Pen • Novolog (all formulations) • Novolog ReliOn (all formulations)	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
ENDOCRINE - Continued			
Insulins – Short Acting	• Humulin R (all formulations) • Novolin R (all formulations) • Novolin R ReliOn (vials only)	• Afrezza • Novolin R ReliOn (prefilled pen, innolets, syringes and cartridges)	
Insulins – Long Acting	• Lantus (cartridges, pens, & vials) • Tresiba FlexTouch and vials	• Basaglar • Basaglar Tempo Pen • insulin degludec FlexTouch & vials • insulin glargine (all manufacturers) • Levemir (Flextouch, & vials) • Rezvoglar • Semglee • Toujeo Solostar	

Miscellaneous Oral Antidiabetic Agents	***Alpha glucosidase inhibitors***
	• acarbose
	
	Biguanides
	• Glumetza
	• metformin
	• metformin ER (all strengths except 500 mg & 1 gram ER tabs, generics of Fortamet)
	
	Meglitinide
	• repaglinide
	
	Sulfonylureas and Combinations
	• glimepiride
	• glipizide
	• glipizide ER
	• glipizide/metformin
	  ○ ST – must have tried metformin
	• glyburide
	• glyburide/metformin
	  ○ ST – must have tried metformin
	
	Thiazolidinediones and Combinations
	• pioglitazone
	  ○ ST – must have tried metformin
	  ○ QL – 1 tablet/day
		Alpha glucosidase inhibitors
		• miglitol
		
		Biguanides
		• metformin 500 mg & 1 gm ER (generics of Fortamet)
		• metformin HCl solution
		  ○ ST – must be 10 years of age or older and less than 12 years of age OR unable to swallow tablets
		
		Generic Medically Necessary PA criteria must be met for the following:
		• metformin ER (generics of Glumetza)
		
		Meglitinide
		• nateglinide
		
		Sulfonylureas and Combinations
		N/A
		
		Thiazolidinediones and Combinations
		• pioglitazone/glimepiride
		  ○ ST – prescriber must provide documentation that separate components are unsuitable for use
		• pioglitazone/metformin
		  ○ ST – prescriber must provide documentation that separate components are unsuitable for use	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
ENDOCRINE - Continued			
SGLT Inhibitors and Combinations ***Note*: For all DPP-4 inhibitor containing agents, the following ST applies – member must not be on concomitant GLP-1 receptor agonist and/or combination therapy (i.e., history of use of GLP-1 RA and/or combination therapy within the past 45 days)***	***SGLT1-I/SGLT2-I*** N/A ***SGLT2-I*** • Farxiga • Jardiance ***SGLT2-I & metformin combination*** • Synjardy • Xigduo XR ***SGLT2-I & DPP4-I combination**** N/A ***SGLT2-I, DPP4-I, & metformin combination**** N/A	***SGLT1-I/SGLT2-I*** • Inpefa ○ ST – must try and fail each of the following active ingredients as monotherapy or combination product: canagliflozin, dapagliflozin, empagliflozin OR medical justification for use ***SGLT2-I*** • dapagliflozin (Farxiga ABA) • Invokana • Steglatro ***SGLT2-I & metformin combination*** • dapagliflozin/metformin (Xigduo ABA) • Invokamet • Invokamet XR • Segluromet • Synjardy XR ***SGLT2-I & DPP4-I combination**** • Glyxambi ○ ST – must have tried and failed combination therapy with preferred agents of the same classes or provide medical justification for use over preferred agents • Qtern ○ ST – must have tried and failed combination therapy with preferred agents of the same classes or provide medical justification for use over preferred agents • Steglujan ○ ST – must have tried and failed combination therapy with preferred agents of the same classes or provide medical justification for use over preferred agents ***SGLT2-I, DPP4-I, & metformin combination**** • Trijardy XR ○ ST – must have tried and failed combination therapy with preferred agents of the same classes or provide medical justification for use over preferred agents	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
ENDOCRINE - Continued			
Testosterones ***See Testosterone PA Criteria for product-specific age and quantity limits***	***Injectable Agents*** PA criteria must be met for the following: • Depo-Testosterone • testosterone cypionate ***Oral Agents*** N/A ***Topical Agents*** PA criteria must be met for the following: • Androderm • Testim 1% (50 mg)/5 gm gel tubes • testosterone 1% (25 mg)/2.5 gm gel packets • testosterone 1% (12.5 mg)/act gel pump • testosterone 1.62% (20.25 mg)/act metered pump gel	***Injectable Agents*** PA criteria must be met for the following: • Aveed • Testopel pellet • testosterone enanthate • Xyosted ***Oral Agents*** PA criteria must be met for the following: • Danazol • Jatenzo • Methitest • methyltestosterone • Tlando • Undecatrex ***Topical Agents*** PA criteria must be met for the following: • Natesto • testosterone 1% (50 mg)/5 gm gel packets/tubes • testosterone 1.62% (40.5 mg)/2.5 gm gel packets • testosterone 1.62% (20.25 mg)/1.25 gm gel packets • testosterone 2% (10 mg)/act metered pump • testosterone 30 mg/act solution • Vogelxo 1% (50 mg)/5 gm gel packets • Vogelxo 1% (12.5 mg)/act gel pump	Testosterones PA Criteria Testosterones PA Form
Urea Cycle Disorders (Hyperammonemia Treatments)	PA criteria must be met for the following: • Carbaglu • Pheburane • sodium phenylbutyrate powder • sodium phenylbutyrate tab	PA criteria must be met for the following: • Olpruva • Ravicti PA criteria AND Generic Medically Necessary PA criteria must be met for the following: • carglumic acid	Urea Cycle Disorder Agents

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
ESTROGEN AND RELATED AGENTS			
Estrogen and Related Agents	***All legend generic products are preferred unless otherwise specified*** • Angeliq • Climara Pro • Combipatch • Depo-estradiol • Evamist mist • Menest • Minivelle • Premarin • Prempro • Provera • Vivelle Dot ***Vaginal Preparations*** • Estring • Premarin Vaginal Cream • Vagifem ***Uterine disorder agents*** PA criteria must be met for the following: • Myfembree • Oriahnn • Orilissa	***All legend brand products are non-preferred unless otherwise specified*** • estradiol TD gel 0.1% • ethinyl estradiol and norethindrone tabs PA criteria must be met for the following: • Veozah Generic Medically Necessary PA criteria must be met for the following: • estradiol TD patch (generic formulations of Minivelle and Vivelle Dot) ***Vaginal Preparations*** • estradiol vaginal cream • Femring • Yuvafem Generic Medically Necessary PA criteria must be met for the following: • estradiol vaginal tablets ***Uterine disorder agents*** PA criteria must be met for the following: • N/A	Uterine Disorder Agents PA Criteria Uterine Disorder Agents PA Form Veozah PA Criteria

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
ESTROGEN AND RELATED AGENTS - Continued			

Contraceptives
 	
Note: All contraceptive agents participating in the Medicaid Drug Rebate Program are preferred unless otherwise specified; Brand Medically Necessary PA criteria will apply to brands with available generics
	Injectable Contraception
	• Depo-SubQ Provera
	• medroxyprogesterone contraceptive 150mg/mL suspension for injection
	  ○ QL – 1mL/84 days for contraception
	
	Oral/Topical Contraception
	• drospirenone
	• norethindrone
	• Phexxi
	  ○ QL – 1 box/month
	• progestin/estrogen combinations
	• Twirla
	• Xulane
	
	Long-Acting Reversible Contraception
	• Kyleena
	  ○ QL – 1 device/365 days
	• Liletta
	  ○ QL – 1 device/365 days
	• Mirena
	  ○ QL – 1 device/365 days
	• Nexplanon
	  ○ QL – 1 device/365 days
	• Paragard
	  ○ QL – 1 device/365 days
	• Skyla
	  ○ QL – 1 device/365 days
	
	Emergency Contraception
	• levonorgestrel 1.5mg
	• ulipristal
		Injectable Contraception
		N/A
		
		Oral/Topical Contraception
		• Zafemy
		  ○ ST – must have previous trial of all preferred patch formulations of contraception OR medical justification for use
		
		Long-Acting Reversible Contraception
		N/A
		
		Emergency Contraception
		N/A	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
GASTROINTESTINAL AGENTS			
Anti-ulcer Agents	• misoprostol tablets • sucralfate suspension ○ ST – must be 1 year of age or older and less than 12 years of age OR unable to swallow tablets • sucralfate tablets		
***H. Pylori* Agents**	• Pylera • Voquezna Triple Pak	• Helidac • lansoprazole/amoxicillin/clarithromycin caps • Talicia • Voquezna Dual Pak Generic Medically Necessary PA criteria must be met for the following: • bismuth subcitrate/metronidazole/tetracycline	
H2 Receptor Antagonists	• cimetidine tabs ○ QL – 60/30 days • famotidine tabs ○ QL – 60/30 days • nizatidine caps ○ QL – 60/30 days	• famotidine oral suspension ○ ST – member must be under 12 years of age or unable to swallow tablets	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
GASTROINTESTINAL AGENTS - Continued			
Laxatives and Cathartics	• Linzess; lubiprostone ○ ST – requires trial of lactulose, sorbitol, or polyethylene glycol • Relistor injection ○ ST – requires trial of lactulose, sorbitol or polyethylene glycol AND diagnosis of opioid-induced constipation	• Ibsrela ○ ST – requires trial of lubiprostone and Linzess OR trial of lactulose, sorbitol or polyethylene glycol AND medical justification for use over preferred agents • Motegrity ○ ST – requires trial of lubiprostone and Linzess OR trial of lactulose, sorbitol or polyethylene glycol AND medical justification for use over preferred agents • Movantik ○ ST – requires trial of lactulose, sorbitol or polyethylene glycol AND diagnosis of opioid-induced constipation AND medical justification for use over preferred agents ○ QL – 1 tab/day • Relistor tabs ○ ST – requires trial of lactulose, sorbitol or polyethylene glycol AND diagnosis of opioid-induced constipation AND medical justification for use over preferred agents ○ QL – 3 tabs (450 mg)/day • Symproic ○ ST – requires trial of lactulose, sorbitol or polyethylene glycol AND diagnosis of opioid-induced constipation AND medical justification for use over preferred agents ○ QL – 1 tab (0.2mg)/day • Trulance ○ ST – requires trial of lubiprostone and Linzess OR trial of lactulose, sorbitol or polyethylene glycol AND medical justification for use over preferred agents Generic Medically Necessary PA criteria AND step therapy requirement(s) must be met for the following: • prucalopride ○ ST – requires trial of lubiprostone and Linzess OR trial of lactulose, sorbitol or polyethylene glycol AND medical justification for use over preferred agents	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
GASTROINTESTINAL AGENTS - Continued			
Pancreatic Enzymes ***Note: Access will be granted to non-preferred agents after cumulatively utilizing 30 days of preferred agent therapy in the past 180 days***	• Creon • Zenpep	• Pertzye • Viokace	
Proton Pump Inhibitors ***Note: PA is required for members utilizing therapy for greater than 90 days in a 180-day period.***	***See Proton Pump Inhibitors PA Criteria for product-specific quantity limits*** • Dexilant • esomeprazole capsules • lansoprazole capsules • omeprazole capsules • pantoprazole tablets ***IV Solutions*** N/A ***Oral Solutions*** • Nexium packets • Protonix packets	***See Proton Pump Inhibitors PA Criteria for product-specific quantity limits, step therapy, and criteria to access non-preferred agents*** PA criteria must be met for the following: • omeprazole magnesium/sodium bicarbonate caps • rabeprazole Generic Medically Necessary PA criteria must be met for the following: • dexlansoprazole ***IV Solutions*** PA criteria must be met for the following: • esomeprazole IV • pantoprazole IV ***Oral Solutions*** PA criteria must be met for the following: • Konvomep oral suspension • lansoprazole ODT • omeprazole/sodium bicarb powder • Prilosec packets Generic Medically Necessary PA criteria must be met for the following: • esomeprazole packets • pantoprazole packets	Proton Pump Inhibitor PA Criteria

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
GASTROINTESTINAL AGENTS - Continued			
Ulcerative Colitis Agents	***Oral Formulations*** • Apriso • balsalazide • budesonide DR caps • Dipentum • mesalamine DR cap • mesalamine DR (Lialda) tab • Pentasa • sulfasalazine IR • sulfasalazine ER ***Rectal Formulations*** • mesalamine enema • mesalamine suppositories • sfRowasa	***Oral Formulations*** • budesonide ER tabs • mesalamine DR (Asacol HD) tabs • Ortikos ER caps Generic Medically Necessary PA criteria must be met for the following: • mesalamine ER (Apriso) cap • mesalamine ER (Pentasa) cap ***Rectal Formulations*** • Uceris rectal foam Generic Medically Necessary PA criteria must be met for the following: • budesonide rectal foam	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
GENITOURINARY			

BPH Agents	• alfuzosin ER
	• dutasteride
	• finasteride
	• tamsulosin
		• dutasteride/tamsulosin
		  ○ ST – must provide documentation that separate components are not suitable for use
		• Entadfi
		  ○ ST – prescriber must provide documentation of trial and failure of nonselective alpha-blocker, a selective alpha-blocker, a 5-alpha reductase inhibitor (must include finasteride), and a combination product for the treatment of BPH or a medically justifiable reason that the agents are not suitable for use; therapy duration must not exceed 26 weeks
		• silodosin
		  ○ ST – requires trial of alfuzosin ER and tamsulosin OR medical justification for use of silodosin over alfuzosin ER and tamsulosin
		• tadalafil 2.5mg and 5mg
		  ○ ST – prescriber must provide documentation of trial and failure of nonselective alpha-blocker, a selective alpha-blocker, a 5-alpha reductase inhibitor, and a combination product for the treatment of BPH or a medically justifiable reason that the agents are not suitable for use; therapy duration must not exceed 26 weeks if using concurrently with finasteride	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
GENITOURINARY - Continued			

Urinary Tract Antispasmodic/Anti-Incontinence Agents	• bethanechol
	• fesoterodine ER
	• Myrbetriq tablets
	• oxybutynin IR
	• oxybutynin ER
	• Oxytrol
	• solifenacin
		• darifenacin
		• flavoxate
		• Gemtesa
		  ○ ST – member must have trialed and failed Myrbetriq or have intolerance or contraindication to Myrbetriq
		• Myrbetriq granules
		  ○ ST – must be 3 years of age or older and less than 12 years of age OR unable to swallow tablets
		• tolterodine
		• tolterodine SR
		• trospium
		• trospium ER
		• Vesicare LS
		  ○ ST – must be 2 years of age or older and less than 12 years of age OR unable to swallow tablets
		Generic Medically Necessary PA criteria must be met for the following:
		• mirabegron tablets	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
HEMATOLOGIC			

Direct Oral Anticoagulants	• Eliquis
	  ○ QL – 2 tabs/day of 2.5mg; 4 tabs/day for 7 days, then 2 tabs/day for 5mg
	• Eliquis Starter Pack
	  ○ QL – 1 pack/90 days
	• Pradaxa capsules
	• Xarelto 2.5mg tablets
	  ○ QL – 2 tabs/day
	• Xarelto 10mg tablets
	  ○ QL – 1 tab/day
	• Xarelto 15 mg tablets
	  ○ QL – 2 tabs/day for max 21 consecutive days every 90 days; no duration restriction for once-daily dosing
	• Xarelto 20 mg tablets
	  ○ QL – 1 tab/day
	• Xarelto Starter Kit
	  ○ QL – 1 starter kit/90 days
	• Xarelto suspension
	  ○ ST – must be under 12-years of age or unable to swallow tablets
	  ○ QL – 20 mg/day (20 mL/day)
		• Pradaxa Pak
		  ○ ST – must be under 8 years of age or unable to swallow capsules OR have medical rationale for use of pellet formulation
		• Savaysa
		  ○ QL – 1 tab/day
		  ○ ST – must have trialed Eliquis and Xarelto OR medical justification for use of Savaysa over Eliquis and Xarelto
		
		Generic Medically Necessary PA criteria must be met for the following:
		• dabigatran capsules
		• rivaroxaban 2.5mg tablets
		  ○ QL – 2 tabs/day	

Hematinics	***Erythropoiesis-Stimulating Agents*** PA criteria must be met for the following: • Aranesp • Epogen • Retacrit ***Miscellaneous Hematinics*** • N/A	***Erythropoiesis-Stimulating Agents*** PA criteria must be met for the following: • Mircera • Procrit ***Miscellaneous Hematinics*** PA criteria must be met for the following: • Reblozyl	Hematinic Agents PA Criteria

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
HEMATOLOGIC - Continued			
Leukocyte Stimulants	***Short-Acting*** • Neupogen • Releuko ***Long-Acting*** • Fulphila • Fylnetra	***Short-Acting*** • Granix • Leukine • Nivestym • Zarxio ***Long-Acting*** • Neulasta • Neulasta Onpro • Nyvepria • Rolvedon • Stimufend • Udenyca • Udenyca Onbody • Ziextenzo	

Platelet Aggregation Inhibitors	• aspirin/dipyridamole
	• Brilinta
	  ○ QL – 2 tabs/day
	• cilostazol
	• clopidogrel 75 mg
	• clopidogrel 300 mg tablets
	  ○ QL – 1 tab/Rx
	• Prasugrel
		• Durlaza
		• Zontivity	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
LIPOTROPICS			
Bile Acid Sequestrants	• cholestyramine multi-dose containers • colesevelam tablets and suspension • Prevalite powder/packets	• cholestyramine packets • colestipol (granules/tablets)	
Fibric Acid Derivatives	• fenofibrate micronized cap (generic Antara) • fenofibrate micronized cap (generic Lofibra) • fenofibrate tab (generic Tricor) • gemfibrozil	• fenofibrate cap • fenofibric acid cap (generic Trilipix) • fenofibric acid tab • fenofibrate tab (generic Fenoglide) • Lipofen	
HMG CoA Reductase Inhibitors	• atorvastatin • lovastatin • pravastatin • rosuvastatin • simvastatin	• Altoprev • Atorvaliq ○ ST – must be 10 years of age or older and less than 12 years of age OR unable to swallow tablets • Ezallor • fluvastatin • fluvastatin ER • pitavastatin • Zypitamag	

Lipotropics	• ezetimibe
	• ezetimibe/simvastatin
	  ○ ST – must have trial history of a single-agent HMG CoA reductase inhibitor for 90 of the past 120 days
	• omega-3-acid ethyl esters
	• icosapent ethyl
	  ○ Age – 18 years of age or older
	  ○ QL – 4 capsules/day
	
	PA criteria must be met for the following:
	• Praluent
	• Repatha
		• Nexletol
		  ○ ST – must have trialed and failed two statin agents OR a statin in combination with ezetimibe OR medical justification for use over preferred statins and ezetimibe
		• Nexlizet
		  ○ ST – must have trialed and failed a statin in combination with ezetimibe OR medical justification for use over preferred statins and ezetimibe
		
		PA criteria must be met for the following:
		• Evkeeza
		• Juxtapid
		• Leqvio
		• niacin ER
			PCSK9 Inhibitors and Select Lipotropics PA Criteria
			
			PCSK9 Inhibitors and Select Lipotropics PA Form

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
MULTIPLE SCLEROSIS AGENTS			
Multiple Sclerosis Agents	PSQC/PA criteria must be met for the following: • Ampyra • Avonex • Bafiertam • Betaseron • Copaxone • dalfampridine • dimethyl fumarate • fingolimod 0.5 mg • Gilenya 0.25 mg • Kesimpta • Ocrevus; Ocrevus Zunovo • Rebif • teriflunomide • Tascenso ODT • Tysabri • Zeposia	PSQC/PA criteria must be met for the following: • Briumvi • Extavia • Lemtrada • Mavenclad • Mayzent • Plegridy • Ponvory • Vumerity PSQC/PA criteria AND Generic Medically Necessary PA criteria must be met for the following: • glatiramer • Glatopa	Multiple Sclerosis PA with Quantity Limits Criteria

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
RESPIRATORY			

Antihistamine-Decongestant Combinations/2nd Generation Antihistamines	• cetirizine 5 mg OTC tabs
	  ○ AGE – under 18 years
	• cetirizine 10 mg OTC tabs
	• fexofenadine OTC tabs
	• levocetirizine Rx tabs
	• loratadine 10 mg OTC tabs
	• loratadine 10 mg OTC RDT tabs
	Combinations
	• loratadine/pseudoephedrine 12-hour OTC tabs
	  ○ QL – 2 tablets/day
	  ○ ST – previous trial and failure of a preferred single-agent 2nd generation antihistamine
	• loratadine/pseudoephedrine 24-hour OTC tabs
	  ○ QL – 1 tablet/day
	  ○ ST – previous trial and failure of a preferred single-agent 2nd generation antihistamine
	Liquid Formulation
	• cetirizine 1 mg/ml OTC syrup and Rx syrup
	  ○ AGE – under 12 years or unable to swallow tablet formulation, max age 18 years
	  ○ QL – 10 mL/day
	• loratadine 1 mg/1ml OTC syrup
	  ○ AGE – under 12 years or unable to swallow tablet formulation, max age 18 years
	  ○ QL – 10 mL/day
	• levocetirizine Rx oral solution
	  ○ QL – 10 mL/day
	  ○ ST – must have trial of loratadine solution/syrup or cetirizine solution/syrup
		Note: New patients must first try cetirizine and loratadine within 90 days prior to receiving a non-preferred agent. Patients with an existing PA are not subject to the step edit.
		• desloratadine Rx tabs
		• desloratadine Rx ODT tabs
		Combinations
		• Clarinex-D Rx tabs
		  ○ QL – 2 tablets/day
		  ○ ST – previous trial and failure of loratadine/pseudoephedrine 12-hour OTC tab
		Liquid Formulation
		• Clarinex 0.5 mg/ml Rx syrup
		  ○ QL – 10 mL/day
		  ○ ST – must have trial on both cetirizine and loratadine within the past 90 days	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
RESPIRATORY - Continued			

Beta Adrenergics and Corticosteroids
 	
Note: All agents are limited to 1 diskus or inhaler per month unless otherwise specified
	• Advair Diskus 100/50 mcg, 250/50 mcg, 500/50 mcg
	• Advair HFA 45/21 mcg, 115/21 mcg, 230/21 mcg
	• Airduo Respiclick
	• Dulera 200-5 mcg
	• Trelegy Ellipta
	  ○ Asthma ST – must have tried and failed Advair or Symbicort therapy for at least 90 days of the past 120 days
	  ○ COPD ST – must have tried and failed Anoro Ellipta therapy for at least 90 of the past 120 days
	
	QL of 3 units per 30 days for ages 19 and younger/2 units per 30 days for ages 20 and over apply to the following:
	• Dulera 50-5 mcg, 100-5 mcg
	• Symbicort 80-4.5 mcg, 160-4.5 mcg
		• Airduo Digihaler
		• Airsupra
		  ○ AGE – 18 years of age and older
		  ○ QL – 2 inhalers per 30 days
		• Breo Ellipta
		• Breztri Aerosphere
		  ○ ST – must have tried and failed Trelegy Ellipta or have contraindication or intolerance to use
		• fluticasone/salmeterol HFA (ABA Advair HFA) 45-21 mcg, 115-21 mcg, 230-21 mcg
		• fluticasone/salmeterol Respiclick (ABA Airduo Respiclick) 55-13 mcg, 113-14 mcg, 232-14 mcg
		  ○ ST – must have tried at least 90 days of therapy with Airduo Respiclick
		• fluticasone/vilanterol
		• Wixela
		
		Generic Medically Necessary PA criteria must be met for the following:
		• fluticasone/salmeterol (generic Advair Diskus) 100/50 mcg, 250/50 mcg, 500/50 mcg
		
		QL of 3 units per 30 days for ages 19 and younger/2 units per 30 days for ages 20 and over apply AND Generic Medically Necessary PA criteria apply to the following:
		• budesonide/formoterol 80-4.5 mcg, 160-4.5 mcg
		• Breyna	

Beta Agonists – Long Acting	• Serevent	• arformoterol • formoterol • Striverdi Respimat	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
RESPIRATORY - Continued			

Beta Agonists – Short Acting	• albuterol nebs/syrup – (all strengths)
	
	QL of 3 canisters per 30 days for ages 18 and younger/2 canisters per 30 days for ages 19 and over apply to the following:
	• Ventolin HFA
	• Xopenex HFA
	  ○ ST – must have tried an albuterol HFA inhaler in the past 90 days
		• albuterol tablets (brand/generic)
		• levalbuterol neb solution
		  ○ QL – 2 prescriptions per 180 days, 1 box of 25 per prescription
		• terbutaline
		
		QL of 3 canisters per 30 days for ages 18 and younger/2 canisters per 30 days for ages 19 and over apply to the following:
		• albuterol HFA
		• levalbuterol HFA
		• Proair Digihaler
		• Proair Respiclick	

Bronchodilator Agents-Beta Adrenergic and Anticholinergic Combinations
 	
Note: Must not concurrently use >1 inhaled anticholinergic agent (excluding short-acting nebulization solution)
	Short-Acting
	• Atrovent HFA
	  ○ QL – 2 inhalers/30 days
	• Combivent Respimat
	  ○ QL – 2 inhalers/30 days
	• ipratropium solution
	  ○ QL – 2 boxes/30 days
	• ipratropium/albuterol solution
	  ○ QL – 3 boxes/30 days
	
	Long-Acting
	• Spiriva Handihaler
	  ○ QL – 1 inhaler/30 days
	• Anoro Ellipta
	  ○ QL – 1 inhaler/30 days
	• Incruse Ellipta
	  ○ QL – 1 inhaler/30 days
	• Spiriva Respimat 1.25 mcg
	  ○ ST – must have diagnosis of asthma
	  ○ QL – 1 inhaler/30 days
	• Spiriva Respimat 2.5 mcg
	  ○ ST – must have trial and failure of Spiriva Handihaler for a least 14 days
	• QL – 1 inhaler/30 days
		Short-Acting
		N/A
		
		Long-Acting
		• Bevespi Aerosphere
		  ○ QL – 1 inhaler/30 days
		• Duaklir Pressair
		  ○ QL – 1 inhaler/30 days
		• Stiolto Respimat
		  ○ QL – 1 box (60 inhalations)/30 days
		• Tudorza Pressair
		  ○ QL – 1 inhaler/30 days
		• Yupelri
		  ○ QL – 1 box (90mL)/30 days
		
		Generic Medically Necessary PA criteria must be met for the following:
		• tiotropium inhalation capsules
		• QL – 1 inhaler/30 days	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
RESPIRATORY - Continued			
Leukotriene Receptor Antagonists	• montelukast	• montelukast granules ○ ST – must have prescriber documentation indicating tablet formulations are unsuitable for use • zafirlukast • zileuton SR 12 HR • Zyflo	
Nasal Antihistamines/Nasal Anti-Inflammatory Steroids	***Antihistamines/Anticholinergics*** • azelastine 0.1% nasal spray • ipratropium NS ***Steroids/Steroid Combinations*** • Dymista • Fluticasone • Omnaris	***Antihistamines/Anticholinergics*** • azelastine 0.15% nasal spray • olopatadine • Patanase ***Steroids/Steroid Combinations*** • Beconase AQ • budesonide nasal suspension • flunisolide • mometasone nasal susp • Qnasl • Ryaltris • Zetonna Generic Medically Necessary PA criteria must be met for the following: • azelastine/fluticasone nasal spray	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
RESPIRATORY - Continued			

Oral Inhaled Glucocorticoids	• Arnuity Ellipta
	  ○ QL – 1 inhaler/30days
	• Asmanex, Asmanex HFA
	  ○ QL – 1 inhaler/30days
	• budesonide inhalation suspension
	  ○ AGE – 3 years and younger
	  ○ QL – 120 mL/30 days (0.25 mg/2 mL vial, 0.5 mg/2 mL vial); 60 mL/30 days (1 mg/2 mL vial)
	• fluticasone propionate HFA
	• fluticasone Diskus
	• Pulmicort Flexhaler
	• QVAR Redihaler
		• Alvesco
		• Armonair Digihaler
		• budesonide inhalation suspension
		  ○ AGE – 4 years and older
		  ○ QL – 120 mL/30 days (0.25 mg/2 mL vial, 0.5 mg/2 mL vial); 60 mL/30 days (1 mg/2 mL vial)
		• Flovent Diskus
		• Flovent HFA	

Pulmonary Antihypertensives	PSQC/PA criteria must be met for the following: • sildenafil inj/susp/tab • tadalafil • bosentan • Tracleer dispersible tablet	PSQC/PA criteria must be met for the following: • Adempas • ambrisentan • Liqrev • Opsumit • Opsynvi • Orenitram. Orenitram Titration Pack • Tadliq • Tyvaso, Tyvaso DPI • Uptravi • Ventavis • Winrevair	Pulmonary Antihypertensives PA Criteria Pulmonary Antihypertensives PA Form
Respiratory and Allergy Biologics	PSQC/PA criteria must be met for the following: • Dupixent • Fasenra • Nucala • Tezspire • Xolair	PSQC/PA criteria must be met for the following: • Cinqair	Respiratory and Allergy Biologics PA Criteria

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
TARGETED IMMUNOMODULATORS			

Targeted Immunomodulators	PSQC/PA criteria must be met for the following:
	• adalimumab products
	  ○ adalimumab-fkjp
	  ○ Hadlima
	  ○ Humira
	  ○ Simlandi
	  ○ Yusimry
	• Adbry
	• Cimzia
	• Cosentyx
	• Enbrel
	• Entyvio, Entyvio Pen
	• infliximab products
	  ○ Avsola
	  ○ Infliximab (unbranded Remicade)
	• Kevzara
	• Kineret
	• Litfulo
	• Nemluvio
	• Olumiant
	• Orencia vials & syringes
	• Otezla
	• Rinvoq
	• Rinvoq LQ
	• Siliq
	• Simponi, Simponi Aria
	• Taltz
	• tocilizumab products
	  ○ Actemra
	  ○ Tyenne
	• Xeljanz
	• Xeljanz oral solution
	  ○ AGE - the member is 2 years of age or older and weighing 10 kg or more AND less than 18 years of age and weighing less than 40 kg, OR provider has submitted documentation supporting inability to swallow tablet formulation
	• Xeljanz XR
		PSQC/PA criteria must be met for the following:
		• adalimumab products
		  ○ Abrilada
		  ○ adalimumab-aacf
		  ○ adalimumab-aaty
		  ○ adalimumab-adaz
		  ○ adalimumab-adbm
		  ○ adalimumab-ryvk
		  ○ Amjevita
		  ○ Cyltezo
		  ○ Hulio
		  ○ Hyrimoz
		  ○ Idacio
		  ○ Yuflyma
		• Arcalyst
		• Bimzelx
		• Cibinqo
		• Ebglyss
		• Ilaris
		• Ilumya
		• infliximab products
		  ○ Inflectra
		  ○ Remicade
		  ○ Renflexis
		  ○ Zymfentra
		• Omvoh
		• Skyrizi
		• Sotyktu
		• Spevigo
		• ustekinumab products
		  ○ Stelara
		  ○ Steqeyma
		  ○ Yesintek
		• tocilizumab products
		  ○ Tofidence
		• Tremfya
		• Velsipity
			Targeted Immunomodulators PA Criteria

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
TOPICAL AGENTS			
Dry Eye Disease or Keratoconjunctivitis ***See Dry Eye Disease or Keratoconjunctivitis PA Criteria for product-specific quantity limits*** ***Note: No more than a 30-day supply may be dispensed at one time.***	PSQC/PA criteria must be met for the following: • Restasis single dose • Xiidra	PA criteria must be met for the following: • Cequa • cyclosporine single dose emulsion • Eysuvis • Miebo • Restasis Multidose • Tyrvaya • Verkazia • Vevye	Dry Eye Disease or Keratoconjunctivitis PA criteria

Miotics-Intraocular Pressure Reducers	• Alphagan-P 0.1%
	• Alphagan-P 0.15%
	• apraclonidine
	• Azopt
	• Betoptic-S
	• brimonidine 0.2% solution
	• carteolol
	• Combigan
	• dorzolamide
	• dorzolamide/timolol
	• Iopidine 1%
	• latanoprost
	• levobunolol
	• Lumigan 0.01% drops
	• metipranolol
	• pilocarpine
	• Rhopressa
	• Rocklatan
	• timolol maleate solution
	• Travatan Z
		• Betaxolol
		• Betimol
		• bimatoprost 0.03%
		• Cosopt PF
		• Iyuzeh
		  ○ ST – must have tried and failed latanoprost OR prescriber has provided medical justification for use of Iyuzeh over latanoprost
		• Phospholine Iodide
		• Simbrinza
		  ○ ST – must provide documentation that separate components are not suitable for use (Azopt/brimonidine)
		• timolol gel
		• Timoptic-XE
		• Vyzulta
		• Xelpros
		• Zioptan
		
		PA criteria must be met for the following:
		• Vuity
		
		Generic Medically Necessary PA criteria must be met for the following:
		• brimonidine 0.1% solution
		• brimonidine 0.15% solution
		• brimonidine/timolol solution
		• brinzolamide suspension
		• tafluprost
		• timolol hemihydrate solution
		• travoprost 0.004%
			Presbyopia Agents PA criteria

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
TOPICAL AGENTS - Continued			
Ophthalmic Antihistamines	• Alaway • azelastine • Bepreve • Ketotifen	• epinastine • Zerviate Generic Medically Necessary PA criteria must be met for the following: • bepotastine besilate	
Ophthalmic Anti-Inflammatory Agents	***NSAIDs*** • diclofenac 0.1% ophth soln • flurbiprofen 0.3% ophth soln • ketorolac 0.4% ophth soln • ketorolac 0.5% ophth soln • Nevanac 0.1% ophth soln ***Steroids*** • Alrex 0.2% ophth susp • dexamethasone sod phos 0.1% ophth soln • Durezol 0.05% ophth emul • Flarex 0.1% ophth susp • FML Liquifilm 0.1% ophth susp • Lotemax 0.5% ophth gel/ointment/susp • prednisolone acetate 1% ophth suspension • Pred Mild 0.12% ophth susp • prednisolone sod phos 1% ophth soln	***NSAIDs*** • Acuvail 0.45% ophth soln • bromfenac 0.075% ophth soln • bromfenac 0.09% ophth soln • Ilevro 0.3% ophth soln • Prolensa 0.07% ophth soln Generic Medically Necessary PA criteria must be met for the following: • bromfenac 0.07% ophth soln ***Steroids*** • FML Forte 0.25% ophth susp • Inveltys 1% ophth susp • Lotemax SM 0.38% ophth gel • Maxidex 0.1% ophth susp Generic Medically Necessary PA criteria must be met for the following: • difluprednate 0.05% ophth emul • fluorometholone 0.1% ophth susp • loteprednol 0.2% ophth susp • loteprednol ophth gel/susp 0.5%	
Ophthalmic Mast Cell Stabilizers	• cromolyn	• Alocril • Alomide	
Otic Preparations	• acetic acid solution • fluocinolone acetonide oil	• acetic acid HC	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
TOPICAL AGENTS - Continued			
Topical Anti-Inflammatory Agents – NSAIDS	• diclofenac 1% gel • Pennsaid topical solution	All of the following require physician documentation indicating oral medications are unsuitable for use AND trial and failure of diclofenac 1% gel and Pennsaid topical solution, OR medical justification for use over preferred agents • diclofenac solution • diclofenac epolamine patch ○ QL – 2 patches per day	
Topical Antiparasitics ***Unless otherwise specified, all products are limited to one bottle or one tube per claim***	• Natroba • permethrin 5% cream • permethrin 1% lotion	• Crotan • ivermectin lotion • Lindane shampoo • Malathion • spinosad • VanaLice	
Topical Immunomodulators	PA criteria must be met for the following: • Eucrisa • Opzelura • pimecrolimus cream • tacrolimus ointment	PA criteria must be met for the following: • Zoryve 0.15% cream • Zoryve 0.3% cream • Zoryve 0.3% foam	Topical Immunomodulators PA criteria

Topical Post-Herpetic Neuralgia Agents	• lidocaine patches
	  ○ QL – 3 boxes/30 days
	• Lidoderm
	  ○ QL – 3 boxes/30 days
	• ZTlido
	  ○ QL – 3 boxes/30 days
	  ○ ST – must have previous trial of at least 30 days of therapy with preferred lidocaine 5% patches
		• Lidotral
		  ○ QL – 3 boxes/30 days
		• Synera
		• Qutenza
		  ○ QL – 4 patches/3 months
		  ○ ST – must have tried lidocaine patches and over-the-counter capsaicin cream	

MISCELLANEOUS INFORMATION	
Preferred Brand Drug List	Mental Health Medications Medical Necessity Prior Authorization Form
OTC Drug Formulary	Antipsychotic Therapy PA with QL
Pharmacy Supplements Formulary	Sedative Hypnotics Benzodiazepine PA Criteria
OTC Contraceptive Agents Formulary	Benzodiazepine and Opioid Concurrent Therapy PA Form
Brand Medically Necessary/Generic Medically Necessary Prior Authorization Form	SSRI/SNRI/NRI Duplicate Therapy PA Criteria with QL
IHCP Early Refill Prior Authorization Request Form	Stimulants PA Criteria
Non-Drug-Specific PA Criteria	Hetlioz PA Criteria
PBM Call Center LTC ProDUR and Home Health PA Request Form	Hetlioz PA Form
PBM Call Center Prior Authorization Form	Igalmi PA Criteria
Vaccine Utilization Edits	Narcolepsy Agents PA Criteria
Vaccine Utilization Edits for VFC-Enrolled Pharmacies	Narcolepsy Agents PA Form
	Nuplazid PA Criteria
	Utilization Edits for Mental Health Medications

MISCELLANEOUS INFORMATION - Continued	
Allergy Specific Immunotherapy PA Criteria	Muscular Dystrophy Agents PA Criteria
Amyloid Beta-Directed Antibodies	Muscular Dystrophy Agents PA Form
Antiviral Monoclonal Antibodies (Synagis) PA	Niemann-Pick Disease Agents PA Criteria
Antiviral Monoclonal Antibodies (Synagis) PA Form	Non-SUPDL Agents PA and ST
Aromatase Inhibitors PA Criteria	Nuedexta PA Criteria
Complement Inhibitor Agents PA	Nuedexta PA Form
Corticotropin	Oxervate PA Criteria
Cushing Syndrome Agents	Phenylketonuria Agents PA
Cushing Syndrome Agents PA Form	Phosphodiesterase Inhibitors for COPD
Cystic Fibrosis Inhaled Agents PA Criteria	Phosphodiesterase Inhibitors for COPD PA Form
Cystic Fibrosis Agents PA Criteria	Pompe Disease Agents PA Criteria
Cystic Fibrosis Agents PA Form	Prenatal Vitamins High Dollar Limit PA
Daybue PA Criteria	Roctavian PA Criteria
Disposable Insulin Delivery Devices PA	Sickle Cell Agents PA Criteria
Egrifta PA Criteria	Sickle Cell Agents PA Form
Elevidys PA Criteria	Skyclarys PA criteria
Elmiron PA Criteria	Solaraze PA Criteria
Epidermolysis Bullosa Agents PA	Somatostatin Analog PA Criteria
Gralise, Horizant, and Lyrica CR PA Criteria	Spinal Muscular Atrophy Agents PA Criteria
Gralise, Horizant, and Lyrica CR PA Form	Spinal Muscular Atrophy Agents PA Form
HCG PA Criteria	Thrombopoietin Receptor Agonist Agents PA
Hemophilia B Gene Therapy PA	Topical Doxepin PA
Hepatitis B Agents PA Criteria	Topical Lidocaine QL
High Dollar Compounded PA Criteria	Topical Steroid PA
High Dollar Compounded PA Request Form	Topical Agents PA Form
Immunoglobulin A Nephropathy (IgAN) Agents PA	Transthyretin Stabilizer Agents PA Criteria
Intravesical Immunotherapy PA	Tzield PA
Lucemyra PA Criteria	Tzield PA Form
Lucemyra PA Form	Wegovy PA
MASH/MASLD Agents	Zepbound PA
Mepron PA Criteria	Zurzuvae PA criteria