Virginia Medicaid's Preferred Drug List (PDL)/ Common Core Formulary

7/1/21

Virginia Medicaid's Pharmacy Benefits Management System
Phone: 800-932-6648 Fax: 800-932-6651

General Information:

- **Virginia Medicaid's Preferred Drug List (PDL)/ Common Core Formulary only includes select drug classes, other classes will pay such as but not limited to diuretics, many cardiac agents, many antibiotics etc.**
- PDL preferred drugs do not require Service Authorizations (SA) unless subject to additional clinical criteria (e.g., long acting opioids, hepatitis C therapies, growth hormone)
- Non-preferred drugs require a SA
- Drugs not on the PDL are subject to Virginia's mandatory generic substitution requirements.
- SAs may be submitted by fax, phone or WebPA. For urgent requests, please call **800-932-6648.** Fax requests receive a response within 24 hours.

PDL drug coverage information can be found at http://www.VirginiaMedicaidPharmacyServices.com. **The following "routine" PDL criteria guidelines will be applied to all non-preferred drugs.**

1. Is there any reason the member cannot be changed to a preferred drug within the same class? Acceptable reasons include:
   - Allergy to preferred drug.
   - Contraindication to or drug-to-drug interaction with preferred drug.
   - History of unacceptable/toxic side effects to preferred drug.
   - Member's condition is clinically stable; changing to a preferred drug might cause deterioration of the member's condition.
2. The requested drug may be approved if both of the following are true:
   - There has been a therapeutic failure of at least **two** preferred drugs **within the same class as appropriate for diagnosis unless otherwise noted in the clinical criteria**. A therapeutic failure of only one preferred drug is required when there is only one preferred drug within a therapeutic class.
   - The requested drug's corresponding generic (if a generic is available **and** covered by the State) has been attempted and failed or is contraindicated.

All changes from last posting will be highlighted in yellow.

**Members currently receiving aripiprazole oral solution, Geodon® (IM), Nuplazid or olanzapine/fluoxetine will be "grandfathered" for a period not to exceed one year. After that time, the prescriber will need to submit a service authorization request documenting the medical necessity of the non-preferred drug.

LEGEND

AG = age edit
CE= clinical edit
ST = step edit
QL = quantity limit
cap = capsule
cr = cream
ER = extended release
inj = injection
IR = immediate release
ODT = oral disintegrating tablet
oint = ointment
soln = solution
supp = suppository
susp = suspension
tab = tablet

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	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Analgesics			
	*** Opioids – Long Acting (LAO)**		
	Preferred (Sch III-VI)	***Non-Preferred***	***All Long Acting Opioids (preferred and non-preferred) require submission of a Clinical SA. Refer to combined short/long-acting opioid SA form (Short & Long Acting Opioid SA Form)** **LENGTH OF AUTHORIZATIONS** • Up to 3 months for (includes HIV/AIDS, Chronic back pain, Arthritis, Fibromyalgia, Diabetic neuropathy, Postherpetic Neuralgia). • Up to 6 months for chronic pain (includes Cancer pain, Sickle cell disease, Palliative care, End-of-Life Care, Hospice). Daily dose limits have been established for all LAO. Quantity limits can be found at : **Daily Dose Limits for Short & Long Acting Opioids**
	Butrans® (buprenorphine) Transdermal Patch	*Belbuca (buprenorphine buccal film)* *buprenorphine (generic Butrans®)* *ConZip® (tramadol ER)* *Ryzolt™ (tramadol ER)* *tramadol ER* *Ultram ER® (tramadol ER)*	
	Preferred (Sch II)	***Non-Preferred***	
	fentanyl 12, 25, 50, 75 & 100 mcg patches **morphine sulfate ER tab**	*Arymo™ER* *~~Duragesic~~®* *Embeda* *Exalgo®* *fentanyl 37.5 mcg, 62.5 mcg, and 87.5 mcg patches* *hydromorphone ER* *Hysingla ER™* *Kadian® ER* *Morphabond™ ER* *morphine ER cap (generic Avinza®)* *morphine ER cap (generic Kadian®)* *MS Contin®* *Nucynta® ER* *Oramorph ® SR®* *oxycodone-long acting* *OxyContin®* *oxymorphone ER* *Xartemis™ XR* *Xtampza ER®* *Zohydro ER™*	

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
***Methadone Drugs**		
	Dolophine® *Methadose® oral soln & tab* *methadone oral soln & tab*	*Methadone requires the completion of the Clinical SA form **(Methadone SA Form)** unless prescribed for neonatal abstinence syndrome for an infant under the age of one.
***Opioids – Short Acting**		
***Transmucosal Immediate Release Fentanyl**		**LENGTH OF AUTHORIZATIONS:** • Up to 3 months for (includes HIV/AIDS, Chronic back pain, Arthritis, Fibromyalgia, Diabetic neuropathy, Postherpetic Neuralgia). • Up to 6 months for chronic pain (includes Cancer pain, Sickle cell disease, Palliative care, End-of-Life Care, Hospice).
	Actiq® *Fentora®* *fentanyl citrate* *Lazanda®* *Subsys®*	
Short-Acting Opioids		
codeine/APAP **hydrocodone/APAP** **hydrocodone/ibuprofen** **hydromorphone** **morphine IR** **oxycodone IR** **oxycodone/APAP** **tramadol HCl 50mg** **tramadol HCl/APAP**	*Abstral®* *Apadaz™* *codeine tab/soln* *butalbital comp with codeine* *butalbital/caffeine/APAP w/codeine* *butorphanol tartrate nasal* *dihydrocodeine/APAP/caffeine* *dihydrocodeine/ASA/caffeine* *hydromorphone liq/supp* *meperidine tab* *morphine supp* *Nucynta®* *Oxaydo®* *oxycodone/APAP(generic PrimLev™)* *oxycodone conc* *oxycodone oral syringe* *oxycodone/ASA* *oxycodone/ibuprofen* *oxymorphone HCl* *Panlor®* *pentazocine/naloxone* *PrimLev™*	***All Short-Acting Opioids (preferred and non-preferred) require the submission of a Clinical SA if prescribed for > 7 days or if more than two 7 day supply prescriptions within 60 days. Refer to combined short/long-acting opioid SA form (Short & Long Acting Opioid SA Form)**

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	RoxyBond™ *tramadol 100 Mg* *Ultracet®* *Ultram®* *Zamicet ®soln*	
Opioid Dependency **CLOSED CLASS**		***All Buprenorphine Containing Drugs (non-preferred) require submission of Clinical SA. Refer to ~~(Sublocade Form)~~ or (Oral Buprenorphine SA Form)**
***buprenorphine SL** ***Suboxone® film** ***Sublocade™ SQ**	*~~*Bunavail™~~* **buprenorphine/naloxone tab SL* **buprenorphine/naloxone film SL* **Cassipa®* **Probuphine® implant* **Zubsolv™*	**Quantity Limits**
naloxone syringe & vial **Naloxone Carpuject** **naltrexone tab** **Narcan® Nasal Spray** **Vivitrol®**	*Evzio® injection*	

~~Bunavail™ 2.1–0.3mg buccal film~~	~~1/day~~
~~Bunavail™ 4.2–0.7mg buccal film~~	~~2/day~~
~~Bunavail™ 6.3–1mg buccal film~~	~~3/day~~
buprenorphine SL tab 2mg	3/day
buprenorphine SL tab 8mg	2/day
buprenorphine/naloxone SL tab 2–0.5mg	3/day
buprenorphine/naloxone SL tab 8–2mg	3/day
buprenorphine/naloxone SL film 2–0.5mg	3/day
buprenorphine/naloxone SL film 4–1mg	1/day
buprenorphine/naloxone SL film 8–2mg	3/day
Cassipa® 16mg-4mg	1/day
Suboxone® SL film 2–0.5mg	3/day
Suboxone® SL film 4–1mg	1/day
Suboxone® SL film 8–2mg	3/day
Suboxone® SL film 12–3mg	2/day
Zubsolv™ SL tab 0.7–0.18 mg	2/day
Zubsolv™ SL tab 1.4–0.36mg	2/day
Zubsolv™ SL tab 2.9–0.71mg	2/day
Zubsolv™ SL tab 5.7–1.4mg	2/day
Zubsolv™ SL tab 8.6–2.1mg	2/day
Zubsolv™ SL tab 11.4–2.9mg	2/day

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Preferred Agents	*Non-Preferred Agents*	*SA Criteria*

Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)

Oral NSAIDs		
Children's Motrin® susp (OTC) **ibuprofen cap** **ibuprofen tab (OTC & Rx)** **Infant's ibuprofen drops** **meloxicam tab** **naproxen tab** **naproxen sodium (OTC)** **naproxen EC (Rx)** **sulindac**	*Anaprox® IR & DS®* *Advil®* *Aleve®* *Arthrotec®* *Cataflam®* **Celebrex® & *celecoxib* *Daypro®* *diclofenac potassium* *diclofenac sodium SR* *diclofenac sodium/misoprostol* *diflunisal* *Duexis®* *etodolac IR & SR* *Feldene®* *fenoprofen* *flurbiprofen* *ibuprofen tab chew OTC* *Indocin® supp* *indomethacin IR, SR & rectal* *ketoprofen IR & ER* *ketorolac* *ketorolac tromethamine (generic for Sprix® nasal spray)* *meclofenamate* *mefenamic* *meloxicam susp* *meloxicam (generic Vivlodex™)* *Mobic®* *Motrin®* *nabumetone* *Nalfon®* *Naprelan®*	**LENGTH OF AUTHORIZATIONS: 1 year** **Routine PDL edits plus** ***Step edit required for Celebrex® and celecoxib** • History of a trial of a minimum of two (2) different non-COX2 NSAIDs within the past year**; OR** • Concurrent use of anticoagulants (i.e., warfarin, heparin, etc.)**,** methotrexate, oral corticosteroids; **OR** • History of previous GI bleed or conditions associated with GI toxicity risk factors (i.e., PUD, GERD, etc); **OR** • Specific indication for Celebrex® for which preferred drugs are not indicated.

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	Naprosyn® *naproxen CR (generic Naprelan®)* *naproxen-esomeprazole mag (generic Vimovo®)DR* *naproxen sodium (RX)* *naproxen susp* *oxaprozin* *piroxicam* *Ponstel®* *Prevacid Naprapac®* *Sprix® nasal spray* *Tivorbex™* *tolmetin sodium* *Vimovo®* *Vivlodex™* *Voltaren®XR* *Zipsor®* *Zorvolex™*	
Topical NSAIDs		**LENGTH OF AUTHORIZATIONS:** **1 year** **Routine PDL edits plus** **Clinical Criteria for Non-Preferred Topical NSAIDs; *Flector®, Pennsaid®, Vopac MDS, & Xrylix™ Kit:** • Approval is based on member failing the oral generic of the desired drug and at least one other preferred NSAID (to equal a total of at least two preferred). For example, a member who failed ibuprofen or naproxen will still need to try oral diclofenac for approval of Flector®. • Pennsaid®, Vopac MDS, and Xrylix™ Kit can only be approved for the FDA approved indication of osteoarthritis of the knee. ***Quantity limit for Flector® and Licart™ patch = 30 patches per RX*** ****Solaraze® 3% & Diclofenac Sodium 3 % Clinical Criteria**: • Approved only for the topical treatment of actinic keratosis
diclofenac sodium 1% gel **diclofenac sodium 1% gel (OTC)**	***diclofenac sodium 3 % gel* **Flector® patch (QL)* *Licart™ patch (diclofenac epolamine 0.013gm (QL)* **Pennsaid® top soln, soln pkt & pump* ***Solaraze 3% top gel* **Vopac MDS* **Voltaren® 1% gel* **Voltaren® 1% gel (OTC)* **XrylixTM Kit*	

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Antibiotic-Anti-Infective			
	***Antibiotics, Inhaled**	**CLOSED CLASS**	

	Bethkis® *(QL, AG)*
	Kitabis™ Pak *(QL, AG)*
	****Tobi Podhaler® *(QL, AG, SE)***
		****Arikayce® *(amikacin liposome)***
		Cayston®
		Tobi® inhalation neb soln (QL, AG)
		tobramycin (generic Bethkis®)
		tobramycin Pak (generic Kitabis™ Pak) (QL, AG)
		tobramycin inhalation neb soln (generic Tobi® inhalation) (QL, AG)
			LENGTH OF AUTHORIZATIONS: **1 year**
			Routine PDL edits plus
			**Tobi Podhaler®
			• Requires a clinical reason as to why one of the preferred tobramycin inhalation nebulizer solutions cannot be used (Bethkis® or Kitabis™).
			
			****Clinical Criteria for Arikayce®**
			Duration of Approval: 12 months
			Initial Approval Criteria
			• Patient is ≥ 18 years of age; AND
			• Diagnosis of Mycobacterium avium complex (MAC) lung disease as determined by the following:
			  ○ chest radiography or high-resolution computed tomography (HRCT) scan; AND
			  ○ at least 2 positive sputum cultures; AND
			  ○ other conditions such as tuberculosis and lung malignancy have been ruled out; AND
			• Patient has failed a multi-drug regimen with a macrolide (clarithromycin or azithromycin), rifampin, and ethambutol. (Failure is defined as continual positive sputum cultures for MAC while adhering to a multi-drug treatment regimen for a minimum duration of 6 months); AND
			• Patient has documented failure or intolerance to aerosolized administration of amikacin solution for injection, including pretreatment with a bronchodilator; AND
			• Arikayce will be prescribed in conjunction with a multi-drug antimycobacterial regimen
			
			*Minimum age for use is 6 years for all tobramycin inhalation nebulizer solution (Bethkis®, Kitabis™ Pak, Tobi® and Tobi Podhaler®) and 7 years for Cayston®.

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
			Quantity Limits: *Arikayce = 590 mg/8.4 Ml (28 vials)/28 days* *Each carton contains a 28-day supply of medication (28 vials)* Bethkis® = 224Ml (56 amps)/28 days Cayston® = 84 Ml/(56 amps)/28 days Kitabis™ Pak = 280Ml (56 amps)/28 days Tobi Podhaler® = 224 capsule/28 day Tobi® inhalation *neb* = 280Ml (56 amps)/28 days tobramycin = 280Ml (56 amps)/28 days
	Antifungals, Oral		
	fluconazole tab/susp **griseofulvin susp** **nystatin tab/susp** **terbinafine tab**	*Ancobon ®* *clotrimazole (mucous mem)* *Cresemba®* *Diflucan® tab/susp* *flucytosine* *Gris-Peg®* *griseofulvin tab* *griseofulvin ultramicrosize* *itraconazole* *itraconazole solution (generic for Sporanox® soln)* *ketoconazole* *Lamisil ® tab/granules* *Noxafil®* **Onmel®* *Posaconazole tab (generic for Noxafil)* **Sporanox® cap/soln* *Tolsura™* *Vfend® tab/susp* *voriconazole tab & powder for susp*	**LENGTH OF AUTHORIZATIONS**: Duration of the prescription (up to 12 months) **Routine PDL edits plus** *** Clinical Criteria for all Non-Preferred oral Antifungals. Requires the submission of a Clinical SA. Refer to Antifungal Oral SA Form**

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Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Cephalosporins, Oral		
Second Generation Cephalosporins		**LENGTH OF AUTHORIZATIONS**: Date of service only; no refills. **Routine PDL edits plus** **Clinical Criteria for Non-Preferred Cephalosporins** • Infection caused by an organism resistant to preferred drugs, OR • A therapeutic failure to no less than a three-day trial of **one preferred cephalosporin**; **OR** • The member is completing a course of therapy with a non-preferred drug initiated in the hospital.
cefaclor capsule **cefprozil tab/susp** **cefuroxime tab**	*cefaclor ER* *cefaclor susp* *Ceftin® tab/susp*	
Third Generation Cephalosporins		
cefdinir cap/susp	*Cedax® cap/susp* *ceftibuten* *cefditoren pivoxil* *cefixime suspension* *cefpodoxime proxetil cap/susp* *Spectracef®* *Suprax® chewable tab/cap/susp*	
Macrolides, Oral		
Macrolides & Ketolides		**LENGTH OF AUTHORIZATIONS**: Date of service only; no refills **Routine PDL edits plus** **Clinical Criteria for Non-Preferred Macrolides and Ketolides** • Infection caused by an organism resistant to preferred drugs; **OR** • A therapeutic failure to no less than a **three-day trial of one preferred drug within the same class**; **OR** • The member is completing a course of therapy with a non-preferred drug which was initiated in the hospital. *** Ketek® Clinical Criteria** • Treatment of community-acquired pneumonia (of mild to moderate severity) **AND** • Infection is caused by one of the following microorganism: *Streptococcus pneumoniae, Haemophilus 9nfluenza, Moraxella catarrhalis, Chlamydophila pneumoniae, or Mycoplasma pneumoniae.***AND** • A therapeutic failure to no less than a **three-day trial of one preferred drug within the same class**; **OR** • The member is completing a course of therapy with a non-preferred drug initiated in the hospital.
azithromycin pack/susp/tab **clarithromycin tab/susp** **E.E.S.® 200 susp** **erythromycin base cap DR** **erythromycin ethylsuccinate 200mg susp** **erythromycin stearate**	*Biaxin® tab* *clarithromycin ER* *Eryped® 200 susp* *Eryped® 400 susp* *Ery-tab®* *E.E.S.® 400 tab* *Erythrocin® Stearate* *erythromycin base tab* *erythromycin ethylsuccinate 400mg tab(Generic E.E.S.® 400)* **Ketek®* *PCE®* *Zithromax® pac/tab/susp* *ZMAX® susp*	

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Otic		
Ciprodex® **ofloxacin** **neomycin/polymyxin/hc soln/ sus**	*Cetraxal®* *Cipro HC®* *ciprofloxacin/dexamethasone (generic Ciprodex)* *ciprofloxacin and fluocinolone acetonide (generic Otovel)* *Otovel*	**LENGTH OF AUTHORIZATIONS:** Date of service only; no refills **Routine PDL edits**
Quinolones, Oral		
Second Generation Quinolones		**LENGTH OF AUTHORIZATIONS**: Date of service only; no refills **Routine PDL edits plus**: **Clinical Criteria for Non-Preferred Quinolones** • Infection caused by an organism resistant to preferred drugs; **OR** • A therapeutic failure to no less than a **three-day trial of one preferred quinolone**; **OR** • The member is completing a course of therapy with a non-preferred drug initiated in the hospital.
ciprofloxacin susp/tab	*Cipro® IR & XR & susp* *ciprofloxacin ER* *Noroxin®* *ofloxacin*	
Third Generation Quinolones		
levofloxacin tab	*Baxdela™ tab* *Levaquin® tab/susp* *levofloxacin susp* *moxifloxacin*	
Topical Antibiotics		
mupirocin ointment	**Altabax™ (QL)* *Bactroban® cr/ointment* *Centany®* *Centany AT® Kit*	**LENGTH OF AUTHORIZATIONS**: Date of service only; no refills **Routine PDL edits** **Quantity Limit = 15 grams per 34 days*
Vaginal Antibiotics		
Cleocin® Ovules **Clindesse® cr** **metronidazole gel** **Nuvessa™** **Vandazole™ gel**	*Cleocin® cr* *clindamycin cr* *Metrogel®*	**LENGTH OF AUTHORIZATIONS**: Date of Service **Routine PDL edits**

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	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Antivirals			
	***Hepatitis C Agents** **CLOSED CLASS**		
	Interferon		**LENGTH OF AUTHORIZATIONS**: 8 weeks (initial approval) ***ALL Hepatitis C Drugs (Preferred and Non-Preferred) require the submission of a Clinical SA. Refer to Hepatitis C Antivirals Preferred SA Form or Hepatitis C Antivirals Non-Preferred SA Form**
	Peg-Intron®	*Pegasys® Proclick/syringe/kit/vial*	
	Protease Inhibitor		
		Olysio™ (discontinued)	
	***Nucleotide Analog NS5A & NS5B Polymerase Inhibitors & Combinations**		
	sofosbuvir /velpatasvir (generic Epclusa®)	*Epclusa®* *Sovaldi®* *Vosevi™*	
	***NS5A, NS3/4A Inhibitor Combinations**		
	Mavyret™	*Technivie™* *Viekira Pak™* *Viekira XR™* *Zepatier®*	
	***NS5B & Protease Inhibitor combinations**		
		Harvoni® *Ledipasvir/Sofosbuvir (generic Harvoni®)*	
	Herpes Oral		
	acyclovir cap/tab/susp **famciclovir** **valacyclovir**	*Famvir®* *Sitavig® buccal tab* *Valtrex®* *Zovirax® tab/susp*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits**
	Herpes Topical		
	Abreva OTC®	*acyclovir cr (generic Zovirax cr)*	**LENGTH OF AUTHORIZATIONS**: 1 year

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	docosanol **Zovirax® cr**	*acyclovir oint* *Denavir®* *Xerese® cr* *Zovirax® oint*	**Routine PDL edits**
	Influenza		
	oseltamivir susp/ cap	*Flumadine® tab* *rimantadine* *Relenza Disk®* *Tamiflu® susp/cap* *Xofluza™*	**LENGTH OF AUTHORIZATIONS:** Date of service only **Routine PDL edits**
Blood Modifiers			
	Bile Salts		
	ursodiol mg cap, tab	*Actigal®* *Chenodal®* *Cholbam®* *Ocaliva®* *Urso®* *Urso® Forte tab*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits**
	Phosphate Binders		
	calcium acetate 667mg cap **sevelamer carbonate tab**	*Auryxia™* *calcium acetate 667mg tab* *Eliphos* *Fosrenol® chewable tab* *lanthanum carbonate chewable tab* *Phoslyra® powder, tab* *Renagel®* *Renvela®* *sevelamer carbonate powder packet* *sevelamer HCL (generic Renagel)* *Velphoro® chewable tab*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits**
Bone Resorption Suppression and Related Agents			
	Bisphosphonates		
	alendronate tab	*Actonel®*	**LENGTH OF AUTHORIZATIONS**: 1 year

	Preferred Agents	Non-Preferred Agents	SA Criteria
	ibandronate	*alendronate soln* *Atelvia DR®* *Boniva®* *Binosto™* *etidronate* *Fosamax®tab & Fosamax® plus D* *risedronate DR*	**Routine PDL edits** .
	Calcitonins		
	calcitonin-salmon nasal	*Miacalcin®*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits**
	Others		
	raloxifene	*Evista®* **Forteo®* *teriparatide* **Tymlos™*	**LENGTH OF AUTHORIZATIONS**: Initial approval will be for 1 year **Routine PDL edits for Evista®** **Clinical SA must be completed for (Forteo® OR Tymlos™ SA Form)**
Cardiac			
	Anticoagulants **CLOSED CLASS**		
	Low Molecular Weight Heparin includes FactorXA Inhibitor		**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits plus**
	enoxaparin	*Arixtra®* *fondaparinux* *Fragmin® syringe & vial* *Lovenox®*	
	Oral Anticoagulants		**Clinicial Criteria for Savaysa™** • Diagnosis of: • Non-valvular Atrial Fibrillation, **OR** • deep vein thrombosis, **OR** • pulmonary embolism ; **AND** • Documentation that CrCl is NOT ≥ 95mL/min calculated by Cockcroft-Gault equation **Bristol-Myers Squibb announced it will discontinue sales of all strengths of Coumadin due to unexpected manufacturing issues that could not be resolved expediously. Supply is expected to be depleted by 8/31/2020.**
	Eliquis™ **Eliquis™ Dose Pack** **Jantoven** **Pradaxa®** **Xarelto®** **Xarelto® Starter Pack** **warfarin**	*apixaban (generic Eliquis™)* ~~*Coumadin®*~~ **Savaysa™*	

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Antihypertensive Agents		
ACE Inhibitors		**LENGTH OF AUTHORIZATIONS: 1 year** **Routine PDL edits**
benazepril **enalapril** **lisinopril** **ramipril** **quinapril**	*Accupril®* *Altace®* *captopril* *Epaned™ soln* *fosinopril* *Lotensin®* *Mavik®* *moexipril* *Monopril®* *perindopril* *Qbrelis™* *ramipril* *trandolapril* *Univasc®* *Vasotec®* *Zestril®*	
ACE Inhibitors + Calcium Channel Blocker Combinations		
amlodipine/benazepril	*Lotrel®* *Tarka®* *trandolapril-verapamil ER*	
ACE Inhibitors + Diuretic Combinations		
benazepril/HCTZ **lisinopril/HCTZ** **enalapril/HCTZ**	*Accuretic®* *captopril/HCTZ* *fosinopril/HCTZ* *Lotensin HCT®* *moexipril/HCTZ* *quinapril/HCTZ* *Vaseretic®* *Zestoretic®*	

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Angiotensin Receptor Blockers		**LENGTH OF AUTHORIZATIONS:** **1 year** **Routine PDL edits plus** *Quantity Limit = 2 per day for Entresto™*
Entresto™ *(QL) **irbesartan** **losartan** **olmesartan** **valsartan**	*Atacand®* *Avapro®* *Benicar®* *candesartan* *Cozaar®* *Diovan®* *Edarbi®* *eprosartan mesylate* *Micardis®* *Teveten®*	
Angiotensin Receptor Blockers + Calcium Channel Blocker Combinations		
amlodipine/olmesartan **amlodipine/valsartan**	*Azor®* *amlodipine/olmesartan/HCTZ* *amlodipine/valsartan/HCTZ* *Exforge® & Exforge® HCT* *Tribenzor®*	
Angiotensin Receptor Blockers + Diuretic Combinations		
irbesartan/HCTZ **losartan/HCTZ** **olmesartan/HCTZ** **valsartan/HCTZ**	*Atacand HCT®* *Avalide®* *Benicar HCT®* *candesartan/HCTZ* *Diovan HCT®* *Edarbyclor®* *Hyzaar®* *Micardis HCT®* *telmisartan/HCTZ* *Teveten HCT®*	
Antihypertensives, Sympatholytics CLOSED CLASS		
Catapres®-TTS **clonidine tab**	*Catapres®* *clonidine (transdermal)*	

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
guanfacine **methyldopa** **~~reserpine~~**	*Clorpres®* *methyldopa/HCTZ* *Tenex®*	
Beta Blockers		***Clinical Criteria for Hemangeol™** • Diagnosis treatment of proliferating infantile hemangioma requiring systemic therapy; **AND**
atenolol **bisoprolol** **carvedilol** **labetalol** **metoprolol tartrate** **metoprolol succinate** **propranolol tab & ER/soln** **Sorine®** **sotalol AF** **sotalol HCL**	*acebutaolol* *Betapace® IR & AF®* *betaxolol* *Bystolic®* *Carvedilol ER* *Coreg® IR & CR®* *Corgard®* **Hemangeol™* *Inderal® XL* *Innopran® XL* *Kapspargo™ Sprinkle* *Levatol®* *Lopressor®* *nadolol* *pindolol* *propranolol LA* *Sectral®* *Sotylize ™* *Tenormin®* *timolol maleate* *Toprol XL®* *Trandate®* *Zebeta®*	
Beta Blockers + Diuretic Combinations		
atenolol/chlorthalidone **bisoprolol/HCTZ**	*Corzide®* *Dutoprol®* *Lopressor HCT®* *metoprolol/HCTZ* *nadolol/bendroflumethiazide* *propranolol/HCTZ* *Tenoretic®*	

Preferred Agents	Non-Preferred Agents	SA Criteria
	Ziac®	
Calcium Channel Blockers –Dihydropyridine		
Afeditab CR® **amlodipine** **Nifedical XL®** **nifedipine** **nifedipine ER**	*Adalat CC®* *Consensi® (amlodipine/celecoxib)* *felodipine ER* *isradipine* *Katerzia™oral suspension* *nisoldipine* *nicardipine* *Norvasc®* *Procardia®* *Procardia XL®* *Sular®*	
Calcium Channel Blockers- Non-Dihydropyridine		
Cartia XT® **diltiazem IR, ER q12hr & 24hr** **Taztia XT®** **verapamil tab IR & ER**	*Calan® IR & SR* *Cardizem® IR, CD & LA* *Isoptin SR®* diltiazem LA *Matzim LA* *Tiazac®* *verapamil 360 cap* *verapamil ER cap* *Verelan® & Verelan PM®*	
Direct Renin Inhibitors (includes combination)		
	aliskiren 150 & 300mg (generic for Tekturna) *Tekamlo®* *Tekturna®* *Tekturna HCT®* *Twynsta®* *telmisartan/amlodipine*	

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Lipotropics		
Bile Acid Sequestrants		**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits plus**
cholestyramine powder reg & light **colestipol tab** **Prevalite®**	*Colestid® granule/packet/tab* *colesevelam tab and Pkt (generic Welchol)* *colestipol HCl granules* *Questran® powder/powder Light* *Welchol® pack, tab*	
Cholesterol Absorption Inhibitor (CAI) and /or ACL Inhibitor (adenosine triphosphate citrate lyase)		
ezetimibe	*Nexletol® (bempedoic acid)* *Nexlizet® (bempedoic acid/ ezetimibe)* *Zetia®*	**Routine PDL and** **Clinical criteria Nexletol™ or Nexlizet™** **Initial Approval Criteria** • Patient is ≥ 18 years of age; AND • Patient has diagnosis of heterozygous familial hypercholesterolemia (HeFH) or established atherosclerotic cardiovascular disease (ASCVD); AND • Patient has failed to achieve a target LDL-C despite physician attestation that the patient is adherent to maximally tolerated doses of statins prior to the lipid panel demonstrating suboptimal reduction; AND • Patient can be classified into ONE of the following risk factor groups: ○ Extremely high risk ASCVD: (defined as extensive or active burden of ASCVD, or ASCVD with extremely high burden of adverse or poorly controlled risk cardio-metabolic risk factors including HeFH or severe hypercholesterolemia [SH] LDL-C > 220 mg/dl) with an LDL-C ≥ 70 mg/dL; OR ○ Very high risk ASCVD: (defined as less extensive ASCVD and poorly controlled cardiometabolic risk factors) with an LDL-C ≥ 100 mg/dL; OR ○ High risk ASCVD: (defined as either less extensive ASCVD and well-controlled risk factors or primary prevention HeFH or SH >220 mg/dl with poorly controlled risk factors) with LDL-C ≥ 130 mg/dL; AND

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
			• Therapy will be used in conjunction with maximally-tolerated doses of a statin; AND • Therapy will not be used with concurrent doses of simvastatin > 20 mg or pravastatin > 40mg; **Renewal Criteria** • Laboratory analyses demonstrate a reduction in LDL-C when compared to the baseline values (prior to initiating bempedoic acid or bempedoic acid/ezetimibe); AND Patient has shown continued adherence to maximally tolerated statin dosage
	Fibric Acid Derivatives		
	fenofibrate (generic Tricor® 48mg 145mg) **gemfibrozil**	*Antara®* *fenofibrate (generics for Antara®, Fenoglide® & Lipofen®)* *fenofibrate (generics for Triglide®)* *fenofibric acid* *Fenoglide®* *Fibricor®* *Lipofen®* *Lofibra®* *Lopid®* *Tricor®* *Triglide®* *Trilipix™*	
	HMG CoA Reductase Inhibitors and Combo (High Potency Statins)		
	atorvastatin **rosuvastatin** **simvastatin**	*amlodipine/atorvastatin* *Caduet®* *Crestor®* *Ezallor Sprinkle (rosuvastatin)* *Lipitor®* *Liptruzet®*	

Preferred Agents	Non-Preferred Agents	SA Criteria
	Livalo® *simvastatin sol (generic for Flolipid sol)* *simvastatin/ezetimibe* *Vytorin®* *Zocor®* *Zypitamag ™*	
HMG CoA Reductase Inhibitors and Combinations (Statins)		
lovastatin **pravastatin**	*Advicor®* *Altoprev®* *fluvastatin* *Lescol®and Lescol XL®* *Mevacor®* *Pravachol®*	
Microsomal Triglyceride Transfer Protein Inhibitor		
	**Juxtapid ™*	***Clinical Criteria for Juxtapid™. Refer to Juxtapid™ SA Fax Form**
Niacin Derivatives		
niacin ER	*Niaspan®* *Niacor®*	
Omega 3 Fatty Acid Agent		
******omega-3 acid ethyl esters (ST)*** **Omega-3 OTC**	*icosapent ethyl (generic Vascepa®)* ****Lovaza® (ST)* *Vascepa®(ST)*	*****Clinical Criteria for Lovaza® and omega-3 acid ethyl esters** • Step edit requires trial and failure of any other lipotropic; **OR** • Documented high triglycerides of ≥ 500 mg/dL. **LENGTH OF AUTHORIZATIONS**: Three months for initial approval; six months for renewal ***ALL PCSK9 Inhibitors require the submission of a Clinical SA. Refer to PCSK9 or M4V SA Form**
***Proprotein Convertase Subtilisin Kexin Type 9 (PCSK9) Inhibitors**		
	Praluent® *Repatha®*	
Platelet Inhibitors		
Brilinta® **clopidogrel** **dipyridamole**	**Aggrenox®* **ASA/dipyridamole* ***ASA/omeprazole (generic Yosprala®)*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits plus**

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
prasugrel (generic Effient®)	***Durlaza ER™* *Effient®* *Persantine®* *Plavix®* ***Yosprala® Tab* ****Zontivity™*	**Clinical Criteria for Select Non-Preferred Platelet Inhibitors** ***Aggrenox® & ASA/dipyridamole** • Aspirin and dipyridamole are covered as separate drugs without SA; clinical reason as to why the individual drugs cannot be used separately. ****Durlaza ER™ & *Yosprala® Tab** • Aspirin is covered without SA; clinical reason as to why aspirin cannot be used. ***** **Zontivity™** • Diagnosis of MI (myocardial infarction) or PAD (peripheral arterial disease); **AND** • Members must not have a history of stroke, TIA, ICH, GI bleed and peptic ulcer; **AND** • Must have concomitant therapy with clopidogrel, unless member has a contraindication to clopidogrel in which case member must have concomitant therapy with aspirin; **AND** • Member is 18 years of age or older; **AND** • Prescribed by or in consultation with a cardiologist.
***Pulmonary Arterial Hypertension Agents**		
Inhaled Prostacyclin Analogues		**LENGTH OF AUTHORIZATIONS: 1 year** **Routine PDL edits plus** ***Clinical Criteria for all preferred and non-preferred PDE-5** • Diagnosis of pulmonary hypertension in members >18 years is required; **AND** • The prescriber must be a pulmonary specialist or cardiologist; **AND** • Must have a rationale for not taking the sildenafil tablet to receive a SA for injectable Revatio®
Ventavis®	*Tyvaso®*	
Oral Endothelin Receptor Antagonist		
ambrisentan (generic Letairis) 5 & 10mg **Tracleer® tab**	*bosentan (generic Tracleer®)* *Letairis® 5 & 10 mg* *Opsumit®* *Tracleer® susp*	
***Phosphodiesterase 5 Inhibitors (PDE-5)**		
Alyq (tadalafil) **sildenafil tab/susp** **tadalafil**	*Adcirca®* *Revatio® tab/inj/susp*	

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	Prostacyclin Vasodilator and Receptor Agonist		
		Orenitram™ *Uptravi®*	
	Soluble Guanylate Cyclase Stimulators		
		Adempas®	
Central Nervous System			
	Alzheimer's Agents		
	Cholinesterase Inhibitors		**LENGTH OF AUTHORIZATIONS**: Length of prescription (up to 3 months) **Routine PDL edits**
	donepezil OTD & tab **Exelon® (transderm)**	*Aricept® ODT, tab* *Exelon® cap* *galantamine IR, ER tab/soln* *Memantine ER (generic Namenda XR)* *Namzaric® (donepezil/memantine)* *Razadyne® IR, ER* *rivastigmine cap & patch*	
	NMDA Receptor Antagonist		
	memantine tab	*memantine Dose Pack* memantine soln *Namenda® Dose Pack/XR tab* *Namenda® tab*	
	Anticonvulsants		
	Barbiturates		**LENGTH OF AUTHORIZATIONS:** **1 year** **Routine PDL edits plus** ***Clinicial Criteria for Onfi®** • Patient is at least two years of age or older; **AND** • Patient must have a diagnosis of seizures associated with Lennox-Gastaut syndrome (LGS) **AND** • Using as adjunctive therapy with other anticonvulsants
	phenobarbital elixir/tab **primidone**	*Mysoline®*	
	Benzodiazepines		
	***clobazam tab** (generic Onfi®tab) **clonazepam tab**	*clonazepam ODT* *Diastat® rectal* *Diastat® AcuDial™ rectal* ***Nayzilam®*	

Preferred Agents	Non-Preferred Agents	SA Criteria
diazepam rectal & Device rectal *****Valtoco® Nasal**	**Onfi®susp/tab* *Sympazan™ (clobazam)*	**** Clinicial Criteria for Nayzilam®** • **Patient is at least 12 years of age or older; AND** Diagnosis of acute treatment of intermittent, stereotypic episodes of frequent seizure activity that are distinct from a patient's usual seizure pattern in patients with epilepsy *****Clinical Criteria for Valtoco® Nasal** (this is reviewed electronically, AutoPA) Duration of Approval: 1 year • Patient must be 6 years of age or older; AND • Patient has been diagnosed with o intermittent, stereotypic episodes of frequent seizure activity (i.e., seizure clusters, acute repetitive seizures) that are distinct from a patient's usual seizure pattern
Cannabidiol		
***Epidiolex® (cannabidiol)**		***Clinical Criteria for Epidiolex®** (this is reviewed electronically, AutoPA) Duration of Approval: 1 year • Patient must be ≥ 1 years of age; AND • Patient has been diagnosed with o Epilepsy and recurrent seizures including Lennox-Gastaut syndrome, Dravet syndrome, or tuberous sclerosis complex
Carbamazepine Derivatives		
carbamazepine chewable tab/susp/tab **carbamazepine ER** **carbamazepine XR** **oxcarbazepine susp & tab**	*Aptiom®* *Carbatrol®* *Equetro® cap* *Oxtellar™ XR* *Tegretol® susp/tab* *Tegretol®XR* *Trileptal® susp/tab* *vigabatrin powder pack*	
Hydantoins		
phenytoin cap/chew tab/ susp **phenytoin ext cap**	*Dilantin® cap* *Dilantin® Infatab, susp*	

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	Peganone® *Phenytek®*	
Succinimides		
ethosuximide cap/syrup	*Celontin®* *Zarontin® cap/syrup*	
Valproic Acid and Derivatives		
divalproex tab/sprinkle **divalproex ER** **valproic acid cap, sol**	*Depakene® cap/syrup* *Depakote® ER & sprinkle*	
Other Anticonvulsants		
Gabitril® **lamotrigine tab** **lamotrigine chew tab** **lamotrigine XR** **levetiracetam soln/tab** **levetiracetam ER** **roweepra (generic version levetiracetam)** **Vimpat® soln/tab** **topiramate tab/sprinkle cap** **zonisamide cap**	*Banzel® susp/tab* *Briviact®* *Diacomit®* *felbamate susp/tab* *Felbatol® susp/tab* ** Fintepla®* *Fycompa® susp/tab* *Keppra® soln/tab* *Keppra® XR* *Lamictal® XR* *Lamictal® ODT/ODT dose pk* *Lamictal® tab/dose pk* *Lamictal® XR dose pk* *lamotrigine tab dose pk & ODT* *Potiga®* *rufinamide(generic Banzel® susp)* *Qudexy™ XR* *Sabril® powder pack/tab* *tiagabine* *Topamax® tab/sprinkle* *Trokendi™ XR* *vigabatrin (generic Sabril® tab)* *Xcopri®* *Zonegran®*	***Clinical Criteria for Fintepla®** • Patient is at least two years of age or older; AND • Patient must have a diagnosis of Dravet syndrome

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Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Antidepressants		
Other		**LENGTH OF AUTHORIZATIONS:** **1 year** **Routine PDL edits**
bupropion IR, SR &XL **desvenlafaxine ER tab (generic for Pristiq®)** **mirtazapine ODT/tab** **trazodone tab** **venlafaxine IR tab & ER cap**	*Aplenzin®* *Brintellix®* *bupropion XL (generic Forfivo® XL)* *desvenlafaxine ER tablet (generic for Khedezla™)* *Effexor® XR* *Emsam® transdermal* *Fetzima®* *Forfivo® XL* *Khedezla™* *Marplan®* *Nardil®* *nefazodone* *Oleptro® ER* *Parnate®* *phenelzine* *Pristiq®* *Remeron® ODT/tab* *tranylcypromine sulfate* *Trintellix* *venlafaxine ER tab* *Viibryd® tab/dose pk* *Wellbutrin® IR, SR & XL*	
SSRI		
citalopram soln/tab **escitalopram tab** **fluoxetine cap/soln** **fluvoxamine tab** **paroxetine tab** **sertraline conc, sol, tab**	*Brisdelle®* *Celexa® tab* *escitalopram soln* *fluoxetine DR cap/tab* *fluvoxamine ER* *Lexapro® tab* *Luvox® CR* *paroxetine CR* *Paxil® tab/susp & Paxil® CR*	

Preferred Agents	Non-Preferred Agents	SA Criteria
	Pexeva® *Prozac® cap/weekly* *Sarafem®* *Zoloft® conc/tab*	
Antimigraine Agents		
sumatriptan succinate tab **cartridge/vial/pen** **Imitrex® nasal** **rizatriptan tab/MLT**	*almotriptan* *Alsuma®* *Amerge®* *Axert®* *Cambia®* *eletriptan (generic Relpax®)* *Frova®* *frovatriptan (generic Frova®)* *Imitrex® cartridge /pen/tab/vial* *Maxalt® tab & MLT* *Migranow™ Kit* *naratriptan* *Onzetra™ Xsail™* *Relpax®* *sumatriptan KITS* *Sumavel® Dosepro* *sumatriptan nasal* *sumatriptan/naproxen (generic Treximet®)* *Tosymra* *Treximet®* *Zembrace ™ SymTouch ™* *Zomig® tab/nasal spray/ZMT*	**LENGTH OF AUTHORIZATIONS:** **1 year** **Routine PDL edits**
Antimigraine Agents, Others **Calcitonin Gene-related Peptide Antagonist (CGRP)**		
Emgality™ Syringe **Emgality™ Pen** **Ajovy®** **Ajovy® Autoinjector**	*Aimovig™* *Emgality™ 100MG Syringe*	***All Nonpreferred CGRPs require the submission of a Clinical SA. Refer to fax form Antimigraine Agents, Others SA Form**

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Ajovy Autoinjector 3-Pk		**Ajovy®, Emgality™, Ubrelvy® have an AutoPA and require a trial of 2 generic triptans, no clinical SA**
Acute treatment of migraine		
Ubrelvy®	*Nurtec™ ODT* *Reyvow®*	**Nurtec™ ODT has a quantity limit of 8 units per month**
***Antipsychotics** *(AG)*		
Atypical		**LENGTH OF AUTHORIZATIONS: 1 year or 6 months for members < 18 yrs** **Routine PDL edits plus** ***ALL antipsychotics for children 0 to 17 years of age (preferred and non-preferred) require the submission of a Clinical SA. Refer to (Antipsychotics In Children Less Than 18 Years SA Form)** ****Clinical Criteria Nuplazid™** • Indicated for the treatment of hallucinations and delusions associated with Parkinson's disease psychosis. *Quantity Limit Nuplazid™ = 2 per day* *****Clinical Criteria for Abilify Mycite®** **Initial Approval Criteria: For Three months SA** Patient must: • Be ≥ 18 years of age; AND • Have tolerability to oral aripiprazole with suboptimal effects (as assessed by prescriber) that may be due to adherence problems; AND • Have a smart phone compatible with the device; AND • Give consent to a healthcare provider and caregiver (if applicable) to monitor the portal; AND • There is a documented intervention by prescriber if nonadherence is detected **Renewal Criteria: Every 3 Months Reevaluate** • Patient must:
aripiprazole tab **clozapine tab** **Latuda®** **olanzapine ODT, tab, IM** **quetiapine tab** **quetiapine fumarate ER** **risperidone ODT/soln/tab** **ziprasidone cap**	*Abilify® tab/IM inj* ****Abilify Mycite®(with sensor)* ***aripiprazole ODT, soln* *asenapine (generic for Saphris®)* *Caplyta Capsule™* *Clozaril®* *clozapine ODT* *Fanapt® tab & titration pk* *Fazaclo®* ***Geodon® tab, IM* *Invega®* ***Nuplazid™ tab, cap (QL)(AG)* ***olanzapine/fluoxetine* *paliperidone ER* *Rexulti® tab* *Risperdal® ODT/soln/tab* *Saphris®* *Secuado®Patch* *Seroquel® IR* *Seroquel® XR* *Versacloz™* *Vraylar™* *ziprasidone IM (generic for Geodon®)* *Zyprexa® tab/IM/Zydis*	

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
			• Continue to meet initial criteria; AND • Have prescriber attestation that patient benefited from therapy; AND • Have prescriber attestation that there is a continued need for device (e.g., continued suboptimal effects and/or compliance); AND • Have a healthcare provider and caregiver (if applicable) agree to continue to monitor device; AND • Not have worsened target symptoms; AND • Not have had any treatment-limited adverse effects (e.g., • Not have had any treatment-limited adverse effects (e.g., hypersensitivity, suicidality, neuroleptic malignant syndrome, tardive dyskinesia, metabolic changes, pathological gambling and other compulsive behaviors, orthostatic hypotension, falls, seizures, cognitive and motor impairment, dysphagia, disruption in body temperature regulation, and leukopenia, neutropenia, and agranulocytosis); AND • Have a healthcare provider state reason why the patient cannot use long acting injectable atypical antipsychotic if there is continued nonadherence.
	Atypical, Long Acting Injectable	**CLOSED CLASS**	**LENGTH OF AUTHORIZATIONS:** **1 year**
	Abilify Maintena® **Aristada®** **Aristada® Initio** **Risperdal Consta®** **Invega Sustenna® &Trinza®**	*Perseris™ (risperidone)* *Zyprexa® Relprevv™*	**Routine PDL edits**
	Typical		**LENGTH OF AUTHORIZATIONS:** **1 year**
	amitriptyline/perphenazine **chlorpromazine** **fluphenazine elixir/soln/tab** **fluphenazine decantate** **haloperidol decantate** **haloperidol lactate conc** **haloperidol tab** **loxapine** **perphenazine** **trifluoperazine** **thiothixene**	*Haldol decanoate (injection)* *pimozide* *Moban®* *molindone*	**Routine PDL edits**

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	thioridazine		
	Neuropathic Pain		
	capsaicin OTC topical **duloxetine 20, 30 & 60 mg (generic for Cymbalta®)** **gabapentin cap/tab/soln** **lidocaine 5% patch** **pregabalin cap**	*Cymbalta®* *Dermacinrx® PHN Pak™ Kit* *Drizalma™ Sprinkle* *duloxetine 40 mg (generic for Irenka™)* *Gralise™ (gabapentin, extend release)* *Horizant ™ (gabapentin enacarbil, extended release)* *Irenka™* *Lidoderm® patch* *LidoPure Patch* *Lyrica CR* *Lyrica® soln* *Lyrica®* *Neurontin® cap/tab/soln* *pregabalin sol* *Qutenza Kit® (Topical) (capsaicin)* *Savella™ & Savella™ Dose Pak* *Zilacaine Patch* *Ztlido™ 1.8% (lidocaine topical system)*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL** Plus **Criteria for Lyrica solution:** − If diagnosis is epilepsy/seizures, patient must have a problem swallowing tablets/capsules AND clinical reason why at least TWO preferred seizure medications cannot be used. − For other diagnoses, patient must have a problem swallowing tablets/capsules AND routine PDL • If Lyrica CR is requested, routine PDL applies. Note – This is NOT indicated for epilepsy/seizures.
	Non-Ergot Dopamine Receptor Agonist		
	pramipexole **ropinirole HCl**	*Mirapex® IR & ER* *Neupro®* *pramipexole ER* *Requip® XR* *ropinirole HCl ER*	**LENGTH OF AUTHORIZATIONS:** **1 year** **Routine PDL edits**
	Sedatives / Hypnotics		
	temazepam 15 & 30 mg	*estazolam* *flurazepam* *Halcion®* *Restoril®*	**LENGTH OF AUTHORIZATIONS**: Length of the prescription (up to 3 months) **Routine PDL edits**

Preferred Agents	Non-Preferred Agents	SA Criteria
	temazepam 7.5 mg & 22.5 mg *triazolam*	
Sedatives / Hypnotics (Non-Benzodiazepine)		
eszopiclone **zaleplon** **zolpidem**	*Ambien® IR & CR* *Belsomra®* *Dayvigo™* *doxepin (generic for Silenor®)* *Edluar™* **Hetlioz™* *Intermezzo®* *Lunesta®* *Rozerem®* *Silenor®* *Sonata®* *zolpidem CR* *Zolpimist ™ spray* *zolpidem (generic Intermezzo®)*	**LENGTH OF AUTHORIZATIONS**: 6 months. **For Renewal -** must document therapeutic benefit and confirm compliance Routine PDL edits plus ***Clinical Criteria for Hetlioz™** • For the treatment of Non-24-Hour Sleep-Wake Disorder (Non-24), **AND** • Member must be age 18 years of age or older. • Quantity limit = 1 tablet per day.
Skeletal Muscle Relaxants		
baclofen **chlorzoxazone** **cyclobenzaprine HCL** **dantrolene sodium** **methocarbamol** **tizanidine tab**	*Amrix®* **carisoprodol* **carisoprodol/ASA* **carisoprodol/ASA/codeine* *cyclobenzaprine ER* *Dantrium®* *Fexmid®* *Lorzone®* *metaxalone* *orphenadrine citrate* *orphenadrine/ASA/caffeine* *Parafon Forte® DSC* *Robaxin®* *Skelaxin®* **Soma®* *tizanidine cap* *Zanaflex®*	**LENGTH OF AUTHORIZATIONS:** • 1 year for chronic conditions • Duration of prescription (up to 3 months) for acute conditions • One month per every 6 months for carisoprodol drugs **Routine PDL edits plus** ***Clinical Criteria for Carisoprodol Drugs. Refer to Soma/carisoprodol SA Fax Form**

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Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Smoking Cessation		
bupropion SR **Chantix®** **Chantix® DS PK** **nicotine gum/lozenge/patch**	*Nicoderm CQ® Patch* *Nicorette® Gum/Lozenges* *Nicotrol® Inhaler & NS* *Zyban®*	**LENGTH OF AUTHORIZATIONS:** 6 months **Routine PDL edits**
***Stimulants/ADHD Medications** *(AG)* **CLOSED CLASS**		
Amphetamine Drugs		**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits** *All stimulants (preferred and non-preferred) require the submission of Clinical SA if prescribed for a child less than four or an adult eighteen years and older. Refer to Stimulant SA form (Stimulant/ADHD Medications SA Form) ***This does not include nonstimulant agents such as* atomoxetine *(generic for Strattera®,) clonidine ER,* guanfacine ER or others**
Adderall®XR **amphetamine salts combo** *(generic for Adderall IR)* **dextroamphetamine** *(generic for Dexedrine)* **Vyvanse® cap/chewable tab** (lisdexamfetamine)	*Adderall® IR (amphetamine salts combo)* *Adzenys XR ODT™* *Adzenys ER™ susp* *Adzenys® ER* *amphetamine salts combo XR* *amphetamine sulfate (generic Evekeo®)* *amphetamine susp (generic Adzenys ER™ susp)* *Desoxyn®* *Dexedrine®* *dextroamphetamine SR & soln* *Dyanavel® XR susp* *Evekeo®* *Evekeo™ ODT* *methamphetamine* *Mydayis ER™* *Procentra® soln* *Zenzedi™*	
Methylphenidate Drugs		
All methylphenidate IR generic **Concerta®** **Daytrana® Transdermal** **Focalin® IR & XR**	*Adhansia™XR* *Aptensio ™ XR* *Cotempla XR-ODT™* *dexmethylphenidate IR & XR* *Jornay PM* *Metadate CD®* *Metadate ER®*	

	Preferred Agents	Non-Preferred Agents	SA Criteria
		Methylin ER®, soln IR *methylphenidate chew & soln* *methylphenidate ER, LA, SR* *methylphenidate ER(generic Relexxii®)* *methylphenidate ER(generic Aptensio™ XR)* *Ritalin® IR, LA® & SR®* *Relexxii®* *QuilliChew ER™* *Quillivant™ XR susp*	
	Miscellaneous Drugs		
	atomoxetine *(generic for Strattera®)* **clonidine ER** **guanfacine ER**	****armodafinil (generic Nuvigil™)* ****modafinil* ****Nuvigil ™ (AG)* ****Provigil®(AG)* *Intuniv®* *Sunosi™* *Strattera®* *Wakix®*	****Nuvigil™/Provigil®/armodafinil/modafinil:** **Refer to Narcolepsy Medications SA Form**
Dermatologic			
	Acne Agents, Topical *(AG)		
	Combo Benzoyl Peroxide , Clindamycin, Erythromycin Topical		**LENGTH OF AUTHORIZATIONS:** 1 year **Routine PDL edits plus** ***Clinical Criteria for Dermatologic Acne Agents** • Prescriptions for members over the age of 18 years will require the submission of a SA to evaluate treatment diagnosis; **AND** • Drugs are intended for acne **only. SA for a cosmetic indication cannot be approved.**
	Acne Medication gel, lot **benzoyl peroxide wash, cr, gel, lot (OTC)** **clindacin ETZ 1% pledget** **clindamycin ph 1% solution** **clindamycin Phos 1% pledget, swab**	*Acanya™ w/pump* *Acne Clearing System® (OTC)* *Aczone® Gel and Gel Pump* *Aklief®* *Amzeeq™* *Arazlo™* *Avar Cleanser, Medicated Pad*	

	Preferred Agents	Non-Preferred Agents		SA Criteria
	clindamycin/benzoyl peroxide (Duac®) **erythromycin solution** **Panoxyl-4 Acne Cr Wash (OTC)** **Panoxyl 10 cleansing bar, foaming wash (OTC)**	*Avar-E* *Avar-E LS* *Avar LS Cleanser, Medicated Pad* *Azelex®* *Benzaclin®& Benzaclin® Pump* *BP 10-1* *Benzefoam™ regular &Ultra™* *Benzepro* *benzoyl peroxide wash/cr/gel/ lotion/foam/towelette (RX)* *benzoyl peroxide 6%, 9% cleanser (OTC)* *BPO Kit* *Cleocin T®* *Clindacin™ Pac Kit* *Clindagel®* *clindamycin phosphate(generic for Clindagel®)* *clindamycin/benzoyl peroxide (generic for Acanya® Pump)* *clindamycin/benzoyl peroxide (generics for Benzaclin®)* *clindamycin phosphate foam, el, lotion, med swab* *clindamycin/tretinoin (generic Veltin®)* *Delos™ Lotion* *Duac® gel* *erythromycin gel/med. swab* *Evoclin™* *Inova™* *Lavoclen™Cleanser & Kit* *Neuac™ topical/kit* *Onexton™ gel & w/Pump* *Ovace® Wash*		

Preferred Agents	Non-Preferred Agents	SA Criteria
	Ovace® Plus shampoo/cr/lotion/foam *Pacnex®HP & LP* *Panoxyl® 3% cr (OTC)* *Promiseb®Complete* *Rosula Cleanser* *Se BPO® Wash Kit & cleanser* *Sulfacetamide Cleanser ER* *Sulfacetamide Cleanser, Shampoo, Susp* *Sulfacetamide Sodium/Sulfur Cr, Susp, Sunscreen* *SSS 10-5 Foam* *Sulfacetamide/Sulfur/Cleanser, Cleanser Kit, Lotion Med. Pad* *Sulfacetamide/Sulfur/Urea Cleanser* *Sumadan Wash, Kit* *Sumadan XLT* *Sumaxin CP Kit* *Veltin®*	
Retinoids/Combinations, Topical		
Differin 0.1% gel (OTC) **Retin®A 0.025., 0.05, 0.1 % cr & 0.01, 0.025% gel**	*Acnefree® Severe Kit (OTC)* *adapalene 0.1% cr/gel/lot* *adapalene 0.3% gel/gel w/pump* *adapalene-benzoyl peroxide (generic Epiduo®)* *Altreno™* *Atralin® 0.05% gel* *Avage® 0.1% cr* *Avita® 0.025% cr/gel* *Differin® 0.1% cr/gel/lot RX* *Differin® 0.3% gel pump* *Epiduo® & Epiduo® Forte Gel* **Fabior™01% Foam (AG)* *Renova® 0.02% cr/cr pump*	***Age Edit for Fabior™ Foam** • Member must be between the ages of 12 and 18 years of age

	Preferred Agents	Non-Preferred Agents	SA Criteria
		Retin®-A Micro 0.04%, 0.1% gel *Retin®-A Micro 0.08%, 0.04%, 0.1% pump* *Tazorac® cr/gel* *tazarotene 0.1% cr* *tretinoin 0.025, 0.1% cr & 0.01, 0.025, 0.05% gel* *tretinoin microsphere 0.04% & 0.1% gel* *Ziana® gel*	
	Antifungal Topical		
	antifungal 1% cr, powder **antifungal 2% cr** **ciclopirox soln** **ciclodan 8% soln** **clotrimazole cr (OTC & RX)** **clotrimazole soln (OTC)** **clotrimazole-betamethasone cr** **ketoconazole shampoo** **ketoconazole cr** **miconazole cr/spray (OTC)** **nystatin cr/oint/ powder** **terbinafine cr (OTC)** **tolnaftate cr/powder/soln (OTC)**	*Alevazol® OTC* *Azolen® Tincture OTC* *Bensal HP®* *Ciclodan® Kit* *ciclopirox cr/shampoo/gel* *ciclopirox kit* *ciclopirox suspension* *clotrimazole soln (RX)* *clotrimazole-betamethasone lot* **CNL 8™ Kit* *Desenex® Aero Powder (OTC)* *econazole* *Ertaczo®* *Exelderm® cr & soln* *Extina®* *Fungi-Nail® (OTC)* *Fungoid® Kit (OTC)* *Fungoid® (OTC)* **Jublia®* *ketoconazole foam* **Kerydin®* *Lamisil AT® cr/gel (OTC)* *Lamisil® Spray (OTC)*	**LENGTH OF AUTHORIZATIONS: 6 months** **Routine PDL edits plus** **Select non-preferred topical Antifungals (CNL-8™, Jublia®, Kerydin™, Luzu®, Penlac®) require the submission of a Clinical SA. Refer to Antifungal Topical SA Form**

	Preferred Agents	Non-Preferred Agents	SA Criteria
		Loprox® Kit/ Shampoo/susp *Lotrimin AF® cr (OTC)* *Lotrimin Ultra® (OTC)* *Lotrisone® cr* *luliconazole (generic for Luzu)* ***Luzu®* *miconazole nitrate (OTC)* *miconazole Oint/ powder (OTC)* *Mentax®* *Naftin® cr/gel* *Naftifine CR* *Nyata Kit®* *Nizoral A-D® Shampoo (OTC)* *nystatin-triamcinolone cr/oint* *oxiconazole cr (generic Oxistat®)* *Oxistat® cr* *Oxistat® Lotion* *Pediaderm AF®* *PediPak®* **Penlac®* *tavaborole (generic Kerydin®)* *Tinactin® Aero powder/spray(OTC)* *tolnaftate aero powde/spray (OTC)* *Vusion®*	
	Immunomodulators Atopic Dermatitis		
	***Elidel®**	**Eucrisa™* ***Dupixent ® (QL, AG)* *pimecrolimus (new generic for Elidel)* **Protopic®* **tacrolimus*	**LENGTH OF AUTHORIZATIONS**: 1 year; EXCEPT Dupixent® 6 months **ATOPIC DERMATITIS - REAUTHORIZATION**: • Documentation (i.e., progress note) of positive clinical response will be required Length of authorization: Initial approval = 6 months; renewal = 1 year **Routine PDL edits plus** ***Clinical Criteria for Elidel®, Eucrisa™, Protopic®& tacrolimus** • Member must have a FDA approved diagnosis:

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
			○ Atopic dermatitis ○ Elidel® mild to moderate for ages > 2 years ○ Eucisa™: mild to moderate for ages equal to or > 3months ○ Protopic® 0.03%: moderate to severe for ages > 2 years. ○ Protopic® 0.1%: moderate to severe for ages > 18 years; **AND** • Failure to topical corticosteroids (i.e., desonide, fluticasone propionate, hydrocortisone butyrate, etc.) **** See Cytokine and CAM Antagonists Appendix A for Clinical Criteria**** ****Clinical Criteria for Dupixent®** ❖ **Atopic Dermatitis** • ≥ 6 years of age; **AND** • Diagnosis of moderate to severe atopic dermatitis; **AND** • Prior documented trial and failure (or contraindication) of 1 topical corticosteroids of medium to high potency (e.g., mometasone, fluocinolone) and 1 topical calcineurin inhibitors (tacrolimus or pimecrolimus); **AND** • Inadequate response to a 3 month minimum trial of at least 1 immunosuppressive systemic agent (e.g., cyclosporine, azathioprine, methotrexate, mycophenolate mofetil, etc.); **AND** • Inadequate response (or is not a candidate) to a 3 month minimum trial of phototherapy (e.g., psoralens with UVA light [PUVA], UVB, etc) provided member has reasonable access to photo treatment; **AND** Is not pregnant; **AND** ***Quantity limit Dupixent®*** *2 prefilled syringes for the initial dose, then 1 single-dose syringe every 14 days* ❖ **Chronic Rhinosinusitis with Nasal Polyposis** • ≥ 18 years of age; AND • Diagnosis of In adequately controlled Chronic Rhinosinusitis with Nasal Polyposis (CRSwNP) • Is Add to current maintenance treatment
	Psoriasis, Topical		
	calcipotriene cr/oint/soln	*betamethasone/ calcipotriene*	**LENGTH OF AUTHORIZATIONS:** **1 year**

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
		Calcitrene® *calcitriol* *calcipotriene/betamethasone (generic for Taclonex®)* *Dovonex®* *Duobrii ™* **Enstilar ® Foam (AG)* *Micanol®* *Sorilux™* *Taclonex® & Taclonex® Scalp* *Vectical*	**Routine PDL edits plus** ***Clinical Criteria for Enstilar ® Foam** • Length of Authorization: 4 weeks • Diagnosis of plaque psoriasis**; AND** • Minimum age of 18 years
	Rosacea Agents, Topical		
	Metrocream® **Metrogel®** **Metrolotion®**	*azelaic acid (generic for Finacea®)* *Finacea® foam/gel* *ivermectin (generic Soolantra)* *metronidazole cr/gel/lot* *Mirvaso®* *Noritate®* *Rosadan™ Kit* *Soolantra®* *Zilxi™*	**LENGTH OF AUTHORIZATIONS:** **1 year** **Routine PDL edits**
	Steroids		
	Steroids, Topical Low Potency		**LENGTH OF AUTHORIZATIONS:** **1 year**
	hydrocortisone cr/gel/lot/oint	*anusol-hc 2.5% cr* *alclometasone cr/oint* *aqua glycolic HC* *Capex® shampoo* *Derma-smoothe-FS* *desonate gel/cr/lot/oint* *Desowen® lot* *fluocinolone 0.01% oil* *Micort™-HC* *Pediaderm® HC & Pediaderm® TA*	**Routine PDL edits**

Preferred Agents	Non-Preferred Agents	SA Criteria
	Texacort®	
Steroids, Topical Medium Potency		
fluticasone propionate cr/oint **mometasone furoate cr/oint/soln**	*betamethasone valerate foam* *clocortolone cr* *Cloderm®* *Cordran® tape* *Cutivate® cr/lot* *Dermatop® cr/oint* *Elocon® cr/oint/soln* *fluocinolone acetonide cr/oint/soln* *flurandrenolide cr/oint/tape* *fluticasone propionate lot* *hydrocortisone valerate cr/oint* *hydrocortisone butyrate (generic for locoid lotion)* *hydrocortisone butyrate cr/oint/soln/ emollient* *Luxiq®* *Momexin®* *Pandel®* *prednicarbate cr/oint* *Synalar ®* *Synalar TS®* *Ticanase kit®*	
Steroids, Topical High Potency		**LENGTH OF AUTHORIZATIONS:** **1 year** **Routine PDL edits plus** ***Clinical Criteria for Sernivo™*** • Length of Authorization: 4 weeks (treatment beyond 4 weeks is not recommended). • Member must have diagnosis of mild to moderate plaque psoriasis: **AND**
betamethasone valerate cr/lot/oint **triamcinolone acetonide cr/lot/oint**	*amcinonide cr/lot/oint* *betamet diprop & prop gly cr/lot/oint* *betamet diprop cr/foam/gel/lot/oint* *DermacinRx® SilaPak™* *DermacinRx® Silazone* *DermacinRx® Therazole Pak*	

	Preferred Agents	Non-Preferred Agents	SA Criteria
		desoximetasone cr/gel/oint/spray *desoximetasone (generic Topicort® spray)* *diflorasone diacetate cr/oint* *Diprolene® lot/oint* *DiproleneAF®cr* *Ellzia™ Pak Kit* *fluocinonide cr/ emollient/ gel/oint/soln* *Halog® cr/oint* *Kenalog® aerosol* *Loprox® Suspension Kit* **Sernivo™* *Silazone® II Kit* *Topicort® cr/gel/oint/spray* *Trianex® oint* *triamcinolone spray* *triamcinolone/dimethicone* *Vanos®cr* *Whytederm®Tdpak*	• At least 18 years of age
	Steroids, Topical Very High Potency		
	clobetasol emollient **clobetasol propionate cr/gel/oint/soln** **halobetasol propionate cr**	*Apexicon™E* *Bryhali™ (halobetasol propionate)* *clobetasol lot/shampoo* *clobetasol propionate foam/spray* *Clobex® lot/shampoo/spray* *Clodan® kit* *Halonate®* *halobetasol propionate oint (generic for Lexette®)* *Impeklo™* *Olux®* *Olux®-E* *Temovate® oint*	

	Preferred Agents	Non-Preferred Agents	SA Criteria
		Ultravate® cr/lotion/oint *Ultravate® PAC & Ultravate® X*	
Endocrine and Metabolic Agents			
	Androgenic Agents (Testosterone – Topical)		
	AndroGel® Pump **Androderm® Patch**	*AndroGel® packet, patch* *Axiron® soln* *Fortesta®* *Natesto Nasal Gel ®* *Testim®* *testosterone pump (generic for AndroGel® Pump)* *testosterone (generic for Axiron®)* *testosterone gel/packet/pump (generic for Vogelxo™)* *testosterone (generic for Fortesta®)* *Vogelxo™ gel/packet/pump* *Xyosted™*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits Plus**
	Antihyperuricemics		
	Allopurinol **colchicine tabs** **Probenecid®** **probenecid & colchicine**	*colchicine caps* *Colcrys®* *febuxostat (generic Uloric®)* *Gloperba ®* *Mitigare®* *Uloric®*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits plus**
	Contraceptives*(long-acting IUDs & injectable)		
	Kyleena™ **Liletta®** **medroxyprogesterone 150mg** **Mirena®** **Nexplanon®** **Paragard®**	*Depo-Provera® 104 mg and 150 mg*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits**

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Skyla®		
Diabetes Hypoglycemics: Injectable Amylin Analogs		
	**SymLin®* **SymLin® Pens*	**LENGTH OF AUTHORIZATIONS**: 1 year ***Clinical Criteria for Injectable Amylin Analogs** • Member must have a history of at least a 90day trial of insulin. • SymLin® is only indicated as adjunct therapy with insulin. • Member meeting ALL of the following criteria may be approved: o Diagnosis of Type 1 or 2 diabetes; **AND** o On insulin therapy, **AND** o Failure to achieve adequate glycemic control (HbA1c ≤ 6.5%)
Diabetes Hypoglycemics: Injectable and Oral Incretin Mimetics CLOSED CLASS		
Byetta® *(*exenatide) **Bydureon™ (**exenatide ER) **Trulicity™ (lixisenatide)** **Victoza®** *(*liraglutide)	*Adlyxin™ (lixisenatide)* *Bydureon™ Bcise SQ* *Soliqua® 100/33 (insulin glargine & lixisenatide inj)* *Ozempic®* *Rybelsus Tab ®* *Tanzeum™ (albiglutide)* *Xultophy® 100/3.6 (insulin glargine & lixisenatide inj)*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits**
Diabetes Hypoglycemics: Injectable Insulins		
Insulin Mix		**LENGTH OF AUTHORIZATIONS: 1 year** **Routine PDL edits**
Humalog® Mix 50/50 vial **Humalog® Mix 75/25 vial** **Humulin® 70/30 Pen OTC, vial** **Novolog® Mix 70/30 pen/vial**	*Humalog® Mix 50/50 Kwikpen* *Humalog® Mix 75/25 Kwikpen* *insulin lispro protamine mix pen(generic for Humalog mix pen)* *Novolin® 70/30 vial (OTC)*	

Preferred Agents	Non-Preferred Agents	SA Criteria
Insulin N		
Humulin® N pen/vial (OTC)	*Humulin® N pen* *Novolin® N vial (OTC)*	
Insulin R		
Humulin® R pen/vial	*Novolin® R vial (OTC)*	
Long-Acting Insulins		
Lantus® Solostar® & vial (insulin glargine) **Levemir® pen/vial** (insulin detemir)	*Basaglar® KwikPen® (insulin glargine)* *Semglee™ (insulin glargine)* *Toujeo® Solostar®(insulin glargine) 300 Units/mL* *Tresiba® FlexTouch® Pen (insulin degludec) 100 U/ml, 200 U/ml*	
Rapid-Acting Insulins		
Humulin 500 U/M pen/vial **Humalog® vial** **Humalog® Cartridge** **Humalog Kwikpen 100 unit/ml** **Humalog Jr. Kwikpen** **Novolog® cart/vial/Flexpen** **insulin lispro vial**	*Admelog® Solostar Pen/vial* *Afrezza® cartridge (inhalation)* *Apidra® cartridge/Solostar/vial* *Fiasp®/FlexTouch® Pen/PenFill®* *Humalog Kwikpen 200 unit/ml* *insulin lispro Jr. Kwikpen (generic for Humalog Jr. Kwikpen)* *Lyumjev™*	
Diabetes Oral Hypoglycemics		
Oral Hypoglycemics Alpha-Glucosidase Inhibitors		**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits plus** **Metformin Step Edit for all Oral Hypoglycemics (excluding metformin)** • Member is 18 or older • Patients with a **hemoglobin A1C< 7.5%** must have a minimum 90-day trial of metformin (unless contraindicated*)
acarbose	*Glyset®* *miglitol (generic Glyset®)*	
Oral Hypoglycemics Biguanides		
metformin **metformin ER** *(generic for Glucophage® XR)*	*Fortamet®* *Glucophage® IR & XR* *Glutmetza®* *Riomet® susp*	

Preferred Agents	Non-Preferred Agents	SA Criteria
	metformin ER (generic Fortamet®) *metformin ER (generic Glumetza®)* *metformin (generic Riomet®)*	• Patients with a hemoglobin **A1C ≥ 7.5%** should be started on metformin (unless contraindicated) **plus a second agent** (e.g., DPP-IV, SGLT2, GLP-1 receptor agonists, TZDs, sulfonylureas). **A 90-day trial of metformin is NOT required**. ***Contraindications include:** • severe renal impairment (eGFR below 30mL/min/1.73m2) • known intolerance • acute or chronic metabolic acidosis including diabetic ketoacidosis Age edit for all Oral Hypoglycemics is 18 years of age or older, except Metformin which is 10 years of age.
Oral Hypoglycemics Biguanide Combination Drugs		
glyburide/metformin	*glipizide/metformin* *Glucovance®*	
Oral Hypoglycemics DPP-IV Inhibitors & Combination CLOSED		
Janumet® **Janumet XR®** **Januvia®** **Jentadueto™** **Tradjenta™**	*alogliptin (generic Nesina™)* *alogliptin/metformin (generic Kazano™)* *alogliptin/pioglitazone (generic Oseni™)* *Jentadueto XR™* *Kazano™* *Kombiglyze XR™* *Nesina™* *Onglyza™* *Oseni™* *Trijardy™ XR (empagliflozin/linagliptin/metform)*	
Oral Hypoglycemics Meglitinides		
repaglinide **nateglinide**	*Prandin® & PrandiMet™* *repaglinide/metformin* *Starlix*	
Oral Hypoglycemics Second Generation Sulfonylureas		
glimepiride **glipizide** **glipizide ER** **glyburide** **glyburide micronized**	*Amaryl®* *Diabeta®* *Glucotrol®* *Glucotrol XL®* *Glynase®*	

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
***Oral Hypoglycemics Sodium Glucose Co-Transporter 2 Inhibitor CLOSED CLASS**		
Farxiga™ (AG) **Glyxambi® (AG)** **Invokana™ (AG)** **Invokamet™ (AG)** **Invokamet™ XR (AG)** **Jardiance®(AG)** **Synjardy® (AG)** **Xigduo™ XR (AG)**	*Segluromet™* *(ertugliflozin/metformin)* *Steglatro™* *Steglujan™* *Synjardy® XR*	
Oral Hypoglycemics Thiazolidinediones		
pioglitazone	*Avandia®* *Actoplus Met® IR & XR* *Actos®* *Avandaryl®* *Avandamet®* *Duetact®* *pioglitazone/metformin* *pioglitazone/glimepiride*	
Erythropoiesis Stimulating Proteins		
Epogen® **Retacrit™**	*Aranesp® vial/syringe* *Procrit®* *Mircera®*	**LENGTH OF AUTHORIZATIONS**: for duration of the prescription up to 6 months **Routine PDL edits** *Omontys® is not PDL eligible, may be covered under medical benefit*
Glucocorticoids, Oral		
budesonide EC **dexamethasone soln/tab** **hydrocortisone** **methylprednisolone dose pk** **methylprednisolone 4 mg tab** **prednisolone sodium phosphate soln** **prednisolone soln** **prednisone soln/tab/dose pk**	*Alkindi® Sprinkle* *Cortef®* *cortisone acetate* *dexamethasone elixir/intensol* *Dexpak®* **Emflaza™ (AG)* *Hemady®* **Emflaza™ (AG)* *Entocort® EC*	**LENGTH OF AUTHORIZATIONS**: **1 year** **Routine PDL edits plus** ***Clinical Criteria for Emflaza™** • Trial and failure of all drugs does not apply to Emflaza™ • Diagnosis for treatment of Duchenne muscular dystrophy (DMD) • Minimum Age Limit = 2 years of age

Preferred Agents	Non-Preferred Agents	SA Criteria
	Flo-Pred® *Medrol ® dose pk/tab* *methylprednisolone 8,16 & 32mg tab* *Millipred DP® tab Does Pk* *Millipred® soln/tab* *Orapred ®ODT* *Ortikos™* *prednisolone sod phosphate ODT/ soln* *prednisone intensol* *Rayos® DR tab* *TaperDex®* *Veripred®*	
***Growth Hormone**	**CLOSED CLASS**	
Genotropin® Cartridge, Miniquick **Norditropin FlexPro®**	*Humatrope® cartridge/vial* *Nutropin AQ® NuSpin™* *Omnitrope® cartridge/vial* *Saizen® cartridge/vial* *Serostim® vial* *Zomacton® vial* *Zorbtive® vial*	**LENGTH OF AUTHORIZATIONS**: 1 year **ALL Growth Hormone drugs (preferred and non-preferred) require the submission of a Clinical SA. Refer to (Growth Hormone SA Fax Form)**
***Hereditary Angioedema (HAE) Agents**		
Berinert® **Cinryze™** **Kalbitor®**	*Firazyr®* *Haegarda®* *Icatibant (generic Firazyr®)* *Orladeyo™* *Ruconest®* *Takhzyro™*	**LENGTH OF AUTHORIZATIONS:** 1 year **Routine PDL edits plus** *** ALL Hereditary Angioedema drugs (preferred and non-preferred) require the submission of a Clinical SA. Refer to Hereditary Angioedema (HAE) SA Form** ****Black box warning KALBITOR®** **Anaphylaxis has been reported after administration of KALBITOR®. Because of the risk of anaphylaxis, KALBITOR should only be administered by a healthcare professional with appropriate medical support to manage anaphylaxis and hereditary angioedema. Healthcare**

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
			professionals should be aware of the similarity of symptoms between hypersensitivity reactions and hereditary angioedema and patients should be monitored closely.
	***Pancreatic Enzymes**		

	Creon®
	Zenpep®
		Pancreaze®
		Pertzye®
		Ultresa®
		Viokace®
			LENGTH OF AUTHORIZATION: 1 year
			Routine PDL edits plus
			***Clinical Criteria for Pancreatic Enzymes**
			• All drugs preferred and non preferred require a diagnosis of pancreatic insufficiency due to cystic fibrosis or chronic pancreatitis or pancreatectomy.
			  • If a member has a diagnosis of Cystic Fibrosis they do not have to try and fail of a preferred.
			  • If member has a feeding tube, then two different pancreatic enzymes can be approved for use together.

	Progestational Agents		
	Makena® Auto-injector **medroxyprogesterone acetate (tab only)** **norethindrone acetate** **progesterone cap/inj**	*Aygestin®* *Crinone (Vaginal)* *Depo-Provera 400 MG/ML* *hydroxyprogesterone caproate SDV* *hydroxyprogesterone caproate (generic for Makena MDV)* *Makena® Multi Dose Vial (MDV)& Single Dose Vial (SDV)* *Prometrium®* *Provera®*	**LENGTH OF AUTHORIZATIONS:** 1 year **Routine PDL edits**
	Progestins Used For Cachexia		
	megestrol acetate	*Megace®* *Megace® ES* *megestrol suspension ES*	**LENGTH OF AUTHORIZATIONS:** 1 year **Routine PDL edits**
	Vaginal Estrogens		
	Premarin® Vaginal cr	*Estrace ®Vaginal cr*	**LENGTH OF AUTHORIZATIONS:** 6 months

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	Vagifem® Vaginal tab	*estradiol cream (generic Estrace ®)* *Estring® Vaginal ring* *Femring® Vaginal ring* *Imvexxy®* *Intrarosa™* *Osphena® tab* *Yuvafem®*	**Routine PDL edits**
Gastrointestinal			
	G I Antibiotics		
	Firvanq™ sol **metronidazole tab** **vancomycin cap**	*Aemcolo™* *Alinia®* *Dificid®* *Flagyl® cap/tab/ER* *metronidazole cap* *neomycin* *nitazoxanide (generic Alinia®)* *paromomycin* *Solosec™* *Tindamax®* *tinidazole* *Xifaxan®* *vancomycin compounded oral soln kit* *Vancocin®*	**Length of authorization:** 1 year **Routine PDL edits plus**
	Antiemetic/Antivertigo Agents		
	Cannabinoids (delta-9THC derivatives)		**LENGTH OF AUTHORIZATIONS:** 6 months ***Dronabinol plus all non-preferred Antiemetic/Antivertigo agents require submission of a Clinical SA. Refer to Antiemetic/Antivertigo SA form**
	***dronabinol cap**	**Cesamet™* **Marinol ®* **Syndros®*	
	5HT3 Receptor Blockers		**LENGTH OF AUTHORIZATIONS:** 3 months, unless otherwise noted **Routine PDL**
	ondansetron ODT/soln/tab	*Aloxi®* *Anzemet®* *Akynzeo®*	

Preferred Agents	Non-Preferred Agents	SA Criteria
	granisetron Granisol ® soln/tab *Kytril®* *palonosetron (generic Aloxi®)* *Sancuso® patch* *Zofran® ODT/soln/tab* *Zuplenz® film*	
NK-1 Receptor Antagonist		**LENGTH OF AUTHORIZATIONS:** Length of chemotherapy regimen or a maximum of 6 months
	aprepitant capsule/pack *Cinvanti™ (Intraven)* *Emend® Bi Pak/ cap* *Emend® Tri-fold pack/susp* *Varubi™ IV, Tab*	
Other		**LENGTH OF AUTHORIZATIONS**: 1 year, unless otherwise noted
HM motion relief 25 mg tab **meclizine cap, tab chew, tab** **metoclopramide sol, syr, tab, vial** **motion sickness rlf 25 mg tab** **motion-time tab chew** ****phenadoz sup** **Prochlorperazine tab** ****promethazine sol, syrp, tab** *(AG)* **SM motion sickness 25 mg tab** **travel sickness 25 mg tab chew**	*Antivert®* *Barhemsys®* *Bonjesta™* *Compazine®supp/tab* *Compro®* *Diclegis®* *dimenhydrinate* *doxylamine succinate/ vit B6* *Metozolv® ODT* *metoclopramide ODT* ***Phenergan® (AG)* *prochlorperazine supp* ***promethazine 50mg supp (AG)* *Reglan®* *scopolamine (generic Transderm-Scop®)* *Tigan®* *Transderm-Scop®* *trimethobenzamide* *Vistaril®*	**Promethazine products approved for members ≥ 2 years
***GI Motility, Chronic**		

Preferred Agents	Non-Preferred Agents	SA Criteria
Amitiza® **Linzess™** **Movantik®**	*Alosetron* *lubiprostone (generic Amitiza®)* *Lotronex®* *Motegrity™* *Relistor®* *Symproic®* *Trulance™* *Viberzi™*	**LENGTH OF AUTHORIZATIONS**: 6 months **Routine PDL edits plus** ***All GI Motility drugs (preferred and non-preferred) require the submission of a Clinical SA. Refer to Chronic GI Motility SA form**
H. Pylori Treatment		
Pylera®	*Helidac®* *Omeclamox®-Pak* *lansoprazole/amoxicillin/ clarithromycin* *Prevpac®* *Talicia®*	**LENGTH OF AUTHORIZATIONS**: 14 days **Routine PDL edits**
Histamine-2 Receptor Antagonists (H-2 RA)		
famotidine (OTC & RX) ***famotidine oral susp**	*cimetidine tab/syrup (OTC/RX)* *nizatidine cap/susp* *Pepcid ® susp/tab (OTC/RX)* *ranitidine cap (OTC/RX)* *Zantac® syrup/tab (OTC/RX)*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits plus** ***AutoPA for famotidine oral susp** • Is under 12 years of age • Continuation of therapy, has a claim in past 90 days • Is using a Tube feeding
Proton Pump Inhibitors		
omeprazole RX **pantoprazole**	*Aciphex® DR tab/sprinkle* *Dexilant®* *esomeprazole magnesium cap/susp* *esomeprazole strontium* *lansoprazole cap* *Nexium®* *omeprazole OTC* *omeprazole magnesium OTC* *omeprazole/sodium bicarbonate*	**LENGTH OF AUTHORIZATIONS**: 12 weeks; unless member meets an exception; then 1 year **Routine PDL edits plus** ***All non-preferred Proton Pump Inhibitors require submission of a Clinical SA. Refer to Proton Pump Inhibitor SA form** **Preferred agents require a SA for use over 90 days**

	Preferred Agents	Non-Preferred Agents	SA Criteria
		pantoprazole susp (generic Protonix® susp) *Prevacid® RX, OTC& Solutab* *Prilosec® Rx & Susp* *Protonix®* *rabeprazole DR tab* *Zegerid® cap/OTC/susp packet*	
	Ulcerative Colitis Oral and Rectal Preparations (5-ASA DERIVATIVES)		
	Ulcerative Colitis – Oral		**LENGTH OF AUTHORIZATIONS:** **1 year** ***Routine PDL edits*** **Giazo is limited to an 8week supply*
	Apriso® **balsalazide disodium** **Pentasa®** **sulfasalazine DR & IR**	*Asacol ®HD* *Azulfidine® IR &DR* *budesonide ER (generic Uceris™)* *Colazal®* *Delzicol™* *Dipentum* **Giazo™ (QL)* *Lialda®* *mesalamine (generic Asacol® HD)* *mesalamine (generic Lialda®)* *Uceris™*	
	Ulcerative Colitis – Rectal		
	mesalamine rectal supp **mesalamine enema**	*Canasa® rectal supp* *mesalamine kit* *Rowasa® enema/kit* *SFRowasa®* *Uceris®*	
Genitourinary			
	Alpha-Blockers and Androgen Hormone Inhibitors For Benign Prostatic Hypertrophy (BPH)		
	Alpha-Blockers for BPH		**LENGTH OF AUTHORIZATIONS:** **1 year** **Routine PDL edits plus**
	alfuzosin **tamsulosin HCL**	*Flomax ®* *Rapaflo®* *Silodosin (generic Rapaflo)* *Uroxatral®*	

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Androgen Hormone Inhibitors for BPH		
dutasteride **finasteride**	*Avodart* ® *Dutasteride/tamsulosin* *Jalyn*® *Proscar*®	
Phosphodiesterase (PDE) 5 Inhibitor for BPH		***Step edit for Cialis**® & tadalafil 5mg - trial and failure of Alpha Blockers and Androgen Inhibitors for BPH. Prescriber must attest that the member is not on the state's sex offenders list. Consult or evaulation by Urologist.
	**Cialis*® *(ST)* *tadalafil 5mg (ST)*	
Urinary Antispasmodics (Bladder Relaxant)		
oxybutynin tab/syrup **oxybutynin ER** **solifenacin** **Toviaz™**	*darifenacin ER (generic Enablex®)* *Detrol® & Detrol® LA* *Ditropan® & *Ditropan® XL* *flavoxate* *Gelnique™ gel/gel Pump* *Myrbetriq™* *Oxytrol® transdermal includes OTC* *Sanctura XR* *trospium IR & ER* *tolterodine IR & ER* *VESIcare®*	
Immunological Agents		
***Multiple Sclerosis**		
Avonex® **Avonex® Adm Pack** **Betaseron®** **Copaxone 20 mg syringe®** ****Kesimpta® (ST)** **Tecfidera®**	****Ampyra®* *Aubagio®* *Bafiertam™ (monomethyl fumarate)* *Copaxone® 40 mg syringe®* *dimethyl fumarate (generic Tecfidera®)* *dalfampridine ER (genericAmpyra®)* *Extavia® Kit* **Gilenya® ~~(ST)~~* *Glatopa™* *Mavenclad®*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits plus.** ***All agents require adherence to the documented PI age and diagnosis.** ****Kesimpta® requires step trial of brand Tecfidera® or a preferred Injectable agent, to be determined by an AutoPA.** **Mayzent, Mavenclad or Zeposia SA Form**

Preferred Agents	Non-Preferred Agents	SA Criteria
	Mayzent® *Plegridy®* *Rebif® SQ* *Rebif® Rebidose Pen®* *****Vumerity™* *Zeposia®*	~~**Step Edit for Gilenya®** – a trial and failure of a preferred injectable drug. In order to receive a non-preferred oral drug both an injectable preferred and Gilenya® must have been tried and failed.~~ ~~Vumerity™~~ ~~Approved for the treatment of relapsing forms of multiple sclerosis, to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults.~~ *****Select non-preferred MS drugs (Amprya®) require the submission of a Clinical SA. Refer to MS - Ampyra® SA form**
Drugs to improve walking in patients with (MS)		
	****Ampyra®* ****dalfampridine ER (generic Ampyra®)*	
Cytokine and CAM Antagonists And Related Agents		**CLOSED CLASS**
Enbrel® Pen, Sureclick, Syringe, Vial **Humira® Pen, Syringe** **methotrexate tab/PF vial/MDV** **Renflexis®**	*Actemra® SQ & ACTPEN* *Arcalyst®* *Avsola™* *Cimzia® & Cimzia® Syringe Kit* *Cosentyx™* *Enspryng™* *Entyvio®* ***Dupixent®* *Ilaris®* *Ilumya™* *Inflectra®* *Kevzara® inj, pen* *Kineret®* *Olumiant®* *Otezla®* *Otrexup®* *Orencia®* *Rasuvo™* *Remicade®* *Rinvoq™* *Skyrizi™* *Siliq®*	**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edits plus** ***All non-preferred Cytokine and CAM Antagonists require submission of a Clinical SA. Refer to Cytokine and CAM Antagonists and Related Agents SA Form** **** See Cytokine and CAM Antagonists Appendix A for Clinical Criteria**** For a list of Cytokine and CAM Antagonists and criteria for approval see **Appendix A**

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
		Simponi® *Stelara® vial/syringe* *Taltz®* *Tremfya™* *Trexall®* *Xatmep™* *Xeljanz™ & Xeljanz™ XR*	
Ophthalmic			
	Antibiotics		
	bacitracin/polymyxin b sulfate oint **ciprofloxacin drops** **erythromycin** **gentamicin drops/oint** **moxifloxacin drops (**Vigamox generic**)** **ofloxacin drops** **polymyxin/trimethoprim** **tobramycin**	*AzaSite™ drops* *bacitracin* *Besivance® drops* *Bleph®-10* *Ciloxan® drops/oint* *Garamycin ®drops/oint* *gatifloxacin 0.5% soln* *Ilotycin®* *levofloxacin drops* *moxifloxacin drops (generic Moxeza®)* *Moxeza® drops* *Natacyn®* *neomycin/polymix/gramicidin* *neomycin/bacitracin/polymyxin oint* *Neosporin ®* *Ocuflox® s* *Polytrim®* *sulfacetamide oint/ soln* *Tobrex® drops/oint* *Vigamox®* *Zymaxid®*	**LENGTH OF AUTHORIZATIONS**: Date of service only; no refills **Routine PDL edits**

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Antibiotic/Steroid Combinations		
neomycin/polymyxin/dexamethasone oint/susp **sulfacetamide/prednisolone** **Tobradex® oint/susp**	*Blephamide®* *Blephamide® S.O.P.* *Maxitrol® oint/susp* *neomycin/bacitracin/poly/HC* *neomycin/polymyxin/HC* *Pred-G®oint/susp* *Tobradex® ST* *tobramycin/dexamethasone susp* *Zylet®*	**LENGTH OF AUTHORIZATION**: Date of service only; no refills **Routine PDL edits**
Antihistamines/Mast Cell Stabilizers		
Antihistamines		**LENGTH OF AUTHORIZATIONS:** 1 year **Routine PDL edits** *Ilevro™ is limited to 1 bottle plus 1 refill
Alaway OTC® **ketotifen fumerate** **olopatadine (generic Patanol & Pataday)** **Pazeo®** **Zaditor® OTC**	*Bepreve®* *Elestat®* *epinastine 0.05% eye drops* **Ilevro™ 0.3% (QL)* *Lastacaft®* *Optivar®* *Patanol® Rx and OTC* *Pataday® Rx and OTC* *Zerviate ™*	
Mast Cell Stabilizers		
cromolyn sodium	*Alocril®* *Alomide®*	
Anti-inflammatory Agents		
NSAIDS		**LENGTH OF AUTHORIZATIONS**: Date of service only; no refills **Routine PDL edits** *Ilevro™ is limited to 1 bottle plus 1 refill
diclofenac sodium **flurbiprofen sodium** **ketorolac 0.4%& 0.5%**	*Acular® 0.5% & LS® 0.4%* *Acuvail®* *bromfenac 0.09%* *BromSite ™* **Ilevro™0.3% (QL)* *Inveltys ™ (loteprednol etabonate)*	

Preferred Agents	Non-Preferred Agents	SA Criteria
	Nevanac® *Ocufen®* *Prolensa™*	
Corticosteriods		
Durezol® **fluorometholone** **prednisolone acetate**	*Alrex™* *Dexamethasone* *Flarex®* *FML®, FML Forte® & FML® S.O.P.* *loteprednol etabonate (generic for Lotemax™)* *Lotemax™ drops/gel/oint* *Maxidex®* *Omnipred®* *Pred Forte® & Pred Mild®* *prednisolone sod phosphate* *Vexol®* *Yutiq® (fluocinolone acetonide intravitreal implant)*	
Glaucoma Agents		
Alpha 2 Adrenergic Agents		**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits**
Alphagan P® 0.1 & 0.15% **brimonidine 0.2%**	*apraclonidine 0.5% drops* *brimonidine tartrate 0.15%* *Iopidine® 0.5% & 1%*	
Beta Blockers		
carteolol 1% **Combigan®** **levobunolol 0.5%** **metipranolol 0.3%** **timolol maleate**	*Betagan® 0.5%* *betaxolol 0.5%* Betoptic-S® 0.25% *Istalol® 0.5%* *timolol (generic for Timoptic Ocudose)* *Timoptic® drops 0.25% & 0.5%* *Timoptic® XE 0.25% & 0.5% sol-gel*	

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	Carbonic Anhydrase Inhibitors		
	Azopt® 1% **dorzolamide** **dorzolamide/timolol**	*Cosopt® 0.5%-2%* *Cosopt® PF* *Simbrinza™* *Trusopt® 2%* *dorzolamide/timolol PF*	
	Rho Kinase Inhibitor		
	Rhopressa® **Rocklatan**		
	Prostaglandin Analogs		
	latanoprost **Travatan Z®**	*bimatoprost* *Lumigan® 0.03% & 0.01%* *Rescula®* *travoprost 0.004%* *Vyzulta™* *Xalatan® 0.005%* *Xelpros® (latanoprost)* *Zioptan™*	
Respiratory			
	***Anti-Allergens, Oral**		
	Grass Pollen		**LENGTH OF AUTHORIZATIONS**: 1 year
		**Oralair® SL*	
	Peanut		
		**Palforzia™*	***All non-preferred Anti-Allergen drugs require the submission of a Clinical SA. Refer to Oralair SA Form or Palforzia SA Form**
	Antihistamines: First and Second Generation		
	First Generation Antihistamines		**LENGTH OF AUTHORIZATIONS**: 1 year
	Generic only class	*All Brands require a SA*	**Routine PDL edits**

Virginia Medicaid's Preferred Drug List (PDL)/ Common Core Formulary

7/1/21

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Second Generation Antihistamines and Combinations		
cetirizine liquid 1mg/1mL (RX/OTC) **cetirizine tabs OTC** **levocetirizine tab/OTC** **loratadine tab/syrup OTC**	*cetirizine chew tab (OTC)* *cetirizine liquid 5mg/5mL (OTC)* *cetirizine D tab (OTC)* *Clarinex®* *Clarinex-D®* *desloratadine ODT* *fexofenadine* *fexofenadine/PSE ER* *fexofenadine suspension* *loratadine ODT* *loratadine D 12 & 24 hr* ~~*Semprex-D®*~~	Endo has made a business decision to permanently discontinue Semprex-D. There are no generic version
Beta-Adrenergic Agents		
Long Acting Beta Adrenergic s (LABA) MDIs or Nebulizers		**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits plus** **Clinical Criteria for LABAs for Children** **LENGTH OF AUTHORIZATION: 3 months** ~~Each drug listed below will require a SA for ages less than the FDA/PI indicated age.~~
Foradil® *(AG)* **Serevent Diskus®** *(AG)*	*Arcapta DS(AG)* *Brovana®(AG)* *Perforomist® (AG)* *Striverdi® Respimat (AG)*	

~~**Brand Name**~~	~~**Age where SA is required**~~	~~**FDA Indications**~~
~~*Advair ®HFA~~	~~Children < 12~~	~~Asthma & COPD~~
~~Advair ®Diskus & Wixela® 100/50~~	~~Children < 4~~	~~Asthma & COPD~~
~~*Advair ®Diskus & Wixela® 250/50~~	~~Children < 12~~	~~Asthma & COPD~~
~~Advair ®Diskus & Wixela® 500/50~~	~~Children < 12~~	~~Asthma & COPD~~
~~Airduo™ Respiclick®~~	~~Children < 12~~	~~Asthma only~~
~~Anoro™ Ellipta~~	~~Children & Adolescents < 18~~	~~COPD only~~
~~Arcapta® Neohaler~~	~~Children & Adolescents < 18~~	~~COPD only~~
~~ArmonAir® Digihaler™~~	~~Children < 12~~	~~Asthma only~~

Preferred Agents	Non-Preferred Agents	SA Criteria		
		~~Bevespi Aerosphere™~~	~~Children & Adolescents < 18~~	~~COPD only~~
		~~Breo® Ellipta™~~	~~Children & Adolescents < 18~~	~~Asthma & COPD~~
		~~Brovana®~~	~~Children & Adolescents < 18~~	~~COPD only~~
		~~*Dulera®~~	~~Children < 12~~	~~Asthma only~~
		~~Dupixent®~~	~~Children < 12~~	~~Asthma only~~
		~~fluticasone/salmeterol pow~~	~~Children < 12~~	~~Asthma only~~
		~~Foradil® Aerolizer~~	~~Children < 5~~	~~Asthma & COPD~~
		~~Perforomist®~~	~~Children & Adolescents < 18~~	~~COPD only~~
		~~Serevent® Diskus~~	~~Children < 4~~	~~Asthma & COPD~~
		~~Stiolto™ Respimat®~~	~~Children < 18 years~~	~~COPD only~~
		~~Striverdi® Respimat~~	~~Children < 18 years~~	~~COPD only~~
		~~*Symbicort® 80/4.5~~	~~Children < 6~~	~~Asthma & COPD~~
		~~*Symbicort® 160/4.5~~	~~Children < 12~~	~~Asthma & COPD~~
Short Acting Metered Dose Inhalers or Devices				
Proair® HFA **Ventolin® HFA**	*albuterol HFA (Proair®)* *albuterol HFA (Ventolin®)* *albuterol HFA (Proventil®)* *levalbuterol tartrate HFA* *ProAir® Digihaler™* *ProAir® RespiClick* *Proventil® HFA* *Xopenex® HFA*			
Short Acting Nebulizers				
albuterol sulfate (premixed)	*levalbuterol soln* *Xopenex®*			
Biologic: Human Monoclonal IgG4 Antibody Inhibits Interleukin-4 (IL-4) and Interleukin-13 (IL-13)				
	Dupixent®	**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edits plus**		

	Preferred Agents	Non-Preferred Agents	SA Criteria

			• Routine PDL
			• ≥ 12 years of age; AND
			• Diagnosis Moderate to severe Asthma with
			  ○ eosinophilic phenotype; OR
			  ○ Oral corticosteroid dependent; AND
			• Prescribing provider is a pulmonologist or
			• An allergy/asthma specialist; AND
			• Have a diagnosis of step 5 or higher (moderate to severe) asthma; AND
			• Inadequately controlled asthma despite treatment with high dose inhaled or oral corticosteroid daily for at least 3 consecutive months; AND
			• Along-acting beta agonist (unless is not a candidate) daily for at least 3 consecutive months; AND
			• Is Add to current maintenance treatment; AND
			• Is not pregnant

	COPD: Bronchodilators and Phosphodiesterase 4 (PDE4) Inhibitors CLOSED CLASS		
	Atrovent HFA® **Anoro™ Ellipta®** (AG) **Bevespi Aerosphere™** **Combivent® Respimat** **ipratropium bromide soln** **ipratropium/albuterol nebs** **Spiriva®** **Stiolto Respimat™ (AG)**	**Daliresp®* *Duaklir Pressair* *Incruse™ Ellipta®* *Lonhala™ Magnair™* *Spiriva® Respimat* *Tudorza™* *Yupelri™ (revefenacin)*	**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edits plus** ***Clinical Criteria for Daliresp®** • If the member has a diagnosis of severe COPD associated with chronic bronchitis and a history of exacerbations; **AND** • Trial/failure on at least one first-line or second-line agent (inhaled anticholinergics, long acting beta agonists or inhaled corticosteroids); **AND** • Adjunctive therapy (Daliresp® must be used in conjunction with first-line or second-line agent).
	Corticosteroids: Inhaled and Nasal Steroids		
	Inhaled Corticosteroids: Combination Drugs (Glucocorticoid and Long Acting Beta Adrenergic) CLOSED CLASS		**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits**
	Advair® Diskus (AG) **Advair® HFA(AG)** **Asmanex Twisthaler** **Dulera®** *(AG)*	*AirDuo® Digihaler®* *Airduo ™ Respiclick® (AG)* *Breo® Ellipta™ (AG)* *Breztri Aerosphere™*	

Preferred Agents	Non-Preferred Agents	SA Criteria
Symbicort® *(AG)*	*fluticasone/salmeterol (generic Airduo)* *fluticasone/salmeterol powder (generic Advair) (AG)* *Trelegy® Ellipta* *Wixela® (fluticasone/ salmeterol) (AG /*	
Inhaled Corticosteroids: Metered Dose Inhalers CLOSED CLASS		
Flovent® Diskus & HFA **Pulmicort Flexhaler®**	*Alvesco®* *Aerospan™* *ArmonAir® Digihaler™(AG)* *Arnuity™ Ellipta®* *Asmanex HFA®* *QVAR® & QVAR® Redihaler*	
Inhaled Corticosteroids: Nebulizer Solution CLOSED CLASS		**LENGTH OF AUTHORIZATIONS**: 1 year
budesonide respules	*Pulmicort® Respules*	
Nasal Steroids		**Routine PDL edits**
fluticasone Rx	*Azelastine/fluticasone nasal spray (generic for Dymista®)* *Beconase AQ®* *budesonide (generic for Rhinocort® Aqua)* *budesonide (generic Rhinocort® Allergy OTC)* *Children's Qnasl™* *Clarispray OTC* *Dymista®* *Flonase®* *Flonase Sensimist (OTC)* *flunisolide* *fluticasone OTC*	

	Preferred Agents	Non-Preferred Agents	SA Criteria
		mometasone (generic Nasonex®) *Nasonex®* *Omnaris®* *Qnasl™* *Rhinocort Aqua®* *Rhinocort® Allergy OTC* *Sinuva®* *Ticanase®* *triamcinolone OTC* *triamcinolone acetonide* *Veramyst®* *Xhance™* *Zetonna™*	
	***Cough and Cold Drug**		
	Ala-Hist DM **benzonatate cap** **codeine/ promethazine** **guaifenesin/codeine phosphate** **hydrocodone/ homatropine** **Iophen-C NR** **phenylephrine HCl/promethazine HCl** **promethazine DM syrup** **Tusnel® Pediatric Drops**	*lohist-DM syrup* *All other Legend cough and cold drugs are non-preferred* *Tessalon ® perle*	**LENGTH OF AUTHORIZATION**: Date of Service Only **Routine PDL edits** *** Children under the age of 6 years are not eligible for cough and cold drugs.**
	Epinephrine, Self-Injected		
	epinephrine 0.15 mg & 0.3 mg (authorized generic EpiPen® & EpiPen® Jr)	*Auvi-Q®* *Epipen®* *Epipen® Jr* *epinephrine 0.15mg & 0.3mg (generic Adrenaclick)* *Symjepi™ (epinephrine)*	**LENGTH OF AUTHORIZATIONS**: **1 year** **Routine PDL edits**

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	Intranasal Antihistamines		
	azelastine 0.1%	*Astepro® 0.15%* *olopatadine* *Patanase®*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits**
	Leukotriene Receptor Antagonists		
	montelukast tabs/chewable tabs	*Accolate®* *Singulair® tabs/chew tabs/granules* *montelukast granules* *zafirlukast* *Zyflo™* *Zyflo CR™* *zileuton ER*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits**