# The West Virginia Bureau for Medical Services
# Office of Pharmacy Services

## Preferred Drug List
## and
## Prior Authorization Criteria

*This is not an all-inclusive list of available covered drugs and includes only managed categories. Refer to cover page for complete list of rules governing this Preferred Drug List (PDL).*

- Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. A current listing of all covered over the counter (OTC) products may be found at the BMS Website by clicking the hyperlink.
- Prior authorization (PA) of any non-preferred agent requires that class criteria, and in some cases drug-specific criteria, be followed unless documentation is provided indicating that the use of these agents would be medically contraindicated. “Exceptions” to the PA criteria should be detailed on the PA form for consideration – these include relative contraindications, such as potential drug-drug interactions, adverse effects, intolerance, and drug-disease interactions.
- Required trials of preferred agents are defined as “failed” or otherwise satisfied only when efficacy has not been observed despite patient adherence to a dose and duration which should have produced therapeutic effects.
- Unless otherwise specified, all requests to “grandfather” existing drug therapy will require clinical reasoning from the prescriber detailing why the patient cannot be transitioned to a preferred agent from the Medicaid PDL. Please note that this requirement includes therapy that may have been previously preferred on the Medicaid PDL but has since changed to non-preferred status.
- The use of pharmaceutical samples will not be considered when evaluating the members’ medical condition or prior prescription history for drugs that require prior authorization.
- Other drug utilization review restrictions may apply, including, but not limited to, therapeutic duplication, drug-drug interaction, ingredient duplication, etc.
- Quantity limits may apply. Refer to the Limits List on the BMS Website by clicking the hyperlink.
- Unless otherwise indicated, non-preferred combination products require medical reasoning beyond convenience or enhanced compliance as to why the clinical need cannot be met with a preferred agent or combination of preferred single-ingredient agents containing the same, or similar, active ingredient.
- Acronyms
    - Clinical (CL) – Requires clinical PA. For detailed clinical criteria, please go to the PA criteria page by clicking the hyperlink.
    - Non-Reviewed (NR) – Denotes a new drug which has not yet been reviewed by the Pharmaceutical and Therapeutics (P&T) Committee. **These agents are available only on appeal to the BMS Medical Director.**
    - Automatic PA (AP) – Non-preferred and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA criteria column.

| CLASSES CHANGING | Status Changes | PA Criteria Changes | New Drugs |
|---|---|---|---|
| ANALGESICS, NON-NARCOTIC SHORT ACTING | | | X |
| ANTIHEMOPHILIA AGENTS | | | X |
| ANTIPSYCHOTICS, ATYPICAL AND COMBINATION | | | X |
| DIABETES AGENTS, DPP-4 INHIBITORS | | | X |
| EPINEPHRINE, SELF-ADMINISTERED | | | X |
| HYPOPARATHYROID AGENTS | | | X |
| HYPOGLYCEMIA AGENTS | X | | |
| IMMUNOMODULATORS, ATOPIC DERMATITIS | | | X |
| SKELETAL MUSCLE RELAXANTS | | | X |
| STIMULANTS AND RELATED AGENTS – NON-AMPHETAMINE | | | X |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **ACNE AGENTS, TOPICAL[AP]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a thirty (30) day trial of one (1) preferred retinoid and two (2) unique chemical entities in two (2) other subclasses, including the generic version of the requested non-preferred product, before they will be approved, unless one (1) of the exceptions on the PA form is present.<br><br>In cases of pregnancy, a trial of retinoids will *not* be required. For members eighteen (18) years of age or older, a trial of retinoids will *not* be required.<br>Acne kits are non-preferred.<br><br>**Specific Criteria for subclass will be listed below. NOTE**: Non-preferred agents in the Rosacea subclass are available only on appeal and require at least a thirty (30) day trial of all preferred agents in that subclass. | | |
| **ANDROGEN RECEPTOR INHIBITORS** | | |
| | WINLEVI CREAM (clascoterone) | |
| **ANTI-INFECTIVE** | | |
| CLINDAGEL (clindamycin)<br>clindamycin lotion, medicated swab, solution<br>erythromycin gel, solution | AMZEEQ FOAM (minocycline)<br>CLEOCIN-T (clindamycin)<br>CLINDACIN ETZ KIT, MEDICATED SWAB (clindamycin)<br>CLINDACIN P (clindamycin)<br>CLINDACIN PAC (clindamycin)<br>clindamycin foam, gel<br>dapsone<br>ERYGEL (erythromycin)<br>erythromycin medicated swab<br>EVOCLIN (clindamycin)<br>FABIOR (tazarotene)<br>KLARON (sulfacetamide)<br>OVACE/PLUS (sulfacetamide)<br>sodium sulfacetamide 10% cleansing gel<br>sulfacetamide | |
| **RETINOIDS** | | |
| adapalene gel<br>RETIN-A (tretinoin)<br>RETIN-A MICRO (tretinoin) | adapalene cream, lotion<br>ALTRENO LOTION (tretinoin)<br>ARAZLO (tazarotene)<br>ATRALIN (tretinoin)<br>AVITA (tretinoin)<br>tazarotene cream, foam, gel<br>tretinoin cream, gel<br>tretinoin gel micro | **In addition to the Class Criteria:** PA required for members eighteen (18) years of age or older. |
| **KERATOLYTICS** | | |
| benzoyl peroxide cleanser (Rx, OTC), 10% cream (OTC), gel (Rx, OTC), lotion (OTC), wash (OTC) | BENZEFOAM (benzoyl peroxide)<br>BP 10-1 (benzoyl peroxide)<br>BPO (benzoyl peroxide) | |
| **COMBINATION AGENTS** | | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| BENZAMYCIN PAK (benzoyl peroxide/ erythromycin)<br>benzoyl peroxide/clindamycin gel (generic DUAC only)<br>clindamycin phosphate/benzoyl peroxide (generic ACANYA)<br>ONEXTON (clindamycin phosphate/benzoyl peroxide)<br>sulfacetamide sodium/sulfur suspension<br>ZIANA (clindamycin/tretinoin)* | ACANYA (clindamycin phosphate/benzoyl peroxide)<br>adapalene-benzoyl peroxide*<br>AVAR/-E/LS (sulfur/sulfacetamide)<br>benzoyl peroxide/clindamycin gel (all generics other than DUAC)<br>benzoyl peroxide/erythromycin<br>benzoyl peroxide/urea<br>CABTREO (clindamycin/adapalene/benzoyl peroxide)<br>clindamycin-tretinoin gel*<br>NEUAC (clindamycin phosphate/benzoyl peroxide)<br>SSS 10-4 (sulfacetamide/sulfur)<br>SSS 10-5 foam (sulfacetamide/sulfur)<br>sulfacetamide sodium/sulfur cloths, lotion, pads<br>sulfacetamide/sulfur cleanser, wash<br>sulfacetamide/sulfur wash kit<br>sulfacetamide sodium/sulfur/urea<br>SUMADAN/XLT (sulfacetamide/sulfur)<br>SUMAXIN/TS (sulfacetamide sodium/sulfur)<br>ZMA CLEAR (sulfacetamide sodium/sulfur) | **In addition to the Class Criteria:** Non-preferred combination agents require thirty (30) day trials of the corresponding preferred single agents before they will be approved.<br><br>*PA required for combination agents with Retinoid products for members eighteen (18) years of age or older. |
| **ROSACEA AGENTS** | | |
| azelaic acid gel<br>metronidazole cream<br>metronidazole gel 0.75% (NDCs 00115-1474-46, 00713-0637-37, 51672-4116-06, 66993-0962-45 only) | FINACEA FOAM (azelaic acid)<br>ivermectin<br>metronidazole gel (all other NDCs)<br>metronidazole lotion<br>NORITATE CREAM (metronidazole)<br>RHOFADE (oxymetazoline)<br>ROSADAN (metronidazole) | **Subclass criteria:** Non-preferred agents are available only on appeal and require evidence of thirty (30) day trials of all chemically unique preferred agents in the subclass. |
| **ALZHEIMER'S AGENTS[AP]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a thirty (30) day trial of a preferred agent in the same subclass before they will be approved, unless one (1) of the exceptions on the PA form is present.<br><br>Prior authorization is required for members up to forty-five (45) years of age if there is no diagnosis of Alzheimer's disease. | | |
| **CHOLINESTERASE INHIBITORS** | | |
| donepezil 5 mg and 10 mg<br>donepezil ODT<br>EXELON PATCHES (rivastigmine)<br>galantamine tablets<br>galantamine ER capsules<br>RAZADYNE ER (galantamine)<br>rivastigmine capsules | ADLARITY PATCHES (donepezil)<br>ARICEPT (donepezil)<br>donepezil 23 mg*<br>galantamine solution<br>rivastigmine patches | *Donepezil 23 mg tablets will be authorized if the following criteria are met:<br>1. There is a diagnosis of moderate-to-severe Alzheimer's Disease; **AND**<br>2. There has been a trial of donepezil 10 mg daily for at least three (3) months and donepezil 20 mg daily for an additional one (1) month. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **NMDA RECEPTOR ANTAGONIST** | | |
| memantine<br>memantine ER | memantine solution<br>NAMENDA (memantine) solution, titration pak<br>NAMENDA XR (memantine) | |
| **CHOLINESTERASE INHIBITOR/NMDA RECEPTOR ANTAGONIST COMBINATIONS** | | |
| | NAMZARIC (donepezil/memantine) | Combination agents require thirty (30) day trials of each corresponding preferred single agent. |
| **ANALGESICS, NARCOTIC LONG-ACTING (Non-parenteral)[AP]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require six (6) day trials of three (3) chemically distinct preferred agents (excluding fentanyl) **AND** a six (6) day trial of the generic form of the requested non-preferred agent (if available) before they will be approved, unless one (1) of the exceptions on the PA form is present. If no generic form is available for the requested non-preferred brand agent, then another generic non-preferred agent must be trialed instead. **NOTE: All long-acting opioid agents require prior authorization for children under eighteen (18) years of age.** Requests must be for an FDA approved age and indication and specify previous opioid and non-opioid therapies attempted. | | |
| BUTRANS (buprenorphine)<br>fentanyl transdermal 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr, and 100 mcg/hr[CL/PA]<br>morphine ER tablets<br>tramadol ER tablets (generic ULTRAM ER) | ARYMO ER (morphine sulfate)<br>BELBUCA (buprenorphine buccal film)*<br>buprenorphine buccal film<br>buprenorphine patches (all labelers including 00093)<br>CONZIP ER (tramadol)<br>fentanyl transdermal 37.6 mcg/hr, 62.5 mcg/hr, and 87.5 mcg/hr<br>hydrocodone ER capsules and tablets<br>hydromorphone ER<br>HYSINGLA ER (hydrocodone)<br>KADIAN (morphine)<br>methadone**<br>MORPHABOND ER (morphine sulfate)<br>morphine ER capsules (generic AVINZA)<br>morphine ER capsules (generic KADIAN)<br>MS CONTIN (morphine)<br>oxycodone ER<br>OXYCONTIN (oxycodone)<br>oxymorphone ER<br>tramadol ER (generic CONZIP ER)***<br>ULTRAM ER (tramadol)<br>ZOHYDRO ER (hydrocodone) | *Belbuca prior authorization requires manual review. Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.<br><br>**Methadone will be authorized without a trial of the preferred agents if a diagnosis of cancer is submitted.<br><br>***Tramadol ER (generic ConZip) requires a manual review and may be authorized for ninety (90) days with submission of a detailed treatment plan including anticipated duration of treatment and scheduled follow-ups with the prescriber. |
| **ANALGESICS, NARCOTIC SHORT-ACTING (Non-parenteral)[AP]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require six (6) day trials of at least four (4) chemically distinct preferred agents (based on the narcotic ingredient only), including the generic formulation of the requested non-preferred agent, before they will be approved, unless one (1) of the exceptions on the PA form is present. **NOTE: All tramadol and codeine products require a prior authorization for children under eighteen (18) years of age.** Requests must be for an FDA approved age and indication and specify non-opioid therapies attempted. | | |
| APAP/codeine<br>butalbital/APAP/caffeine/codeine 50-325-30 mg<br>codeine | ABSTRAL (fentanyl)<br>ACTIQ (fentanyl)<br>butalbital/APAP/caffeine/codeine 50-300-30 mg | Fentanyl buccal, nasal, and sublingual products will only be authorized for a diagnosis of cancer and as an adjunct to a |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| hydrocodone/APAP 2.5/325 mg, 5/325 mg, 7.5/325 mg, and 10/325 mg<br>hydrocodone/APAP solution<br>hydromorphone tablets<br>meperidine oral solution<br>morphine<br>NUCYNTA (tapentadol)<br>oxycodone capsules, solution, tablets<br>oxycodone/APAP<br>oxycodone/ASA<br>tramadol tablets<br>tramadol/APAP | butalbital/ASA/caffeine/codeine<br>butorphanol<br>DEMEROL (meperidine)<br>dihydrocodeine/APAP/caffeine<br>DILAUDID (hydromorphone)<br>fentanyl<br>FENTORA (fentanyl)<br>FIORICET W/ CODEINE (butalbital/APAP/ caffeine/codeine)<br>FIORINAL W/ CODEINE (butalbital/ASA/caffeine/ codeine)<br>hydrocodone/APAP 5/300 mg, 7.5/300 mg and 10/300 mg<br>hydrocodone/ibuprofen<br>hydromorphone liquid, suppositories<br>levorphanol<br>LORCET (hydrocodone/APAP)<br>LORTAB (hydrocodone/APAP)<br>LORTAB SOLUTION (hydrocodone/acetaminophen)<br>meperidine tablets<br>morphine rectal suppository<br>NORCO (hydrocodone/APAP)<br>oxycodone concentrate<br>oxycodone/ibuprofen<br>oxymorphone<br>pentazocine/naloxone<br>PERCOCET (oxycodone/APAP)<br>QDOLO SOLUTION (tramadol)<br>ROXICODONE (oxycodone)<br>ROXYBOND (oxycodone)<br>SEGLENTIS (celecoxib/tramadol)*<br>tramadol solution<br>ULTRACET (tramadol/APAP)<br>VICOPROFEN (hydrocodone/ibuprofen) | long-acting agent. These dosage forms will not be authorized for monotherapy.<br><br>**Limits:** Unless the patient has escalating cancer pain or another diagnosis supporting increased quantities of short-acting opioids, all short-acting solid forms of the narcotic analgesics are limited to 120 tablets per thirty (30) days. Longer-acting medications should be maximized to prevent unnecessary breakthrough pain in chronic pain therapy.<br><br>Immediate release tramadol is limited to 240 tablets per thirty (30) days.<br><br>*Seglentis requires medical reasoning beyond convenience or enhanced compliance as to why the clinical need cannot be met with a preferred agent or combination of preferred single ingredient agents. |
| **ANALGESICS, NON-NARCOTIC SHORT ACTING** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a thirty (30) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| **SODIUM CHANNEL BLOCKER (Nav 1.8)** | | |
| JOURNAVX (suzetrigine) | | |
| **ANDROGENIC AGENTS** | | |
| **CLASS PA CRITERIA:** A non-preferred agent will only be authorized if one (1) of the exceptions on the PA form is present. | | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| ANDRODERM (testosterone)[CL/PA*]<br>ANDROGEL PUMP (testosterone)[CL/PA*]<br>TESTIM (testosterone)<br>testosterone cypionate vial[CL/PA*]<br>testosterone enanthate vial[CL/PA*]<br>testosterone gel 1.62% | ANDROGEL PACKETS (testosterone)<br>ANDROID (methyltestosterone)<br>AVEED (testosterone undecanoate)<br>FORTESTA (testosterone)<br>JATENZO (testosterone undecanoate)<br>METHITEST (methyltestosterone)<br>methyltestosterone capsules<br>NATESTO (testosterone)<br>testosterone gel<br>testosterone solution pump<br>TESTRED (methyltestosterone)<br>TLANDO (testosterone undecanoate)<br>VOGELXO (testosterone)<br>XYOSTED (testosterone enanthate) | *Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. |
| **ANESTHETICS, TOPICAL[AP]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require ten (10) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| lidocaine<br>lidocaine/prilocaine<br>xylocaine | lidocaine/hydrocortisone<br>LIDOTRAL CREAM (lidocaine)<br>LIDOZION LOTION (lidocaine)<br>SYNERA (lidocaine/tetracaine) | |
| **ANGIOTENSIN MODULATORS[AP]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require fourteen (14) day trials of each preferred agent in the same subclass, with the exception of the Direct Renin Inhibitors, before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| **ACE INHIBITORS** | | |
| benazepril<br>captopril<br>enalapril<br>fosinopril<br>lisinopril<br>quinapril<br>ramipril<br>trandolapril | ACCUPRIL (quinapril)<br>ALTACE (ramipril)<br>enalapril solution<br>EPANED SOLUTION (enalapril)*<br>LOTENSIN (benazepril)<br>moexipril<br>perindopril<br>PRINIVIL (lisinopril)<br>QBRELIS SOLUTION (lisinopril)**<br>VASOTEC (enalapril)<br>ZESTRIL (lisinopril) | *Epaned solution (enalapril solution) will be authorized with a diagnosis of hypertension, symptomatic heart failure or asymptomatic left ventricular dysfunction provided that the patient is less than (<) seven (7) years of age **OR** is unable to ingest a solid dosage form due to documented oral-motor difficulties or dysphagia.<br><br>**Qbrelis solution may be authorized for children six (6) to ten (10) years of age who are unable to tolerate a solid dosage form. Qbrelis may also be authorized for older patients with clinical documentation indicating oral-motor difficulties or dysphagia. |
| **ACE INHIBITOR COMBINATION DRUGS** | | |
| benazepril/amlodipine<br>benazepril/HCTZ<br>captopril/HCTZ<br>enalapril/HCTZ<br>fosinopril/HCTZ | ACCURETIC (quinapril/HCTZ)<br>LOTENSIN HCT (benazepril/HCTZ)<br>LOTREL (benazepril/amlodipine)<br>TARKA (trandolapril/verapamil)<br>trandolapril/verapamil | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| lisinopril/HCTZ<br>quinapril/HCTZ | VASERETIC (enalapril/HCTZ)<br>ZESTORETIC (lisinopril/HCTZ) | |
| **ANGIOTENSIN II RECEPTOR BLOCKERS (ARBs)** | | |
| irbesartan<br>losartan<br>olmesartan<br>telmisartan<br>valsartan | ATACAND (candesartan)<br>AVAPRO (irbesartan)<br>BENICAR (olmesartan)<br>candesartan<br>COZAAR (losartan)<br>DIOVAN (valsartan)<br>EDARBI (azilsartan)<br>MICARDIS (telmisartan) | |
| **ARB COMBINATIONS** | | |
| irbesartan/HCTZ<br>losartan/HCTZ<br>olmesartan/amlodipine<br>olmesartan/amlodipine/HCTZ<br>olmesartan/HCTZ<br>valsartan/amlodipine<br>valsartan/amlodipine/HCTZ<br>valsartan/HCTZ | ATACAND-HCT (candesartan/HCTZ)<br>AVALIDE (irbesartan/HCTZ)<br>AZOR (olmesartan/amlodipine)<br>BENICAR-HCT (olmesartan/HCTZ)<br>candesartan/HCTZ<br>DIOVAN-HCT (valsartan/HCTZ)<br>EDARBYCLOR (azilsartan/chlorthalidone)<br>EXFORGE (valsartan/amlodipine)<br>EXFORGE HCT (valsartan/amlodipine/HCTZ)<br>HYZAAR (losartan/HCTZ)<br>MICARDIS-HCT (telmisartan/HCTZ)<br>telmisartan/amlodipine<br>telmisartan/HCTZ<br>TRIBENZOR (olmesartan/amlodipine/HCTZ) | |
| **DIRECT RENIN INHIBITORS** | | |
| | aliskiren<br>TEKTURNA (aliskiren)<br>TEKTURNA HCT (aliskiren/HCTZ) | **Substitute for Class Criteria:** Tekturna requires a thirty (30) day trial of one (1) preferred ACE, ARB, or combination agent, at the maximum tolerable dose, before it will be authorized unless one (1) of the exceptions on the PA form is present. |
| **ANTIANGINAL & ANTI-ISCHEMIC** | | |
| **CLASS PA CRITERIA:** Agents in this class may only be authorized for patients with angina who are also taking a calcium channel blocker, a beta blocker, or a nitrite as single agents or a combination agent containing one (1) of these ingredients. | | |
| ranolazine [AP] | ASPRUZYO SPRINKLE ER (ranolazine)<br>RANEXA | |
| **ANTIBIOTICS, GI & RELATED AGENTS** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a fourteen (14) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| metronidazole tablets<br>neomycin<br>tinidazole<br>VANCOCIN (vancomycin)<br>vancomycin capsules<br>XIFAXAN 200 mg (rifaximin)* | AEMCOLO TABLETS (rifamycin)**<br>DIFICID (fidaxomicin)*<br>FIRVANQ SOLUTION (vancomycin)****<br>FLAGYL (metronidazole)<br>LIKMEZ (metronidazole)***<br>metronidazole capsules<br>paromomycin<br>vancomycin solution****<br>VOWST CAPSULES (fecal microbiota spores)*<br>XIFAXAN 550 mg (rifaximin)* | *Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.<br><br>**Aemcolo may be authorized after a trial of Xifaxan 200 mg tablets.<br><br>***Likmez may be authorized for those who are unable to ingest solid dosage forms of metronidazole due to documented oral motor difficulties or dysphagia.<br><br>****Vancomycin solution and Firvanq solution may be authorized for children up to nine (9) years of age who are unable to ingest solid dosage forms of vancomycin. Therapy may be authorized for older patients with clinical documentation indicating oral motor difficulties or dysphagia. |
| **ANTIBIOTICS, INHALED** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a twenty-eight (28) day trial of a preferred agent and documentation of therapeutic failure before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| KITABIS PAK (tobramycin)<br>tobramycin 300 mg/5 ml (generic TOBI) | BETHKIS (tobramycin)<br>CAYSTON (aztreonam)<br>TOBI (tobramycin)<br>TOBI PODHALER (tobramycin)<br>tobramycin 300 mg/4 ml (generic KITABIS) | |
| **ANTIBIOTICS, TOPICAL** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require ten (10) day trials of at least one (1) preferred agent, including the generic formulation of the requested non-preferred agent, before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| bacitracin (Rx, OTC)<br>gentamicin sulfate<br>mupirocin ointment | CENTANY (mupirocin)<br>CORTISPORIN (bacitracin/neomycin/polymyxin/HC)<br>mupirocin cream<br>neomycin/polymyxin/pramoxine<br>XEPI CREAM (ozenoxacin) | |
| **ANTIBIOTICS, VAGINAL** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require trials of each chemically unique preferred agent at the manufacturer's recommended duration, before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| CLEOCIN OVULE (clindamycin)<br>CLEOCIN CREAM (clindamycin)<br>metronidazole gel | clindamycin cream<br>CLINDESSE (clindamycin)<br>METROGEL (metronidazole)<br>NUVESSA (metronidazole)<br>SOLOSEC (secnidazole)<br>VANDAZOLE (metronidazole)<br>XACIATO GEL (clindamycin) | |
| **ANTICOAGULANTS** | | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **CLASS PA CRITERIA:** Non-preferred agents require a trial of each preferred agent in the same subclass, unless one (1) of the exceptions on the PA form is present. | | |
| **INJECTABLE[CL/PA]** | | |
| enoxaparin | ARIXTRA (fondaparinux)<br>fondaparinux<br>FRAGMIN (dalteparin)<br>LOVENOX (enoxaparin) | |
| **ORAL** | | |
| ELIQUIS (apixaban)<br>PRADAXA (dabigatran)<br>warfarin<br>XARELTO TABLETS (rivaroxaban) | dabigatran<br>PRADAXA ORAL PELLETS (dabigatran etexilate)<br>SAVAYSA (edoxaban)<br>XARELTO SUSPENSION (rivaroxaban) | |
| **ANTICONVULSANTS** | | |
| **CLASS PA CRITERIA:** For a diagnosis of seizure disorder, non-preferred agents require a fourteen (14) day trial of a preferred agent in the same subclass before they will be approved, unless one (1) of the exceptions on the PA form is present; patients currently on established therapies shall be grandfathered.<br><br>For all other diagnoses, non-preferred agents require a thirty (30) day trial of a preferred agent in the same subclass before they will be approved, unless one (1) of the exceptions on the PA form is present.<br><br>In situations where AB-rated generic equivalent products are available, "Brand Medically Necessary" must be hand-written by the prescriber on the prescription for the brand name product to be reimbursed. | | |
| **ADJUVANTS** | | |
| BRIVIACT (brivaracetam)<br>carbamazepine<br>carbamazepine ER<br>CARBATROL (carbamazepine)<br>DEPAKOTE SPRINKLE CAPSULES (divalproex)<br>divalproex<br>divalproex ER<br>divalproex sprinkle capsules<br>EPITOL (carbamazepine)<br>lacosamide solution, tablets<br>LAMICTAL (lamotrigine)<br>LAMICTAL CHEWABLE TABLETS (lamotrigine)<br>LAMICTAL XR (lamotrigine)<br>lamotrigine<br>lamotrigine ODT<br>levetiracetam IR<br>levetiracetam ER<br>levetiracetam IR suspension<br>oxcarbazepine tablets | APTIOM (eslicarbazepine)<br>BANZEL (rufinamide)<br>carbamazepine oral suspension<br>DEPAKOTE (divalproex)<br>DEPAKOTE DR (divalproex<br>DEPAKOTE ER (divalproex)<br>DIACOMIT CAPSULES/POWDER PACK (stiripentol)**<br>ELEPSIA XR (levetiracetam)<br>EPRONTIA SOLUTION (topiramate)****<br>EQUETRO (carbamazepine)<br>felbamate<br>FELBATOL (felbamate)<br>FINTEPLA SOLUTION (fenfluramine)*****<br>FYCOMPA (perampanel)<br>KEPPRA (levetiracetam)<br>KEPPRA SOLUTION (levetiracetam)<br>KEPPRA XR (levetiracetam)<br>LAMICTAL ODT (lamotrigine)<br>lamotrigine dose pack<br>lamotrigine ER | *Topiramate ER will be authorized after a thirty (30) day trial of topiramate IR.<br><br>**Diacomit may only be approved as adjunctive therapy for diagnosis of Dravet Syndrome when prescribed by, or in consultation with a neurologist **AND** requires a thirty (30) day trial of valproate and clobazam unless one (1) of the exceptions on the PA form is present.<br>Diacomit must be used concurrently with clobazam.<br><br>***Trokendi XR is available only on appeal.<br><br>****Eprontia requires medical reasoning beyond convenience or enhanced compliance as to why the medical need cannot be met by using the preferred Topamax (topiramate) sprinkle capsules.<br><br>*****Full PA criteria for Fintepla may be found on the PA Criteria page by clicking the hyperlink. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| QUDEXY XR (topiramate ER)<br>TEGRETOL SUSPENSION (carbamazepine)<br>TEGRETOL XR (carbamazepine)<br>topiramate IR tablets<br>topiramate ER*<br>topiramate IR sprinkle capsules<br>topiramate ER sprinkle capsules (generic QUDEXY)<br>TRILEPTAL SUSPENSION (oxcarbazepine)<br>valproic acid<br>zonisamide | methsuximide<br>MOTPOLY XR (lacosamide)*******<br>oxcarbazepine suspension<br>OXTELLAR XR (oxcarbazepine)<br>rufinamide oral suspension, tablets<br>SABRIL (vigabatrin)<br>SPRITAM (levetiracetam)<br>TEGRETOL TABLETS (carbamazepine)<br>tiagabine<br>TOPAMAX SPRINKLE CAPSULES (topiramate)<br>TOPAMAX TABLETS (topiramate)<br>TRILEPTAL TABLETS (oxcarbazepine)<br>TROKENDI XR (topiramate)***<br>vigabatrin tablet/powder pack<br>VIGAFYDE (vigabatrin solution)<br>VIMPAT SOLUTION, TABLETS (lacosamide)<br>XCOPRI (cenobamate)<br>ZONISADE SOLUTION (zonisamide)****** | ******Zonisade may only be authorized for those who are unable to ingest solid dosage forms due to documented oral-motor difficulties or dysphagia **AND** have had a fourteen (14) day trial with a preferred agent available in a non-solid dosage form resulting in an inadequate treatment response.<br><br>*******Motpoly XR capsules may be authorized after a medical reason beyond convenience or enhanced compliance, as to why the clinical need cannot be met by using a preferred lacosamide agent, is provided. |
| **BARBITURATES[AP]** | | |
| phenobarbital<br>primidone | MYSOLINE (primidone) | |
| **BENZODIAZEPINES[AP]** | | |
| clonazepam<br>DIASTAT (diazepam rectal)<br>diazepam rectal gel<br>diazepam tablets<br>NAYZILAM NASAL SPRAY (midazolam)<br>VALTOCO NASAL SPRAY (diazepam) | clobazam*<br>clonazepam ODT<br>DIASTAT ACUDIAL (diazepam)<br>KLONOPIN (clonazepam)<br>LIBERVANT BUCCAL FILM (diazepam)**<br>ONFI (clobazam)*<br>ONFI SUSPENSION (clobazam)*<br>SYMPAZAN (clobazam film)* | *Clobazam will be authorized as adjunctive therapy with any chronic anti-seizure medication, with the exception of other benzodiazepines. **NOTE:** generic clobazam is preferred over brand Onfi.<br><br>**Libervant requires review by the Medical Director and is available only on appeal. |
| **CANNABINOIDS** | | |
| EPIDIOLEX SOLUTION (cannabidiol)[AP]* | | *Epidiolex may be authorized after fourteen (14) day trials of two (2) of the following agents within the past twelve (12) months: clobazam, levetiracetam, valproate, lamotrigine, topiramate, rufinamide or felbamate. |
| **HYDANTOINS[AP]** | | |
| DILANTIN CAPSULES, CHEWABLE<br>TABLETS, SUSPENSION (phenytoin sodium extended)<br>PEGANONE (ethotoin)<br>phenytoin capsules, chewable tablets, suspension | PHENYTEK (phenytoin) | |
| **SUCCINIMIDES** | | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| CELONTIN (methsuximide)<br>ethosuximide capsules<br>ethosuximide syrup | ZARONTIN CAPSULES (ethosuximide)<br>ZARONTIN SYRUP (ethosuximide) | |
| **ANTIDEPRESSANTS, OTHER** | | |
| **CLASS PA CRITERIA:** See below for individual subclass criteria. | | |
| **MAOIs[AP]** | | |
| | MARPLAN (isocarboxazid)<br>NARDIL (phenelzine)<br>phenelzine<br>tranylcypromine | Patients stabilized on MAOI agents will be grandfathered. |
| **SNRIs[AP]** | | |
| desvenlafaxine succinate ER (generic PRISTIQ)<br>duloxetine capsules<br>venlafaxine ER capsules<br>venlafaxine IR tablets | CYMBALTA (duloxetine)<br>desvenlafaxine fumarate ER<br>EFFEXOR XR (venlafaxine)<br>FETZIMA (levomilnacipran)<br>PRISTIQ (desvenlafaxine)<br>venlafaxine ER tablets | Non-preferred agents require separate thirty (30) day trials of a preferred agent in this subclass **AND** an SSRI before they will be approved, unless one (1) of the exceptions on the PA form is present. |
| **SECOND GENERATION NON-SSRI, OTHER[AP]** | | |
| bupropion IR<br>bupropion SR<br>bupropion XL<br>mirtazapine<br>trazodone | APLENZIN (bupropion HBr)<br>AUVELITY (dextromethorphan HBr/bupropion)*<br>EMSAM (selegiline)<br>FORFIVO XL (bupropion)<br>nefazodone<br>REMERON (mirtazapine)<br>TRINTELLIX (vortioxetine)<br>VIIBRYD (vilazodone HCl)<br>vilazodone<br>WELLBUTRIN SR (bupropion)<br>WELLBUTRIN XL (bupropion) | Non-preferred agents require separate thirty (30) day trials of a preferred agent in this subclass **AND** an SSRI before they will be approved, unless one (1) of the exceptions on the PA form is present.<br><br>*Auvelity may be approved after the following has been met:<br>1. The diagnosis is Major depressive disorder; **AND**<br>2. Documentation is provided giving medical reasoning beyond convenience as to why the clinical need cannot be met with using a combination of the preferred individual components; **AND**<br>3. A trial of sixty (60) days resulting in an inadequate clinical response, with two (2) distinct classes used to treat major depressive disorder, with one (1) of the trials being bupropion. |
| **SELECTED TCAs** | | |
| imipramine HCl | imipramine pamoate | Non-preferred agents require a twelve (12) week trial of imipramine HCl before they will be approved, unless one (1) of the exceptions on the PA form is present. |
| **ANTIDEPRESSANTS, SSRIs[AP]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require thirty (30) day trials of at least two (2) preferred agents before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| Upon hospital discharge, patients admitted with a primary mental health diagnosis who have been stabilized on a non-preferred SSRI will receive an authorization to continue that drug. | | |
| citalopram<br>escitalopram tablets<br>fluoxetine capsules, solution<br>fluvoxamine<br>paroxetine<br>sertraline | CELEXA (citalopram)<br>citalopram capsules<br>escitalopram solution<br>fluoxetine tablets<br>fluoxetine DR capsules<br>fluvoxamine ER<br>LEXAPRO (escitalopram)<br>paroxetine 7.5 mg capsules<br>paroxetine ER<br>paroxetine suspension<br>PAXIL (paroxetine)<br>PAXIL CR (paroxetine)<br>PEXEVA (paroxetine)<br>PROZAC (fluoxetine)<br>SARAFEM (fluoxetine)<br>sertraline capsules<br>ZOLOFT (sertraline) | |
| **ANTIEMETICS**[AP] | | |
| **CLASS PA CRITERIA:** See below for subclass criteria. | | |
| **5HT3 RECEPTOR BLOCKERS** | | |
| granisetron tablets<br>ondansetron ODT, solution, tablets | ondansetron vials<br>SANCUSO (granisetron)<br>SUSTOL (granisetron)<br>ZOFRAN (ondansetron)<br>ZUPLENZ (ondansetron) | Non-preferred agents require a three (3) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. |
| **CANNABINOIDS** | | |
| | dronabinol*<br>MARINOL (dronabinol)* | *Dronabinol will only be authorized for:<br>1. The treatment of anorexia associated with weight loss in patients with AIDS or cancer and unresponsive to megestrol; **OR**<br>2. The prophylaxis of chemotherapy induced nausea and vomiting unresponsive to three (3) day trials of ondansetron or promethazine for patients who are eighteen (18) to sixty-five (65) years of age. |
| **SUBSTANCE P ANTAGONISTS** | | |
| aprepitant<br>EMEND 125 mg CAPSULES (aprepitant)<br>EMEND SUSPENSION (aprepitant) | EMEND 80 mg CAPSULES, DOSEPAK (aprepitant)<br>VARUBI (rolapitant) | Non-preferred agents require a three (3) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. |
| **COMBINATIONS** | | |
| doxylamine/pyridoxine (generic DICLEGIS) | AKYNZEO (netupitant/palonosetron)<br>BONJESTA (doxylamine/pyridoxine) | Non-preferred agents may only be approved after a trial and failure of a preferred agent unless one (1) of the exceptions |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | DICLEGIS (doxylamine/pyridoxine) | on the PA form is present. |
| **ANTIFUNGALS, ORAL** | | |
| **CLASS PA CRITERIA:** Non-preferred agents will only be authorized if one (1) of the exceptions on the PA form is present. | | |
| clotrimazole<br>fluconazole*<br>griseofulvin***<br>nystatin<br>terbinafine[CL/PA] | ANCOBON (flucytosine)<br>CRESEMBA (isavuconazonium )[CL/PA**]<br>BREXAFEMME (ibrexafungerp)<br>DIFLUCAN (fluconazole)<br>flucytosine<br>itraconazole<br>ketoconazole****<br>MYCELEX (clotrimazole)<br>NOXAFIL (posaconazole)<br>ORAVIG (miconazole)<br>posaconazole tablets<br>SPORANOX (itraconazole)<br>TOLSURA (itraconazole)<br>VFEND (voriconazole)<br>VIVJOA (oteseconazole)<br>voriconazole suspension<br>voriconazole tablets | *PA is required when limits are exceeded.<br><br>**Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.<br><br>***PA is not required for griseofulvin suspension for children up to eighteen (18) years of age for the treatment of tinea capitis.<br><br>****Ketoconazole will be authorized if the following criteria are met:<br>1. Diagnosis of one (1) of the following fungal infections: blastomycosis, coccidioidomycosis, histoplasmosis, chromomycosis, or paracoccidioidomycosis; **AND**<br>2. Documented failure or intolerance of all other diagnosis-appropriate antifungal therapies, i.e. itraconazole, fluconazole, flucytosine, etc.; **AND**<br>3. Baseline assessment of the liver status including alanine aminotransferase (ALT), aspartate aminotransferase (AST), total bilirubin, alkaline phosphatase, prothrombin time, and international normalized ratio (INR) before starting treatment; **AND**<br>4. Weekly monitoring of serum ALT for the duration of treatment (If ALT values increase to a level above the upper limit of normal or 30% above baseline, or if the patient develops symptoms of abnormal liver function, treatment should be interrupted, and a full set of liver tests be obtained. Liver tests should be repeated to ensure normalization of values.); **AND**<br>5. Assessment of all concomitant medications for potential adverse drug interactions with ketoconazole.<br>**Ketoconazole will not be authorized for treatment for fungal infections of the skin and nails.** |
| **ANTIFUNGALS, TOPICAL[AP]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require fourteen (14) day trials of two (2) preferred agents before they will be approved, unless one (1) of the exceptions on the PA form is present. If a non-preferred shampoo is requested, a fourteen (14) day trial of one (1) preferred product (i.e., ketoconazole shampoo) is required. | | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **ANTIFUNGALS** | | |
| econazole<br>ketoconazole cream, shampoo<br>miconazole (OTC)<br>nystatin | CICLODAN (ciclopirox)<br>ciclopirox<br>ERTACZO (sertaconazole)<br>EXELDERM (sulconazole)<br>EXTINA (ketoconazole)<br>GYNAZOLE 1 CREAM (butoconazole)<br>JUBLIA (efinaconazole)*<br>KERYDIN (tavaborole)<br>ketoconazole foam<br>KETODAN (ketoconazole)<br>LOPROX (ciclopirox)<br>luliconazole cream<br>LUZU (luliconazole)<br>miconazole/petrolatum/zinc oxide<br>naftifine cream<br>NAFTIN GEL (naftifine)<br>oxiconazole cream<br>OXISTAT (oxiconazole)**<br>sulconazole nitrate cream, solution<br>tavaborole 5% topical solution<br>VUSION (miconazole/petrolatum/zinc oxide) | *Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.<br><br>**Oxistat cream will be authorized for children up to thirteen (13) years of age for tinea corporis, tinea cruris, tinea pedis, and tinea (pityriasis) versicolor. |
| **ANTIFUNGAL/STEROID COMBINATIONS** | | |
| clotrimazole/betamethasone cream | clotrimazole/betamethasone lotion<br>nystatin/triamcinolone | |
| **ANTIHEMOPHILIA FACTOR AGENTS[CL/PA]** | | |
| **CLASS PA CRITERIA:** All agents will require prior authorization, and non-preferred agents require medical reasoning explaining why the need cannot be met using a preferred product.<br><br>All currently established regimens shall be grandfathered with documentation of adherence to therapy. | | |
| **FACTOR VIII** | | |
| AFSTYLA<br>ALPHANATE<br>HEMOFIL M<br>HUMATE-P<br>JIVI<br>KOATE<br>KOGENATE FS<br>KOVALTRY<br>NOVOEIGHT<br>NUWIQ<br>WILATE<br>XYNTHA<br>XYNTHA SOLOFUSE | ADVATE<br>ADYNOVATE<br>ALTUVIIIO<br>ELOCTATE<br>ESPEROCT<br>RECOMBINATE<br>VONVENDI | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **BYPASSING AGENTS** | | |
| | FEIBA<br>NOVOSEVEN<br>SEVENFACT | |
| **FACTOR IX** | | |
| ALPHANINE SD<br>ALPROLIX<br>BENEFIX<br>IXINITY<br>MONONINE<br>PROFILNINE<br>RIXUBIS | IDELVION<br>REBINYN | |
| **FACTOR IXa/IX** | | |
| HEMLIBRA (emicizumab-kxwh) | | |
| **NON-FACTOR REPLACEMENT** | | |
| | HYMPAVZI (marstacimab-hncq) | |
| **ANTIHYPERTENSIVES, SYMPATHOLYTICS** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require thirty (30) day trials of each preferred unique chemical entity in the corresponding formulation before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| clonidine patch<br>clonidine tablets | | |
| **ANTIHYPERURICEMICS** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a thirty (30) day trial of one (1) of the preferred agents for the prevention of gouty arthritis attacks (colchicine/probenecid, probenecid, or allopurinol) before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| **ANTIMITOTICS** | | |
| colchicine tablets | colchicine capsules<br>COLCRYS TABLETS (colchicine)<br>MITIGARE (colchicine)<br>GLOPERBA (colchicine)* | In the case of acute gouty attacks, a ten (10) day supply (twenty (20) units) of the preferred agent(s) in this subclass will be authorized per ninety (90) days.<br><br>*Gloperba may only be authorized for those who are unable to ingest solid dosage forms due to documented oral-motor difficulties or dysphagia. |
| **ANTIMITOTIC-URICOSURIC COMBINATION** | | |
| colchicine/probenecid | | |
| **URICOSURIC** | | |
| probenecid | | |
| **XANTHINE OXIDASE INHIBITORS** | | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| allopurinol<br>febuxostat tablets | ULORIC (febuxostat)<br>ZYLOPRIM (allopurinol) | |
| **ANTIMIGRAINE AGENTS, PROPHYLAXIS**[CL/PA] | | |
| **CLASS PA CRITERIA: All agents require a prior authorization.** Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. Non-preferred agents require a ninety (90) day trial of all preferred agents. | | |
| AIMOVIG (erenumab)<br>AJOVY (fremanezumab)<br>EMGALITY AUTO-INJECTOR, 120 mg SYRINGES (galcanezumab) | EMGALITY 300 mg SYRINGES (galcanezumab)*<br>NURTEC ODT (rimegepant)**<br>QULIPTA (atogepant) | *Emgality 300 mg/3 mL requires review by the Medical Director and is available only on appeal.<br><br>**Nurtec ODT for a diagnosis of **Migraine Prophylaxis**: Maximum Quantity limit of sixteen (16) tablets per thirty-two (32) days. |
| **ANTIMIGRAINE AGENTS, ACUTE**[AP] | | |
| **CLASS PA CRITERIA:** Non-preferred agents require three (3) day trials of each preferred unique chemical entity as well as a three (3) day trial using the same route of administration as the requested agent (if available), before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| | **TRIPTANS** | |
| IMITREX NASAL SPRAY (sumatriptan)<br>naratriptan<br>rizatriptan ODT<br>rizatriptan tablet<br>sumatriptan injection pens, vials<br>sumatriptan nasal spray<br>sumatriptan tablets<br>zolmitriptan tablets<br>zolmitriptan ODT | almotriptan<br>AMERGE (naratriptan)<br>eletriptan<br>FROVA (frovatriptan)<br>frovatriptan<br>MAXALT (rizatriptan)<br>MAXALT MLT (rizatriptan)<br>ONZETRA XSAIL (sumatriptan)*<br>RELPAX (eletriptan)<br>sumatriptan cartridges<br>TOSYMRA NASAL SPRAY (sumatriptan)*<br>ZEMBRACE SYMTOUCH (sumatriptan)<br>zolmitriptan nasal spray<br>ZOMIG (zolmitriptan)<br>ZOMIG ZMT (zolmitriptan) | ***In addition to the Class Criteria:** Onzetra Xsail and Tosymra require three (3) day trials of each preferred oral, nasal, and injectable forms of sumatriptan. |
| | **TRIPTAN COMBINATIONS** | |
| | sumatriptan/naproxen sodium<br>TREXIMET (sumatriptan/naproxen sodium) | |
| | **OTHER** | |
| NURTEC ODT (rimegepant)* | CAMBIA (diclofenac)<br>D.H.E 45 AMPULE (dihydroergotamine)**<br>dihydroergotamine injection, nasal spray**<br>ELYXYB (celecoxib)<br>MIGERGOT RECTAL SUPPOSITORY (ergotamine/caffeine)**<br>MIGRANAL SPRAY (dihydroergotamine)**<br>REYVOW (lasmiditan)*** | *Nurtec ODT For a diagnosis of **Migraine Treatment**: requires three (3) day trials of two (2) preferred chemically distinct triptans before it may be approved, unless one (1) of the exceptions on the PA form is present. Maximum Quantity limit of eight (8) tablets per thirty (30) days.<br><br>**All non-preferred Ergot Alkaloid agents require three (3) day trials of (2) preferred triptans as well as a three (3) day trial of |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | TRUDHESA SPRAY (dihydroergotamine)**<br>UBRELVY (ubrogepant)***<br>ZAVZPRET NASAL SPRAY (zavegepant)**** | a preferred triptan using the same route of administration as the requested agent (if available), before they will be approved, unless one (1) of the exceptions on the PA form is present. **NOTE: Ergot derivatives should not be used with or within twenty-four (24) hours of triptans.**<br><br>**<u>**Additional Ergot Alkaloid criteria:**</u><br>**<u>Nasal spray:</u>**<br>Dihydroergotamine nasal spray and Trudhesa spray may only be authorized after a trial and failure of Migranal spray.<br><br>**<u>Rectal suppository:</u>**<br>Migergot rectal suppository may only be authorized after a trial and failure of a preferred triptan nasal spray.<br><br>**<u>Injection:</u>**<br>Dihydroergotamine injection and D.H.E 45 ampule may only be approved for cluster headaches.<br><br>***Ubrelvy and Reyvow require three (3) day trials of two (2) preferred chemically distinct triptans as well as a three (3) day trial of Nurtec ODT before they may be approved, unless one (1) of the exceptions on the PA form is present.<br><br>****Zavzpret may be authorized after a trial and failure of a preferred CGRP agent used for acute treatment **AND** a trial and failure of two (2) chemically distinct preferred triptans, including sumatriptan nasal spray (unless contraindicated). |
| **ANTIPARASITICS, TOPICAL[AP]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require trials of each preferred agent (which are age and weight appropriate) before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| NATROBA (spinosad)<br>permethrin 5% cream<br>pyrethrins-piperonyl butoxide (OTC) | ELIMITE CREAM (permethrin)<br>EURAX (crotamiton)<br>ivermectin 0.5% lotion<br>LICE EGG REMOVER (OTC) (benzalkonium chloride)<br>lindane<br>malathion<br>OVIDE (malathion)<br>SKLICE (ivermectin)<br>spinosad<br>VANALICE (piperonyl/pyrethrum) | |
| **ANTIPARKINSON'S AGENTS** | | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **CLASS PA CRITERIA:** Patients starting therapy on drugs in this class must show a documented allergy to all preferred agents in the corresponding subclass before a non-preferred agent will be authorized. | | |
| **ANTICHOLINERGICS** | | |
| benztropine<br>trihexyphenidyl | | |
| **COMT INHIBITORS** | | |
| entacapone | COMTAN (entacapone)<br>ONGENTYS (opicapone)<br>TASMAR (tolcapone)<br>tolcapone | COMT Inhibitor agents will only be approved as add-on therapy to a levodopa-containing regimen for treatment of documented motor complications. |
| **DOPAMINE AGONISTS** | | |
| APOKYN PEN (apomorphine)<br>bromocriptine<br>pramipexole<br>ropinirole | apomorphine cartridge<br>KYNMOBI FILM (apomorphine)<br>MIRAPEX ER (pramipexole)*<br>NEUPRO (rotigotine)<br>pramipexole ER<br>ropinirole ER | *Mirapex ER will be authorized for a diagnosis of Parkinsonism without a trial of preferred agents. |
| **OTHER ANTIPARKINSON'S AGENTS** | | |
| amantadine[AP*]<br>carbidopa/levodopa<br>levodopa/carbidopa/entacapone<br>selegiline | AZILECT (rasagiline)<br>Carbidopa<br>CREXONT (carbidopa/levodopa)<br>GOCOVRI ER (amantadine)<br>INBRIJA (levodopa)<br>levodopa/carbidopa ODT<br>LODOSYN (carbidopa)<br>NOURIANZ (istradefylline)<br>OSMOLEX ER (amantadine)<br>PARLODEL (bromocriptine)<br>rasagiline<br>RYTARY (levodopa/carbidopa)<br>SINEMET (levodopa/carbidopa)<br>STALEVO (levodopa/carbidopa/entacapone)<br>XADAGO (safinamide)<br>ZELAPAR (selegiline) | *Amantadine will not be authorized for the treatment or prophylaxis of influenza. |
| **ANTIPSORIATICS, TOPICAL** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a thirty (30) day trial of a preferred agent. Documentation describing the reason for failure of the preferred agent must be provided. The required trial may be overridden when documented evidence is provided that the use of these preferred agent(s) would be medically contraindicated. | | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| calcipotriene solution<br>ENSTILAR (calcipotriene/betamethasone)<br>TACLONEX SUSPENSION (calcipotriene/ betamethasone) | calcipotriene cream<br>calcipotriene/betamethasone ointment, suspension<br>calcitriol<br>SORILUX (calcipotriene)<br>tazarotene cream<br>VTAMA (tapinarof)<br>ZORYVE 0.3% CREAM, FOAM (roflumilast) | |
| **ANTIPSYCHOTICS, ATYPICAL AND COMBINATION** | | |
| **CLASS PA CRITERIA: All antipsychotic agents require prior authorization for children up to eighteen (18) years of age. All PA requests for antipsychotics for children six (6) years of age and younger will be reviewed by Medicaid's consultant psychiatrist.**<br><br>Non-preferred agents require thirty (30) day trials of two (2) preferred Atypical Antipsychotics approved or medically accepted for the member's diagnosis or indication, including the generic formulation of the requested agent (if available), before they will be approved unless one (1) of the exceptions on the PA form is present. When determining requests for non-preferred products, any trial utilizing a preferred agent whose dose or duration was limited due to adverse effects or clear lack of efficacy will be considered complete only if the agent was being taken within the FDA-approved therapeutic range.*<br><br>Patients shall be grandfathered onto their existing therapy, provided the requested agent is being used according to the manufacturer label. Continuation of therapy for an off-label indication or non-standard dosage may be granted a thirty (30) day prior authorization while the Medical Director reviews the request.<br><br>*According to manufacturer dosing recommendations. | | |
| **SINGLE INGREDIENT** | | |
| ABILIFY ASIMTUFII (aripiprazole) CL/PA<br>ABILIFY MAINTENA (aripiprazole)CL/PA<br>aripiprazole tablets<br>ARISTADA (aripiprazole)CL/PA<br>ARISTADA INITIO (aripiprazole)CL/PA<br>asenapine sublingual tablets<br>clozapine<br>INVEGA HAFYERA (paliperidone)CL/PA*<br>INVEGA SUSTENNA (paliperidone)CL/PA<br>INVEGA TRINZA (paliperidone)CL/PA**<br>lurasidone<br>olanzapine<br>olanzapine ODT<br>paliperidone ER<br>PERSERIS (risperidone)CL/PA<br>quetiapineAP for the 25 mg Tablet Only***<br>quetiapine ER<br>RYKINDO (risperidone)<br>risperidone ODT, solution, tablets<br>VRAYLAR (cariprazine)******<br>ziprasidone | ABILIFY MYCITE (aripiprazole)<br>ABILIFY TABLETS (aripiprazole)<br>ADASUVE (loxapine)<br>aripiprazole ODT<br>aripiprazole solution<br>CAPLYTA (lumateperone)<br>clozapine ODT<br>CLOZARIL (clozapine)<br>COBENFY (xanomeline/trospium)<br>ERZOFRI (paliperidone)<br>FANAPT (iloperidone)<br>GEODON (ziprasidone)<br>GEODON IM (ziprasidone)<br>INVEGA ER (paliperidone)<br>LATUDA (lurasidone)<br>LYBALVI (olanzapine/samidorphan)****<br>NUPLAZID (pimavanserin)*****<br>olanzapine IMCL/PA<br>olanzapine/fluoxetine<br>REXULTI (brexpiprazole)<br>RISPERDAL (risperidone)<br>RISPERDAL CONSTA (risperidone)CL/PA | **The following criteria exceptions apply to the specified products:**<br><br>*Invega Hafyera may only be authorized after four (4) months treatment with Invega Sustenna or at least a one (1) three (3) month cycle with Invega Trinza.<br><br>**Invega Trinza will be authorized after four (4) months treatment with Invega Sustenna<br><br>***Quetiapine 25 mg will be authorized:<br>1. For a diagnosis of schizophrenia; **OR**<br>2. For a diagnosis of bipolar disorder; **OR**<br>3. When prescribed concurrently with other strengths of Seroquel in order to achieve therapeutic treatment levels.<br>**Quetiapine 25 mg will not be authorized for use as a sedative hypnotic.**<br><br>****Patient must have had a positive response with olanzapine and experienced clinically significant weight gain (documentation must be provided) which necessitated |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | SAPHRIS (asenapine)<br>SECUADO (asenapine)<br>SEROQUEL (quetiapine)<br>SEROQUEL XR (quetiapine)<br>UZEDY (risperidone)<br>VERSACLOZ (clozapine)<br>ZYPREXA (olanzapine)<br>ZYPREXA IM (olanzapine)CL/PA<br>ZYPREXA RELPREVV (olanzapine) | disruption of treatment. Patient must also have had an intolerance, inadequate treatment response or contraindication to two (2) preferred antipsychotics, which have a lower potential of weight gain, prior to Lybalvi approval***. Prior to initiating Lybalvi, there should be at least a seven (7) day opioid-free interval from the last use of short-acting opioids, and at least a fourteen (14) day opioid free interval from the last use of long-acting opioids to avoid precipitation of opioid withdrawal.***<br><br>*****Nuplazid may only be authorized for the treatment of Parkinson Disease Induced Psychosis after documented treatment failure with quetiapine.<br><br>******Vraylar may be authorized for the indication of major depressive disorder only after a thirty (30) day trial and failure of two (2) preferred antidepressants. For all other indications, a thirty (30) day trial and failure of one (1) preferred antipsychotic is required. |
| **ANTIRETROVIRALSAP** | | |
| **CLASS PA CRITERIA:** Non-preferred drugs require medical reasoning beyond convenience or enhanced compliance as to why the clinical need cannot be met with a preferred agent or combination of preferred agents. **NOTE**: Regimens consisting of preferred agents will result in no more than one (1) additional unit per day over equivalent regimens composed of non-preferred agents. Patients already on a non-preferred regimen shall be grandfathered. | | |
| **SINGLE TABLET REGIMENS** | | |
| BIKTARVY (bictegravir/emtricitabine/tenofovir alafenamide)<br>COMPLERA (emtricitabine/rilpivirine/tenofovir disoproxil fumarate)<br>DELSTRIGO (doravirine/lamivudine/tenofovir disoproxil fumarate)<br>DOVATO (dolutegravir/lamivudine)<br>efavirenz/emtricitabine/tenofovir disoproxil fumarate<br>GENVOYA (elvitegravir/cobicistat/ emtricitabine/tenofovir alafenamide)<br>ODEFSEY (emtricitabine/rilpivirine/tenofovir alafenamide)<br>TRIUMEQ (abacavir/dolutegravir/lamivudine) | ATRIPLA (efavirenz/emtricitabine/tenofovir disoproxil fumarate)<br>efavirenz/lamivudine/tenofovir disoproxil fumarate<br>JULUCA (dolutegravir/rilpivirine)<br>SYMFI (efavirenz/lamivudine/tenofovir disoproxil fumarate)<br>SYMFI LO (efavirenz/lamivudine/tenofovir disoproxil fumarate)<br>STRIBILD (elvitegravir/cobicistat/emtricitabine/ tenofovir disoproxil fumarate)*<br>SYMTUZA (darunavir/cobicistat/emtricitabine/ tenofovir alafenamide)<br>TRIUMEQ PD (abacavir/dolutegravir/lamivudine) | *Stribild requires medical reasoning beyond convenience or enhanced compliance as to why the medical need cannot be met with the preferred agent Genvoya. |
| **INTEGRASE STRAND TRANSFER INHIBITORS** | | |
| ISENTRESS (raltegravir potassium)<br>TIVICAY (dolutegravir sodium)<br>TIVICAY PD (dolutegravir sodium) | ISENTRESS HD (raltegravir potassium) | |
| **NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTI)** | | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| abacavir sulfate tablets<br>EMTRIVA (emtricitabine)<br>EPIVIR SOLUTION (lamivudine)<br>lamivudine<br>tenofovir disoproxil fumarate<br>VIREAD ORAL POWDER (tenofovir disoproxil fumarate)<br>ZIAGEN SOLUTION (abacavir sulfate)<br>zidovudine | abacavir sulfate solution<br>didanosine DR capsules<br>emtricitabine capsules<br>EPIVIR TABLETS (lamivudine)<br>RETROVIR (zidovudine)<br>stavudine<br>VIDEX EC (didanosine)<br>VIDEX SOLUTION (didanosine)<br>VIREAD TABLETS (tenofovir disoproxil fumarate)<br>ZIAGEN TABLETS (abacavir sulfate) | |
| **NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITOR (NNRTI)** | | |
| efavirenz | EDURANT (rilpivirine)<br>etravirine<br>INTELENCE (etravirine)<br>nevirapine<br>nevirapine ER<br>PIFELTRO (doravirine)<br>SUSTIVA (efavirenz)<br>VIRAMUNE ER 24H (nevirapine)<br>VIRAMUNE SUSPENSION (nevirapine) | |
| **PHARMACOENHANCER – CYTOCHROME P450 INHIBITOR** | | |
| TYBOST (cobicistat) | | |
| **PROTEASE INHIBITORS (PEPTIDIC)** | | |
| atazanavir<br>EVOTAZ (atazanavir/cobicistat)<br>REYATAZ POWDER PACK (atazanavir)<br>ritonavir tablets | fosamprenavir<br>LEXIVA (fosamprenavir)<br>NORVIR (ritonavir)<br>REYATAZ CAPSULES (atazanavir)<br>VIRACEPT (nelfinavir mesylate) | Norvir powder pack may be authorized for those who are unable to ingest solid dosage forms due to documented oral motor difficulties or dysphagia. |
| **PROTEASE INHIBITORS (NON-PEPTIDIC)** | | |
| darunavir<br>PREZCOBIX (darunavir/cobicistat) | APTIVUS (tipranavir)<br>PREZISTA (darunavir) | |
| **ENTRY INHIBITORS – CCR5 CO-RECEPTOR ANTAGONISTS** | | |
| | maraviroc<br>SELZENTRY (maraviroc) | |
| **ENTRY INHIBITORS – FUSION INHIBITORS** | | |
| | FUZEON (enfuvirtide)* | *Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. |
| **COMBINATION PRODUCTS – NRTIs** | | |
| abacavir/lamivudine<br>lamivudine/zidovudine | abacavir/lamivudine/zidovudine<br>CIMDUO (lamivudine/tenofovir disoproxil fumarate)<br>COMBIVIR (lamivudine/zidovudine) | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | EPZICOM (abacavir/lamivudine)<br>TEMIXYS (lamivudine/tenofovir disoproxil fumarate)<br>TRIZIVIR (abacavir/lamivudine/zidovudine) | |
| **COMBINATION PRODUCTS – NUCLEOSIDE & NUCLEOTIDE ANALOG RTIs** | | |
| DESCOVY (emtricitabine/tenofovir alafenamide)<br>emtricitabine/tenofovir alafenamide | TRUVADA (emtricitabine/tenofovir alafenamide) | |
| **COMBINATION PRODUCTS – PROTEASE INHIBITORS** | | |
| lopinavir/ritonavir | KALETRA (lopinavir/ritonavir) | |
| **PRODUCTS FOR PRE-EXPOSURE PROPHYLAXIS (PrEP)** | | |
| APRETUDE (cabotegravir)<br>DESCOVY (emtricitabine/tenofovir alafenamide)<br>emtricitabine/tenofovir alafenamide | TRUVADA (emtricitabine/tenofovir alafenamide) | |
| **ANTIVIRALS, ORAL** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require five (5) day trials of each preferred agent in the same subclass before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| **ANTI HERPES** | | |
| acyclovir<br>valacyclovir | famciclovir<br>SITAVIG (acyclovir)<br>VALTREX (valacyclovir)<br>ZOVIRAX (acyclovir) | |
| **ANTI-INFLUENZA** | | |
| oseltamivir | FLUMADINE (rimantadine)<br>RELENZA (zanamivir)<br>rimantadine<br>TAMIFLU (oseltamivir)<br>XOFLUZA (baloxavir) | **In addition to the Class Criteria**: The anti-influenza agents will be authorized only for a diagnosis of influenza. |
| **ANTIVIRALS, TOPICAL[AP]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a five (5) day trial of the preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| acyclovir ointment<br>ZOVIRAX CREAM (acyclovir)<br>DENAVIR (penciclovir) | acyclovir cream<br>docosanol cream<br>penciclovir cream<br>ZOVIRAX OINTMENT (acyclovir) | |
| **BETA BLOCKERS[AP]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require fourteen (14) day trials of three (3) chemically distinct preferred agents, including the generic formulation of the requested non-preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **BETA BLOCKERS** | | |
| acebutolol<br>atenolol<br>betaxolol<br>bisoprolol<br>HEMANGEOL (propranolol)*<br>metoprolol<br>metoprolol ER<br>nadolol<br>nebivolol<br>pindolol<br>propranolol<br>propranolol ER<br>SORINE (sotalol)<br>sotalol<br>timolol | BETAPACE (sotalol)<br>BYSTOLIC (nebivolol)<br>CORGARD (nadolol)<br>INDERAL LA (propranolol)<br>INDERAL XL (propranolol)<br>INNOPRAN XL (propranolol)<br>KAPSPARGO SPRINKLE (metoprolol)<br>LOPRESSOR (metoprolol)<br>TENORMIN (atenolol)<br>TOPROL XL (metoprolol) | *Hemangeol will be authorized for the treatment of proliferating infantile hemangioma requiring systemic therapy. |
| **BETA BLOCKER/DIURETIC COMBINATION DRUGS** | | |
| atenolol/chlorthalidone<br>bisoprolol/HCTZ<br>metoprolol/HCTZ<br>propranolol/HCTZ | nadolol/bendroflumethiazide<br>TENORETIC (atenolol/chlorthalidone)<br>ZIAC (bisoprolol/HCTZ) | |
| **BETA- AND ALPHA-BLOCKERS** | | |
| carvedilol<br>labetalol | carvedilol ER capsules<br>COREG (carvedilol)<br>COREG CR (carvedilol) | |
| **BLADDER RELAXANT PREPARATIONS[AP]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require thirty (30) day trials of each chemically distinct preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present | | |
| DETROL LA (tolterodine)<br>fesoterodine ER<br>GELNIQUE (oxybutynin)<br>MYRBETRIQ TABLETS (mirabegron)<br>oxybutynin IR<br>oxybutynin ER<br>OXYTROL (oxybutynin)<br>solifenacin | darifenacin ER tablets<br>DETROL (tolterodine)<br>DITROPAN XL (oxybutynin)<br>ENABLEX (darifenacin)<br>flavoxate<br>GEMTESA (vibegron)<br>mirabegron ER<br>MYRBETRIQ SUSPENSION (mirabegron)<br>tolterodine<br>tolterodine ER<br>TOVIAZ (fesoterodine)<br>trospium<br>trospium ER<br>VESICARE (solifenacin)<br>VESICARE LS (solifenacin) | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **BONE RESORPTION SUPPRESSION AND RELATED AGENTS** | | |
| **CLASS PA CRITERIA:** See below for class criteria. | | |
| **BISPHOSPHONATES** | | |
| alendronate tablets<br>ibandronate | ACTONEL (risedronate)<br>alendronate solution<br>ATELVIA (risedronate)<br>BINOSTO (alendronate)<br>BONIVA (ibandronate)<br>FOSAMAX TABLETS (alendronate)<br>FOSAMAX PLUS D (alendronate/vitamin D)<br>risedronate | Non-preferred agents require thirty (30) day trials of **each** preferred Bisphosphonate agent before they will be approved, unless one (1) of the exceptions on the PA form is present. |
| **OTHER BONE RESORPTION SUPPRESSION AND RELATED AGENTS** | | |
| | calcitonin<br>EVISTA (raloxifene)*<br>FORTEO (teriparatide)<br>MIACALCIN (calcitonin)<br>raloxifene*<br>teriparatide<br>TYMLOS (abaloparatide) | Non-preferred agents require a thirty (30) day trial of a preferred Bisphosphonate agent before they will be approved, unless one (1) of the exceptions on the PA form is present.<br><br>*Raloxifene will be authorized for postmenopausal women with osteoporosis who are at high risk for invasive breast cancer. |
| **BPH TREATMENTS** | | |
| **CLASS PA CRITERIA:** See below for individual subclass criteria. | | |
| **5-ALPHA-REDUCTASE (5AR) INHIBITORS AND PDE-5 AGENTS** | | |
| finasteride | AVODART (dutasteride)<br>CIALIS 5 mg (tadalafil)<br>dutasteride<br>ENTADFI CAPSULES (finasteride/tadalafil)*<br>PROSCAR (finasteride)<br>tadalafil | Non-preferred 5-ALPHA-REDUCTASE (5AR) agents require a thirty (30) day trial of finasteride before they will be approved, unless one (1) of the exceptions on the PA form is present.<br><br>Non-preferred PDE-5 agents require thirty (30) day trials of finasteride **AND** a preferred alpha blocker before they will be approved, unless one (1) of the exceptions on the PA form is present.<br><br>*Documentation of medical reasoning beyond convenience must be provided as to why the clinical need cannot be met with finasteride used in combination with tadalafil. |
| **ALPHA BLOCKERS** | | |
| alfuzosin<br>doxazosin<br>tamsulosin<br>terazosin | CARDURA (doxazosin)<br>CARDURA XL (doxazosin)<br>FLOMAX (tamsulosin)<br>RAPAFLO (silodosin)<br>silodosin | Non-preferred alpha blockers require thirty (30) day trials of at least two (2) preferred agents in this subclass, including the generic formulation of the requested non-preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. |
| **5-ALPHA-REDUCTASE (5AR) INHIBITORS/ALPHA BLOCKER COMBINATION** | | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | dutasteride/tamsulosin<br>JALYN (dutasteride/tamsulosin) | **Substitute for Class Criteria:** Concurrent thirty (30) day trials of dutasteride and tamsulosin are required before the non-preferred agent will be authorized. |
| **BRONCHODILATORS, BETA AGONIST[AP]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require thirty (30) day trials of each chemically distinct preferred agent in their corresponding subclass unless one (1) of the exceptions on the PA form is present. | | |
| **INHALATION SOLUTION** | | |
| albuterol | arformoterol<br>BROVANA (arformoterol)<br>formoterol<br>levalbuterol<br>metaproterenol<br>PERFOROMIST (formoterol)<br>XOPENEX (levalbuterol)* | *Xopenex Inhalation Solution will be authorized for twelve (12) months for a diagnosis of asthma or COPD for patients on concurrent asthma controller therapy (either oral or inhaled) with documentation of failure on a trial of albuterol or documented intolerance of albuterol, or for concurrent diagnosis of heart disease. |
| **INHALERS, LONG-ACTING** | | |
| SEREVENT (salmeterol) | STRIVERDI RESPIMAT (olodaterol) | |
| **INHALERS, SHORT-ACTING** | | |
| albuterol HFA<br>PROAIR HFA (albuterol)<br>PROAIR RESPICLICK (albuterol)<br>PROVENTIL HFA (albuterol)<br>VENTOLIN HFA (albuterol) | PROAIR DIGIHALER (albuterol)<br>XOPENEX HFA (levalbuterol) | *Airsupra can be found in Glucocorticoids, Inhaled section of PDL. |
| **ORAL** | | |
| albuterol syrup | albuterol ER<br>albuterol IR<br>metaproterenol<br>terbutaline | |
| **CALCIUM CHANNEL BLOCKERS[AP]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require fourteen (14) day trials of each preferred agent within the corresponding subclass before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| **LONG-ACTING** | | |
| amlodipine<br>diltiazem ER/CD<br>felodipine ER<br>nifedipine ER<br>verapamil ER | CALAN SR (verapamil)<br>CARDIZEM CD, LA (diltiazem)<br>DILT-XR<br>diltiazem LA<br>KATERZIA SUSPENSION (amlodipine)*<br>levamlodipine maleate<br>MATZIM LA (diltiazem)<br>nisoldipine<br>NORLIQVA (amlodipine)*<br>NORVASC (amlodipine)<br>PROCARDIA XL (nifedipine) | *Katerzia and Norliqva may be authorized for children who are six (6) to ten (10) years of age who are unable to ingest solid dosage forms.<br>Therapy may be authorized for older patients with clinical documentation indicating oral-motor difficulties or dysphagia. In addition, Norliqva may only be authorized for patients who have a documented allergy or are unable to tolerate Katerzia. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | SULAR (nisoldipine)<br>TIAZAC (diltiazem)<br>verapamil ER PM<br>VERELAN/VERELAN PM (verapamil) | |
| **SHORT-ACTING** | | |
| diltiazem<br>verapamil | CARDIZEM (diltiazem)<br>isradipine<br>nicardipine<br>nifedipine<br>nimodipine<br>NYMALIZE SOLUTION (nimodipine)<br>PROCARDIA (nifedipine) | |
| **CEPHALOSPORINS AND RELATED ANTIBIOTICS** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a five (5) day trial of a preferred agent within the corresponding subclass before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| **BETA LACTAMS AND BETA LACTAM/BETA-LACTAMASE INHIBITOR COMBINATIONS** | | |
| amoxicillin/clavulanate IR | amoxicillin/clavulanate ER<br>AUGMENTIN (amoxicillin/clavulanate) | |
| **CEPHALOSPORINS** | | |
| cefaclor capsules<br>cefadroxil tablets<br>cefdinir<br>cefuroxime tablets<br>cephalexin capsules, suspension | cefaclor suspension<br>cefaclor ER tablets<br>cefadroxil capsules<br>cefadroxil suspension<br>cefixime<br>cefpodoxime<br>cefprozil<br>cefuroxime suspension<br>cephalexin tablets<br>KEFLEX (cephalexin)<br>SUPRAX (cefixime) | |
| **COPD AGENTS** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a sixty (60) day trial of one preferred agent from the corresponding subclass before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| **ANTICHOLINERGIC[AP]** | | |
| ATROVENT HFA (ipratropium)<br>INCRUSE ELLIPTA (umeclidinium)<br>ipratropium nebulizer solution<br>SPIRIVA (tiotropium)<br>SPIRIVA RESPIMAT (tiotropium) | LONHALA MAGNAIR (glycopyrrolate)<br>TUDORZA (aclidinium)<br>YUPELRI SOLUTION (revefenacin) | |
| **ANTICHOLINERGIC-BETA AGONIST COMBINATIONS[AP]** | | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| albuterol/ipratropium nebulizer solution<br>ANORO ELLIPTA (umeclidinium/vilanterol)<br>COMBIVENT RESPIMAT (albuterol/ipratropium)<br>STIOLTO RESPIMAT (tiotropium/olodaterol) | BEVESPI (glycopyrrolate/formoterol)<br>DUAKLIR PRESSAIR (aclidinium/formoterol)* | ***In addition to the Class PA Criteria:** Duaklir Pressair requires sixty (60) day trials of each long-acting preferred agent, as well as a sixty (60) day trial of Stiolto Respimat. |
| **ANTICHOLINERGIC-BETA AGONIST-GLUCOCORTICOID COMBINATIONS** | | |
| | BREZTRI AEROSPHERE (budesonide/ glycopyrrolate/formoterol)**<br>TRELEGY ELLIPTA (fluticasone/umeclidinium/ vilanterol)* | *Trelegy Ellipta may be prior authorized for patients currently established on the individual components for at least thirty (30) days.<br><br>**Breztri may be prior authorized for patients currently established on the individual components for at least thirty (30) days. |
| **PHOSPHODIESTERASE INHIBITORS** | | |
| | DALIRESP (roflumilast)<br>OHTUVAYRE (ensifentrine)*<br>roflumilast | *Ohtuvayre is being used for the maintenance treatment of patients with moderate to severe COPD **AND** the patient has had a documented side effect, allergy, treatment failure, or a contraindication to maximally tolerated dual therapy with at least one (1) inhaled long-acting muscarinic antagonist (LAMA) **AND** at least one (1) inhaled long-acting beta-agonist (LABA) **OR** maximally tolerated triple therapy with at least one (1) inhaled LAMA + LABA **AND** at least one (1) inhaled corticosteroid (when blood eosinophils greater than or equal to (≥) 300 cells/microL). |
| **CROHNS DISEASE ORAL STEROIDS** | | |
| **ORAL** | | |
| budesonide ER capsules (generic ENTOCORT EC) | ENTOCORT EC (budesonide)*<br>ORTIKOS (budesonide)* | *Please see the following PDL classes for PDL status of additional agents used for induction and remission (Cytokine and CAM Antagonists/Immunosuppressives, Oral/Ulcerative Colitis Agents).<br><br>*Entocort EC and Ortikos may only be authorized if the patient has a documented allergy, or intolerance, to the generic budesonide 3 mg twenty-four (24) hour capsules. |
| **CYTOKINE & CAM ANTAGONISTS**[CL/PA] | | |
| **CLASS PA CRITERIA:** Non-preferred agents require ninety (90) day trials of all preferred agents which are indicated for the diagnosis, unless one (1) of the exceptions on the PA form is present. *Patients stabilized for at least six (6) months on their existing non-preferred regimen shall be grandfathered (provided the current therapy is for a labeled indication AND a more cost-effective biosimilar product is not available). In cases where a biosimilar exists but is also non-preferred, the PA vendor shall advise the provider which product is the most cost-effective agent. All off-label requests require review by the Medical Director.* **Full PA criteria may be found on the** PA Criteria **page by clicking the link.** | | |
| **ANTI-TNFs** | | |
| AVSOLA (infliximab-axxq)<br>ENBREL (etanercept)<br>HUMIRA (adalimumab) | ABRILADA (adalimumab-afzb)<br>adalimumab-aacf<br>adalimumab-aaty | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| infliximab<br>SIMPONI SUBCUTANEOUS (golimumab) | adalimumab-adbm<br>adalimumab-adaz<br>adalimumab-fkjp<br>AMJEVITA (adalimumab-atto)<br>CIMZIA (certolizumab pegol)<br>CYLTEZO (adalimumab-adbm)<br>HADLIMA (adalimumab-bwwd)<br>HULIO (adalimumab-fkjp)<br>HYRIMOZ (adalimumab-adaz)<br>IDACIO (adalimumab-aacf)<br>INFLECTRA (infliximab-dyyb)<br>REMICADE (infliximab)<br>RENFLEXIS (infliximab-abda)<br>SIMLANDI (adalimumab-ryvk)<br>SIMPONI ARIA (golimumab)<br>YUFLYMA (adalimumab-aaty)<br>YUSIMRY (adalimumab-aqvh)<br>ZYMFENTRA (infliximab-dyyb) | |
| **OTHERS** | | |
| KINERET (anakinra)<br>ORENCIA CLICKJECT, VIAL (abatacept)<br>OTEZLA (apremilast)<br>TALTZ (ixekizumab)*<br>TYENNE (tocilizumab-aazg)<br>XELJANZ (tofacitinib) | ACTEMRA ACTPEN (tocilizumab)<br>ACTEMRA SUBCUTANEOUS (tocilizumab)<br>BIMZELX (bimekizumab-bkzx)<br>COSENTYX (secukinumab)<br>ENTYVIO (vedolizumab)<br>ILARIS (canakinumab)<br>ILUMYA (tildrakizumab)<br>KEVZARA (sarilumab)<br>OLUMIANT (baricitinib)<br>OMVOH (mirikizumab-mrkz)<br>ORENCIA SYRINGE (abatacept)<br>RINVOQ ER (upadacitinib)**<br>SILIQ (brodalumab)<br>SKYRIZI (risankizumab-rzaa)<br>SOTYKTU (deucravacitinib)<br>STELARA SUBCUTANEOUS (ustekinumab)<br>TOFIDENCE (tocilizumab-bavi)<br>TREMFYA (guselkumab)<br>VELSIPITY (etrasimod)<br>XELJANZ XR (tofacitinib) | *Taltz will be authorized for treatment of plaque psoriasis, psoriatic arthritis, and ankylosing spondylitis only after inadequate response to a ninety (90) day trial of one (1) preferred Anti-TNF gent.<br><br>**Full criteria for Rinvoq ER may be found on the PA Criteria page by clicking the hyperlink. |
| **DIABETES AGENTS, BIGUANIDES** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a ninety (90) day trial of a preferred agent of similar duration before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| metformin<br>metformin ER (generic GLUCOPHAGE XR) | FORTAMET (metformin ER)<br>GLUCOPHAGE XR (metformin ER) | *Glumetza will be approved only after a thirty (30) day trial of Fortamet. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | GLUMETZA (metformin ER)*<br>metformin solution (generic RIOMET)<br>metformin ER (generic GLUMETZA and FORTAMET)<br>RIOMET (metformin) | |
| **DIABETES AGENTS, DPP-4 INHIBITORS** | | |
| **CLASS PA CRITERIA:** Non-preferred agents are available only on appeal. **NOTE:** DPP-4 inhibitors will NOT be approved in combination with a GLP-1 agonist. | | |
| JANUMET (sitagliptin/metformin)<br>JANUMET XR (sitagliptin/metformin)<br>JANUVIA (sitagliptin)<br>JENTADUETO (linagliptin/metformin)<br>TRADJENTA (linagliptin) | alogliptin<br>alogliptin/metformin<br>alogliptin/pioglitazone<br>JENTADUETO XR (linagliptin/metformin)<br>KAZANO (alogliptin/metformin)<br>KOMBIGLYZE XR (saxagliptin/metformin)<br>NESINA (alogliptin)<br>ONGLYZA (saxagliptin)<br>OSENI (alogliptin/pioglitazone)<br>sitagliptin<br>sitagliptin/metformin<br>ZITUVIO (sitagliptin)<br>ZITUVIMET (sitagliptin/metformin)<br>ZITUVIMET XR (sitagliptin/metformin) | |
| **DIABETES AGENTS, GLP-1 AGONISTS[CL/PA]** | | |
| **Preferred agents may be authorized with a diagnosis of Diabetes Mellitus Type II.**<br><br>**CLASS PA CRITERIA:** Non-preferred agents will only be approved (in six (6) month intervals) if ALL of the following criteria has been met:<br>1) Diagnosis of Diabetes Mellitus Type II.<br>2) Current A1C must be submitted. Agents in this class will not be approved for patients with a starting A1C of less than (<) 7%.<br>3) Documentation demonstrating ninety (90) days of compliance on all current diabetic therapies is provided.<br>4) Documentation demonstrating treatment failure with all unique preferred agents in the same class.<br><br>Re-authorizations will require documentation of continued compliance on all diabetic therapies and A1c levels must reach goal (either an A1c of less than or equal to (≤) 8% or demonstrated continued improvement).<br><br>**NOTE: GLP-1 agents will NOT be approved in combination with a DPP-4 inhibitor.** | | |
| OZEMPIC (semaglutide)<br>TRULICITY (dulaglutide)<br>VICTOZA (liraglutide) | ADLYXIN (lixisenatide)<br>BYDUREON BCISE (exenatide)<br>BYETTA (exenatide)<br>liraglutide<br>MOUNJARO (tirzepatide)<br>RYBELSUS (semaglutide) | |
| **DIABETES AGENTS, INSULIN AND RELATED AGENTS** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a ninety (90) day trial of a pharmacokinetically similar agent before they will be approved, unless one (1) of the exceptions exceptions on the PA form is present. | | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| APIDRA (insulin glulisine)<br>HUMALOG (insulin lispro)<br>HUMALOG JR KWIKPEN (insulin lispro)<br>HUMALOG KWIKPEN U-100 (insulin lispro)<br>HUMALOG MIX PENS (insulin lispro/lispro protamine)<br>HUMALOG MIX VIALS (insulin lispro/lispro protamine)<br>HUMULIN 70/30 (insulin)<br>HUMULIN R U-500 VIALS (insulin)<br>HUMULIN R U-500 KWIKPEN (insulin)<br>insulin aspart flexpen, penfill, vials<br>insulin aspart/aspart protamine pens, vials<br>insulin glargine (labeler 00955 only)<br>insulin lispro kwikpen U-100, vials<br>LANTUS (insulin glargine)<br>NOVOLOG (insulin aspart)<br>NOVOLOG MIX (insulin aspart/aspart protamine)<br>NOVOLIN N (insulin)<br>TOUJEO SOLOSTAR (insulin glargine)<br>TOUJEO MAX SOLOSTAR (insulin glargine) | ADMELOG (insulin lispro)<br>AFREZZA (insulin)[CL/PA]<br>BASAGLAR (insulin glargine)<br>FIASP (insulin aspart)<br>HUMALOG U-200 KWIKPEN (insulin lispro)<br>HUMULIN PENS (insulin)<br>HUMULIN R VIAL (insulin)<br>HUMULIN N VIAL (insulin)<br>insulin glargine<br>insulin lispro junior kwikpen<br>insulin lispro protamine mix<br>LYUMJEV (insulin lispro)<br>NOVOLIN (insulin)<br>REZVOGLAR (insulin glargine-aglr)<br>SEMGLEE (insulin glargine)<br>SOLIQUA (insulin glargine/lixisenatide)*<br>TRESIBA (insulin degludec)**<br>TRESIBA FLEXTOUCH (insulin degludec)**<br>XULTOPHY (insulin degludec/liraglutide)* | *Non-preferred insulin combination products require that the patient must already be established on the individual agents at doses not exceeding the maximum dose achievable with the combination product and require medical reasoning beyond convenience or enhanced compliance as to why the clinical need cannot be met with a combination of preferred single-ingredient agents.<br><br>**Patients stabilized on Tresiba may be grandfathered at the request of the prescriber if the prescriber considers the preferred products to be clinically inappropriate.<br><br>**Tresiba U-100 may be approved only for: Patients who have demonstrated at least a six (6) month history of compliance on a preferred long-acting insulin and who continue to have regular incidents of hypoglycemia.<br><br>**Tresiba U-200 may be approved only for: Patients who require once daily doses of at least sixty (60) units of long-acting insulin and have demonstrated at least a six (6) month history of compliance on preferred long-acting insulin and who continue to have regular incidents of hypoglycemia. |
| **DIABETES AGENTS, MEGLITINIDES** | | |
| **CLASS PA CRITERIA:** Non-preferred agents are available only on appeal. | | |
| **MEGLITINIDES** | | |
| nateglinide<br>repaglinide | PRANDIN (repaglinide)<br>STARLIX (nateglinide) | |
| **MEGLITINIDE COMBINATIONS** | | |
| | repaglinide/metformin | |
| **DIABETES AGENTS, MISCELLANEOUS AGENTS** | | |
| **CLASS PA CRITERIA:** Welchol will be authorized for add-on therapy for Diabetes Mellitus Type II when there is a previous history of a thirty (30) day trial of an oral diabetic agent. | | |
| colesevelam | SYMLIN (pramlintide)*<br>WELCHOL (colesevelam)[AP] | *Symlin will be authorized with a history of bolus insulin utilization in the past ninety (90) days with no gaps in insulin therapy greater than (>) thirty (30) days. |
| **DIABETES AGENTS, SGLT2 INHIBITORS** | | |
| **CLASS PA CRITERIA:** Non-preferred agents will only be approved (in six (6) month intervals) if ALL of the following criteria have been met:<br>1) Current A1C must be submitted. Agents in this class will not be approved for patients with a starting A1C of less than (<) 7%.<br>2) Documentation demonstrating ninety (90) days of compliance on all current diabetic therapies is provided.<br>3) Documentation demonstrating treatment failure with all unique preferred agents in the same class. | | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| Re-authorizations will require documentation of continued compliance on all diabetic therapies and A1c levels must reach goal (either an A1c of less than or equal to (≤) 8% or demonstrated continued improvement).<br><br>**For all other FDA approved indications:** A thirty (30) day trial and failure of each preferred SGLT2 is required. | | |
| **SGLT2 INHIBITORS** | | |
| FARXIGA (dapagliflozin)<br>JARDIANCE (empagliflozin) | dapagliflozin<br>INVOKANA (canagliflozin)<br>STEGLATRO (ertugliflozin) | |
| **SGLT2 COMBINATIONS** | | |
| SYNJARDY (empagliflozin/metformin)<br>XIGDUO XR (dapagliflozin/metformin) | dapagliflozin/metformin<br>GLYXAMBI (empagliflozin/linagliptin)<br>INVOKAMET (canagliflozin/metformin)<br>INVOKAMET XR (canagliflozin/metformin)<br>QTERN (dapagliflozin/saxagliptin)<br>SEGLUROMET (ertugliflozin/metformin<br>STEGLUJAN (ertugliflozin/sitagliptin)<br>SYNJARDY XR (empagliflozin/metformin)<br>TRIJARDY XR (empagliflozin/linagliptin/ metformin) | |
| **DIABETES AGENTS, TZD** | | |
| **CLASS PA CRITERIA:** Non-preferred agents are available only on appeal. | | |
| **THIAZOLIDINEDIONES** | | |
| pioglitazone | ACTOS (pioglitazone)<br>AVANDIA (rosiglitazone) | |
| **TZD COMBINATIONS** | | |
| | ACTOPLUS MET (pioglitazone/metformin)*<br>DUETACT (pioglitazone/glimepiride)*<br>pioglitazone/glimepiride<br>pioglitazone/metformin | *Patients are required to use the components of Actoplus Met and Duetact separately. Exceptions will be handled on a case-by-case basis. |
| **DRY EYE PRODUCTS** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a sixty (60) day trial of the preferred agent(s). | | |
| RESTASIS (cyclosporine)<br>XIIDRA (lifitegrast) | CEQUA (cyclosporine)<br>cyclosporine dropperette<br>RESTASIS MULTIDOSE (cyclosporine)*<br>TYRVAYA (varenicline)<br>VEVYE (cyclosporine) | *Restasis Multidose is approvable only on appeal and requires medical reasoning as to why the clinical need cannot be met with the preferred product (Restasis). |
| **EPINEPHRINE, SELF-ADMINISTERED** | | |
| **CLASS PA CRITERIA:** A non-preferred agent may be authorized with documentation showing the patient's inability to follow the instructions, or the patient's failure to understand the training for the preferred agent(s). | | |
| epinephrine (labeler 49502 only)<br>EPIPEN (epinephrine) | AUVI-Q (epinephrine)<br>epinephrine (all labelers except 49502) | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| EPIPEN JR (epinephrine) | NEFFY NASAL SPRAY (epinephrine)<br>SYMJEPI (epinephrine) | |
| **ERYTHROPOIESIS STIMULATING PROTEINS**[CL/PA] | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a thirty (30) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| EPOGEN (rHuEPO)<br>RETACRIT (epoetin alpha) | ARANESP (darbepoetin)<br>MIRCERA (methoxy PEG-epoetin)<br>PROCRIT (rHuEPO) | Erythropoiesis agents will be authorized if the following criteria are met:<br>1. Hemoglobin or hematocrit less than (<) 10/30 respectively. For renewal, hemoglobin or hematocrit levels greater than (>) 12/36 will require dosage reduction or discontinuation. Exceptions will be considered on an individual basis after medical documentation is reviewed (laboratory values must be dated within six (6) weeks of request); **AND**<br>2. Transferrin saturation greater than or equal to (≥) 20%, ferritin levels greater than or equal to (≥) 100 mg/ml, or on concurrent therapeutic iron therapy (laboratory values must be dated within three (3) weeks of request). For re-authorization, transferrin saturation or ferritin levels are not required if the patient has been responsive to the erythropoietin agent; **AND**<br>3. For HIV-infected patients, endogenous serum erythropoietin level must be less than or equal to (≤) 500 mU/ml to initiate therapy; **AND**<br>4. No evidence of untreated GI bleeding, hemolysis, or Vitamin B-12, iron or folate deficiency. |
| **FLUOROQUINOLONES, ORAL**[AP] | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a five (5) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| CIPRO SUSPENSION (ciprofloxacin)<br>ciprofloxacin<br>levofloxacin tablets | BAXDELA (delafloxacin)<br>CIPRO TABLETS (ciprofloxacin)<br>ciprofloxacin suspension<br>levofloxacin solution<br>moxifloxacin<br>ofloxacin | |
| **GLUCOCORTICOIDS, INHALED**[AP] | | |
| **CLASS PA CRITERIA:** Non-preferred agents require thirty (30) day trials of each chemically unique preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| **GLUCOCORTICOIDS** | | |
| ARNUITY ELLIPTA (fluticasone)<br>ASMANEX TWISTHALER (mometasone)<br>budesonide nebulizer 0.5 mg/2 ml and 0.25 | ALVESCO (ciclesonide)<br>ARMONAIR DIGIHALER (fluticasone)<br>ASMANEX HFA (mometasone)* | *Fluticasone HFA and Asmanex HFA are approved for children less than or equal to (≤) ten (10) years of age. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| mg/2 ml solution<br>PULMICORT FLEXHALER (budesonide) | budesonide nebulizer solution 1 mg/2 ml<br>fluticasone HFA*<br>PULMICORT NEBULIZER SOLUTION (budesonide)<br>QVAR REDIHALER (beclomethasone) | |
| **GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS** | | |
| ADVAIR DISKUS (fluticasone/salmeterol)<br>ADVAIR HFA (fluticasone/salmeterol)<br>DULERA (mometasone/formoterol)<br>SYMBICORT (budesonide/formoterol) | AIRDUO DIGIHALER (fluticasone/salmeterol)<br>AIRDUO RESPICLICK (fluticasone/salmeterol)<br>AIRSUPRA (albuterol/budesonide)<br>BREO ELLIPTA (fluticasone/vilanterol)<br>budesonide/formoterol<br>fluticasone/salmeterol<br>fluticasone/vilanterol<br>WIXELA (fluticasone/salmeterol) | |
| **GROWTH HORMONES AND ACHONDROPLASIA AGENTS** CL/PA | | |
| **CLASS PA CRITERIA:** Non-preferred agents require three (3) month trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| GENOTROPIN (somatropin)<br>NORDITROPIN (somatropin) | HUMATROPE (somatropin)<br>INCRELEX (mecasermin)<br>NGENLA (somatrogon-ghla)<br>NUTROPIN AQ (somatropin)<br>OMNITROPE (somatropin)<br>SAIZEN (somatropin)<br>SEROSTIM (somatropin)<br>SKYTROFA (lonapegsomatropin)<br>SOGROYA (somapacitan-beco)<br>VOXZOGO (vosoritide)*<br>ZOMACTON (somatropin)<br>ZORBTIVE (somatropin) | Patients already on a non-preferred agent will receive authorization to continue therapy on that agent for the duration of the existing PA.<br><br>*Full PA criteria for Voxzogo may be found on the PA Criteria page by clicking the hyperlink. |
| ***H. PYLORI* TREATMENT** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a trial of the combination of individual preferred components of the requested non-preferred agent and must be used at the recommended dosages, frequencies, and duration of the non-preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| Please use individual components:<br>preferred PPI (omeprazole or pantoprazole)<br>amoxicillin<br>tetracycline capsules<br>metronidazole<br>clarithromycin<br>bismuth<br>PYLERA (bismuth/metronidazole/tetracycline) | HELIDAC (bismuth/metronidazole/tetracycline)<br>lansoprazole/amoxicillin/clarithromycin<br>OMECLAMOX-PAK (omeprazole/amoxicillin/clarithromycin)<br>TALICIA (omeprazole/amoxicillin/rifabutin)<br>tetracycline tablets<br>VOQUEZNA DUAL PAK (vonoprazan/amoxicillin)<br>VOQUEZNA TRIPLE PAK (vonoprazan/amoxicillin/clarithromycin) | |
| **HEART FAILURE TREATMENTS** | | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| This is not an all-inclusive list of agents available for the treatment of heart failure. Please see beta blockers and SGLT-2 agents. | | |
| ENTRESTO (sacubitril/valsartan)* | ENTRESTO SPRINKLE CAPSULES (sacubitril/ valsartan)**<br>INPEFA (sotagliflozin)***<br>VERQUVO (vericiguat)**** | *Entresto may be authorized only for patients greater than or equal to (≥) one (1) year of age diagnosed with chronic heart failure<br><br>**Entresto sprinkle capsules may be authorized for children who are one (1) to nine (9) years of age who are unable to ingest solid dosage forms. Therapy may be authorized for older patients with clinical documentation indicating oral-motor difficulties or dysphagia.<br><br>***Inpefa may be authorized for an FDA approved indication **AND** clinical reasoning must be provided as to why the medical need cannot be met with a preferred SGLT2 agent.<br><br>****Full PA criteria for Verquvo may be found on the PA Criteria page by clicking the hyperlink. |
| **HEPATITIS B TREATMENTS** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require ninety (90) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| BARACLUDE SOLUTION (entecavir)*<br>entecavir<br>lamivudine HBV | adefovir<br>BARACLUDE TABLETS (entecavir)<br>EPIVIR HBV (lamivudine)<br>HEPSERA (adefovir)<br>VEMLIDY (tenofovir alafenamide) | *Baraclude solution will be authorized only for patients with documentation of dysphagia. |
| **HEPATITIS C TREATMENTS**[CL/PA] | | |
| **CLASS PA CRITERIA:** For patients starting therapy in this class, preferred regimens may be found on the PA Criteria page. Requests for non-preferred regimens require medical reasoning why a preferred regimen cannot be used. | | |
| MAVYRET (pibrentasvir/glecaprevir)*<br>ribavirin<br>sofosbuvir/velpatasvir (labeler 72626)* | EPCLUSA (sofosbuvir/velpatasvir)*<br>HARVONI (ledipasvir/sofosbuvir)*<br>ledipasvir/sofosbuvir*<br>PEGASYS (pegylated interferon)<br>PEG-INTRON (pegylated interferon)<br>RIBASPHERE RIBAPAK (ribavirin)<br>RIBASPHERE 400 mg and 600 mg (ribavirin)<br>SOVALDI (sofosbuvir)*<br>VIEKIRA XR (dasabuvir/ombitasvir/paritaprevir/ ritonavir)*<br>VOSEVI (sofosbuvir/velpatasvir/voxilaprevir)<br>ZEPATIER (elbasvir/grazoprevir) | *Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. |
| **HYPERPARATHYROID AGENTS**[AP] | | |
| **CLASS PA CRITERIA:** Non-preferred agents require thirty (30) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| cinacalcet<br>paricalcitol capsules | doxercalciferol<br>HECTOROL (doxercalciferol)<br>paricalcitol injection<br>RAYALDEE (calcifediol)<br>SENSIPAR (cinacalcet)<br>ZEMPLAR (paricalcitol) | |
| **HYPERPHOSPHATEMIA AGENTS[AP]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a thirty (30) day trial of at least two (2) preferred agents before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| calcium acetate capsules<br>CALPHRON (calcium acetate)<br>MAGNEBIND RX (calcium carbonate/folic acid/magnesium carbonate)<br>PHOSLYRA (calcium acetate)<br>sevelamer carbonate | AURYXIA (ferric citrate)<br>calcium acetate tablets<br>FOSRENOL (lanthanum)<br>lanthanum chewable tablets<br>RENAGEL (sevelamer)<br>RENVELA (sevelamer carbonate)<br>sevelamer carbonate powder packet<br>sevelamer HCl<br>VELPHORO (sucroferric oxyhydroxide)<br>XPHOZAH (tenapanor) | |
| **HYPOGLYCEMIA TREATMENTS** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require clinical reasoning beyond convenience why the preferred glucagon products cannot be used. | | |
| BAQSIMI SPRAY (glucagon)<br>glucagon vial<br>glucagon emergency kit<br>GVOKE (glucagon)<br>ZEGALOGUE (dasiglucagon) | GLUCAGEN HYPOKIT (glucagon) | |
| **HYPOPARATHYROID AGENTS** | | |
| | YORVIPATH (palopegteriparatide)* | *Yorvipath may be approvable for adult patients diagnosed with hypoparathyroidism who have documentation supporting the inability to achieve disease control with conventional therapies such as prescribed calcium supplements and prescribed active forms of vitamin D. |
| **IMMUNOMODULATORS, ATOPIC DERMATITIS** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a thirty (30) day trial of a medium-to-high potency topical corticosteroid **AND all** preferred agents in this class unless one (1) of the exceptions on the PA form is present. Requirement for topical corticosteroids may be excluded with involvement of sensitive areas such as the face and skin folds. | | |
| ADBRY (tralokinumab)*<br>DUPIXENT (dupilumab)*<br>ELIDEL (pimecrolimus)<br>tacrolimus ointment | CIBINQO (abrocitinib)*<br>EBGLYSS (lebrikizumab)<br>EUCRISA (crisaborole)[AP]**<br>OPZELURA CREAM (ruxolitinib)*<br>pimecrolimus cream<br>ZORYVE CREAM 0.15% (roflumilast) | *Full PA criteria may be found on the PA Criteria page by clicking the hyperlink<br><br>**Eucrisa requires a thirty (30) day trial of Elidel **OR** a medium to high potency corticosteroid unless contraindicated. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **IMMUNOMODULATORS, GENITAL WARTS & ACTINIC KERATOSIS AGENTS** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require thirty (30) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| CONDYLOX GEL (podofilox)<br>EFUDEX (fluorouracil)<br>imiquimod cream | ALDARA (imiquimod)<br>CARAC (fluorouracil)<br>diclofenac 3% gel<br>fluorouracil 0.5% cream<br>fluorouracil 5% cream<br>imiquimod pump<br>podofilox<br>TOLAK (fluorouracil 4% cream)<br>VEREGEN (sinecatechins)<br>ZYCLARA CREAM, PUMP (imiquimod)* | *Zyclara will be authorized for a diagnosis of actinic keratosis. |
| **IMMUNOSUPPRESSIVES, ORAL** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a fourteen (14) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| azathioprine<br>cyclosporine<br>cyclosporine, modified<br>mycophenolate mofetil<br>sirolimus<br>tacrolimus capsules | ASTAGRAF XL (tacrolimus)<br>AZASAN (azathioprine)<br>CELLCEPT (mycophenolate mofetil)<br>ENVARSUS XR (tacrolimus)<br>everolimus tablets<br>IMURAN (azathioprine)<br>LUPKYNIS (voclosporin)*<br>mycophenolic acid<br>mycophenolic mofetil suspension<br>MYFORTIC (mycophenolic acid)<br>MYHIBBIN (mycophenolate mofetil suspension)***<br>NEORAL (cyclosporine, modified)<br>PROGRAF (tacrolimus)<br>RAPAMUNE (sirolimus)<br>REZUROCK (belumosudil)**<br>SANDIMMUNE (cyclosporine)<br>ZORTRESS (everolimus) | *Lupkynis requires a ninety (90) day trial of Benlysta prior to approval. Full PA criteria for Lupkynis may be found on the PA Criteria page by clicking the hyperlink.<br><br>**Rezurock may be authorized after a trial of two (2) systemic treatments for chronic graft-versus-host disease. Examples of systemic therapy may include methylprednisolone, Imbruvica (ibrutinib capsules and tablets), cyclosporine, tacrolimus, sirolimus, mycophenolate mofetil and imatinib.<br><br>***Myhibbin may be authorized for those who are unable to ingest solid dosage forms due to documented oral-motor difficulties or dysphagia AND documentation is provided as to why the clinical need cannot be met with mycophenolate suspension. |
| **INTRANASAL RHINITIS AGENTS[AP]** | | |
| **CLASS PA CRITERIA:** See below for individual subclass criteria. | | |
| | **ANTICHOLINERGICS** | |
| ipratropium | ATROVENT (ipratropium) | Non-preferred agents require thirty (30) day trials of one (1) preferred nasal anti-cholinergic agent, **AND** one (1) preferred antihistamine, **AND** one (1) preferred intranasal corticosteroid agent before they will be approved, unless one (1) of the exceptions on the PA form is present. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **ANTIHISTAMINES** | | |
| azelastine<br>olopatadine | PATANASE (olopatadine) | |
| **COMBINATIONS** | | |
| | azelastine/fluticasone<br>DYMISTA (azelastine/fluticasone)*<br>RYALTRIS (olopatadine HCl/mometasone)** | *Dymista requires a concurrent thirty (30) day trial of each preferred component before it will be approved, unless one (1) of the exceptions on the PA form is present.<br><br>**Ryaltris requires a thirty (30) day trial of each individual component before it may be approved. |
| **CORTICOSTEROIDS** | | |
| fluticasone propionate<br>OMNARIS (ciclesonide)<br>QNASL HFA (beclomethasone)<br>ZETONNA (ciclesonide) | BECONASE AQ (beclomethasone)<br>flunisolide<br>mometasone<br>NASONEX (mometasone) | Non-preferred agents require thirty (30) day trials of each preferred agent in this subclass before they will be approved, unless one (1) of the exceptions on the PA form is present. |
| **IRRITABLE BOWEL SYNDROME/SHORT BOWEL SYNDROME/SELECTED GI AGENTS** | | |
| **CLASS PA CRITERIA:** All agents are approvable only for patients eighteen (18) years of age and older. **See below for additional subclass criteria.** | | |
| **CONSTIPATION** | | |
| LINZESS 145 mcg and 290 mcg (linaclotide)<br>lubiprostone capsules<br>MOVANTIK (naloxegol)<br>TRULANCE (plecanatide) | AMITIZA (lubiprostone)<br>IBSRELA (tenapanor)<br>LINZESS 72 mcg (linaclotide)<br>MOTEGRITY (prucalopride)<br>RELISTOR INJECTION (methylnaltrexone)<br>RELISTOR TABLETS (methylnaltrexone)<br>SYMPROIC (naldemedine) | No agent shall be approved to treat opioid induced constipation (OIC) without evidence of at least ninety (90) days of opioid use preceding the request. Continuation of coverage shall be granted with evidence of continuous and concurrent opioid use.<br><br>**Agents may be authorized only for their FDA-approved labeled indication. The following agent-specific criteria shall also apply, unless one (1) of the exceptions on the PA form is present:**<br><br>**Ibsrela** requires thirty (30) day trials of each preferred agent for IBS-C, however for males, a trial of lubiprostone is not required.<br><br>**Linzess 72 mcg** may only be approved for a diagnosis of chronic idiopathic constipation (CIC) AND for those who cannot tolerate the 145 mcg dose. Linzess may also be approvable for a diagnosis of functional constipation for pediatric patients six (6) to seventeen (17) years of age.<br><br>**Motegrity** requires a thirty (30) day trial of both lubiprostone and Linzess. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | | **Relistor** and **Symproic** are indicated for OIC and require thirty (30) day trials of both Movantik and lubiprostone. |
| | **DIARRHEA** | |
| | alosetron<br>LOTRONEX (alosetron)<br>MYTESI (crofelemer)<br>VIBERZI (eluxadoline) | Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. |
| **LAXATIVES AND CATHARTICS** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| CLENPIQ (sodium picosulfate/magnesium oxide/citric acid)<br>COLYTE<br>GOLYTELY<br>MOVIPREP<br>NULYTELY<br>OSMOPREP<br>peg 3350<br>sod sulfate-pot sulf-mag sulf (generic SUPREP) | peg 3350-sod sulf-NaCL-KCL-asb powder<br>SUFLAVE (peg 350-sod sulf, chl-pot-mag)<br>SUPREP<br>SUTAB (magnesium sulfate/potassium sulfate/ sodium sulfate) | |
| **LEUKOTRIENE MODIFIERS** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require thirty (30) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| montelukast<br>zafirlukast | ACCOLATE (zafirlukast)<br>SINGULAIR (montelukast)<br>zileuton<br>ZYFLO (zileuton) | |
| **LIPOTROPICS, OTHER (Non-statins)** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a twelve (12) week trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| | **BEMPEDOIC ACIDS** | |
| | NEXLIZET (bempedoic acid/ezetimibe)<br>NEXLETOL (bempedoic acid) | Nexlizet and Nexletol may be approved if the following criteria are met:<br>1. Patient must meet all age and indication restrictions imposed by the current FDA approved label; **AND**<br>2. Documentation must be submitted indicating that the patient failed to reach an LDL less than (<) 70 mg/dL after an eight (8) week trial of either atorvastatin 40 mg - 80 mg + ezetimibe **OR** rosuvastatin 20 mg - 40 mg + ezetimibe. **NOTE**: If the patient failed to tolerate the first statin, then they must be trialed on |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | | the second statin for eight (8) weeks or until intolerance occurs. |
| **BILE ACID SEQUESTRANTS[AP]** | | |
| cholestyramine<br>colesevelam<br>colestipol tablets | COLESTID (colestipol)<br>colestipol granules<br>QUESTRAN (cholestyramine)<br>WELCHOL (colesevelam)* | *Welchol will be authorized for add-on therapy for Diabetes Mellitus Type II when there is a previous history of a thirty (30) day trial of an oral agent (metformin, sulfonylurea, or thiazolidinedione (TZD)). See HYPOGLYCEMICS, MISCELLANEOUS. |
| **CHOLESTEROL ABSORPTION INHIBITORS** | | |
| ezetimibe | ZETIA (ezetimibe) | |
| **FATTY ACIDS** | | |
| omega-3 acid ethyl esters | icosapent ethyl capsules<br>LOVAZA (omega-3-acid ethyl esters) | Icosapent ethyl capsules may be approved if the following criteria are met (A or B):<br>A. The patient has a triglyceride level of at least 500 mg/dL and has previously completed at least a twelve (12) week trial on omega-3 acid ethyl esters; **OR**<br>B. The patient has an initial triglyceride level of at least 150 mg/dL; **AND** The patient has either established cardiovascular disease or diabetes; **AND** The patient will be concurrently receiving a statin. |
| **FIBRIC ACID DERIVATIVES[AP]** | | |
| fenofibrate 54 mg and 160 mg<br>fenofibrate micronized 67 mg, 134 mg and 200 mg<br>fenofibrate nanocrystallized 48 mg and 145 mg<br>gemfibrozil | ANTARA (fenofibrate)<br>fenofibrate 40 mg tablets<br>fenofibrate 150 mg capsules<br>fenofibrate 43 mg, 50 mg, 120 mg and 130 mg<br>fenofibrate micronized 30 mg and 90 mg<br>fenofibric acid<br>FENOGLIDE (fenofibrate)<br>FIBRICOR (fenofibric acid)<br>LIPOFEN (fenofibrate)<br>LOPID (gemfibrozil)<br>TRICOR (fenofibrate nanocrystallized)<br>TRILIPIX (fenofibric acid) | |
| **MTP INHIBITORS** | | |
| | JUXTAPID (lomitapide)* | *Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. |
| **PCSK-9 INHIBITORS** | | |
| PRALUENT (alirocumab)*<br>REPATHA (evolocumab)* | LEQVIO (inclisiran)* | *Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. |
| **LIPOTROPICS, STATINS[AP]** | | |
| **CLASS PA CRITERIA:** See below for individual subclass criteria. | | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **STATINS** | | |
| atorvastatin<br>lovastatin<br>pravastatin<br>rosuvastatin<br>simvastatin** | ALTOPREV (lovastatin)<br>ATORVALIQ (atorvastatin)***<br>CRESTOR (rosuvastatin)<br>EZALLOR SPRINKLE (rosuvastatin)*<br>fluvastatin<br>fluvastatin ER<br>LESCOL XL (fluvastatin)<br>LIPITOR (atorvastatin)<br>LIVALO (pitavastatin)<br>PRAVACHOL (pravastatin)<br>ZOCOR (simvastatin)**<br>ZYPITAMAG (pitavastatin) | Non-preferred agents require twelve (12) week trials of two (2) preferred agents, including the generic formulation of the requested non-preferred agent, before they will be approved, unless one (1) of the exceptions on the PA form is present.<br><br>*Ezallor sprinkle will only be authorized for those who are unable to ingest solid dosage forms due to documented oral-motor difficulties or dysphagia.<br><br>**Zocor/simvastatin 80 mg tablets will require a clinical PA.<br><br>***Atorvaliq may be authorized for children who are six (6) to ten (10) years of age who are unable to ingest solid dosage forms.<br>Therapy may be authorized for older patients with clinical documentation indicating oral-motor difficulties or dysphagia. |
| **STATIN COMBINATIONS** | | |
| | amlodipine/atorvastatin<br>CADUET (atorvastatin/amlodipine)<br>ezetimibe/simvastatin*<br>VYTORIN (simvastatin/ezetimibe)* | Non-preferred agents require thirty (30) day concurrent trials of the corresponding preferred single agents before they will be approved, unless one (1) of the exceptions on the PA form is present.<br><br>*Vytorin will be authorized only after an insufficient response to a twelve (12) week trial of the maximum tolerable dose of atorvastatin or rosuvastatin, unless one (1) of the exceptions on the PA form is present.<br>Vytorin 80/10 mg tablets will require a clinical PA. |
| **MABS, ANTI-IL/IgE** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require ninety (90) day trials of all preferred agents which are indicated for the diagnosis. **Full PA Criteria may be found on the PA Criteria page by clicking the link.** | | |
| DUPIXENT (dupilumab)<br>FASENRA (benralizumab)<br>NUCALA AUTOINJECTOR, SYRINGE (mepolizumab)<br>XOLAIR VIAL (omalizumab) | NUCALA VIAL (mepolizumab)<br>TEZSPIRE (tezepelumab-ekko)<br>XOLAIR SYRINGES (omalizumab) | |
| **MACROLIDES** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a five (5) day trial of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| **MACROLIDES** | | |
| azithromycin packet, suspension, tablets<br>clarithromycin tablets | clarithromycin ER<br>clarithromycin suspension<br>E.E.S. (erythromycin ethylsuccinate) | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | ERYPED (erythromycin ethylsuccinate)<br>ERY-TAB (erythromycin)<br>ERYTHROCIN (erythromycin stearate)<br>erythromycin tablets/capsules DR<br>erythromycin tablets<br>erythromycin estolate<br>ZITHROMAX (azithromycin) | |
| **MULTIPLE SCLEROSIS AGENTS[CL/PA]** | | |
| **CLASS PA CRITERIA: All agents require a prior authorization and documented diagnosis of multiple sclerosis.** Preferred oral agents require a ninety (90) day trial of any preferred injectable agent. Non-preferred agents require ninety (90) day trials of two (2) chemically unique preferred agents (in the same subclass) before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| **INTERFERONS[AP]** | | |
| AVONEX (interferon beta-1a)<br>AVONEX PEN (interferon beta-1a)<br>BETASERON (interferon beta-1b)<br>REBIF (interferon beta-1a)<br>REBIF REBIDOSE (interferon beta-1a) | EXTAVIA KIT (interferon beta-1b)<br>EXTAVIA VIAL (interferon beta-1b)<br>PLEGRIDY (peginterferon beta-1a) | |
| **NON-INTERFERONS** | | |
| COPAXONE 20 mg (glatiramer)<br>dalfampridine ER**<br>dimethyl fumarate***<br>fingolimod<br>KESIMPTA INJECTION (ofatumumab)****<br>teriflunomide* | AMPYRA (dalfampridine)**<br>AUBAGIO (teriflunomide)*<br>BAFIERTAM CAPSULES (monomethyl fumarate)<br>COPAXONE 40 mg (glatiramer)*****<br>GILENYA (fingolimod)<br>glatiramer<br>GLATOPA (glatiramer)<br>MAVENCLAD (cladribine)<br>MAYZENT (siponimod)******<br>PONVORY (ponesimod)<br>TASCENSO ODT (fingolimod lauryl sulfate)<br>TECFIDERA (dimethyl fumarate)***<br>VUMERITY (diroximel fumarate)<br>ZEPOSIA (ozanimod) | **In addition to the Class PA Criteria, the following conditions and criteria may also apply:**<br><br>*Aubagio (teriflunomide) requires the following additional criteria to be met:<br>1. Diagnosis of relapsing multiple sclerosis; **AND**<br>2. Measurement of transaminase and bilirubin levels within the six (6) months before initiation of therapy and ALT levels at least monthly for six (6) months after initiation of therapy; **AND**<br>3. Complete blood count (CBC) within six (6) months before initiation of therapy; **AND**<br>4. Female patients must have a negative pregnancy test before initiation of therapy and be established on a reliable method of contraception if appropriate; **AND**<br>5. Patient is between eighteen (18) to sixty-five (65) years of age; **AND**<br>6. Negative tuberculin skin test before initiation of therapy.<br><br>**Dalfampridine ER and Ampyra require the following additional criteria to be met:<br>1. Diagnosis of multiple sclerosis; **AND**<br>2. No history of seizures; **AND**<br>3. No evidence of moderate or severe renal impairment |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | | 4. Initial authorization will be issued for thirty (30) days, with a limit of two (2) tablets per day. If the patient shows improvement, additional quantities may be authorized.<br><br>***Dimethyl fumarate and Tecfidera require the following additional criteria to be met:<br>1. Diagnosis of relapsing multiple sclerosis; **AND**<br>2. Complete blood count (CBC) within six (6) months of initiation of therapy and six (6) months after initiation; **AND**<br>3. Complete blood count (CBC) annually during therapy.<br><br>****Kesimpta may be approved with documentation of treatment failure/inadequate treatment response after a ninety (90) day trial of at least one (1) preferred MS agent. Documentation of a negative Hepatitis B test must be provided.<br><br>*****Copaxone 40 mg will only be authorized for documented injection site issues.<br><br>******Mayzent may be authorized with no additional requirement beyond the diagnosis for patients with documented secondary progressive MS. |
| **NEUROPATHIC PAIN** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a thirty (30) day trial of a preferred agent in the corresponding dosage form (oral or topical) before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| capsaicin (OTC)<br>duloxetine<br>gabapentin<br>lidocaine patch 5%<br>LYRICA CAPSULES, SOLUTION (pregabalin)<br>pregabalin capsules | CYMBALTA (duloxetine)<br>DRIZALMA SPRINKLE (duloxetine)*<br>gabapentin ER (generic Gralise)<br>GRALISE (gabapentin)**<br>HORIZANT (gabapentin)***<br>lidocaine patch 4%<br>LIDODERM (lidocaine)<br>LYRICA CR (pregabalin)****<br>NEURONTIN (gabapentin)<br>pregabalin ER tablets (generic LYRICA CR)<br>pregabalin solution<br>SAVELLA (milnacipran)*****<br>ZTLIDO PATCH (lidocaine) | *Drizalma sprinkle will only be authorized for those who are unable to ingest solid dosage forms due to documented oral-motor difficulties or dysphagia.<br><br>**Gralise will be authorized only if the following criteria are met:<br>1. Diagnosis of postherpetic neuralgia; **AND**<br>2. Trial of a tricyclic antidepressant for at least thirty (30) days; **AND**<br>3. Ninety (90) day trial of gabapentin immediate release formulation (positive response without adequate duration); **AND**<br>4. The request is for once daily dosing with 1800 mg maximum daily dosage. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | | ***Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.<br><br>****Lyrica CR requires medical reasoning beyond convenience as to why the need cannot be met using preferred pregabalin capsules.<br><br>*****Savella will be authorized for a diagnosis of fibromyalgia only after a ninety (90) day trial of one (1) preferred agent. |
| **NSAIDS[AP]** | | |
| **CLASS PA CRITERIA:** See below for subclass PA criteria. | | |
| **NON-SELECTIVE** | | |
| diclofenac (IR, SR)<br>flurbiprofen<br>ibuprofen capsules, chewable tablets, suspension, tablets (Rx, OTC)<br>indomethacin<br>ketoprofen<br>ketorolac<br>meloxicam tablets<br>nabumetone<br>naproxen sodium capsules, tablets<br>naproxen sodium DS tablets<br>piroxicam<br>sulindac | DAYPRO (oxaprozin)<br>diclofenac potassium capsules, tablets<br>diflunisal<br>DUEXIS (famotidine/ibuprofen)<br>EC-naproxen DR tablets<br>etodolac IR<br>etodolac SR<br>famotidine/ibuprofen<br>FELDENE (piroxicam)<br>fenoprofen<br>INDOCIN SUSPENSION (indomethacin)<br>INDOCIN SUPPOSITORIES (indomethacin)<br>indomethacin ER<br>ketoprofen ER<br>ketorolac spray<br>LOFENA (diclofenac)<br>meclofenamate<br>mefenamic acid<br>meloxicam submicronized capsules (generic VIVLODEX)<br>meloxicam suspension<br>MOBIC TABLETS (meloxicam)<br>NALFON (fenoprofen)<br>NAPRELAN (naproxen)<br>naproxen suspension<br>naproxen CR<br>oxaprozin<br>RELAFEN DS (nabumetone)<br>SPRIX (ketorolac)<br>TIVORBEX (indomethacin)<br>tolmetin | Non-preferred agents require thirty (30) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | VIVLODEX (meloxicam)<br>VOLTAREN (diclofenac)<br>ZIPSOR (diclofenac potassium)<br>ZORVOLEX (diclofenac) | |
| **NSAID/GI PROTECTANT COMBINATIONS** | | |
| | ARTHROTEC (diclofenac/misoprostol)<br>diclofenac/misoprostol<br>ibuprofen/famotidine<br>naproxen/esomeprazole<br>VIMOVO (naproxen/esomeprazole) | Non-preferred agents are only available on appeal and require medical reasoning beyond convenience as to why the need cannot be met with the combination of preferred single agents. |
| **COX-II SELECTIVE** | | |
| celecoxib | CELEBREX (celecoxib) | |
| **TOPICAL** | | |
| diclofenac gel (Rx)* | diclofenac patch<br>diclofenac solution<br>LICART PATCH (diclofenac)<br>PENNSAID (diclofenac) | Non-preferred agents require a thirty (30) day trial of the preferred topical agent and thirty (30) day trials of each preferred oral NSAID before they will be approved, unless one (1) of the exceptions on the PA form is present.<br><br>*Diclofenac gel will be limited to 100 grams per month. |
| **OPHTHALMIC ANTIBIOTICS[AP]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require three (3) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| bacitracin/polymyxin ointment<br>ciprofloxacin*<br>erythromycin<br>gentamicin<br>moxifloxacin*<br>neomycin/bacitracin/polymyxin<br>ofloxacin*<br>polymyxin/trimethoprim<br>tobramycin<br>TOBREX OINTMENT (tobramycin) | AZASITE (azithromycin)<br>bacitracin<br>BESIVANCE (besifloxacin)*<br>BLEPH-10 (sulfacetamide)<br>CILOXAN (ciprofloxacin)*<br>gatifloxacin*<br>neomycin/polymyxin/gramicidin<br>OCUFLOX (ofloxacin)*<br>POLYTRIM (polymyxin/trimethoprim)<br>sulfacetamide drops<br>sulfacetamide ointment<br>TOBREX (tobramycin)<br>VIGAMOX (moxifloxacin)*<br>XDEMVY (lotilaner)**<br>ZYMAXID (gatifloxacin)* | *Prior authorization of any fluoroquinolone agent requires three (3) day trials of all other preferred agents unless definitive laboratory cultures exist indicating the need to use a fluoroquinolone.<br><br>**Xdemvy may be authorized for the treatment of demodex blepharitis without further restrictions. |
| **OPHTHALMIC ANTIBIOTIC/STEROID COMBINATIONS[AP]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require three (3) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| BLEPHAMIDE (prednisolone/sulfacetamide)<br>MAXITROL OINTMENT, SUSPENSION | BLEPHAMIDE S.O.P. (prednisolone/ sulfacetamide) | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| (neomycin/polymyxin/dexamethasone)<br>neomycin/bacitracin/polymyxin/hydrocortisone<br>neomycin/polymyxin/dexamethasone<br>PRED-G SUSPENSION (prednisolone/ gentamicin)<br>sulfacetamide/prednisolone<br>TOBRADEX OINTMENT (tobramycin/ dexamethasone)<br>TOBRADEX SUSPENSION (tobramycin/ dexamethasone)<br>TOBRADEX ST (tobramycin/ dexamethasone)<br>tobramycin/dexamethasone suspension<br>ZYLET (loteprednol/tobramycin) | neomycin/polymyxin/hydrocortisone<br>PRED-G OINTMENT (prednisolone/gentamicin) | |
| **OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS[AP]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require thirty (30) day trials of three (3) preferred chemically unique agents before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| ALAWAY (ketotifen)<br>ALREX (loteprednol)<br>azelastine<br>BEPREVE (bepotastine)<br>cromolyn<br>EYSUVIS (loteprednol)<br>ketotifen<br>ZADITOR (OTC) (ketotifen) | ALOCRIL (nedocromil)<br>ALOMIDE (lodoxamide)<br>bepotastine<br>epinastine<br>loteprednol<br>LUMIFY (brimonidine)<br>olopatadine 0.1%<br>olopatadine 0.2%<br>PATADAY ONCE and TWICE DAILY (olopatadine)<br>ZERVIATE (cetirizine) | |
| **OPHTHALMICS, ANTI-INFLAMMATORIES** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require five (5) day trials of at least two (2) preferred agents before they will be approved, unless one (1) of the exceptions on the PA form is present. Trials must include at least one (1) agent with the same mechanism of action as the requested non-preferred agent. | | |
| dexamethasone<br>diclofenac<br>DUREZOL (difluprednate)<br>FLAREX (fluorometholone)<br>FML (fluorometholone)<br>FML FORTE (fluorometholone)<br>FML S.O.P. (fluorometholone)<br>ketorolac<br>LOTEMAX GEL, OINTMENT, SUSPENSION (loteprednol)<br>MAXIDEX (dexamethasone)<br>NEVANAC (nepafenac)<br>PRED FORTE (prednisolone)<br>PRED MILD (prednisolone) | ACULAR (ketorolac)<br>ACULAR LS (ketorolac)<br>ACUVAIL (ketorolac tromethamine)<br>bromfenac<br>BROMSITE (bromfenac)<br>difluprednate<br>fluorometholone<br>flurbiprofen<br>ILEVRO (nepafenac)<br>INVELTYS (loteprednol)<br>LOTEMAX SM (loteprednol etabonate)<br>loteprednol drops, gel<br>OMNIPRED (prednisolone)<br>OZURDEX (dexamethasone) | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| prednisolone acetate<br>prednisolone sodium phosphate | PROLENSA (bromfenac)<br>RETISERT (fluocinolone)<br>TRIESENCE (triamcinolone) | |
| **OPHTHALMICS, GLAUCOMA AGENTS** | | |
| **CLASS PA CRITERIA:** Non-preferred agents will only be authorized if there is an allergy to all preferred agents in the corresponding subclass. | | |
| **COMBINATION AGENTS** | | |
| COMBIGAN (brimonidine/timolol)<br>dorzolamide/timolol<br>SIMBRINZA (brinzolamide/brimonidine) | brimonidine-timolol<br>COSOPT PF (dorzolamide/timolol) | |
| **BETA BLOCKERS** | | |
| BETOPTIC S (betaxolol)<br>carteolol<br>levobunolol<br>timolol drops | betaxolol<br>ISTALOL (timolol)<br>timolol gel<br>TIMOPTIC (timolol) | |
| **CARBONIC ANHYDRASE INHIBITORS** | | |
| AZOPT (brinzolamide)<br>dorzolamide | brinzolamide<br>TRUSOPT (dorzolamide) | |
| **PARASYMPATHOMIMETICS** | | |
| pilocarpine | | |
| **PROSTAGLANDIN ANALOGS** | | |
| latanoprost<br>TRAVATAN-Z (travoprost) | bimatoprost<br>IYUZEH (latanoprost)<br>LUMIGAN (bimatoprost)<br>tafluprost<br>travoprost<br>VYZULTA (latanoprostene)*<br>XALATAN (latanoprost)<br>XELPROS (latanoprost)<br>ZIOPTAN (tafluprost) | *Vyzulta prior authorization requires failure on a three (3) month trial of at least one (1) preferred prostaglandin eye drop used in combination with an agent from another subclass. |
| **RHO-KINASE INHIBITORS** | | |
| RHOPRESSA (netarsudil)<br>ROCKLATAN (netarsudil/latanoprost) | | |
| **SYMPATHOMIMETICS** | | |
| ALPHAGAN P SOLUTION (brimonidine)<br>brimonidine 0.2% | apraclonidine<br>brimonidine 0.15%<br>IOPIDINE (apraclonidine) | |
| **OPIATE DEPENDENCE TREATMENTS** | | |
| **CLASS PA CRITERIA:** Bunavail and Zubsolv may only be approved with a documented intolerance or allergy to Suboxone films AND buprenorphine/naloxone tablets.<br><br>*West Virginia Medicaid's buprenorphine coverage policy may be viewed by clicking on the following link: Buprenorphine Coverage Policy and Related Forms | | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| BRIXADI (buprenorphine)[CL/PA]<br>buprenorphine/naloxone tablets*<br>KLOXXADO SPRAY (naloxone)<br>naloxone cartridge/syringe/vial<br>naloxone nasal spray (OTC)<br>NARCAN NASAL SPRAY (naloxone)<br>OPVEE (nalmefene)<br>REXTOVY NASAL SPRAY (naloxone)<br>SUBLOCADE (buprenorphine solution)[CL/PA*]<br>SUBOXONE FILM (buprenorphine/naloxone)*<br>VIVITROL (naltrexone) | BUNAVAIL (buprenorphine/naloxone)*<br>buprenorphine tablets*<br>buprenorphine/naloxone film*<br>lofexidine<br>LUCEMYRA (lofexidine)**<br>naloxone nasal spray (Rx)<br>ZIMHI (naloxone hydrochloride)<br>ZUBSOLV (buprenorphine/naloxone)* | **Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. |
| **ORAL AND TOPICAL CONTRACEPTIVES** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a trial with three (3) preferred contraceptive products including a trial with a preferred product with the same route of administration as the requested non-preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| AFIRMELLE<br>ALTAVERA<br>AMETHYST<br>APRI<br>AUBRA<br>AUBRA EQ<br>AUROVELA<br>AVIANE<br>AYUNA<br>AZURETTE<br>BALZIVA<br>BEYAZ<br>BLISOVI FE<br>CAMILA<br>CAMRESE 3 MONTH<br>CHATEAL<br>CHATEAL EQ<br>CYRED<br>CYRED EQ<br>DEBLITANE<br>desogestrel-ethinyl estradiol<br>desogestrel-ethinyl estradiol/ethinyl estradiol<br>DOLISHALE<br>drospirenone-ethinyl estradiol<br>ENSKYCE<br>ERRIN<br>ESTARYLLA | ALYACEN<br>AMETHIA 3 MONTH<br>ARANELLE<br>ASHLYNA 3 MONTH<br>AUROVELA 24 FE<br>AUROVELA FE<br>BALCOLTRA<br>BLISOVI 24 FE<br>BRIELLYN<br>CAMRESE LO 3 MONTH<br>CHARLOTTE 24 FE CHEWABLE TABLETS<br>CRYSELLE<br>CURAE<br>DASETTA<br>DAYSEE 3 MONTH<br>drospirenone-ethinyl estradiol-levomefolate<br>ECONTRA EZ<br>ECONTRA ONE-STEP<br>ELINEST<br>ELLA<br>ENPRESSE<br>ethynodiol-ethinyl estradiol<br>FAYOSIM 3 MONTH<br>FINZALA<br>GEMMILY<br>HAILEY<br>HAILEY 24 FE | *Phexxi may be approvable when it is prescribed for the prevention of pregnancy; **AND** reasoning is provided as to why the clinical need cannot be met with a preferred agent. Phexxi will not be approved for use by patients who are also using hormonal contraceptive vaginal rings. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| FALMINA | ICLEVIA 3 MONTH | |
| HAILEY FE | INTROVALE 3 MONTH | |
| HEATHER | JAIMIESS 3 MONTH | |
| HER STYLE | JASMIEL | |
| INCASSIA | JOYEAUX | |
| ISIBLOOM | JUNEL | |
| JENCYCLA | JUNEL FE 24 | |
| JOLESSA 3 MONTH | KAITLIB FE | |
| JULEBER | KALLIGA | |
| JUNEL FE | KELNOR 1-35 | |
| KARIVA | KELNOR 1-50 | |
| KURVELO | LARIN | |
| LARIN FE | LARIN 24 FE | |
| LESSINA | LAYOLIS FE CHEWABLE TABLETS | |
| LEVONEST | LEENA | |
| levonorgestrel | levonorgestrel-ethinyl estradiol 3 month (generic JOLESSA) | |
| levonorgestrel-ethinyl estradiol | | |
| levonorgestrel-ethinyl estradiol 3 month (generic LOSEASONIQUE) | LEVORA-28 | |
| | LOESTRIN | |
| levonorgestrel-ethinyl estradiol-ferrous bisglycinate | LOESTRIN FE | |
| | LOJAIMIESS 3 MONTH | |
| LILLOW | LOSEASONIQUE 3 MONTH | |
| LO LOESTRIN FE | LOW-OGESTREL | |
| LORYNA | LO-ZUMANDIMINE | |
| LUTERA | MERZEE | |
| LYLEQ | MICROGESTIN | |
| LYZA | MICROGESTIN 24 FE | |
| MARLISSA | MINASTRIN 24 FE CHEWABLE TABLETS | |
| MIBELAS 24 FE | MIRCETTE | |
| MICROGESTIN FE | NECON | |
| MILI | NEXTSTELLIS | |
| MONO-LINYAH | norethindrone-ethinyl estradiol-iron capsules | |
| MY CHOICE | norethindrone-ethinyl estradiol-iron chewable tablets | |
| MY WAY | | |
| NATAZIA | NORTREL | |
| NEW DAY | OPTION 2 | |
| NIKKI | PHEXXI VAGINAL GEL* | |
| NORA-BE | PHILITH | |
| norethindrone | PIMTREA | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| norethindrone-ethinyl estradiol-iron tablets | QUARTETTE | |
| norethindrone-ethinyl estradiol | RECLIPSEN | |
| norgestimate-ethinyl estradiol | RIVELSA 3 MONTH | |
| NORLYDA | SAFYRAL | |
| NYLIA | SEASONIQUE 3 MONTH | |
| NYMYO | SETLAKIN 3 MONTH | |
| OCELLA | SIMPESSE 3 MONTH | |
| OPCICON ONE-STEP | SLYND | |
| PORTIA | SYEDA | |
| SHAROBEL | TARINA 24 FE | |
| SIMLIYA | TAYSOFY | |
| SPRINTEC | TILIA FE | |
| SRONYX | TRI-LEGEST FE | |
| TARINA FE | TRIVORA-28 | |
| TARINA FE 1-20 EQ | TURQOZ | |
| TAYTULLA | TYBLUME CHEWABLE TABLETS | |
| TRI-ESTARYLLA | TYDEMY | |
| TRI FEMYNOR | VELIVET | |
| TRI-LINYAH | VESTURA | |
| TRI-LO-ESTARYLLA | VYFEMLA | |
| TRI-LO-MARZIA | WERA | |
| TRI-LO-MILI | WYMZYA FE CHEWABLE TABLETS | |
| TRI-LO-SPRINTEC | XULANE PATCH | |
| TRI-MILI | | |
| TRI-NYMYO | | |
| TRI-SPRINTEC | | |
| TRI-VYLIBRA | | |
| TRI-VYLIBRA LO | | |
| TULANA | | |
| TWIRLA PATCH | | |
| VIENVA | | |
| VIORELE | | |
| VOLNEA | | |
| VYLIBRA | | |
| YASMIN-28 | | |
| YAZ | | |
| ZAFEMY PATCH | | |
| ZOVIA 1-35 | | |
| ZOVIA 1-35E | | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| ZUMANDIMINE | | |
| **OTIC ANTIBIOTICS[AP]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require five (5) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| CIPRO HC (ciprofloxacin/hydrocortisone)<br>ciprofloxacin/dexamethasone<br>CORTISPORIN-TC (colistin/hydrocortisone/ neomycin)<br>neomycin/polymyxin/HC solution, suspension<br>ofloxacin | ciprofloxacin<br>ciprofloxacin/fluocinolone<br>OTOVEL (ciprofloxacin/fluocinolone) | |
| **PAH AGENTS[CL/PA]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a thirty (30) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| **ACTIVIN SIGNALING INHIBITOR** | | |
| | WINREVAIR (sotatercept-csrk) | |
| **COMBINATIONS** | | |
| | OPSYNVI (macitentan/tadalafil)* | *Opsynvi requires review by the Medical Director and is available only on appeal. |
| **ENDOTHELIN RECEPTOR ANTAGONISTS** | | |
| bosentan<br>LETAIRIS (ambrisentan) | ambrisentan<br>OPSUMIT (macitentan)<br>TRACLEER SUSPENSION (bosentan)<br>TRACLEER TABLETS (bosentan) | |
| **GUANYLATE CYCLASE INHIBITORS** | | |
| | ADEMPAS (riociguat)* | *Adempas requires a thirty (30) day trial of a preferred agent from any other PAH Class before it may be approved, unless one (1) of the exceptions on the PA form is present. |
| **PAH AGENTS – PDE5s** | | |
| sildenafil tablets | ADCIRCA (tadalafil)<br>LIQREV (sildenafil)*<br>REVATIO IV (sildenafil)<br>REVATIO SUSPENSION (sildenafil)<br>REVATIO TABLETS (sildenafil)<br>sildenafil suspension (generic REVATIO)**<br>TADLIQ SUSPENSION (tadalafil)*** | *Liqrev may be authorized for those who are unable to ingest solid dosage forms due to documented oral-motor difficulties or dysphagia **AND** documentation is provided as to why the clinical need cannot be met with either Revatio or sildenafil suspension.<br><br>**Sildenafil suspension may be authorized for those who are unable to ingest solid dosage forms due to documented oral-motor difficulties or dysphagia **AND** documentation is provided as to why the clinical need cannot be met with Revatio. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | | ***Tadliq may be authorized for those who are unable to ingest solid dosage forms due to documented oral-motor difficulties or dysphagia **AND** after a thirty (30) day trial of Revatio resulting in an inadequate treatment response. |
| **PAH AGENTS – PROSTACYCLINS** | | |
| epoprostenol (generic FLOLAN)<br>epoprostenol (generic VELETRI)<br>VENTAVIS (iloprost)* | FLOLAN (epoprostenol)<br>ORENITRAM ER (treprostinil)<br>REMODULIN (treprostinil sodium)<br>treprostinil (generic REMODULIN)<br>TYVASO (treprostinil)<br>TYVASO DPI (treprostinil)<br>UPTRAVI (selexipag)<br>VELETRI (epoprostenol) | *Ventavis will only be authorized for the treatment of pulmonary artery hypertension (WHO Group 1) in patients with NYHA Class III or IV symptoms. |
| **PANCREATIC ENZYMES[AP]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a thirty (30) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. For members with cystic fibrosis, a trial of a preferred agent will not be required. | | |
| CREON<br>PERTZYE<br>ZENPEP | PANCREAZE<br>VIOKACE | |
| **PITUITARY SUPPRESSIVE AGENTS, LHRH[CL/PA]** | | |
| **CLASS PA CRITERIA:** Unless otherwise noted, non-preferred agents are available only on appeal. | | |
| FENSOLVI SYRINGE (leuprolide acetate)<br>LUPANETA (leuprolide)<br>LUPRON DEPOT KIT (leuprolide)<br>LUPRON DEPOT-PED KIT (leuprolide)<br>MYFEMBREE (relugolix/estradiol/ norethindrone)*<br>ORILISSA (elagolix)*<br>SYNAREL (nafarelin)<br>TRELSTAR (triptorelin)<br>TRIPTODUR (triptorelin) | leuprolide<br>ORIAHNN (elagolix/estradiol/norethindrone)*<br>SUPPRELIN LA KIT (histrelin) | *Full PA criteria for Myfembree, Orilissa and Oriahnn may be found on the PA Criteria page by clicking the hyperlink. In addition, Orilissa and Oriahnn may only be approved if there is a documented side effect, allergy, or treatment failure with Myfembree. Use of GnRH receptor antagonists will be limited to twenty-four (24) months. |
| **PLATELET AGGREGATION INHIBITORS** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a thirty (30) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| BRILINTA (ticagrelor)<br>clopidogrel<br>dipyridamole<br>prasugrel | clopidogrel kit<br>dipyridamole/aspirin<br>EFFIENT (prasugrel)<br>PLAVIX (clopidogrel)<br>ZONTIVITY (vorapaxar) | |
| **POTASSIUM REMOVING AGENTS** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a thirty (30) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| LOKELMA (sodium zirconium cyclosilicate) | KIONEX (sodium polystyrene sulfonate)<br>SPS (sodium polystyrene sulfonate)<br>VELTASSA (patiromer calcium sorbitex) | |
| **PROGESTINS FOR CACHEXIA** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require a thirty (30) day trial of a preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| megestrol | | |
| **PROTON PUMP INHIBITORS[AP]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require sixty (60) day trials of both omeprazole (Rx) and pantoprazole at the maximum recommended dose, inclusive of a concurrent thirty (30) day trial at the maximum dose of an $H_2$ antagonist before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| omeprazole (Rx)<br>pantoprazole tablets<br>PROTONIX GRANULES (pantoprazole)* | ACIPHEX (rabeprazole)<br>ACIPHEX SPRINKLE (rabeprazole)<br>DEXILANT (dexlansoprazole)<br>dexlansoprazole DR capsules<br>esomeprazole magnesium<br>KONVOMEP (omeprazole/sodium bicarbonate)<br>lansoprazole (Rx)<br>NEXIUM (esomeprazole)<br>NEXIUM PACKETS (esomeprazole)<br>omeprazole/sodium bicarbonate (Rx)<br>pantoprazole granule packets<br>PREVACID CAPSULES (lansoprazole)<br>PREVACID SOLUTABS (lansoprazole)*<br>PRILOSEC (Rx) (omeprazole)<br>PROTONIX DR TABLETS (pantoprazole)<br>Rabeprazole<br>VOQUEZNA (vonoprazan)**<br>ZEGERID (Rx) (omeprazole/sodium bicarbonate) | *Prior authorization is required for members nine (9) years of age or older for these agents.<br><br>**Voquezna (vonoprazan) is NOT a PROTON PUMP INHIBITOR but will remain on the PDL in this class due to similar indications. |
| **SEDATIVE HYPNOTICS[AP]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require thirty (30) day trials of all preferred agents in **BOTH subclasses** before they will be approved, unless one (1) of the exceptions on the PA form is present. All agents except melatonin will be limited to fifteen (15) tablets in a thirty (30) day period. **NOTE**: WV Medicaid covers melatonin up to a maximum dose of 9 mg/day without a PA. Melatonin labeler code 51645 is preferred. Please refer to the posted Covered OTC Products for a complete list of payable NDCs. | | |
| **BENZODIAZEPINES** | | |
| temazepam 15 mg and 30 mg | estazolam<br>flurazepam<br>HALCION (triazolam)<br>RESTORIL (temazepam)<br>temazepam 7.5 mg and 22.5 mg<br>triazolam | |
| **OTHERS** | | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| BELSOMRA (suvorexant)**<br>melatonin<br>ROZEREM (ramelteon)<br>zolpidem 5 mg and 10 mg | AMBIEN (zolpidem)<br>AMBIEN CR (zolpidem)<br>DAYVIGO (lemborexant)<br>doxepin 3 mg and 6 mg<br>EDLUAR (zolpidem)<br>eszopiclone<br>HETLIOZ (tasimelteon)CL*<br>LUNESTA (eszopiclone)<br>QUVIVIQ (daridorexant)<br>ramelteon<br>SILENOR (doxepin)<br>tasimelteon<br>zaleplon<br>zolpidem ER 6.25 mg and 12.5 mg | For treatment naïve female patients, zolpidem and zolpidem ER maximum dosages will be limited to 5 mg and 6.25 mg respectively per day.<br><br>*Full PA criteria may be found on the PA Criteria page by clicking the hyperlink.<br><br>**Belsomra may be approved after a trial of zolpidem or temazepam, unless one (1) of the exceptions on the PA form is present. |
| **SKELETAL MUSCLE RELAXANTS**AP | | |
| **CLASS PA CRITERIA:** See below for individual subclass criteria. | | |
| **ACUTE MUSCULOSKELETAL RELAXANT AGENTS** | | |
| chlorzoxazone (generic PARAFON FORTE)<br>cyclobenzaprine IR 5 mg and 10 mg<br>methocarbamol | AMRIX (cyclobenzaprine)<br>carisoprodol*<br>carisoprodol/ASA*<br>carisoprodol/ASA/codeine*<br>chlorzoxazone (generic LORZONE)<br>cyclobenzaprine ER<br>cyclobenzaprine IR 7.5 mg<br>FEXMID (cyclobenzaprine)<br>LORZONE (chlorzoxazone)<br>metaxalone<br>orphenadrine<br>orphenadrine ER<br>ROBAXIN (methocarbamol)<br>SKELAXIN (metaxalone)<br>SOMA (carisoprodol)<br>TANLOR (methocarbamol) | Non-preferred agents require thirty (30) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present, with the exception of carisoprodol.<br><br>*Carisoprodol requires thirty (30) day trials of each of the preferred acute musculoskeletal relaxants and Skelaxin before it will be approved. |
| **MUSCULOSKELETAL RELAXANT AGENTS USED FOR SPASTICITY** | | |
| baclofen<br>tizanidine tablets | baclofen solution*, suspension<br>DANTRIUM (dantrolene)<br>dantrolene<br>FLEQSUVY (baclofen)*<br>LYVISPAH GRANULE PACKETS (baclofen)*<br>tizanidine capsules<br>ZANAFLEX (tizanidine) | Non-preferred agents require thirty (30) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present.<br><br>*Oral baclofen solution, Fleqsuvy (baclofen suspension) and Lyvispah granules may only be authorized for those who are unable to ingest solid dosage forms due to documented oral-motor difficulties or dysphagia. In addition, Fleqsuvy and Lyvispah may only be authorized if there is a documented intolerance to oral baclofen solution. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **STEROIDS, TOPICAL** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require five (5) day trials of one (1) form of **EACH** preferred unique active ingredient in the corresponding potency group before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| **VERY HIGH & HIGH POTENCY** | | |
| betamethasone dipropionate cream<br>betamethasone valerate cream<br>betamethasone valerate lotion<br>betamethasone valerate ointment<br>clobetasol emollient<br>clobetasol propionate cream, gel, ointment, solution<br>clobetasol propionate shampoo<br>fluocinonide gel<br>triamcinolone acetonide cream, ointment<br>triamcinolone acetonide lotion | amcinonide<br>APEXICON E (diflorasone diacetate)<br>betamethasone dipropionate gel, lotion, ointment<br>BRYHALI LOTION (halobetasol)<br>clobetasol lotion<br>clobetasol propionate foam, spray<br>CLODAN KIT (clobetasol propionate)<br>CLODAN SHAMPOO (clobetasol propionate)<br>desoximetasone cream, gel, ointment, spray<br>diflorasone diacetate<br>DIPROLENE (betamethasone dipropionate/ propylene glycol)<br>fluocinonide cream<br>fluocinonide ointment<br>fluocinonide solution<br>fluocinonide/emollient<br>halcinonide cream<br>halobetasol propionate<br>HALOG (halcinonide)<br>IMPEKLO LOTION (clobetasol propionate)<br>KENALOG (triamcinolone acetonide)<br>LEXETTE FOAM (halobetasol)<br>OLUX (clobetasol propionate)<br>OLUX-E (clobetasol propionate emulsion)<br>PSORCON (diflorasone diacetate)<br>TEMOVATE (clobetasol propionate)<br>TOPICORT CREAM, GEL, OINTMENT (desoximetasone)<br>TOPICORT SPRAY (desoximetasone)<br>TOVET FOAM (clobetasol)<br>ULTRAVATE (halobetasol propionate)<br>ULTRAVATE PAC cream<br>VANOS (fluocinonide) | |
| **MEDIUM POTENCY** | | |
| fluticasone propionate cream, ointment<br>mometasone furoate<br>triamcinolone acetonide 0.025% and 0.1% cream | BESER LOTION (fluticasone)<br>betamethasone valerate foam<br>clocortolone cream<br>CLODERM (clocortolone pivalate)<br>CORDRAN (flurandrenolide)<br>CUTIVATE (fluticasone propionate) | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | fluocinolone acetonide cream, ointment, solution<br>flurandrenolide cream, lotion, ointment<br>fluticasone propionate lotion<br>hydrocortisone butyrate cream<br>hydrocortisone butyrate ointment, solution<br>hydrocortisone valerate<br>LOCOID (hydrocortisone butyrate)<br>LOCOID LIPOCREAM (hydrocortisone butyrate/ emollient)<br>LUXIQ (betamethasone valerate)<br>PANDEL (hydrocortisone probutate)<br>prednicarbate | |
| **LOW POTENCY** | | |
| fluocinolone oil<br>hydrocortisone acetate (Rx, OTC)<br>hydrocortisone cream (Rx, OTC)<br>hydrocortisone lotion<br>hydrocortisone ointment (Rx, OTC)<br>hydrocortisone solution (OTC)<br>hydrocortisone-aloe cream (OTC)<br>hydrocortisone-aloe ointment (OTC) | alclometasone dipropionate<br>AQUA GLYCOLIC HC (hydrocortisone)<br>DERMA-SMOOTHE FS (fluocinolone acetonide)<br>DESONATE (desonide)<br>desonide cream, ointment<br>desonide lotion<br>hydrocortisone/mineral oil/petrolatum<br>hydrocortisone acetate/urea<br>hydrocortisone/aloe gel<br>SCALPICIN (OTC) (hydrocortisone)<br>SYNALAR (fluocinolone)<br>TEXACORT (hydrocortisone) | |
| **STIMULANTS AND RELATED AGENTS** | | |
| **CLASS PA CRITERIA:** A prior authorization is required for adults eighteen (18) years of age or older. Non-preferred agents require a thirty (30) day trial of at least one (1) preferred agent in the same subclass and with a similar duration of effect and mechanism of action, unless one (1) of the exceptions on the PA form is present. **NOTE**: Children under eighteen (18) years of age may continue their existing therapy at the discretion of the prescriber. | | |
| **AMPHETAMINES** | | |
| ADDERALL XR (amphetamine salt combination)<br>amphetamine salt combination ER<br>amphetamine salt combination IR<br>dextroamphetamine ER<br>dextroamphetamine IR<br>DYANAVEL XR SUSPENSION (amphetamine)<br>PROCENTRA SOLUTION (dextroamphetamine) | ADDERALL (amphetamine salt combination)<br>ADZENYS XR ODT (amphetamine)<br>ADZENYS ER SUSPENSION (amphetamine)<br>amphetamine tablets<br>DESOXYN (methamphetamine)<br>DEXEDRINE ER (dextroamphetamine)<br>dextroamphetamine solution<br>DYANAVEL XR TABLETS (amphetamine)<br>EVEKEO (amphetamine)<br>EVEKEO ODT (amphetamine)<br>lisdexamfetamine<br>methamphetamine<br>MYDAYIS (dextroamphetamine/amphetamine salt)* | **In addition to the Class Criteria**: thirty (30) day trials of at least three (3) antidepressants are required before amphetamines will be authorized for depression.<br><br>*Mydayis requires a thirty (30) day trial of at least one (1) long-acting preferred agent in this subclass and a trial of Adderall XR. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | VYVANSE CHEWABLE TABLETS (lisdexamfetamine)<br>VYVANSE CAPSULES (lisdexamfetamine)<br>XELSTRYM PATCHES (dextroamphetamine)<br>ZENZEDI (dextroamphetamine) | |
| **NON-AMPHETAMINE** | | |
| atomoxetine*<br>clonidine IR<br>clonidine ER<br>CONCERTA (methylphenidate)<br>dexmethylphenidate IR<br>dexmethylphenidate XR<br>guanfacine ER<br>guanfacine IR<br>methylphenidate IR<br>methylphenidate CD capsules<br>methylphenidate ER 24 tablets (generic CONCERTA)<br>methylphenidate ER tablets (generic RITALIN SR)<br>methylphenidate ER CD capsules<br>methylphenidate solution<br>QUILLICHEW ER (methylphenidate)<br>QUILLIVANT XR (methylphenidate)<br>RITALIN LA (methylphenidate) | ADHANSIA XR (methylphenidate)<br>APTENSIO XR (methylphenidate)<br>AZSTARYS (dexmethylphenidate/ serdexmethylphenidate)<br>COTEMPLA XR ODT (methylphenidate)<br>DAYTRANA (methylphenidate)<br>FOCALIN IR (dexmethylphenidate)<br>FOCALIN XR (dexmethylphenidate)<br>INTUNIV (guanfacine ER)<br>JORNAY PM (methylphenidate)<br>METHYLIN SOLUTION (methylphenidate)<br>methylphenidate chewable tablets<br>methylphenidate ER capsules<br>methylphenidate ER 72 mg tablets<br>methylphenidate ER LA capsules<br>methylphenidate LA capsules<br>methylphenidate patches<br>ONYDA XR (clonidine)<br>QELBREE (viloxazine)**<br>RELEXXII (methylphenidate ER)<br>RITALIN (methylphenidate)<br>STRATTERA (atomoxetine)* | *Strattera (atomoxetine) is limited to a maximum of 100 mg per day.<br><br>**Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. |
| **NARCOLEPTIC AGENTS** | | |
| armodafinil*<br>modafinil*<br>NUVIGIL (armodafinil)*<br>PROVIGIL (modafinil)* | sodium oxybate**<br>SUNOSI (solriamfetol)*<br>WAKIX (pitolisant)***<br>XYREM (sodium oxybate)**<br>XYWAV (calcium/magnesium/potassium/sodium oxybate)** | *Full PA criteria for narcoleptic agents may be found on the PA Criteria page by clicking the hyperlink.<br><br>**Full PA criteria for Xyrem/Xywav may be found on the PA Criteria page by clicking the hyperlink.<br><br>***Wakix is approvable only with documentation of treatment failure after thirty (30) day trials of armodafinil, modafinil and Sunosi. |
| **TETRACYCLINES** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require ten (10) day trials of each preferred agent before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| doxycycline hyclate capsules<br>doxycycline hyclate 100 mg tablets | demeclocycline**<br>DORYX (doxycycline hyclate) | *Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| doxycycline monohydrate 50 mg and 100 mg capsules<br>minocycline capsules<br>tetracycline capsules | doxycycline hyclate 50 mg, 75 mg and 150 mg tablets<br>doxycycline hyclate DR 75 mg, 100 mg, 150 mg and 200 mg tablets<br>doxycycline hyclate DR 50 mg tablets<br>doxycycline monohydrate 40 mg, 75 mg and 150 mg capsules<br>doxycycline monohydrate tablets<br>doxycycline monohydrate suspension<br>MINOCIN (minocycline)<br>minocycline ER capsules<br>minocycline tablets<br>MINOLIRA ER (minocycline)<br>MORGIDOX KIT (doxycycline)<br>NUZYRA (omadacycline)*<br>SOLODYN (minocycline)<br>tetracycline tablets<br>VIBRAMYCIN CAPSULES, SUSPENSION, SYRUP (doxycycline)<br>XIMINO (minocycline) | **Demeclocycline will be authorized for conditions caused by susceptible strains of organisms designated in the product information supplied by the manufacturer. A C&S report must accompany this request.<br>Demeclocycline will also be authorized for SIADH. |
| **ULCERATIVE COLITIS AGENTS[AP]** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require thirty (30) day trials of each preferred dosage form or chemical entity before the corresponding non-preferred agent of that dosage form or chemical entity will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| **ORAL** | | |
| APRISO (mesalamine)<br>ASACOL HD (mesalamine)<br>balsalazide<br>PENTASA 250 mg (mesalamine)<br>PENTASA 500 mg (mesalamine)<br>sulfasalazine | AZULFIDINE (sulfasalazine)<br>budesonide ER tablets<br>COLAZAL (balsalazide)<br>DELZICOL (mesalamine)<br>DIPENTUM (olsalazine)<br>LIALDA (mesalamine)<br>mesalamine<br>UCERIS (budesonide)<br>ZEPOSIA (ozanimod) | |
| **RECTAL** | | |
| mesalamine | DELZICOL DR (mesalamine)<br>mesalamine kit<br>ROWASA (mesalamine)<br>SF ROWASA (mesalamine)<br>UCERIS (budesonide) | |
| **VAGINAL RING CONTRACEPTIVES** | | |
| **CLASS PA CRITERIA:** Non-preferred drugs require medical reasoning beyond convenience or enhanced compliance as to why the clinical need cannot be met with a preferred agent. | | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| NUVARING (etonogestrel/ethinyl estradiol) | ANNOVERA (segesterone/ethinyl estradiol)<br>ELURYNG (etonogestrel/ethinyl estradiol)<br>etonogestrel/ethinyl estradiol vaginal rings | |
| **VASODILATORS, CORONARY** | | |
| **CLASS PA CRITERIA:** Non-preferred agents require thirty (30) day trials of each preferred dosage form before they will be approved, unless one (1) of the exceptions on the PA form is present. | | |
| **SUBLINGUAL NITROGLYCERIN** | | |
| nitroglycerin spray (generic NITROLINGUAL)<br>nitroglycerin sublingual<br>NITROSTAT SUBLINGUAL (nitroglycerin) | GONITRO SPRAY POWDER (nitroglycerin)<br>nitroglycerin spray (generic NITROMIST)<br>NITROLINGUAL SPRAY (nitroglycerin)<br>NITROMIST (nitroglycerin) | |
| **TOPICAL NITROGLYCERIN** | | |
| MINITRAN PATCHES (nitroglycerin)<br>NITRO-BID OINTMENT<br>nitroglycerin patches | NITRO-DUR PATCHES (nitroglycerin) | |
| **VMAT INHIBITORS** | | |
| **CLASS PA CRITERIA: All agents require a prior authorization.** Full PA criteria may be found on the PA Criteria page by clicking the hyperlink. | | |
| AUSTEDO TABLETS (deutetrabenazine)<br>AUSTEDO XR (deutetrabenazine)<br>INGREZZA CAPSULES (valbenazine)<br>INGREZZA SPRINKLE CAPSULES (valbenazine)<br>tetrabenazine tablets | XENAZINE TABLETS | |
| **MISCELLANEOUS COVERED AGENTS** | | |
| **This category contains covered agents which either did not easily fit into a single PDL category or had criteria that was too lengthy to cite within the PDL itself. Full criteria for the agents listed below may be found by following this link: (https://dhhr.wv.gov/bms/BMS%20Pharmacy/Pages/PA-Criteria.aspx). Please note that some agents may be available only by billing the appropriate HCPCS code noted in the criteria.** | | |
| Abecma<br>Adbry<br>Afinitor<br>Albenza and Emverm<br>Alyftrek<br>Amondys 45<br>Antifungal Agents<br>Atypical Antipsychotic Agents for Children up to eighteen (18) years of age<br>Austedo<br>Belbuca<br>Benlysta<br>Botox<br>Breyanzi<br>Cabenuva<br>Camzyos<br>Carbaglu | | |

Carvykti
Casgevy
CGRP Receptor Antagonists (antimigraine agents, prophylaxis)
Cibinqo
Continuous Glucose Monitors
Corlanor
Cresemba
Cuvposa
Cytokine & CAM Antagonists
Diclegis
Dificid
Dojolvi
Droxidopa
Duavee
Dupixent
Elevidys
Emflaza
Enspryng
Esbriet
Evrysdi
ExJade
Exondys 51
Fasenra
Ferriprox
Fintepla
Fuzeon
Gattex
Growth Hormone for Adults
Growth Hormone for Children
Hepatitis C PA Criteria
Hereditary Angioedema Agents (prophylaxis)
Hereditary Angioedema Agents (treatment)
Hetlioz
Home Infusion Drugs and Supplies
Horizant
HP Acthar
HyQvia
Increlex
Ingrezza
Jublia
Juxtapid
Kalydeco
Kerendia
Ketoconazole
Korlym
Kuvan
Kymriah
Kynamro

Leqvio
Lucemyra
Lutathera
Lupkynis
Luxturna
Lyfgenia
Max PPI an H2RA
Mozobil
Myalept
Myfembree
Mytesi
Narcoleptic Agents
Natpara
Nexletol and Nexlizet
Non-Sedating Antihistamines
Nucala
Nuzyra
OFEV
Oforta
Omnipod
Opzelura
Orilissa
Oralair
Oriahnn
Orkambi
Osphena
Oxlumo
Palynziq
PCSK9 Inhibitor
Qelbree
Rectiv
Riluzole
Rinvoq
Risperdal Consta
Sirturo
Spinraza
Spravato
Suboxone Policy
Symdeko
Synagis
Testosterone
Tezspire
Thalomid
Tobacco Cessation Policy
Trikafta
Tryvio
V-Go
Viberzi and Lotronex
Veozah

Verquvo
Vowst
Voxzogo
Vyondys 53
Wegovy
Winrevair
Xanax XR
Xenazine
Xhance
Xifaxan
Xolair
Xyrem and Xywav
Yescarta
Zolgensma
Zulresso
Zurampic
Zurzuvae
Zynteglo
Zyvox