- Prior authorization for a non-preferred agent in any category will be given only if there has been a trial of the preferred brand/generic equivalent or preferred formulation of the active ingredient, at a therapeutic dose, that resulted in a partial response with a documented intolerance.
- Prior authorization of a non-preferred isomer, pro-drug, or metabolite will be considered with a trial of a preferred parent drug of the same chemical entity, at a therapeutic dose, that resulted in a partial response with documented intolerance or a previous trial and therapy failure, at a therapeutic dose, with a preferred drug of a different chemical entity indicated to treat the submitted diagnosis. (The required trial may be overridden when documented evidence is provided that the use of these preferred agent(s) would be medically contraindicated.)
- Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC drugs are not covered unless specified.
- PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to, appropriate dosing, duplication of therapy, etc.
- 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.
- Prior Authorization Criteria that applies among multiple sub-categories will be listed directly under the main category's name. PA Criteria specific to a sub-category will be listed in the sub-category.
- Quantity limits may apply. Refer to the Limits List at the BMS Website by clicking the hyperlink.
- Acronyms
- CL - Requires clinical PA. For detailed clinical criteria, please refer to the BMS Website by clicking the hyperlink.
    - NR - New drug has not been reviewed by P & T Committee
    - 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 |
|---|---|---|---|
| ALZHEIMER'S AGENTS | XXXX | | XXXX |
| ANALGESICS, NARCOTIC LONG ACTING (NON-PARENTERAL) | XXXX | XXXX | |
| ANALGESICS, NARCOTIC SHORT ACTING (NON-PARENTERAL) | XXXX | | |
| ANDROGENIC AGENTS | XXXX | | XXXX |
| ANGIOTENSIN MODULATORS | XXXX | | XXXX |
| ANTICOAGULANTS | XXXX | | |
| ANTICONVULSANTS | XXXX | | |
| ANTIFUNGALS, ORAL | | | XXXX |
| ANTIPSYCHOTICS, ATYPICAL | XXXX | | |
| BETA BLOCKERS | XXXX | XXXX | |
| BLADDER RELAXANT PREPARATIONS | XXXX | | |
| BRONCHODILATORS, BETA AGONIST | | | XXXX |
| COPD AGENTS | | | XXXX |
| CYTOKINE & CAM ANTAGONISTS | XXXX | XXXX | |
| GLUCOCORTICOIDS, INHALED | XXXX | | |
| GROWTH HORMONE | XXXX | | |
| HEPATITIS C TREATMENTS | XXXX | | XXXX |
| HYPERPARATHYROID AGENTS | | | XXXX |
| HYPOGLYCEMICS, BIGUANIDES | | XXXX | |
| HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS | XXXX | XXXX | XXXX |
| HYPOGLYCEMICS, INSULIN AND RELATED AGENTS | XXXX | | |
| HYPOGLYCEMICS, MEGLITINIDES | | XXXX | |
| HYPOGLYCEMICS, SGLT2 INHIBITORS | | XXXX | |
| HYPOGLYCEMICS, TZD | | XXXX | |
| IMMUNE GLOBULINS, IV | XXXX | | |

| | | | |
|---|---|---|---|
| INTRANASAL RHINITIS AGENTS | XXXX | | |
| LIPOTROPICS, OTHER (NON-STATINS) | XXXX | | XXXX |
| MULTIPLE SCLEROSIS AGENTS | XXXX | | XXXX |
| NEUROPATHIC PAIN | | | XXXX |
| OPHTHALMIC ANTIBIOTICS | XXXX | | |
| OPHTHALMIC ANTIBIOTICS/STEROID COMBINATIONS | XXXX | | |
| OPHTHALMIC ALLERGIC CONJUNCTIVITIS | XXXX | | |
| OPHTHALMICS, GLAUCOMA AGENTS | XXXX | | |
| OTIC ANTIBIOTICS | XXXX | | |
| SEDATIVE HYPNOTICS | | XXXX | |
| STIMULANTS AND RELATED AGENTS | XXXX | | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **ACNE AGENTS, TOPICAL[AP]** | | |
| **CATEGORY PA CRITERIA:** Thirty (30) day trials each 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, are required before the non-preferred agent will be authorized 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 sub-categories will be listed below. | | |
| **ANTI-INFECTIVE** | | |
| clindamycin gel, lotion, medicated swab, solution<br>erythromycin gel, solution | ACZONE (dapsone)<br>AKNE-MYCIN (erythromycin)<br>AZELEX (azelaic acid)<br>CLEOCIN-T (clindamycin)<br>CLINDACIN PAC (clindamycin)<br>CLINDAGEL (clindamycin)<br>clindamycin foam<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 cleanser<br>sulfacetamide cleanser ER<br>sulfacetamide shampoo<br>sulfacetamide suspension | |
| **RETINOIDS** | | |
| RETIN-A (tretinoin)<br>TAZORAC (tazarotene) | adapalene<br>ATRALIN (tretinoin)<br>AVITA (tretinoin)<br>DIFFERIN (adapalene)<br>RETIN-A MICRO (tretinoin)<br>tretinoin cream, gel<br>tretinoin gel micro | **In addition to the Category Criteria**: PA required for members eighteen (18) years of age or older for Retinoids sub-class. |
| **KERATOLYTICS** | | |
| benzoyl peroxide cleanser Rx & OTC, 10% cream OTC, gel Rx & OTC, lotion OTC, wash OTC | BENZEFOAM ULTRA (benzoyl peroxide)<br>BENZEPRO (benzoyl peroxide)<br>benzoyl peroxide cloths, medicated pads, microspheres cleanser<br>BP 10-1 (benzoyl peroxide) | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | BP WASH 7% LIQUID<br>DELOS (benzoyl peroxide)<br>DESQUAM-X (benzoyl peroxide)<br>LAVOCLEN (benzoyl peroxide)<br>PACNEX/HP/LP (benzoyl peroxide)<br>PANOXYL-4, -8 OTC (benzoyl peroxide)<br>PERSA-GEL OTC (benzoyl peroxide)<br>SASTID (sulfur)<br>SULPHO-LAC (sulfur) | |
| | **COMBINATION AGENTS** | |
| erythromycin/benzoyl peroxide | ACANYA (clindamycin phosphate/benzoyl peroxide)<br>AVAR/-E/LS (sulfur/sulfacetamide)<br>BENZACLIN GEL (benzoyl peroxide/ clindamycin)<br>BENZAMYCIN PAK (benzoyl peroxide/ erythromycin)<br>benzoyl peroxide/clindamycin gel<br>benzoyl peroxide/urea<br>CERISA (sulfacetamide sodium/sulfur)<br>CLARIFOAM EF (sulfacetamide/sulfur)<br>CLENIA (sulfacetamide sodium/sulfur)<br>DUAC (benzoyl peroxide/clindamycin)<br>EPIDUO (adapalene/benzoyl peroxide)*<br>INOVA 4/1, 5/2 (benzoyl peroxide/salicylic acid)<br>NEUAC (clindamycin phosphate/benzoyl peroxide)<br>NUOX (benzoyl peroxide/sulfur)<br>ONEXTON (clindamycin phosphate/benzoyl peroxide)<br>PRASCION (sulfacetamide sodium/sulfur)<br>SE 10-5 SS (sulfacetamide/sulfur)<br>SSS 10-4 (sulfacetamide /sulfur)<br>SSS 10-5 foam (sulfacetamide /sulfur)<br>sulfacetamide sodium/sulfur cloths, lotion, pads, suspension<br>sulfacetamide/sulfur wash/cleanser<br>sulfacetamide/sulfur wash kit<br>sulfacetamide sodium/sulfur/ urea<br>SUMADAN/XLT (sulfacetamide/sulfur)<br>SUMAXIN/TS (sulfacetamide sodium/sulfur)<br>VELTIN (clindamycin/tretinoin)* | **In addition to the Category PA**: Thirty (30) day trials of combinations of the corresponding preferred single agents available are required before non-preferred combination agents will be authorized.<br><br>*PA required for combination agents with Retinoid products for members eighteen (18) years of age or older. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | ZIANA (clindamycin/tretinoin)* | |
| **ALZHEIMER'S AGENTS[AP]** | | |
| **CATEGORY PA CRITERIA:** A thirty (30) day trial of a preferred agent is required before a non-preferred agent will be authorized 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 and 10 mg | ARICEPT (donepezil)<br>donepezil 23 mg*<br>EXELON CAPSULE (rivastigmine)<br>EXELON PATCH (rivastigmine)<br>galantamine<br>galantamine ER<br>RAZADYNE (galantamine)<br>RAZADYNE ER (galantamine)<br>rivastigmine | *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. |
| **NMDA RECEPTOR ANTAGONIST** | | |
| NAMENDA (memantine) | memantine<br>NAMENDA XR (memantine) | |
| **CHOLINESTERASE INHIBITOR/NMDA RECEPTOR ANTAGONIST COMBINATIONS** | | |
| | NAMZARIC (donepezil/memantine) | |
| **ANALGESICS, NARCOTIC LONG ACTING (Non-parenteral)[AP]** | | |
| **CATEGORY PA CRITERIA:** Six (6) day trials of two (2) chemically distinct preferred agents are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PDL form is present. In addition, a six (6) day trial of the generic form of the requested non-preferred agent, if available, is required before the non-preferred agent will be authorized. If no generic form is available for the requested non-preferred brand agent, then another generic non-preferred agent must be trialed instead. | | |
| BUTRANS (buprenorphine)<br>EMBEDA (morphine/naltrexone)<br>fentanyl transdermal 12, 25, 50, 75, 100 mcg/hr<br>morphine ER tablets<br>NUCYNTA ER (tapentadol) | CONZIP ER (tramadol)<br>DOLOPHINE (methadone)<br>DURAGESIC (fentanyl)<br>EXALGO ER (hydromorphone)<br>fentanyl transdermal 37.5, 62.5, 87.5 mcg/hr<br>hydromorphone ER<br>HYSINGLA ER (hydrocodone)<br>KADIAN (morphine)<br>methadone*<br>morphine ER capsules (generic for Avinza)<br>morphine ER capsules (generic for Kadian)<br>MS CONTIN (morphine)<br>OPANA ER (oxymorphone)<br>oxycodone ER*<br>OXYCONTIN (oxycodone) | ***Methadone, oxycodone ER and oxymorphone ER will be authorized without a trial of the preferred agents if a diagnosis of cancer is submitted.<br><br>**Tramadol ER 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. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | oxymorphone ER*<br>tramadol ER**<br>ULTRAM ER (tramadol)<br>XARTEMIS XR (oxycodone/ acetaminophen)<br>ZOHYDRO ER (hydrocodone) | |
| **ANALGESICS, NARCOTIC SHORT ACTING (Non-parenteral)[AP]** | | |
| **CATEGORY PA CRITERIA:** Six (6) day trials each of at least four (4) chemically distinct preferred agents (based on narcotic ingredient only), including the generic formulation of the requested non-preferred agent, are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. | | |
| APAP/codeine<br>butalbital/APAP/caffeine/codeine<br>codeine<br>hydrocodone/APAP 2.5/325 mg, 5/325 mg, 7.5/325 mg,10/325 mg<br>hydrocodone/APAP solution<br>hydrocodone/ibuprofen<br>hydromorphone tablets<br>morphine<br>NUCYNTA (tapentadol)<br>oxycodone tablets, concentrate, solution<br>oxycodone/APAP<br>oxycodone/ASA<br>pentazocine/naloxone<br>ROXICET SOLUTION (oxycodone/ acetaminophen)<br>tramadol<br>tramadol/APAP | ABSTRAL (fentanyl)<br>ACTIQ (fentanyl)<br>butalbital/ASA/caffeine/codeine<br>butorphanol<br>CAPITAL W/CODEINE (APAP/codeine)<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, 10/300 mg<br>hydromorphone liquid, suppositories<br>IBUDONE (hydrocodone/ibuprofen)<br>LAZANDA (fentanyl)<br>levorphanol<br>LORCET (hydrocodone/APAP)<br>LORTAB (hydrocodone/APAP)<br>meperidine<br>NORCO (hydrocodone/APAP)<br>ONSOLIS (fentanyl)<br>OPANA (oxymorphone)<br>OXECTA (oxycodone)<br>oxycodone capsules<br>oxycodone/ibuprofen<br>oxymorphone<br>PERCOCET (oxycodone/APAP)<br>PRIMLEV (oxycodone/APAP)<br>REPREXAIN (hydrocodone/ibuprofen) | Fentanyl buccal, nasal and sublingual products will only be authorized for a diagnosis of cancer and as an adjunct to a 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 for the purpose of maximizing the use of longer acting medications to prevent unnecessary breakthrough pain in chronic pain therapy. Immediate-release tramadol is limited to 240 tablets per thirty (30) days. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | ROXICODONE (oxycodone)<br>RYBIX ODT (tramadol)<br>SUBSYS (fentanyl)<br>SYNALGOS-DC (dihydrocodeine/ASA/ caffeine)<br>TYLENOL W/CODEINE (APAP/codeine)<br>ULTRACET (tramadol/APAP)<br>ULTRAM (tramadol)<br>VEDROCET (hydrocodone/APAP)<br>VICODIN<br>VICOPROFEN (hydrocodone/ibuprofen)<br>XODOL (hydrocodone/acetaminophen)<br>XYLON (hydrocodone/ibuprofen)<br>ZAMICET (hydrocodone/APAP) | |
| **ANDROGENIC AGENTS** | | |
| **CATEGORY PA CRITERIA:** A non-preferred agent will only be authorized if one (1) of the exceptions on the PA form is present. | | |
| ANDRODERM (testosterone)<br>ANDROGEL (testosterone) | AXIRON (testosterone)<br>FORTESTA (testosterone)<br>NATESTO (testosterone)<br>TESTIM (testosterone)<br>testosterone gel<br>VOGELXO (testosterone) | |
| **ANESTHETICS, TOPICAL**[AP] | | |
| **CATEGORY PA CRITERIA:** Ten (10) day trials of each of the preferred topical anesthetics are required before a non-preferred topical anesthetic will be authorized unless one (1) of the exceptions on the PA form is present | | |
| lidocaine<br>lidocaine/prilocaine<br>xylocaine | EMLA (lidocaine/prilocaine)<br>LIDAMANTLE (lidocaine)<br>LIDAMANTLE HC (lidocaine/hydrocortisone)<br>lidocaine/hydrocortisone<br>SYNERA (lidocaine/tetracaine) | |
| **ANGIOTENSIN MODULATORS**[AP] | | |
| **CATEGORY PA CRITERIA:** Fourteen (14) day trials of each of the preferred agents in the corresponding group, with the exception of the Direct Renin Inhibitors, are required before a non-preferred agent will be authorized 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 | ACCUPRIL (quinapril)<br>ACEON (perindopril)<br>ALTACE (ramipril)<br>EPANED (enalapril)*<br>LOTENSIN (benazepril)<br>MAVIK (trandolapril)<br>moexipril | *Epaned will be authorized if the following critieria are met:<br>Diagnosis of hypertension, symptomatic heart failure or asymptomatic left ventricular dysfunction; **AND**<br>a Patient is less than seven (7) years of age; **OR**<br>b Patient is unable to ingest a solid dosage form (eg. an oral tablet or capsule) due to documented oral-motor difficulties or dysphagia. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | perindopril<br>PRINIVIL (lisinopril)<br>trandolapril<br>UNIVASC (moexipril)<br>VASOTEC (enalapril)<br>ZESTRIL (lisinopril) | |
| **ACE INHIBITOR COMBINATION DRUGS** | | |
| benazepril/amlodipine<br>benazepril/HCTZ<br>captopril/HCTZ<br>enalapril/HCTZ<br>fosinopril/HCTZ<br>lisinopril/HCTZ<br>quinapril/HCTZ | ACCURETIC (quinapril/HCTZ)<br>CAPOZIDE (captopril/HCTZ)<br>LOTENSIN HCT (benazepril/HCTZ)<br>LOTREL (benazepril/amlodipine)<br>moexipril/HCTZ<br>PRINZIDE (lisinopril/HCTZ)<br>TARKA (trandolapril/verapamil)<br>trandolapril/verapamil<br>VASERETIC (enalapril/HCTZ)<br>ZESTORETIC (lisinopril/HCTZ) | |
| **ANGIOTENSIN II RECEPTOR BLOCKERS (ARBs)** | | |
| BENICAR (olmesartan)<br>irbesartan<br>losartan<br>MICARDIS (telmisartan)<br>valsartan | ATACAND (candesartan)<br>AVAPRO (irbesartan)<br>candesartan<br>COZAAR (losartan)<br>DIOVAN (valsartan)<br>EDARBI (azilsartan)<br>eprosartan<br>telmisartan<br>TEVETEN (eprosartan) | |
| **ARB COMBINATIONS** | | |
| AZOR (olmesartan/amlodipine)<br>BENICAR-HCT (olmesartan/HCTZ)<br>EXFORGE HCT (valsartan/amlodipine/HCTZ)<br>irbesartan/HCTZ<br>losartan/HCTZ<br>MICARDIS-HCT (telmisartan/HCTZ)<br>TRIBENZOR (olmesartan/amlodipine/HCTZ)<br>valsartan/amlodipine<br>valsartan/HCTZ | ATACAND-HCT (candesartan/HCTZ)<br>AVALIDE (irbesartan/HCTZ)<br>candesartan/HCTZ<br>DIOVAN-HCT (valsartan/HCTZ)<br>EDARBYCLOR (azilsartan/chlorthalidone)<br>ENTRESTO (valsartan/sucubitril)*<br>EXFORGE (valsartan/amlodipine)<br>HYZAAR (losartan/HCTZ)<br>telmisartan/amlodipine<br>telmisartan HCTZ<br>TEVETEN-HCT (eprosartan/HCTZ)<br>TWYNSTA (telmisartan/amlodipine)<br>valsartan/amlodipine/HCTZ | *Entresto will only be authorized for patients diagnosed with heart-failure NYHA classification 2-4 with an EF < 40%. No preferred drug trial is required to receive authorization |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | **DIRECT RENIN INHIBITORS** | |
| | AMTURNIDE (aliskiren/amlodipine/HCTZ)<br>TEKAMLO (aliskiren/amlodipine)<br>TEKTURNA (aliskiren)<br>TEKTURNA HCT (aliskiren/HCTZ)<br>VALTURNA (aliskiren/valsartan) | **Substitute for Category Criteria**: A thirty (30) day trial of one (1) preferred ACE, ARB, or combination agent, at the maximum tolerable dose, is required before Tekturna will be authorized unless one (1) of the exceptions on the PA form is present.<br><br>Amturnide, Tekamlo, Tekturna HCT or Valturna will be authorized if the criteria for Tekturna are met and the patient also needs the other agents in the combination. |
| **ANTIANGINAL & ANTI-ISCHEMIC** | | |
| **CATEGORY PA CRITERIA:** Ranexa will 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. | | |
| | RANEXA (ranolazine)[AP] | |
| **ANTIBIOTICS, GI** | | |
| **CATEGORY PA CRITERIA:** A fourteen (14) day trial of a preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. | | |
| metronidazole tablet<br>neomycin<br>TINDAMAX (tinidazole) | ALINIA (nitazoxanide)<br>DIFICID (fidaxomicin)*<br>FLAGYL (metronidazole)<br>FLAGYL ER (metronidazole ER)<br>metronidazole capsule<br>paromomycin<br>tinidazole<br>VANCOCIN (vancomycin)<br>vancomycin**<br>XIFAXAN (rifaximin)*** | *Dificid will be authorized if the following criteria are met:<br>1. There is a diagnosis of severe *C. difficile* infection **and**<br>2. There is no response to prior treatment with vancomycin for ten (10) to fourteen (14) days.<br><br>**Vancomycin will be authorized after a fourteen (14) day trial of metronidazole for *C. difficile* infections of mild to moderate severity.<br>**Vancomycin will be authorized for severe *C. difficile* infections with no previous trial of metronidazole.<br><br>***Full Xifaxin PA criteria may be found at the BMS Website, by clicking the hyperlink. |
| **ANTIBIOTICS, INHALED** | | |
| **CATEGORY PA CRITERIA:** A twenty-eight (28) day trial of the preferred agent and documentation of therapeutic failure is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. | | |
| BETHKIS (tobramycin)<br>KITABIS PAK (tobramycin) | CAYSTON (aztreonam)<br>TOBI (tobramycin)<br>TOBI PODHALER<br>tobramycin | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **ANTIBIOTICS, TOPICAL** | | |
| **CATEGORY PA CRITERIA:** Ten (10) day trials of at least one (1) preferred agent, including the generic formulation of a requested non-preferred agent, are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. | | |
| bacitracin<br>gentamicin sulfate<br>mupirocin ointment | ALTABAX (retapamulin)<br>BACTROBAN (mupirocin)<br>CENTANY (mupirocin)<br>CORTISPORIN (bacitracin/neomycin/polymyxin/HC)<br>mupirocin cream<br>neomycin/polymyxin/pramoxine | |
| **ANTIBIOTICS, VAGINAL** | | |
| **CATEGORY PA CRITERIA:** A trial, the duration of the manufacturer's recommendation, of each preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. | | |
| clindamycin cream<br>METROGEL (metronidazole) | AVC (sulfanilamide)<br>CLEOCIN CREAM (clindamycin)<br>CLEOCIN OVULE (clindamycin)<br>CLINDESSE (clindamycin)<br>metronidazole<br>NUVESSA (metronidazole)<br>VANDAZOLE (metronidazole) | |
| **ANTICOAGULANTS** | | |
| **CATEGORY PA CRITERIA:** Trials of each preferred agent will be required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. | | |
| **INJECTABLE**[CL] | | |
| enoxaparin | ARIXTRA (fondaparinux)<br>fondaparinux<br>FRAGMIN (dalteparin)<br>LOVENOX (enoxaparin) | |
| **ORAL** | | |
| COUMADIN (warfarin)<br>ELIQUIS (apixaban)[AP]*<br>PRADAXA (dabigatran)[AP]**<br>warfarin<br>XARELTO (rivaroxaban)[AP]*** | SAVAYSA (edoxaban) | *Eliquis will be authorized for the following indications:<br>1. Non-valvular atrial fibrillation **or**<br>2. Deep vein thombrosis (DVT) and pulmonary embolism (PE) **or**<br>3. DVT prophylaxis if treatment is limited to thirty-five (35) days for hip replacement surgeries or twelve (12) days for knee replacement surgeries.<br><br>**Pradaxa will be authorized for the following indications:<br>1. Non-valvular atrial fibrillation **or**<br>2. To reduce the risk of recurrent DVT and PE in patients who have previously been treated **or** |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | | 3. Treatment of acute DVT and PE in patients who have been treated with a parenteral anticoagulant for five (5) to (10) days**.**<br><br>***Xarelto will be authorized for the following indications::<br>1. Non-valvular atrial fibrillation **or**<br>2. DVT, and PE, and reduction in risk of recurrence of DVT and PE **or**<br>1. DVT prophylaxis if treatment is limited to thirty-five (35) days for hip replacement surgeries or twelve (12) days for knee replacement surgeries. |
| **ANTICONVULSANTS** | | |
| **CATEGORY PA CRITERIA:** A fourteen (14) day trial of one (1) of the preferred agents in the corresponding group is required for treatment naïve patients with a diagnosis of a seizure disorder before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.<br><br>A thirty (30) day trial of one (1) of the preferred agents in the corresponding group is required for patients with a diagnosis other than seizure disorders unless one (1) of the exceptions on the PA form is present.<br><br>Non-preferred anticonvulsants will be authorized for patients on established therapies with a diagnosis of seizure disorders with no trials of preferred agents required. In situations where AB-rated generic equivalent products are available, “Brand Medically Necessary” must be hand-written by the prescriber on the prescription in order for the brand name product to be reimbursed. | | |
| **ADJUVANTS** | | |
| carbamazepine<br>carbamazepine ER<br>carbamazepine XR<br>CARBATROL (carbamazepine)<br>DEPAKOTE SPRINKLE (divalproex)<br>divalproex<br>divalproex ER<br>EPITOL (carbamazepine)<br>felbamate<br>FYCOMPA (perampanel)<br>GABITRIL (tiagabine)<br>lamotrigine<br>levetiracetam IR<br>levetiracetam ER<br>oxcarbazepine suspension and tablets<br>TEGRETOL XR (carbamazepine)<br>topiramate IR<br>topiramate ER*<br>valproic acid | APTIOM (eslicarbazepine)<br>BANZEL(rufinamide)<br>DEPAKENE (valproic acid)<br>DEPAKOTE (divalproex)<br>DEPAKOTE ER (divalproex)<br>divalproex sprinkle<br>EQUETRO (carbamazepine)<br>FANATREX SUSPENSION (gabapentin)<br>FELBATOL (felbamate)***<br>KEPPRA (levetiracetam)<br>KEPPRA XR (levetiracetam)<br>LAMICTAL (lamotrigine)<br>LAMICTAL CHEWABLE (lamotrigine)<br>LAMICTAL ODT (lamotrigine)<br>LAMICTAL XR (lamotrigine)<br>lamotrigine dose pack<br>lamotrigine ER<br>ONFI (clobazam) ****<br>ONFI SUSPENSION (clobazam) ****<br>OXTELLAR XR (oxcarbazepine) | *Topiramate ER will be authorized after a thirty (30) day trial of topiramate IR.<br><br>**Vimpat will be approved as monotherapy or adjunctive therapy for members seventeen (17) years of age or older with a diagnosis of partial-onset seizure disorder.<br><br>***Patients stabilized on Felbatol will be grandfathered<br><br>****Onfi will be authorized if the following criteria are met:<br>1. Adjunctive therapy for Lennox-Gastaut **or**<br>2. Generalized tonic, atonic or myoclonic seizures **and**<br>3. Previous failure of at least two (2) non-benzodiazepine anticonvulsants and previous failure of clonazepam.<br>(For continuation, prescriber must include information regarding improved response/effectiveness with this medication) |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| VIMPAT(lacosamide)[AP**]<br>zonisamide | POTIGA (ezogabine)<br>QUDEXY XR (topiramate ER)<br>SABRIL (vigabatrin)<br>STAVZOR (valproic acid)<br>TEGRETOL (carbamazepine)<br>tiagabine<br>TOPAMAX (topiramate)<br>TRILEPTAL SUSPENSION and TABLETS (oxcarbazepine)<br>TROKENDI XR (topiramate)<br>ZONEGRAN (zonisamide) | |
| | **BARBITURATES[AP]** | |
| phenobarbital<br>primidone | MYSOLINE (primidone) | |
| | **BENZODIAZEPINES[AP]** | |
| clonazepam<br>DIASTAT (diazepam rectal)<br>diazepam tablets | clonazepam ODT<br>diazepam rectal gel<br>KLONOPIN (clonazepam)<br>VALIUM TABLETS (diazepam) | |
| | **HYDANTOINS[AP]** | |
| DILANTIN (phenytoin sodium, extended)<br>PEGANONE (ethotoin)<br>phenytoin capsules, chewable tablets, suspension | DILANTIN INFATABS (phenytoin)<br>PHENYTEK (phenytoin) | |
| | **SUCCINIMIDES** | |
| CELONTIN (methsuximide)<br>ethosuximide syrup<br>ZARONTIN (ethosuximide) capsules | ethosuximide capsules<br>ZARONTIN (ethosuximide) syrup | |
| **ANTIDEPRESSANTS, OTHER** | | |
| **CATEGORY PA CRITERIA:** See below for individual sub-class criteria. | | |
| | **MAOIs[AP]** | |
| | MARPLAN (isocarboxazid)<br>NARDIL (phenelzine)<br>PARNATE (tranylcypromine)<br>phenelzine<br>tranylcypromine | Patients stabilized on MAOI agents will be grandfathered. |
| | **SNRIs[AP]** | |
| duloxetine capulses<br>venlafaxine ER capsules | CYMBALTA (duloxetine)<br>desvenlafaxine ER<br>desvenlafaxine fumarate ER | A thirty (30) day trial each of a preferred agent and an SSRI is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | EFFEXOR XR (venlafaxine)<br>FETZIMA (levomilnacipran)<br>KHEDEZLA (desvenlafaxine)<br>PRISTIQ (desvenlafaxine)<br>venlafaxine IR<br>VENLAFAXINE ER TABLETS (venlafaxine) | |
| **SECOND GENERATION NON-SSRI, OTHER[AP]** | | |
| bupropion IR<br>bupropion SR<br>bupropion XL<br>mirtazapine<br>trazodone | APLENZIN (bupropion hbr)<br>BRINTELLIX (vortioxetine)<br>EMSAM (selegiline)<br>FORFIVO XL (bupropion)<br>nefazodone<br>OLEPTRO ER (trazodone)<br>REMERON (mirtazapine)<br>VIIBRYD (vilazodone hcl)<br>WELLBUTRIN (bupropion)<br>WELLBUTRIN SR (bupropion)<br>WELLBUTRIN XL (bupropion) | A thirty (30) day trial each of a preferred agent and an SSRI is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. |
| **SELECTED TCAs** | | |
| imipramine hcl | imipramine pamoate<br>TOFRANIL (imipramine hcl)<br>TOFRANIL PM (imipramine pamoate) | A twelve (12) week trial of imipramine hcl is required before a non-preferred TCA will be authorized unless one (1) of the exceptions on the PA form is present. |
| **ANTIDEPRESSANTS, SSRIs[AP]** | | |
| **CATEGORY PA CRITERIA:** Thirty (30) day trials each of two (2) of the preferred agents are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.<br><br>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 | BRISDELLE (paroxetine)<br>CELEXA (citalopram)<br>escitalopram solution<br>fluvoxamine ER<br>fluoxetine tablets<br>LEXAPRO (escitalopram)<br>LUVOX CR (fluvoxamine)<br>PAXIL (paroxetine)<br>PAXIL CR (paroxetine)<br>paroxetine ER<br>PEXEVA (paroxetine)<br>PROZAC (fluoxetine)<br>SARAFEM (fluoxetine)<br>ZOLOFT (sertraline) | . |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **ANTIEMETICS**[AP] | | |
| **CATEGORY PA CRITERIA:** A three (3) day trial of a preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. PA is required for ondansetron when limits are exceeded. | | |
| **5HT3 RECEPTOR BLOCKERS** | | |
| ondansetron ODT, solution, tablets | ANZEMET (dolasetron)<br>granisetron<br>GRANISOL (granisetron)<br>ondansetron vials<br>SANCUSO (granisetron)<br>ZOFRAN (ondansetron)<br>ZUPLENZ (ondansetron) | |
| **CANNABINOIDS** | | |
| | CESAMET (nabilone)*<br>dronabinol<br>MARINOL (dronabinol)** | *Cesamet will be authorized only for the treatment of nausea and vomiting associated with cancer chemotherapy for patients who have failed to respond adequately to three (3) day trials of conventional treatments such as promethazine or ondansetron and are eighteen (18) years of age or older.<br><br>**Marinol (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 from eighteen (18) up to sixty-five (65) years of age. |
| **SUBSTANCE P ANTAGONISTS** | | |
| EMEND (aprepitant) | | |
| **COMBINATIONS** | | |
| | AKYNZEO (netupitant/ palonosetron | |
| **ANTIFUNGALS, ORAL** | | |
| **CATEGORY PA CRITERIA:** Non-preferred agents will be authorized only if one (1) of the exceptions on the PA form is present. | | |
| clotrimazole<br>fluconazole*<br>nystatin<br>terbinafine [CL] | ANCOBON (flucytosine)<br>CRESEMBA (isovuconazonium)<br>DIFLUCAN (fluconazole)<br>flucytosine<br>GRIFULVIN V TABLET (griseofulvin)<br>griseofulvin<br>GRIS-PEG (griseofulvin)<br>itraconazole<br>ketoconazole** | *PA is required when limits are exceeded.<br><br>PA is not required for griseofulvin suspension for children up to six (6) 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 of the following fungal infections: blastomycosis, coccidioidomycosis, histoplasmosis, chromomycosis, or paracoccidioidomycosis **and** |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | LAMISIL (terbinafine)<br>MYCELEX (clotrimazole)<br>MYCOSTATIN Tablets (nystatin)<br>NIZORAL (ketoconazole)<br>NOXAFIL (posaconazole)<br>ONMEL (itraconazole)<br>ORAVIG (miconazole)<br>SPORANOX (itraconazole)<br>VFEND (voriconazole)<br>voriconazole suspension<br>voriconazole tablets | 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 ration (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] | | |
| **CATEGORY PA CRITERIA:** Fourteen (14) day trials of two (2) of the preferred agents are required before a non-preferred agents will be authorized 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 (ketoconazole shampoo) is required. | | |
| **ANTIFUNGALS** | | |
| econazole<br>ketoconazole cream, shampoo<br>MENTAX (butenafine)<br>miconazole (OTC)<br>nystatin | CICLODAN (ciclopirox)<br>ciclopirox<br>ERTACZO (sertaconazole)<br>EXELDERM (sulconazole)<br>EXTINA (ketoconazole)<br>JUBLIA (efinaconazole)<br>ketoconazole foam<br>KERYDIN (tavaborole)<br>KETODAN (ketoconazole)<br>LOPROX (ciclopirox)<br>LUZU (luliconazole)<br>MYCOSTATIN (nystatin)<br>NAFTIN CREAM (naftifine)<br>NAFTIN GEL (naftifine)<br>NIZORAL (ketoconazole)<br>OXISTAT (oxiconazole)*<br>PEDIPIROX-4 (ciclopirox)<br>PENLAC (ciclopirox) | *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. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | VUSION (miconazole/petrolatum/zinc oxide)<br>XOLEGEL (ketoconazole) | |
| | **ANTIFUNGAL/STEROID COMBINATIONS** | |
| clotrimazole/betamethasone<br>nystatin/triamcinolone | KETOCON PLUS<br>(ketoconazole/hydrocortisone)<br>LOTRISONE (clotrimazole/betamethasone) | |
| **ANTIHYPERTENSIVES, SYMPATHOLYTICS** | | |
| **CATEGORY PA CRITERIA:** A thirty (30) day trial of each preferred unique chemical entity in the corresponding formulation is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. | | |
| CATAPRES-TTS (clonidine)<br>clonidine tablets | clonidine patch<br>NEXICLON XR (clonidine)<br>CATAPRES TABLETS (clonidine) | |
| **ANTIHYPERURICEMICS** | | |
| **CATEGORY PA CRITERIA:** A thirty (30) day trial of one (1) of the preferred agents for the prevention of gouty arthritis attacks (colchicine/probenecid, probenecid, or allopurinol) is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. | | |
| | **ANTIMITOTICS** | |
| | COLCRYS (colchicine)<br>colchicine capsules*<br>colchicine tablets | *In the case of acute gouty attacks, a ten (10) day supply (twenty (20) capsules) of colchicine will be authorized per ninety (90) days. |
| | **ANTIMITOTIC-URICOSURIC COMBINATION** | |
| colchicine/probenecid | | |
| | **URICOSURIC** | |
| probenecid | | |
| | **XANTHINE OXIDASE INHIBITORS** | |
| allopurinol | ULORIC (febuxostat)<br>ZYLOPRIM (allopurinol) | |
| **ANTIMIGRAINE AGENTS, OTHER**[AP] | | |
| **CATEGORY PA CRITERIA:** Three (3) day trials of each unique chemical entity of the preferred Antimigraine Triptan agents are required before Cambia will be authorized unless (1) of the exceptions on the PA form is present. | | |
| | CAMBIA (diclofenac) | |
| **ANTIMIGRAINE AGENTS, TRIPTANS**[AP] | | |
| **CATEGORY PA CRITERIA:** Three (3) day trials of each unique chemical entity of the preferred agents are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. Quantity limits apply for this drug class. | | |
| | **TRIPTANS** | |
| IMITREX INJECTION (sumatriptan)[CL] | almotriptan | **In addition to the Category Criteria**: Three (3) day trials of |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| IMITREX NASAL SPRAY (sumatriptan)<br>naratriptan<br>rizatriptan<br>sumatriptan tablets | AMERGE (naratriptan)<br>AXERT (almotriptan)<br>FROVA (frovatriptan)<br>IMITREX tablets (sumatriptan)<br>MAXALT (rizatriptan)<br>MAXALT MLT (rizatriptan)<br>RELPAX (eletriptan)<br>rizatriptan ODT<br>sumatriptan nasal spray/injection*<br>SUMAVEL (sumatriptan)<br>zolmitriptan<br>zolmitriptan ODT<br>ZOMIG (zolmitriptan)<br>ZOMIG ZMT (zolmitriptan) | each preferred agent will be required before Imitrex injection is authorized.<br><br>*AP does not apply to nasal spray or injectable sumatriptan. |
| **TRIPTAN COMBINATIONS** | | |
| | TREXIMET (sumatriptan/naproxen sodium) | |
| **ANTIPARASITICS, TOPICAL[AP]** | | |
| **CATEGORY PA CRITERIA:** Trials of each of the preferred agents (which are age and weight appropriate) are required before non-preferred agents will be authorized unless one (1) of the exceptions on the PA form is present. | | |
| NATROBA (spinosad)<br>permethrin 5% cream<br>permethrin 1% lotion (OTC)<br>pyrethrins-piperonyl butoxide OTC<br>SKLICE (ivermectin)<br>ULESFIA (benzyl alcohol) | EURAX (crotamiton)<br>LICE EGG REMOVER OTC (benzalkonium chloride)<br>lindane<br>malathion<br>OVIDE (malathion)<br>spinosad | |
| **ANTIPARKINSON'S AGENTS** | | |
| **CATEGORY PA CRITERIA:** Patients starting therapy on drugs in this class must show a documented allergy to all of the preferred agents in the corresponding class, before a non-preferred agent will be authorized. | | |
| **ANTICHOLINERGICS** | | |
| benztropine<br>trihexyphenidyl | COGENTIN (benztropine) | |
| **COMT INHIBITORS** | | |
| | COMTAN (entacapone)<br>entacapone<br>TASMAR (tolcapone) | |
| **DOPAMINE AGONISTS** | | |
| pramipexole<br>ropinirole | MIRAPEX (pramipexole)<br>MIRAPEX ER (pramipexole)<br>NEUPRO (rotigotine) | Mirapex, Mirapex ER, Requip, and Requip XL will be authorized for a diagnosis of Parkinsonism with no trials of preferred agents required. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | pramipexole ER<br>REQUIP (ropinirole)<br>REQUIP XL (ropinirole)<br>ropinirole ER | |
| **OTHER ANTIPARKINSON'S AGENTS** | | |
| amantadine[AP]<br>bromocriptine<br>carbidopa/levodopa<br>levodopa/carbidopa/entacapone<br>selegiline | AZILECT (rasagiline)<br>ELDEPRYL (selegiline)<br>levodopa/carbidopa ODT<br>carbidopa<br>LODOSYN (carbidopa)<br>PARCOPA (levodopa/carbidopa)<br>PARLODEL (bromocriptine)<br>RYTARY (levodopa/carbidopa)<br>SINEMET (levodopa/carbidopa)<br>STALEVO (levodopa/carbidopa/entacapone)<br>ZELAPAR (selegiline) | Amantadine will be authorized only for a diagnosis of Parkinsonism. |

## ANTIPSORIATICS, TOPICAL

**CATEGORY PA CRITERIA:** Thirty (30) day trials of two (2) preferred unique chemical entities are required before non-preferred agents will be authorized unless one (1) of the exceptions on the PA form is present.

| PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|---|---|---|
| calcipotriene ointment<br>TACLONEX (calcipotriene/ betamethasone)<br>TAZORAC (tazarotene) | calcipotriene cream<br>calcipotriene solution<br>calcipotriene/betamethasone ointment<br>CALCITRENE (calcipotriene)<br>calcitriol<br>DOVONEX (calcipotriene)<br>SORILUX (calcipotriene)<br>VECTICAL (calcitriol) | |

## ANTIPSYCHOTICS, ATYPICAL

**CATEGORY PA CRITERIA:** A fourteen (14) day trial of a preferred generic agent is required before a Preferred Brand will be authorized.

All antipsychotic agents require prior authorization for children up to six (6) years of age.

Non-preferred agents will be authorized if the following criteria have been met:
1. A fourteen (14) day trial of a preferred generic agent **and**
2. Two (2) fourteen (14) day trials of additional preferred products unless one (1) of the exceptions on the PA form is present.

Upon discharge, a hospitalized patient stabilized on a non-preferred agent may receive authorization to continue this drug for labeled indications and at FDA recommended dosages.

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | **SINGLE INGREDIENT** | |
| ABILIFY (aripiprazole)* [AP]<br>ABILIFY MAINTENA (aripiprazole)** [CL]<br>clozapine<br>clozapine ODT<br>INVEGA SUSTENNA (paliperidone)** [CL]<br>INVEGA TRINZA (paliperidone)*** [CL]<br>LATUDA (lurasidone)**** [AP]<br>olanzapine<br>olanzapine ODT<br>quetiapine***** [AP for the 25 mg Tablet Only]<br>RISPERDAL CONSTA (risperidone) ** [CL]<br>risperidone<br>ziprasidone | ADASUVE (loxapine)<br>aripiprazole<br>CLOZARIL (clozapine)<br>FANAPT (iloperidone)<br>FAZACLO (clozapine)<br>GEODON (ziprasidone)<br>GEODON IM (ziprasidone)<br>INVEGA (paliperidone)<br>olanzapine IM**<br>REXULTI (brexipiprazole)<br>RISPERDAL (risperidone)<br>SAPHRIS (asenapine)<br>SEROQUEL (quetiapine)<br>SEROQUEL XR (quetiapine)<br>VERSACLOZ (clozapine)<br>ZYPREXA (olanzapine)<br>ZYPREXA IM (olanzapine)**<br>ZYPREXA RELPREVV (olanzapine) | *Abilify will be prior authorized via electronic PA for MDD if the following criteria are met:<br>1. The patient is eighteen (18) years of age or older **and**<br>2. Diagnosis of Major Depressive Disorder (MDD) **and**<br>3. Prescribed as adjunctive therapy with buproprion, an SSRI agent or an SNRI agent **and**<br>4. The daily dose does not exceed 15 mg<br><br>**All injectable antipsychotic products require clinical prior authorization and will be approved on a case-by-case basis.<br><br>***Invega Trinza will be authorized after four months' treatment with Invega Sustenna<br><br>****Latuda will be authorized for patients only after a trial of one other preferred drug<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. |
| | **ATYPICAL ANTIPSYCHOTIC/SSRI COMBINATIONS** | |
| | olanzapine/fluoxetine<br>SYMBYAX (olanzapine/fluoxetine) | |
| **ANTIVIRALS, ORAL** | | |
| **CATEGORY PA CRITERIA:** Five (5) day trials each of the preferred agents are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. | | |
| | **ANTI HERPES** | |
| acyclovir<br>valacyclovir | famciclovir<br>FAMVIR (famciclovir)<br>SITAVIG (acyclovir)<br>VALTREX<br>ZOVIRAX (acyclovir) | |
| | **ANTI-INFLUENZA** | |
| RELENZA (zanamivir)<br>TAMIFLU (oseltamivir) | FLUMADINE (rimantadine)<br>rimantadine | **In addition to the Category Criteria**: The anti-influenza agents will be authorized only for a diagnosis of influenza. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **ANTIVIRALS, TOPICAL[AP]** | | |
| **CATEGORY PA CRITERIA:** A five (5) day trial of the preferred agent will be required before a non-preferred agent will be approved unless one (1) of the exceptions on the PA form is present. | | |
| ZOVIRAX CREAM (acyclovir) | ABREVA (docosanol)<br>acyclovir ointment<br>DENAVIR (penciclovir)<br>ZOVIRAX OINTMENT (acyclovir) | |
| **BETA BLOCKERS[AP]** | | |
| **CATEGORY PA CRITERIA:** Fourteen (14) day trials each of three (3) chemically distinct preferred agents, including the generic formulation of a requested non-preferred agent, are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. | | |
| **BETA BLOCKERS** | | |
| acebutolol<br>atenolol<br>betaxolol<br>bisoprolol<br>metoprolol<br>metoprolol ER<br>nadolol<br>pindolol<br>propranolol<br>sotalol<br>timolol | BETAPACE (sotalol)<br>BYSTOLIC (nebivolol)<br>CORGARD (nadolol)<br>HEMANGEOL (propranolol)*<br>INDERAL LA (propranolol)<br>INDERAL XL (propranolol)<br>INNOPRAN XL (propranolol)<br>KERLONE (betaxolol)<br>LEVATOL (penbutolol)<br>LOPRESSOR (metoprolol)<br>propranolol ER**<br>SECTRAL (acebutolol)<br>TENORMIN (atenolol)<br>TOPROL XL (metoprolol)<br>ZEBETA (bisoprolol) | *Hemangeol will be authorized for the treatment of proliferating infantile hemangioma requiring systemic therapy.<br><br>**Propranolol ER shall be authorized for patients with a diagnosis of migraines. Existing users will be grandfathered for use in migraine prophylaxis. |
| **BETA BLOCKER/DIURETIC COMBINATION DRUGS** | | |
| atenolol/chlorthalidone<br>bisoprolol/HCTZ<br>metoprolol/HCTZ<br>nadolol/bendroflumethiazide<br>propranolol/HCTZ | CORZIDE (nadolol/bendroflumethiazide)<br>DUTOPROL (metoprolol ER/HCTZ ER)<br>LOPRESSOR HCT (metoprolol/HCTZ)<br>TENORETIC (atenolol/chlorthalidone)<br>ZIAC (bisoprolol/HCTZ) | |
| **BETA- AND ALPHA-BLOCKERS** | | |
| carvedilol<br>labetalol | COREG (carvedilol)<br>COREG CR (carvedilol)<br>TRANDATE (labetalol) | |
| **BLADDER RELAXANT PREPARATIONS[AP]** | | |
| **CATEGORY PA CRITERIA:** A thirty (30) day trial of each chemically distinct preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. | | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| oxybutynin IR<br>oxybutynin ER<br>VESICARE (solifenacin) | DETROL (tolterodine)<br>DETROL LA (tolterodine)<br>DITROPAN XL (oxybutynin)<br>ENABLEX (darifenacin)<br>flavoxate<br>GELNIQUE (oxybutynin)<br>MYRBETRIQ (mirabegron)<br>OXYTROL (oxybutynin)<br>SANCTURA (trospium)<br>SANCTURA XR (trospium)<br>tolterodine<br>tolterodine ER<br>TOVIAZ (fesoterodine)<br>trospium<br>trospium ER | |
| **BONE RESORPTION SUPPRESSION AND RELATED AGENTS** | | |
| **CATEGORY PA CRITERIA:** A thirty (30) day trial of the preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. | | |
| **BISPHOSPHONATES** | | |
| alendronate tablets | ACTONEL (risedronate)<br>ACTONEL WITH CALCIUM (risedronate/ calcium)<br>alendronate solution<br>ATELVIA (risedronate)<br>BINOSTO (alendronate)<br>BONIVA (ibandronate)<br>DIDRONEL (etidronate)<br>etidronate<br>FOSAMAX TABLETS (alendronate)<br>FOSAMAX PLUS D (alendronate/vitamin D)<br>ibandronate<br>risedronate | |
| **OTHER BONE RESORPTION SUPPRESSION AND RELATED AGENTS** | | |
| calcitonin | EVISTA (raloxifene)*<br>FORTEO (teriparatide)<br>FORTICAL (calcitonin)<br>MIACALCIN (calcitonin)<br>raloxifene | *Evista will be authorized for postmenopausal women with osteoporosis or at high risk for invasive breast cancer. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **BPH TREATMENTS** | | |
| **CATEGORY PA CRITERIA:** Thirty (30) day trials each of at least two (2) chemically distinct preferred agents, including the generic formulation of the requested non-preferred agent, are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. | | |
| **5-ALPHA-REDUCTASE (5AR) INHIBITORS** | | |
| finasteride | AVODART (dutasteride)<br>CIALIS 5 mg (tadalafil)<br>PROSCAR (finasteride) | |
| **ALPHA BLOCKERS** | | |
| alfuzosin<br>doxazosin<br>tamsulosin<br>terazosin | CARDURA (doxazosin)<br>CARDURA XL (doxazosin)<br>FLOMAX (tamsulosin)<br>HYTRIN (terazosin)<br>RAPAFLO (silodosin)<br>UROXATRAL (alfuzosin) | |
| **5-ALPHA-REDUCTASE (5AR) INHIBITORS/ALPHA BLOCKER COMBINATION** | | |
| | JALYN (dutasteride/tamsulosin) | **Substitute for Category Criteria**: Concurrent thirty (30) day trials of dutasteride and tamsulosin are required before the non-preferred agent will be authorized. |
| **BRONCHODILATORS, BETA AGONIST**[AP] | | |
| **CATEGORY PA CRITERIA:** Thirty (30) day trials each of the chemically distinct preferred agents in their corresponding groups are required before a non-preferred agent in that group will be authorized unless one (1) of the exceptions on the PA form is present. | | |
| **INHALATION SOLUTION** | | |
| ACCUNEB (albuterol)*<br>albuterol | BROVANA (arformoterol)<br>levalbuterol<br>metaproterenol<br>PERFOROMIST (formoterol)<br>XOPENEX (levalbuterol) | *No PA is required for Accuneb for children up to five (5) years of age. |
| **INHALERS, LONG-ACTING** | | |
| FORADIL (formoterol)<br>SEREVENT (salmeterol) | ARCAPTA (indacaterol maleate)<br>STRIVERDI RESPIMAT (olodaterol) | |
| **INHALERS, SHORT-ACTING** | | |
| PROAIR HFA (albuterol)<br>PROVENTIL HFA (albuterol) | MAXAIR (pirbuterol)<br>PROAIR RESPICLICK (albuterol)<br>VENTOLIN HFA (albuterol)<br>XOPENEX HFA (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. |
| **ORAL** | | |
| albuterol IR, ER<br>terbutaline | metaproterenol<br>VOSPIRE ER (albuterol) | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **CALCIUM CHANNEL BLOCKERS[AP]** | | |
| **CATEGORY PA CRITERIA:** A fourteen (14) day trial of each preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. | | |
| **LONG-ACTING** | | |
| amlodipine<br>diltiazem ER<br>felodipine ER<br>nifedipine ER<br>verapamil ER | ADALAT CC (nifedipine)<br>CALAN SR (verapamil)<br>CARDENE SR (nicardipine)<br>CARDIZEM CD, LA (diltiazem)<br>COVERA-HS (verapamil)<br>diltiazem LA<br>DYNACIRC CR (isradipine)<br>ISOPTIN SR (verapamil)<br>MATZIM LA (diltiazem)<br>nisoldipine<br>NORVASC (amlodipine)<br>PLENDIL (felodipine)<br>PROCARDIA XL (nifedipine)<br>SULAR (nisoldipine)<br>TIAZAC (diltiazem)<br>verapamil ER PM<br>VERELAN/VERELAN PM (verapamil) | |
| **SHORT-ACTING** | | |
| diltiazem<br>verapamil | CALAN (verapamil)<br>CARDIZEM (diltiazem)<br>isradipine<br>nicardipine<br>nifedipine<br>nimodipine<br>NIMOTOP (nimodipine)<br>NYMALIZE SOLUTION (nimodipine)<br>PROCARDIA (nifedipine) | |
| **CEPHALOSPORINS AND RELATED ANTIBIOTICS[AP]** | | |
| **CATEGORY PA CRITERIA:** A five (5) day trial of the preferred agent is required before a non-preferred agent will be authorized 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)<br>AUGMENTIN XR (amoxicillin/clavulanate)<br>MOXATAG (amoxicillin) | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **CEPHALOSPORINS** | | |
| cefaclor capsule<br>cefadroxil capsule, tablet<br>cefdinir<br>cefuroxime tablet<br>cephalexin capsule, suspension | CEDAX (ceftibuten)<br>cefaclor suspension<br>cefaclor ER tablet<br>cefadroxil suspension<br>cefditoren<br>cefpodoxime<br>cefprozil<br>ceftibuten capsule, suspension<br>CEFTIN (cefuroxime)<br>cefuroxime suspension<br>cephalexin tablet<br>KEFLEX (cephalexin)<br>OMNICEF (cefdinir)<br>RANICLOR (cefaclor)<br>SPECTRACEF (cefditoren)<br>SUPRAX (cefixime) | |
| **COLONY STIMULATING FACTORS** | | |
| **CATEGORY PA CRITERIA:** A thirty (30) day trial of one (1) of the preferred agents is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present | | |
| LEUKINE (sargramostim)<br>NEUPOGEN (filgrastim) | NEULASTA (pegfilgrastim) | . |
| **COPD AGENTS** | | |
| **CATEGORY PA CRITERIA:** A thirty (30) day trial of a preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. | | |
| **ANTICHOLINERGIC[AP]** | | |
| ATROVENT HFA (ipratropium)<br>ipratropium<br>SPIRIVA (tiotropium) | INCRUSE ELLIPTA (umeclidinium)<br>SPIRIVA RESPIMAT (tiotropium)<br>TUDORZA (aclidinium) | **Substitute for Category Criteria**: A thirty (30) day trial of tiotropium is required before a non-preferred agent will be authorized. |
| **ANTICHOLINERGIC-BETA AGONIST COMBINATIONS[AP]** | | |
| albuterol/ipratropium<br>COMBIVENT RESPIMAT (albuterol/ipratropium) | ANORO ELLIPTA (umeclidinium/vilanterol)*<br>DUONEB (albuterol/ipratropium)<br>STIOLTO RESPIMAT (tiotropium/olodaterol)* | *Anoro Ellipta and Stiolto Respimat will be authorized if the following criteria are met:<br>1) Patient must be eighteen (18) years of age or older; **AND**<br>2) Patient must have had a diagnosis of COPD; **AND**<br>3) Patient must have had a thirty (30) day trial of a LABA; **AND**<br>4) Patient must have had a **concurrent thirty (**30) day trial with a long-acting anticholinergic;<br>Prior-authorization will be denied for patients with a sole diagnosis of asthma. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | **PDE4 INHIBITOR** | |
| | DALIRESP (roflumilast)* | *Daliresp will be authorized if the following criteria are met:<br>1. Patient is forty (40) years of age or older **and**<br>2. Diagnosis of severe chronic obstructive pulmonary disease (COPD) associated with chronic bronchitis and multiple exacerbations requiring systemic glucocorticoids in the preceding six (6) months **and**<br>**3.** Concurrent therapy with an inhaled corticosteroid and long-acting bronchodilator and evidence of compliance **and**<br>**4.** No evidence of moderate to severe liver impairment (Child-Pugh Class B or C) **and**<br>5. No concurrent use with strong cytochrome P450 inducers (rifampicin, phenobarbital, carbamazepine or phenytoin) |
| **CYTOKINE & CAM ANTAGONISTS[CL]** | | |
| **CATEGORY PA CRITERIA:** Non-preferred agents require ninety (90) day trials of both Humira and Enbrel unless one (1) of the exceptions on the PA form is present. For the indication of plaque psoriasis, an additional ninety (90) day trial of Cosentyx will be required. | | |
| | **ANTI-TNFs** | |
| ENBREL (etanercept) *<br>HUMIRA (adalimumab) * | CIMZIA (certolizumab pegol)<br>SIMPONI (golimumab) | *Additional criteria for this category may be found at the BMS Website, by clicking the hyperlink. |
| | **OTHERS** | |
| COSENTYX (secukinumab)* | ACTEMRA syringe (tocilizumab)<br>KINERET (anakinra)<br>ORENCIA syringe (abatacept)<br>OTEZLA (apremilast)<br>STELARA syringe (ustekinumab)<br>XELJANZ (tofacitinib)** | *Cosentyx will be authorized for treatment of plaque psoriasis only after inadequate response to a ninety (90) day trial of Humira.<br><br>**Additional criteria for this category may be found at the BMS Website, by clicking the hyperlink. |
| **EPINEPHRINE, SELF-INJECTED** | | |
| **CATEGORY PA CRITERIA:** A non-preferred agent will be authorized upon documentation showing the patient's inability to follow the instructions, or the patient's failure to understand the training for both preferred agents. | | |
| epinephrine<br>EPIPEN (epinephrine)<br>EPIPEN JR (epinephrine) | ADRENACLICK (epinephrine)<br>AUVI-Q (epinephrine) | |
| **ERYTHROPOIESIS STIMULATING PROTEINS[CL]** | | |
| **CATEGORY PA CRITERIA:** A thirty (30) day trial of the preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. | | |
| PROCRIT (rHuEPO) | ARANESP (darbepoetin)<br>EPOGEN (rHuEPO) | Erythropoiesis agents will be authorized if the following criteria are met: |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | | 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. (Lab oratory values must be dated within six (6) weeks of request.) **and**<br>2. Transferrin saturation ≥ 20%, ferritin levels ≥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 ≤ 500mU/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]** | | |
| **CATEGORY PA CRITERIA:** A five (5) day trial of a preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. | | |
| CIPRO SUSPENSION (ciprofloxacin)<br>ciprofloxacin<br>levofloxacin tablet | AVELOX (moxifloxacin)<br>CIPRO TABLETS (ciprofloxacin)<br>CIPRO XR (ciprofloxacin)<br>ciprofloxacin ER<br>ciprofloxacin suspension<br>FACTIVE (gemifloxacin)<br>LEVAQUIN (levofloxacin)<br>levofloxacin solution<br>moxifloxacin<br>NOROXIN (norfloxacin)<br>ofloxacin | |
| **GLUCOCORTICOIDS, INHALED[AP]** | | |
| **CATEGORY PA CRITERIA:** Thirty (30) day trials of each of the preferred agents are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.<br>A prior authorization will be required for children nine (9) years of age or older, and for individuals unable to use an MDI. | | |
| **GLUCOCORTICOIDS** | | |
| ASMANEX TWISTHALER (mometasone)<br>FLOVENT HFA (fluticasone)<br>FLOVENT DISKUS (fluticasone)<br>PULMICORT RESPULES (budesonide)*<br>QVAR (beclomethasone) | AEROSPAN (flunisolide)**<br>ALVESCO (ciclesonide)<br>ARNUITY ELLIPTA (fluticasone)<br>ASMANEX HFA (mometasone)<br>budesonide<br>PULMICORT FLEXHALER (budesonide) | *Pulmicort Respules are preferred for children up to nine (9) years of age.<br>Brand Pulmicort Respules are preferred over the generic formulation.<br><br>**Aerospan will be authorized for children ages 6 through 11 |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | | years old without a trial of a preferred agent. |
| **GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS** | | |
| ADVAIR HFA (fluticasone/salmeterol)<br>BREO ELLIPTA (fluticasone/vilanerol)<br>DULERA (mometasone/formoterol)<br>SYMBICORT(budesonide/formoterol) | ADVAIR DISKUS (fluticasone/salmeterol) | **Substitute for Category Criteria**: For a diagnosis of COPD, thirty (30) day trials of each of the preferred agents in this category indicated for COPD are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. |
| **GROWTH HORMONE**[CL] | | |
| **CATEGORY PA CRITERIA:** A trial of each preferred agents is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. | | |
| GENOTROPIN (somatropin)<br>NORDITROPIN (somatropin)<br>NUTROPIN AQ (somatropin) | HUMATROPE (somatropin)<br>INCRELEX (mecasermin)<br>OMNITROPE (somatropin)<br>SAIZEN (somatropin)<br>SEROSTIM (somatropin)<br>TEV-TROPIN (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. |
| ***H. PYLORI* TREATMENT** | | |
| **CATEGORY PA CRITERIA:** A trial of the preferred agent or individual preferred components of the non-preferred agent (with omeprazole or pantoprazole) at the recommended dosages, frequencies and duration is required before the brand name combination packages will be authorized 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<br>metronidazole<br>clarithromycin<br>bismuth | HELIDAC (bismuth/metronidazole/tetracycline)<br>lansoprazole/amoxicillin/clarithromycin<br>OMECLAMOX-PAK (omeprazole/amoxicillin/clarithromycin)<br>PREVPAC (lansoprazole/amoxicillin/clarithromycin)<br>PYLERA (bismuth/metronidazole/tetracycline) | |
| **HEPATITIS B TREATMENTS** | | |
| **CATEGORY PA CRITERIA:** A thirty (30) day trial of the preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. | | |
| EPIVIR HBV (lamivudine)<br>TYZEKA (telbivudine) | adefovir<br>BARACLUDE (entecavir)<br>HEPSERA (adefovir)<br>lamivudine HBV | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **HEPATITIS C TREATMENTS[CL]** | | |
| **CATEGORY PA CRITERIA:** For patients starting therapy in this class, a trial of the preferred agent of a dosage form is required before a non-preferred agent of that dosage form will be authorized. | | |
| HARVONI (ledipasvir/sofosbuvir)*<br>PEGASYS (pegylated interferon)<br>PEG-INTRON (pegylated interferon)<br>ribavirin<br>SOVALDI (sofosbuvir)*<br>TECHNIVIE (ombitasvir/paritaprevir/ritonavir)*<br>VIEKIRA PAK (dasabuvir/ombitasvir/paritaprevir/ritonavir)* | COPEGUS (ribavirin)<br>DAKLINZA (daclatasvir)*<br>MODERIBA 400 mg, 600 mg<br>MODERIBA DOSE PACK<br>OLYSIO (simeprevir)*<br>REBETOL (ribavirin)<br>RIBASPHERE RIBAPAK (ribavirin)<br>RIBASPHERE 400 mg, 600 mg (ribavirin) | *Full PA criteria may be found at [the BMS Website,] by clicking the hyperlink. |
| **HYPERPARATHYROID AGENTS[AP]** | | |
| **CATEGORY PA CRITERIA:** A thirty (30) day trial of a preferred agent will be required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. | | |
| HECTOROL (doxercalciferol)<br>paricalcitol capsule | doxercalciferol<br>NATPARA (parathyroid hormone)<br>paricalcitol injection<br>SENSIPAR (cinacalcet)<br>ZEMPLAR (paricalcitol) | |
| **HYPOGLYCEMICS, BIGUANIDES** | | |
| **CATEGORY PA CRITERIA:** A ninety (90) day trial of one (1) preferred agent will be required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. | | |
| Metformin<br>metformin ER | FORTAMET (metformin ER)<br>GLUCOPHAGE (metformin)<br>GLUCOPHAGE XR (metformin ER)<br>GLUMETZA (metformin ER)<br>RIOMET (metformin) | Glumetza will be approved only after a 30-day trial of Fortamet. |
| **HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS** | | |
| **CATEGORY PA CRITERIA:** All agents (preferred and non-preferred) require a previous history of a thirty (30) day trial of metformin.<br><br>All agents will be approved in six (6) month intervals. For re-authorizations, documentation that A1C levels have decreased by at least 1% or are maintained at ≤8% is required. A1C levels submitted must be for the most recent thirty (30) day period. | | |
| **INJECTABLE** | | |
| BYDUREON (exenatide)*<br>BYETTA (exenatide)[AP]<br>VICTOZA (liraglutide) | SYMLIN (pramlintide) **<br>TANZEUM (albiglutide)[AP]<br>TRULICITY (dulaglutide) | **In addition to the Category Criteria**: A thirty (30) day trial of one (1) preferred agent with a chemical entity distinct from the requested non-preferred agent will be required before a non-preferred agent will be authorized unless one (1) of the |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | | exceptions on the PA form is present.<br><br>Concurrent therapy with a bolus insulin is contraindicated with all agents in this class<br><br>*Bydureon may be authorized after thirty (30) day trial of Byetta and will not be authorized with concurrent insulin therapy of any kind.<br><br>**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. |
| **ORAL** AP | | |
| JENTADUETO (linagliptin/metformin) AP<br>TRADJENTA (linagliptin) AP | JANUMET (sitagliptin/metformin) AP<br>JANUMET XR (sitagliptin/metformin) AP<br>JANUVIA (sitagliptin) AP<br>KAZANO (alogliptin/metformin)<br>KOMBIGLYZE XR (saxagliptin/metformin) *<br>NESINA (alogliptin)<br>ONGLYZA (saxagliptin)<br>OSENI (alogliptin/pioglitazone) | **In addition to the Category Criteria**: A ninety (90) day trial of the corresponding (single drug vs. combination drug) preferred agent is required before a non-preferred agent will be approved.<br><br>*Kombiglyze XR will be authorized after thirty (30) day trials of the preferred combination agents. |
| **HYPOGLYCEMICS, INSULIN AND RELATED AGENTS** | | |
| **CATEGORY PA CRITERIA:** Humulin pens and Humalog Mix pens will be authorized only for patients who cannot utilize vials due to impaired vision or dexterity. | | |
| HUMALOG (insulin lispro)<br>HUMALOG MIX VIALS (insulin lispro/lispro protamine)<br>HUMULIN VIALS (insulin)<br>LANTUS (insulin glargine)<br>LEVEMIR (insulin detemir)<br>NOVOLOG (insulin aspart)<br>NOVOLOG MIX (insulin aspart/aspart protamine) | AFREZZA (insulin) CL<br>APIDRA (insulin glulisine) AP*<br>HUMALOG PEN/KWIKPEN (insulin lispro)<br>HUMALOG MIX PENS (insulin lispro/lispro protamine)<br>HUMULIN PENS (insulin)<br>NOVOLIN (insulin)<br>TOUJEO SOLOSTAR (insulin glargine)** | *Apidra will be authorized if the following criteria are met:<br>1. Patient is four (4) years of age or older; **and**<br>2. Patient is currently on a regimen including a longer acting or basal insulin, **and**<br>3. Patient has had a trial of a similar preferred agent, Novolog or Humalog, with documentation that the desired results were not achieved.<br><br>**Toujeo Solostar will be authorized only after 6 months of compliance on preferred long-acting insulin. Toujeo will **only** be approved for once daily doses of at least 60 units. |
| **HYPOGLYCEMICS, MEGLITINIDES** | | |
| **CATEGORY PA CRITERIA:** All agents (preferred and non-preferred) require a previous history of a thirty (30) day trial of metformin.<br><br>All agents will be approved in six (6) month intervals. For re-authorizations, documentation that A1C levels have decreased by at least 1% or are maintained at ≤8% is required. A1C levels submitted must be for the most recent thirty (30) day period. | | |
| **MEGLITINIDES** | | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| nateglinide<br>PRANDIN (repaglinide) | repaglinide<br>STARLIX (nateglinide) | |
| **MEGLITINIDE COMBINATIONS** | | |
| | PRANDIMET (repaglinide/metformin) | |

## HYPOGLYCEMICS, BILE ACID SEQUESTRANTS

**CATEGORY PA CRITERIA:** Welchol will be authorized for add-on therapy for type 2 diabetes when there is a previous history of a thirty (30) day trial of an oral agent (sulfonylurea, thiazolidinedione (TZD) or metformin).

| PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|---|---|---|
| WELCHOL (colesevelam)[AP] | | |

## HYPOGLYCEMICS, SGLT2 INHIBITORS

**CATEGORY PA CRITERIA:** All agents will be approved in six (6) month intervals if the following criteria are met:

**Initial starts** require a diagnosis of Type 2 Diabetes and an A1C taken within the last 60 days reflecting the patient's current and stabilized regimen. Current A1C must be less than or equal to (≤) 10.5%. No agent in this category shall be approved except as add on therapy to a regimen consisting of metformin (unless contraindicated) and at least one other oral agent prescribed at the maximum tolerable doses for at least 60 days.

**Re-authorizations** require continued maintenance on a regimen consisting of metformin and at least one other oral agent at the maximum tolerable doses. Documentation must be submitted that the A1C has decreased by at least 1% or is maintained at ≤8%.

| PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|---|---|---|
| **SGLT2 INHIBITORS** | | |
| | FARXIGA (dapagliflozin)<br>INVOKANA (canagliflozin)<br>JARDIANCE (empagliflozin) | |
| **SGLT2 COMBINATIONS** | | |
| | GLYXAMBI (empagliflozin/linagliptin)<br>INVOKAMET (canagliflozin/metformin)<br>SYNJARDY (empagliflozin/metformin)<br>XIGDUO XR (dapagliflozin/metformin) | |

## HYPOGLYCEMICS, TZD[AP]

**CATEGORY PA CRITERIA:** All agents (preferred and non-preferred) require a previous history of a thirty (30) day trial of metformin.

All agents will be approved in six (6) month intervals. For re-authorizations, documentation that A1C levels have decreased by at least 1% or are maintained at ≤8% is required. A1C levels submitted must be for the most recent thirty (30) day period.

| PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
|---|---|---|
| **THIAZOLIDINEDIONES** | | |
| Pioglitazone | ACTOS (pioglitazone)<br>AVANDIA (rosiglitazone) | |
| **TZD COMBINATIONS** | | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | ACTOPLUS MET (pioglitazone/ metformin)<br>ACTOPLUS MET XR (pioglitazone/ metformin)<br>AVANDAMET (rosiglitazone/metformin)<br>AVANDARYL (rosiglitazone/glimepiride)<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. |
| **IMMUNE GLOBULINS, IV[CL]** | | |
| **CATEGORY PA CRITERIA:** Immune globulin agents will be authorized according to FDA approved indications. | | |
| BIVIGAM (human immunoglobulin gamma)<br>CARIMUNE NF (human immunoglobulin gamma)<br>FLEBOGAMMA DIF (human immunoglobulin gamma)<br>GAMMAGARD LIQUID (human immunoglobulin gamma)<br>GAMMAGARD S-D (human immunoglobulin gamma)<br>GAMMAKED (human immunoglobulin gamma)<br>GAMMAPLEX (human immunoglobulin gamma)<br>GAMUNEX-C (human immunoglobulin gamma)<br>OCTAGAM (human immunoglobulin gamma)<br>PRIVIGEN (human immunoglobulin gamma) | | |
| **IMMUNE GLOBULINS, OTHER[CL]** | | |
| **CATEGORY PA CRITERIA:** Immune globulin agents will be authorized according to FDA approved indications.<br>A trial of a preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. | | |
| CYTOGAM (human cytomegalovirus immune globulin)<br>GAMASTAN S-D VIAL (human immunoglobulin gamma)<br>HEPAGAM B (hepatitis b immune globulin (human))<br>HIZENTRA (human immunoglobulin gamma)<br>VARIZIG (varicella zoster immune globulin (human)) | HYQVIA (human immuneglobulin g and hyaluronidase) | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **IMMUNOMODULATORS, ATOPIC DERMATITIS**[AP] | | |
| **CATEGORY PA CRITERIA:** A thirty (30) day trial of a preferred medium or high potency topical corticosteroid is required before coverage of Elidel will be considered; additionally, a thirty (30) day trial of Elidel is required before a non-preferred agent will be considered, unless one (1) of the exceptions on the PA form is present. | | |
| ELIDEL (pimecrolimus)[AP] | PROTOPIC (tacrolimus)<br>tacrolimus ointment | A thirty (30) day trial of a preferred medium or high potency topical corticosteroid is required before coverage of Elidel will be considered; additionally, a thirty (30) day trial of Elidel is required before Protopic will be considered, unless one (1) of the exceptions on the PA form is present. |
| **IMMUNOMODULATORS, TOPICAL & GENITAL WARTS AGENTS** | | |
| **CATEGORY PA CRITERIA:** A thirty (30) day trial of both preferred agents is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. | | |
| ALDARA (imiquimod)<br>CONDYLOX GEL (podofilox) | CONDYLOX SOLUTION (podofilox)<br>imiquimod<br>podofilox<br>VEREGEN (sinecatechins)<br>ZYCLARA (imiquimod)* | *Zyclara will be authorized for a diagnosis of actinic keratosis. |
| **IMMUNOSUPPRESSIVES, ORAL** | | |
| **CATEGORY PA CRITERIA:** A fourteen (14) day trial of a preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. | | |
| azathioprine<br>cyclosporine<br>cyclosporine, modified<br>mycophenolate mofetil<br>PROGRAF (tacrolimus)<br>RAPAMUNE (sirolimus)<br>sirolimus | ASTAGRAF XL (tacrolimus)<br>AZASAN (azathioprine)<br>CELLCEPT (mycophenolate mofetil)<br>IMURAN (azathioprine)<br>MYFORTIC (mycophenolic acid)<br>mycophenolic acid<br>mycophenolic mofetil suspension<br>NEORAL (cyclosporine, modified)<br>SANDIMMUNE (cyclosporine)<br>tacrolimus<br>ZORTRESS (everolimus) | |
| **INTERMITTENT CLAUDICATION**[AP] | | |
| **CATEGORY PA CRITERIA:** A thirty (30) day trial of one of the preferred agents will be required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. | | |
| cilostazol<br>pentoxifylline | PLETAL (cilostazol) | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **INTRANASAL RHINITIS AGENTS[AP]** | | |
| **CATEGORY PA CRITERIA:** See below for individual sub-class criteria. | | |
| | **ANTICHOLINERGICS** | |
| Ipratropium | ATROVENT(ipratropium) | Thirty (30) day trials each of one (1) of the nasal anti-cholinergic, one (1) of the antihistamine, and one (1) of the corticosteroid preferred agents are required before a non-preferred anti-cholinergic will be authorized unless one (1) of the exceptions on the PA form is present. |
| | **ANTIHISTAMINES** | |
| ASTEPRO (azelastine)<br>PATANASE (olopatadine) | azelastine | Thirty (30) day trials of each preferred intranasal antihistamines and a thirty (30) day trial of one (1) of the preferred intranasal corticosteroids are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. |
| | **COMBINATIONS** | |
| | DYMISTA (azelastine / fluticasone) | A concurrent thirty (30) day trial of each of the preferred components is required before Dymista will be authorized unless one (1) of the exceptions on the PA form is present. |
| | **CORTICOSTEROIDS** | |
| fluticasone propionate<br>QNASL HFA (beclomethasone) | BECONASE AQ (beclomethasone)<br>budesonide<br>FLONASE (fluticasone propionate)<br>flunisolide<br>NASACORT AQ (triamcinolone)<br>NASONEX (mometasone)<br>OMNARIS (ciclesonide)<br>RHINOCORT AQUA (budesonide)<br>triamcinolone<br>VERAMYST (fluticasone furoate)<br>ZETONNA (ciclesonide) | Thirty (30) day trials of each preferred agent in the corticosteroid group are required before a non-preferred corticosteroid agent will be authorized unless one (1) of the exceptions on the PA form is present. |
| **IRRITABLE BOWEL SYNDROME** | | |
| **CATEGORY PA CRITERIA:** Thirty (30) day trial of the preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. | | |
| AMITIZA (lubiprostone)[CL*]<br>LINZESS (linaclotide) [CL**] | LOTRONEX (alosetron) | *Amitiza will be prior authorized for patients if the following criteria are met:<br>1. Diagnosis of chronic idiopathic constipation, with less than three spontaneous bowel movements per week **or**<br>2. Female with a diagnosis of Irritable Bowel Syndrome with Constipation (IBS-C) **or**<br>3. Diagnosis of opioid induced constipation accompanied by a |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | | diagnosis of non-cancer chronic pain (Diagnosis of chronic pain must be documented with diagnostic studies, if appropriate.)<br>**and each of the following:**<br>1. Greater than 18 years of age<br>2. Documentation of change in diet<br>3. Documented failure of at least fourteen (14) days of therapy each with osmotic and bulk forming laxatives<br>4. Negative pregnancy test prior to starting therapy if at risk<br>5. Capable of complying with effective contraceptive measures if at risk<br>6. Be appropriately screened for colon cancer, history of bowel obstruction, hepatic or renal disease, hypothyroidism, pelvic floor abnormalities, and spinal cord abnormalities.<br><br>**Linzess will be authorized if the following criteria are met:<br>1. Diagnosis of chronic idiopathic constipation, with less than three spontaneous bowel movements per week; **or**<br>2. Diagnosis of Irritable Bowel Syndrome with Constipation (IBS-C); **and**<br>3. Patient is eighteen (18) years of age or older **and**<br>4. Documented failure of at least one month of therapy with osmotic or bulk forming laxatives **and**<br>5. Appropriate screening for colon cancer, history of bowel obstruction, hepatic or renal disease, hypothyroidism, pelvic floor abnormalities, and spinal cord abnormalities. |
| **LAXATIVES AND CATHARTICS** | | |
| **CATEGORY PA CRITERIA:** Thirty (30) day trials each of the preferred agents are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. | | |
| COLYTE<br>GOLYTELY<br>NULYTELY<br>peg 3350 | HALFLYTELY-BISACODYL KIT<br>MOVIPREP<br>OSMOPREP<br>PREPOPIK<br>SUPREP | |
| **LEUKOTRIENE MODIFIERS** | | |
| **CATEGORY PA CRITERIA:** Thirty (30) day trials each of the preferred agents are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. | | |
| ACCOLATE (zafirlukast)<br>montelukast | SINGULAIR (montelukast)<br>zafirlukast<br>ZYFLO (zileuton) | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
| **LIPOTROPICS, OTHER (Non-statins)[AP]** | | |
| **CATEGORY PA CRITERIA:** A twelve (12) week trial of one (1) of the preferred agents is required before a non-preferred agent in the corresponding category will be authorized. | | |
| **BILE ACID SEQUESTRANTS** | | |
| cholestyramine<br>colestipol tablets | COLESTID (colestipol)<br>colestipol granules<br>KYNAMRO (mipomersen)<br>QUESTRAN (cholestyramine)<br>WELCHOL (colesevelam)* | *Welchol will be authorized for add-on therapy for type 2 diabetes 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** | | |
| ZETIA (ezetimibe) [AP] | | Zetia will be authorized with prior use of a HMG-CoA reductase inhibitor within the previous six (6) months. |
| **FATTY ACIDS** | | |
| | LOVAZA (omega-3-acid ethyl esters)<br>omega-3 acid ethyl esters<br>VASCEPA (icosapent ethyl) | These agents shall only be authorized when the patient has an initial triglyceride level ≥ 500 mg/dL and has had inadequate response or intolerance to trials of BOTH a nicotinic acid and a fibrate, unless otherwise contraindicated. |
| **FIBRIC ACID DERIVATIVES** | | |
| fenofibrate 54, 150 and 160 mg<br>fenofibrate micronized 67mg, 134mg & 200mg<br>fenofibrate nanocrystallized 48 mg, 145 mg<br>gemfibrozil | ANTARA (fenofibrate)<br>FENOGLIDE (fenofibrate)<br>FIBRICOR (fenofibric acid)<br>fenofibrate 43, 50, 120 and 130 mg<br>fenofibric acid<br>LIPOFEN (fenofibrate)<br>LOFIBRA (fenofibrate)<br>LOPID (gemfibrozil)<br>TRICOR (fenofibrate nanocrystallized)<br>TRIGLIDE (fenofibrate)<br>TRILIPIX (fenofibric acid) | |
| **NIACIN** | | |
| niacin<br>NIACOR (niacin)<br>NIASPAN (niacin) | niacin ER | |
| **PCSK-9 INHIBITORS** | | |
| | PRALUENT (alirocumab) | Praluent PA criteria is available at the [BMS Website by clicking on this hyperlink.] |
| **LIPOTROPICS, STATINS[AP]** | | |
| **CATEGORY PA CRITERIA:** See below for individual sub-class criteria. | | |
| **STATINS** | | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| atorvastatin<br>CRESTOR (rosuvastatin)<br>lovastatin<br>pravastatin<br>simvastatin[CL]* | ALTOPREV (lovastatin)<br>fluvastatin<br>LESCOL (fluvastatin)<br>LESCOL XL (fluvastatin)<br>LIPITOR (atorvastatin)<br>LIVALO (pitavastatin)<br>MEVACOR (lovastatin)<br>PRAVACHOL (pravastatin)<br>ZOCOR (simvastatin)* | Twelve (12) week trials each of two (2) of the preferred statins, including the generic formulation of a requested non-preferred agent, are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.<br><br>*Zocor/simvastatin 80mg tablets will require a clinical PA |
| **STATIN COMBINATIONS** | | |
| | ADVICOR (lovastatin/niacin)<br>amlodipine/atorvastatin<br>CADUET (atorvastatin/amlodipine)<br>LIPTRUZET (atorvastatin/ezetimibe)<br>SIMCOR (simvastatin/niacin ER)<br>VYTORIN (simvastatin/ezetimibe)* | Thirty (30) day concurrent trials of the appropriate single agents are required before a non-preferred Statin combination will be authorized.<br><br>*Vytorin will be authorized only after an insufficient response to the maximum tolerable dose of atorvastatin or rosuvastatin after twelve (12) weeks, unless one (1) of the exceptions on the PA form is present.<br><br>Vytorin 80/10mg tablets will require a clinical PA |
| **MACROLIDES/KETOLIDES** | | |
| **CATEGORY PA CRITERIA:** See below for individual sub-class criteria. | | |
| **KETOLIDES** | | |
| | KETEK (telithromycin) | Requests for telithromycin will be authorized if there is documentation of the use of any antibiotic within the past twenty-eight (28) days. |
| **MACROLIDES** | | |
| azithromycin<br>BIAXIN XL (clarithromycin)<br>clarithromycin<br>erythromycin base | BIAXIN (clarithromycin)<br>clarithromycin ER<br>E.E.S. (erythromycin ethylsuccinate)<br>E-MYCIN (erythromycin)<br>ERYC (erythromycin)<br>ERYPED (erythromycin ethylsuccinate)<br>ERY-TAB (erythromycin)<br>ERYTHROCIN (erythromycin stearate)<br>erythromycin estolate<br>PCE (erythromycin)<br>ZITHROMAX (azithromycin)<br>ZMAX (azithromycin) | Five (5) day trials each of the preferred agents are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **MULTIPLE SCLEROSIS AGENTS** | | |
| **CATEGORY PA CRITERIA:** A diagnosis of multiple sclerosis and a thirty (30) day trial of a preferred agent in the corresponding class (interferon or non-interferon) will be required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. | | |
| **INTERFERONS**AP | | |
| AVONEX (interferon beta-1a)AP<br>AVONEX PEN (interferon beta-1a)AP<br>BETASERON (interferon beta-1b) AP | EXTAVIA KIT (interferon beta-1b)<br>EXTAVIA VIAL (interferon beta-1b)<br>PLEGRIDY (peginterferon beta-1a)<br>REBIF (interferon beta-1a)<br>REBIF REBIDOSE (interferon beta-1a) | |
| **NON-INTERFERONS** | | |
| COPAXONE 20 mg (glatiramer)AP<br>GILENYA (fingolimod) AP* | AMPYRA (dalfampridine)CL**<br>AUBAGIO (teriflunomide)CL***<br>COPAXONE 40 mg (glatiramer)CL****<br>GLATOPA (glatiramer)<br>TECFIDERA (dimethyl fumarate)CL***** | *Gilenya will be approved after a thirty (30) day trial of a preferred injectable agent.<br><br>**Ampyra will be authorized if the following criteria are 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 **and**<br>4. Initial prescription will be authorized for thirty (30) days only.<br><br>***Aubagio will be authorized if the following criteria are met:<br>1. Diagnosis of relapsing multiple sclerosis **and**<br>2. Measurement of transaminase and bilirubin levels within the (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 cell 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 from eighteen (18) up to sixty-five (65) years of age **and**<br>6. Negative tuberculin skin test before initiation of therapy<br><br>****Copaxone 40mg will only be authorized for documented injection site issues.<br><br>*****Tecfidera will be authorized if the following criteria are met:<br>1. Diagnosis of relapsing multiple sclerosis **and**<br>2. A thirty (30) day trial of a preferred agent in the corresponding class **and**<br>3. Complete blood count (CBC) within six (6) months of |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | | initiation of therapy and six (6) months after initiation **and**<br>4. Complete blood count (CBC) annually during therapy. |
| **NEUROPATHIC PAIN** | | |
| **CATEGORY PA CRITERIA:** A trial of a preferred agent in the corresponding dosage form (oral or topical) will be required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. | | |
| capsaicin OTC<br>duloxetine<br>gabapentin capsules, solution<br>LIDODERM (lidocaine)[AP]* | CYMBALTA (duloxetine)<br>gabapentin tablets<br>GRALISE (gabapentin)**<br>HORIZANT (gabapentin)<br>IRENKA (duloxetine)<br>lidocaine patch<br>LYRICA CAPSULE (pregabalin)***<br>LYRICA SOLUTION (pregabalin)***<br>NEURONTIN (gabapentin)<br>QUTENZA (capsaicin)<br>SAVELLA (milnacipran)****<br>ZOSTRIX OTC (capsaicin) | *Lidoderm patches will be authorized for a diagnosis of post-herpetic neuralgia.<br><br>**Gralise will be authorized if the following criteria are met:<br>1. Diagnosis of post herpetic neuralgia **and**<br>2. Trial of a tricyclic antidepressant for a least thirty (30) days **and**<br>3. Trial of gabapentin immediate release formulation (positive response without adequate duration) **and**<br>4. Request is for once daily dosing with 1800 mg maximum daily dosage.<br><br>***Lyrica will be authorized if the following criteria are met:<br>1. Diagnosis of seizure disorders or neuropathic pain associated with a spinal cord injury **or**<br>2. Diagnosis of fibromyalgia, postherpetic neuralgia, or diabetic neuropathy AND a history of a trial of duloxetine at the generally accepted maximum therapeutic dose of 60 mg/day OR gabapentin at a therapeutic dose range between 900 mg and 2,400 mg per day for thirty (30) days within the previous twenty-four (24) month period or an intolerance due to a potential adverse drug-drug interaction, drug-disease interaction, or intolerable side effect (In cases of renal impairment, doses may be adjusted based on the degree of impairment.)<br><br>****Savella will be authorized for a diagnosis of fibromyalgia or a previous thirty (30) day trial of a drug that infers fibromyalgia: duloxetine, gabapentin, amitriptyline or nortriptyline. |
| **NSAIDS[AP]** | | |
| **CATEGORY PA CRITERIA:** Thirty (30) day trials of each of the preferred agents are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. | | |
| **NON-SELECTIVE** | | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| diclofenac (IR, SR)<br>etodolac IR<br>flurbiprofen<br>ibuprofen (Rx and OTC)<br>INDOCIN SUSPENSION (indomethacin)<br>indomethacin<br>ketoprofen<br>ketorolac<br>nabumetone<br>naproxen (Rx and OTC)<br>piroxicam<br>sulindac | ANAPROX (naproxen)<br>ANSAID (flurbiprofen)<br>CATAFLAM (diclofenac)<br>CLINORIL (sulindac)<br>DAYPRO (oxaprozin)<br>diflunisal<br>DUEXIS (famotidine/ibuprofen)<br>etodolac SR<br>FELDENE (piroxicam)<br>fenoprofen<br>INDOCIN SUPPOSITORIES (indomethacin)<br>indomethacin ER<br>ketoprofen ER<br>meclofenamate<br>mefenamic acid<br>MOTRIN (ibuprofen)<br>NALFON (fenoprofen)<br>NAPRELAN (naproxen)<br>NAPROSYN (naproxen)<br>oxaprozin<br>PONSTEL (meclofenamate)<br>SPRIX (ketorolac)<br>tolmetin<br>VOLTAREN (diclofenac)<br>ZIPSOR (diclofenac potassium)<br>ZORVOLEX (diclofenac) | |
| **NSAID/GI PROTECTANT COMBINATIONS** | | |
| | ARTHROTEC (diclofenac/misoprostol)<br>diclofenac/misoprostol<br>VIMOVO (naproxen/esomeprazole) | |
| **COX-II SELECTIVE** | | |
| meloxicam | CELEBREX (celecoxib)<br>celecoxib<br>MOBIC (meloxicam) | COX-II Inhibitor agents will be authorized if the following criteria are met:<br><br>Patient has a history or risk of a serious GI complication **or** Agent is requested for treatment of a chronic condition **and**<br>1. Patient is seventy (70) years of age or older, **or**<br>2. Patient is currently on anticoagulation therapy**.** |
| **TOPICAL** | | |
| VOLTAREN GEL (diclofenac)*[AP] | diclofenac solution<br>FLECTOR PATCH (diclofenac)**<br>PENNSAID (diclofenac) | **In addition to the Category Criteria**: Thirty (30) day trials of each of the preferred oral NSAIDS are required before a topical NSAID gel or solution will be authorized unless one (1) of the exceptions on the PA form is present. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | | *Voltaren Gel will be authorized if the following criteria are met:<br>1. Thirty (30) day trials of two (2) of the preferred oral NSAIDs, **or**.<br>2. The patient is on anticoagulant therapy **or**<br>3. The patient has had a GI bleed or ulcer diagnosed in the last two (2) years.<br>Prior authorizations will be limited to 100 grams per month.<br><br>**Flector patches will be authorized for a diagnosis of acute strain, sprain or injury after a five (5) day trial of one (1) of the preferred oral NSAIDs and for a maximum duration of fourteen (14) days unless one (1) of the exceptions on the PA form is present. |
| **OPHTHALMIC ANTIBIOTICS**[AP] | | |
| **CATEGORY PA CRITERIA:** Three (3) day trials of each of the preferred agents are required before non-preferred agents will be authorized unless one (1) of the exceptions on the PA form is present. | | |
| bacitracin/polymyxin ointment<br>BESIVANCE (besifloxacin)<br>ciprofloxacin*<br>erythromycin<br>gentamicin<br>MOXEZA (moxifloxacin)*<br>neomycin/polymyxin/gramicidin<br>ofloxacin*<br>polymyxin/trimethoprim<br>sulfacetamide<br>tobramycin<br>VIGAMOX (moxifloxacin)* | AZASITE (azithromycin)<br>bacitracin<br>BLEPH-10 (sulfacetamide)<br>CILOXAN (ciprofloxacin)<br>GARAMYCIN (gentamicin)<br>gatifloxacin<br>ILOTYCIN (erythromycin)<br>levofloxacin<br>NATACYN (natamycin)<br>neomycin/bacitracin/polymyxin<br>NEOSPORIN (neomycin/polymyxin/gramicidin)<br>OCUFLOX (ofloxacin)<br>POLYTRIM (polymyxin/trimethoprim)<br>sulfacetamide ointment<br>TOBREX (tobramycin)<br>ZYMAR (gatifloxacin)<br>ZYMAXID (gatifloxacin) | The American Academy of Ophthalmology guidelines on treating bacterial conjunctivitis recommend as first line treatment options: erythromycin ointment, sulfacetamide drops, or polymyxin/trimethoprim drops.<br><br>*A prior authorization is required for the fluoroquinolone agents for patients up to twenty-one (21) years of age unless there has been a trial of a first line treatment option within the past ten (10) days. |
| **OPHTHALMIC ANTIBIOTIC/STEROID COMBINATIONS**[AP] | | |
| **CATEGORY PA CRITERIA:** Three (3) day trials of each of the preferred agents are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. | | |
| BLEPHAMIDE (prednisolone/sulfacetamide)<br>neomycin/polymyxin/dexamethasone<br>sulfacetamide/prednisolone | BLEPHAMIDE S.O.P. (prednisolone/ sulfacetamide)<br>MAXITROL ointment (neomycin/polymyxin/ | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| TOBRADEX OINTMENT (tobramycin/ dexamethasone)<br>TOBRADEX ST (tobramycin/ dexamethasone)<br>TOBRADEX SUSPENSION (tobramycin/ dexamethasone) | dexamethasone)<br>MAXITROL suspension (neomycin/polymyxin/ dexamethasone)<br>neomycin/bacitracin/polymyxin/ hydrocortisone<br>neomycin/polymyxin/hydrocortisone<br>PRED-G (prednisolone/gentamicin)<br>tobramycin/dexamethasone suspension<br>ZYLET (loteprednol/tobramycin) | |
| **OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS**[AP] | | |
| **CATEGORY PA CRITERIA:** Thirty (30) day trials of each of three (3) of the preferred agents are required before a non-preferred agent will be authorized, unless one (1) of the exceptions on the PA form is present. | | |
| ALAWAY (ketotifen)<br>cromolyn<br>ketotifen<br>PATADAY (olopatadine)<br>ZADITOR OTC (ketotifen)<br>ZYRTEC ITCHY EYE (ketotifen) | ALAMAST (pemirolast)<br>ALOCRIL (nedocromil)<br>ALOMIDE (lodoxamide)<br>ALREX (loteprednol)<br>azelastine<br>BEPREVE (bepotastine)<br>CROLOM (cromolyn)<br>ELESTAT (epinastine)<br>EMADINE (emedastine)<br>epinastine<br>LASTACAFT (alcaftadine)<br>OPTICROM (cromolyn)<br>OPTIVAR (azelastine)<br>PATANOL (olopatadine)<br>PAZEO (olopatadine) | |
| **OPHTHALMICS, ANTI-INFLAMMATORIES- IMMUNOMODULATORS** | | |
| **CATEGORY PA CRITERIA:** See below for individual sub-class criteria. | | |
| | RESTASIS (cyclosporine) | Restasis will be authorized if the following criteria are met:<br>1.) Patient must be sixteen (16) years of age or greater; **AND**<br>2.) Prior Authorization must be requested by an ophthalmologist or optometrist; **AND**<br>3.) Clinically diagnosed tear deficiency due to ocular inflammation in patients with keratoconjunctivitis sicca or dry eye syndrome (also known as dry eye); **AND**<br>4.) Patient must have a functioning lacrimal gland; **AND**<br>5.) Patient using artificial tears at least four (4) times a day over the last thirty (30) days; **AND**<br>6.) Patient must not have an active ocular infection |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| PREFERRED AGENTS | NON-PREFERRED AGENTS | PA CRITERIA |
| **OPHTHALMIC ANTI-INFLAMMATORIES[AP]** | | |
| **CATEGORY PA CRITERIA:** Five (5) day trials of each of the preferred agents are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. | | |
| dexamethasone<br>diclofenac<br>fluorometholone<br>flurbiprofen<br>ketorolac<br>prednisolone acetate | ACULAR (ketorolac)<br>ACULAR LS (ketorolac)<br>ACUVAIL (ketorolac tromethamine)<br>BROMDAY (bromfenac)<br>bromfenac<br>DUREZOL (difluprednate)<br>FLAREX (fluorometholone)<br>FML (fluorometholone)<br>FML FORTE (fluorometholone)<br>FML S.O.P. (fluorometholone)<br>ILEVRO (nepafenac)<br>LOTEMAX DROPS, OINTMENT (loteprednol)<br>LOTEMAX GEL (loteprednol)<br>MAXIDEX (dexamethasone)<br>NEVANAC (nepafenac)<br>OMNIPRED (prednisolone)<br>OZURDEX (dexamethasone)<br>PRED FORTE (prednisolone)<br>PRED MILD (prednisolone)<br>prednisolone sodium phosphate<br>PROLENSA (bromfenac)<br>RETISERT (fluocinolone)<br>TRIESENCE (triamcinolone)<br>VEXOL (rimexolone)<br>XIBROM (bromfenac) | |
| **OPHTHALMICS, GLAUCOMA AGENTS** | | |
| **CATEGORY PA CRITERIA:** A non-preferred agent will only be authorized if there is an allergy to the preferred agents. | | |
| **COMBINATION AGENTS** | | |
| COMBIGAN (brimonidine/timolol)<br>dorzolamide/timolol<br>SIMBRINZA (brinzolamide/brimonidine) | COSOPT (dorzolamide/timolol)<br>COSOPT PF (dorzolamide/timolol) | |
| **BETA BLOCKERS** | | |
| BETOPTIC S (betaxolol)<br>carteolol<br>levobunolol<br>metipranolol<br>timolol | BETAGAN (levobunolol)<br>betaxolol<br>BETIMOL (timolol)<br>ISTALOL (timolol)<br>OPTIPRANOLOL (metipranolol) | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | TIMOPTIC (timolol) | |
| **CARBONIC ANHYDRASE INHIBITORS** | | |
| AZOPT (brinzolamide)<br>dorzolamide | TRUSOPT (dorzolamide) | |
| **PARASYMPATHOMIMETICS** | | |
| PHOSPHOLINE IODIDE (echothiophate iodide) | pilocarpine | |
| **PROSTAGLANDIN ANALOGS** | | |
| latanoprost<br>TRAVATAN-Z (travoprost) | bimatoprost<br>LUMIGAN (bimatoprost)<br>RESCULA (unoprostone)<br>travoprost<br>XALATAN (latanoprost)<br>ZIOPTAN (tafluprost) | |
| **SYMPATHOMIMETICS** | | |
| brimonidine 0.2% | ALPHAGAN P 0.1% Solution (brimonidine)<br>ALPHAGAN P 0.15% Solution (brimonidine)<br>apraclonidine<br>brimonidine 0.15%<br>IOPIDINE (apraclonidine) | |

## OPIATE DEPENDENCE TREATMENTS

**CATEGORY PA CRITERIA:** Buprenorphine/naloxone tablets, Bunavail and Zubsolv will only be approved with a documented intolerance of or allergy to Suboxone strips. See below for further criteria.

| | | |
|---|---|---|
| SUBOXONE FILM (buprenorphine/naloxone)[CL]<br>VIVITROL (naltrexone) [CL]<br>naloxone | EVZIO (naloxone)<br>buprenorphine/naloxone tablets<br>BUNAVAIL (buprenorphine/naloxone)<br>ZUBSOLV (buprenorphine/naloxone) | Suboxone PA criteria is available at the BMS Website, by clicking the hyperlink.<br><br>Vivitrol PA criteria is available at the BMS Website, by clicking the hyperlink.<br><br>Evzio PA criteria is available at the BMS Website, by clicking the hyperlink. |

## OTIC ANTIBIOTICS[AP]

**CATEGORY PA CRITERIA:** Five (5) day trials of each of the preferred agents are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.

| | | |
|---|---|---|
| CIPRO HC (ciprofloxacin/hydrocortisone)<br>CIPRODEX (ciprofloxacin/dexamethasone)*<br>ciprofloxacin<br>COLY-MYCIN S (colistin/hydrocortisone/ neomycin/thonzonium bromide)<br>neomycin/polymyxin/HC solution/suspension | CORTISPORIN-TC (colistin/hydrocortisone/ neomycin)<br>ofloxacin | *Ciprodex is limited to patients up to nine (9) years of age. Age exceptions will be handled on a case-by-case basis. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **PAH AGENTS – ENDOTHELIN RECEPTOR ANTAGONISTS[CL]** | | |
| **CATEGORY PA CRITERIA:** A thirty (30) day trial of a preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. | | |
| LETAIRIS (ambrisentan)<br>TRACLEER (bosentan) | OPSUMIT (macitentan) | Letairis and Tracleer will be authorized for a diagnosis of pulmonary arterial hypertension (PAH). |
| **PAH AGENTS – GUANYLATE CYCLASE STIMULATOR[CL]** | | |
| **CATEGORY PA CRITERIA:** A thirty (30) day trial of a preferred PAH agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. | | |
| | ADEMPAS (riociguat) | |
| **PAH AGENTS – PDE5s[CL]** | | |
| **CATEGORY PA CRITERIA:** A thirty (30) day trial of the preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.<br>Patients stabilized on non-preferred agents will be grandfathered. | | |
| sildenafil | ADCIRCA (tadalafil)<br>REVATIO IV (sildenafil)<br>REVATIO SUSPENSION (sildenafil)<br>REVATIO TABLETS (sildenafil) | |
| **PAH AGENTS – PROSTACYCLINS[CL]** | | |
| **CATEGORY PA CRITERIA:** A thirty (30) day trial of a preferred agent, including the preferred generic form of the non-preferred agent, is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. | | |
| epoprostenol<br>VENTAVIS (iloprost)* | FLOLAN (epoprostenol)<br>ORENITRAM ER (treprostinil)<br>REMODULIN (treprostinil sodium)<br>TYVASO (treprostinil)<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]** | | |
| **CATEGORY PA CRITERIA:** A thirty (30) day trial of a preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.<br>Non-preferred agents will be authorized for members with cystic fibrosis. | | |
| CREON<br>PANCRELIPASE 5000<br>ZENPEP | PANCREAZE<br>PERTZYE<br>ULTRESA<br>VIOKACE | |
| **PHOSPHATE BINDERS[AP]** | | |
| **CATEGORY PA CRITERIA:** Thirty (30) day trials of at least two (2) preferred agents are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. | | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| calcium acetate<br>MAGNEBIND RX (calcium carbonate, folic acid, magnesium carbonate)<br>PHOSLYRA (calcium acetate)<br>RENAGEL (sevelamer) | AURYXIA (ferric citrate)<br>ELIPHOS (calcium acetate)<br>FOSRENOL (lanthanum)<br>PHOSLO (calcium acetate)<br>RENVELA (sevelamer carbonate)<br>sevelamer carbonate<br>VELPHORO (sucroferric oxyhydroxide) | |
| **PLATELET AGGREGATION INHIBITORS** | | |
| **CATEGORY PA CRITERIA:** A thirty (30) day trial of a preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. | | |
| AGGRENOX (dipyridamole/ASA)<br>BRILINTA (ticagrelor)<br>clopidogrel<br>EFFIENT (prasugrel) | dipyridamole<br>PERSANTINE (dipyridamole)<br>PLAVIX (clopidogrel)<br>TICLID (ticlopidine)<br>ticlopidine<br>ZONTIVITY (vorapaxar) | |
| **PROGESTINS FOR CACHEXIA** | | |
| **CATEGORY PA CRITERIA:** A thirty (30) day trial of the preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. | | |
| megestrol | MEGACE (megestrol)<br>MEGACE ES (megestrol) | |
| **PROTON PUMP INHIBITORS**[AP] | | |
| **CATEGORY PA CRITERIA:** Sixty (60) day trials of each of 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 are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present | | |
| omeprazole (Rx)<br>pantoprazole<br>PREVACID SOLUTABS (lansoprazole)* | ACIPHEX (rabeprazole)<br>ACIPHEX SPRINKLE (rabeprazole)<br>DEXILANT (dexlansoprazole)<br>esomeprazole strontium<br>lansoprazole Rx<br>NEXIUM (esomeprazole)<br>omeprazole/sodium bicarbonate (Rx)<br>PREVACID CAPSULES (lansoprazole)<br>PRILOSEC Rx (omeprazole)<br>PROTONIX (pantoprazole)<br>rabeprazole<br>ZEGERID Rx (omeprazole/sodium bicarbonate) | *Prior authorization is required for Prevacid Solutabs for members eight (8) years of age or older. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **SEDATIVE HYPNOTICS**[AP] | | |
| **CATEGORY PA CRITERIA:** Thirty (30) day trials of the preferred agents in both categories are required before any non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. All agents in this class will be limited to fifteen (15) tablets in a thirty (30) day period. | | |
| **BENZODIAZEPINES** | | |
| temazepam 15, 30 mg | DALMANE (flurazepam)<br>DORAL (quazepam)<br>estazolam<br>flurazepam<br>HALCION (triazolam)<br>quazepam<br>RESTORIL (temazepam)<br>temazepam 7.5, 22.5 mg<br>triazolam | |
| **OTHERS** | | |
| zolpidem 5, 10 mg | AMBIEN (zolpidem)<br>AMBIEN CR (zolpidem)<br>BELSOMRA (suvorexant)<br>chloral hydrate<br>EDLUAR (zolpidem)<br>eszopiclone<br>INTERMEZZO (zolpidem)<br>LUNESTA (eszopiclone)<br>ROZEREM (ramelteon)<br>SILENOR (doxepin)<br>SOMNOTE (chloral hydrate)<br>SONATA (zaleplon)<br>zaleplon<br>zolpidem ER 6.25, 12.5 mg<br>ZOLPIMIST (zolpidem) | Strengths of zolpidem that are non-preferred (6.25 and 12.5 mg) must be created by combining or splitting the preferred doses (5 and 10 mg) of zolpidem, if appropriate.<br><br>For treatment naïve female patients, zolpiderm and zolpidem ER maximum dosages will be limited to 5 mg and 6.25 mg respectively per day. |
| **SKELETAL MUSCLE RELAXANTS**[AP] | | |
| **CATEGORY PA CRITERIA:** See below for individual sub-class criteria. | | |
| **ACUTE MUSCULOSKELETAL RELAXANT AGENTS** | | |
| chlorzoxazone<br>cyclobenzaprine IR 5, 10 mg<br>methocarbamol | AMRIX (cyclobenzaprine)<br>carisoprodol<br>carisoprodol/ASA<br>carisoprodol/ASA/codeine<br>cyclobenzaprine ER<br>cyclobenzaprine IR 7.5 mg<br>FEXMID (cyclobenzaprine)<br>FLEXERIL (cyclobenzaprine) | Thirty (30) day trials of each of the preferred acute musculoskeletal relaxants are required before a non-preferred acute musculoskeletal agent will be authorized, with the exception of carisoprodol.<br><br>Thirty (30) day trials of each of the preferred acute musculoskeletal relaxants and Skelaxin are required before carisoprodol will be authorized. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | LORZONE (chlorzoxazone)<br>metaxalone<br>orphenadrine<br>orphenadrine/ASA/caffeine<br>orphenadrine ER<br>PARAFON FORTE (chlorzoxazone)<br>ROBAXIN (methocarbamol)<br>SKELAXIN (metaxalone)<br>SOMA (carisoprodol) | |
| **MUSCULOSKELETAL RELAXANT AGENTS USED FOR SPASTICITY** | | |
| baclofen<br>tizanidine tablets | DANTRIUM (dantrolene)<br>dantrolene<br>tizanidine capsules<br>ZANAFLEX (tizanidine) | Thirty (30) day trials of both preferred skeletal muscle relaxants associated with the treatment of spasticity are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. |
| **STEROIDS, TOPICAL** | | |
| **CATEGORY PA CRITERIA:** Five (5) day trials of one (1) form of each preferred unique active ingredient in the corresponding potency group are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. | | |
| **VERY HIGH & HIGH POTENCY** | | |
| betamethasone dipropionate cream, lotion<br>betamethasone valerate cream<br>clobetasol propionate cream/gel/ointment/solution<br>clobetasol emollient<br>fluocinonide cream, gel, solution<br>fluocinonide/emollient<br>halobetasol propionate<br>triamcinolone acetonide cream, ointment | amcinonide<br>APEXICON (diflorasone diacetate)<br>APEXICON E (diflorasone diacetate)<br>betamethasone dipropionate gel, lotion, ointment<br>betamethasone valerate lotion, ointment,<br>clobetasol lotion, shampoo<br>clobetasol propionate foam<br>CLOBEX (clobetasol propionate)<br>CLODAN (clobetasol propionate)<br>CORMAX (clobetasol propionate)<br>desoximetasone cream/gel/ointment<br>diflorasone diacetate<br>DIPROLENE (betamethasone dipropionate/propylene glycol)<br>DIPROLENE AF (betamethasone dipropionate/propylene glycol)<br>DIPROSONE (betamethasone dipropionate)<br>fluocinonide ointment<br>halcinonide<br>HALAC (halobetasol propionate)<br>HALOG (halcinonide)<br>HALONATE (halobetasol propionate) | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | KENALOG (triamcinolone acetonide)<br>LIDEX (fluocinonide)<br>LIDEX-E (fluocinonide)<br>OLUX (clobetasol propionate)<br>OLUX-E (clobetasol propionate/emollient)<br>PSORCON (diflorasone diacetate)<br>TEMOVATE (clobetasol propionate)<br>TEMOVATE-E (clobetasol propionate/emollient)<br>TOPICORT CREAM, GEL, OINTMENT (desoximetasone)<br>TOPICORT SPRAY (desoximetasone)<br>triamcinolone acetonide lotion<br>ULTRAVATE (halobetasol propionate)<br>ULTRAVATE PAC cream<br>ULTRAVATE X (halobetasol propionate / lactic acid)<br>VANOS (fluocinonide) | |
| **MEDIUM POTENCY** | | |
| fluticasone propionate cream, ointment<br>hydrocortisone butyrate ointment, solution<br>hydrocortisone valerate<br>mometasone furoate<br>triamcinolone acetonide 0.025% and 0.1% cream | ARISTOCORT (triamcinolone)<br>BETA-VAL (betamethasone valerate)<br>betamethasone valerate foam<br>CLODERM (clocortolone pivalate)<br>clocortolone cream<br>CORDRAN/CORDRAN SP (flurandrenolide)<br>CUTIVATE (fluticasone propionate)<br>DERMATOP (prednicarbate)<br>ELOCON (mometasone furoate)<br>fluocinolone acetonide cream, ointment, solution<br>fluticasone propionate lotion<br>hydrocortisone butyrate cream<br>LOCOID (hydrocortisone butyrate)<br>LOCOID LIPOCREAM (hydrocortisone butyrate/emollient)<br>LUXIQ (betamethasone valerate)<br>MOMEXIN (mometasone)<br>PANDEL (hydrocortisone probutate)<br>prednicarbate<br>TOPICORT LP (desoximetasone)<br>TRIDERM (triamcinolone acetonide)<br>WESTCORT (hydrocortisone valerate) | |
| **LOW POTENCY** | | |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| desonide cream, ointment<br>hydrocortisone acetate (Rx, OTC)<br>hydrocortisone cream (Rx, OTC)<br>hydrocortisone lotion OTC<br>hydrocortisone ointment (Rx, OTC)<br>hydrocortisone solution OTC<br>hydrocortisone-aloe cream OTC<br>hydrocortisone-aloe ointment OTC | ACLOVATE (alclometasone dipropionate)<br>alclometasone dipropionate<br>AQUA GLYCOLIC HC (hydrocortisone)<br>CAPEX (fluocinolone acetonide)<br>DERMA-SMOOTHE FS (fluocinolone acetonide)<br>DESONATE (desonide)<br>desonide lotion<br>DESOWEN (desonide)<br>fluocinolone oil<br>hydrocortisone/mineral oil/petrolatum<br>hydrocortisone acetate/urea<br>hydrocortisone lotion<br>hydrocortisone/aloe gel<br>LOKARA (desonide)<br>PEDIADERM HC (hydrocortisone)<br>PEDIADERM TA (hydrocortisone)<br>SCALPICIN OTC (hydrocortisone)<br>SYNALAR (fluocinolone)<br>TEXACORT (hydrocortisone)<br>VERDESO (desonide) | |
| **STIMULANTS AND RELATED AGENTS** | | |
| **CATEGORY PA CRITERIA:** A PA is required for adults eighteen (18) years of age or older.<br><br>A thirty (30) day trial of one of the preferred agents in each group (amphetamines and non-amphetamines) is required before a non-preferred agent will be authorized. In addition, a thirty (30) day trial of a long-acting preferred agent in each class is required before a non-preferred long-acting stimulant will be authorized.<br><br>Patients stabilized on non-preferred agents will be grandfathered. | | |
| **AMPHETAMINES** | | |
| amphetamine salt combination IR<br>DEXEDRINE ER (dextroamphetamine)<br>dextroamphetamine IR<br>PROCENTRA solution (dextroamphetamine)<br>VYVANSE (lisdexamfetamine) | ADDERALL XR* (amphetamine salt combination)<br>amphetamine salt combination ER<br>DESOXYN (methamphetamine)<br>DEXEDRINE IR (dextroamphetamine)<br>dextroamphetamine ER<br>dextroamphetamine solution<br>EVEKEO (amphetamine)<br>methamphetamine<br>ZENZEDI (dextroamphetamine) | **In addition to the Category Criteria**: Thirty (30) day trials of at least three (3) antidepressants are required before amphetamines will be authorized for depression.<br><br>*Adderall XR is preferred over its generic equivalents. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | **NON-AMPHETAMINE** | |
| clonidine IR<br>DAYTRANA (methylphenidate)<br>dexmethylphenidate IR<br>FOCALIN XR (dexmethylphenidate)<br>guanfacine IR<br>METADATE CD (methylphenidate)<br>METHYLIN SOLUTION (methylphenidate)<br>methylphenidate IR<br>methylphenidate ER (authorized generic Concerta – Actavis labeler 00591)<br>STRATTERA (atomoxetine)* | APTENSIO XR (methylphenidate)<br>clonidine ER<br>CONCERTA (methylphenidate)<br>dexmethylphenidate XR<br>FOCALIN IR (dexmethylphenidate)<br>guanfacine ER**<br>INTUNIV (guanfacine extended-release)<br>KAPVAY (clonidine extended-release)**<br>METHYLIN CHEWABLE TABLETS (methylphenidate)<br>methylphenidate chewable tablets, solution<br>methylphenidate CD<br>methylphenidate ER<br>methylphenidate LA<br>modafinil***<br>NUVIGIL (armodafinil) ***<br>PROVIGIL (modafinil) ***<br>QUILLIVANT XR (methylphenidate)<br>RITALIN (methylphenidate)<br>RITALIN LA (methylphenidate) | *Strattera does not required a PA for adults eighteen (18) years of age or older.<br>Strattera will not be authorized for concurrent administration with amphetamines or methylphenidates, except for thirty (30) days or less for tapering purposes. Strattera is limited to a maximum of 100 mg per day.<br><br>**Guanfacine ER and Kapvay/clonidine ER will be authorized if the following criteria are met:<br>1. Fourteen (14) day trials of at least one (1) preferred product from the amphetamine and non-amphetamine class **and**<br>2. A fourteen (14) day trial of clonidine IR (for Kapvay) and guanfacine IR (for guanfacine ER) unless one (1) of the exceptions on the PA form is present.<br>In cases of a diagnosis of Tourette's syndrome, tics, autism or disorders included in the autism spectrum, only a fourteen (14) day trial of clonidine (for Kapvay) will be required for approval.<br><br>***Provigil is preferred over its generic equivalent and Nuvigil. These drugs will only be authorized for patients sixteen (16) years of age or older with a diagnosis of narcolepsy. |
| **TETRACYCLINES** | | |
| **CATEGORY PA CRITERIA:** A ten (10) day trial of each of the preferred agents is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. | | |
| doxycycline hyclate capsules, tablets<br>doxycycline monohydrate 50, 100 mg capsules<br>minocycline capsules<br>tetracycline | ADOXA (doxycycline monohydrate)<br>demeclocycline*<br>DORYX (doxycycline hyclate)<br>doxycycline hyclate tablet DR<br>doxycycline monohydrate 40, 75, 150 mg capsule<br>doxycycline monohydrate tablet<br>doxycycline monohydrate suspension<br>DYNACIN (minocycline)<br>MINOCIN (minocycline)<br>minocycline ER capsules<br>minocycline tablets<br>MONODOX (doxycycline monohydrate)<br>MORGIDOX KIT (doxycycline)<br>ORACEA (doxycycline monohydrate)<br>SOLODYN (minocycline)<br>VIBRAMYCIN CAPSULES, SUSPENSION, | *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. |

| THERAPEUTIC DRUG CLASS | | |
|---|---|---|
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| | SYRUP (doxycycline) | |
| **ULCERATIVE COLITIS AGENTS[AP]** | | |
| **CATEGORY PA CRITERIA:** Thirty (30) day trials of each of the preferred dosage form or chemical entity must be tried before the corresponding non-preferred agent of that dosage form or chemical entity will be authorized unless one (1) of the exceptions on the PA form is present. | | |
| **ORAL** | | |
| APRISO (mesalamine)<br>balsalazide<br>DELZICOL (mesalamine)<br>PENTASA (mesalamine) 250 mg<br>sulfasalazine | ASACOL HD (mesalamine)<br>AZULFIDINE (sulfasalazine)<br>COLAZAL (balsalazide)<br>DIPENTUM (olsalazine)<br>GIAZO (balsalazide)<br>LIALDA (mesalamine)<br>PENTASA (mesalamine) 500 mg<br>UCERIS (budesonide) | |
| **RECTAL** | | |
| CANASA (mesalamine)<br>mesalamine | mesalamine kit<br>ROWASA (mesalamine)<br>SF ROWASA (mesalamine)<br>UCERIS (budesonide) | |
| **VASODILATORS, CORONARY** | | |
| **CATEGORY PA CRITERIA:** A thirty (30) day trial of each preferred dosage form will be required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. | | |
| **SUBLINGUAL NITROGLYCERIN** | | |
| nitroglycerin sublingual<br>NITROLINGUAL SPRAY (nitroglycerin)<br>NITROSTAT SUBLINGUAL (nitroglycerin) | nitroglycerin spray<br>NITROMIST (nitroglycerin) | |