



**BUREAU FOR MEDICAL SERVICES  
WEST VIRGINIA MEDICAID  
PREFERRED DRUG LIST WITH PRIOR AUTHORIZATION CRITERIA**  
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- 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.



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<b>CLASSES CHANGING</b>	<b>Status Changes</b>	<b>PA Criteria Changes</b>	<b>New Drugs</b>
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
<b>HYPOGLYCEMICS, BIGUANIDES</b>		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		



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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		



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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
<b>ACNE AGENTS, TOPICAL<sup>AP</sup></b>		
<p><b>CATEGORY PA CRITERIA:</b> 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.</p> <p>In cases of pregnancy, a trial of retinoids will <i>not</i> be required. For Members eighteen (18) years of age or older, a trial of retinoids will <i>not</i> be required. Acne kits are non-preferred.</p> <p>Specific Criteria for sub-categories will be listed below.</p>		
<b>ANTI-INFECTIVE</b>		
clindamycin gel, lotion, medicated swab, solution erythromycin gel, solution	ACZONE (dapson) AKNE-MYCIN (erythromycin) AZELEX (azelaic acid) CLEOCIN-T (clindamycin) CLINDACIN PAC (clindamycin) CLINDAGEL (clindamycin) clindamycin foam erythromycin medicated swab EVOCLIN (clindamycin) FABIOR (tazarotene) KLARON (sulfacetamide) OVACE/PLUS (sulfacetamide) sodium sulfacetamide 10% cleansing gel sulfacetamide cleanser sulfacetamide cleanser ER sulfacetamide shampoo sulfacetamide suspension	
<b>RETINOIDS</b>		
RETIN-A (tretinoin) TAZORAC (tazarotene)	adapalene ATRALIN (tretinoin) AVITA (tretinoin) DIFFERIN (adapalene) RETIN-A MICRO (tretinoin) tretinoin cream, gel tretinoin gel micro	<b>In addition to the Category Criteria:</b> PA required for members eighteen (18) years of age or older for Retinoids sub-class.
<b>KERATOLYTICS</b>		
benzoyl peroxide cleanser Rx & OTC, 10% cream OTC, gel Rx & OTC, lotion OTC, wash OTC	BENZEFOAM ULTRA (benzoyl peroxide) BENZEPRO (benzoyl peroxide) benzoyl peroxide cloths, medicated pads, microspheres cleanser BP 10-1 (benzoyl peroxide)	



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



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	ZIANA (clindamycin/tretinoin)*	
<b>ALZHEIMER'S AGENTS<sup>AP</sup></b>		
<b>CATEGORY PA CRITERIA:</b> 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.		
Prior authorization is required for members up to forty-five (45) years of age if there is no diagnosis of Alzheimer's disease		
<b>CHOLINESTERASE INHIBITORS</b>		
donepezil 5 and 10 mg	ARICEPT (donepezil) donepezil 23 mg* EXELON CAPSULE (rivastigmine) EXELON PATCH (rivastigmine) galantamine galantamine ER RAZADYNE (galantamine) RAZADYNE ER (galantamine) rivastigmine	*Donepezil 23 mg tablets will be authorized if the following criteria are met: 1. There is a diagnosis of moderate-to-severe Alzheimer's Disease <b>and</b> 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.
<b>NMDA RECEPTOR ANTAGONIST</b>		
NAMENDA (memantine)	memantine NAMENDA XR (memantine)	
<b>CHOLINESTERASE INHIBITOR/NMDA RECEPTOR ANTAGONIST COMBINATIONS</b>		
	NAMZARIC (donepezil/memantine)	
<b>ANALGESICS, NARCOTIC LONG ACTING (Non-parenteral)<sup>AP</sup></b>		
<b>CATEGORY PA CRITERIA:</b> 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) EMBEDA (morphine/naltrexone) fentanyl transdermal 12, 25, 50, 75, 100 mcg/hr morphine ER tablets	CONZIP ER (tramadol) DOLOPHINE (methadone) DURAGESIC (fentanyl) EXALGO ER (hydromorphone) fentanyl transdermal 37.5, 62.5, 87.5 mcg/hr hydromorphone ER HYSINGLA ER (hydrocodone) KADIAN (morphine) methadone* morphine ER capsules (generic for Avinza) morphine ER capsules (generic for Kadian) MS CONTIN (morphine) NUCYNTA ER (tapentadol) OPANA ER (oxymorphone) oxycodone ER*	*Methadone, oxycodone ER and oxymorphone ER will be authorized without a trial of the preferred agents if a diagnosis of cancer is submitted.  **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.



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	OXYCONTIN (oxycodone) oxymorphone ER* tramadol ER** ULTRAM ER (tramadol) XARTEMIS XR (oxycodone/ acetaminophen) ZOHYDRO ER (hydrocodone)	
<b>ANALGESICS, NARCOTIC SHORT ACTING (Non-parenteral)<sup>AP</sup></b>		
<b>CATEGORY PA CRITERIA:</b> 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 butalbital/APAP/caffeine/codeine codeine hydrocodone/APAP 2.5/325 mg, 5/325 mg, 7.5/325 mg,10/325 mg hydrocodone/APAP solution hydrocodone/ibuprofen hydromorphone tablets morphine oxycodone tablets, <b>concentrate, solution</b> oxycodone/APAP oxycodone/ASA pentazocine/naloxone ROXICET SOLUTION (oxycodone/ acetaminophen) tramadol tramadol/APAP	ABSTRAL (fentanyl) ACTIQ (fentanyl) butalbital/ASA/caffeine/codeine butorphanol CAPITAL W/CODEINE (APAP/codeine) DEMEROL (meperidine) dihydrocodeine/ APAP/caffeine DILAUDID (hydromorphone) fentanyl FENTORA (fentanyl) FIORICET W/ CODEINE (butalbital/APAP/caffeine/codeine) FIORINAL W/ CODEINE (butalbital/ASA/caffeine/codeine) hydrocodone/APAP 5/300 mg, 7.5/300 mg, 10/300 mg hydromorphone liquid, suppositories IBUDONE (hydrocodone/ibuprofen) LAZANDA (fentanyl) levorphanol LORCET (hydrocodone/APAP) LORTAB (hydrocodone/APAP) meperidine NORCO (hydrocodone/APAP) <b>NUCYNTA (tapentadol)</b> ONSOLIS (fentanyl) OPANA (oxymorphone) OXECTA (oxycodone) <b>oxycodone capsules</b> oxycodone/ibuprofen oxymorphone PERCOCET (oxycodone/APAP)	Fentanyl <b>buccal, nasal and sublingual products</b> 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.  <b>Limits:</b> 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.



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	PRIMLEV (oxycodone/APAP) REPRESAIN (hydrocodone/ibuprofen) <b>ROXICODONE (oxycodone)</b> RYBIX ODT (tramadol) SUBSYS (fentanyl) SYNALGOS-DC (dihydrocodeine/ASA/ caffeine) TYLENOL W/CODEINE (APAP/codeine) ULTRACET (tramadol/APAP) ULTRAM (tramadol) VEDROCET (hydrocodone/APAP) VICODIN VICOPROFEN (hydrocodone/ibuprofen) XODOL (hydrocodone/acetaminophen) XYLON (hydrocodone/ibuprofen) ZAMICET (hydrocodone/APAP)	
<b>ANDROGENIC AGENTS</b>		
<b>CATEGORY PA CRITERIA:</b> A non-preferred agent will only be authorized if one (1) of the exceptions on the PA form is present.		
ANDRODERM (testosterone) ANDROGEL (testosterone)	AXIRON (testosterone) FORTESTA (testosterone) <b>NATESTO (testosterone)</b> <b>TESTIM (testosterone)</b> testosterone gel VOGELXO (testosterone)	
<b>ANESTHETICS, TOPICAL<sup>AP</sup></b>		
<b>CATEGORY PA CRITERIA:</b> 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 lidocaine/prilocaine xylocaine	EMLA (lidocaine/prilocaine) LIDAMANTLE (lidocaine) LIDAMANTLE HC (lidocaine/hydrocortisone) lidocaine/hydrocortisone SYNERA (lidocaine/tetracaine)	
<b>ANGIOTENSIN MODULATORS<sup>AP</sup></b>		
<b>CATEGORY PA CRITERIA:</b> 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.		
<b>ACE INHIBITORS</b>		
benazepril captopril enalapril fosinopril lisinopril	ACCUPRIL (quinapril) ACEON (perindopril) ALTACE (ramipril) EPANED (enalapril)* LOTENSIN (benazepril)	*Epaned will be authorized if the following criteria are met: 1 Diagnosis of hypertension, symptomatic heart failure or asymptomatic left ventricular dysfunction; <b>AND</b> a Patient is less than seven (7) years of age; <b>OR</b> b Patient is unable to ingest a solid dosage form (eg. an



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quinapril ramipril	MAVIK (trandolapril) moexipril perindopril PRINIVIL (lisinopril) trandolapril UNIVASC (moexipril) VASOTEC (enalapril) ZESTRIL (lisinopril)	oral tablet or capsule) due to documented oral-motor difficulties or dysphagia.
<b>ACE INHIBITOR COMBINATION DRUGS</b>		
benazepril/amlodipine benazepril/HCTZ captopril/HCTZ enalapril/HCTZ fosinopril/HCTZ lisinopril/HCTZ quinapril/HCTZ	ACCURETIC (quinapril/HCTZ) CAPOZIDE (captopril/HCTZ) LOTENSIN HCT (benazepril/HCTZ) LOTREL (benazepril/amlodipine) moexipril/HCTZ PRINZIDE (lisinopril/HCTZ) TARKA (trandolapril/verapamil) trandolapril/verapamil VASERETIC (enalapril/HCTZ) ZESTORETIC (lisinopril/HCTZ)	
<b>ANGIOTENSIN II RECEPTOR BLOCKERS (ARBs)</b>		
BENICAR (olmesartan) irbesartan losartan MICARDIS (telmisartan) valsartan	ATACAND (candesartan) AVAPRO (irbesartan) candesartan COZAAR (losartan) DIOVAN (valsartan) EDARBI (azilsartan) eprosartan telmisartan TEVETEN (eprosartan)	
<b>ARB COMBINATIONS</b>		
AZOR (olmesartan/amlodipine) BENICAR-HCT (olmesartan/HCTZ) EXFORGE HCT (valsartan/amlodipine/HCTZ) irbesartan/HCTZ losartan/HCTZ MICARDIS-HCT (telmisartan/HCTZ) TRIBENZOR (olmesartan/amlodipine/HCTZ) valsartan/amlodipine valsartan/HCTZ	ATACAND-HCT (candesartan/HCTZ) AVALIDE (irbesartan/HCTZ) candesartan/HCTZ DIOVAN-HCT (valsartan/HCTZ) EDARBYCLOR (azilsartan/chlorthalidone) ENTRESTO (valsartan/sucubitril)* EXFORGE (valsartan/amlodipine) HYZAAR (losartan/HCTZ) telmisartan/amlodipine telmisartan HCTZ TEVETEN-HCT (eprosartan/HCTZ) TWYNSTA (telmisartan/amlodipine) 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



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<b>DIRECT RENIN INHIBITORS</b>		
	AMTURNIDE (aliskiren/amlodipine/HCTZ) TEKAMLO (aliskiren/amlodipine) TEKTURNA (aliskiren) TEKTURNA HCT (aliskiren/HCTZ) VALTURNA (aliskiren/valsartan)	<b>Substitute for Category Criteria:</b> 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.  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.
<b>ANTIANGINAL &amp; ANTI-ISCHEMIC</b>		
<b>CATEGORY PA CRITERIA:</b> 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) <sup>AP</sup>	
<b>ANTIBIOTICS, GI</b>		
<b>CATEGORY PA CRITERIA:</b> 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 neomycin TINDAMAX (tinidazole)	ALINIA (nitazoxanide) DIFICID (fidaxomicin)* FLAGYL (metronidazole) FLAGYL ER (metronidazole ER) metronidazole capsule paromomycin tinidazole VANCOCIN (vancomycin) vancomycin** XIFAXAN (rifaximin)***	*Dificid will be authorized if the following criteria are met: 1. There is a diagnosis of severe <i>C. difficile</i> infection <b>and</b> 2. There is no response to prior treatment with vancomycin for ten (10) to fourteen (14) days.  **Vancomycin will be authorized after a fourteen (14) day trial of metronidazole for <i>C. difficile</i> infections of mild to moderate severity. ** Vancomycin will be authorized for severe <i>C. difficile</i> infections with no previous trial of metronidazole.  ***Full Xifaxin PA criteria may be found at <a href="#">the BMS Website</a> , by clicking the hyperlink.
<b>ANTIBIOTICS, INHALED</b>		
<b>CATEGORY PA CRITERIA:</b> 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) KITABIS PAK (tobramycin)	CAYSTON (aztreonam) TOBI (tobramycin) TOBI PODHALER tobramycin	



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<b>ANTIBIOTICS, TOPICAL</b>		
<b>CATEGORY PA CRITERIA:</b> 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 gentamicin sulfate mupirocin ointment	ALTABAX (retapamulin) BACTROBAN (mupirocin) CENTANY (mupirocin) CORTISPORIN (bacitracin/neomycin/polymyxin/Hc) mupirocin cream neomycin/polymyxin/pramoxine	
<b>ANTIBIOTICS, VAGINAL</b>		
<b>CATEGORY PA CRITERIA:</b> 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 METROGEL (metronidazole)	AVC (sulfanilamide) CLEOCIN CREAM (clindamycin) CLEOCIN OVULE (clindamycin) CLINDESSE (clindamycin) metronidazole NUVESSA (metronidazole) VANDAZOLE (metronidazole)	
<b>ANTICOAGULANTS</b>		
<b>CATEGORY PA CRITERIA:</b> 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.		
<b>INJECTABLE<sup>CL</sup></b>		
enoxaparin	ARIXTRA (fondaparinux) fondaparinux FRAGMIN (dalteparin) LOVENOX (enoxaparin)	
<b>ORAL</b>		
COUMADIN (warfarin) ELIQUIS (apixaban) <sup>AP*</sup> PRADAXA (dabigatran) <sup>AP**</sup> warfarin XARELTO (rivaroxaban) <sup>AP***</sup>	SAVAYSA (edoxaban)	*Eliquis will be authorized for the following indications: 1. Non-valvular atrial fibrillation <b>or</b> 2. Deep vein thrombosis (DVT) and pulmonary embolism (PE) <b>or</b> 3. DVT prophylaxis if treatment is limited to thirty-five (35) days for hip replacement surgeries or twelve (12) days for knee replacement surgeries.  **Pradaxa will be authorized for the following indications: 1. Non-valvular atrial fibrillation <b>or</b> 2. To reduce the risk of recurrent DVT and PE in patients who have previously been treated <b>or</b>



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PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
		<p>3. Treatment of acute DVT and PE in patients who have been treated with a parenteral anticoagulant for five (5) to (10) days.</p> <p>***Xarelto will be authorized for the following indications::</p> <ol style="list-style-type: none"> <li>1. Non-valvular atrial fibrillation <b>or</b></li> <li>2. DVT, and PE, and reduction in risk of recurrence of DVT and PE <b>or</b></li> <li>1. DVT prophylaxis if treatment is limited to thirty-five (35) days for hip replacement surgeries or twelve (12) days for knee replacement surgeries.</li> </ol>
<b>ANTICONVULSANTS</b>		
<p><b>CATEGORY PA CRITERIA:</b> 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.</p> <p>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.</p> <p>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.</p>		
<b>ADJUVANTS</b>		
carbamazepine carbamazepine ER carbamazepine XR CARBATROL (carbamazepine) DEPAKOTE SPRINKLE (divalproex) divalproex divalproex ER EPITOL (carbamazepine) felbamate FYCOMPA (perampanel) GABITRIL (tiagabine) lamotrigine levetiracetam IR levetiracetam ER oxcarbazepine suspension and tablets TEGRETOL XR (carbamazepine) topiramate IR topiramate ER* valproic acid	APTIOM (eslicarbazepine) BANZEL(rufinamide) DEPAKENE (valproic acid) DEPAKOTE (divalproex) DEPAKOTE ER (divalproex) divalproex sprinkle EQUETRO (carbamazepine) FANATREX SUSPENSION (gabapentin) FELBATOL (felbamate)*** KEPPRA (levetiracetam) KEPPRA XR (levetiracetam) LAMICTAL (lamotrigine) LAMICTAL CHEWABLE (lamotrigine) LAMICTAL ODT (lamotrigine) LAMICTAL XR (lamotrigine) lamotrigine dose pack lamotrigine ER ONFI (clobazam) **** ONFI SUSPENSION (clobazam) **** OXTELLAR XR (oxcarbazepine)	<p>*Topiramate ER will be authorized after a thirty (30) day trial of topiramate IR.</p> <p>**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.</p> <p>***Patients stabilized on Felbatol will be grandfathered</p> <p>****Onfi will be authorized if the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. Adjunctive therapy for Lennox-Gastaut <b>or</b></li> <li>2. Generalized tonic, atonic or myoclonic seizures <b>and</b></li> <li>3. Previous failure of at least two (2) non-benzodiazepine anticonvulsants and previous failure of clonazepam.</li> </ol> <p>(For continuation, prescriber must include information regarding improved response/effectiveness with this medication)</p>



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VIMPAT(lacosamide) <sup>AP**</sup> zonisamide	POTIGA (ezogabine) QUDEXY XR (topiramate ER) SABRIL (vigabatrin) STAVZOR (valproic acid) TEGRETOL (carbamazepine) tiagabine TOPAMAX (topiramate) TRILEPTAL <b>SUSPENSION</b> and TABLETS (oxcarbazepine) TROKENDI XR (topiramate) ZONEGRAN (zonisamide)	
<b>BARBITURATES<sup>AP</sup></b>		
phenobarbital primidone	MYSOLINE (primidone)	
<b>BENZODIAZEPINES<sup>AP</sup></b>		
clonazepam DIASTAT (diazepam rectal) diazepam tablets	clonazepam ODT diazepam rectal gel KLONOPIN (clonazepam) VALIUM TABLETS (diazepam)	
<b>HYDANTOINS<sup>AP</sup></b>		
DILANTIN (phenytoin <b>sodium, extended</b> ) PEGANONE (ethotoin) phenytoin capsules, chewable tablets, suspension	DILANTIN INFATABS (phenytoin) PHENYTEK (phenytoin)	
<b>SUCCINIMIDES</b>		
CELONTIN (methsuximide) ethosuximide syrup ZARONTIN (ethosuximide) capsules	ethosuximide capsules ZARONTIN (ethosuximide) syrup	
<b>ANTIDEPRESSANTS, OTHER</b>		
<b>CATEGORY PA CRITERIA:</b> See below for individual sub-class criteria.		
<b>MAOIs<sup>AP</sup></b>		
	MARPLAN (isocarboxazid) NARDIL (phenelzine) PARNATE (tranylcypromine) phenelzine tranylcypromine	Patients stabilized on MAOI agents will be grandfathered.
<b>SNRIS<sup>AP</sup></b>		
duloxetine capulsles venlafaxine ER capsules	CYMBALTA (duloxetine) desvenlafaxine ER 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.



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	EFFEXOR XR (venlafaxine) FETZIMA (levomilnacipran) KHEDEZLA (desvenlafaxine) PRISTIQ (desvenlafaxine) venlafaxine IR VENLAFAXINE ER TABLETS (venlafaxine)	
<b>SECOND GENERATION NON-SSRI, OTHER<sup>AP</sup></b>		
bupropion IR bupropion SR bupropion XL mirtazapine trazodone	APLENZIN (bupropion hbr) BRINTELLIX (vortioxetine) EMSAM (selegiline) FORFIVO XL (bupropion) nefazodone OLEPTRO ER (trazodone) REMERON (mirtazapine) VIIBRYD (vilazodone hcl) WELLBUTRIN (bupropion) WELLBUTRIN SR (bupropion) 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.
<b>SELECTED TCAs</b>		
imipramine hcl	imipramine pamoate TOFRANIL (imipramine hcl) 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.
<b>ANTIDEPRESSANTS, SSRIs<sup>AP</sup></b>		
<b>CATEGORY PA CRITERIA:</b> 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.		
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 escitalopram tablets fluoxetine capsules, solution fluvoxamine paroxetine sertraline	BRISDELLE (paroxetine) CELEXA (citalopram) escitalopram solution fluvoxamine ER fluoxetine tablets LEXAPRO (escitalopram) LUVOX CR (fluvoxamine) PAXIL (paroxetine) PAXIL CR (paroxetine) paroxetine ER PEXEVA (paroxetine) PROZAC (fluoxetine) SARAFEM (fluoxetine) ZOLOFT (sertraline)	



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<b>ANTIEMETICS<sup>AP</sup></b>		
<b>CATEGORY PA CRITERIA:</b> 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.		
<b>5HT3 RECEPTOR BLOCKERS</b>		
ondansetron ODT, solution, tablets	ANZEMET (dolasetron) granisetron GRANISOL (granisetron) ondansetron vials SANCUSO (granisetron) ZOFRAN (ondansetron) ZUPLENZ (ondansetron)	
<b>CANNABINOIDS</b>		
	CESAMET (nabilone)* dronabinol 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.  **Marinol (dronabinol) will only be authorized for: 1. The treatment of anorexia associated with weight loss in patients with AIDS or cancer and unresponsive to megestrol <b>or</b> 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.
<b>SUBSTANCE P ANTAGONISTS</b>		
EMEND (aprepitant)		
<b>COMBINATIONS</b>		
	AKYNZEO (netupitant/ palonosetron)	
<b>ANTIFUNGALS, ORAL</b>		
<b>CATEGORY PA CRITERIA:</b> Non-preferred agents will be authorized only if one (1) of the exceptions on the PA form is present.		
clotrimazole fluconazole* nystatin terbinafine <sup>CL</sup>	ANCOBON (flucytosine) <b>CRESEMBA (isavuconazonium)</b> DIFLUCAN (fluconazole) flucytosine GRIFULVIN V TABLET (griseofulvin) griseofulvin GRIS-PEG (griseofulvin) itraconazole ketoconazole**	*PA is required when limits are exceeded.  PA is not required for griseofulvin suspension for children up to eighteen (18) years of age for the treatment of tinea capitis.  **Ketoconazole will be authorized if the following criteria are met: 1. Diagnosis of one of the following fungal infections: blastomycosis, coccidioidomycosis, histoplasmosis, chromomycosis, or paracoccidioidomycosis <b>and</b>



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	LAMISIL (terbinafine) MYCELEX (clotrimazole) MYCOSTATIN Tablets (nystatin) NIZORAL (ketoconazole) NOXAFIL (posaconazole) ONMEL (itraconazole) ORAVIG (miconazole) SPORANOX (itraconazole) VFEND (voriconazole) voriconazole suspension voriconazole tablets	<ol style="list-style-type: none"> <li>2. Documented failure or intolerance of all other diagnosis-appropriate antifungal therapies, i.e. itraconazole, fluconazole, flucytosine, etc <b>and</b></li> <li>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 <b>and</b></li> <li>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.) <b>and</b></li> <li>5. Assessment of all concomitant medications for potential adverse drug interactions with ketoconazole.</li> </ol> Ketoconazole will not be authorized for treatment for fungal infections of the skin and nails.
<b>ANTIFUNGALS, TOPICAL<sup>AP</sup></b>		
<b>CATEGORY PA CRITERIA:</b> 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.		
<b>ANTIFUNGALS</b>		
econazole ketoconazole cream, shampoo MENTAX (butenafine) miconazole (OTC) nystatin	CICLODAN (ciclopirox) ciclopirox ERTACZO (sertaconazole) EXELDERM (sulconazole) EXTINA (ketoconazole) JUBLIA (efinaconazole) ketoconazole foam KERYDIN (tavaborole) KETODAN (ketoconazole) LOPROX (ciclopirox) LUZU (luliconazole) MYCOSTATIN (nystatin) NAFTIN CREAM (naftifine) NAFTIN GEL (naftifine) NIZORAL (ketoconazole) OXISTAT (oxiconazole)* PEDIPROX-4 (ciclopirox) 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.



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	VUSION (miconazole/petrolatum/zinc oxide) XOLEGEL (ketoconazole)	
<b>ANTIFUNGAL/STEROID COMBINATIONS</b>		
clotrimazole/betamethasone nystatin/triamcinolone	KETOCON PLUS (ketoconazole/hydrocortisone) LOTRISONE (clotrimazole/betamethasone)	
<b>ANTIHYPERTENSIVES, SYMPATHOLYTICS</b>		
<b>CATEGORY PA CRITERIA:</b> 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) clonidine tablets	clonidine patch NEXICLON XR (clonidine) CATAPRES TABLETS (clonidine)	
<b>ANTIHYPERTENSIVES, SYMPATHOLYTICS</b>		
<b>CATEGORY PA CRITERIA:</b> 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.		
<b>ANTIMITOTICS</b>		
	COLCRYS (colchicine) colchicine capsules* 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.
<b>ANTIMITOTIC-URICOSURIC COMBINATION</b>		
colchicine/probenecid		
<b>URICOSURIC</b>		
probenecid		
<b>XANTHINE OXIDASE INHIBITORS</b>		
allopurinol	ULORIC (febuxostat) ZYLOPRIM (allopurinol)	
<b>ANTIMIGRAINE AGENTS, OTHER<sup>AP</sup></b>		
<b>CATEGORY PA CRITERIA:</b> 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)	
<b>ANTIMIGRAINE AGENTS, TRIPTANS<sup>AP</sup></b>		
<b>CATEGORY PA CRITERIA:</b> 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.		
<b>TRIPTANS</b>		
IMITREX INJECTION (sumatriptan) <sup>CL</sup>	almotriptan	<b>In addition to the Category Criteria:</b> Three (3) day trials of



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IMITREX NASAL SPRAY (sumatriptan) naratriptan rizatriptan sumatriptan tablets	AMERGE (naratriptan) AXERT (almotriptan) FROVA (frovatriptan) IMITREX tablets (sumatriptan) MAXALT (rizatriptan) MAXALT MLT (rizatriptan) RELPAX (eletriptan) rizatriptan ODT sumatriptan nasal spray/injection* SUMAVEL (sumatriptan) zolmitriptan zolmitriptan ODT ZOMIG (zolmitriptan) ZOMIG ZMT (zolmitriptan)	each preferred agent will be required before Imitrex injection is authorized.  *AP does not apply to nasal spray or injectable sumatriptan.
<b>TRIPTAN COMBINATIONS</b>		
	TREXIMET (sumatriptan/naproxen sodium)	
<b>ANTIPARASITICS, TOPICAL<sup>AP</sup></b>		
<b>CATEGORY PA CRITERIA:</b> 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) permethrin 5% cream permethrin 1% lotion (OTC) pyrethrins-piperonyl butoxide OTC SKLICE (ivermectin) ULESFIA (benzyl alcohol)	EURAX (crotamiton) LICE EGG REMOVER OTC (benzalkonium chloride) lindane malathion OVIDE (malathion) spinosad	
<b>ANTIPARKINSON'S AGENTS</b>		
<b>CATEGORY PA CRITERIA:</b> 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.		
<b>ANTICHOLINERGICS</b>		
benztropine trihexyphenidyl	COGENTIN (benztropine)	
<b>COMT INHIBITORS</b>		
	COMTAN (entacapone) entacapone TASMAR (tolcapone)	
<b>DOPAMINE AGONISTS</b>		
pramipexole ropinirole	MIRAPEX (pramipexole) MIRAPEX ER (pramipexole) NEUPRO (rotigotine)	Mirapex, Mirapex ER, Requip, and Requip XL will be authorized for a diagnosis of Parkinsonism with no trials of preferred agents required.



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	pramipexole ER REQUIP (ropinirole) REQUIP XL (ropinirole) ropinirole ER	
<b>OTHER ANTIPARKINSON'S AGENTS</b>		
amantadine <sup>AP</sup> bromocriptine carbidopa/levodopa levodopa/carbidopa/entacapone selegiline	AZILECT (rasagiline) ELDEPRYL (selegiline) levodopa/carbidopa ODT carbidopa LODOSYN (carbidopa) PARCOPA (levodopa/carbidopa) PARLODEL (bromocriptine) RYTARY (levodopa/carbidopa) SINEMET (levodopa/carbidopa) STALEVO (levodopa/carbidopa/entacapone) ZELAPAR (selegiline)	Amantadine will be authorized only for a diagnosis of Parkinsonism.
<b>ANTIPSORIATICS, TOPICAL</b>		
<b>CATEGORY PA CRITERIA:</b> 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.		
calcipotriene ointment TACLONEX (calcipotriene/ betamethasone) TAZORAC (tazarotene)	calcipotriene cream calcipotriene solution calcipotriene/betamethasone ointment CALCITRENE (calcipotriene) calcitriol DOVONEX (calcipotriene) SORILUX (calcipotriene) VECTICAL (calcitriol)	
<b>ANTIPSYCHOTICS, ATYPICAL</b>		
<b>CATEGORY PA CRITERIA:</b> 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:		
<ol style="list-style-type: none"> <li>1. A fourteen (14) day trial of a preferred generic agent <b>and</b></li> <li>2. Two (2) fourteen (14) day trials of additional preferred products unless one (1) of the exceptions on the PA form is present.</li> </ol>		
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.		



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<b>SINGLE INGREDIENT</b>		
ABILIFY (aripiprazole)* AP ABILIFY MAINTENA (aripiprazole)** CL clozapine <b>clozapine ODT</b> INVEGA SUSTENNA (paliperidone)** CL <b>INVEGA TRINZA (paliperidone)*** CL</b> LATUDA (lurasidone)**** AP olanzapine <b>olanzapine ODT</b> quetiapine***** AP for the 25 mg Tablet Only RISPERDAL CONSTA (risperidone) ** CL risperidone ziprasidone	ADASUVE (loxapine) aripiprazole CLOZARIL (clozapine) FANAPT (iloperidone) FAZACLO (clozapine) GEODON (ziprasidone) GEODON IM (ziprasidone) INVEGA (paliperidone) olanzapine IM** <b>REXULTI (brexipiprazole)</b> RISPERDAL (risperidone) <b>SAPHRIS (asenapine)</b> SEROQUEL (quetiapine) SEROQUEL XR (quetiapine) VERSACLOZ (clozapine) ZYPREXA (olanzapine) ZYPREXA IM (olanzapine)** ZYPREXA RELPREVV (olanzapine)	*Abilify will be prior authorized via electronic PA for MDD if the following criteria are met: 1. The patient is eighteen (18) years of age or older <b>and</b> 2. Diagnosis of Major Depressive Disorder (MDD) <b>and</b> 3. Prescribed as adjunctive therapy with bupropion, an SSRI agent or an SNRI agent <b>and</b> 4. The daily dose does not exceed 15 mg  **All injectable antipsychotic products require clinical prior authorization and will be approved on a case-by-case basis.  <b>***Invega Trinza will be authorized after four months' treatment with Invega Sustenna</b>  <b>****Latuda will be authorized for patients only after a trial of one other preferred drug</b>  *****Quetiapine 25 mg will be authorized: 1. For a diagnosis of schizophrenia <b>or</b> 2. For a diagnosis of bipolar disorder <b>or</b> 3. When prescribed concurrently with other strengths of Seroquel in order to achieve therapeutic treatment levels. *****Quetiapine 25 mg will not be authorized for use as a sedative hypnotic.
<b>ATYPICAL ANTIPSYCHOTIC/SSRI COMBINATIONS</b>		
	olanzapine/fluoxetine SYMBYAX (olanzapine/fluoxetine)	
<b>ANTIVIRALS, ORAL</b>		
<b>CATEGORY PA CRITERIA:</b> 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.		
<b>ANTI HERPES</b>		
acyclovir valacyclovir	famciclovir FAMVIR (famciclovir) SITAVIG (acyclovir) VALTRESX ZOVIRAX (acyclovir)	
<b>ANTI-INFLUENZA</b>		
RELENZA (zanamivir) TAMIFLU (oseltamivir)	FLUMADINE (rimantadine) rimantadine	<b>In addition to the Category Criteria:</b> The anti-influenza agents will be authorized only for a diagnosis of influenza.



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<b>ANTIVIRALS, TOPICAL<sup>AP</sup></b>		
<b>CATEGORY PA CRITERIA:</b> 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) acyclovir ointment DENA VIR (penciclovir) ZOVIRAX OINTMENT (acyclovir)	
<b>BETA BLOCKERS<sup>AP</sup></b>		
<b>CATEGORY PA CRITERIA:</b> 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.		
<b>BETA BLOCKERS</b>		
acebutolol atenolol betaxolol bisoprolol metoprolol metoprolol ER nadolol pindolol propranolol sotalol timolol	BETAPACE (sotalol) BYSTOLIC (nebivolol) CORGARD (nadolol) HEMANGEOL (propranolol)* INDERAL LA (propranolol) INDERAL XL (propranolol) INNOPRAN XL (propranolol) KERLONE (betaxolol) LEVATOL (penbutolol) LOPRESSOR (metoprolol) propranolol ER** SECTRAL (acebutolol) TENORMIN (atenolol) TOPROL XL (metoprolol) ZEBETA (bisoprolol)	*Hemangeol will be authorized for the treatment of proliferating infantile hemangioma requiring systemic therapy.  ** Propranolol ER shall be authorized for patients with a diagnosis of migraines. Existing users will be grandfathered for use in migraine prophylaxis.
<b>BETA BLOCKER/DIURETIC COMBINATION DRUGS</b>		
atenolol/chlorthalidone bisoprolol/HCTZ metoprolol/HCTZ nadolol/bendroflumethiazide propranolol/HCTZ	CORZIDE (nadolol/bendroflumethiazide) DUTOPROL (metoprolol ER/HCTZ ER) LOPRESSOR HCT (metoprolol/HCTZ) TENORETIC (atenolol/chlorthalidone) ZIAC (bisoprolol/HCTZ)	
<b>BETA- AND ALPHA-BLOCKERS</b>		
carvedilol labetalol	COREG (carvedilol) COREG CR (carvedilol) TRANDATE (labetalol)	



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<b>BLADDER RELAXANT PREPARATIONS<sup>AP</sup></b>		
<b>CATEGORY PA CRITERIA:</b> 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.		
oxybutynin IR oxybutynin ER VESICARE (solifenacin)	DETROL (tolterodine) DETROL LA (tolterodine) DITROPAN XL (oxybutynin) ENABLEX (darifenacin) flavoxate GELNIQUE (oxybutynin) MYRBETRIQ (mirabegron) OXYTROL (oxybutynin) SANCTURA (trospium) SANCTURA XR (trospium) tolterodine tolterodine ER <b>TOVIAZ (fesoterodine)</b> trospium trospium ER	
<b>BONE RESORPTION SUPPRESSION AND RELATED AGENTS</b>		
<b>CATEGORY PA CRITERIA:</b> 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.		
<b>BISPHOSPHONATES</b>		
alendronate tablets	ACTONEL (risedronate) ACTONEL WITH CALCIUM (risedronate/ calcium) alendronate solution ATELVIA (risedronate) BINOSTO (alendronate) BONIVA (ibandronate) DIDRONEL (etidronate) etidronate FOSAMAX TABLETS (alendronate) FOSAMAX PLUS D (alendronate/vitamin D) ibandronate risedronate	
<b>OTHER BONE RESORPTION SUPPRESSION AND RELATED AGENTS</b>		
calcitonin	EVISTA (raloxifene)* FORTEO (teriparatide) FORTICAL (calcitonin) MIACALCIN (calcitonin)	*Evista will be authorized for postmenopausal women with osteoporosis or at high risk for invasive breast cancer.



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	raloxifene	
<b>BPH TREATMENTS</b>		
<b>CATEGORY PA CRITERIA:</b> 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.		
<b>5-ALPHA-REDUCTASE (5AR) INHIBITORS</b>		
finasteride	AVODART (dutasteride) CIALIS 5 mg (tadalafil) PROSCAR (finasteride)	
<b>ALPHA BLOCKERS</b>		
alfuzosin doxazosin tamsulosin terazosin	CARDURA (doxazosin) CARDURA XL (doxazosin) FLOMAX (tamsulosin) HYTRIN (terazosin) RAPAFLO (silodosin) UROXATRAL (alfuzosin)	
<b>5-ALPHA-REDUCTASE (5AR) INHIBITORS/ALPHA BLOCKER COMBINATION</b>		
	JALYN (dutasteride/tamsulosin)	<b>Substitute for Category Criteria:</b> Concurrent thirty (30) day trials of dutasteride and tamsulosin are required before the non-preferred agent will be authorized.
<b>BRONCHODILATORS, BETA AGONIST<sup>AP</sup></b>		
<b>CATEGORY PA CRITERIA:</b> 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.		
<b>INHALATION SOLUTION</b>		
ACCUNEB (albuterol)* albuterol	BROVANA (arformoterol) levalbuterol metaproterenol PERFOROMIST (formoterol) XOPENEX (levalbuterol)	*No PA is required for Accuneb for children up to five (5) years of age.
<b>INHALERS, LONG-ACTING</b>		
FORADIL (formoterol) SEREVENT (salmeterol)	ARCAPTA (indacaterol maleate) STRIVERDI RESPIMAT (olodaterol)	
<b>INHALERS, SHORT-ACTING</b>		
PROAIR HFA (albuterol) PROVENTIL HFA (albuterol)	MAXAIR (pirbuterol) <b>PROAIR RESPICLICK (albuterol)</b> VENTOLIN HFA (albuterol) 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.



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<b>ORAL</b>		
albuterol IR, ER terbutaline	metaproterenol VOSPIRE ER (albuterol)	
<b>CALCIUM CHANNEL BLOCKERS<sup>AP</sup></b>		
<b>CATEGORY PA CRITERIA:</b> 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.		
<b>LONG-ACTING</b>		
amlodipine diltiazem ER felodipine ER nifedipine ER verapamil ER	ADALAT CC (nifedipine) CALAN SR (verapamil) CARDENE SR (nicardipine) CARDIZEM CD, LA (diltiazem) COVERA-HS (verapamil) diltiazem LA DYNACIRC CR (isradipine) ISOPTIN SR (verapamil) MATZIM LA (diltiazem) nisoldipine NORVASC (amlodipine) PLENDIL (felodipine) PROCARDIA XL (nifedipine) SULAR (nisoldipine) TIAZAC (diltiazem) verapamil ER PM VERELAN/VERELAN PM (verapamil)	
<b>SHORT-ACTING</b>		
diltiazem verapamil	CALAN (verapamil) CARDIZEM (diltiazem) isradipine nicardipine nifedipine nimodipine NIMOTOP (nimodipine) NYMALIZE SOLUTION (nimodipine) PROCARDIA (nifedipine)	
<b>CEPHALOSPORINS AND RELATED ANTIBIOTICS<sup>AP</sup></b>		
<b>CATEGORY PA CRITERIA:</b> 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.		
<b>BETA LACTAMS AND BETA LACTAM/BETA-LACTAMASE INHIBITOR COMBINATIONS</b>		
amoxicillin/clavulanate IR	amoxicillin/clavulanate ER AUGMENTIN (amoxicillin/clavulanate)	



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	AUGMENTIN XR (amoxicillin/clavulanate) MOXATAG (amoxicillin)	
<b>CEPHALOSPORINS</b>		
cefaclor capsule cefadroxil capsule, tablet cefdinir cefuroxime tablet cephalexin capsule, suspension	CEDAX (ceftibuten) cefaclor suspension cefaclor ER tablet cefadroxil suspension cefditoren cefpodoxime cefprozil ceftibuten capsule, suspension CEFTIN (cefuroxime) cefuroxime suspension cephalexin tablet KEFLEX (cephalexin) OMNICEF (cefdinir) RANICLOR (cefaclor) SPECTRACEF (cefditoren) SUPRAX (cefixime)	
<b>COLONY STIMULATING FACTORS</b>		
<b>CATEGORY PA CRITERIA:</b> 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) NEUPOGEN (filgrastim)	NEULASTA (pegfilgrastim)	.
<b>COPD AGENTS</b>		
<b>CATEGORY PA CRITERIA:</b> 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.		
<b>ANTICHOLINERGIC<sup>AP</sup></b>		
ATROVENT HFA (ipratropium) ipratropium SPIRIVA (tiotropium)	INCRUSE ELLIPTA (umeclidinium) SPIRIVA RESPIMAT (tiotropium) TUDORZA (aclidinium)	<b>Substitute for Category Criteria:</b> A thirty (30) day trial of tiotropium is required before a non-preferred agent will be authorized.
<b>ANTICHOLINERGIC-BETA AGONIST COMBINATIONS<sup>AP</sup></b>		
albuterol/ipratropium COMBIVENT RESPIMAT (albuterol/ipratropium)	ANORO ELLIPTA (umeclidinium/vilanterol)* DUONEB (albuterol/ipratropium) STIOLTO RESPIMAT (tiotropium/olodaterol)*	*Anoro Ellipta and Stiolto Respimat will be authorized if the following criteria are met: 1) Patient must be eighteen (18) years of age or older; <b>AND</b> 2) Patient must have had a diagnosis of COPD; <b>AND</b> 3) Patient must have had a thirty (30) day trial of a LABA; <b>AND</b> 4) Patient must have had a <b>concurrent thirty (30) day trial</b> with a long-acting anticholinergic;



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		Prior-authorization will be denied for patients with a sole diagnosis of asthma.
<b>PDE4 INHIBITOR</b>		
	DALIRESP (roflumilast)*	*Daliresp will be authorized if the following criteria are met: 1. Patient is forty (40) years of age or older <b>and</b> 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 <b>and</b> 3. Concurrent therapy with an inhaled corticosteroid and long-acting bronchodilator and evidence of compliance <b>and</b> 4. No evidence of moderate to severe liver impairment (Child-Pugh Class B or C) <b>and</b> 5. No concurrent use with strong cytochrome P450 inducers (rifampicin, phenobarbital, carbamazepine or phenytoin)
<b>CYTOKINE &amp; CAM ANTAGONISTS<sup>CL</sup></b>		
<b>CATEGORY PA CRITERIA:</b> 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.		
<b>ANTI-TNFs</b>		
ENBREL (etanercept) * HUMIRA (adalimumab) *	CIMZIA (certolizumab pegol) SIMPONI (golimumab)	*Additional criteria for this category may be found at <a href="#">the BMS Website</a> , by clicking the hyperlink.
<b>OTHERS</b>		
<b>COSENTYX (secukinumab)*</b>	ACTEMRA syringe (tocilizumab) KINERET (anakinra) ORENCIA syringe (abatacept) OTEZLA (apremilast) STELARA syringe (ustekinumab) XELJANZ (tofacitinib)**	*Cosentyx will be authorized for treatment of plaque psoriasis only after inadequate response to a ninety (90) day trial of Humira.  **Additional criteria for this category may be found at <a href="#">the BMS Website</a> , by clicking the hyperlink.
<b>EPINEPHRINE, SELF-INJECTED</b>		
<b>CATEGORY PA CRITERIA:</b> 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 EPIPEN (epinephrine) EPIPEN JR (epinephrine)	ADRENACLICK (epinephrine) AUVI-Q (epinephrine)	



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<b>ERYTHROPOIESIS STIMULATING PROTEINS<sup>CL</sup></b>		
<b>CATEGORY PA CRITERIA:</b> 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.		
PROCRT (rHuEPO)	ARANESP (darbepoetin) EPOGEN (rHuEPO)	Erythropoiesis agents will be authorized if the following criteria are met: 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.) <b>and</b> 2. Transferrin saturation $\geq$ 20%, ferritin levels $\geq$ 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 <b>and</b> 3. For HIV-infected patients, endogenous serum erythropoietin level must be $\leq$ 500mU/ml to initiate therapy <b>and</b> 4. No evidence of untreated GI bleeding, hemolysis, or Vitamin B-12, iron or folate deficiency.
<b>FLUOROQUINOLONES (Oral)<sup>AP</sup></b>		
<b>CATEGORY PA CRITERIA:</b> 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) ciprofloxacin levofloxacin tablet	AVELOX (moxifloxacin) CIPRO TABLETS (ciprofloxacin) CIPRO XR (ciprofloxacin) ciprofloxacin ER ciprofloxacin suspension FACTIVE (gemifloxacin) LEVAQUIN (levofloxacin) levofloxacin solution moxifloxacin NOROXIN (norfloxacin) ofloxacin	
<b>GLUCOCORTICOIDS, INHALED<sup>AP</sup></b>		
<b>CATEGORY PA CRITERIA:</b> 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. A prior authorization will be required for children nine (9) years of age or older, and for individuals unable to use an MDI.		



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<b>GLUCOCORTICOIDS</b>		
ASMANEX TWISTHALER (mometasone) FLOVENT HFA (fluticasone) FLOVENT DISKUS (fluticasone) PULMICORT RESPULES (budesonide)* QVAR (beclomethasone)	AEROSPAN (flunisolide)** ALVESCO (ciclesonide) ARNUITY ELLIPTA (fluticasone) ASMANEX HFA (mometasone) budesonide PULMICORT FLEXHALER (budesonide)	*Pulmicort Respules are preferred for children up to nine (9) years of age. Brand Pulmicort Respules are preferred over the generic formulation.  <b>**Aerospan will be authorized for children ages 6 through 11 years old without a trial of a preferred agent.</b>
<b>GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS</b>		
ADVAIR HFA (fluticasone/salmeterol) <b>BREO ELLIPTA (fluticasone/vilanterol)</b> DULERA (mometasone/formoterol) SYMBICORT(budesonide/formoterol)	<b>ADVAIR DISKUS (fluticasone/salmeterol)</b>	<b>Substitute for Category Criteria:</b> 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.
<b>GROWTH HORMONE<sup>CL</sup></b>		
<b>CATEGORY PA CRITERIA:</b> 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) NORDITROPIN (somatropin) <b>NUTROPIN AQ (somatropin)</b>	HUMATROPE (somatropin) INCRELEX (mecasermin) OMNITROPE (somatropin) SAIZEN (somatropin) SEROSTIM (somatropin) TEV-TROPIN (somatropin) 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.
<b>H. PYLORI TREATMENT</b>		
<b>CATEGORY PA CRITERIA:</b> 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: preferred PPI (omeprazole or pantoprazole) amoxicillin tetracycline metronidazole clarithromycin bismuth	HELIDAC (bismuth/metronidazole/tetracycline) lansoprazole/amoxicillin/clarithromycin OMECLAMOX-PAK (omeprazole/amoxicillin/clarithromycin) PREVPAC (lansoprazole/amoxicillin/clarithromycin) PYLERA (bismuth/metronidazole/tetracycline)	



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<b>HEPATITIS B TREATMENTS</b>		
<b>CATEGORY PA CRITERIA:</b> 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) TYZEKA (telbivudine)	adefovir BARACLUDE (entecavir) HEPSERA (adefovir) lamivudine HBV	
<b>HEPATITIS C TREATMENTS<sup>CL</sup></b>		
<b>CATEGORY PA CRITERIA:</b> 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)* PEGASYS (pegylated interferon) PEG-INTRON (pegylated interferon) ribavirin SOVALDI (sofosbuvir)* TECHNIVIE (ombitasvir/paritaprevir/ritonavir)* VIEKIRA PAK (dasabuvir/ombitasvir/ paritaprevir/ritonavir)*	COPEGUS (ribavirin) DAKLINZA (daclatasvir)* MODERIBA 400 mg, 600 mg MODERIBA DOSE PACK OLYSIO (simeprevir)* REBETOL (ribavirin) RIBASPHERE RIBAPAK (ribavirin) RIBASPHERE 400 mg, 600 mg (ribavirin)	*Full PA criteria may be found at <a href="#">the BMS Website</a> , by clicking the hyperlink.
<b>HYPERPARATHYROID AGENTS<sup>AP</sup></b>		
<b>CATEGORY PA CRITERIA:</b> 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) paricalcitol capsule	doxercalciferol NATPARA (parathyroid hormone) paricalcitol injection SENSIPAR (cinacalcet) ZEMPLAR (paricalcitol)	
<b>HYPOGLYCEMICS, BIGUANIDES</b>		
<b>CATEGORY PA CRITERIA:</b> 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 metformin ER	FORTAMET (metformin ER) GLUCOPHAGE (metformin) GLUCOPHAGE XR (metformin ER) GLUMETZA (metformin ER) RIOMET (metformin)	Glumetza will be approved only after a 30-day trial of Fortamet.



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<b>HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS</b>		
<b>CATEGORY PA CRITERIA:</b> 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.		
<b>INJECTABLE</b>		
<b>BYDUREON (exenatide)*</b> BYETTA (exenatide) <sup>AP</sup> VICTOZA (liraglutide)	SYMLIN (pramlintide) ** TANZEUM (albiglutide) <sup>AP</sup> TRULICITY (dulaglutide)	<p><b>In addition to the Category Criteria:</b> 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 exceptions on the PA form is present.</p> <p>Concurrent therapy with a bolus insulin is contraindicated with all agents in this class</p> <p>*Bydureon will not be authorized with concurrent insulin therapy of any kind.</p> <p>**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.</p>
<b>ORAL<sup>AP</sup></b>		
JENTADUETO (linagliptin/metformin) <sup>AP</sup> TRADJENTA (linagliptin) <sup>AP</sup>	<b>JANUMET (sitagliptin/metformin)<sup>AP</sup></b> JANUMET XR (sitagliptin/metformin) <sup>AP</sup> <b>JANUVIA (sitagliptin)<sup>AP</sup></b> KAZANO (alogliptin/metformin) KOMBIGLYZE XR (saxagliptin/metformin) * NESINA (alogliptin) ONGLYZA (saxagliptin) OSENI (alogliptin/pioglitazone)	<p><b>In addition to the Category Criteria:</b> 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.</p> <p>*Kombiglyze XR will be authorized after thirty (30) day trials of the preferred combination agents.</p>
<b>HYPOGLYCEMICS, INSULIN AND RELATED AGENTS</b>		
<b>CATEGORY PA CRITERIA:</b> 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) HUMALOG MIX VIALS (insulin lispro/lispro protamine) HUMULIN VIALS (insulin) LANTUS (insulin glargine) LEVEMIR (insulin detemir) NOVOLOG (insulin aspart)	AFREZZA (insulin) <sup>CL</sup> APIDRA (insulin glulisine) <sup>AP*</sup> HUMALOG PEN/KWIKPEN (insulin lispro) HUMALOG MIX PENS (insulin lispro/lispro protamine) HUMULIN PENS (insulin) <b>NOVOLIN (insulin)</b>	<p>*Apidra will be authorized if the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. Patient is four (4) years of age or older; <b>and</b></li> <li>2. Patient is currently on a regimen including a longer acting or basal insulin, <b>and</b></li> <li>3. Patient has had a trial of a similar preferred agent, Novolog or Humalog, with documentation that the desired results were not achieved.</li> </ol>



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NOVOLOG MIX (insulin aspart/aspart protamine)	TOUJEO SOLOSTAR (insulin glargine)**	**Toujeo Solostar will be authorized only after 6 months of compliance on preferred long-acting insulin. Toujeo will <b>only</b> be approved for once daily doses of at least 60 units.
<b>HYPOGLYCEMICS, MEGLITINIDES</b>		
<b>CATEGORY PA CRITERIA:</b> 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.		
<b>MEGLITINIDES</b>		
nateglinide PRANDIN (repaglinide)	repaglinide STARLIX (nateglinide)	
<b>MEGLITINIDE COMBINATIONS</b>		
	PRANDIMET (repaglinide/metformin)	
<b>HYPOGLYCEMICS, BILE ACID SEQUESTRANTS</b>		
<b>CATEGORY PA CRITERIA:</b> 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).		
WELCHOL (colesevelam) <sup>AP</sup>		
<b>HYPOGLYCEMICS, SGLT2 INHIBITORS</b>		
<b>CATEGORY PA CRITERIA:</b> All agents will be approved in six (6) month intervals if the following criteria are met:		
<b>Initial starts</b> 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.		
<b>Re-authorizations</b> require <u>continued</u> 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%.		
<b>SGLT2 INHIBITORS</b>		
	FARXIGA (dapagliflozin) INVOKANA (canagliflozin) JARDIANCE (empagliflozin)	
<b>SGLT2 COMBINATIONS</b>		
	GLYXAMBI (empagliflozin/linagliptin) INVOKAMET (canagliflozin/metformin) SYNJARDY (empagliflozin/metformin) XIGDUO XR (dapagliflozin/metformin)	



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<b>HYPOGLYCEMICS, TZD<sup>AP</sup></b>		
<b>CATEGORY PA CRITERIA:</b> 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.		
<b>THIAZOLIDINEDIONES</b>		
Pioglitazone	ACTOS (pioglitazone) AVANDIA (rosiglitazone)	
<b>TZD COMBINATIONS</b>		
	ACTOPLUS MET (pioglitazone/ metformin) ACTOPLUS MET XR (pioglitazone/ metformin) AVANDAMET (rosiglitazone/metformin) AVANDARYL (rosiglitazone/glimepiride) DUETACT (pioglitazone/glimepiride) pioglitazone/glimepiride 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.
<b>IMMUNE GLOBULINS, IV<sup>CL</sup></b>		
<b>CATEGORY PA CRITERIA:</b> Immune globulin agents will be authorized according to FDA approved indications.		
BIVIGAM (human immunoglobulin gamma) CARIMUNE NF (human immunoglobulin gamma) FLEBOGAMMA DIF (human immunoglobulin gamma) GAMMAGARD LIQUID (human immunoglobulin gamma) GAMMAGARD S-D (human immunoglobulin gamma) GAMMAKED (human immunoglobulin gamma) GAMMAPLEX (human immunoglobulin gamma) GAMUNEX-C (human immunoglobulin gamma) OCTAGAM (human immunoglobulin gamma) PRIVIGEN (human immunoglobulin gamma)		



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<b>IMMUNE GLOBULINS, OTHER<sup>CL</sup></b>		
<b>CATEGORY PA CRITERIA:</b> Immune globulin agents will be authorized according to FDA approved indications. 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) GAMASTAN S-D VIAL (human immunoglobulin gamma) HEPAGAM B (hepatitis b immune globulin (human)) HIZENTRA (human immunoglobulin gamma) VARIZIG (varicella zoster immune globulin (human))	HYQVIA (human immunoglobulin g and hyaluronidase)	
<b>IMMUNOMODULATORS, ATOPIC DERMATITIS<sup>AP</sup></b>		
<b>CATEGORY PA CRITERIA:</b> 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) <sup>AP</sup>	PROTOPIC (tacrolimus) 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.
<b>IMMUNOMODULATORS, TOPICAL &amp; GENITAL WARTS AGENTS</b>		
<b>CATEGORY PA CRITERIA:</b> 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) CONDYLOX GEL (podofilox)	CONDYLOX SOLUTION (podofilox) imiquimod podofilox VEREGEN (sinecatechins) ZYCLARA (imiquimod)*	*Zyclara will be authorized for a diagnosis of actinic keratosis.
<b>IMMUNOSUPPRESSIVES, ORAL</b>		
<b>CATEGORY PA CRITERIA:</b> 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 cyclosporine cyclosporine, modified mycophenolate mofetil PROGRAF (tacrolimus) RAPAMUNE (sirolimus)	ASTAGRAF XL (tacrolimus) AZASAN (azathioprine) CELLCEPT (mycophenolate mofetil) IMURAN (azathioprine) MYFORTIC (mycophenolic acid) mycophenolic acid	



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sirolimus	mycophenolic mofetil suspension NEORAL (cyclosporine, modified) SANDIMMUNE (cyclosporine) tacrolimus ZORTRESS (everolimus)	
<b>INTERMITTENT CLAUDICATION<sup>AP</sup></b>		
<b>CATEGORY PA CRITERIA:</b> 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 pentoxifylline	PLETAL (cilostazol)	
<b>INTRANASAL RHINITIS AGENTS<sup>AP</sup></b>		
<b>CATEGORY PA CRITERIA:</b> See below for individual sub-class criteria.		
<b>ANTICHOLINERGICS</b>		
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.
<b>ANTIHISTAMINES</b>		
ASTEPRO (azelastine) 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.
<b>COMBINATIONS</b>		
	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.
<b>CORTICOSTEROIDS</b>		
fluticasone propionate <b>QNASL HFA (beclomethasone)</b>	BECONASE AQ (beclomethasone) budesonide FLONASE (fluticasone propionate) flunisolide NASACORT AQ (triamcinolone) <b>NASONEX (mometasone)</b> OMNARIS (ciclesonide) RHINOCORT AQUA (budesonide) triamcinolone VERAMYST (fluticasone furoate) 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.



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<b>IRRITABLE BOWEL SYNDROME</b>		
<b>CATEGORY PA CRITERIA:</b> 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) <sup>CL*</sup> LINZESS (linaclotide) <sup>CL**</sup>	LOTRONEX (alosetron)	<p>*Amitiza will be prior authorized for patients if the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. Diagnosis of chronic idiopathic constipation, with less than three spontaneous bowel movements per week <b>or</b></li> <li>2. Female with a diagnosis of Irritable Bowel Syndrome with Constipation (IBS-C) <b>or</b></li> <li>3. Diagnosis of opioid induced constipation accompanied by a diagnosis of non-cancer chronic pain (Diagnosis of chronic pain must be documented with diagnostic studies, if appropriate.)</li> </ol> <p><b>and each of the following:</b></p> <ol style="list-style-type: none"> <li>1. Greater than 18 years of age</li> <li>2. Documentation of change in diet</li> <li>3. Documented failure of at least fourteen (14) days of therapy each with osmotic and bulk forming laxatives</li> <li>4. Negative pregnancy test prior to starting therapy if at risk</li> <li>5. Capable of complying with effective contraceptive measures if at risk</li> <li>6. Be appropriately screened for colon cancer, history of bowel obstruction, hepatic or renal disease, hypothyroidism, pelvic floor abnormalities, and spinal cord abnormalities.</li> </ol> <p>**Linzess will be authorized if the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. Diagnosis of chronic idiopathic constipation, with less than three spontaneous bowel movements per week; <b>or</b></li> <li>2. Diagnosis of Irritable Bowel Syndrome with Constipation (IBS-C); <b>and</b></li> <li>3. Patient is eighteen (18) years of age or older <b>and</b></li> <li>4. Documented failure of at least one month of therapy with osmotic or bulk forming laxatives <b>and</b></li> <li>5. Appropriate screening for colon cancer, history of bowel obstruction, hepatic or renal disease, hypothyroidism, pelvic floor abnormalities, and spinal cord abnormalities.</li> </ol>
<b>LAXATIVES AND CATHARTICS</b>		
<b>CATEGORY PA CRITERIA:</b> 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	HALFLYTELY-BISACODYL KIT	



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GOLYTELY NULYTELY peg 3350	MOVIPREP OSMOPREP PREPOPIK SUPREP	
<b>LEUKOTRIENE MODIFIERS</b>		
<b>CATEGORY PA CRITERIA:</b> 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) montelukast	SINGULAIR (montelukast) zafirlukast ZYFLO (zileuton)	
<b>LIPOTROPICS, OTHER (Non-statins)<sup>AP</sup></b>		
<b>CATEGORY PA CRITERIA:</b> 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.		
<b>BILE ACID SEQUESTRANTS</b>		
cholestyramine colestipol tablets	COLESTID (colestipol) colestipol granules KYNAMRO (mipomersen) QUESTRAN (cholestyramine) 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.
<b>CHOLESTEROL ABSORPTION INHIBITORS</b>		
ZETIA (ezetimibe) <sup>AP</sup>		Zetia will be authorized with prior use of a HMG-CoA reductase inhibitor within the previous six (6) months.
<b>FATTY ACIDS</b>		
	LOVAZA (omega-3-acid ethyl esters) omega-3 acid ethyl esters VASCEPA (icosapent ethyl)	These agents shall only be authorized when the patient has an initial triglyceride level $\geq$ 500 mg/dL and has had inadequate response or intolerance to trials of BOTH a nicotinic acid and a fibrate, unless otherwise contraindicated.
<b>FIBRIC ACID DERIVATIVES</b>		
fenofibrate 54, 150 and 160 mg fenofibrate micronized 67mg, 134mg & 200mg fenofibrate nanocrystallized 48 mg, 145 mg gemfibrozil	ANTARA (fenofibrate) FENOGLIDE (fenofibrate) FIBRICOR (fenofibric acid) fenofibrate 43, 50, 120 and 130 mg fenofibric acid LIPOFEN (fenofibrate) LOFIBRA (fenofibrate) LOPID (gemfibrozil) TRICOR (fenofibrate nanocrystallized) TRIGLIDE (fenofibrate) TRILIPIX (fenofibric acid)	



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<b>NIACIN</b>		
niacin NIACOR (niacin) NIASPAN (niacin)	niacin ER	
<b>PCSK-9 INHIBITORS</b>		
	<b>PRALUENT (alirocumab)</b>	Praluent PA criteria is available at the <a href="#">BMS Website by clicking on this hyperlink.</a>
<b>LIPOTROPICS, STATINS<sup>AP</sup></b>		
<b>CATEGORY PA CRITERIA:</b> See below for individual sub-class criteria.		
<b>STATINS</b>		
atorvastatin CRESTOR (rosuvastatin) lovastatin pravastatin simvastatin <sup>CL*</sup>	ALTOPREV (lovastatin) fluvastatin LESCOL (fluvastatin) LESCOL XL (fluvastatin) LIPITOR (atorvastatin) LIVALO (pitavastatin) MEVACOR (lovastatin) PRAVACHOL (pravastatin) 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.  *Zocor/simvastatin 80mg tablets will require a clinical PA
<b>STATIN COMBINATIONS</b>		
	ADVICOR (lovastatin/niacin) amlodipine/atorvastatin CADUET (atorvastatin/amlodipine) LIPTRUZET (atorvastatin/ezetimibe) SIMCOR (simvastatin/niacin ER) VYTORIN (simvastatin/ezetimibe)*	Thirty (30) day concurrent trials of the appropriate single agents are required before a non-preferred Statin combination will be authorized.  *Vytorin will be authorized only after an insufficient response to the maximum tolerable dose of atorvastatin <b>or rosuvastatin</b> after twelve (12) weeks, unless one (1) of the exceptions on the PA form is present.  Vytorin 80/10mg tablets will require a clinical PA
<b>MACROLIDES/KETOLIDES</b>		
<b>CATEGORY PA CRITERIA:</b> See below for individual sub-class criteria.		
<b>KETOLIDES</b>		
	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.
<b>MACROLIDES</b>		
azithromycin BIAXIN XL (clarithromycin)	BIAXIN (clarithromycin) clarithromycin ER	Five (5) day trials each of the preferred agents are required before a non-preferred agent will be authorized unless one (1) of



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clarithromycin erythromycin base	E.E.S. (erythromycin ethylsuccinate) E-MYCIN (erythromycin) ERYC (erythromycin) ERYPED (erythromycin ethylsuccinate) ERY-TAB (erythromycin) ERYTHROCIN (erythromycin stearate) erythromycin estolate PCE (erythromycin) ZITHROMAX (azithromycin) ZMAX (azithromycin)	the exceptions on the PA form is present.
<b>MULTIPLE SCLEROSIS AGENTS</b>		
<b>CATEGORY PA CRITERIA:</b> 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.		
<b>INTERFERONS<sup>AP</sup></b>		
AVONEX (interferon beta-1a) <sup>AP</sup> AVONEX PEN (interferon beta-1a) <sup>AP</sup> BETASERON (interferon beta-1b) <sup>AP</sup>	EXTAVIA KIT (interferon beta-1b) EXTAVIA VIAL (interferon beta-1b) PLEGRIDY (peginterferon beta-1a) REBIF (interferon beta-1a) REBIF REBIDOSE (interferon beta-1a)	
<b>NON-INTERFERONS</b>		
COPAXONE 20 mg (glatiramer) <sup>AP</sup> GILENYA (fingolimod) <sup>AP*</sup>	AMPYRA (dalfampridine) <sup>CL**</sup> AUBAGIO (teriflunomide) <sup>CL***</sup> COPAXONE 40 mg (glatiramer) <sup>CL****</sup> GLATOPA (glatiramer) TECFIDERA (dimethyl fumarate) <sup>CL*****</sup>	*Gilenya will be approved after a thirty (30) day trial of a preferred injectable agent.  **Ampyra will be authorized if the following criteria are met: 1. Diagnosis of multiple sclerosis <b>and</b> 2. No history of seizures <b>and</b> 3. No evidence of moderate or severe renal impairment <b>and</b> 4. Initial prescription will be authorized for thirty (30) days only.  ***Aubagio will be authorized if the following criteria are met: 1. Diagnosis of relapsing multiple sclerosis <b>and</b> 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 <b>and</b> 3. Complete blood cell count (CBC) within six (6) months before initiation of therapy <b>and</b> 4. Female patients must have a negative pregnancy test before initiation of therapy and be established on a reliable method of contraception if appropriate <b>and</b>



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		5. Patient is from eighteen (18) up to sixty-five (65) years of age <b>and</b> 6. Negative tuberculin skin test before initiation of therapy  ****Copaxone 40mg will only be authorized for documented injection site issues.  *****Tecfidera will be authorized if the following criteria are met: 1. Diagnosis of relapsing multiple sclerosis <b>and</b> 2. A thirty (30) day trial of a preferred agent in the corresponding class <b>and</b> 3. Complete blood count (CBC) within six (6) months of initiation of therapy and six (6) months after initiation <b>and</b> 4. Complete blood count (CBC) annually during therapy.
<b>NEUROPATHIC PAIN</b>		
<b>CATEGORY PA CRITERIA:</b> 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 duloxetine gabapentin capsules, solution LIDODERM (lidocaine) <sup>AP*</sup>	CYMBALTA (duloxetine) gabapentin tablets GRALISE (gabapentin)** HORIZANT (gabapentin) IRENKA (duloxetine) lidocaine patch LYRICA CAPSULE (pregabalin)*** LYRICA SOLUTION (pregabalin)*** NEURONTIN (gabapentin) QUTENZA (capsaicin) SAVELLA (milnacipran)**** ZOSTRIX OTC (capsaicin)	*Lidoderm patches will be authorized for a diagnosis of post-herpetic neuralgia.  **Gralise will be authorized if the following criteria are met: 1. Diagnosis of post herpetic neuralgia <b>and</b> 2. Trial of a tricyclic antidepressant for a least thirty (30) days <b>and</b> 3. Trial of gabapentin immediate release formulation (positive response without adequate duration) <b>and</b> 4. Request is for once daily dosing with 1800 mg maximum daily dosage.  ***Lyrica will be authorized if the following criteria are met: 1. Diagnosis of seizure disorders or neuropathic pain associated with a spinal cord injury <b>or</b> 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.)



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		****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.
<b>NSAIDS<sup>AP</sup></b>		
<b>CATEGORY PA CRITERIA:</b> 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.		
<b>NON-SELECTIVE</b>		
diclofenac (IR, SR) etodolac IR flurbiprofen ibuprofen (Rx and OTC) INDOCIN SUSPENSION (indomethacin) indomethacin ketoprofen ketorolac nabumetone naproxen (Rx and OTC) piroxicam sulindac	ANAPROX (naproxen) ANSAID (flurbiprofen) CATAFLAM (diclofenac) CLINORIL (sulindac) DAYPRO (oxaprozin) diflunisal DUEXIS (famotidine/ibuprofen) etodolac SR FELDENE (piroxicam) fenoprofen INDOCIN SUPPOSITORIES (indomethacin) indomethacin ER ketoprofen ER meclofenamate mefenamic acid MOTRIN (ibuprofen) NALFON (fenoprofen) NAPRELAN (naproxen) NAPROSYN (naproxen) oxaprozin PONSTEL (meclofenamate) SPRIX (ketorolac) tolmetin VOLTAREN (diclofenac) ZIPSOR (diclofenac potassium) ZORVOLEX (diclofenac)	
<b>NSAID/GI PROTECTANT COMBINATIONS</b>		
	ARTHROTEC (diclofenac/misoprostol) diclofenac/misoprostol VIMOVO (naproxen/esomeprazole)	
<b>COX-II SELECTIVE</b>		
meloxicam	CELEBREX (celecoxib) celecoxib	COX-II Inhibitor agents will be authorized if the following criteria are met:



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	MOBIC (meloxicam)	Patient has a history or risk of a serious GI complication <b>or</b> Agent is requested for treatment of a chronic condition <b>and</b> 1. Patient is seventy (70) years of age or older, <b>or</b> 2. Patient is currently on anticoagulation therapy.
<b>TOPICAL</b>		
VOLTAREN GEL (diclofenac)* <sup>AP</sup>	diclofenac solution FLECTOR PATCH (diclofenac)** PENNSAID (diclofenac)	<b>In addition to the Category Criteria:</b> 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.  *Voltaren Gel will be authorized if the following criteria are met: 1. Thirty (30) day trials of two (2) of the preferred oral NSAIDs, <b>or</b> . 2. The patient is on anticoagulant therapy <b>or</b> 3. The patient has had a GI bleed or ulcer diagnosed in the last two (2) years. Prior authorizations will be limited to 100 grams per month.  **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.
<b>OPHTHALMIC ANTIBIOTICS<sup>AP</sup></b>		
<b>CATEGORY PA CRITERIA:</b> 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 <b>BESIVANCE (besifloxacin)</b> ciprofloxacin* erythromycin gentamicin MOXEZA (moxifloxacin)* <b>neomycin/polymyxin/gramicidin</b> ofloxacin* polymyxin/trimethoprim sulfacetamide tobramycin VIGAMOX (moxifloxacin)*	AZASITE (azithromycin) bacitracin BLEPH-10 (sulfacetamide) CILOXAN (ciprofloxacin) GARAMYCIN (gentamicin) gatifloxacin ILOTYCIN (erythromycin) levofloxacin NATACYN (natamycin) neomycin/bacitracin/polymyxin NEOSPORIN (neomycin/polymyxin/gramicidin) OCUFLOX (ofloxacin) POLYTRIM (polymyxin/trimethoprim) sulfacetamide ointment TOBREX (tobramycin)	The American Academy of Ophthalmology guidelines on treating bacterial conjunctivitis recommend as first line treatment options: erythromycin ointment, sulfacetamide drops, or polymyxin/trimethoprim drops.  *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.



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<b>PREFERRED AGENTS</b>	<b>NON-PREFERRED AGENTS</b>	<b>PA CRITERIA</b>
	ZYMAR (gatifloxacin) ZYMAXID (gatifloxacin)	
<b>OPHTHALMIC ANTIBIOTIC/STEROID COMBINATIONS<sup>AP</sup></b>		
<b>CATEGORY PA CRITERIA:</b> 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) neomycin/polymyxin/dexamethasone sulfacetamide/prednisolone TOBRADEX OINTMENT (tobramycin/ dexamethasone) <b>TOBRADEX ST (tobramycin/ dexamethasone)</b> TOBRADEX SUSPENSION (tobramycin/ dexamethasone)	<b>BLEPHAMIDE S.O.P. (prednisolone/ sulfacetamide)</b> MAXITROL ointment (neomycin/polymyxin/ dexamethasone) MAXITROL suspension (neomycin/polymyxin/ dexamethasone) neomycin/bacitracin/polymyxin/ hydrocortisone neomycin/polymyxin/hydrocortisone PRED-G (prednisolone/gentamicin) tobramycin/dexamethasone suspension ZYLET (loteprednol/tobramycin)	
<b>OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS<sup>AP</sup></b>		
<b>CATEGORY PA CRITERIA:</b> 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) cromolyn ketotifen PATADAY (olopatadine) ZADITOR OTC (ketotifen) ZYRTEC ITCHY EYE (ketotifen)	ALAMAST (pemirolast) ALOCRIL (nedocromil) ALOMIDE (Iodoxamide) <b>ALREX (loteprednol)</b> azelastine BEPREVE (bepotastine) CROLOM (cromolyn) ELESTAT (epinastine) EMADINE (emedastine) epinastine LASTACAFT (alcaftadine) OPTICROM (cromolyn) OPTIVAR (azelastine) PATANOL (olopatadine) PAZEO (olopatadine)	



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<b>OPHTHALMICS, ANTI-INFLAMMATORIES- IMMUNOMODULATORS</b>		
<b>CATEGORY PA CRITERIA:</b> See below for individual sub-class criteria.		
	RESTASIS (cyclosporine)	Restasis will be authorized if the following criteria are met: 1.) Patient must be sixteen (16) years of age or greater; <b>AND</b> 2.) Prior Authorization must be requested by an ophthalmologist or optometrist; <b>AND</b> 3.) Clinically diagnosed tear deficiency due to ocular inflammation in patients with keratoconjunctivitis sicca or dry eye syndrome (also known as dry eye); <b>AND</b> 4.) Patient must have a functioning lacrimal gland; <b>AND</b> 5.) Patient using artificial tears at least four (4) times a day over the last thirty (30) days; <b>AND</b> 6.) Patient must not have an active ocular infection
<b>OPHTHALMIC ANTI-INFLAMMATORIES<sup>AP</sup></b>		
<b>CATEGORY PA CRITERIA:</b> 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 diclofenac fluorometholone flurbiprofen ketorolac prednisolone acetate	ACULAR (ketorolac) ACULAR LS (ketorolac) ACUVAIL (ketorolac tromethamine) BROMDAY (bromfenac) bromfenac DUREZOL (difluprednate) FLAREX (fluorometholone) FML (fluorometholone) FML FORTE (fluorometholone) FML S.O.P. (fluorometholone) ILEVRO (nepafenac) LOTEMAX DROPS, OINTMENT (loteprednol) LOTEMAX GEL (loteprednol) MAXIDEX (dexamethasone) NEVANAC (nepafenac) OMNIPRED (prednisolone) OZURDEX (dexamethasone) PRED FORTE (prednisolone) PRED MILD (prednisolone) prednisolone sodium phosphate PROLENSA (bromfenac) RETISERT (fluocinolone) TRIESENCE (triamcinolone)	



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	VEXOL (rimexolone) XIBROM (bromfenac)	
<b>OPHTHALMICS, GLAUCOMA AGENTS</b>		
<b>CATEGORY PA CRITERIA:</b> A non-preferred agent will only be authorized if there is an allergy to the preferred agents.		
<b>COMBINATION AGENTS</b>		
COMBIGAN (brimonidine/timolol) dorzolamide/timolol SIMBRINZA (brinzolamide/brimonidine)	COSOPT (dorzolamide/timolol) COSOPT PF (dorzolamide/timolol)	
<b>BETA BLOCKERS</b>		
BETOPTIC S (betaxolol) carteolol levobunolol metipranolol timolol	BETAGAN (levobunolol) betaxolol BETIMOL (timolol) ISTALOL (timolol) OPTIPRANOLOL (metipranolol) TIMOPTIC (timolol)	
<b>CARBONIC ANHYDRASE INHIBITORS</b>		
AZOPT (brinzolamide) dorzolamide	TRUSOPT (dorzolamide)	
<b>PARASYMPATHOMIMETICS</b>		
PHOSPHOLINE IODIDE (echothiophate iodide)	pilocarpine	
<b>PROSTAGLANDIN ANALOGS</b>		
latanoprost TRAVATAN-Z (travoprost)	bimatoprost LUMIGAN (bimatoprost) RESCULA (unoprostone) travoprost XALATAN (latanoprost) ZIOPTAN (tafluprost)	
<b>SYMPATHOMIMETICS</b>		
brimonidine 0.2%	ALPHAGAN P 0.1% Solution (brimonidine) <b>ALPHAGAN P 0.15% Solution (brimonidine)</b> apraclonidine brimonidine 0.15% IOPIDINE (apraclonidine)	
<b>OPIATE DEPENDENCE TREATMENTS</b>		
<b>CATEGORY PA CRITERIA:</b> 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.		
<b>NARCAN NASAL SPRAY (naloxone)</b> SUBOXONE FILM (buprenorphine/naloxone) <sup>CL</sup> VIVITROL (naltrexone) <sup>CL</sup>	EVZIO (naloxone) buprenorphine/naloxone tablets BUNAVAIL (buprenorphine/naloxone) ZUBSOLV (buprenorphine/naloxone)	Suboxone PA criteria is available at <a href="#">the BMS Website</a> , by clicking the hyperlink.  Vivitrol PA criteria is available at <a href="#">the BMS Website</a> , by clicking



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naloxone		the hyperlink.  Evzio PA criteria is available at <a href="#">the BMS Website</a> , by clicking the hyperlink.
<b>OTIC ANTIBIOTICS<sup>AP</sup></b>		
<b>CATEGORY PA CRITERIA:</b> 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) CIPRODEX (ciprofloxacin/dexamethasone)* ciprofloxacin COLY-MYCIN S (colistin/hydrocortisone/ neomycin/thonzonium bromide) neomycin/polymyxin/HC solution/suspension	CORTISPORIN-TC (colistin/hydrocortisone/ neomycin) ofloxacin	*Ciprodex is limited to patients up to nine (9) years of age. Age exceptions will be handled on a case-by-case basis.
<b>PAH AGENTS – ENDOTHELIN RECEPTOR ANTAGONISTS<sup>CL</sup></b>		
<b>CATEGORY PA CRITERIA:</b> 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) TRACLEER (bosentan)	OPSUMIT (macitentan)	Letairis and Tracleer will be authorized for a diagnosis of pulmonary arterial hypertension (PAH).
<b>PAH AGENTS – GUANYLATE CYCLASE STIMULATOR<sup>CL</sup></b>		
<b>CATEGORY PA CRITERIA:</b> 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)	
<b>PAH AGENTS – PDE5s<sup>CL</sup></b>		
<b>CATEGORY PA CRITERIA:</b> 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. Patients stabilized on non-preferred agents will be grandfathered.		
sildenafil	ADCIRCA (tadalafil) REVATIO IV (sildenafil) REVATIO SUSPENSION (sildenafil) REVATIO TABLETS (sildenafil)	
<b>PAH AGENTS – PROSTACYCLINS<sup>CL</sup></b>		
<b>CATEGORY PA CRITERIA:</b> 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 VENTAVIS (iloprost)*	FLOLAN (epoprostenol) ORENITRAM ER (treprostinil)	*Ventavis will only be authorized for the treatment of pulmonary artery hypertension (WHO Group 1) in patients with NYHA Class



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	REMODULIN (treprostinil sodium) TYVASO (treprostinil) VELETRI (epoprostenol)	III or IV symptoms.
<b>PANCREATIC ENZYMES<sup>AP</sup></b>		
<b>CATEGORY PA CRITERIA:</b> 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. Non-preferred agents will be authorized for members with cystic fibrosis.		
CREON PANCRELIPASE 5000 ZENPEP	PANCREAZE PERTZYE ULTRESA VIOKACE	
<b>PHOSPHATE BINDERS<sup>AP</sup></b>		
<b>CATEGORY PA CRITERIA:</b> 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.		
calcium acetate MAGNEBIND RX (calcium carbonate, folic acid, magnesium carbonate) PHOSLYRA (calcium acetate) RENAGEL (sevelamer)	AURYXIA (ferric citrate) ELIPHOS (calcium acetate) FOSRENOL (lanthanum) PHOSLO (calcium acetate) RENVELA (sevelamer carbonate) sevelamer carbonate VELPHORO (sucroferric oxyhydroxide)	
<b>PLATELET AGGREGATION INHIBITORS</b>		
<b>CATEGORY PA CRITERIA:</b> 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) BRILINTA (ticagrelor) clopidogrel EFFIENT (prasugrel)	dipyridamole PERSANTINE (dipyridamole) PLAVIX (clopidogrel) TICLID (ticlopidine) ticlopidine ZONTIVITY (vorapaxar)	
<b>PROGESTINS FOR CACHEXIA</b>		
<b>CATEGORY PA CRITERIA:</b> 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) MEGACE ES (megestrol)	



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<b>PROTON PUMP INHIBITORS<sup>AP</sup></b>		
<b>CATEGORY PA CRITERIA:</b> 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 <sub>2</sub> 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) pantoprazole PREVACID SOLUTABS (lansoprazole)*	ACIPHEX (rabeprazole) ACIPHEX SPRINKLE (rabeprazole) DEXILANT (dexlansoprazole) esomeprazole strontium lansoprazole Rx NEXIUM (esomeprazole) omeprazole/sodium bicarbonate (Rx) PREVACID CAPSULES (lansoprazole) PRILOSEC Rx (omeprazole) PROTONIX (pantoprazole) rabeprazole ZEGERID Rx (omeprazole/sodium bicarbonate)	*Prior authorization is required for Prevacid Solutabs for members eight (8) years of age or older.
<b>SEDATIVE HYPNOTICS<sup>AP</sup></b>		
<b>CATEGORY PA CRITERIA:</b> 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.		
<b>BENZODIAZEPINES</b>		
temazepam 15, 30 mg	DALMANE (flurazepam) DORAL (quazepam) estazolam flurazepam HALCION (triazolam) quazepam RESTORIL (temazepam) temazepam 7.5, 22.5 mg triazolam	
<b>OTHERS</b>		
zolpidem 5, 10 mg	AMBIEN (zolpidem) AMBIEN CR (zolpidem) BELSOMRA (suvorexant) chloral hydrate EDLUAR (zolpidem) eszopiclone INTERMEZZO (zolpidem) LUNESTA (eszopiclone) ROZEREM (ramelteon)	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.  For treatment naïve female patients, zolpidem and zolpidem ER maximum dosages will be limited to 5 mg and 6.25 mg respectively per day.



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	SILENOR (doxepin) SOMNOTE (chloral hydrate) SONATA (zaleplon) zaleplon zolpidem ER 6.25, 12.5 mg ZOLPIMIST (zolpidem)	
<b>SKELETAL MUSCLE RELAXANTS<sup>AP</sup></b>		
<b>CATEGORY PA CRITERIA:</b> See below for individual sub-class criteria.		
<b>ACUTE MUSCULOSKELETAL RELAXANT AGENTS</b>		
chlorzoxazone cyclobenzaprine IR 5, 10 mg methocarbamol	AMRIX (cyclobenzaprine) carisoprodol carisoprodol/ASA carisoprodol/ASA/codeine cyclobenzaprine ER cyclobenzaprine IR 7.5 mg FEXMID (cyclobenzaprine) FLEXERIL (cyclobenzaprine) LORZONE (chlorzoxazone) metaxalone orphenadrine orphenadrine/ASA/caffeine orphenadrine ER PARAFON FORTE (chlorzoxazone) ROBAXIN (methocarbamol) SKELAXIN (metaxalone) SOMA (carisoprodol)	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.  Thirty (30) day trials of each of the preferred acute musculoskeletal relaxants and Skelaxin are required before carisoprodol will be authorized.
<b>MUSCULOSKELETAL RELAXANT AGENTS USED FOR SPASTICITY</b>		
baclofen tizanidine tablets	DANTRIUM (dantrolene) dantrolene tizanidine capsules 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.
<b>STERIODS, TOPICAL</b>		
<b>CATEGORY PA CRITERIA:</b> 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.		



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<b>VERY HIGH &amp; HIGH POTENCY</b>		
betamethasone dipropionate cream, lotion betamethasone valerate cream clobetasol propionate cream/gel/ointment/solution clobetasol emollient fluocinonide cream, gel, solution fluocinonide/emollient halobetasol propionate triamcinolone acetonide cream, ointment	amcinonide APEXICON (diflorasone diacetate) APEXICON E (diflorasone diacetate) betamethasone dipropionate gel, lotion, ointment betamethasone valerate lotion, ointment, clobetasol lotion, shampoo clobetasol propionate foam CLOBEX (clobetasol propionate) CLODAN (clobetasol propionate) CORMAX (clobetasol propionate) desoximetasone cream/gel/ointment diflorasone diacetate DIPROLENE (betamethasone dipropionate/propylene glycol) DIPROLENE AF (betamethasone dipropionate/propylene glycol) DIPROSONE (betamethasone dipropionate) fluocinonide ointment halcinonide HALAC (halobetasol propionate) HALOG (halcinonide) HALONATE (halobetasol propionate) KENALOG (triamcinolone acetonide) LIDEX (fluocinonide) LIDEX-E (fluocinonide) OLUX (clobetasol propionate) OLUX-E (clobetasol propionate/emollient) PSORCON (diflorasone diacetate) TEMOVATE (clobetasol propionate) TEMOVATE-E (clobetasol propionate/emollient) TOPICORT CREAM, GEL, OINTMENT (desoximetasone) TOPICORT SPRAY (desoximetasone) triamcinolone acetonide lotion ULTRAVATE (halobetasol propionate) ULTRAVATE PAC cream ULTRAVATE X (halobetasol propionate / lactic acid) VANOS (fluocinonide)	



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<b>MEDIUM POTENCY</b>		
fluticasone propionate cream, ointment hydrocortisone butyrate ointment, solution hydrocortisone valerate mometasone furoate triamcinolone acetonide 0.025% and 0.1% cream	ARISTOCORT (triamcinolone) BETA-VAL (betamethasone valerate) betamethasone valerate foam CLODERM (clocortolone pivalate) clocortolone cream CORDRAN/CORDRAN SP (flurandrenolide) CUTIVATE (fluticasone propionate) DERMATOP (prednicarbate) ELOCON (mometasone furoate) fluocinolone acetonide cream, ointment, solution fluticasone propionate lotion hydrocortisone butyrate cream LOCOID (hydrocortisone butyrate) LOCOID LIPOCREAM (hydrocortisone butyrate/emollient) LUXIQ (betamethasone valerate) MOMEXIN (mometasone) PANDEL (hydrocortisone probutate) prednicarbate TOPICORT LP (desoximetasone) TRIDERM (triamcinolone acetonide) WESTCORT (hydrocortisone valerate)	
<b>LOW POTENCY</b>		
desonide cream, ointment hydrocortisone acetate (Rx, OTC) hydrocortisone cream (Rx, OTC) hydrocortisone lotion OTC hydrocortisone ointment (Rx, OTC) hydrocortisone solution OTC hydrocortisone-aloe cream OTC hydrocortisone-aloe ointment OTC	ACLOVATE (acclometasone dipropionate) alclometasone dipropionate AQUA GLYCOLIC HC (hydrocortisone) CAPEX (fluocinolone acetonide) DERMA-SMOOTH FS (fluocinolone acetonide) DESONATE (desonide) desonide lotion DESOWEN (desonide) fluocinolone oil hydrocortisone/mineral oil/petrolatum hydrocortisone acetate/urea hydrocortisone lotion hydrocortisone/aloe gel LOKARA (desonide) PEDIADERM HC (hydrocortisone) PEDIADERM TA (hydrocortisone) SCALPICIN OTC (hydrocortisone)	



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**EFFECTIVE  
01/01/2016  
Version 2016.1k**

<b>THERAPEUTIC DRUG CLASS</b>		
<b>PREFERRED AGENTS</b>	<b>NON-PREFERRED AGENTS</b>	<b>PA CRITERIA</b>
	SYNALAR (fluocinolone) TEXACORT (hydrocortisone) VERDESO (desonide)	
<b>STIMULANTS AND RELATED AGENTS</b>		
<b>CATEGORY PA CRITERIA:</b> A PA is required for adults eighteen (18) years of age or older.		
<p>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.</p> <p>Patients stabilized on non-preferred agents will be grandfathered.</p>		
<b>AMPHETAMINES</b>		
amphetamine salt combination IR <b>DEXEDRINE ER (dextroamphetamine)</b> dextroamphetamine IR PROCENTRA solution (dextroamphetamine) VYVANSE (lisdexamfetamine)	ADDERALL XR* (amphetamine salt combination) amphetamine salt combination ER DESOXYN (methamphetamine) DEXEDRINE IR (dextroamphetamine) dextroamphetamine ER dextroamphetamine solution <b>EVEKEO (amphetamine)</b> methamphetamine ZENZEDI (dextroamphetamine)	<p><b>In addition to the Category Criteria:</b> Thirty (30) day trials of at least three (3) antidepressants are required before amphetamines will be authorized for depression.</p> <p>*Adderall XR is preferred over its generic equivalents.</p>



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THERAPEUTIC DRUG CLASS		
PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
<b>NON-AMPHETAMINE</b>		
clonidine <b>IR</b> DAYTRANA (methylphenidate) <b>dexmethylphenidate IR</b> FOCALIN XR (dexmethylphenidate) guanfacine <b>IR</b> METADATE CD (methylphenidate) <b>METHYLIN SOLUTION (methylphenidate)</b> methylphenidate <b>IR</b> <b>methylphenidate ER (authorized generic Concerta – Actavis labeler 00591)</b> STRATTERA (atomoxetine)*	<b>APTENSIO XR (methylphenidate)</b> clonidine ER CONCERTA (methylphenidate) dexmethylphenidate XR <b>FOCALIN IR (dexmethylphenidate)</b> guanfacine ER** INTUNIV (guanfacine extended-release) KAPVAY (clonidine extended-release)** METHYLIN CHEWABLE TABLETS (methylphenidate) methylphenidate <b>chewable tablets</b> , solution methylphenidate CD <b>methylphenidate ER</b> methylphenidate LA modafinil*** NUVIGIL (armodafinil) *** PROVIGIL (modafinil) *** QUILLIVANT XR (methylphenidate) RITALIN (methylphenidate) RITALIN LA (methylphenidate)	*Strattera does not required a PA for adults eighteen (18) years of age or older. 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.  **Guanfacine ER and Kapvay/clonidine ER will be authorized if the following criteria are met: 1. Fourteen (14) day trials of at least one (1) preferred product from the amphetamine and non-amphetamine class <b>and</b> 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.  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.  ***Provigil is preferred over its generic equivalent and Nuvigil. <b>These drugs</b> will only be authorized for patients sixteen (16) years of age or older with a diagnosis of narcolepsy.
<b>TETRACYCLINES</b>		
<b>CATEGORY PA CRITERIA:</b> 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 doxycycline monohydrate 50, 100 mg capsules minocycline capsules tetracycline	ADOXA (doxycycline monohydrate) demeclocycline* DORYX (doxycycline hyclate) doxycycline hyclate tablet DR doxycycline monohydrate 40, 75, 150 mg capsule doxycycline monohydrate tablet doxycycline monohydrate suspension DYNACIN (minocycline) MINOCIN (minocycline) minocycline ER capsules minocycline tablets MONODOX (doxycycline monohydrate) MORGIDOX KIT (doxycycline) ORACEA (doxycycline monohydrate) SOLODYN (minocycline) 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. Demeclocycline will also be authorized for SIADH.



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<b>THERAPEUTIC DRUG CLASS</b>		
<b>PREFERRED AGENTS</b>	<b>NON-PREFERRED AGENTS</b>	<b>PA CRITERIA</b>
	SYRUP (doxycycline)	
<b>ULCERATIVE COLITIS AGENTS<sup>AP</sup></b>		
<b>CATEGORY PA CRITERIA:</b> 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.		
<b>ORAL</b>		
APRISO (mesalamine) balsalazide DELZICOL (mesalamine) PENTASA (mesalamine) 250 mg sulfasalazine	ASACOL HD (mesalamine) AZULFIDINE (sulfasalazine) COLAZAL (balsalazide) DIPENTUM (olsalazine) GIAZO (balsalazide) LIALDA (mesalamine) PENTASA (mesalamine) 500 mg UCERIS (budesonide)	
<b>RECTAL</b>		
CANASA (mesalamine) mesalamine	mesalamine kit ROWASA (mesalamine) SF ROWASA (mesalamine) UCERIS (budesonide)	
<b>VASODILATORS, CORONARY</b>		
<b>CATEGORY PA CRITERIA:</b> 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.		
<b>SUBLINGUAL NITROGLYCERIN</b>		
nitroglycerin sublingual NITROLINGUAL SPRAY (nitroglycerin) NITROSTAT SUBLINGUAL (nitroglycerin)	nitroglycerin spray NITROMIST (nitroglycerin)	