Indiana Medicaid Preferred Drug List (PDL)

OptumRx Call Center

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

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

Indiana Health Coverage Programs (IHCP) Drug Coverage

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

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

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 Drugs that will be or have been withdrawn from the market will be removed from the PDL as part of routine periodic updating of the PDL.

Nomenclature

- **Preferred Drug List (PDL)** - a list of drugs within select therapeutic drug classes, developed and maintained by the Drug Utilization Review (DUR) Board, designated as *preferred* or *non-preferred* based upon clinical and financial considerations.
    - **Preferred Drug** – Covered drug designated by the DUR Board as a principle agent for use within a therapeutic class.
        - Mental health drugs are considered *preferred* (see Mental Health Drugs section below).
    - **Non-preferred Drug** – Covered drug designated by the DUR Board as secondary agent for use within a therapeutic class. Non-preferred drugs typically require prior authorization.
        - Grandfathering - The process whereby criteria are established exempting a drug from prior authorization, under specific conditions, when it would otherwise require prior authorization.
        - Brand name drugs, with an available substitutable generic, are *non-preferred* unless otherwise specified on the PDL. All preferred brand products on the PDL with a new available generic will list the generic agent added as non-preferred until it is financially advantageous to move to preferred. Once the generic agent is financially advantageous, it will replace the brand product as preferred. All non-preferred brand products on the PDL with a new available generic will list the generic agent added as non-preferred until it is reviewed by the Therapeutics Committee in the product's regularly scheduled review cycle.
            - Prior authorization is typically required for a prescriber's specification of "brand medically necessary".

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

- **Status Pending Drug –** Covered drug that is subject to the PDL, but for which *preferred* or *non-preferred* status has yet to be assigned.
- **Neutral Drug** – Covered drug that is in a therapeutic class not included on the PDL. As such, the drug has neither *preferred* nor *non-preferred* status.
- **Line Extension Drug** – A new strength, formulation, or dosage form of a particular chemical entity for a given manufacturer that has been approved by the FDA. The PDL status of a line extension drug is the same as the status of the chemical entity to which it pertains unless otherwise determined by the DUR Board.

Prior Authorization (PA)

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

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

Mental Health Drugs

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

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Effective August 1, 2019 (V 1.0)

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

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
ANTI-INFECTIVES			
Antivirals – Anti-Herpetic	acyclovir valacyclovir ST- must have diagnosis of HIV or trial and failure of acyclovir or medical justification for use	famciclovir; Sitavig Valtrex ST - requires HIV therapy	
Antivirals – Influenza	amantidine; oseltamivir; Relenza; rimantadine AGE - 60 years and older	Flumadine; Rapivab; Xofluza rimantadine AGE - under 60 years old	
Cephalosporins – 3rd Generation	cefdinir; cefpodoxime; Suprax capsules	Cedax; cefditoren; cefixime capsules; Suprax chewable tablets, non-chewable tablets, and suspension	
Fluoroquinolones ***Note: All fluoroquinolones will be limited to 14 days per claim***	ciprofloxacin; levofloxacin; moxifloxacin	Baxdela; ciprofloxacin ER; Factive; ofloxacin Cipro suspension; ciprofloxacin suspension; levofloxacin solution PA - must meet criteria	PA Criteria for ciprofloxacin and levofloxacin solution
Hepatitis C Agents	Pegasys; Pegintron; ribavirin; Rebetol solution Epclusa; Mavyret; Zepatier PA - must meet criteria	Copegus; Moderiba; Rebetol capsules; ribapack dosepack Daklinza; Harvoni; ledipasvir/sofosbuvir; Olysio; sofosbuvir/velpatasvir; Sovaldi; Technivie; Viekira/Viekira XR; Vosevi PA – must meet criteria	Hepatitis C Agents PA Criteria Hepatitis C Agents PA Form

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
ANTI-INFECTIVES - Continued			
Macrolides	azithromycin suspension; clarithromycin; erythromycin capsules azithromycin oral tablets QL - one pkg/30 days of 3 or 6 tablet package Eryped ST – member must be under 18 years of age or unable to swallow tablets/capsules	E.E.S. tablets; Ery-Tab; erythrocin stearate; erythromycin ethylsuccinate; erythromycin tablets; Zmax E.E.S. Granules ST – must have trialed and failed Eryped OR must be under 18 years of age or unable to swallow tablets/capsules and medical justification for use over preferred agents Dificid - PA - must meet criteria	Dificid PA Criteria Dificid PA Form
Ophthalmic Antibiotics	all generics unless otherwise specified; Besivance; Ciloxan ointment; ciprofloxacin; erythromycin; Gentak ointment; gentamicin; neomycin/polymyxin B/gramicidin; ofloxacin; polymyxin B/bacitracin; polymyxin B/trimethoprim; tobramycin moxifloxacin AGE - 30 years of age or older; ST- patients under 30 years of age must have tried at least one preferred agent within the past 30 days	Azasite; bacitracin eye ointment; gatifloxacin; levofloxacin; Natacyn; neomycin/bacitracin/polymyxin eye ointment Moxeza AGE - 30 years of age or older; ST- must have trialed and failed moxifloxacin OR medical justification for use over preferred agents	
Ophthalmic Antibiotics/ Corticosteroid Combinations	all generics unless otherwise specified; gentamicin/prednisolone; neomycin/polymyxin B/dexamethasone; sulfacetamide sodium/pred; Tobradex suspension and ointment	blephamide; blephamide S.O.P.; neomycin/polymyxin/hc drops; Pred-G; tobramycin/dexamethasone suspension and ointment; Zylet	
Oral Non-Systemic Antifungals	clotrimazole troches; nystatin suspension; nystatin tablets	Oravig	
Otic Antibiotics	All generics unless otherwise specified; Ciprodex; Cipro HC; neomycin/polymyxin B/hydrocortisone; ofloxacin otic solution; Otovel	ciprofloxacin; Coly-Mycin S; Otiprio	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
ANTI-INFECTIVES - Continued			
Systemic Antifungals	fluconazole QL - 50 mg 3 tabs/30 days; 150 mg 4 tabs/30 days itraconazole; ketoconazole; terbinafine	Cresemba; Onmel; Tolsura; voriconazole tabs itraconazole solution; voriconazole suspension ST – must be 18 years of age and under or unable to swallow tablets Noxafil ST - must have tried fluconazole for treatment of oropharyngeal candidiasis or must be severely immunocompromised and need prophylaxis against invasive Aspergillus or Candida infections	
Topical Antifungals	all generics unless otherwise specified; ciclopirox (cream & topical solution); clotrimazole; miconazole	baza antifungal cream; ciclopirox gel, kit, topical shampoo, & topical suspension; econazole; Ecoza; Ertaczo; Exelderm; Extina; Jublia; Kerydin topical solution; ketoconazole topical foam; Loprox kit; luliconazole; Luzu; Mentax; naftifine; Oxistat; Vusion	
Topical Antivirals	Zovirax cream	Abreva cream; Acyclovir cream and ointment; Denavir cream	
Topical Antiviral and Antiinflammatory Steroid Combinations	Xerese QL - 1 tube per claim per 90 days	N/A	
Vaginal Antimicrobials	***Antibacterials*** Clindesse; metronidazole vaginal gel ***Antifungals*** clotrimazole; miconazole cream; terconazole cream; tioconazole	***Antibacterials*** clindamycin cream; Nuvessa ***Antifungals*** Gynazole 1; miconazole combination pack; miconazole suppositories; terconazole suppositories	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
ANTIMIGRAINE			
Antimigraine Preparations	sumatriptan nasal spray QL - 1 box - 6 inhalers/30 days sumatriptan stat dose or stat dose refill package QL - 1 box - 2 injections/30 days sumatriptan vial QL - 2 vials - 2 injections/30 days Relpax QL - 1 box - 6 tabs/30 days rizatriptan ODT QL - 1 box - 12 tabs/30 days sumatriptan tablets; Treximet QL - 1 box - 9 tabs/30 days	almotriptan; eletriptan; zolmitriptan; zolmitriptan ODT QL - 1 box - 6 tabs/30 days frovatriptan; naratriptan; sumatriptan/naproxen QL - 1 box - 9 tabs/30 days rizatriptan QL - 1 box - 12 tabs/30 days Zomig Nasal Spray QL - 1 box - 6 inhalers/30 days Sumavel DosePro QL - 2 injections/30 days Onzetra Xsail QL – 1 box (8 pouches)/30 days Zembrace SymTouch QL – 1 box (4 injections)/30 days Aimovig ST – trial and failure of propranolol or topiramate or documented intolerance or contraindication for use QL – 140mg (2 injections)/month Ajovy ST – trial and failure of propranolol or topiramate or documented intolerance or contraindication for use QL – 225mg/month or 675mg/3 months Emgality ST – trial and failure of propranolol or topiramate or documented intolerance or contraindication for use QL – 240mg loading dose; then 120mg/month QL cluster headache - 300mg at start of headache and once monthly thereafter until end of headache	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
CARDIOVASCULAR			
ACE Inhibitors	benazepril; enalapril; fosinopril; lisinopril; quinapril; ramipril	captopril; moexepril; perindopril; trandolapril Epaned; Qbrelis AGE – Must be under 18 years of age or unable to swallow tablets	
ACE Inhibitor Combinations	***ACE Inhibitors with Calcium Channel Blockers*** amlodipine/benazepril QL - 30 caps/30 days ***ACE Inhibitors with Diuretics*** benazepril/HCTZ; captopril/HCTZ; enalapril/HCTZ; lisinopril/HCTZ; quinapril/HCTZ	***ACE Inhibitors with Calcium Channel Blockers*** Prestalia; trandolapril/verapamil QL - 30 caps/30 days ***ACE Inhibitors with Diuretics*** fosinopril/HCTZ; moexipril/HCTZ	
Alpha Adrenergic Blockers	doxazosin; prazosin; terazosin	Cardura XL	
Angiotensin Receptor Blockers	irbesartan; losartan; Micardis QL - 1 tab/day Diovan QL - 2 tabs or caps/day on 40mg, 80mg, & 160mg; 1 tab/day on 320mg	candesartan QL - 2 tabs/day on 4mg, 8mg, & 16mg; 1 tab/day on 32mg Edarbi; eprosartan; telmisartan QL - 1 tab/day Olmesartan QL - 3 tabs/day on 5mg; 1 tab/day on 20mg & 40mg valsartan QL - 2 tabs or caps/day on 40mg, 80mg, & 160mg; 1 tab/day on 320mg	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
CARDIOVASCULAR - Continued			
Angiotensin Receptor Blocker Combinations	***Angiotensin Receptor Blockers with Diuretics*** Diovan HCT; losartan/hctz; Micardis HCT ***Angiotensin Receptor Blockers with Calcium Channel Blockers*** N/A ***Angiotensin Receptor Blockers with Calcium Channel Blockers and Diuretics*** N/A ***Angiotensin Receptor Blockers with Beta Blockers*** N/A	***Angiotensin Receptor Blockers with Diuretics*** candesartan/hctz; Edarbyclor; irbesartan/hctz; olmesartan/hctz; telmisartan/hctz; valsartan/hctz ***Angiotensin Receptor Blockers with Calcium Channel Blockers*** olmesartan/amlodipine; telmisartan/amlodipine; valsartan/amlodipine ***Angiotensin Receptor Blockers with Calcium Channel Blockers and Diuretics*** amlodipine/olmesartan/hctz; amlodipine/valsartan/hctz ***Angiotensin Receptor Blockers with Beta Blockers*** Byvalson ST – Prescriber must provide documentation that separate components are unsuitable for use	
Beta Adrenergic Blockers *** Note: Inderal, Lopressor, and Tenormin are cross-indicated drugs***	acebutolol; atenolol; bisoprolol; Bystolic; carvedilol; labetalol; metoprolol; metoprolol succinate ER; propranolol; propranolol ER caps; sotalol; timolol	betaxolol; Kapspargo; nadolol; pindolol Hemangeol solution; Sotylize oral solution ST – member must be under 18 years of age or unable to swallow tablets Coreg CR QL – 1 cap/day	
Beta Adrenergic Blockers with Diuretics	atenolol/chlorthalidone; bisoprolol/HCTZ	Dutoprol; metoprolol/HCTZ; nadolol/bendroflumethiazide; propranolol/HCTZ	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
CARDIOVASCULAR - Continued			
Calcium Channel Blockers	amlodipine; Calan SR; diltiazem (long-acting formulations); diltiazem (non-time released); felodipine ER; Isoptin SR; nifedipine (long-acting formulations); verapamil (long-acting formulations); verapamil (non-time released); verapamil ER PM	Cardizem LA; Isradipine (non-time released); Matzim LA; nicardipine (non-time released); nisoldipine nifedipine (short acting) Effective 12/31/09 - No PA until further notice nimodipine ST – must have a diagnosis of subarachnoid hemorrhage	
Calcium Channel Blockers with HMG CoA Reductase Inhibitors	N/A	amlodipine/atorvastatin	
Miscellaneous Cardiac Agents	Entresto	Corlanor PA – must meet criteria	Corlanor PA Criteria Corlanor PA Form

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
CNS AND OTHERS			
Agents for the Treatment of Opiate Addiction	Buprenorphine/naloxone sublingual tablets; Suboxone PA - must meet criteria QL – 24mg/day buprenorphine sublingual tablets PA- must meet criteria naloxone injection; Narcan Nasal	Bunavail PA-must meet criteria QL – 24mg/day Buprenorphine/naloxone sublingual films PA – must meet criteria QL – 24mg/day Zubsolv PA – must meet criteria QL – 17.1mg/day Sublocade PA – must meet criteria QL – 300mg/month initiation; 100mg/month renewal Evzio	Buprenorphine/naloxone and Buprenorphine PA Criteria Buprenorphine/naloxone and buprenorphine initiation PA form Buprenorphine/naloxone and buprenorphine renewal PA form

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
CNS AND OTHERS - continued			
Antiemetic/Antivertigo Agents	Emend oral capsules QL - 6 caps/Rx Cinvanti injection QL – 2 vials/Rx ondansetron oral tablets & disintegrating tablets QL - 90 tabs/30 days ondansetron oral solution QL - 1 bottle/Rx ondansetron solution for injection Diclegis oral tabs QL – 4 tabs/day; Max 270 days/365 days	Akynzeo; Emend vials; granisetron oral tablets; granisetron solution for injection; Sustol Anzemet oral tabs QL - 10 tabs/Rx aprepitant oral capsules QL – 6 caps/Rx Palonosetron injection, Varubi injection QL - 1 vial/Rx Dronabinol; Syndros SilentAuth - must meet criteria Emend suspension ST – must have tried Emend oral capsules or have inability to swallow or tolerate the capsule formulation QL – 3 packets (125mg each)/Rx Sancuso transdermal system ST - physician documentation required indicating oral medications are unsuitable for patient use Bonjesta QL – 2 tabs/day doxylamine/pyridoxine oral tabs QL – 4 tabs/day; Max 270/365 days Varubi QL – 4 tabs/Rx Zuplenz QL – 10 films/Rx	Dronabinol Prior Authorization Criteria

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
CNS AND OTHERS - continued			
Antiseizure Agents	All generic agents are preferred unless otherwise specified Celontin; Fycompa; Lyrica; Onfi; Oxtellar XR; Spritam; Trokendi XR; Vimpat	All brand agents are non-preferred unless otherwise specified felbamate; tiagabine; vigabatrin; vigadrone Diacomit; Epidiolex PA – must meet criteria	Antiseizure Agents Prior Authorization Criteria
Gastroprotective Agents	N/A	diclofenac-misoprostol delayed release tablets; celecoxib; Duexis; Vimovo SilentAuth - must meet criteria	COX II NSAID Prior Authorization Criteria
Narcotic Antitussive/1st Generation Antihistamine Combinations ***Note: All narcotic antitussives will require PA for members under 18 years of age ***	promethazine with codeine AGE - 18 years and older; QL - 6 oz/Rx	hydrocodone/chlorpheniramine suspension AGE – 18 years and older; QL - 4 oz/Rx Tussicaps AGE - 18 years and older; QL - 2 caps/Rx Hycofenix; Zutripro; hydrocodone/chlorpheniramine/PSE AGE – 18 years and older; QL – 8 oz/Rx; ST – must have a trial of a preferred agent and 1 OTC antitussive	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
CNS AND OTHERS - Continued			
Narcotics ***Note: All codeine products will require PA for members under 18 years of age ***	Embeda; Nucynta ER SilentAuth - must meet criteria butorphanol QL - limit 2 vials per 30 days for migraine pain; limit 1 vial per 30 days for short term pain SilentAuth - must meet criteria fentanyl patches (all strengths) QL - 10 patches per 30 days; SilentAuth - must meet criteria Tramadol; tramadol/APAP QL - 400 mg/day; AGE – 18 years and older SilentAuth - must meet criteria Butrans QL - 4 patches/28 days SilentAuth- must meet criteria	All non-preferred agents ST - patients must have tried two preferred short-acting agents within the past six months if requesting a short-acting drug; patients must have tried two preferred long-acting agents within the past 90 days if requesting a long-acting drug (examples of long-acting preferred agents include Butrans, Embeda, fentanyl patches, morphine sulfate ER tablets, Nucynta ER, all other preferred agents are considered short-acting) Abstral sublingual tablets; Actiq lozenges; fentanyl citrate lozenges; fentanyl oral transmucosal; Fentora buccal tablets; Lazanda PA - must meet PA criteria for fentanyl citrate products Apadaz; apap/caffeine/dihydrocodeine; Belbuca; benzhydrocodone/APAP; Dvorah; methadone; Morphabond; morphine sulfate ER capsules; Nalocet; Oxaydo; oxycodone/ibuprofen; oxymorphone IR; Roxybond; Zamicet SilentAuth - must meet criteria Arymo ER QL – 3 tabs/day; SilentAuth – must meet criteria Conzip QL - 1 tab/day; AGE – 18 years and older; SilentAuth - must meet criteria hydromorphone ER QL - 1 tab/day (8 mg, 16 mg); 2 tabs/day (12 mg, 32 mg) SilentAuth - must meet criteria Nucynta	APAP High Dose PA Criteria Fentanyl Citrate PA Criteria Long Acting Narcotics Quantity Limits Opiate Overutilization with Quantity Limits PA Criteria Opiate with Concurrent Buprenorphine/Naloxone PA Form

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
CNS AND OTHERS - Continued			
Narcotics - Continued		Hysingla ER QL – 1 tab/day; SilentAuth – must meet criteria Opana ER; oxymorphone ER QL – 2 tabs/day; SilentAuth – must meet criteria oxycodone ER QL - 2 tabs/day; SilentAuth - must meet criteria Oxycontin QL - 2 tabs/day; SilentAuth - must meet criteria tramadol ER QL - 1 tab/day; AGE – 18 years of age and older; Step - history of tramadol immediate release (IR) for 90 of the past 120 days Xartemis XR QL – 4 tabs/day; SilentAuth – must meet criteria Xtampza ER ; Zohydro ER QL – 2 caps/day; SilentAuth – must meet criteria Buprenorphine patches QL - 4 patches/28 days SilentAuth- must meet criteria	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
CNS AND OTHERS - Continued			
Skeletal Muscle Relaxants	baclofen; chlorzoxazone; cyclobenzaprine IR (tabs); methocarbamol; orphenadrine citrate; tizanidine tablets	cyclobenzaprine ER (caps); dantrolene; metaxalone; tizanidine capsules Amrix ST - must try cyclobenzaprine within the past 30 days carisoprodol QL - 4 tabs/day PA - must meet criteria carisoprodol combination products QL - 8 tabs/day PA - must meet criteria carisoprodol/asa/codeine PA – must meet criteria	Soma Combination PA Criteria Soma Combination PA Form
Smoking Deterrent Agents	bupropion SR 150; Commit lozenge; Nicoderm; Nicorette; nicotine gum; nicotine patch Chantix Age – 18 years of age or older	Nicorelief; Nicotrol NS; Nicotrol Inhaler	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
DERMATOLOGIC			
Acne Agents ***All acne agents have an age restriction of 25 years and under** ***All acne agents for members over the age of 25 years require step therapy with an OTC acne product**	All legend generic products are preferred unless otherwise specified Acanya; Amnesteem/Claravis/Myorisan/Sotret; Azelex; Epiduo; Klaron; Retin-A (all formulations except micro); Ziana Differin (cream, gel, lotion) AGE - 25 years and under; ST - must have tried a preferred tretinoin product	All legend brand products are non-preferred unless otherwise specified Note: A 14-day trial each of at least 2 preferred agents is required prior to receiving a non-preferred agent. adapalene cream; adapalene gel; adapalene/benzoyl peroxide gel; Avita; Benzepro; Benzepro Short Contact; Benziq wash; BP cleanser; BP cream; BP pads; BP 10-1 wash; clindamycin 1.2%/benzoyl peroxide 2.5%, clindamycin phosphate-tretinoin gel; dapsone gel; Erygel; RE wash; Seb-prev wash; sodium sulfacetamide med pads; sulfacetamide sod top susp; Avar cleanser; Prascion cleanser; Prascion FC cleanser; Prascion RA cream; PR benzoyl peroxide wash; sodium sulfacetamide-sulfur lotion; sodium-sulf sulfur cleanser; sodium-sulf sulfur wash; clindamycin foam; sulfacetamide topical lotion; tretinoin; Zenatane	
Antipsoriatics	calcipotriene cream; Oxsoralen-Ultra; Soriatane; Taclonex scalp suspension; Tazorac; Vectical ointment	acitretin; calcipotriene ointment/topical solution; calcipotriene/betamethasone ointment; calcitriol ointment; methoxsalen; tazarotene Sorilux foam ST - 14 day trial each of 2 preferred topical agents required	
ELECTROLYTE DEPLETERS			
Electrolyte Depleters	calcium acetate capsules; calcium carbonate; Eliphos; Fosrenol; Magnebind; Magnebind Rx; Renagel; Renvela; Veltassa Phoslyra QL - 60mL/day	Auryxia; calcium acetate tabs; lanthum carbonate chew; Lokelma; sevelamer; Velphoro Fosrenol powder packet ST – member must be under 18 years of age or unable to swallow tablets	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
ENDOCRINE			
Anaphylaxis Agents	epinephrine auto-injector	Adrenaclick; Epipen; Symjepi	
Antidiabetic Agents (oral)	acarbose; glimepiride; glipizide; glipizide ER; Glumetza glyburide; Glyset; metformin; metformin ER (all strengths except 500mg & 1 gram ER tabs, generics of Fortamet); Prandin glipizide/metformin; glyburide/metformin; ST - must have tried metformin in the past 100 days ***DPP4 Inhibitors and Combinations*** Januvia; Janumet; Janumet XR; Jentadueto; Kombiglyze XR; Onglyza; Tradjenta ST - must have tried metformin in the past 100 days ***Thiazolidinediones and Combinations*** pioglitazone QL - 34 tabs/30 days; ST - must have tried metformin within the past 100 days **SGLT2 Inhibitors and Combinations** Farxiga; Jardiance; Invokana ST – must have tried metformin in the past 100 days	chlorpropamide; metformin 500 mg & 1 gm ER (generics of Fortamet); metformin ER (generics of Glumetza); miglitol; nateglinide; repaglinide; tolazamide; tolbutamide Riomet ST – member must be under 18 years of age or unable to swallow tablets Metformin HCl solution ST – must have tried and failed Riomet solution in the past 90 days ***DPP4 Inhibitors and Combinations*** alogliptin; alogliptin/metformin; alogliptin/pioglitazone; Kazano; Nesina; Oseni ST - must have tried a preferred agent for 60 of the past 100 days Jentadueto XR ST – prescriber must provide documentation that separate components are unsuitable for use ***Thiazolidinediones and Combinations*** Avandia QL - 34 tabs/30 days; ST - must have tried a preferred agent for 60 of the past 100 days Actoplus Met XR; pioglitazone/glimepiride; pioglitazone/metformin ST - prescriber must provide documentation that separate components are unsuitable for use **SGLT2 Inhibitors and Combinations** Glyxambi; Invokamet; Invokamet XR; Qtern; Segluromet; Steglujan; Synjardy; Synjardy XR; Xigduo XR ST – prescriber must provide documentation that separate components are unsuitable for use Steglatro	
Bone Formation Stimulating Agents	Forteo PA - must meet criteria	Evenity; Tymlos PA - must meet criteria	Bone Formation Stimulating Agents PA Criteria Bone Formation Stimulating Agents PA Form

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DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
ENDOCRINE - Continued			
Growth Hormones	Genotropin; Omnitrope; Serostim; Zorbtive PA - must meet criteria	Humatrope PA - patients with the diagnosis of Short Stature Homeobox-containing gene (SHOX) deficiency who meet other appropriate criteria for growth hormone therapy may receive Humatrope Norditropin PA – patients with a diagnosis of Noonan's syndrome who meet other appropriate criteria for growth hormone therapy may receive Norditropin Nutropin/Nutropin AQ PA - patients with the diagnosis of growth failure associated with chronic renal insufficiency who meet other appropriate criteria for growth hormone therapy may receive Nutropin/Nutropin AQ Saizen; Zomacton PA - must meet criteria	Growth Hormone PA Criteria Growth Hormone for Adults PA Form Growth Hormone for Children PA Form
Insulins – Intermediate Acting	Humalog Mix 50/50; Humalog Mix 75/25; Humulin N; Humulin 50/50; Humulin 70/30 (all formulations); Novolin N; Novolin 70/30; Novolog Mix 70/30 (all formulations); Relion N vials only; Relion 70/30 vials only	Relion N; Relion 70/30 (prefilled pen, innolets, syringes and cartridges)	
Insulins – Rapid Acting	Apidra; Apidra SoloStar ; Humalog (all formulations); Novolog (all formulations)	Admelog; Admelog Solostar; Fiasp; insulin lispro	
Insulins – Short Acting	Humulin (all formulations); Novolin R (all formulations); Relion R vials only	Afrezza ; Relion R (prefilled pen, innolets, syringes and cartridges)	
Insulins – Long Acting	Lantus (cartridges, pens, & vials); Levemir (Flextouch, & vials) Tresiba Flex & vials ST – trial of Lantus or Levemir for 90 of the past 120 days	Basaglar; Toujeo Solostar	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
ENDOCRINE - Continued			
Non-Insulin Injectable Hypoglycemics and Combinations	Bydureon QL - 2mg/week; ST - must have tried metformin in the past 100 days Byetta QL - 20mcg/day; ST - must have tried metformin in the past 100 days Victoza QL - 1.8mg/day; ST - must have tried metformin in the past 100 days	Adlyxin QL - 20mcg/day Bydureon BCise QL - 2mg/week Ozempic QL - 1mg/week Tanzeum QL - 50mg/week Trulicity QL - 1.5mg/week Symlin pens ST – must currently be on meal-time insulin (Apidra, Humalog, Humulin R, Novolin R, Novolog, or Relion R) **Combination Agents** Soliqua QL - (60 units glargine/20mcg lixisenatide)/day ST – must have tried a preferred non-insulin injectable hypoglycemic or long-acting insulin for at least 90 days in the past 120 days Xultophy QL - (50 units degludec/1.8mg liraglutide)/day ST – must have tried a preferred non-insulin injectable hypoglycemic or long-acting insulin for at least 90 days in the past 120 days	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
ENDOCRINE - Continued			
Bone Resorption Inhibitors	alendronate; etidronate; raloxifene	calcitonin-salmon; Fosamax Plus D; ibandronate alendronate oral solution 70mg/75mL ST – must have tried alendronate tablets or have inability to swallow or tolerate the tablet formulation Atelvia & risedronate tablets ST - must try alendronate within the past 90 days Binosto PA - documentation required establishing a need for product in solution Ibandronate pre-filled syringe QL - one single-use, pre-filled syringe per 90 days Prolia injection PA - must meet criteria	Prolia PA Criteria

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
ENDOCRINE - Continued			
Testosterones	**Injectable Agents** Depo-Testosterone; testosterone cypionate PA – must meet criteria **Topical Agents – must meet PA criteria; must be 18 years of age or older** Androgel 1%/5gm gel packets; Androgel 1.62%/2.5gm gel packets QL – 60 packets/30 days Androgel 1%/2.5gm gel packets; Androgel 1.62%/1.25gm gel packets QL – 30 packets/30 days Androgel 1% metered pump QL – 300gm/30days Androgel 1.62% metered pump QL – 150gm/30days Androderm QL – 1 box/30 days	**Injectable Agents** Aveed; Testopel pellet; testosterone enanthate; Xyosted PA – must meet criteria **Oral Agents** Anadrol-50; Androxy; Danazol; Methitest; methyltestosterone; oxandrolone **Topical Agents – must meet PA criteria; must be 18 years of age or older** Fortesta QL – 120gm/30 days Natesto QL – 3 boxes/30 days Striant buccal tablet QL – 2 tabs/day Testosterone solution 30mg/act QL – 180mL/30 days Testim; Testosterone 1% gel; Testosterone 1.62% gel; Testosterone 50mg/5gm-10mg/actuation gel; Testosterone 50mg/5gm-12.5mg/actuation metered pump gel; Vogelxo QL – 300gm/30 days	Testosterones PA Criteria Testosterones PA Form

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
ESTROGEN AND RELATED AGENTS			
Estrogen and Related Agents	All legend generic products are preferred unless otherwise specified Depo-estradiol; Evamist mist; Makena; Menest; Premarin; Prempro; Provera; Vivelle Dot medroxyprogesterone contraceptive 150mg/mL suspension for injection QL – 1mL/84 days for female members **Vaginal Preparations** Estring; Premarin Vaginal Cream; Vagifem	All legend brand products are non-preferred unless otherwise specified estradiol TD patch; ethinyl estradiol and norethindrone tabs; hydroxyprogesterone caproate Depo-Provera Contraceptive 150mg/mL suspension for injection QL – 1mL/84 days for female members **Vaginal Preparations** estradiol vaginal cream; Femring; Yuvafem	
GENITOURINARY			
BPH Agents	alfuzosin ER; finasteride; tamsulosin	dutasteride; Jalyn; Rapaflo tadalafil 2.5mg and 5mg ST – prescriber must provide documentation of trial and failure of nonselective alpha-blocker, a selective alpha-blocker, a 5-alpha reductase inhibitor, and a combination product for the treatment of BPH or a medically justifiable reason that the agents are not suitable for use	
Urinary Tract Antispasmodic/Anti-Incontinence Agents	Enablex; Gelnique; oxybutynin IR; oxybutynin ER; Oxytrol; Toviaz; Vesicare	darifenacin; flavoxate; Myrbetriq; solifenacin; tolterodine/tolterodine SR; trospium/trospium ER	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
GI AGENTS			
Anti-ulcer Agents	Carafate suspension PA; ST - must meet criteria and following step edit: "trial on tablets within the past 90 days for patients 18 years of age and older or must be unable to swallow tablets" misoprostol tablets; sucralfate tablets PA - must meet criteria	N/A	Carafate and Cytotec PA Criteria Carafate and Cytotec PA Form
***H. Pylori* Agents**	Pylera	Omeclamox; lansoprazole/amoxicillin/clarithromycin caps	
H2 Receptor Antagonists	cimetidine tabs; famotidine tabs; nizatidine caps; ranitidine tabs QL - 60/30 days cimetidine liquid; ranitidine syrup	ranitidine capsules famotidine oral suspension; nizatidine oral solution ST – member must be under 18 years of age or unable to swallow tablets	
Laxatives and Cathartics	Amitiza; Linzess ST - requires trial of lactulose, sorbitol or polyethylene glycol within past 90 days Movantik ST - requires trial of lactulose, sorbitol or polyethylene glycol within past 90 days AND diagnosis of opioid-induced constipation QL – 1 tab/day	Motegrity; Trulance ST - requires trial of Amitiza or Linzess OR trial of lactulose, sorbitol or polyethylene glycol within past 90 days and medical justification for use over preferred agents Relistor tabs ST - requires trial of Movantik OR trial of lactulose, sorbitol or polyethylene glycol within past 90 days AND diagnosis of opioid-induced constipation AND medical justification for use over preferred agents QL – 3 tabs (450mg)/day Symproic ST - requires trial of Movantik OR trial of lactulose, sorbitol or polyethylene glycol within past 90 days AND diagnosis of opioid-induced constipation AND medical justification for use over preferred agents QL – 1 tabs (0.2mg)/day	
Pancreatic Enzymes	Creon; Pancrelipase; Zenpep	Pancreaze; Pertzye; Viokace; Ultresa	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
GI AGENTS - Continued			
Proton Pump Inhibitors	Note: All patients must first try 2 preferred agents for a total length of therapy of 4 weeks, unless the patient is intolerant to these agents, before receiving a non-preferred PPI. Patients with an existing PPI prior authorization are not subject to the step edit. PA is required for members utilizing therapy for greater than 90 days in a 180-day period. omeprazole 10 mg QL – 2 caps/day omeprazole 20 mg QL – 4 caps/day omeprazole 40 mg QL - 2 caps/day Dexilant QL - 1 cap/day esomeprazole capsules QL – 1 cap/day Nexium packets; Protonix packets QL - 1 packet/day pantoprazole tablets QL - 2 tabs/day	esomeprazole strontium ST - must try 2 preferred agents for a total length of therapy of 4 weeks, unless the patient is intolerant to these agents lansoprazole caps; omeprazole magnesium/sodium bicarbonate caps – QL 1 cap/day; ST - must try 2 preferred agents for a total length of therapy of 4 weeks, unless the patient is intolerant to these agents rabeprazole – QL-1 tab/day; ST - must try 2 preferred agents for a total length of therapy of 4 weeks, unless the patient is intolerant to these agents Nexium IV, pantoprazole IV PA - must be NPO or medical justification required describing reason oral preferred agents are inappropriate Aciphex Sprinkle (QL – 1 cap/day); lansoprazole ODT (QL – 1 tab/day); Prilosec packets (QL – 1 packet/day); Zegerid Powder (QL – 1 packet/day) AGE - must be 12 years of age or younger; ST - must try Nexium packets and Protonix packets for a total length of therapy of 4 weeks, unless patient is intolerant to these agents	Proton Pump Inhibitor PA Criteria
Ulcerative Colitis Agents	Apriso; balsalazide; Canasa; Delzicol; Dipentum; Lialda; mesalamine enema; Pentasa; sulfasalazine; Sulfazine EC	Giazo; mesalamine DR tablets; mesalamine suppository; Uceris rectal foam	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
HEMATOLOGIC			
Direct Factor XA Inhibitors	Eliquis QL -2 tabs/day Eliquis Starter Pack QL – 1 pack/90 days Xarelto 2.5mg tablets QL – 2 tabs/day Xarelto 10mg tablets QL - 1 tab/day Xarelto 15 mg tablets QL - 2 tabs/day for max 21 consecutive days every 90 days; no duration restriction for once-daily dosing Xarelto 20 mg tablets QL - 1 tab/day Xarelto Starter Kit QL – 1 starter kit/90 days	Savaysa QL – 1 tab/day	
Direct Thrombin Inhibitors	Pradaxa	N/A	
Hematinics	Aranesp; Epogen; Procrit	Mircera	
Heparin and Related Products	fondaparinux QL - 1 syringe/day Fragmin (prefilled syringes only); heparin (generics only); enoxaparin (prefilled syringes only)	Fragmin (formulations other than prefilled syringes);	
Leukocyte Stimulants	Fulphila; Neupogen	Granix; Leukine, Neulasta; Nivestym; Udenyca; Zarxio	
Platelet Aggregation Inhibitors	Aggrenox; cilostazol; clopidogrel 75 mg Brilinta PA - diagnosis of ACS and concurrent use of ASA required QL - 2 tabs/day clopidogrel 300 mg tablets QL - 1 tab/Rx	aspirin/dipyridamole; Durlaza; Yosprala Prasugrel SilentAuth - must meet criteria Zontivity SilentAuth – must meet criteria	Effient PA Criteria Brilinta PA Criteria Zontivity PA Criteria

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
LIPOTROPICS			
Bile Acid Sequestrants	cholestyramine multi-dose containers; Prevalite powder/packets; Welchol tablets/suspension	colestipol (granules/tablets); cholestyramine packets; colesevelam	
Fibric Acid Derivatives	fenofibrate; gemfibrozil	Antara; fenofibric acid; fenoglide; Lipofen	
HMG CoA Reductase Inhibitors	atorvastatin; Crestor; lovastatin; pravastatin; simvastatin	Altoprev; fluvastatin; fluvastatin ER; Livalo; rosuvastatin; Zypitamag	
Lipotropics	Lovaza Vytorin ST - trial of an HMG CoA reductase inhibitor for 90 of the past 120 days or documented intolerance to these agents ezetimibe ST - patients currently or previously on an HMG-CoA reductase inhibitor or fenofibrate for 90 of the past 120 days or documented intolerance to these agents	Niacor; niacin ER; Vascepa ezetimibe/simvastatin ST - trial of Vytorin OR trial of an HMG CoA reductase inhibitor for 90 of the past 120 days or documented intolerance to these agents AND medical justification for use over preferred agent omega-3-acid ethyl esters ST – must have a trial of Lovaza or documented intolerance for use Praluent; Repatha PA – must meet criteria	PCSK9 Inhibitors PA Criteria PCSK9 Inhibitors PA Form

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
MULTIPLE SCLEROSIS AGENTS			
Multiple Sclerosis Agents	Aubagio; Avonex; Betaseron; Copaxone; dalfampridine; Gilenya; Ocrevus; Plegridy; Rebif; Tecfidera SilentAuth - must meet criteria	Extavia; glatiramer; Glatopa; Lemtrada; Mavenclad; Mayzent; Tysabri SilentAuth - must meet criteria	Multiple Sclerosis PA with Quantity Limits Criteria
RESPIRATORY			
Antihistamine-Decongestant Combinations/2nd Generation Antihistamines	Note: All preferred OTC agents are covered for pediatric patients; only OTC cetirizine/loratadine tabs are covered for adults cetirizine 5 mg non-chewable OTC tabs; cetirizine 10 mg non-chewable OTC tabs; levocetirizine tablets; loratadine 10 mg OTC tabs & redi-tabs; loratadine/pseudoephedrine 12 hour & 24 hour OTC tabs cetirizine 1mg/ml OTC syrup; levocetirizine oral solution; loratadine 1mg/1ml OTC syrup QL - 10 mls/day	Note: New patients must first try cetirizine and loratadine within 90 days prior to receiving a non-preferred agent. All patients with an existing prior authorization are not subject to the step edit. Clarinex-D tabs; desloratadine tabs; desloratadine orally disintegrating tabs; fexofenadine; fexofenadine/pseudoephedrine Allegra 30 mg/5ml suspension; Clarinex 0.5 mg/ml syrup QL - 10 mls/day; ST - must have trial on both cetirizine and loratadine within the past 90 days	
Antiviral Monoclonal Antibody	N/A	Synagis PA - must meet criteria	Synagis PA Criteria Synagis PA Form
Beta Adrenergics and Corticosteroids **Note: All agents are limited to 1 diskus or inhaler per month**	Advair 100/50; Advair 250/50; Advair HFA 45/21; Advair HFA 115/21; fluticasone/salmeterol 100/50 fluticasone/salmeterol 250/50 Advair 500/50; fluticasone/salmeterol 500/50 ST - must have tried Advair 100/50, Advair 250/50, or Flovent within the past 100 days Advair HFA 230/21 ST - must have tried Advair HFA 45/21, Advair HFA 115/21, or Flovent HFA within the past 100 days Dulera; Symbicort	Airduo Respiclick; Breo Ellipta; Wixela Trelegy Ellipta ST – must have tried and failed Anoro Ellipta and Flovent HFA concurrent therapy for at least 30 days	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
RESPIRATORY - Continued			
Beta Agonists – Long Acting	Serevent; Striverdi Respimat	Arcapta; Brovana; Perforomist	
Beta Agonists – Short Acting	albuterol all strengths/formulations excluding tablets Proair HFA; Proventil HFA QL - 3 canisters per 30 days for ages 18 and younger; 2 canisters per 30 days for ages 19 and over Xopenex HFA QL - 3 canisters per 30 days for ages 18 and younger; 2 canisters per 30 days for ages 19 and over ST – must have tried Proair HFA or Proventil HFA in the past 90 days	albuterol tablets (brand/generic); Proair Respiclick levalbuterol QL - 2 prescriptions per 180 days, 1 box of 24 per prescription albuterol HFA; levalbuterol HFA; Relion Ventolin HFA; Ventolin HFA QL - 3 canisters per 30 days for ages 18 and younger; 2 canisters per 30 days for ages 19 and over	
Bronchodilator Agents-Beta Adrenergic and Anticholinergic Combinations **Note: Must not concurrently use >1 inhaled anticholinergic agent (excluding nebulization solution)**	Combivent Respimat QL - 2 inhalers/30 days ipratropium solution QL - 2 boxes/30 days ipratropium/albuterol solution QL - 3 boxes/30 days Spiriva QL - 1 handihaler/30 days Atrovent HFA QL - 2 inhalers/30 days Anoro Ellipta; Bevespi Aerosphere; Tudorza Pressair QL - 1 inhaler/30 days	Incruse Ellipta; Spiriva Respimat QL - 1 inhaler/30 days Seebri Neohaler; Utibron Neohaler QL – 1 box (60 inhalations)/30 days Stiolto Respimat QL – 1 box (60 inhalations)/30 days Lonhala Magnair QL – 1 kit (60 vials)/30 days Yupelri QL – 1 box (90mL)/30 days	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
RESPIRATORY - Continued			
Leukotriene Receptor Antagon ists	montelukast	zafirlukast; Zyflo; zileuton SR 12 HR montelukast granules ST – must have prescriber documentation indicating tablet formulations are unsuitable for use	
Monoclonal Antibodies for Treatment of Respiratory Conditions	N/A	Cinqair; Dupixent; Fasenra; Nucala; Xolair SilentAuth - must meet criteria	Monoclonal Antibodies for Respiratory Conditions PA Criteria
Nasal Antihistamines/Nasal Anti-Inflammatory Steroids	azelastine 0.1% nasal spray; Dymista; fluticasone; ipratropium NS; Omnaris	azelastine 0.15% nasal spray; Beconase AQ; budesonide nasal suspension; flunisolide; mometasone nasal susp; olopatadine; Patanase; Qnasl; Veramyst; Zetonna	
Oral Inhaled Glucocorticoids	Asmanex; Asmanex HFA QL – 1 inhaler/30days Alvesco; Flovent HFA; Pulmicort Flexhaler; Qvar Pulmicort inhalation suspension AGE - 3 years and younger; QL - 120 mL/30 days (0.25 mg/2 mL vial, 0.5 mg/2 mL vial); 60mL/30 days (1mg/2mL vial)	Aerospan; ArmonAir Respiclick; Flovent Diskus; QVAR RediHaler Arnuity Ellipta QL – 1 inhaler/30 days budesonide inhalation suspension AGE - 3 years and younger; QL - 120 mL/30 days (0.25 mg/2 mL vial, 0.5 mg/2 mL vial); 60 mL/30 days (1 mg/2 mL vial)	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
RESPIRATORY - Continued			
Phosphodiesterase -4 Inhibitors	N/A	Daliresp PA - must meet criteria	Daliresp PA Criteria Daliresp PA Form
Pulmonary Antihypertensives	tadalafil; sildenafil SilentAuth - must meet criteria Opsumit; Tracleer PA – must meet criteria	ambrisentan; Adempas; bosentan; Orenitram; Uptravi PA – must meet criteria sildenafil suspension SilentAuth – must meet criteria	Pulmonary Antihypertensives PA Criteria Pulmonary Antihypertensives PA Form

TARGETED IMMUNOMODULATORS			
Targeted Immunomodulators	Cimzia; Cosentyx; Enbrel; Humira; Kineret; Orencia vials & syringes; Otezla; Simponi; Xeljanz/Xeljanz XR SilentAuth – must meet criteria	Actemra; Entyvio; Ilaris; Ilumya; Inflectra; Kevzara; Olumiant; Remicade; Renflexis; Siliq; Skyrizi; Stelara; Taltz; Tremfya SilentAuth – must meet criteria	Targeted Immunomodulators PA Criteria

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
TOPICAL AGENTS			
Miotics-Intraocular Pressure Reducers	apraclonidine; Azopt; betaxolol; brimonidine 0.2% solution; carteolol; Combigan; dorzolamide; dorzolamide/timolol; Iopidine 1%; latanoprost; levobunolol; Lumigan 0.01% drops; metipranolol; pilocarpine; Rhopressa; Simbrinza; timolol; Travatan Z	Betimol; Betoptic-S; bimatoprost 0.3%; brimonidine 0.15% solution; Cosopt PF; Phospholine Iodide; Rescula; Rocklatan; timolol gel; Timoptic-XE; Vyzulta; Xelpros; Zioptan	
Ophthalmic Antihistamines	Alaway; Bepreve; Ketotifen; Lastacaft; Pazeo	azelastine; Emadine; epinastine; olopatadine	
Ophthalmic Anti-Inflammatory Agents	diclofenac eye drops; flurbiprofen eye drops; Ilevro; ketorolac 0.4% oph soln; ketorolac 0.5% oph soln	Acuvail oph soln; bromfenac oph drops; Bromsite; Nevanac eye drops; Prolensa	
Ophthalmic Anti-Inflammatory Agents/Immunomodulator – Type ***Note: No more than a 30-day supply may be dispensed at one time.***	Restasis QL - 2 vials/day; PA – must meet criteria	Cequa; Xiidra QL - 60 vials/30 days (12 pouches containing 5 containers); PA – must meet criteria Restasis Multidose QL - 2 bottles/ 30 days; PA – must meet criteria	Ophthalmic Anti-Inflammatory/Immunomodulator-Type
Ophthalmic Mast Cell Stabilizers	cromolyn	Alocril; Alomide	
Otic Preparations	acetic acid solution	acetic acid/aluminum drops; acetic acid HC	
Topical Anti-Inflammatory Agents – NSAIDS	Voltaren Gel	diclofenac 1% gel; Flector Patch; Pennsaid topical solution ST - physician documentation required indicating oral medications are unsuitable for patient use and trial and failure of Voltaren Gel or medical justification for use	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
TOPICAL AGENTS - Continued			
Topical Antiparasitics **Unless otherwise specified, all products are limited to one bottle or one tube per claim**	permethrin 5% cream; permethrin 1% lotion; pyrethrin products; Sklice; spinosad	Eurax cream; Eurax lotion; Lindane lotion; Lindane shampoo; malathion; Ulesfia Natroba QL - one bottle per claim per month	
Topical Immunomodulators	Elidel; Protopic	Enstilar; Eucrisa; pimecrolimus cream; tacrolimus ointment	
Topical PostHerpetic Neuralgia Agents	lidocaine patches QL – 3 boxes/30 days	Synera ZTlido QL – 3 boxes/30 days Qutenza ST – must have tried lidocaine patches and over-the-counter capsaicin cream QL – 4 patches/3 months	
Wound Care Products	Santyl QL - limit of 60 gm per 30 days Regranex QL - limit of one-15 gm tube per 28 days; ST - must be on diabetes medication in the past 90 days	N/A	Wound Care PA Criteria

MISCELANEOUS INFORMATION	
Preferred Brand Drug List OTC Drug Formulary Pharmacy Supplements Formulary Brand Medically Necessary Prior Authorization Form IHCP Early Refill Prior Authorization Request Form Non-Drug-Specific PA Criteria PBM Call Center LTC ProDUR and Home Health PA Request Form PBM Call Center Prior Authorization Form	Allergy Specific Immunotherapy PA Criteria Aromatase Inhibitors PA Criteria Cystic Fibrosis Agents PA Criteria Cystic Fibrosis Agents PA Form Egrifta PA Criteria Exondys 51 PA Criteria Exondys 51 PA Form Gonadotropin-Releasing Hormone (GnRH) Analog PA Criteria Gralise, Horizant, and Lyrica CR PA Criteria Gralise, Horizant, and Lyrica CR PA Form HCG PA Criteria High Dollar Compounded PA Criteria High Dollar Compounded PA Request Form Lucemyra PA Criteria Lucemyra PA Form Misc. Step Therapy PA Criteria Nuedexta PA Criteria Nuedexta PA Form Nuplazid PA Criteria Prenatal Vitamins High Dollar Limit PA Solaraze PA Criteria Spinraza PA Criteria Spinraza PA Form Step Therapy NSAIDs Topical Doxepin PA Topical Steroid PA Topical Agent PA Form
Mental Health Medications Medical Necessity Prior Authorization Form Antipsychotic Therapy PA with QL Sedative Hypnotics Benzodiazepine PA Criteria Benzodiazepine and Opioid Concurrent Therapy PA Form SSRI/SNRI Duplicate Therapy PA Criteria Stimulants Duplicate Therapy PA Criteria Utilization Edits for Mental Health Medications	