

Indiana Medicaid Statewide Uniform Preferred Drug List (SUPDL)

OptumRx Call Center

For prior authorization requests, claims processing issues or questions about the SUPDL, 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 Drugs that will be or have been withdrawn from the market will be removed from the SUPDL as part of routine periodic updating of the SUPDL.

Nomenclature

- **Statewide Uniform Preferred Drug List (SUPDL)** - 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.
 - Legacy continuation of therapy - 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 SUPDL. All preferred brand products on the SUPDL 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 SUPDL 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".

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- 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 SUPDL, 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 SUPDL. 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 SUPDL 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 SUPDL) 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 SUPDL document. Non-specific criteria are located at the end of the SUPDL 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 SUPDL document. ***Lack of inclusion on the SUPDL 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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| 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 | |
| Antivirals – Influenza | amantadine; oseltamivir; Relenza rimantadine AGE - 60 years and older | Rapivab; Xofluza rimantadine AGE - under 60 years old | |
| Cephalosporins – 3rd Generation | cefdinir; cefpodoxime | cefixime capsules and suspension; Suprax chewable and suspension | |
| Fluoroquinolones *Note: All fluoroquinolones will be limited to 14 days per claim* | ciprofloxacin; levofloxacin; moxifloxacin | Baxdela; ofloxacin Cipro suspension; ciprofloxacin suspension; levofloxacin solution PA - must meet criteria | PA Criteria for ciprofloxacin and levofloxacin solution |
| Hepatitis C Agents | Pegasys; Pegintron; ribavirin Epclusa 200-50mg; Epclusa 150-37.5mg; Mavyret; sofosbuvir/velpatasvir 400-100mg; Zepatier PA - must meet criteria; treatment naïve patients must only meet age and quantity limits | Epclusa 400-100mg; Harvoni; ledipasvir/sofosbuvir; Sovaldi; Viekira; Vosevi PA – must meet criteria | Hepatitis C Agents PA Criteria Hepatitis C Agents PA Form |
| Macrolides | azithromycin suspension; azithromycin 600mg oral tablets; clarithromycin; erythromycin capsules azithromycin 500mg oral tablets QL – 7 tablets/30 days azithromycin 250mg oral tablets QL – 6 tablets/30 days erythromycin ethylsuccinate susp ST – member must be under 18 years of age or unable to swallow tablets/capsules | E.E.S. tablets; erythrocin stearate; erythromycin tablets; erythromycin tablets EC; Zmax E.E.S. Granules ST – must have trialed and failed erythromycin ethylsuccinate susp 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 |

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| DRUG CLASS | PREFERRED | NON-PREFERRED | PA CRITERIA (if applicable) |
|--|--|--|--------------------------------|
| ANTI-INFECTIVES - Continued | | | |
| Ophthalmic Antibiotics | <p>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</p> <p>moxifloxacin</p> <p>AGE - 30 years of age or older; ST- patients under 30 years of age must have tried at least one preferred agent other than moxifloxacin within the past 30 days</p> | <p>Azasite; bacitracin eye ointment; gatifloxacin; levofloxacin; Natacyn; neomycin/bacitracin/polymyxin eye ointment</p> <p>Moxeza</p> <p>AGE - 30 years of age or older; ST- must have trialed and failed moxifloxacin and at least on preferred agent other than moxifloxacin OR medical justification for use over preferred agents</p> | |
| Ophthalmic Antibiotics/ Corticosteroid Combinations | <p>all generics unless otherwise specified; gentamicin/prednisolone; neomycin/polymyxin B/dexamethasone; sulfacetamide sodium/pred; Tobradex ointment; tobramycin/dexamethasone suspension; Zylet</p> | <p>Blephamide S.O.P.; neomycin/polymyxin/hc drops; Pred-G</p> | |
| Otic Antibiotics | <p>All generics are preferred unless otherwise specified</p> <p>ofloxacin otic solution</p> <p>Antibiotic/Steroid Combinations</p> <p>ciprofloxacin-dexamethasone otic; Cipro HC; Coly-Mycin S; Cortisporin TC Otic suspension; neomycin/polymyxin B/hydrocortisone</p> | <p>ciprofloxacin; Otiprio</p> <p>Antibiotic/Steroid Combinations</p> <p>ciprofloxacin-fluocinolone PF otic</p> | |

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|------------------------------------|--|--|--|
| ANTI-INFECTIVES - Continued | | | |
| Systemic Antifungals | fluconazole QL - 50 mg 3 tabs/30 days; 150 mg 4 tabs/30 days itraconazole; ketoconazole; terbinafine | Cresemba; Tolsura; voriconazole tabs Brexafemme, Vivjoa – PA – must meet criteria itraconazole solution; voriconazole suspension ST – must be 18 years of age and under or unable to swallow tablets Noxafil tablet and 200 mg/5 mL suspension ST - must have tried fluconazole for treatment of oropharyngeal candidiasis or must be severely immunocompromised and need prophylaxis against invasive Aspergillus or Candida infections posaconazole tablet and 200 mg/5 mL suspension ST - must have tried fluconazole for treatment of oropharyngeal candidiasis or must be severely immunocompromised and need prophylaxis against invasive Aspergillus or Candida infections AND meet Generic Medically Necessary PA criteria | Antimicrobials for Treatment of Vaginal Infections PA Criteria Antimicrobials for Treatment of Vaginal Infections PA form |

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| ANTI-INFECTIVES - Continued | | | |
| Topical Antifungals | all generics unless otherwise specified; ciclopirox (cream & topical solution); clotrimazole; Exelderm cream and solution; miconazole | ciclopirox gel, kit, topical shampoo, & topical suspension; econazole; Ertaczo; Extina; Jublia; ketoconazole topical foam; Loprox kit; luliconazole; Luzu; Mentax; miconazole/zinc/pet oint; naftifine; Naftin; Oxistat; tavaborole solution; Vusion sulconazole cream and solution PA – must meet Generic Medically Necessary PA criteria | |
| Topical Antivirals | Zovirax cream | Acyclovir ointment; Denavir cream; docosanol cream Acyclovir cream PA – must meet Generic Medically Necessary PA criteria | |
| Topical Antiviral and Anti-inflammatory Steroid Combinations | Xerese QL - 1 tube per claim per 90 days | N/A | |
| Vaginal Antimicrobials | Antibacterials Cleocin 2% cream; Clindesse; metronidazole vaginal gel; Nuvessa; Solosec; Vandazole Antifungals clotrimazole; Gynazole-1; miconazole cream; terconazole cream; tioconazole | Antibacterials Cleocin Ovules; Xaciato clindamycin 2% cream PA – must meet Generic Medically Necessary PA criteria Antifungals miconazole combination pack; miconazole suppositories; terconazole suppositories | |

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| DRUG CLASS | PREFERRED | NON-PREFERRED | PA CRITERIA (if applicable) |
|----------------------------------|---|---|--|
| ANTIMIGRAINE | | | |
| Antimigraine Preparations | <p>Nurtec ODT PA – must meet criteria QL - 8 tabs/30 days for acute treatment; QL - 16 tabs/30 days for preventative treatment</p> <p>Ubrelvy PA – must meet criteria QL - 10 tabs/20 days</p> <p>rizatriptan; rizatriptan ODT QL - 1 box - 12 tabs/30 days</p> <p>sumatriptan tablets QL - 1 box - 9 tabs/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</p> <p>Zomig nasal spray QL - 1 box - 6 inhalers/30 days</p> <p>Prophylaxis</p> <p>Ajovy PA – must meet criteria QL – 225mg/month or 675mg/3 months</p> <p>Emgality PA – must meet criteria QL – 240mg loading dose; then 120mg/month QL cluster headache – 300mg at start of headache and once monthly thereafter until end of headache</p> <p>Qulipta PA – must meet criteria QL – 1 tab/day</p> | <p>almotriptan; eletriptan; zolmitriptan; zolmitriptan ODT QL - 1 box - 6 tabs/30 days</p> <p>frovatriptan; naratriptan; sumatriptan/naproxen; Treximet QL - 1 box - 9 tabs/30 days</p> <p>Sumatriptan nasal spray QL - 1 box - 6 inhalers/30 days</p> <p>zolmitriptan nasal spray QL - 1 box - 6 inhalers/30 days</p> <p>PA – must meet Generic Medically Necessary PA criteria</p> <p>Onzetra Xsail QL – 1 box (8 pouches)/30 days</p> <p>Reyvow PA – must meet criteria QL - 50 mg dose – 4 (50 mg) tabs/30 days; 100 mg dose – 4 (100 mg) tabs/30 days; 200 mg dose – 8 (100 mg) tabs/30 days</p> <p>Tosymra Solution</p> <p>Zembrace SymTouch QL – 1 box (4 injections)/30 days</p> <p>Prophylaxis</p> <p>Aimovig PA – must meet criteria QL – 140mg/month</p> <p>Vyepti PA – must meet criteria QL – 3mL/90 days</p> | Antimigraine PA Criteria |

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| DRUG CLASS | PREFERRED | NON-PREFERRED | PA CRITERIA (if applicable) |
|--------------------------------------|--|--|--------------------------------|
| CARDIOVASCULAR | | | |
| ACE Inhibitors | benazepril; enalapril; fosinopril; lisinopril; quinapril; ramipril | captopril; moexipril; perindopril; trandolapril enalapril 1 mg/mL solution; Qbrelis ST – Must be under 18 years of age or unable to swallow tablets | |
| ACE Inhibitor Combinations | <i>ACE Inhibitors with Calcium Channel Blockers</i> amlodipine/benazepril QL - 30 caps/30 days <i>ACE Inhibitors with Diuretics</i> benazepril/HCTZ; enalapril/HCTZ; lisinopril/HCTZ; quinapril/HCTZ | <i>ACE Inhibitors with Calcium Channel Blockers</i> trandolapril/verapamil QL - 30 caps/30 days <i>ACE Inhibitors with Diuretics</i> fosinopril/HCTZ | |
| Angiotensin Receptor Blockers | irbesartan; telmisartan QL - 1 tab/day losartan QL – 2 tabs/day for 25mg & 50mg; 1 tab/day for 100mg Diovan QL - 2 tabs/day or caps/day for 40mg, 80mg, 160mg; 1 tab/day for 320mg olmesartan QL - 3 tabs/day on 5mg; 1 tab/day on 20mg & 40mg Edarbi QL - 1 tab/day | candesartan QL - 2 tabs/day on 4mg, 8mg, & 16mg; 1 tab/day on 32mg valsartan QL - 2 tabs/day or caps/day for 40mg, 80mg, 160mg; 1 tab/day for 320mg PA – must meet Generic Medically Necessary PA criteria | |

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|--|--|---|--------------------------------|
| CARDIOVASCULAR - Continued | | | |
| Angiotensin Receptor Blocker Combinations | <p>Angiotensin Receptor Blockers with Diuretics Edarbyclor; losartan/HCTZ; valsartan/HCTZ</p> <p>Angiotensin Receptor Blockers with Calcium Channel Blockers N/A</p> <p>Angiotensin Receptor Blockers with Calcium Channel Blockers and Diuretics N/A</p> | <p>Angiotensin Receptor Blockers with Diuretics candesartan/HCTZ; irbesartan/HCTZ; olmesartan/HCTZ; telmisartan/HCTZ</p> <p>Angiotensin Receptor Blockers with Calcium Channel Blockers olmesartan/amlodipine; telmisartan/amlodipine; valsartan/amlodipine ST – trial and failure of individual components</p> <p>Angiotensin Receptor Blockers with Calcium Channel Blockers and Diuretics amlodipine/olmesartan/HCTZ; amlodipine/valsartan/HCTZ ST – trial and failure of individual components</p> | |
| Beta Adrenergic Blockers | acebutolol; atenolol; bisoprolol; carvedilol; labetalol; metoprolol; metoprolol succinate ER; nebivolol; propranolol; propranolol ER caps; sotalol; timolol | betaxolol; Kapsargo; nadolol; pindolol Hemangeol solution; Sotylize oral solution ST – member must be under 18 years of age or unable to swallow tablets carvedilol ER cap QL – 1 cap/day | |
| Beta Adrenergic Blockers with Diuretics | atenolol/chlorthalidone; bisoprolol/HCTZ | metoprolol/HCTZ | |

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|-------------------------------------|--|---|---|
| CARDIOVASCULAR - Continued | | | |
| Calcium Channel Blockers | <p><i>Dihydropyridine</i> amlodipine; felodipine ER; nifedipine (short-acting); nifedipine ER</p> <p><i>Non-Dihydropyridine</i> Calan SR; diltiazem (long-acting formulations); diltiazem (non-time released); nimodipine; verapamil (long-acting formulations); verapamil (non-time released)</p> <p><i>Liquid Formulation</i> Norliqva ST – member must be under 18 years of age or unable to swallow tablets</p> <p><i>Combinations</i> N/A</p> | <p><i>Dihydropyridine</i> Isradipine (non-time released); levamlodipine; nicardipine (non-time released); nisoldipine</p> <p><i>Non-Dihydropyridine</i> Cardizem LA/CD; Matzim LA; verapamil ER PM</p> <p><i>Liquid Formulation</i> Katerzia; Nymalize ST – member must be under 18 years of age or unable to swallow tablets</p> <p><i>Combinations</i> amlodipine/atorvastatin ST – prescriber must provide documentation that separate components are not suitable for use</p> | |
| Miscellaneous Cardiac Agents | <p>Corlanor; Entresto PA – must meet criteria</p> | <p>Camzyos; Verquvo PA – must meet criteria</p> | <p>Cardiac Agents PA Criteria</p> <p>Cardiac Agents PA Form</p> |

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| DRUG CLASS | PREFERRED | NON-PREFERRED | PA CRITERIA (if applicable) |
|---|--|---|--------------------------------|
| CNS AND OTHERS | | | |
| Agents for the Treatment of Opioid Addiction or Overdose | <p>Agents for Opioid Use Disorder Buprenorphine sublingual tablets; Buprenorphine/naloxone sublingual tablets; Suboxone Film QL – 24mg/day; Age – 16 years of age and older</p> <p>Zubsolv QL – 17.2mg/day; Age – 16 years of age and older</p> <p>Agents for Opioid Overdose Kloxxado; nalmefene; naloxone injection; naloxone nasal spray; Narcan Nasal; Zimhi</p> | <p>Agents for Opioid Use Disorder buprenorphine/naloxone sublingual films QL – 24mg/day; Age – 16 years of age and older PA – must meet Generic Medically Necessary PA criteria</p> <p>Sublocade QL – 300mg/month initiation; 100mg/month renewal; Age – 18 years of age and older</p> <p>Agents for Opioid Overdose N/A</p> | |

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| DRUG CLASS | PREFERRED | NON-PREFERRED | PA CRITERIA (if applicable) |
|--------------------------------------|---|--|---|
| CNS AND OTHERS - continued | | | |
| Antiemetic/Antivertigo Agents | <p><i>Appetite Stimulant</i> N/A</p> <p><i>H1 Antagonist/Vitamin</i> Bonjesta QL – 2 tabs/day</p> <p><i>Selective 5-HT3 Receptor Antagonist</i> ondansetron oral tablets & disintegrating tablets QL - 90 tabs/30 days</p> <p>ondansetron oral solution QL - 1 bottle/Rx</p> <p>ondansetron solution for injection</p> <p><i>Substance P-Neurokinin 1 Receptor Antagonist</i> Emend oral capsules QL - 6 caps/Rx</p> <p>fosaprepitant vials QL – 2 vials/Rx</p> <p><i>Substance P-NK 1 Antagonist/Selective 5-HT3 Antagonist</i> N/A</p> | <p><i>Appetite Stimulant</i> Dronabinol SilentAuth - must meet criteria</p> <p><i>H1 Antagonist/Vitamin</i> doxylamine/pyridoxine oral tabs QL – 4 tabs/day; Max 270/365 days</p> <p><i>Selective 5-HT3 Receptor Antagonist</i> Anzemet oral tabs QL - 10 units/Rx</p> <p>granisetron oral tablets; granisetron solution for injection; Sustol</p> <p>palonosetron injection QL - 1 vial/Rx</p> <p>Sancuso transdermal system ST – physician documentation required indicating oral medications are unsuitable for patient use</p> <p><i>Substance P-Neurokinin 1 Receptor Antagonist</i> aprepitant oral capsules - QL – 6 caps/Rx PA – must meet Generic Medically Necessary PA criteria</p> <p>Cinvanti injection QL – 2 vials/Rx</p> <p>Emend IV solution QL – 2 vials/Rx</p> <p>Emend suspension ST – must have tried Emend oral capsules or have inability to swallow or tolerate the capsule formulation; QL – 3 packets /Rx</p> <p><i>Substance P-NK 1 Antagonist/Selective 5-HT3 Antagonist</i> Akynzeo ST – must have tried and failed combination therapy with preferred agents of the same classes or provide medical justification for use</p> | Dronabinol Prior Authorization Criteria |

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| DRUG CLASS | PREFERRED | NON-PREFERRED | PA CRITERIA (if applicable) |
|---|--|---|--|
| CNS AND OTHERS – continued | | | |
| Antiseizure Agents Note: Utilization Edits may apply for mental health medications; see Utilization Edits for Mental Health Medications for associated quantity limits | All generic agents are preferred unless otherwise specified Carbatrol; Celontin; Depakote Sprinkle; Diastat rectal; Dilantin susp/cap/chew; Felbatol; Gabitril; Lamictal chew; Lamictal XR Kit; Nayzilam; Neurontin tab/cap; Oxtellar XR; Qudexy XR; Sympazan; Tegretol IR/XR/susp; Trileptal Susp; Trokendi XR; Valtoco carbamazepine ER tab; carbamazepine suspension; topiramate ER capsule; topiramate ER sprinkle capsule PA – must meet Generic Medically Necessary PA criteria Depakote DR; Depakote ER; Lamictal IR/ODT/XR; Lamictal IR/ODT Starter Kit; Lyrica; Onfi; Topamax; Trileptal IR tab PA – must meet Brand Medically Necessary PA criteria Eprontia PA – must meet criteria | All brand agents are non-preferred unless otherwise specified Banzel suspension; lacosamide IV and oral solution; rufinamide tab; vigabatrin; vigadrone PA – must meet criteria felbamate; rufinamide suspension; tiagabine PA – must meet Antiseizure Agents PA criteria AND meet Generic Medically Necessary PA criteria Diacomit; Epidiolex; Fintepla; Zonisade; Ztalmu PA – must meet criteria Xcopri Titration Pak QL – 1 Pak/90 days | Antiseizure Agents Prior Authorization Criteria Utilization Edits for Mental Health Medications |
| Gastroprotective Agents | Celebrex; Vimovo | diclofenac-misoprostol delayed release tablets; Duexis celecoxib; ibuprofen-famotidine; naproxen-esomeprazole magnesium PA – must meet Generic Medically Necessary PA criteria Elyxyb ST – member is unable to swallow capsule formulation QL – 120 mg/day (4.8 mL/day) | |
| Movement Disorder Agents | Austedo; Austedo Titration Kit; Ingrezza; Ingrezza Therapy Pack; Tetrabenazine PA – must meet criteria | Austedo XR; Austedo XR Titration Kit PA – must meet criteria | Movement Disorder Agents PA Criteria |

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|---|--|--|--|
| CNS AND OTHERS - Continued | | | |
| Narcotic Antitussives and Combinations *Note: All narcotic antitussives will require PA for members under 18 years of age * | guaifenesin/codeine 100-10mg/5mL solution; promethazine with codeine; hydrocodone/ homatropine syrup; hydromet syrup AGE - 18 years and older; QL - 6 oz/Rx SilentAuth – must meet criteria Hydrocodone/homatropine tab; promethazine VC/codeine syrup AGE – 18 years and older SilentAuth - must meet criteria | hydrocodone polst/chlorpheniramine polst ER AGE – 18 years and older; QL - 4 oz/Rx SilentAuth - must meet criteria | Opioid Overutilization with Quantity Limits PA Criteria |
| Narcotics Note: All codeine products will require PA for members under 18 years of age | Short Acting apap/codeine; buprenorphine inj; codeine sulfate; codeine/butalbital/apap/ caffeine; codeine/butalbital/asa/caffeine; hydrocodone/apap; hydrocodone/ibu; hydromorphone; levorphanol; meperidine; morphine; nalbuphine; oxycodone; oxycodone/apap; pentazocine/naloxone SilentAuth - must meet criteria butorphanol injection AGE – 18 years of age and older; SilentAuth - must meet criteria butorphanol 10mg/mL nasal spray AGE – 18 years of age or older; QL – 10 mL/30 days SilentAuth - must meet criteria Nucynta QL 6 tabs/day; SilentAuth - must meet criteria Tramadol; tramadol/APAP QL - 400 mg/day; AGE – 18 years and older 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 Short Acting fentanyl citrate lozenges; fentanyl citrate buccal tablets; Fentora buccal tablets PA - must meet Fentanyl Citrate PA criteria Apadaz; apap/caffeine/dihydrocodeine; benzhydrocodone/APAP; Lortab Elixir; Nalocet; oxycodone/ibuprofen; oxymorphone IR; Prolate; RoxyBond; Trezix SilentAuth - must meet criteria Qdolo; tramadol 5 mg/mL solution AGE – 18 years of age and older; ST - must be unable to swallow tablets; SilentAuth – must meet criteria Seglantis (celecoxib/tramadol) Age – 18 years of age and older; ST – prescriber must provide documentation that separate components are unsuitable for use; PA – must meet criteria | APAP High Dose PA Criteria Fentanyl Citrate PA Criteria Opioid Overutilization with Quantity Limits PA Criteria Opioid PA Form – Request to Exceed MME Limit Opioid with Concurrent Buprenorphine/Naloxone PA Form |

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|--|---|---|--------------------------------|
| CNS AND OTHERS - Continued | | | |
| <p>Narcotics – Continued</p> <p>Note: All codeine products will require PA for members under 18 years of age</p> | <p>Long Acting <i>*See Opioid Overutilization with Quantity Limits PA Criteria for established quantity limits</i></p> <p>Butrans QL - 4 patches/28 days SilentAuth- must meet criteria</p> <p>fentanyl patches QL - 10 patches/30 days SilentAuth - must meet criteria</p> <p>Morphine ER tab (MS Contin)*; Nucynta ER* SilentAuth - must meet criteria</p> | <p>Long Acting <i>*See Opioid Overutilization with Quantity Limits PA Criteria for established quantity limits</i></p> <p>Buprenorphine patches QL - 4 patches/28 days; SilentAuth- must meet criteria AND meet Generic Medically Necessary PA criteria</p> <p>Belbuca; hydrocodone ER cap (Zohydro)*; Hysingla ER*; hydromorphone ER tab (Exalgo)*; methadone*; morphine ER cap (Avinza, Kadian)*; oxycodone ER tab*; Oxycontin*; oxymorphone ER tab (Opana)*; Xtampza ER* SilentAuth – must meet criteria</p> <p>hydrocodone ER tab (Hysingla ER) SilentAuth – must meet criteria AND meet Generic Medically Necessary PA criteria</p> <p>Tramadol ER (Conzip, Ryzolt, Ultram ER)* AGE – 18 years of age and older; ST – history of tramadol immediate release (IR) for 90 of the past 120 days; SilentAuth- must meet criteria</p> | |

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|---|--|--|--|
| CNS AND OTHERS - Continued | | | |
| Skeletal Muscle Relaxants Note: All codeine products will require PA for members under 18 years of age | baclofen; chlorzoxazone; cyclobenzaprine IR (tabs); methocarbamol; orphenadrine citrate; tizanidine tablets Granules/Liquid Formulation Lyvispah granules ST – 12 to 17 years of age or unable to swallow tablets | dantrolene; Fexmid; Lorzone; metaxalone; Norgesic Forte; tizanidine capsules Amrix ST - must try cyclobenzaprine tablets within the past 30 days cyclobenzaprine ER (caps) ST – must try cyclobenzaprine tablets within the past 30 days AND meet Generic Medically Necessary PA criteria carisoprodol; QL - 4 tabs/day PA - must meet criteria Granules/Liquid Formulation baclofen 5 mg/5 mL solution; Fleqsuvy suspension ST – 12 to 17 years of age or unable to swallow tablets; trial and failure of Lyvispah (baclofen) or medical rationale for use | Carisoprodol Agents PA Criteria Carisoprodol Agents PA Form |
| Smoking Deterrent Agents | Nicotine Replacement nicotine gum QL – 24 pieces/day Age – 10 years of age or older nicotine lozenge QL – 20 pieces/day Age – 10 years of age or older nicotine patch QL – 1 patch/day Age – 10 years of age or older nicotine patch kit QL – 1 kit/90 days Age – 10 years of age or older Other Smoking Deterrents bupropion SR 150 Chantix; varenicline Age – 18 years of age or older | Nicotine Replacement Nicorelief; Nicotrol NS; Nicotrol Inhaler Other Smoking Deterrents N/A | |

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|---|--|--|--|
| DERMATOLOGIC | | | |
| <p>Acne Agents Note: All acne agents have an age restriction of 25 years and under</p> <p>Note: All acne agents for members over the age of 25 years require step therapy with an OTC acne product</p> <p>Note: A 14-day trial each of at least 2 preferred agents is required prior to receiving a non-preferred agent.</p> | <p>All legend generic products are preferred unless otherwise specified</p> <p>Azelex; Retin-A (all formulations except micro); Ziana</p> <p>Adapalene (cream, gel) AGE - 25 years and under; ST - must have tried a preferred topical tretinoin product</p> <p>Oral Formulations Accutane; Amnesteem; Claravis; Myorisan; Zenatane</p> | <p>All legend brand products are non-preferred unless otherwise specified</p> <p>adapalene/benzoyl peroxide gel; Avita; Benzepro; Benzepro Short Contact; Benziq wash; BP cleanser; BP cream; BP pads; BP 10-1 wash; clindamycin foam; clindamycin 1.2%/benzoyl peroxide 2.5%; 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; Retin-A Micro; sodium sulfacetamide-sulfur lotion/cream; sodium sulfacetamide-sulfur cleanser; sodium sulfacetamide-sulfur wash; sulfacetamide topical lotion; tretinoin microsphere</p> <p>clindamycin phosphate-tretinoin gel; tretinoin cream and gel PA – must meet Generic Medically Necessary PA criteria</p> <p>Oral Formulations isotretinoin</p> | |
| <p>Antipsoriatics</p> | <p>calcipotriene cream; calcipotriene topical solution; Enstilar; Taclonex scalp suspension; tazarotene 0.1% cream; Vectical ointment</p> <p>acitretin PA – must meet criteria</p> | <p>calcipotriene 0.005% foam; calcipotriene ointment; calcipotriene/betamethasone ointment; calcitriol ointment; Duobrii; methoxsalen; Sorilux foam; tazarotene 0.05% gel; tazarotene 0.1% gel; Vtama</p> <p>calcipotriene/betamethasone suspension PA – must meet Generic Medically Necessary PA criteria</p> | <p>Soriatane PA Criteria</p> |

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|------------------------------|---|--|--------------------------------|
| ELECTROLYTE DEPLETERS | | | |
| Electrolyte Depleters | <p>Phosphate Binders calcium acetate capsules; calcium acetate tabs; calcium carbonate; Fosrenol Chew; Magnebind; Magnebind Rx; Renagel; Renvela tabs and powder</p> <p>Phoslyra QL - 60mL/day</p> <p>Potassium Binders Lokelma; Veltassa</p> | <p>Phosphate Binders Auryxia; Velphoro</p> <p>Fosrenol powder packet ST – member must be under 18 years of age or unable to swallow tablets</p> <p>lanthanum carbonate chew; sevelamer carbonate tabs and powder; sevelamer HCl tabs (Renagel) PA – must meet Generic Medically Necessary PA criteria</p> <p>Potassium Binders N/A</p> | |

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|--|---|---|---|
| ENDOCRINE | | | |
| Anaphylaxis Agents | epinephrine auto-injector | Auvi-Q; EpiPen; Symjepi | |
| Bone Formation Stimulating Agents | Forteo PA - must meet criteria | Evenity; teriparatide; Tymlos PA - must meet criteria | Bone Formation Stimulating Agents PA Criteria Bone Formation Stimulating Agents PA Form[|
| Bone Resorption Inhibitors | <i>Bisphosphonates</i> alendronate; etidronate risedronate tablets ST - must try alendronate within the past 90 days <i>Bone Modifying Monoclonal Antibodies</i> N/A <i>Calcitonin</i> calcitonin-salmon nasal <i>SERMs</i> raloxifene | <i>Bisphosphonates</i> Atelvia; 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 ibandronate pre-filled syringe QL - one single-use, pre-filled syringe per 90 days <i>Bone Modifying Monoclonal Antibodies</i> Prolia injection PA - must meet criteria Xgeva PA – must meet criteria <i>Calcitonin</i> calcitonin (salmon) injection ST – trial and failure of calcitonin-salmon nasal or medical justification for use <i>SERMs</i> N/A | Bone Resorption Inhibitors PA Criteria |

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|---|---|---|---|
| ENDOCRINE - Continued | | | |
| DPP4 Inhibitors and Combination Agents | <p>DPP4-I Januvia; saxagliptin; Tradjenta ST - must have tried metformin</p> <p>DPP4-I & metformin combination Janumet; Janumet XR; Jentadueto; Jentadueto XR; Kazano; saxagliptin/metformin ER ST - must have tried metformin</p> <p>DPP4-I & thiazolidinedione combination N/A</p> | <p>DPP4-I alogliptin; Nesina ST - must have tried a preferred agent for 60 of the past 100 days</p> <p>DPP4-I & metformin combination alogliptin/metformin ST - must have tried a preferred combination agent for 60 of the past 100 days</p> <p>DPP4-I & thiazolidinedione combination alogliptin/pioglitazone; Oseni ST - must have tried and failed combination therapy with preferred agents of the same classes for 60 of the past 100 days</p> | |
| GLP-1 Receptor Agonists and Combinations | <p>GLP-1 RA Byetta; Ozempic; Trulicity; Victoza SilentAuth – must meet criteria</p> <p>GIP/GLP-1 RA N/A</p> <p>Combination Agents Soliqua SilentAuth – must meet criteria</p> | <p>GLP-1 RA Adlyxin; Bydureon BCise; Rybelsus SilentAuth – must meet criteria</p> <p>GIP/GLP-1 RA Mounjaro SilentAuth – must meet criteria</p> <p>Combination Agents Xultophy SilentAuth – must meet criteria</p> | GLP-1 RA and Combinations PA Criteria |
| Glucagon Agents | Baqsimi nasal spray; Glucagen hypokit; Gvoke injection; Zegalogue injection | Glucagon Kit | |

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|---------------------------------------|--|---|--|
| ENDOCRINE - Continued | | | |
| Growth Hormones | Genotropin; Norditropin; Serostim; Zorbtive PA - must meet criteria | Humatrope; Nutropin/Nutropin AQ; Omnitrope; Saizen; Zomacton PA – must meet criteria Increlex; Skytrofa; Sogroya; Voxzogo PA - must meet criteria | Growth Hormone PA Criteria Growth Hormone for Adults PA Form Growth Hormone for Children PA Form |
| Insulins – Intermediate Acting | insulin aspart (70/30); 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); Novolog ReliOn 70/30; ReliOn N vials only; ReliOn 70/30 vials only | insulin lispro protamine/insulin lispro Kwikpen ReliOn N; ReliOn 70/30 (prefilled pen, innolets, syringes and cartridges) | |
| Insulins – Rapid Acting | Apidra; Apidra SoloStar; Humalog (all formulations); Novolog (all formulations except ReliOn) | Admelog; Admelog Solostar; Fiasp; Humalog Tempo Pen; insulin aspart (all formulations); insulin lispro (all formulations); Lyumjev; Lyumjev Tempo Pen; Novolog ReliOn | |
| 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 | Insulin glargine (manufactured by Winthrop); Lantus (cartridges, pens, & vials); Levemir (Flextouch, & vials) Tresiba Flex & vials ST – trial of Lantus or Levemir for 90 of the past 120 days | Basaglar; Basaglar Tempo Pen; insulin degludec; insulin glargine (all other manufacturers); Rezvoglar; Semglee; Toujeo Solostar | |

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|---|---|---|--------------------------------|
| ENDOCRINE - Continued | | | |
| Miscellaneous Oral Antidiabetic Agents | <p><i>Alpha glucosidase inhibitors</i> acarbose</p> <p><i>Biguanides</i> Glumetza; metformin; metformin ER (all strengths except 500mg & 1 gram ER tabs, generics of Fortamet)</p> <p><i>Meglitinide</i> repaglinide</p> <p><i>Sulfonylureas and Combinations</i> glimepiride; glipizide; glipizide ER; glyburide</p> <p>glipizide/metformin; glyburide/metformin ST - must have tried metformin</p> <p><i>Thiazolidinediones and Combinations</i> pioglitazone QL - 34 tabs/30 days; ST - must have tried metformin</p> | <p><i>Alpha glucosidase inhibitors</i> miglitol</p> <p><i>Biguanides</i> metformin 500 mg & 1 gm ER (generics of Fortamet)</p> <p>metformin ER (generics of Glumetza) PA – must meet Generic Medically Necessary PA criteria</p> <p>Metformin HCl solution ST – member must be under 18 years of age or unable to swallow tablets</p> <p><i>Meglitinide</i> nateglinide</p> <p><i>Sulfonylureas and Combinations</i> N/A</p> <p><i>Thiazolidinediones and Combinations</i> pioglitazone/glimepiride; pioglitazone/metformin ST – prescriber must provide documentation that separate components are unsuitable for use</p> | |

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|--|---|--|--------------------------------|
| ENDOCRINE - Continued | | | |
| SGLT2 Inhibitors and Combinations | <p><i>SGLT2-I</i> Farxiga; Jardiance; Invokana</p> <p><i>SGLT2-I & metformin combination</i> Invokamet; Synjardy; Xigduo XR</p> <p><i>SGLT2-I & DPP4-I combination</i> N/A</p> <p><i>SGLT2-I, DPP4-I, & metformin combination</i> N/A</p> | <p><i>SGLT2-I</i> Steglatro</p> <p><i>SGLT2-I & metformin combination</i> Invokamet XR; Segluromet; Synjardy XR</p> <p><i>SGLT2-I & DPP4-I combination</i> Glyxambi; Qtern; Steglujan ST-must have tried and failed combination therapy with preferred agents of the same classes or provide medical justification for use</p> <p><i>SGLT2-I, DPP4-I, & metformin combination</i> Trijardy XR ST-must have tried and failed combination therapy with preferred agents of the same classes or provide medical justification for use</p> | |

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| DRUG CLASS | PREFERRED | NON-PREFERRED | PA CRITERIA (if applicable) |
|------------------------------|--|--|--|
| ENDOCRINE - Continued | | | |
| Testosterones | Injectable Agents Depo-Testosterone; testosterone cypionate PA – must meet criteria Oral Agents N/A Topical Agents – must meet PA criteria Androderm QL – 1 box/30 days Androgel 1.62% (20.25 mg)/act metered pump gel QL – 150 gm/30days Testim 1% (50 mg)/5 gm gel packets QL – 60 packets/30 days testosterone 1% (25 mg)/2.5 gm gel packets QL – 30 packets/30 days testosterone 1% (12.5 mg)/act gel pump QL – 300 gm/30 days testosterone 1.62% (20.25 mg)/act metered pump gel QL – 150 gm/30days | Injectable Agents Aveed; Testopel pellet; testosterone enanthate; Xyosted PA – must meet criteria Oral Agents Danazol; Jatenzo; Methitest; methyltestosterone; oxandrolone; Tlando PA – must meet criteria Topical Agents – must meet PA criteria Natesto QL – 3 boxes/30 days testosterone 1% (50 mg)/5 gm gel packets QL – 60 packets/30 days testosterone 1.62% (40.5 mg)/2.5 gm gel packets QL – 60 packets/30 days testosterone 1.62% (20.25 mg)/1.25 gm gel packets QL – 30 packets/30 days testosterone 2% (10 mg)/act metered pump QL – 120 gm/30 days testosterone 30 mg/act solution QL – 180 mL/30 days Vogelxo 1% (50 mg)/5 gm gel packets; Vogelxo 1% (12.5 mg)/act gel pump QL – 300 gm/30 days | Testosterones PA Criteria Testosterones PA Form |

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|--|--|--|---|
| ESTROGEN AND RELATED AGENTS | | | |
| Estrogen and Related Agents | <p>All legend generic products are preferred unless otherwise specified</p> <p>Depo-estradiol; Evamist mist; Menest; Minivelle; Premarin; Prempro; Provera; Vivelle Dot</p> <p>Vaginal Preparations Estring; Premarin Vaginal Cream; Vagifem</p> <p>Uterine disorder agents Myfembree; Oriahnn; Orilissa PA – must meet criteria</p> | <p>All legend brand products are non-preferred unless otherwise specified</p> <p>estradiol TD gel 0.1%; ethinyl estradiol and norethindrone tabs</p> <p>estradiol TD patch (generic formulations of Minivelle and Vivelle Dot) PA – must meet Generic Medically Necessary PA criteria</p> <p>Vaginal Preparations estradiol vaginal cream; Femring; Yuvafem</p> <p>estradiol vaginal tablets PA – must meet Generic Medically Necessary PA criteria</p> <p>Uterine disorder agents N/A</p> | <p>Uterine Disorder Agents PA Criteria</p> <p>Uterine Disorder Agents PA Form</p> |
| Contraceptives Note: All contraceptive agents participating in the Medicaid Drug Rebate Program are preferred; Brand Medically Necessary PA criteria will apply to brands with available generics | <p>Injectable Contraception Depo-SubQ Provera</p> <p>medroxyprogesterone contraceptive 150mg/mL suspension for injection QL – 1mL/84 days for contraception</p> <p>Oral/Topical Contraception drospirenone; norethindrone; progestin/estrogen combinations</p> <p>Phexxi QL – 1 box/month</p> <p>Long-Acting Reversible Contraception Kyleena; Liletta; Mirena; Nexplanon; Skyla</p> <p>Emergency Contraception levonorgestrel 1.5mg; ulipristal</p> | | |

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|---------------------------------|--|---|--------------------------------|
| GASTROINTESTINAL AGENTS | | | |
| Anti-ulcer Agents | Carafate suspension ST – must be under 18 years of age, unable to swallow tablets, or have a trial of tablet formulation within the past 90 days misoprostol tablets; sucralfate tablets | sucralfate suspension PA – must meet Generic Medically Necessary PA criteria | |
| H. Pylori Agents | Pylera | Helidac; Omeclamox; lansoprazole/amoxicillin/clarithromycin caps; Talicia bismuth subcitrate/metronidazole/tetracycline PA – must meet Generic Medically Necessary PA criteria | |
| H2 Receptor Antagonists | cimetidine tabs; famotidine tabs; nizatidine caps; ranitidine tabs QL - 60/30 days | famotidine oral suspension 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 | Ibsrela; Motegrity; Trulance ST - requires trial of Amitiza and Linzess OR trial of lactulose, sorbitol or polyethylene glycol AND medical justification for use over preferred agents Movantik (QL – 1 tab/day); Relistor tabs (QL – 3 tabs (450 mg/day)) ST - requires trial of lactulose, sorbitol or polyethylene glycol AND diagnosis of opioid-induced constipation AND medical justification for use over preferred agents QL – 1 tab/day Symproic ST - requires trial of lactulose, sorbitol or polyethylene glycol AND diagnosis of opioid-induced constipation AND medical justification for use over preferred agents QL – 1 tab (0.2mg)/day lubiprostone ST – requires trial of lactulose, sorbitol, or polyethylene glycol AND meet Generic Medically Necessary PA criteria | |

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|--|---|--|---|
| GASTROINTESTINAL AGENTS - Continued | | | |
| Pancreatic Enzymes Note: Access will be granted to non-preferred agents after cumulatively utilizing 30 days of preferred agent therapy in the past 180 days | Creon; Zenpep | Pertzye; Viokace | |
| Proton Pump Inhibitors Note: ST – Before accessing a non-preferred PPI, 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. Patients with an existing PPI prior authorization are not subject to the step edit. Note: PA is required for members utilizing therapy for greater than 90 days in a 180-day period. | omeprazole 10 mg, omeprazole 40 mg QL – 2 caps/day omeprazole 20 mg QL – 4 caps/day Dexilant, esomeprazole capsules QL – 1 cap/day lansoprazole capsules QL – 1 cap/day pantoprazole tablets QL – 2 tabs/day IV Solutions N/A Oral Solutions Nexium packets; Protonix packets QL – 1 packet/day | esomeprazole strontium dexlansoprazole PA – must meet Generic Medically Necessary PA criteria QL – 1 cap/day omeprazole magnesium/sodium bicarbonate caps QL – 1 cap/day rabeprazole QL – 1 tab/day IV Solutions Nexium IV, pantoprazole IV PA - must be NPO or medical justification required describing reason oral preferred agents are inappropriate Oral Solutions esomeprazole packets (QL – 1 packet/day); lansoprazole ODT (QL – 1 tab/day); pantoprazole packets (QL – 1 packet/day); Prilosec packets (QL – 1 packet/day); omeprazole/sodium bicarb powder (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 (esomeprazole packets, pantoprazole packets, and omeprazole/sodium bicarb powder must meet Generic Medically Necessary PA criteria) Konvomep oral suspension (QL – 20 mL/day) AGE – must be 12 years of age or younger; ST – must try Nexium packets, Protonix packets, and Zegerid powder for a total length of therapy of 4 weeks, unless patient is intolerant to these agents | Proton Pump Inhibitor PA Criteria |

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|--|---|---|--------------------------------|
| GASTROINTESTINAL AGENTS - Continued | | | |
| Ulcerative Colitis Agents | <p>Oral Formulations Apriso; balsalazide; budesonide DR caps; Delzicol; Dipentum; Lialda; Pentasa; sulfasalazine IR; sulfasalazine ER</p> <p>Rectal Formulations mesalamine enema; mesalamine suppositories; sfRowasa</p> | <p>Oral Formulations budesonide ER tabs; Ortikos ER caps</p> <p>mesalamine ER (Apriso) cap; mesalamine DR (Delzicol) cap; mesalamine DR (Lialda) tab; mesalamine ER (Pentasa) cap PA – must meet Generic Medically Necessary PA criteria</p> <p>Rectal Formulations Uceris rectal foam</p> <p>budesonide rectal foam PA – must meet Generic Medically Necessary PA criteria</p> | |

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|----------------------|--|---|--------------------------------|
| GENITOURINARY | | | |
| BPH Agents | alfuzosin ER; dutasteride; finasteride; tamsulosin | <p>dutasteride/tamsulosin ST – must provide documentation that separate components are not suitable for use</p> <p>silodosin ST – requires trial of alfuzosin ER and tamsulosin OR medical justification for use of silodosin</p> <p>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; therapy duration must not exceed 26 weeks if using concurrently with finasteride</p> <p>Entadfi ST – prescriber must provide documentation of trial and failure of nonselective alpha-blocker, a selective alpha-blocker, a 5-alpha reductase inhibitor (must include finasteride), and a combination product for the treatment of BPH or a medically justifiable reason that the agents are not suitable for use; therapy duration must not exceed 26 weeks</p> | |

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|---|--|--|--------------------------------|
| GENITOURINARY - Continued | | | |
| Urinary Tract Antispasmodic/Anti-Incontinence Agents | bethanechol; Gelnique; Myrbetriq; oxybutynin IR; oxybutynin ER; Oxytrol; solifenacin; Toviaz | darifenacin; flavoxate; tolterodine/tolterodine SR; trospium/trospium ER fesoterodine ER PA – must meet Generic Medically Necessary PA criteria Myrbetriq granules ST – member must be under 18 years of age or unable to swallow tablets OR prescriber must provide medical rationale Vesicare LS ST – member must be 2 to 17 years of age or unable to swallow tablets Gemtesa ST – member must have trialed and failed Myrbetriq or have intolerance or contraindication to Myrbetriq | |

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|--|---|--|--|
| HEMATOLOGIC | | | |
| Direct Oral Anticoagulants | <p>Eliquis QL -2 tabs/day of 2.5mg; 4 tabs/day for 7 days, then 2 tabs/day for 5mg Eliquis Starter Pack QL – 1 pack/90 days</p> <p>Pradaxa</p> <p>Xarelto 2.5mg tablets QL – 2 tabs/day Xarelto 10mg tablets QL - 1 tab/day</p> <p>Xarelto 15 mg tablets QL - 2 tabs/day for max 21 consecutive days every 90 days; no duration restriction for once-daily dosing</p> <p>Xarelto 20 mg tablets QL - 1 tab/day Xarelto Starter Kit QL – 1 starter kit/90 days</p> <p>Xarelto suspension ST – member must be under 18 years of age or unable to swallow tablets; QL – 20 mg/day (20 mL/day)</p> | <p>dabigatran PA – must meet Generic Medically Necessary PA criteria</p> <p>Pradaxa Pak ST – must be under 8 years of age or unable to swallow capsules OR have medical rationale for use of pellet formulation</p> <p>Savaysa QL – 1 tab/day ST – must have trialed Eliquis and Xarelto OR medical justification for use of Savaysa</p> | |
| Hematinics | <p>Aranesp; Epogen; Retacrit PA – must meet criteria</p> | <p>Mircera; Procrit; Reblozyl PA – must meet criteria</p> | Hematinic Agents PA Criteria |
| Leukocyte Stimulants | <p>Short-Acting Nivestym</p> <p>Long-Acting Fulphila; Fylnetra</p> | <p>Short-Acting Granix; Leukine; Neupogen; Releuko; Zarxio</p> <p>Long-Acting Neulasta; Nyvepria; Rolvedon; Stimufend; Udenyca; Ziextenzo</p> | |
| Platelet Aggregation Inhibitors | <p>aspirin/dipyridamole; cilostazol; clopidogrel 75 mg; Prasugrel</p> <p>Brilinta QL - 2 tabs/day</p> <p>clopidogrel 300 mg tablets QL - 1 tab/Rx</p> | <p>Durlaza; Zontivity</p> | |

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|-------------------------------------|---|---|--|
| LIPOTROPICS | | | |
| Bile Acid Sequestrants | cholestyramine multi-dose containers; colesevelam tablets and suspension; Prevalite powder/packets | cholestyramine packets; colestipol (granules/tablets) | |
| Fibric Acid Derivatives | fenofibrate cap; fenofibrate tab (generic Fenoglide); fenofibrate tab (generic Tricor); gemfibrozil | Antara; fenofibrate micronized cap (generic Antara); fenofibrate micronized cap (generic Lofibra); fenofibric acid cap (generic Trilipix); fenofibric acid tab; Lipofen | |
| HMG CoA Reductase Inhibitors | atorvastatin; lovastatin; pravastatin; rosuvastatin; simvastatin | Altoprev; Ezallor; fluvastatin; fluvastatin ER; Livalo; Zypitamag | |
| Lipotropics | omega-3-acid ethyl esters ezetimibe/simvastatin ST - trial of an HMG CoA reductase inhibitor for 90 of the past 120 days or documented intolerance to these agents ezetimibe Praluent; Repatha PA – must meet criteria Vascepa Age – 18 years of age or older QL – 4 capsules/day | Leqvio PA – must meet criteria niacin ER PA – must meet criteria icosapent ethyl PA – must meet Generic Medically Necessary PA criteria Age – 18 years of age or older QL – 4 capsules/day Nexletol ST – must have trialed and failed two statin agents OR a statin in combination with ezetimibe OR medical justification for use Nexlizet ST- must have trialed and failed a statin in combination with ezetimibe OR medical justification for use Evkeeza; Juxtapid PA – must meet criteria | PCSK9 Inhibitors and Select Lipotropics PA Criteria PCSK9 Inhibitors and Select Lipotropics PA Form |

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|----------------------------------|--|---|---|
| MULTIPLE SCLEROSIS AGENTS | | | |
| Multiple Sclerosis Agents | Avonex; Betaseron; Copaxone; dalfampridine; dimethyl fumarate; fingolimod 0.5 mg; Gilenya 0.25 mg; Kesimpta; Ocrevus; Plegridy; Rebif; teriflunomide; Tascenso ODT; Vumerity; Zeposia SilentAuth - must meet criteria | Bafiertam; Briumvi; Extavia; Lemtrada; Mavenclad; Mayzent; Ponvory; Tysabri SilentAuth - must meet criteria glatiramer; Glatopa SilentAuth – must meet criteria AND meet Generic Medically Necessary PA criteria | Multiple Sclerosis PA with Quantity Limits Criteria |

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| DRUG CLASS | PREFERRED | NON-PREFERRED | PA CRITERIA (if applicable) |
|---|--|--|--|
| RESPIRATORY | | | |
| Antihistamine-Decongestant Combinations/2nd Generation Antihistamines | cetirizine 5 mg OTC tabs AGE – under 18 years cetirizine 10 mg OTC tabs; fexofenadine OTC tabs; levocetirizine Rx tabs; loratadine 10 mg OTC tabs; loratadine 10 mg OTC RDT tabs Combinations loratadine/pseudoephedrine 12-hour OTC tabs QL – 2 tablets/day; ST – previous trial and failure of a preferred single-agent 2 nd generation antihistamine loratadine/pseudoephedrine 24-hour OTC tabs QL – 1 tablet/day; ST – previous trial and failure of a preferred single-agent 2 nd generation antihistamine Liquid Formulation cetirizine 1 mg/ml OTC syrup; cetirizine 1 mg/mL Rx syrup; loratadine 1 mg/1ml OTC syrup AGE – under 18 years; QL - 10 mL/day levocetirizine Rx oral solution QL – 10mL/day; ST – must have trial of loratadine solution or cetirizine syrup | Note: New patients must first try cetirizine and loratadine within 90 days prior to receiving a non-preferred agent. Patients with an existing PA are not subject to the step edit. desloratadine Rx tabs; desloratadine Rx ODT tabs Combinations Clarinet-D Rx tabs QL – 2 tablets/day; ST – previous trial and failure of loratadine/pseudoephedrine 12-hour OTC tab Liquid Formulation Clarinet 0.5 mg/ml Rx syrup QL - 10 mL/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 |

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| DRUG CLASS | PREFERRED | NON-PREFERRED | PA CRITERIA (if applicable) |
|--|--|---|--------------------------------|
| RESPIRATORY - Continued | | | |
| Beta Adrenergics and Corticosteroids Note: All agents are limited to 1 diskus or inhaler per month unless otherwise specified | Advair HFA 45/21; Advair HFA 115/21 Advair HFA 230/21 ST - must have tried Advair HFA 45/21, Advair HFA 115/21, or Flovent HFA within the past 100 days Advair Diskus 100/50; Advair Diskus 250/50 Advair Diskus 500/50 ST - must have tried Advair 100/50, Advair 250/50, or Flovent Diskus within the past 100 days Dulera 50-5mcg; 100-5mcg QL – under 20 years of age, 3 inhalers per 30 days; 20 years and older, 2 inhalers per 30 days Dulera 200-5mcg QL – 1 inhaler/30 days Symbicort 80-4.5mcg, 160-4.5mcg QL – under 20 years of age, 3 inhalers per 30 days; 20 years and older, 2 inhalers per 30 days Trelegy Ellipta ST – must have tried and failed Anoro Ellipta with fluticasone HFA OR Anoro Ellipta with Arnuity Ellipta concurrent therapy for at least 90 days of the past 120 days | Airduo Digihaler; Airduo Respiclick; Breo Ellipta; fluticasone/vilanterol; Wixela Breztri Aerosphere ST – must have tried and failed Trelegy Ellipta or have contraindication or intolerance to use budesonide/formoterol 80-4.5mcg, 160-4.5mcg; Breyna QL – under 20 years of age, 3 inhalers per 30 days; 20 years and older, 2 inhalers per 30 days AND meet Generic Medically Necessary PA criteria fluticasone/salmeterol (generic Advair Diskus) 100/50, 250/50 PA – must meet Generic Medically Necessary PA criteria fluticasone/salmeterol (generic Advair Diskus) 500/50 ST - must have tried Advair 100/50, Advair 250/50, or Flovent Diskus within the past 100 days AND meet Generic Medically Necessary PA criteria | |
| Beta Agonists – Long Acting | Serevent | arformoterol; formoterol; Striverdi Respimat | |

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| RESPIRATORY - Continued | | | |
| Beta Agonists – Short Acting | albuterol all strengths/formulations excluding tablets albuterol HFA; Proair HFA; Proair Respiclick; Proventil HFA; Ventolin 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 albuterol HFA in the past 90 days | albuterol tablets (brand/generic) levalbuterol nebs QL - 2 prescriptions per 180 days, 1 box of 24 per prescription levalbuterol HFA; Proair Digihaler 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 short-acting nebulization solution) | Short-Acting Atrovent HFA; Combivent Respimat QL - 2 inhalers/30 days ipratropium solution QL - 2 boxes/30 days ipratropium/albuterol solution QL - 3 boxes/30 days Long-Acting tiotropium inhalation capsules; Spiriva Handihaler QL - 1 inhaler/30 days Anoro Ellipta; Incruse Ellipta; QL - 1 inhaler/30 days Stiolto Respimat QL – 1 box (60 inhalations)/30 days | Short-Acting N/A Long-Acting Bevespi Aerosphere; Duaklir Pressair; Spiriva Respimat 2.5 mcg QL – 1 inhaler/30 days Spiriva Respimat 1.25 mcg No PA required for diagnosis of asthma QL – 1 inhaler/30 days Lonhala Magnair QL – 1 kit (60 vials)/30 days Tudorza Pressair QL – 1 inhaler/30 days Yupelri QL – 1 box (90mL)/30 days | |

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|--|--|---|--|
| RESPIRATORY - Continued | | | |
| Leukotriene Receptor Antagonists | montelukast | zafirlukast; Zyflo; zileuton SR 12 HR montelukast granules ST – must have prescriber documentation indicating tablet formulations are unsuitable for use | |
| Nasal Antihistamines/Nasal Anti-Inflammatory Steroids | Antihistamines/Anticholinergics azelastine 0.1% nasal spray; ipratropium NS Steroids/Steroid Combinations Dymista; fluticasone; Omnaris | Antihistamines/Anticholinergics azelastine 0.15% nasal spray; olopatadine; Patanase Steroids/Steroid Combinations Beconase AQ; budesonide nasal suspension; flunisolide; mometasone nasal susp; Qnasl; Ryaltris; Zetonna azelastine/fluticasone nasal spray PA – must meet Generic Medically Necessary PA criteria | |
| Oral Inhaled Glucocorticoids | Arnuity Ellipta; Asmanex; Asmanex HFA QL – 1 inhaler/30days Flovent Diskus; Flovent HFA; Pulmicort Flexhaler; QVAR Redihaler 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) | Alvesco; Armonair Digihaler; fluticasone propionate HFA budesonide inhalation suspension AGE - 4 years and older; 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) | |
| Pulmonary Antihypertensives | tadalafil; sildenafil; Revatio suspension SilentAuth - must meet criteria Tracleer, Tracleer dispersible tablet PA – must meet criteria | Adempas; ambrisentan; bosentan; Opsumit; Orenitram; Tyvaso; Tyvaso DPI; Upravi PA – must meet criteria sildenafil suspension; Tadliq SilentAuth – must meet criteria | Pulmonary Antihypertensives PA Criteria Pulmonary Antihypertensives PA Form |
| Respiratory and Allergy Biologics | Dupixent; Fasenna; Xolair SilentAuth - must meet criteria | Cinqair; Nucala, Tezspire SilentAuth - must meet criteria | Respiratory and Allergy Biologics PA Criteria |

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|----------------------------------|---|--|---|
| TARGETED IMMUNOMODULATORS | | | |
| Targeted Immunomodulators | Actemra; Adbry; Enbrel; Humira; infliximab; Kineret; Orencia vials & syringes; Otezla; Simponi; Taltz; Xeljanz SilentAuth – must meet criteria Xeljanz oral solution SilentAuth – must meet criteria for use AND under 18 years of age OR inability to take tablet formulation (e.g., those under 40 kg; those unable to swallow tablets) | Amjevita; Arcalyst; Avsola; Cibinqo; Cimzia; Cosentyx; Entyvio; Ilaris; Ilumya; Inflectra; Kevzara; Olumiant; Remicade; Renflexis; Rinvoq; Siliq; Skyrizi; Sotyktu; Spevigo; Stelara; Tremfya; Xeljanz XR SilentAuth – must meet criteria | Targeted Immunomodulators PA Criteria |

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| DRUG CLASS | PREFERRED | NON-PREFERRED | PA CRITERIA (if applicable) |
|--|---|---|---|
| TOPICAL AGENTS | | | |
| Dry Eye Disease or Keratoconjunctivitis *Note: No more than a 30-day supply may be dispensed at one time.* | Restasis single dose QL - 2 vials/day; SilentAuth – must meet criteria Xiidra QL - 60 vials/30 days (12 pouches containing 5 containers) SilentAuth – must meet criteria | Cequa QL - 60 vials/30 days (12 pouches containing 5 containers); PA – must meet criteria Cyclosporine single dose emulsion QL - 2 vials/day; PA – must meet criteria Eysuvis QL – 2 bottles/2 weeks; PA – must meet criteria Restasis multidose; Tyrvaya QL - 2 bottles/ 30 days; PA – must meet criteria Verkazia QL – 120 vials/30 days; PA – must meet criteria | Dry Eye Disease or Keratoconjunctivitis PA criteria |
| Miotics-Intraocular Pressure Reducers | Alphagan-P 0.1%; Alphagan-P 0.15%; apraclonidine; Azopt; Betoptic-S; brimonidine 0.2% solution; carteolol; Combigan; dorzolamide; dorzolamide/timolol; lopicine 1%; latanoprost; levobunolol; Lumigan 0.01% drops; metipranolol; pilocarpine; Rhopressa; Rocklatan; timolol; Travatan Z | betaxolol; Betimol; bimatoprost 0.03%; Cosopt PF; Phospholine iodide; timolol gel; Timoptic-XE; Vyzulta; Xelpros; Zioptan brimonidine 0.15% solution; brimonidine/timolol soln; brinzolamide suspension; tafluprost; travaprost 0.004% PA – must meet Generic Medically Necessary PA criteria Simbrinza ST – must provide documentation that separate components are not suitable for use (Azopt/brimonidine) Vuity PA – must meet criteria | Presbyopia Agents PA criteria |
| Ophthalmic Antihistamines | Alaway; azelastine; Bepreve; Ketotifen; olopatadine | epinastine; Zerviate bepotastine besilate PA – must meet Generic Medically Necessary PA Criteria | |

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|---|--|---|--|
| TOPICAL AGENTS - Continued | | | |
| Ophthalmic Anti-Inflammatory Agents | All legend generic products are preferred unless otherwise specified NSAIDs flurbiprofen eye drops Steroids Alrex; FML Liquifilm; Lotemax gel/ointment/susp; Pred Forte susp; Pred Mild susp | All legend brand products are non-preferred unless otherwise specified NSAIDs bromfenac; Ilevro Steroids fluorometholone susp; loteprednol gel/susp; prednisolone 1% susp PA – must meet Generic Medically Necessary PA criteria | |
| Ophthalmic Mast Cell Stabilizers | cromolyn | Alocril; Alomide | |
| Otic Preparations | acetic acid solution; Dermotic Oil | acetic acid HC; fluocinolone acetonide oil | |
| Topical Anti-Inflammatory Agents – NSAIDS | diclofenac 1% gel; Pennsaid topical solution | diclofenac epolamine; Flector patch; Licart ER patch ST - physician documentation required indicating oral medications are unsuitable for use and trial and failure of diclofenac 1% gel AND Pennsaid topical solution, or medical justification for use | |
| Topical Antiparasitics Unless otherwise specified, all products are limited to one bottle or one tube per claim | permethrin 5% cream; permethrin 1% lotion; Spinosad | Crotan; ivermectin lotion; Lindane shampoo; malathion; Natroba; VanaLice | |
| Topical Immunomodulators | Elidel; tacrolimus ointment PA – must meet criteria | Eucrisa; Opzelura; Zoryve PA – must meet criteria pimecrolimus cream PA – must meet Generic Medically Necessary PA criteria | Topical Immunomodulators PA criteria |
| Topical Post-Herpetic Neuralgia Agents | lidocaine patches; Lidoderm 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 | |

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MISCELLANEOUS INFORMATION

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| <p>Preferred Brand Drug List</p> <p>OTC Drug Formulary</p> <p>Pharmacy Supplements Formulary</p> <p>OTC Contraceptive Agents Formulary</p> <p>Brand Medically Necessary Prior Authorization Form</p> <p>IHCP Early Refill Prior Authorization Request Form</p> <p>Non-Drug-Specific PA Criteria</p> <p>PBM Call Center LTC ProDUR and Home Health PA Request Form</p> <p>PBM Call Center Prior Authorization Form</p> <p>Vaccine Utilization Edits</p> <p>Vaccine Utilization Edits for VFC-Enrolled Pharmacies</p> | <p>Gralise, Horizant, and Lyrica CR PA Criteria</p> <p>Gralise, Horizant, and Lyrica CR PA Form</p> <p>HCG PA Criteria</p> <p>Hemgenix PA Criteria</p> <p>Hepatitis B Agents PA Criteria</p> <p>High Dollar Compounded PA Criteria</p> <p>High Dollar Compounded PA Request Form</p> <p>Lucemyra PA Criteria</p> <p>Lucemyra PA Form</p> <p>Mepron PA Criteria</p> <p>Muscular Dystrophy Agents PA Criteria</p> <p>Muscular Dystrophy Agents PA Form</p> <p>Non-SUPDL Agents PA and ST</p> <p>Nuedexta PA Criteria</p> <p>Nuedexta PA Form</p> <p>Somatostatin Analog PA Criteria</p> <p>Oxervate PA Criteria</p> <p>Prenatal Vitamins High Dollar Limit PA</p> <p>Sickle Cell Agents PA Criteria</p> <p>Sickle Cell Agents PA Form</p> <p>Solaraze PA Criteria</p> <p>Spinal Muscular Atrophy Agents PA Criteria</p> <p>Spinal Muscular Atrophy Agents PA Form</p> |
| <p>Mental Health Medications Medical Necessity Prior Authorization Form</p> <p>Antipsychotic Therapy PA with QL</p> <p>Sedative Hypnotics Benzodiazepine PA Criteria</p> <p>Benzodiazepine and Opioid Concurrent Therapy PA Form</p> <p>SSRI/SNRI/NRI Duplicate Therapy PA Criteria with QL</p> <p>Stimulants PA Criteria</p> <p>Hetlioz PA Criteria</p> <p>Hetlioz PA Form</p> <p>Narcolepsy Agents PA Criteria</p> <p>Narcolepsy Agents PA Form</p> <p>Nuplazid PA Criteria</p> <p>Utilization Edits for Mental Health Medications</p> | <p>Topical Doxepin PA</p> <p>Topical Lidocaine QL</p> <p>Topical Steroid PA</p> <p>Topical Agents PA Form</p> <p>Tzielid PA</p> <p>Tzielid PA Form</p> <p>Vyndagel and Vyndamax PA Criteria</p> |
| <p>Allergy Specific Immunotherapy PA Criteria</p> <p>Amyloid Beta-Directed Antibodies</p> <p>Aromatase Inhibitors PA Criteria</p> <p>Cushing Syndrome Agents</p> <p>Cushing Syndrome Agents PA Form</p> <p>Cystic Fibrosis Inhaled Agents PA Criteria</p> <p>Cystic Fibrosis Agents PA Criteria</p> <p>Cystic Fibrosis Agents PA Form</p> <p>Daliresp PA Criteria</p> <p>Daliresp PA Form</p> <p>Disposable Insulin Delivery Devices PA</p> <p>Egrifta PA Criteria</p> <p>Elmiron PA Criteria</p> | |

Effective September 1, 2023 V1.0

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 SUPDL as part of routine periodic updating of the SUPDL.