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 Drugs that will be or have been withdrawn from the market will be removed from the SUPDL as part of routine periodic updating of the SUPDL.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 and history of trial and failure of (each of) the preferred agent(s), as confirmed by claims history, chart documentation, or provider attestation including dates of trial for each preferred agent (unless otherwise specified on the SUPDL).
        - 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".
- 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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Effective for FFS claims submitted on or after January 1, 2024. Effective for Managed Care claims submitted on or after January 15, 2024. V1.1

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.

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; clarithromycin; erythromycin capsules azithromycin 600 mg oral tablets QL – 1 tablet/day azithromycin 500 mg oral tablets QL – 7 tablets/30 days azithromycin 250 mg oral tablets QL – 6 tablets/30 days erythromycin ethylsuccinate susp ST – must be under 12 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 tried and failed erythromycin ethylsuccinate suspension OR member must be under 12 years of age or unable to swallow tablets/capsules and prescriber has provided valid medical justification for the use of E.E.S. Granules over preferred agents Dificid - PA - must meet criteria	Dificid PA Criteria Dificid PA Form

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
ANTI-INFECTIVES - Continued			
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 other than moxifloxacin 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 and at least on preferred agent other than 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 ointment; tobramycin/dexamethasone suspension; Zylet	Blephamide S.O.P.; neomycin/polymyxin/hc drops; Pred-G	
Otic Antibiotics	All generics are preferred unless otherwise specified ofloxacin otic solution ***Antibiotic/Steroid Combinations*** ciprofloxacin-dexamethasone otic; Cipro HC; Coly-Mycin S; Cortisporin TC Otic suspension; neomycin/polymyxin B/hydrocortisone	ciprofloxacin; Otiprio ***Antibiotic/Steroid Combinations*** ciprofloxacin-fluocinolone PF otic	

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; Tolsura; voriconazole tabs Brexafemme, Vivjoa – PA – must meet criteria itraconazole solution; voriconazole suspension ST – must be 12 years of age and under or unable to swallow capsules/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 Noxafil PAK ST – must be 2 years of age or older and less than 13 years of age 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

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
ANTI-INFECTIVES - Continued			
Topical Antifungals	all generics unless otherwise specified; ciclopirox (cream & topical solution); clotrimazole; Exelderm cream and solution; Jublia; miconazole; terbinafine 1% cream; tolnaftate 1% cream, powder, spray	ciclopirox gel, kit, topical shampoo, & topical suspension; econazole; Ertaczo; Extina; ketoconazole topical foam; Loprox kit; luliconazole; Luzu; Mentax; miconazole/zinc/pet oint; naftifine 1% cream, 2% cream, 2% gel; Naftin 1% gel; 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 OTC 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; metronidazole vaginal gel; Nuvessa; Solosec ***Antifungals*** clotrimazole; miconazole cream; terconazole cream; tioconazole	***Antibacterials*** Cleocin Ovules; Clindesse; Vandazole clindamycin 2% cream PA – must meet Generic Medically Necessary PA criteria ***Antifungals*** Gynazole-1; miconazole combination pack; miconazole suppositories; terconazole suppositories	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
ANTIMIGRAINE			
Antimigraine Preparations	Elyxyb PA – must meet criteria QL - 6 bottles/30 days Nurtec ODT PA – must meet criteria QL - 8 tabs/30 days for acute treatment; QL - 16 tabs/30 days for preventative treatment Ubrelvy PA – must meet criteria QL - 10 tabs/20 days rizatriptan; rizatriptan ODT QL - 1 box - 12 tabs/30 days 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 Zomig nasal spray QL - 1 box - 6 inhalers/30 days	almotriptan; eletriptan; zolmitriptan; zolmitriptan ODT QL - 1 box - 6 tabs/30 days frovatriptan; naratriptan; sumatriptan/naproxen; Treximet QL - 1 box - 9 tabs/30 days Sumatriptan nasal spray QL - 1 box - 6 inhalers/30 days zolmitriptan nasal spray QL - 1 box - 6 inhalers/30 days PA – must meet Generic Medically Necessary PA criteria Onzetra Xsail QL – 1 box (8 pouches)/30 days 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 Tosymra Solution Zavzpret PA – must meet criteria QL – 6 devices/22 days Zembrace SymTouch QL – 1 box (4 injections)/30 days	Antimigraine PA Criteria

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
ANTIMIGRAINE - Continued			
Antimigraine Preparations - Continued	**Prophylaxis** Ajovy PA – must meet criteria QL – 225mg/month or 675mg/3 months 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 Qulipta PA – must meet criteria QL – 1 tab/day	**Prophylaxis** Aimovig PA – must meet criteria QL – 140mg/month Vyepti PA – must meet criteria QL – 3mL/90 days	Antimigraine PA Criteria

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 12 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; enalapril/HCTZ; lisinopril/HCTZ; quinapril/HCTZ	***ACE Inhibitors with Calcium Channel Blockers*** trandolapril/verapamil QL - 30 caps/30 days ***ACE Inhibitors with Diuretics*** 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	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
CARDIOVASCULAR - Continued			
Angiotensin Receptor Blocker Combinations	***Angiotensin Receptor Blockers with Diuretics*** Edarbyclor; losartan/HCTZ; valsartan/HCTZ ***Angiotensin Receptor Blockers with Calcium Channel Blockers*** N/A ***Angiotensin Receptor Blockers with Calcium Channel Blockers and Diuretics*** N/A	***Angiotensin Receptor Blockers with Diuretics*** candesartan/HCTZ; irbesartan/HCTZ; olmesartan/HCTZ; telmisartan/HCTZ ***Angiotensin Receptor Blockers with Calcium Channel Blockers*** olmesartan/amlodipine; telmisartan/amlodipine; valsartan/amlodipine ST – trial and failure of individual components ***Angiotensin Receptor Blockers with Calcium Channel Blockers and Diuretics*** amlodipine/olmesartan/HCTZ; amlodipine/valsartan/HCTZ ST – trial and failure of individual components	
Beta Adrenergic Blockers	acebutolol; atenolol; bisoprolol; carvedilol; labetalol; metoprolol; metoprolol succinate ER; nebivolol; propranolol; propranolol ER caps; sotalol	betaxolol; Kapspargo; nadolol; pindolol; timolol Hemangeol solution; Sotylize oral solution ST – must be under 12 years of age or unable to swallow capsules/tablets carvedilol ER cap QL – 1 cap/day	
Beta Adrenergic Blockers with Diuretics	atenolol/chlorthalidone; bisoprolol/HCTZ	metoprolol/HCTZ	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
CARDIOVASCULAR - Continued			
Calcium Channel Blockers	***Dihydropyridine*** amlodipine; felodipine ER; nifedipine (short-acting); nifedipine ER ***Non-Dihydropyridine*** Calan SR; Cardizem LA; diltiazem (long-acting formulations); diltiazem (non-time released); nimodipine; verapamil (long-acting formulations); verapamil (non-time released) ***Liquid Formulation*** Norliqva ST –-must be under 12 years of age or unable to swallow tablets ***Combinations*** N/A	***Dihydropyridine*** Isradipine (non-time released); levamlodipine; nicardipine (non-time released); nisoldipine ***Non-Dihydropyridine*** Cardizem CD; Matzim LA; verapamil ER PM ***Liquid Formulation*** Katerzia ST –-must be under 12 years of age or unable to swallow tablets AND previous trial and failure of Norliqva OR medical rationale for use Nymalize ST – must be under 12 years of age or unable to swallow capsules ***Combinations*** amlodipine/atorvastatin ST – prescriber must provide documentation that separate components are not suitable for use	
Miscellaneous Cardiac Agents	Corlanor; Entresto PA – must meet criteria	Camzyos; Verquvo PA – must meet criteria	Cardiac Agents PA Criteria Cardiac Agents PA Form

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
CNS AND OTHERS			
Agents for the Treatment of Opioid Use Disorder or Overdose	***Agents for Opioid Use Disorder – oral*** Buprenorphine sublingual tablets; Buprenorphine/naloxone sublingual tablets; Suboxone Film QL – 24mg/day; Age – 16 years of age and older Zubsolv QL – 17.2mg/day; Age – 16 years of age and older ***Agents for Opioid Use Disorder – injectable*** Sublocade PA – must meet criteria ***Agents for Opioid Overdose*** Kloxxado; nalmefene; naloxone injection; naloxone nasal spray; Narcan Nasal; Opvee; Zimhi	***Agents for Opioid Use Disorder – oral*** buprenorphine/naloxone sublingual films QL – 24mg/day; Age – 16 years of age and older PA – must meet Generic Medically Necessary PA criteria ***Agents for Opioid Use Disorder – injectable*** Brixadi PA – must meet criteria ***Agents for Opioid Overdose*** N/A	Opioid Use Disorder Treatments

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
CNS AND OTHERS - continued			
Antiemetic/Antivertigo Agents	***Appetite Stimulant*** N/A ***H1 Antagonist/Vitamin*** Diclegis QL – 4 tabs/day; Max 270/365 days ***Selective 5-HT3 Receptor Antagonist*** ondansetron oral tablets & disintegrating tablets QL - 90 tabs/30 days ondansetron oral solution QL - 1 bottle/Rx ondansetron solution for injection ***Substance P-Neurokinin 1 Receptor Antagonist*** Emend 80 mg oral capsules, Emend Tripack QL - 6 caps/Rx fosaprepitant vials QL – 2 vials/Rx ***Substance P-NK 1 Antagonist/Selective 5-HT3 Antagonist*** N/A	***Appetite Stimulant*** Dronabinol SilentAuth - must meet criteria ***H1 Antagonist/Vitamin*** Bonjesta QL – 2 tabs/day; Max 270/365 days doxylamine/pyridoxine oral tabs QL – 4 tabs/day; Max 270/365 days PA – must meet Generic Medically Necessary PA criteria ***Selective 5-HT3 Receptor Antagonist*** Anzemet oral tabs QL - 10 units/Rx granisetron oral tablets; granisetron solution for injection; Sustol palonosetron injection – QL - 1 vial/Rx Sancuso transdermal system ST – physician documentation required indicating oral medications are unsuitable for patient use ***Substance P-Neurokinin 1 Receptor Antagonist*** aprepitant 40 mg and 125 mg oral capsules - QL – 6 caps/Rx aprepitant 80 mg oral capsules and 80 mg/125 mg pak- QL – 6 caps/Rx PA – must meet Generic Medically Necessary PA criteria Cinvanti injection QL – 2 vials/Rx Emend IV solution QL – 2 vials/Rx Emend suspension ST – must have tried Emend oral capsules or have inability to swallow or tolerate the capsule formulation; QL – 3 packets /Rx ***Substance P-NK 1 Antagonist/Selective 5-HT3 Antagonist*** Akynzeo ST – must have tried and failed combination therapy with preferred agents of the same classes or provide medical justification for use	

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/solution; 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; methsuximide; rufinamide suspension; tiagabine PA – must meet Antiseizure Agents PA criteria AND meet Generic Medically Necessary PA criteria Diacomit; Epidiolex; Fintepla; Zonisade; Ztalmy 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; ibuprofen-famotidine celecoxib; naproxen-esomeprazole magnesium PA – must meet Generic Medically Necessary PA criteria	
Movement Disorder Agents	benztropine tablet/injection; trihexyphenidyl tablet/solution Austedo/Austedo XR; Austedo/Austedo XR Titration Kit; Ingrezza; Ingrezza Therapy Pack; Tetrabenazine PA – must meet criteria	N/A	Movement Disorder Agents PA Criteria

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
CNS AND OTHERS - Continued			
Narcotic Antitussives and Combinations ***Note: All narcotic antitussives will require PA for members under 18 years of age ***	**See Opioid Overutilization with Age and Quantity Limits PA Criteria for product-specific age and quantity limits** guaifenesin/codeine 100-10mg/5mL solution; hydrocodone/ homatropine syrup; hydrocodone/homatropine tab; Hydromet syrup; promethazine VC/codeine syrup; promethazine with codeine SilentAuth – must meet criteria	**See Opioid Overutilization with Age and Quantity Limits PA Criteria for product-specific age and quantity limits** hydrocodone polst/chlorpheniramine polst ER SilentAuth - must meet criteria	Opioid Overutilization with Age and Quantity Limits PA Criteria
Narcotics **Note: All codeine products will require PA for members under 18 years of age**	**See Opioid Overutilization with Age and Quantity Limits PA Criteria for product-specific age and quantity limits** ***Short Acting*** apap/codeine; buprenorphine inj; butorphanol 10 mg/mL nasal spray; codeine sulfate; codeine/butalbital/apap/ caffeine; codeine/butalbital/asa/caffeine; hydrocodone/apap; hydrocodone/ibu; hydromorphone; levorphanol; meperidine; morphine; nalbuphine; Nucynta; opium tincture; oxycodone; oxycodone/apap; pentazocine/naloxone; tramadol; tramadol/APAP SilentAuth - must meet criteria butorphanol injection AGE – 18 years of age and older SilentAuth - must meet criteria ***Long Acting*** Butrans; fentanyl patches; Morphine ER tab (MS Contin); Nucynta ER SilentAuth- must meet criteria	**See Opioid Overutilization with Age and Quantity Limits PA Criteria for product-specific age and quantity limits** ***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; belladonna and opium suppositories; Nalocet; oxymorphone IR; Prolate; RoxyBond; Seglentis; tramadol 5 mg/mL solution; Trezix SilentAuth - must meet criteria ***Long Acting*** Buprenorphine patches; hydrocodone ER tab (Hysingla ER) SilentAuth- must meet criteria AND meet Generic Medically Necessary PA criteria 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); Tramadol ER (Conzip, Ryzolt, Ultram ER); Xtampza ER SilentAuth – must meet criteria	APAP High Dose PA Criteria Fentanyl Citrate PA Criteria Opioid Overutilization with Age and Quantity Limits PA Criteria Opioid PA Form – Request to Exceed MME Limit Opioid with Concurrent Buprenorphine/Naloxone PA Form

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 ***Granules/Liquid Formulation*** Lyvispah granules ST – 12 to 17 years of age or unable to swallow tablets	dantrolene; Fexmid; Lorzone; metaxalone; Norgesic Forte; orphenadrine/aspirin/caffeine; 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 varenicline Age – 18 years of age or older	***Nicotine Replacement*** Nicotrol NS QL – 12 bottles/30 days Age – 10 years of age or older Nicotrol Inhaler QL – 3 inhalers/31 days Age – 10 years of age or older ***Other Smoking Deterrents*** N/A	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
DERMATOLOGIC			
Acne Agents **Note: All acne agents have an age restriction of 25 years and under** **Note: All acne agents for members over the age of 25 years require step therapy with an OTC acne product** **Note: A 14-day trial each of at least 2 preferred agents is required prior to receiving a non-preferred agent.**	**All legend generic products are preferred unless otherwise specified** Adapalene (cream, gel) AGE - 25 years and under; ST - must have tried a preferred topical tretinoin product benzoyl peroxide cream, liquid, gel Retin-A (all formulations except micro); Ziana ***Oral Formulations*** Accutane; Amnesteem; Claravis; Myorisan; Zenatane	**All legend brand products are non-preferred unless otherwise specified** adapalene/benzoyl peroxide gel; Benzepro; BP cleanser; BP 10-1 wash; clindamycin foam; clindamycin 1.2%/benzoyl peroxide 2.5%; clindamycin 1.2%/benzoyl peroxide 3.75%; dapsone gel; Erygel; sodium sulfacetamide med pads; sulfacetamide sod top susp; Avar cleanser; 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 Avita; clindamycin phosphate-tretinoin gel; tretinoin cream and gel PA – must meet Generic Medically Necessary PA criteria ***Oral Formulations*** isotretinoin	
Antipsoriatics	calcipotriene cream; calcipotriene topical solution; Enstilar; Taclonex scalp suspension; tazarotene 0.1% cream; Vectical ointment acitretin PA – must meet criteria	calcipotriene 0.005% foam; calcipotriene ointment; calcipotriene/betamethasone ointment; calcitriol ointment; Duobrii; methoxsalen; Sorilux foam; tazarotene 0.05% gel; tazarotene 0.1% gel; Vtama calcipotriene/betamethasone suspension PA – must meet Generic Medically Necessary PA criteria	Soriatane PA Criteria

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

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
ENDOCRINE			
Anaphylaxis Agents	epinephrine auto-injector	Auvi-Q; Epipen; Symjepi	
Bone Formation Stimulating Agents	Forteo; teriparatide 600 mcg/2.4 mL PA - must meet criteria	Evenity; teriparatide 620 mcg/2.48 mL; Tymlos PA - must meet criteria	Bone Formation Stimulating Agents PA Criteria Bone Formation Stimulating Agents PA Form[
Bone Resorption Inhibitors	***Bisphosphonates*** alendronate risedronate tablets ST - must try alendronate within the past 90 days ***Bone Modifying Monoclonal Antibodies*** N/A ***Calcitonin*** calcitonin-salmon nasal ***SERMs*** raloxifene	***Bisphosphonates*** Atelvia; Fosamax Plus D; ibandronate alendronate oral solution 70mg/75mL ST – must be 5 years of age or older and less than 12 years of age OR unable to swallow tablets ibandronate pre-filled syringe QL - one single-use, pre-filled syringe per 90 days ***Bone Modifying Monoclonal Antibodies*** Prolia injection PA - must meet criteria Xgeva PA – must meet criteria ***Calcitonin*** calcitonin (salmon) injection ST – trial and failure of calcitonin-salmon nasal or medical justification for use ***SERMs*** N/A	Bone Resorption Inhibitors PA Criteria

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
ENDOCRINE - Continued			
DPP4 Inhibitors and Combination Agents	***DPP4-I*** Januvia; Tradjenta ST - must have tried metformin ***DPP4-I & metformin combination*** Janumet; Janumet XR; Jentadueto; Jentadueto XR; Kazano ST - must have tried metformin ***DPP4-I & thiazolidinedione combination*** N/A	***DPP4-I*** alogliptin; Nesina; saxagliptin ST - must have tried a preferred agent for 60 of the past 100 days ***DPP4-I & metformin combination*** alogliptin/metformin; saxagliptin/metformin ER ST - must have tried a preferred combination agent for 60 of the past 100 days ***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	
GLP-1 Receptor Agonists and Combinations	***GLP-1 RA*** Byetta; Ozempic; Trulicity; Victoza SilentAuth – must meet criteria ***GIP/GLP-1 RA*** N/A ***Combination Agents*** Soliqua SilentAuth – must meet criteria	***GLP-1 RA*** Bydureon BCise; Rybelsus SilentAuth – must meet criteria ***GIP/GLP-1 RA*** Mounjaro SilentAuth – must meet criteria ***Combination Agents*** Xultophy SilentAuth – must meet criteria	GLP-1 RA and Combinations PA Criteria
Glucagon Agents	Baqsimi nasal spray; Glucagen hypokit; Gvoke injection; Zegalogue injection	Glucagon Kit	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
ENDOCRINE - Continued			
Growth Hormones	***Somatropin products*** Genotropin; Norditropin; Serostim; Zorbtive PA - must meet criteria ***Long-acting products*** Skytrofa PA – must meet criteria ***Miscellaneous growth hormone products*** N/A	***Somatropin products*** Humatrope; Nutropin AQ; Omnitrope; Saizen; Zomacton PA – must meet criteria ***Long-acting products*** Ngenla; Sogroya PA - must meet criteria ***Miscellaneous growth hormone products*** Increlex; 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); insulin aspart (all formulations)	Admelog; Admelog Solostar; Fiasp; Humalog Tempo Pen; insulin lispro (all formulations); Lyumjev; Lyumjev Tempo Pen; Novolog (all formulations); 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	Lantus (cartridges, pens, & vials); Levemir (Flextouch, & vials) insulin degludec Flex & vials ST – trial of Lantus or Levemir for 90 of the past 120 days	Basaglar; Basaglar Tempo Pen; insulin glargine (all manufacturers); Rezvoglar; Semglee; Toujeo Solostar; Tresiba Flex and vials	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
ENDOCRINE - Continued			
Miscellaneous Oral Antidiabetic Agents	***Alpha glucosidase inhibitors*** acarbose ***Biguanides*** Glumetza; metformin; metformin ER (all strengths except 500mg & 1 gram ER tabs, generics of Fortamet) ***Meglitinide*** repaglinide ***Sulfonylureas and Combinations*** glimepiride; glipizide; glipizide ER; glyburide glipizide/metformin; glyburide/metformin ST - must have tried metformin ***Thiazolidinediones and Combinations*** pioglitazone QL - 34 tabs/30 days; ST - must have tried metformin	***Alpha glucosidase inhibitors*** miglitol ***Biguanides*** metformin 500 mg & 1 gm ER (generics of Fortamet) metformin ER (generics of Glumetza) PA – must meet Generic Medically Necessary PA criteria metformin HCl solution ST – must be 10 years of age or older and less than 12 years of age OR unable to swallow tablets ***Meglitinide*** nateglinide ***Sulfonylureas and Combinations*** N/A ***Thiazolidinediones and Combinations*** pioglitazone/glimepiride; pioglitazone/metformin ST – prescriber must provide documentation that separate components are unsuitable for use	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
ENDOCRINE - Continued			
SGLT Inhibitors and Combinations	***SGLT1-I/SGLT2-I*** N/A ***SGLT2-I*** Farxiga; Jardiance; Invokana ***SGLT2-I & metformin combination*** Invokamet; Synjardy; Xigduo XR ***SGLT2-I & DPP4-I combination*** N/A ***SGLT2-I, DPP4-I, & metformin combination*** N/A	***SGLT1-I/SGLT2-I*** Inpefa ***SGLT2-I*** Steglatro; Brenzavvy ***SGLT2-I & metformin combination*** Invokamet XR; Segluromet; Synjardy XR ***SGLT2-I & DPP4-I combination*** Glyxambi; Qtern; Steglujan ST-must have tried and failed combination therapy with preferred agents of the same classes or provide medical justification for use ***SGLT2-I, DPP4-I, & metformin combination*** Trijardy XR ST-must have tried and failed combination therapy with preferred agents of the same classes or provide medical justification for use	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
ENDOCRINE - Continued			
Testosterones	**See Testosterone PA Criteria for product-specific age and quantity limits** ***Injectable Agents*** Depo-Testosterone; testosterone cypionate PA – must meet criteria ***Oral Agents*** N/A ***Topical Agents – must meet PA criteria*** Androderm; Testim 1% (50 mg)/5 gm gel tubes; testosterone 1% (25 mg)/2.5 gm gel packets; testosterone 1% (12.5 mg)/act gel pump; testosterone 1.62% (20.25 mg)/act metered pump gel	**See Testosterone PA Criteria for product-specific age and quantity limits** ***Injectable Agents*** Aveed; Testopel pellet; testosterone enanthate; Xyosted PA – must meet criteria ***Oral Agents*** Danazol; Jatenzo; Methitest; methyltestosterone; Tlando PA – must meet criteria ***Topical Agents – must meet PA criteria*** Natesto; testosterone 1% (50 mg)/5 gm gel packets/tubes; testosterone 1.62% (40.5 mg)/2.5 gm gel packets; testosterone 1.62% (20.25 mg)/1.25 gm gel packets; testosterone 2% (10 mg)/act metered pump; testosterone 30 mg/act solution; Vogelxo 1% (50 mg)/5 gm gel packets; Vogelxo 1% (12.5 mg)/act gel pump	Testosterones PA Criteria Testosterones PA Form
Urea Cycle Disorders (Hyperammonemia Treatments)	Buphenyl powder and tab; Carbaglu; Pheburane PA – must meet criteria	carglumic acid; sodium phenylbutyrate powder and tab PA – must meet criteria AND must meet Generic Medically Necessary PA criteria Olpruva; Ravicti PA – must meet criteria	Urea Cycle Disorder Agents

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; Menest; Minivelle; Premarin; Prempro; Provera; Vivelle Dot ***Vaginal Preparations*** Estring; Premarin Vaginal Cream; Vagifem ***Uterine disorder agents*** Myfembree; Oriahnn; Orilissa PA – must meet criteria	**All legend brand products are non-preferred unless otherwise specified** estradiol TD gel 0.1%; ethinyl estradiol and norethindrone tabs estradiol TD patch (generic formulations of Minivelle and Vivelle Dot) PA – must meet Generic Medically Necessary PA criteria Veozah PA – must meet criteria ***Vaginal Preparations*** estradiol vaginal cream; Femring; Yuvafem estradiol vaginal tablets PA – must meet Generic Medically Necessary PA criteria ***Uterine disorder agents*** N/A	Uterine Disorder Agents PA Criteria Uterine Disorder Agents PA Form Veozah PA Criteria

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
ESTROGEN AND RELATED AGENTS - Continued			
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**	***Injectable Contraception*** Depo-SubQ Provera medroxyprogesterone contraceptive 150mg/mL suspension for injection QL – 1mL/84 days for contraception ***Oral/Topical Contraception*** drospirenone; norethindrone; progestin/estrogen combinations; Twirla; Xulane Phexxi QL – 1 box/month ***Long-Acting Reversible Contraception*** Kyleena; Liletta; Mirena; Nexplanon; Skyla ***Emergency Contraception*** levonorgestrel 1.5mg; ulipristal	***Injectable Contraception*** N/A ***Oral/Topical Contraception*** Zafemy ***Long-Acting Reversible Contraception*** N/A ***Emergency Contraception*** N/A	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
GASTROINTESTINAL AGENTS			
Anti-ulcer Agents	Carafate suspension ST – must be 1 year of age or older and less than 12 years of age OR unable to swallow tablets 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 12 years of age or unable to swallow tablets	
Laxatives and Cathartics	Amitiza; Linzess ST - requires trial of lactulose, sorbitol, or polyethylene glycol Relistor injection ST - requires trial of lactulose, sorbitol or polyethylene glycol AND diagnosis of opioid-induced constipation	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 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	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
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, lansoprazole capsules QL – 1 cap/day pantoprazole tablets QL – 2 tabs/day ***IV Solutions*** N/A	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	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
GASTROINTESTINAL AGENTS - Continued			
Proton Pump Inhibitors - continued **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.**	***Oral Solutions*** Nexium packets; Protonix packets QL – 1 packet/day	***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) ST – must be unable to swallow tablet/capsule formulation; 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 and pantoprazole packets must meet Generic Medically Necessary PA criteria) omeprazole/sodium bicarb powder (QL – 1 packet/day); Zegerid Powder (QL – 1 packet/day) AGE - must be 18 years of age or older; ST - must be unable to swallow tablet/capsule formulation; must try Nexium packets and Protonix packets for a total length of therapy of 4 weeks, unless patient is intolerant to these agents (omeprazole/sodium bicarb powder must meet Generic Medically Necessary PA criteria) Konvomep oral suspension (QL – 20 mL/day) AGE – must be 18 years of age or older; 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

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
GASTROINTESTINAL AGENTS - Continued			
Ulcerative Colitis Agents	***Oral Formulations*** Apriso; balsalazide; budesonide DR caps; Delzicol; Dipentum; Lialda; Pentasa; sulfasalazine IR; sulfasalazine ER ***Rectal Formulations*** mesalamine enema; mesalamine suppositories; sfRowasa	***Oral Formulations*** budesonide ER tabs; Ortikos ER caps mesalamine ER (Apriso) cap; mesalamine DR (Delzicol) cap; mesalamine DR (Lialda) tab; mesalamine ER (Pentasa) cap PA – must meet Generic Medically Necessary PA criteria ***Rectal Formulations*** Uceris rectal foam budesonide rectal foam PA – must meet Generic Medically Necessary PA criteria	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
GENITOURINARY			
BPH Agents	alfuzosin ER; dutasteride; finasteride; tamsulosin	dutasteride/tamsulosin ST – must provide documentation that separate components are not suitable for use silodosin ST – requires trial of alfuzosin ER and tamsulosin OR medical justification for use of silodosin 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 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	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
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 – must be 3 years of age or older and less than 12 years of age OR unable to swallow tablets Vesicare LS ST – must be 2 years of age or older and less than 12 years of age OR unable to swallow tablets Gemtesa ST – member must have trialed and failed Myrbetriq or have intolerance or contraindication to Myrbetriq	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
HEMATOLOGIC			
Direct Oral Anticoagulants	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 Pradaxa 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 Xarelto suspension ST – must be under 12-years of age or unable to swallow tablets; QL – 20 mg/day (20 mL/day)	dabigatran PA – must meet Generic Medically Necessary PA criteria Pradaxa Pak ST – must be under 8 years of age or unable to swallow capsules OR have medical rationale for use of pellet formulation Savaysa QL – 1 tab/day ST – must have trialed Eliquis and Xarelto OR medical justification for use of Savaysa	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
HEMATOLOGIC - Continued			
Hematinics	***Erythropoiesis-Stimulating Agents*** Aranesp; Epogen; Retacrit PA – must meet criteria ***Miscellaneous Hematinics*** N/A	***Erythropoiesis-Stimulating Agents*** Mircera; Procrit PA – must meet criteria ***Miscellaneous Hematinics*** Jesduvroq; Reblozyl PA – must meet criteria	Hematinic Agents PA Criteria Jesduvroq PA Criteria
Leukocyte Stimulants	***Short-Acting*** Neupogen ***Long-Acting*** Fylnetra; Nyvepria	***Short-Acting*** Granix; Leukine; Nivestym; Releuko; Zarxio ***Long-Acting*** Fulphila; Neulasta; Rolvedon; Stimufend; Udenyca; Ziextenzo	
Platelet Aggregation Inhibitors	aspirin/dipyridamole; cilostazol; clopidogrel 75 mg; Prasugrel Brilinta QL - 2 tabs/day clopidogrel 300 mg tablets QL - 1 tab/Rx	Durlaza; Zontivity	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
LIPOTROPICS			
Bile Acid Sequestrants	cholestyramine multi-dose containers; colesevelam tablets and suspension; Prevalite powder/packets	cholestyramine packets; colestipol (granules/tablets)	
Fibric Acid Derivatives	fenofibrate micronized cap (generic Antara); fenofibrate tab (generic Tricor); gemfibrozil	Antara; fenofibrate cap; fenofibrate micronized cap (generic Lofibra); fenofibric acid cap (generic Trilipix); fenofibric acid tab; fenofibrate tab (generic Fenoglide); Lipofen	
HMG CoA Reductase Inhibitors	atorvastatin; lovastatin; pravastatin; rosuvastatin; simvastatin	Altoprev; Ezallor; fluvastatin; fluvastatin ER; Livalo; Zypitamag Atorvaliq ST – must be 10 years of age or older and less than 12 years of age OR unable to swallow tablets pitavastatin PA – must meet Generic Medically Necessary PA criteria	
Lipotropics	omega-3-acid ethyl esters ezetimibe/simvastatin ST – must have trial history of a single-agent HMG CoA reductase inhibitor for 90 of the past 120 days 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

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

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 2nd generation antihistamine loratadine/pseudoephedrine 24-hour OTC tabs QL – 1 tablet/day; ST – previous trial and failure of a preferred single-agent 2nd 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/syrup or cetirizine solution/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*** Clarinex-D Rx tabs QL – 2 tablets/day; ST – previous trial and failure of loratadine/pseudoephedrine 12-hour OTC tab ***Liquid Formulation*** Clarinex 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	Antiviral Monoclonal Antibodies PA Antiviral Monoclonal Antibodies PA Form

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 fluticasone 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 fluticasone 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 Asthma ST – must have tried and failed Advair or Symbicort therapy for at least 90 days of the past 120 days COPD ST – must have tried and failed Anoro Ellipta therapy for at least 90 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 fluticasone Diskus within the past 100 days AND meet Generic Medically Necessary PA criteria fluticasone/salmeterol HFA (ABA Advair HFA) 45-21 mcg, 115-21 mcg, 230-21 mcg fluticasone/salmeterol Respiclick (ABA Airduo Respiclick) 55-13 mcg, 113-14 mcg, 232-14 mcg ST – must have tried at least 90 days of therapy with Airduo Respiclick	
Beta Agonists – Long Acting	Serevent	arformoterol; formoterol; Striverdi Respimat	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
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 terbutaline	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
RESPIRATORY - Continued			
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*** Spiriva Handihaler QL - 1 inhaler/30 days Anoro Ellipta; Incruse Ellipta; QL - 1 inhaler/30 days Spiriva Respimat 1.25 mcg ST – must have diagnosis of asthma QL – 1 inhaler/30 days Spiriva Respimat 2.5 mcg ST – must have trial and failure of Spiriva Handihaler for a least 14 days QL – 1 inhaler/30 days	***Short-Acting*** N/A ***Long-Acting*** Bevespi Aerosphere; Duaklir Pressair QL – 1 inhaler/30 days Lonhala Magnair QL – 1 kit (60 vials)/30 days Stiolto Respimat QL – 1 box (60 inhalations)/30 days tiotropium inhalation capsules QL - 1 inhaler/30 days PA – must meet Generic Medically Necessary PA criteria Tudorza Pressair QL – 1 inhaler/30 days Yupelri QL – 1 box (90mL)/30 days	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
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*** azelastine/fluticasone nasal spray; 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	
Oral Inhaled Glucocorticoids	Arnuity Ellipta; Asmanex; Asmanex HFA QL – 1 inhaler/30days fluticasone propionate HFA; fluticasone Diskus; 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; Flovent Diskus; Flovent 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; Liqrev; Opsumit; Orenitram; Orenitram Titration Pack; Tyvaso; Tyvaso DPI; Uptravi; Ventavis PA – must meet criteria sildenafil suspension; Tadliq SilentAuth – must meet criteria	Pulmonary Antihypertensives PA Criteria Pulmonary Antihypertensives PA Form
Respiratory and Allergy Biologics	Dupixent; Fasenra; Nucala; Tezspire; Xolair SilentAuth - must meet criteria	Cinqair SilentAuth - must meet criteria	Respiratory and Allergy Biologics PA Criteria

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
TARGETED IMMUNOMODULATORS			
Targeted Immunomodulators	Actemra; adalimumab-fkjp (Mylan); Adbry; Enbrel; Hadlima; Humira; infliximab; Kineret; Olumiant; Orencia vials & syringes; Otezla; Simponi; Taltz; Xeljanz SilentAuth/PA – must meet criteria Xeljanz oral solution SilentAuth/PA – 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)	adalimumab-adaz (Sandoz); Amjevita; Arcalyst; Avsola; Cibinqo; Cimzia; Cosentyx; Cyltezo; Entyvio; Hulio; Hyrimoz; Idacio; Ilaris; Ilumya; Inflectra; Kevzara; Litfulo; Remicade; Renflexis; Rinvoq; Siliq; Skyrizi; Sotyktu; Spevigo; Stelara; Tremfya; Xeljanz XR; Yuflyma; Yusimry SilentAuth/PA – must meet criteria	Targeted Immunomodulators PA Criteria

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.*	**See Dry Eye Disease or Keratoconjunctivitis PA Criteria for product-specific quantity limits** Restasis single dose; Xiidra SilentAuth – must meet criteria	**See Dry Eye Disease or Keratoconjunctivitis PA Criteria for product-specific quantity limits** Cequa; cyclosporine single dose emulsion; Eysuvis; Miebo; Restasis Multidose; Tyrvaya; Verkazia 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 0.1% solution; brimonidine 0.2% solution; carteolol; Combigan; dorzolamide; dorzolamide/timolol; Iopidine 1%; latanoprost; levobunolol; Lumigan 0.01% drops; metipranolol; pilocarpine; Rhopressa; Rocklatan; timolol solution; 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 Iyuzeh ST – must have tried and failed latanoprost OR prescriber has provided medical justification for use of Iyuzeh over latanoprost 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	

DRUG CLASS	PREFERRED	NON-PREFERRED	PA CRITERIA (if applicable)
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; diclofenac solution; 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**	Natroba; permethrin 5% cream; permethrin 1% lotion	Crotan; ivermectin lotion; Lindane shampoo; malathion; spinosad; 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	

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