# Magellan Medicaid Administration

## Virginia Medicaid's Pharmacy Benefits Management System

## Phone: 800-932-6648 Fax: 800-932-6651

*General Information:*

- The PDL is a list of preferred drugs that the Medicaid Fee-for-Service program allows payment without requiring service authorization (SA). *Please note that not all drug classes are subject to the Virginia Medicaid PDL.*
- **Preferred drugs in select drug classes (e.g., long acting opioids, hepatitis C therapies, growth hormone) may require the submission of a clinical SA.**
- Drug classified as non-preferred will be subject to SA.
- This list is not all inclusive for non-preferred drugs.
- SAs may be submitted by fax, phone or webPA. For urgent requests, please call **800-932-6648.** Fax requests receive a response within 24 hours.
- All new drugs included in a PDL class are non-preferred until reviewed by the P&T Committee.

PDL drug coverage information can be found at http://www.VirginiaMedicaidPharmacyServices.com. **The following "routine" PDL criteria guidelines will be applied to all non-preferred drugs. Select drug classes may have additional criteria that will be clearly denoted.**

1. Is there any reason the member cannot be changed to a preferred drug within the same class? Acceptable reasons include:
   - Allergy to preferred drug.
   - Contraindication to or drug-to-drug interaction with preferred drug.
   - History of unacceptable/toxic side effects preferred drug.
   - Member's condition is clinically stable; changing to a preferred drug might cause deterioration of the member's condition.

2. The requested drug may be approved if both of the following are true:
   - There has been a therapeutic failure of at least **two** preferred drugs **within the same class as appropriate for diagnosis unless otherwise noted in the clinical criteria**. A therapeutic failure of only one preferred drug is required when there is only one preferred drug within a therapeutic class.
   - The requested drug's corresponding generic (if a generic is available **and** covered by the State) has been attempted and failed or is contraindicated.

All changes from last posting will be highlighted in yellow.

Teal highlights indicate where a Brand is preferred over a generic

**Abbreviations**

| | | |
|---|---|---|
| ST = step edit | cr = cream | susp = suspension |
| QL = quantity limit | oint = ointment | tab = tablet |
| AG = age edit | supp = suppository | |

| | Preferred Agents | Non-Preferred Agents | SA Criteria |
|---|---|---|---|
| **Analgesics** | | | |
| | *** Opioids – Long Acting (LAO)** | | |
| | ***Preferred (Sch III-VI)*** | ***Non-Preferred*** | ***All Long Acting Opioids (preferred and non-preferred) require submission of a Clinical SA. Refer to combined short/long-acting opioid SA form (Short & Long Acting Opioid SA Form)**<br><br>**LENGTH OF AUTHORIZATIONS**<br>• Up to 6 months for chronic pain, (includes chronic non-malignant pain, cancer pain, palliative care, end-of-life care)<br>• Up to 1 month for severe post op pain<br><br>Daily dose limits have been established for all LAO. Quantity limits can be found at : **(Daily Dose Limits for Short & Long Acting Opioids)** |
| | **Butrans® (buprenorphine) Transdermal Patch** | *Belbuca (buprenorphine buccal film)*<br>*buprenorphine (generic Butrans®)*<br>*ConZip® (tramadol ER)*<br>*Ryzolt™ (tramadol ER)*<br>*tramadol ER*<br>*Ultram ER® (tramadol ER)* | |
| | ***Preferred (Sch II)*** | ***Non-Preferred*** | |
| | **fentanyl 12, 25, 50, 75 & 100 mcg patches**<br>**morphine sulfate ER tab** | *Arymo™ ER*<br>*Duragesic®*<br>*Embeda*<br>*Exalgo®*<br>*fentanyl 37.5 mcg, 62.5 mcg, and 87.5 mcg patches*<br>*Hysingla ER™*<br>*Kadian® ER*<br>*Morphabond™ ER*<br>*morphine ER cap (generic Avinza®)*<br>*morphine ER cap (generic Kadian®)*<br>*MS Contin®*<br>*Nucynta® ER*<br>*Oramorph® SR®*<br>*oxycodone-long acting*<br>*OxyContin®*<br>*oxymorphone ER*<br>*Xartemis™ XR*<br>*Xtampza ER®*<br>*Zohydro ER™* | |

| Preferred Agents | Non-Preferred Agents | SA Criteria |
|---|---|---|
| ***Methadone Drugs** | | |
| | *Dolophine®*<br>*Methadose® oral soln & tab*<br>*methadone oral soln & tab* | *Methadone requires the completion of the Clinical SA form **(Methadone SA Form)** unless prescribed for neonatal abstinence syndrome for an infant under the age of one. |
| ***Opioids – Short Acting** | | |
| ***Transmucosal Immediate Release Fentanyl** | | **LENGTH OF AUTHORIZATIONS:**<br>• 1 months for severe post-surgical pain, OR<br>• Up to 6 months for chronic pain (includes chronic non-malignant pain, active cancer pain, palliative care, end-of-life care).<br><br>***All Short-Acting Opioids (preferred and non-preferred) require the submission of a Clinical SA if prescribed for > 7 days or if more than two 7 day supply prescriptions within 60 days. (Short & Long Acting Opioid SA Form)** |
| | *Actiq®*<br>*Fentora®*<br>*fentanyl citrate*<br>*Lazanda®*<br>*Subsys®* | |
| **Short-Acting Opioids** | | |
| **codeine/APAP**<br>**codeine/APAP/caff/butal**<br>**hydrocodone/APAP**<br>**hydrocodone/ibuprofen**<br>**hydromorphone**<br>**morphine IR**<br>**Nucynta®**<br>**oxycodone IR**<br>**oxycodone/APAP**<br>**tramadol HCL** | *Abstral®*<br>*codeine tab/soln*<br>*butalbital comp with codeine*<br>*butorphanol tartrate nasal*<br>*dihydrocodeine/APAP/caffeine*<br>*dihydrocodeine/ASA/caffeine*<br>*hydromorphone liq/supp*<br>*meperidine tab*<br>*morphine supp*<br>*Oxaydo®*<br>*oxycodone/APAP (generic PrimLev™)*<br>*Oxycodone conc*<br>*oxycodone/ASA*<br>*oxycodone/ibuprofen*<br>*oxymorphone HCl*<br>*pentazocine/naloxone*<br>*PrimLev™*<br>*tramadol HCL/APAP*<br>*Ultracet®*<br>*Ultram®*<br>*Zamicet ®soln* | |

| | Preferred Agents | Non-Preferred Agents | SA Criteria |
|---|---|---|---|
| | **Opioid Dependency** | | ***All Buprenorphine Containing Drugs (preferred and non-preferred) require submission of Clinical SA. Refer to (Oral Buprenorphine SA Form)** |
| | ***buprenorphine SL**<br>***Suboxone® film**<br>**naloxone syringe & vial**<br>**naltrexone tab**<br>**Narcan® Nasal Spray**<br>**Vivitrol®** | **Bunavail ™*<br>**buprenorphine/naloxone tab*<br>**Zubsolv™*<br>*Evzio®* | Quantity Limits (see table below) |

Quantity Limits

| Drug | Limit |
|---|---|
| Bunavail™ 2.1–0.3mg buccal film | 1/day |
| Bunavail™ 4.2–0.7mg buccal film | 2/day |
| Bunavail™ 6.3–1mg buccal film | 2/day |
| buprenorphine SL tab 2mg | 3/day |
| buprenorphine SL tab 8mg | 2/day |
| buprenorphine/naloxone SL tab 2–0.5mg | 3/day |
| buprenorphine/naloxone SL tab 8–2mg | 2/day |
| Suboxone® SL film 2–0.5mg | 3/day |
| Suboxone® SL film 4–1mg | 1/day |
| Suboxone® SL film 8–2mg | 2/day |
| Suboxone® SL film 12–3mg | 1/day |
| Zubsolv™ SL tab 0.7–0.18 mg | 2/day |
| Zubsolv™ SL tab 1.4–0.36mg | 2/day |
| Zubsolv™ SL tab 2.9–0.71mg | 2/day |
| Zubsolv™ SL tab 5.7–1.4mg | 2/day |
| Zubsolv™ SL tab 8.6–2.1mg | 2/day |
| Zubsolv™ SL tab 11.4–2.9mg | 2/day |

## Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)

| | Preferred Agents | Non-Preferred Agents | SA Criteria |
|---|---|---|---|
| | **Oral NSAIDs** | | **LENGTH OF AUTHORIZATIONS: 1 year** |
| | **Children's Motrin® susp (OTC)**<br>**ibuprofen cap**<br>**ibuprofen tab (OTC & RX)**<br>**Infant's ibuprofen drops, susp (OTC)**<br>**meloxicam tab**<br>**naproxen tab**<br>**naproxen sodium OTC**<br>**naproxen EC (Rx)** | *Anaprox® IR & DS®*<br>*Advil®*<br>*Aleve®*<br>*Arthrotec®*<br>*Cataflam®*<br>**Celebrex® & *celecoxib*<br>*Daypro®*<br>*diclofenac potassium*<br>*diclofenac sodium SR*<br>*diclofenac sodium/misoprostol* | **Routine PDL edits plus**<br><br>***Step edit required for Celebrex® and celecoxib**<br>• History of a trial of a minimum of two (2) different non-COX2 NSAIDs within the past year; **OR**<br>• Concurrent use of anticoagulants (i.e., warfarin, heparin, etc.)**,** methotrexate, oral corticosteroids; **OR**<br>• History of previous GI bleed or conditions associated with GI toxicity risk factors (i.e., PUD, GERD, etc.); **OR**<br>• Specific indication for Celebrex® for which preferred drugs are not indicated. |

| | Preferred Agents | Non-Preferred Agents | SA Criteria |
|---|---|---|---|
| | **sulindac** | *diflunisalDuexis®*<br>*etodolac IR & SR*<br>*Feldene®*<br>*fenoprofen*<br>*flurbiprofen*<br>*ibuprofen tab chew OTC*<br>*Indocin® supp*<br>*indomethacin IR, SR & rectal*<br>*ketoprofen IR & ER*<br>*ketorolac*<br>*meclofenamate*<br>*mefenamic*<br>*meloxicam susp*<br>*Mobic®*<br>*Motrin®*<br>*nabumetone*<br>*Nalfon®*<br>*Naprelan®*<br>*Naprosyn®*<br>*naproxen CR (generic Naprelan®)*<br>*naproxen sodium (RX)*<br>*naproxen susp*<br>*oxaprozin*<br>*piroxicam*<br>*Ponstel®*<br>*Prevacid Naprapac®*<br>*Sprix® nasal spray*<br>*Tivorbex™*<br>*tolmetin sodium*<br>*Vimovo®*<br>*Vivlodex™*<br>*Voltaren®XR*<br>*Zipsor®*<br>*Zorvolex™* | |

| | Preferred Agents | Non-Preferred Agents | SA Criteria |
|---|---|---|---|
| | **Topical NSAIDs** | | **LENGTH OF AUTHORIZATIONS: 1 year** |
| | **Voltaren® 1% gel** | **diclofenac sodium 1 % gel*<br>***diclofenac sodium 3 % gel*<br>**Flector® patch (QL)*<br>**Pennsaid® top soln, soln pkt & pump*<br>***Solaraze 3% top gel*<br>**Vopac MDS*<br>**Xrylix™ Kit* | **Routine PDL edits plus**<br>**Clinical Criteria for Non-Preferred Topical NSAIDs; *Flector®, Pennsaid®, Vopac MDS, & Xrylix™ Kit:**<br>• Approval is based on member failing the oral generic of the desired drug and at least one other preferred NSAID (to equal a total of at least two preferred). For example, a member who failed ibuprofen or naproxen will still need to try oral diclofenac for approval of Flector®.<br>• Pennsaid®, Vopac MDS, and Xrylix™ Kit can only be approved for the FDA approved indication of osteoarthritis of the knee.<br>***Quantity limit for Flector® = 30 patches per RX***<br>****Solaraze® 3% & Diclofenac Sodium 3 % Clinical Criteria**:<br>• Approved only for the topical treatment of actinic keratosis |
| **Antibiotic-Anti-Infective** | | | |
| | ***Antibiotics, Inhaled** | | |
| | **Bethkis®** ***(QL, AG)***<br>**Kitabis™ PAK** ***(QL, AG)***<br>****Tobi Podhaler®** ***(QL, AG)*** | *Cayston® (QL, AG)*<br>*Tobi® inhalation neb soln (QL, AG)*<br>*tobramycin inhalation neb soln (generic Tobi® inhalation) (QL, AG)*<br>*tobramycin Pak (generic Kitabis™ PAK) (QL, AG)* | **LENGTH OF AUTHORIZATIONS: 1 year**<br>**Routine PDL edits plus**<br>*Minimum age for use is 6 years for **all** tobramycin inhalation nebulizer solution (Bethkis®, Kitabis™ Pak, Tobi® and Tobi Podhaler®) and 7 years for Cayston®.<br>**Tobi Podhaler® requires a clinical reason as to why one of the preferred tobramycin inhalation nebulizer solutions cannot be used (Bethkis® or Kitabis™).<br>**Quantity Limits:**<br>Bethkis® = 224mL (56 amps)/28 days<br>Cayston® = 84 mL/(56 amps)/28 days<br>Kitabis™ PAK = 280mL (56 amps)/28 days<br>Tobi Podhaler® = 224 capsule/28 day<br>Tobi® inhalation *neb* = 280mL (56 amps)/28 days<br>tobramycin = 280mL (56 amps)/28 days |

| Preferred Agents | Non-Preferred Agents | SA Criteria |
|---|---|---|
| **Antifungals, Oral** | | |
| **fluconazole tab/susp**<br>**Griseofulvin ® susp**<br>**nystatin tab/susp**<br>**terbinafine** | *Ancobon ®*<br>*clotrimazole (mucous mem)*<br>*Cresemba®*<br>*Diflucan® tab/susp*<br>*flucytosine*<br>*Gris-Peg®*<br>*griseofulvin tab*<br>*griseofulvin ultramicrosize*<br>*itraconazole*<br>*ketoconazole*<br>*Lamisil ® tab/granules*<br>*Noxafil®*<br>**Onmel®*<br>**Sporanox® cap/soln*<br>*Vfend® tab/susp*<br>*voriconazole tab & powder for susp* | **LENGTH OF AUTHORIZATIONS**: Duration of the prescription (up to 12 months)<br><br>**Routine PDL edits plus**<br><br>*** Clinical Criteria for all Non-Preferred oral Antifungals. Requires the submission of a Clinical SA. Refer to (Antifungal Oral SA Form)** |
| **Cephalosporins, Oral** | | |
| **Second Generation Cephalosporins** | | **LENGTH OF AUTHORIZATIONS**: Date of service only; no refills.<br><br>**Routine PDL edits plus**<br><br>**Clinical Criteria for Non-Preferred Cephalosporins**<br><br>• Infection caused by an organism resistant to preferred drugs, OR<br>• A therapeutic failure to no less than a three-day trial of **one preferred cephalosporin; OR**<br>• The member is completing a course of therapy with a non-preferred drug which was initiated in the hospital. |
| **cefaclor cap**<br>**cefprozil tab/susp**<br>**cefuroxime tab** | *cefaclor ER*<br>*cefaclor susp*<br>*Ceftin® tab/susp* | |
| **Third Generation Cephalosporins** | | |
| **cefdinir cap/susp**<br>**cefixime suspension** | *Cedax® cap/susp*<br>*ceftibuten*<br>*cefditoren pivoxil*<br>*cefpodoxime proxetil cap/susp*<br>*Spectracef®*<br>*Suprax® chewable tab/cap/susp* | |

| | Preferred Agents | Non-Preferred Agents | SA Criteria |
|---|---|---|---|
| | **Macrolides, Oral** | | |
| | **Macrolides & Ketolides** | | **LENGTH OF AUTHORIZATIONS**: Date of service only; no refills |
| | **azithromycin pack/susp/tab**<br>**clarithromycin tab/susp**<br>**Ery-tab®**<br>**E.E.S.® 400 tab**<br>**erythromycin base cap DR**<br>**erythrocin stearate**<br>**erythromycin ethylsuccinate 200mg susp**<br>**erythromycin stearate** | *Biaxin® tab*<br>*clarithromycin ER*<br>*Eryped®200 & 400 susp*<br>*E.E.S.® 200 susp*<br>*erythromycin base tab*<br>**Ketek®*<br>*PCE®*<br>*Zithromax® pac/tab/susp*<br>*ZMAX® susp* | **Routine PDL edits plus**<br><br>**Clinical Criteria for Non-Preferred Macrolides and Ketolides**<br>• Infection caused by an organism resistant to preferred drugs; **OR**<br>• A therapeutic failure to no less than a **three-day trial of one preferred drug within the same class**; **OR**<br>• The member is completing a course of therapy with a non-preferred drug which was initiated in the hospital.<br><br>* **Ketek® Clinical Criteria**<br>• Treatment of community-acquired pneumonia (of mild to moderate severity) **AND**<br>• Infection is caused by one of the following microorganism: *Streptococcus pneumoniae, Haemophilus influenzae, Moraxella catarrhalis, Chlamydophila pneumoniae, or Mycoplasma pneumoniae.* **AND**<br>• A therapeutic failure to no less than a **three-day trial of one preferred drug within the same class**; **OR**<br>• The member is completing a course of therapy with a non-preferred drug which was initiated in the hospital. |
| | **Otic** | | |
| | **Ciprodex®** | *Cetraxal®*<br>*Cipro HC®*<br>*ofloxacin*<br>*Otovel* | **LENGTH OF AUTHORIZATIONS:** Date of service only; no refills<br><br>**Routine PDL edits** |

| | Preferred Agents | Non-Preferred Agents | SA Criteria |
|---|---|---|---|
| | **Quinolones, Oral** | | |
| | **Second Generation Quinolones** | | **LENGTH OF AUTHORIZATIONS**: Date of service only; no refills<br><br>**Routine PDL edits plus**:<br><br>**Clinical Criteria for Non-Preferred Quinolones**<br>• Infection caused by an organism resistant to preferred drugs; **OR**<br>• A therapeutic failure to no less than a **three-day trial of one preferred quinolone**; **OR**<br>• The member is completing a course of therapy with a non-preferred drug which was initiated in the hospital. |
| | **ciprofloxacin susp/tab** | *Cipro® IR & XR & susp*<br>*ciprofloxacin ER*<br>*Noroxin®*<br>*ofloxacin* | |
| | **Third Generation Quinolones** | | |
| | **levofloxacin tab** | *Avelox®*<br>*Levaquin® tab/susp*<br>*levofloxacin susp*<br>*moxifloxacin* | |
| | **Topical Antibiotics** | | |
| | **mupirocin ointment** | **Altabax™ (QL)*<br>*Bactroban® cr/ointment*<br>*Centany®*<br>*Centany AT® Kit* | **LENGTH OF AUTHORIZATIONS**: Date of service only; no refills<br><br>**Routine PDL edits**<br><br>**Quantity Limit = 15 grams per 34 days* |
| | **Vaginal Antibiotics** | | |
| | **Cleocin® Ovules**<br>**Clindesse® cr**<br>**metronidazole gel** | *Cleocin® cr*<br>*clindamycin cr*<br>*Metrogel®*<br>*Nuvessa®*<br>*Vandazole™ gel* | **LENGTH OF AUTHORIZATIONS**: Date of Service<br><br>**Routine PDL edits** |
| **Antivirals** | | | |
| | ***Hepatitis C Agents** | | |
| | **Interferon** | | **LENGTH OF AUTHORIZATIONS**: 8 weeks (initial approval for all diagnoses)<br><br>***ALL Hepatitis C Drugs (Preferred and Non-Preferred) require the submission of a Clinical SA. Refer to (Hepatitis C Antivirals SA Form)** |
| | **Peg-Intron®**<br>**Peg-Intron Redipen®** | *Pegasys® Proclick/syringe/kit/vial* | |
| | **Protease Inhibitor** | | |
| | | *Olysio™* | |

| | Preferred Agents | Non-Preferred Agents | SA Criteria |
|---|---|---|---|
| | ***Nucleotide Analog NS5A & NS5B Polymerase Inhibitors & Combinations** | | |
| | | *Daklinza®*<br>*Epclusa®*<br>*Sovaldi®*<br>*Vosevi™* | |
| | ***NS5A, NS3/4A Inhibitor Combinations** | | |
| | **Mavyret™** | *Technivie™*<br>*Viekira Pak™*<br>*Viekira XR™*<br>*Zepatier™* | |
| | ***NS5B & Protease Inhibitor combinations** | | |
| | | *Harvoni®* | |
| | **Herpes Oral** | | |
| | **acyclovir cap/tab/susp**<br>**famciclovir**<br>**valacyclovir** | *Famvir®*<br>*Sitavig® buccal tab*<br>*Valtrex®*<br>*Zovirax® tab/susp* | **LENGTH OF AUTHORIZATIONS**: 1 year<br>**Routine PDL edits** |
| | **Herpes Topical** | | |
| | **Abreva OTC®**<br>**Zovirax® cr** | *acyclovir oint*<br>*Denavir®*<br>*Xerese® cr*<br>*Zovirax® oint* | **LENGTH OF AUTHORIZATIONS**: 1 year<br>**Routine PDL edits** |
| | **Influenza** | | |
| | **amantadine tab/syrup**<br>**Relenza Disk®**<br>**rimantadine**<br>**Tamiflu® cap**/susp | *amantadine cap*<br>*Flumadine® tab*<br>*oseltamivir cap* | **LENGTH OF AUTHORIZATIONS:** Date of service only<br>**Routine PDL edits** |

| | *Preferred Agents* | *Non-Preferred Agents* | *SA Criteria* |
|---|---|---|---|
| **Blood Modifiers** | | | |
| | **Bile Salts** | | |
| | **ursodiol 300 mg tab** | *Actigal®*<br>*Chenodal®*<br>*Cholbam®*<br>*Ocaliva®*<br>*ursodiol cap*<br>*Urso®*<br>*Urso® Forte tab* | **LENGTH OF AUTHORIZATIONS**: 1 year<br><br>**Routine PDL edits** |
| | **Phosphate Binders** | | |
| | **calcium acetate 667mg cap**<br>**Renagel®**<br>**Renvela® tablet** | *Auryxia™*<br>*calcium acetate 667mg tab*<br>*Eliphos®*<br>*Ferric citrate*<br>*Fosrenol®* chewable tab<br>lanthanum carbonate chewable tab<br>*Phoslo®*<br>*Phoslyra®*<br>*Renvela® powder*<br>*sevelamer carbonate powder packet*<br>*Velphoro® chewable tab* | **LENGTH OF AUTHORIZATIONS**: 1 year<br><br>**Routine PDL edits** |
| **Bone Resorption Suppression and Related Agents** | | | |
| | **Bisphosphonates** | | |
| | **alendronate tab** | *Actonel®*<br>*alendronate soln*<br>*Atelvia DR®*<br>*Boniva®*<br>*Binosto™*<br>*etidronate*<br>*Fosamax®tab & Fosamax® plus D*<br>*ibandronate*<br>*risedronate DR* | **LENGTH OF AUTHORIZATIONS**: 1 year<br><br>**Routine PDL edits**<br><br>. |

| | Preferred Agents | Non-Preferred Agents | SA Criteria |
|---|---|---|---|
| | **Calcitonins** | | |
| | **calcitonin-salmon nasal** | *Miacalcin®* | **LENGTH OF AUTHORIZATIONS**: 1 year<br>**Routine PDL edits** |
| | **Others** | | |
| | **raloxifene** | *Evista®*<br>**Forteo®*<br>**Tymlos™* | **LENGTH OF AUTHORIZATIONS**: Initial approval will be for 1 year<br>**Routine PDL edits for Evista®**<br>***Clinical SA must be completed for (Forteo® OR Tymlos™ SA Form)** |
| **Cardiac** | | | |
| | **Anticoagulants** | | |
| | **Low Molecular Weight Heparin includes FactorXA Inhibitor** | | **LENGTH OF AUTHORIZATIONS**: 1 year<br>**Routine PDL edits plus** |
| | **enoxaparin** | *Arixtra®*<br>*fondaparinux*<br>*Fragmin® syringe & vial*<br>*Lovenox®* | |
| | **Oral Anticoagulants** | | **Clinicial Criteria for select (non-preferred) Oral Anticoagulants.** |
| | **Eliquis™**<br>**Pradaxa®**<br>**Xarelto®**<br>**warfarin** | *Coumadin®*<br>**Savaysa™*<br>*Xarelto® Starter Pack* | **Savaysa™*<br>• Diagnosis of:<br>  • Non-valvular Atrial Fibrillation, **OR**<br>  • deep vein thrombosis, **OR**<br>  • pulmonary embolism ; **AND**<br>• Documentation that CrCl is NOT ≥ 95mL/min calculated by Cockcroft-Gault equation; |
| | **Antihypertensive Agents** | | |
| | **ACE Inhibitors** | | **LENGTH OF AUTHORIZATIONS: 1 year** |
| | **benazepril**<br>**enalapril**<br>**lisinopril**<br>**ramipril** | *Accupril®*<br>*Altace®*<br>*captopril*<br>*Epaned™ soln* | **Routine PDL edits** |

| | Preferred Agents | Non-Preferred Agents | SA Criteria |
|---|---|---|---|
| | | *fosinopril*<br>*Lotensin®*<br>*Mavik®*<br>*moexipril*<br>*Monopril®*<br>*perindopril*<br>*Prinivil®*<br>*Qbrelis™*<br>*quinapril*<br>*ramipril*<br>*trandolapril*<br>*Univasc®*<br>*Vasotec®*<br>*Zestril®* | |
| | **ACE Inhibitors + Calcium Channel Blocker Combinations** | | |
| | **amlodipine/benazepril** | *Lotrel®*<br>*Tarka®*<br>*trandolapril-verapamil ER* | |
| | **ACE Inhibitors + Diuretic Combinations** | | |
| | **benazepril/HCTZ**<br>**lisinopril/HCTZ**<br>**enalapril/HCTZ** | *Accuretic®*<br>*captopril/HCTZ*<br>*fosinopril/HCTZ*<br>*Lotensin HCT®*<br>*moexipril/HCTZ*<br>*quinapril/HCTZ*<br>*Vaseretic®*<br>*Zestoretic®* | |
| | **Angiotensin Receptor Blockers** | | **LENGTH OF AUTHORIZATIONS: 1 year** |
| | ***Entresto™** *(QL)*<br>**losartan**<br>**valsartan** | *Atacand®*<br>*Avapro®*<br>*Benicar®*<br>*Byvalson™*<br>*candesartan*<br>*Cozaar®* | **Routine PDL edits plus**<br><br>***Clinical Criteria for Entresto™**<br>• Diagnosis of chronic heart failure (NYHA Class II-IV); **AND**<br>• Member must be ≥ 18 years; **AND** |

| | Preferred Agents | Non-Preferred Agents | SA Criteria |
|---|---|---|---|
| | | *Diovan®*<br>*Edarbi®*<br>*eprosartan mesylate*<br>*irbesartan*<br>*Micardis®*<br>*olmesartan*<br>*Teveten®* | • Left ventricular ejection fraction ≤ 40%<br><br>*Quantity Limit = 2 per day for Entresto™* |
| | **Angiotensin Receptor Blockers + Calcium Channel Blocker Combinations** | | |
| | **amlodipine/valsartan** | *Azor®*<br>*amlodipine/olmesartan*<br>*amlodipine/olmesartan/HCTZ*<br>*amlodipine/valsartan/HCTZ*<br>*Exforge® & Exforge® HCT*<br>*Tribenzor®* | |
| | **Angiotensin Receptor Blockers + Diuretic Combinations** | | |
| | **losartan/HCTZ**<br>**valsartan/HCTZ** | *Atacand HCT®*<br>*Avalide®*<br>*Benicar HCT®*<br>*candesartan/HCTZ*<br>*Diovan HCT®*<br>*Edarbyclor®*<br>*Hyzaar®*<br>*irbesartan/HCTZ*<br>*Micardis HCT®*<br>*olmesartan/HCTZ*<br>*telmisartan/HCTZ*<br>*Teveten HCT®* | |
| | **Antihypertensives, Sympatholytics** | | |
| | **Catapres®-TTS**<br>**clonidine tab**<br>**guanfacine**<br>**methyldopa**<br>**reserpine** | *Catapres®*<br>*clonidine (transdermal)*<br>*Clorpres®*<br>*methyldopa/HCTZ*<br>*Tenex®* | |

| Preferred Agents | Non-Preferred Agents | SA Criteria |
|---|---|---|
| **Beta Blockers** | | ***Clinical Criteria for Hemangeol™**<br>• Diagnosis treatment of proliferating infantile hemangioma requiring systemic therapy; **AND**<br>• Member's age must be between 5weeks and 5 months. |
| **atenolol**<br>**carvedilol**<br>**labetalol**<br>**metoprolol tartrate**<br>**metoprolol succinate**<br>**propranolol tab/soln**<br>**Sorine®**<br>**sotalol AF**<br>**sotalol HCL** | *acebutaolol*<br>*Betapace® IR & AF®*<br>*betaxolol*<br>*bisoprolol*<br>*Bystolic®*<br>*Coreg® IR & CR®*<br>*Corgard®*<br>**Hemangeol™*<br>*Inderal® XL*<br>*Innopran® XL*<br>*Levatol®*<br>*Lopressor®*<br>*nadolol*<br>*pindolol*<br>*propranolol LA*<br>*Sectral®*<br>*Sotylize ™*<br>*Tenormin®*<br>*timolol maleate*<br>*Toprol XL®*<br>*Trandate®*<br>*Zebeta®* | |
| **Beta Blockers + Diuretic Combinations** | | |
| **atenolol/chlorthalidone**<br>**bisoprolol/HCTZ** | *Corzide®*<br>*Dutoprol®*<br>*Lopressor HCT®*<br>*metoprolol/HCTZ*<br>*nadolol/bendroflumethiazide*<br>*propranolol/HCTZ*<br>*Tenoretic®*<br>*Ziac®* | |

| | Preferred Agents | Non-Preferred Agents | SA Criteria |
|---|---|---|---|
| | **Calcium Channel Blockers -Dihydropyridine** | | |
| | **Afeditab CR®**<br>**amlodipine**<br>**Nifedical XL®**<br>**nifedipine**<br>**nifedipine ER** | *Adalat CC®*<br>*felodipine ER*<br>*isradipine*<br>*nisoldipine*<br>*nicardipine*<br>*Norvasc®*<br>*Procardia®*<br>*Procardia XL®*<br>*Sular®* | |
| | **Calcium Channel Blockers- Non-Dihydropyridine** | | |
| | **Cartia XT®**<br>**diltiazem IR, ER q12 hr & 24 hr**<br>**Taztia XT®**<br>**verapamil tab IR & ER** | *Calan® IR & SR*<br>*Cardizem® IR, CD & LA*<br>*Isoptin SR®*<br>*Matzim LA*<br>*Tiazac®*<br>*verapamil ER cap*<br>*Verelan® & Verelan PM®* | |
| | **Direct Renin Inhibitors (includes combination)** | | |
| | | *Tekamlo®*<br>*Tekturna®*<br>*Tekturna HCT®*<br>*Twynsta®*<br>*telmisartan/amlodipine* | |
| | **Lipotropics** | | |
| | **Bile Acid Sequestrants** | | **LENGTH OF AUTHORIZATIONS**: 1 year |
| | **cholestyramine powder reg & light**<br>**colestipol tab**<br>**Prevalite®**<br>**Welchol ® tab** | *Colestid® granule/packet/tab*<br>*colestipol HCl granules*<br>*Questran® powder/powder Light*<br>*Welchol® packet* | **Routine PDL edits plus** |

| | *Preferred Agents* | *Non-Preferred Agents* | *SA Criteria* |
|---|---|---|---|
| | **Cholesterol Absorption Inhibitor (CAI)** | | |
| | **Zetia®** | *Ezetimibe* | |
| | **Fibric Acid Derivatives** | | |
| | **fenofibrate (generic Tricor® 48mg 145mg )**<br>**gemfibrozil** | *Antara®*<br>*fenofibrate (generics for Antara®, Fenoglide® & Lipofen®)*<br>*fenofibric acid*<br>*Fenoglide®*<br>*Fibricor®*<br>*Lipofen®*<br>*Lofibra®*<br>*Lopid®*<br>*Tricor®*<br>*Triglide®*<br>*Trilipix™* | |
| | **HMG CoA Reductase Inhibitors and Combo (High Potency Statins)** | | |
| | **atorvastatin**<br>**rosuvastatin**<br>**simvastatin** | *amlodipine/atorvastatin*<br>*Caduet®*<br>*Crestor®*<br>*Lipitor®*<br>*Liptruzet®*<br>*Livalo®*<br>*simvastatin/ezetimibe*<br>*Vytorin®*<br>*Zocor®* | |
| | **HMG CoA Reductase Inhibitors and Combinations (Statins)** | | |
| | **lovastatin**<br>**pravastatin** | *Advicor®*<br>*Altoprev®*<br>*fluvastatin*<br>*Lescol® and Lescol XL®*<br>*Mevacor®*<br>*Pravachol®* | |

| | Preferred Agents | Non-Preferred Agents | SA Criteria |
|---|---|---|---|
| | **Microsomal Triglyceride Transfer Protein Inhibitor** | | |
| | | **Juxtapid ™* | ***Clinical Criteria for Juxtapid™ (Juxtapid™ SA Fax Form)** |
| | **Niacin Derivatives** | | |
| | **niacin ER** | *Niaspan®*<br>*Niacor®* | |
| | **Omega 3 Fatty Acid Agent** | | |
| | | ****Lovaza® (ST)*<br>****omega-3 acid ethyl esters(ST)*<br>*Vascepa®* | *****Lovaza® and omega-3 acid ethyl esters**<br>• Step edit requires trial and failure of any other lipotropic; **OR**<br>• Documented high triglycerides of ≥ 500 mg/dL. |
| | **Oligonucleotide Inhibitor** | | |
| | | *****Kynamro™* | ****Clinical SA must be completed for **Kynamro™** **(Kynamro™ SA Fax Form)** |
| | ***Proprotein Convertase Subtilisin Kexin Type 9 (PCSK9) Inhibitors** | | **LENGTH OF AUTHORIZATIONS**: Three months for initial approval; six months for renewal |
| | | *Praluent®*<br>*Repatha®* | ***ALL PCSK9 Inhibitors require the submission of a Clinical SA (PCSK9 FAX FORM) (PCSK9 SA Form)** |
| | **Platelet Inhibitors** | | |
| | **Brilinta®**<br>**clopidogrel**<br>**dipyridamole**<br>**Effient®**<br>**ticlopidine HCL** | **Aggrenox®*<br>**ASA/dipyridamole*<br>***Durlaza ER™*<br>*Persantine®*<br>*Plavix®*<br>*prasugrel (generic Effient®)*<br>***Yosprala® Tab*<br>****Zontivity™* | **LENGTH OF AUTHORIZATIONS**: 1 year<br>**Routine PDL edits plus**<br>**Clinical Criteria for Select Non-Preferred Platelet Inhibitors**<br>***Aggrenox® & ASA/dipyridamole**<br>• Aspirin and dipyridamole are covered as separate drugs without SA; clinical reason as to why the individual drugs cannot be used separately.<br>****Durlaza ER™ & *Yosprala® Tab**<br>• Aspirin is covered without SA; clinical reason as to why aspirin cannot be used.<br>*** **Zontivity™**<br>• Diagnosis of MI (myocardial infarction) or PAD (peripheral arterial disease); **AND** |

| | Preferred Agents | Non-Preferred Agents | SA Criteria |
|---|---|---|---|
| | | | • Members must not have a history of stroke, TIA, ICH, GI bleed and peptic ulcer; **AND**<br>• Must have concomitant therapy with clopidogrel, unless member has a contraindication to clopidogrel in which case member must have concomitant therapy with aspirin; **AND**<br>• Member is 18 years of age or older; **AND**<br>• Prescribed by or in consultation with a cardiologist. |
| | ***Pulmonary Arterial Hypertension Agents** | | |
| | **Inhaled Prostacyclin Analogues** | | **LENGTH OF AUTHORIZATIONS: 1 year**<br><br>**Routine PDL edits plus**<br><br>***Clinical Criteria for all preferred and non-preferred PDE-5**<br>• Diagnosis of pulmonary hypertension in members >18 years is required; **AND**<br>• The prescriber must be a pulmonary specialist or cardiologist; **AND**<br>• Must have a rationale for not taking the sildenafil tablet to receive a SA for injectable Revatio® |
| | **Ventavis®** | *Tyvaso®* | |
| | **Oral Endothelin Receptor Antagonist** | | |
| | **Letairis®**<br>**Tracleer®** | *Opsumit®* | |
| | ***Phosphodiesterase 5 Inhibitors (PDE-5)** | | |
| | **Adcirca™**<br>**sildenafil tab** | *Revatio® tab, susp & inj* | |
| | **Prostacyclin Vasodilator and Receptor Agonist** | | |
| | | *Orenitram™*<br>*Uptravi®* | |
| | **Soluble Guanylate Cyclase Stimulators** | | |
| | | *Adempas®* | |
| **Central Nervous System** | | | |
| | **Alzheimer's Agents** | | |
| | **Cholinesterase Inhibitors** | | **LENGTH OF AUTHORIZATIONS**: Length of prescription (up to 3 months)<br><br>**Routine PDL edits** |
| | **donepezil OTD & tab**<br>**Exelon® (transderm)** | *Aricept® ODT, tab*<br>*Exelon® cap*<br>*galantamine IR, ER tab/soln*<br>*Namzaric® (donepezil/memantine)*<br>*Razadyne® IR, ER*<br>*rivastigmine cap & patch* | |

| | *Preferred Agents* | *Non-Preferred Agents* | *SA Criteria* |
|---|---|---|---|
| | **NMDA Receptor Antagonist** | | |
| | **memantine tab & soln** | *memantine Dose Pack*<br>*Namenda® Dose Pack /XR tab*<br>*Namenda® tab* | |
| | **Anticonvulsants** | | |
| | **Barbiturates** | | **LENGTH OF AUTHORIZATIONS: 1 year**<br><br>**Routine PDL edits plus**<br><br>**Clinicial Criteria for select (non-preferred) Benzodiazepines**<br>***Onfi®**<br>• Patient is at least two years of age or older; **AND**<br>• Patient must have a diagnosis of seizures associated with Lennox-Gastaut syndrome (LGS) **AND**<br>• using as adjunctive therapy with other anticonvulsants; **AND**<br>• Prescribing physician should submit documentation of an insufficient response to another medication used for LGS |
| | **phenobarbital elixir/tab**<br>**primidone** | *Mysoline®* | |
| | **Benzodiazepines** | | |
| | **clonazepam**<br>**Diastat® rectal**<br>**Diastat® AcuDial™ rectal** | *clonazepam ODT*<br>*diazepam rectal& Device rectal*<br>*Fin® tab*<br>**Onfi®susp/tab* | |
| | **Carbamazepine Derivatives** | | |
| | **carbamazepine chewable tab/susp/tab**<br>**carbamazepine ER (generic for Carbatrol®)**<br>**oxcarbazepine susp & tab**<br>**Tegretol®XR** | *Aptiom®*<br>*carbamazepine XR*<br>*Carbatrol®*<br>*Equetro® cap*<br>*Oxtellar™ XR*<br>*Tegretol® susp/tab*<br>*Trileptal® susp* & tab<br>*vigabatrin powder pack* | |
| | **Hydantoins** | | |
| | **Dilantin® cap/Infatab**<br>**phenytoin cap/ chew tab/susp**<br>**phenytoin ext cap**<br>**Phenytek®** | *Dilantin® susp*<br>*Peganone®* | |

| | *Preferred Agents* | *Non-Preferred Agents* | *SA Criteria* |
|---|---|---|---|
| | **Succinimides** | | |
| | **ethosuximide cap/syrup** | *Celontin®*<br>*Zarontin® cap/syrup* | |
| | **Valproic Acid and Derivatives** | | |
| | **divalproex tab & sprinkle**<br>**divalproex ER**<br>**valproic acid** | *Depakene® cap/syrup*<br>*Depakote® ER & sprinkle*<br>*Stavzor®* | |
| | **Other Anticonvulsants** | | |
| | **felbamate susp/tab**<br>**Gabitril®**<br>**lamotrigine tab**<br>**lamotrigine XR**<br>**levetiracetam soln/ tab**<br>**levetiracetam ER**<br>**Vimpat® soln/tab**<br>**topiramate tab & sprinkle**<br>**zonisamide** | *Banzel® susp/tab*<br>*Briviact®*<br>*Felbatol® susp/tab*<br>*Fycompa® susp/tab*<br>*Keppra® soln/tab*<br>*Keppra® XR*<br>*Lamictal® XR*<br>*Lamictal® ODT/ODT dose pk*<br>*Lamictal® tab/dose pk*<br>*Lamictal® XR dose pk*<br>*lamotrigine tab dose pk & ODT*<br>*Potiga®*<br>*Qudexy™ XR*<br>*Sabril® powder pack/tab*<br>*tiagabine*<br>*Topamax® tab & sprinkle*<br>*Trokendi™ XR*<br>*Zonegran®* | |
| | **Antidepressants** | | |
| | **Other** | | **LENGTH OF AUTHORIZATIONS:** **1 year** |
| | **bupropion IR, SR &XL**<br>**desvenlafaxine succinate ER**<br>**mirtazapine ODT & tab**<br>**trazodone**<br>**venlafaxine IR & ER cap** | *Aplenzin®*<br>*Brintellix®*<br>*Effexor® XR*<br>*Emsam® transdermal*<br>*Fetzima®* | **Routine PDL edits** |

| | Preferred Agents | Non-Preferred Agents | SA Criteria |
|---|---|---|---|
| | | *Forfivo® XL*<br>*Khedezla™*<br>*Marplan®*<br>*Nardil®*<br>*nefazodone*<br>*Oleptro® ER*<br>*Parnate®*<br>*phenelzine*<br>*Pristiq®*<br>*Remeron® ODT & tab*<br>*tranylcypromine sulfate*<br>*Trintellix*<br>*venlafaxine ER tab*<br>*Viibryd® tab/dose pk*<br>*Wellbutrin® IR, SR & XL* | |
| | **SSRI** | | |
| | **citalopram soln/tab**<br>**escitalopram tab**<br>**fluoxetine cap/soln**<br>**fluvoxamine**<br>**paroxetine tab**<br>**sertraline tab** | *Brisdelle®*<br>*Celexa® tab*<br>*escitalopram soln*<br>*fluoxetine DR cap/tab*<br>*fluvoxamine ER*<br>*Lexapro® soln/tab*<br>*Luvox® CR*<br>*paroxetine CR*<br>*Paxil® tab/susp & Paxil® CR*<br>*Pexeva®*<br>*Prozac® cap/weekly*<br>*Sarafem®*<br>*sertraline conc*<br>*Zoloft® conc/tab* | |
| | **Antimigraine Agents** | | |
| | **Relpax®**<br>**sumatriptan succinate tab cartridge/nasal/vial/pen** | *almotriptan*<br>*Alsuma®*<br>*Amerge®* | **LENGTH OF AUTHORIZATIONS:** **1 year**<br><br>**Routine PDL edits** |

| | *Preferred Agents* | *Non-Preferred Agents* | *SA Criteria* |
|---|---|---|---|
| | **rizatriptan tab & MLT** | *Axert®*<br>*Cambia®*<br>*eletriptan (generic Relpax®)*<br>*Frova®*<br>*frovatriptan (generic Frova®)*<br>*Imitrex® cartridge/nasal/pen/tab/vial*<br>*Maxalt® tab &MLT*<br>*Migranow™ Kit*<br>*naratriptan*<br>*Onzetra™ Xsail™*<br>*sumatriptan KITS*<br>*Sumavel® Dosepro*<br>*Treximet®*<br>*Zecuity® patch*<br>*Zembrace ™ SymTouch ™*<br>*Zomig® tab/nasal spray/ZMT* | |
| | ***Antipsychotics** *(AG)* | | |
| | **Atypical** | | **LENGTH OF AUTHORIZATIONS: 1 year or 6 months for members < 18 yrs** |
| | **aripiprazole soln & tab**<br>**clozapine tab**<br>**Geodon® IM**<br>**Latuda®**<br>**olanzapine ODT/tab**<br>**olanzapine/ fluoxetine**<br>**quetiapine tab**<br>**quetiapine fumarate ER**<br>**risperidone ODT/ soln/tab**<br>**ziprasidone capsule** | *Abilify® tab and IM*<br>*aripiprazole ODT*<br>*Clozaril®*<br>*clozapine ODT*<br>*Fanapt® tab & titration pk*<br>*Fazaclo®*<br>*Geodon®*<br>*Invega®*<br>***Nuplazid™ (QL)(AG)*<br>*olanzapine IM*<br>*paliperidone ER*<br>*Rexulti® tab*<br>*Risperdal® ODT/soln/tab*<br>*Seroquel® IR*<br>*Saphris® SL* | **Routine PDL edits plus**<br><br>***ALL antipsychotics for children 0 to 17 years of age (preferred and non-preferred) require the submission of a Clinical SA. Refer to (Antipsychotics In Children Less Than 18 Years SA Form)**<br><br>****Clinical Criteria Nuplazid™**<br>• Indicated for the treatment of hallucinations and delusions associated with Parkinson's disease psychosis.<br><br>*Quantity Limit Nuplazid™ = 2 per day* |

| | Preferred Agents | Non-Preferred Agents | SA Criteria |
|---|---|---|---|
| | | *Seroquel® XR*<br>*Symbyax®*<br>*Versacloz™*<br>*Vraylar™*<br>*Zyprexa® tab/IM/Zydis* | |
| | **Atypical, Long Acting Injectable** | | **<u>LENGTH OF AUTHORIZATIONS:</u>** **1 year**<br><br>**Routine PDL edits** |
| | **Abilify Maintena®**<br>**Aristada®**<br>**Risperdal Consta®**<br>**Invega Sustenna®**<br>**Invega Trinza®** | *Zyprex*<br>*a® Relprevv™* | |
| | **Typical** | | **<u>LENGTH OF AUTHORIZATIONS:</u>** **1 year**<br><br>**Routine PDL edits** |
| | **amitriptyline/perphenazine**<br>**chlorpromazine**<br>**fluphenazine decantate**<br>**haloperidol decantate**<br>**haloperidol tab**<br>**loxapine**<br>**perphenazine**<br>**trifluoperazine**<br>**thiothixene**<br>**thioridazine** | *fluphenazine elixir/soln/tab*<br>*Haldol decanoate (injection)*<br>*pimozide*<br>*Moban®*<br>*molindone*<br>*Orap®* | |

| Preferred Agents | Non-Preferred Agents | SA Criteria |
|---|---|---|
| **Neuropathic Pain** | | |
| **capsaicin OTC topical**<br>**duloxetine 20, 30 & 60 mg**<br>**gabapentin cap , tab & soln**<br>**lidocaine 5% patch**<br>***Lyrica® cap** *(ST)* | *Cymbalta®*<br>*duloxetine 40 mg*<br>*Gralise™*<br>*Horizant ™*<br>*Irenka™*<br>*Lidoderm® patch*<br>*Lyrica® soln*<br>*Neurontin® cap, tab, soln*<br>*Savella™ & Savella™ Dose Pak*<br>*Qutenza Kit® (Topical)* | **LENGTH OF AUTHORIZATIONS**: 1 year<br><br>**Routine PDL**<br><br>***Step Edit for Lyrica® cap**<br>• Trial and failure of duloxetine or gabapentin |
| **Non-Ergot Dopamine Receptor Agonist** | | |
| **pramipexole**<br>**ropinirole HCl** | *Mirapex® IR & ER*<br>*Neupro®*<br>*pramipexole ER*<br>*Requip® IR & XR*<br>*ropinirole HCl ER* | **LENGTH OF AUTHORIZATIONS: 1 year**<br><br>**Routine PDL edits** |
| **Sedatives / Hypnotics** | | |
| **temazepam 15 & 30 mg** | *estazolam*<br>*flurazepam*<br>*Halcion®*<br>*Restoril®*<br>*temazepam 7.5 mg & 22.5 mg*<br>*triazolam* | **LENGTH OF AUTHORIZATIONS**: Length of the prescription (up to 3 months)<br><br>**Routine PDL edits** |
| **Sedatives / Hypnotics (Non-Benzodiazepine)** | | |
| **zolpidem** | *Ambien® IR & CR*<br>*Belsomra®*<br>*Edluar™*<br>*eszopiclone*<br>**Hetlioz™* | **LENGTH OF AUTHORIZATIONS**: 6 months. **For Renewal -** must document therapeutic benefit and confirm compliance<br><br>Routine PDL edits plus |

| | Preferred Agents | Non-Preferred Agents | SA Criteria |
|---|---|---|---|
| | | *Intermezzo®*<br>*Lunesta®*<br>*Rozerem®*<br>*Silenor®*<br>*Sonata®*<br>*Zaleplon®*<br>*zolpidem CR*<br>*Zolpimist ™ spray*<br>*zolpidem (generic Intermezzo®)* | ***Clinical Criteria for Hetlioz™**<br>• For the treatment of Non-24-Hour Sleep-Wake Disorder (Non-24), **AND**<br>• The member is completely blind, **AND**<br>• Member must be age 18 years of age or older.<br>• Quantity limit = 1 tablet per day. |
| | **Skeletal Muscle Relaxants** | | |
| | **baclofen**<br>**chlorzoxazone**<br>**cyclobenzaprine HCL**<br>**dantrolene sodium**<br>**methocarbamol**<br>**tizanidine tab** | *Amrix®*<br>**carisoprodol*<br>**carisoprodol/ASA*<br>**carisoprodol/ASA/codeine*<br>*cyclobenzaprine ER*<br>*Dantrium®*<br>*Fexmid®*<br>*Lorzone®*<br>*metaxalone*<br>*orphenadrine citrate*<br>*orphenadrine/ASA/caffeine*<br>*Parafon Forte® DSC*<br>*Robaxin®*<br>*Skelaxin®*<br>**Soma®*<br>*tizanidine cap*<br>*Zanaflex®* | **LENGTH OF AUTHORIZATIONS:**<br>• 1 year for chronic conditions<br>• Duration of prescription (up to 3 months) for acute conditions<br>• One month per every 6 months for carisoprodol drugs<br><br>**Routine PDL edits plus**<br><br>***Clinical Criteria for Carisoprodol Drugs (Soma/carisoprodol SA Fax Form)** |
| | **Smoking Cessation** | | |
| | **bupropion SR**<br>**Chantix®**<br>**Chantix® DS PK**<br>**nicotine gum/lozenge/patch** | *Nicoderm CQ® Patch*<br>*Nicorette® Gum/Lozenges*<br>*Nicotrol® Inhaler & NS*<br>*Zyban®* | **LENGTH OF AUTHORIZATIONS:** 6 months<br><br>**Routine PDL edits** |

| | Preferred Agents | Non-Preferred Agents | SA Criteria |
|---|---|---|---|
| | ***Stimulants/ADHD Medications** *(AG)* | | |
| | **Amphetamine Drugs** | | **LENGTH OF AUTHORIZATIONS**: 1 year |
| | ****Adderall®XR** (ST)<br>**amphetamine salts combo**<br>**dextroamphetamine**<br>**Vyvanse®**<br>**Vyvanse® Chewable tab** | *Adderall® IR*<br>*Adzenys XR ODT™*<br>*amphetamine salts combo XR*<br>*Desoxyn®*<br>*Dexedrine®*<br>*dextroamphetamine SR & soln*<br>*Dyanavel™ XR susp*<br>*Evekeo™*<br>*methamphetamine*<br>*Mydayis ER™*<br>*Procentra® soln*<br>*Zenzedi™* | **Routine PDL edits**<br><br>*All stimulants (preferred and non-preferred) require the submission of Clinical SA if prescribed outside the FDA approved age or if patient is > 18 years. Refer to Stimulant SA form (Stimulant/ADHD Medications SA Form) |
| | **Methylphenidate Drugs** | | ****Step Edit for Adderall XR®**<br>If a trial & failure of a preferred drug occurs and the physician requests Adderall XR® or amphetamine salts combo XR. The brand Adderall XR®- is preferred over the generic. |
| | **All methylphenidate generic**<br>**Daytrana® Transdermal**<br>**Focalin XR®**<br>**Focalin®**<br>**IR tab**<br>**QuilliChew ER™**<br>**Quillivant™ XR susp** | *Aptensio ™ XR*<br>*Cotempla XR-ODT™*<br>*Concerta®*<br>*dexmethylphenidate IR & XR*<br>*Metadate CD®*<br>*Metadate ER®*<br>*Methylin ER®, chewIR & soln IR* | |

| Brand name | PI Age Indications |
|---|---|
| Adzenys XR ODT™ | > 6 years |
| Aptensio ™ XR | > 6 years |
| Extended-release once-daily drugs; e.g., Adderall XR, Metadate CD, Concerta® Ritalin LA® etc. | > 6 years |
| Cotempla XR-ODT™ | > 6 years |
| Desoxyn® | > 6 years |
| Dyanavel™ XR susp | > 6 years |
| Evekeo™ | > 6 years |
| Focalin XR® | > 6 years |
| Intuniv® | > 6 years |
| Immediate release formulations: e.g., methylphenidate | > 3 years |
| Kapvay® SR | > 6 years |
| Mydayis™ | > 13 years |
| Strattera® | > 6 years |
| QuilliChew ER™ | > 6 years |
| Quillivant™ XR susp | > 6 years |
| Vyvanse® & Vyvanse® Chewable | > 6 years |
| Zenzedi™ | > 6 years |

| | Preferred Agents | Non-Preferred Agents | SA Criteria |
|---|---|---|---|
| | | *methylphenidate chew & soln*<br>*methylphenidate ER, LA, SR*<br>*Ritalin® IR, LA® & SR®* | |
| | **Miscellaneous Drugs** | | **Step Edit for**Kapvay® SR 12H**<br>Requires trail and failure of one preferred drug.<br><br>***Nuvigil™/Provigil®/armodafinil/modafinil:**:<br>**Length of Authorizations:** 1 year for sleep apnea and narcolepsy; 6 months for shift work sleep disorder.<br><br>• Approvable diagnoses include:<br>○ **Sleep Apnea:** Requires documentation/confirmation via sleep study or that C-PAP has been maximized; **OR**<br>○ **Narcolepsy:** Documentation of diagnosis via sleep study; **OR**<br>○ **Shift Work Sleep disorder: ONLY APPROVABLE FOR 6 MONTHS**, work schedule must be verified and documented. Shift work is defined as working the all night shift.<br><br>• Nuvigil™ age edit > 17 years<br>• Provigil® age edit > 16 years |
| | **guanfacine ER**<br>****Kapvay® SR 12H** *(ST)*<br>**Strattera®** | ****armodafinil (generic Nuvigil™)*<br>*atomoxetine (generic Strattera®)*<br>*clonidine ER (generic Kapvay®)*<br>****modafinil*<br>****Nuvigil ™ (AG)*<br>****Provigil®(AG)*<br>*Intuniv®* | |
| **Dermatologic** | | | |
| | ***Acne Agents, Topical** *(AG)* | | |
| | **Combo Benzoyl Peroxide , Clindamycin, Erythromycin Topical** | | LENGTH OF AUTHORIZATIONS: 1 year<br><br>**Routine PDL edits plus**<br><br>***Clinical Criteria for Dermatologic Acne Agents**<br>• Prescriptions for members over the age of 18 years will require the submission of a SA to evaluate treatment diagnosis; **AND**<br>• Drugs are intended for acne **only. SA for a cosmetic indication cannot be approved.** |
| | **benzoyl peroxide wash/cr/gel/lotion (OTC)**<br>**Benzaclin®**<br>**Benzaclin® Pump**<br>**clindamycin phosphate sol**<br>**erythromycin solution**<br>**Panoxyl-4 Acne Cr Wash (OTC)**<br>**Panoxyl 10 OTC** | *Acanya™ w/pump*<br>*Acne Clearing System® (OTC)*<br>*Aczone® Gel and Gel Pump*<br>*Avar Cleanser, Medicated Pad*<br>*Avar-E*<br>*Avar-E LS*<br>*Avar LS Cleanser, Medicated Pad*<br>*Azelex®*<br>*Benzamycin*<br>*BP 10-1* | |

| | Preferred Agents | Non-Preferred Agents | SA Criteria |
|---|---|---|---|
| | | *Benzefoam™ regular &Ultra™*<br>*Benzepro*<br>*benzoyl peroxide wash/cr/gel/ lotion/foam/towelette (RX)*<br>*benzoyl peroxide 6% , 9% cleanser (OTC)*<br>*BPO Kit*<br>*Cleocin T®*<br>*Clindacin™ Pac Kit*<br>*Clindagel®*<br>*clindamycin/benzoyl peroxide (Benzaclin®) & (Duac®) generics*<br>*clindamycin phosphate foam, el, lotion, med swab*<br>*clindamycin/tretinoin (generic Veltin®)*<br>*Delos™ Lotion™*<br>*Duac® gel*<br>*erythromycin gel, med. swab*<br>*Evoclin™*<br>*Inova™*<br>*Lavoclen ™ Cleanser & Kit*<br>*Neuac™ topical/kit*<br>*Onexton™ gel & w/Pump*<br>*Ovace Wash, Ovace Plus Cream ER, Cleanser ER, Lot, Shampoo, Wash*<br>*Pacnex®HP & LP*<br>*Panoxyl® 3% cr OTC*<br>*Promiseb ® Complete*<br>*Rosula Cleanser*<br>*Se BPO ® Wash Kit & cleanser*<br>*Sulfacetamide Cleanser ER*<br>*Sulfacetamide Cleanser, Shampoo, Susp*<br>*Sulfacetamide Sodium/Sulfur Cr, Susp, Sunscreen* | |

| | Preferred Agents | Non-Preferred Agents | SA Criteria |
|---|---|---|---|
| | | *SSS 10-5 Foam*<br>*Sulfacetamide/Sulfur/Cleanser, Cleanser Kit, Lotion Med. Pad*<br>*Sulfacetamide / Sulfur / Urea Cleanser*<br>*Sumadan Wash, Kit*<br>*Sumadan XLT*<br>*Sumaxin CP Kit*<br>*Veltin®* | |
| | **Retinoids/Combinations , Topical** | | |
| | **Differin® 0.1% cr/gel/lot**<br>**Differin® 0.3% gel**<br>**Retin®A 0.025., 0.05, 0.1 % cr & 0.01, 0.025,% gel** | Acnefree® Severe Kit Otc<br>*adapalene 0.1% cr/gel/lot*<br>*adapalene 0.3% gel/gel w/pump*<br>*adapalene-benzoyl peroxide (generic Epiduo®)*<br>*Atralin® 0.05% gel*<br>*Avage® 0.1% cr*<br>*Avita® 0.025% cr/gel*<br>*Differin 0.1% gel OTC*<br>*Epiduo® & Epiduo® Forte Gel*<br>**Fabior™ 01% Foam (AG)*<br>*Renova® 0.02% cr/cr pump*<br>*Retin®-A Micro 0.04%, 0.1% gel*<br>*Retin®-A Micro* 0.08%, *0.04%, 0.1% pump*<br>*Tazorac® Cr& gel*<br>*tazarotene 0.1% cream*<br>*tretinoin 0.025, 0.1% cr & 0.01, 0.025, 0.05% gel*<br>*tretinoin microsphere 0.04% & 0.1% gel*<br>*Ziana® gel* | ***Age Edit for Fabior™ Foam**<br>• Member must be between the ages of 12 and 18 years of age |

VIRGINIA'S MEDICAID PROGRAM DMAS INNOVATION • QUALITY • VALUE

| | Preferred Agents | Non-Preferred Agents | SA Criteria |
|---|---|---|---|
| | **Antifungal Topical** | | |
| | **ciclopirox soln**<br>**clotrimazole cr (OTC)**<br>**clotrimazole soln (OTC)**<br>**clotrimazole-betamethasone cr**<br>**ketoconazole shampoo**<br>**ketoconazole cr**<br>**miconazole cr & spray (OTC)**<br>**nystatin Cr, Oint & powder**<br>**nystatin-triamcinolone cr & oint**<br>**terbinafine cr (OTC)**<br>**tolnaftate cr, powder & soln (OTC)** | *Alevazol® OTC*<br>*Azolen® Tincture OTC*<br>*Bensal HP®*<br>*Ciclodan® Kit*<br>*ciclopirox cr/shampoo/gel*<br>*ciclopirox kit*<br>*ciclopirox suspension*<br>*clotrimazole cr/ Solu RX*<br>*clotrimazole-betamethasone lot*<br>**CNL 8™ Kit*<br>*Desenex® Aero Powder (OTC)*<br>*econazole*<br>*Ertaczo®*<br>*Exelderm® cr & soln*<br>*Extina®*<br>*Fungi-Nail® (OTC)*<br>*Fungoid® Kit (OTC)*<br>*Fungoid® (OTC)*<br>**Jublia®*<br>*ketoconazole foam*<br>**Kerydin®*<br>*Lamisil AT® cr, gel (OTC)*<br>*Lamisil® Spray (OTC)*<br>*Loprox® Kit, Shampoo, susp*<br>*Lotrimin AF® cr (OTC)*<br>*Lotrimin Ultra® (OTC)*<br>*Lotrisone® cr*<br>***Luzu®*<br>*miconazole nitrate (OTC)*<br>*miconazole Oint (OTC)*<br>*Mentax®*<br>*Naftin® cr & gel*<br>*Naftifine CR*<br>*Nyata Kit®* | **<u>LENGTH OF AUTHORIZATIONS</u>: 6 months**<br><br>**Routine PDL edits plus**<br><br>**Select non-preferred topical Antifungals (CNL-8™, Jublia®, Kerydin™, Luzu®, Penlac®) require the submission of a Clinical SA. Refer to (Antifungal Topical SA Form)** |

| | Preferred Agents | Non-Preferred Agents | SA Criteria |
|---|---|---|---|
| | | *Nizoral A-D® Shampoo (OTC)*<br>*oxiconazole cr (generic Oxistat®)*<br>*Oxistat® cr*<br>*Oxistat® Lotion*<br>*Pediaderm AF®*<br>*PediPak®*<br>**Penlac®*<br>*Tinactin® Aero powder & spray (OTC)*<br>*tolnaftate aero powder & spray (OTC)*<br>*Vusion®* | |
| | **Immunomodulators Atopic Dermatitis** | | |
| | ***Elidel®** | **Eucrisa™*<br>***Dupixent ®(QL, AG)*<br>**Protopic®*<br>**tacrolimus* | **<u>LENGTH OF AUTHORIZATIONS</u>**: 1 year; EXCEPT Dupixent® 6 months<br><br>**Routine PDL edits plus**<br><br>***<u>Clinical Criteria for Elidel®, Eucrisa™, Protopic®& tacrolimus</u>**<br>• Member must have a FDA approved diagnosis:<br>  ○ Atopic dermatitis<br>  ○ Elidel® & Eucisa™: mild to moderate for ages > 2 years.<br>  ○ Protopic® 0.03%: moderate to severe for ages > 2 years.<br>  ○ Protopic® 0.1%: moderate to severe for ages > 18 years; **AND**<br>• Failure to topical corticosteroids (i.e., desonide, fluticasone propionate, hydrocortisone butyrate, etc.)<br><br>****<u>Clinical Criteria for Dupixent®</u>**<br>• ≥ 18 years of age; **AND**<br>• Diagnosis of moderate to severe atopic dermatitis with ≥ 1 of the following:<br>  ○ Involvement of at least 10% of body surface area (BSA); **OR**<br>  ○ Scoring Atopic Dermatitis (SCORAD) score of 20 or more; **OR**<br>  ○ Investigator's Global Assessment (IGA) with a score ≥ 3; **OR**<br>  ○ Eczema Area and Severity Index (EASI) score of ≥ 16; **OR** |

| | Preferred Agents | Non-Preferred Agents | SA Criteria |
|---|---|---|---|
| | | | ○ Incapacitation due to AD lesion location (e.g., head and neck, palms, soles, or genitalia); **AND**<br>• Prior documented trial and failure (or contraindication) of 1 topical corticosteroids of medium to high potency (e.g., mometasone, fluocinolone) and 1 topical calcineurin inhibitors (tacrolimus or pimecrolimus); **AND**<br>• Inadequant response to a 3 month minimum trial of at least 1 immunosuppressive systemic agent (e.g., cyclosporine, azathioprine, methotrexate, mycophenolate mofetil, etc.); **AND**<br>• Inadequant response (or is not a candidate) to a 3 month minimum trial of phototherapy (e.g., psoralens with UVA light [PUVA], UVB, etc) provided member has reasonable access to photo treatment; **AND**<br>• Is not pregnant; **AND**<br>• Is not concurrently receiving a live vaccine<br><br>**Renewal Criteria:** Member must:<br>• Continue to meet above criteria; **AND**<br>• Not have documented toxicity from the agent (e.g., hypersensitivity, conjunctivitis, keratitis, immunogenicity); **AND**<br>• Documented response compared to baseline as measured by measures used to qualify moderate to severe AD at baseline (e.g., pruritus, BSA involvement, EASI, IGA, SCORAD).<br><br>***Quantity limit Dupixent®***<br>*2 prefilled syringes for the initial dose, then 1 single-dose syringe every 14 days* |
| | **Psoriasis, Topical** | | |
| | **calcipotriene cr/oint/soln** | *Calcitrene®*<br>*calcitriol*<br>*Dovonex®*<br>**Enstilar ® Foam (AG)*<br>*Micanol®*<br>*Sorilux™* | **LENGTH OF AUTHORIZATIONS: 1 year**<br><br>**Routine PDL edits plus**<br><br>***Clinical Criteria for Enstilar ® Foam**<br>• Length of Authorization: 4 weeks |

| | Preferred Agents | Non-Preferred Agents | SA Criteria |
|---|---|---|---|
| | | *Taclonex® & Taclonex® Scalp*<br>*Vectical* | • Diagnosis of plaque psoriasis; **AND**<br>• Minimum age of 18 years |
| | **Rosacea Agents, Topical** | | |
| | **Metrocream®**<br>**Metrogel®**<br>**Metrolotion®** | **Finacea® foam and gel**<br>**metronidazole cr & gel, lot**<br>**Mirvaso®**<br>**Noritate®**<br>**Rosadan™ Kit**<br>**Soolantra®** | **LENGTH OF AUTHORIZATIONS: 1 year**<br><br>**Routine PDL edits** |
| | **Steroids** | | |
| | **Steroids, Topical Low Potency** | | **LENGTH OF AUTHORIZATIONS: 1 year**<br><br>**Routine PDL edits** |
| | **alclometasone dipropionate cr/oint**<br>**hydrocortisone cr/gel/lot/oint**<br>**aran** | *aqua glycolic HC*<br>*Capex® shampoo*<br>*Derma-smoothe-FS*<br>*desonate gel/cr/lot/oint*<br>*Desowen® lot*<br>*fluocinolone 0.01% oil*<br>*Micort™-HC*<br>*Pediaderm® HC*<br>*Pediaderm® TA*<br>*Texacort®* | |
| | **Steroids, Topical Medium Potency** | | |
| | **fluticasone propionate cr/oint**<br>**hydrocortisone butyrate cr/oint/soln/ emollient**<br>**mometasone furoate cr/oint/sol** | *betamethasone valerate foam*<br>*clocortolone cr*<br>*Cloderm®*<br>*Cordran® tape*<br>*Cutivate® cr/lot*<br>*Dermatop® cr/oint*<br>*Elocon® cr/oint/soln*<br>*fluocinolone acetonide cr/oint/soln*<br>*flurandrenolide cr, oint, tape*<br>*fluticasone propionate lot*<br>*hydrocortisone valerate cr/oint* | |

| | Preferred Agents | Non-Preferred Agents | SA Criteria |
|---|---|---|---|
| | | *Luxiq®*<br>*Momexin®*<br>*Pandel®*<br>*prednicarbate cr/oint*<br>*Synalar ®*<br>*Synalar TS®*<br>*Ticanase kit®* | |
| | **Steroids, Topical High Potency** | | **LENGTH OF AUTHORIZATIONS: 1 year** |
| | **betamethasone valerate cr/lot/oint**<br>**triamcinolone acetonide cr/lot/oint**<br>**fluocinonide sol** | *amcinonide cr/lot/oint*<br>*betamet diprop & prop gly cr/lot/oint*<br>*betamet diprop cr/foam/gel/lot/oint*<br>*DermacinRx® SilaPak™*<br>*DermacinRx® Silazone*<br>*DermacinRx® Therazole Pak*<br>*desoximetasone cr/gel/oint/spray*<br>*diflorasone diacetate cr/oint*<br>*Diprolene® lot/oint*<br>*DiproleneAF®cr*<br>*Ellzia™ Pak Kit*<br>*fluocinonide cr/ emollient/ gel/oint/soln*<br>*Halog® cr/oint*<br>*Kenalog® aerosol*<br>*Loprox® Suspension Kit*<br>**Sernivo™*<br>*Silazone® II Kit*<br>*Topicort ®cr/gel/oint/spray*<br>*Trianex® oint*<br>*triamcinolone spray*<br>*triamcinolone/dimethicone*<br>*Vanos®cr*<br>*Whytederm®Tdpak* | **Routine PDL edits**<br><br>***Clinical Criteria for Sernivo**™<br>• Length of Authorization: 4 weeks (treatment beyond 4 weeks is not recommended).<br>• Member must have diagnosis of mild to moderate plaque psoriasis: **AND**<br>• At least 18 years of age |

| | Preferred Agents | Non-Preferred Agents | SA Criteria |
|---|---|---|---|
| | **Steroids, Topical Very High Potency** | | |
| | **clobetasol emollient**<br>**clobetasol propionate cr/gel/oint/soln**<br>**halobetasol propionate cr/oint** | *Apexicon™ E*<br>*clobetasol lot/shampoo*<br>*clobetasol propionate foam/spray*<br>*Clobex® lot/shampoo/spray*<br>*Clodan® kit*<br>*Halonate®*<br>*Olux®*<br>*Olux®-E*<br>*Temovate® oint*<br>*Ultravate® cr/lotion/oint*<br>*Ultravate® PAC & Ultravate® X* | |
| **Endocrine and Metabolic Agents** | | | |
| | **Androgenic Agents (Testosterone – Topical)** | | |
| | **Androgel®** | *Androderm®*<br>*Axiron® soln*<br>*Fortesta®*<br>*Natesto Nasal Gel ®*<br>*Testim®*<br>*testosterone (generic for Androgel®)*<br>*testosterone (generic for Axiron®)*<br>*testosterone gel/packet/pump (generic for Vogelxo™)*<br>*testosterone (generic for Fortesta®)*<br>*Vogelxo™ gel/packet/pump* | **LENGTH OF AUTHORIZATIONS**: 1 year<br><br>**Routine PDL edits Plus**<br><br>**Clinical Criteria for all preferred and non-preferred** Androgenic Agents<br><br>Length of Authorization: 1 year<br><br>Routine PDL edit plus<br><br>INITIAL REVIEW CRITERIA<br>• Patient is > 18 years old; AND<br>• Patient is male; AND<br>• Patient has a diagnosis of primary or secondary hypogonadism; AND<br>• Patient does not have a history of prostate carcinoma or male breast carcinoma; AND<br>• Prescriber has submitted the results of two separate serum testosterone levels, each drawn in the morning, which indicate a serum testosterone level below the normal range within the last 6 months.<br>• Testosterone, normal range = 300 to 1,000 ng/dL<br>• Patients who meet criteria should be approved for the preferred agents -> androgel® gel packet or androgel® gel pump. |

| | Preferred Agents | Non-Preferred Agents | SA Criteria |
|---|---|---|---|
| | | | CONTINUATION OF THERAPY CRITERIA<br>• Patient has been compliant with treatment based on refill history<br>• Prescriber submits labs indicating patient has a normal serum testosterone level on therapy (normal range: 300-1,000 ng/dL) within the last 12 months. |
| | **Antihyperuricemics** | | |
| | **allopurinol**<br>**colchicine caps**<br>**Probenecid®**<br>**probenecid & colchicine** | *colchicine tabs*<br>*Colcrys®*<br>*Mitigare®*<br>*Uloric®*<br>***Zurampic®(QL, AG)* | **LENGTH OF AUTHORIZATIONS**: 1 year<br><br>**Routine PDL edits plus**<br><br>****Clinical Criteria for Zurampic®**<br>• Member has not achieved target serum uric acid levels (< 6 mg per dL; 355 µmol per L) with a xanthine oxidase inhibitor alone, **AND**<br>• Member must take in combination with a xanthine oxidase inhibitor, **AND**<br>• Minimum age restriction of 18 years of age<br>• *Quantity limit of 1 per day* |
| | **Contraceptives*(long-acting IUDs & injectable)** | | |
| | **Kyleena™**<br>***Liletta®***<br>**medroxyprogesterone 150mg**<br>**Mirena®**<br>***Nexplanon®***<br>**Paragard®**<br>***Skyla®*** | *Depo-Provera® 104mg and 150 mg* | **LENGTH OF AUTHORIZATIONS**: 1 year<br><br>**Routine PDL edits** |
| | **Diabetes Hypoglycemics: Injectable Amylin Analogs** | | |
| | | **SymLin®*<br>**SymLin® Pens* | **LENGTH OF AUTHORIZATIONS**: 1 year<br>***Clinical Criteria for Injectable Amylin Analogs**<br>• Member must have a history of at least a 90 day trial of insulin.<br>• SymLin® is only indicated as adjunct therapy with insulin. |

| | Preferred Agents | Non-Preferred Agents | SA Criteria |
|---|---|---|---|
| | | | • Member meeting ALL of the following criteria may be approved:<br>○ Diagnosis of Type 1 or 2 diabetes; **AND**<br>○ On insulin therapy; **AND**<br>○ Failure to achieve adequate glycemic control (HbA1c ≤ 6.5%) |
| | **Diabetes Hypoglycemics: Injectable Incretin Mimetics** | | |
| | **Byetta®** (exenatide)<br>**Bydureon™** (exenatide ER)<br>**Victoza®** (liraglutide) | *Adlyxin™ (lixisenatide)*<br>*Soliqua® 100/33 (insulin glargine & lixisenatide inj)*<br>*Tanzeum™ (albiglutide)*<br>*Trulicity™ (lixisenatide)*<br>*Xultophy® 1oo/3.6 (insulin glargine & lixisenatide inj)* | **LENGTH OF AUTHORIZATIONS**: 1 year<br>**Routine PDL edits** |
| | **Diabetes Hypoglycemics: Injectable Insulins** | | |
| | **Insulin Mix** | | **LENGTH OF AUTHORIZATIONS: 1 year**<br>**Routine PDL edits** |
| | **Humalog® Mix 50/50 vial**<br>**Humalog® Mix 75/25 vial**<br>**Humulin® 70/30 vial**<br>**Novolog® Mix 70/30 pen/vial** | *Humalog® Mix 50/50 Kwikpen*<br>*Humalog® Mix 75/25 Kwikpen*<br>*Humulin® 70/30 pen (OTC)*<br>*Novolin® 70/30 vial (OTC)* | |
| | **Insulin N** | | |
| | **Humulin® N vial (OTC)** | *Humulin® N pen*<br>*Novolin® N vial (OTC)* | |
| | **Insulin R** | | |
| | **Humulin® R vial** | *Novolin® R vial (OTC)* | |
| | **Long-Acting Insulins** | | |
| | **Lantus® Solostar® & vial** (insulin glargine inj)<br>**Levemir® pen/vial** (insulin detemir) | *Basaglar® KwikPen® (insulin glargine inj)*<br>*Toujeo® Solostar®(insulin glargine injection) 300 Units/mL* | |

| | Preferred Agents | Non-Preferred Agents | SA Criteria |
|---|---|---|---|
| | | *Tresiba® FlexTouch® Pen (insulin degludec) 100 U/ml, 200 U/ml* | |
| | **Rapid-Acting Insulins** | | |
| | **Humulin 500 U/M pen & vial**<br>**Humalog® vial**<br>**Novolog® cartridge/Flexpen/vial** | *Apidra® cartridge/Solostar/vial*<br>*Humalog® Cartridge*<br>*Humalog Kwikpen®*<br>*Humalog Jr. Kwikpen®*<br>*Afrezza® cartridge (inhalation)* | |
| | **Diabetes Oral Hypoglycemics** | | |
| | **Oral Hypoglycemics Alpha-Glucosidase Inhibitors** | | **<u>LENGTH OF AUTHORIZATIONS</u>**: 1 year<br><br>**Routine PDL edits** |
| | **acarbose** | *Glyset®*<br>*miglitol (generic Glyset®)*<br>*Precose®* | |
| | **Oral Hypoglycemics Biguanides** | | |
| | **metformin**<br>**metformin ER** (generic for Glucophage® XR) | *Fortamet®*<br>*Glucophage® IR & XR*<br>*Glutmetza®*<br>*Riomet® susp*<br>*metformin ER (generic Fortamet®)*<br>*metforman ER (generic Glumetza®)* | |
| | **Oral Hypoglycemics Biguanide Combination Drugs** | | |
| | **glyburide/metformin** | *glipizide/metformin*<br>*Glucovance®* | |
| | **Oral Hypoglycemics DPP-IV Inhibitors & Combination** | | |
| | **Janumet®**<br>**Janumet XR®**<br>**Januvia®**<br>**Jentadueto™** | *alogliptin (generic Nesina™)*<br>*alogliptin/metformin (generic Kazano™)* | |

| | Preferred Agents | Non-Preferred Agents | SA Criteria |
|---|---|---|---|
| | **Tradjenta™** | *alogliptin/pioglitazone (generic Oseni™)*<br>*Jentadueto XR™*<br>*Kazano™*<br>*Kombiglyze XR™*<br>*Nesina™*<br>*Onglyza™*<br>*Oseni™* | |
| | **Oral Hypoglycemics Meglitinides** | | |
| | **repaglinide**<br>**nateglinide** | *Prandin®*<br>*PrandiMet™*<br>*repaglinide/metformin*<br>*Starlix®* | |
| | **Oral Hypoglycemics Second Generation Sulfonylureas** | | |
| | **glimepiride**<br>**glipizide**<br>**glipizide ER**<br>**glyburide**<br>**glyburide micronized** | *Amaryl®*<br>*Diabeta®*<br>*Glucotrol®*<br>*Glucotrol XL®*<br>*Glynase®* | |
| | ***Oral Hypoglycemics Sodium Glucose Co-Transporter 2 Inhibitor** | | **Routine PDL Edits plus** |
| | **Farxiga™ (AG)**<br>**Invokana™ (AG)** | *Glyxambi® (AG)*<br>*Invokamet™ ( AG)*<br>*Invokamet™ XR (AG)*<br>*Jardiance®(AG)*<br>*Synjardy® (AG)*<br>*Synjardy® XR (AG)*<br>*Xigduo™ XR (AG)* | ***Clinical Criteria/Step edit for non-preferred Sodium Glucose Co-Transporter 2 (SGLT2)**<br>**Length of Authorization: Initial approval for 6 months. Renewals for 1 year.**<br>• Approve for Type 2 diabetics who have been compliant with and have not achieved adequate glycemic control **with metformin**; **OR**<br>• Are intolerant to metformin; **AND**<br>• Member must be > 18 years of age. |

| Preferred Agents | Non-Preferred Agents | SA Criteria |
|---|---|---|
| **Oral Hypoglycemics Thiazolidinediones** | | |
| **pioglitazone** | *Avandia®*<br>*Actoplus Met® IR & XR*<br>*Actos®*<br>*Avandaryl®*<br>*Avandamet®*<br>*Duetact®*<br>*pioglitazone/metformin*<br>*pioglitazone/glimepiride* | |
| **Erythropoiesis Stimulating Proteins** | | |
| **Aranesp®**<br>**Procrit®** | *Epogen®*<br>*Mircera®* | **LENGTH OF AUTHORIZATIONS**: for duration of the prescription up to 6 months<br>**Routine PDL edits**<br>*Omontys® is not PDL eligible, may be covered under medical benefit* |
| **Glucocorticoids, Oral** | | |
| **budesonide EC**<br>**dexamethasone soln/tab**<br>**hydrocortisone**<br>**methylprednisolone tab ds pk**<br>**methylprednisolone 4mg tab**<br>**prednisolone sodium phosphate soln**<br>**prednisolone soln**<br>**prednisone soln/tab/tab ds pk** | *Cortef®*<br>*cortisone acetate*<br>*dexamethasone elixir/intensol*<br>*Dexpak®*<br>**Emflaza™ (AG)*<br>*Entocort® EC*<br>*Flo-Pred®*<br>*Medrol ®Tab ds pk & tab*<br>*methylprednisolone 8,16 & 32mg tab*<br>*Millipred DP® tab Ds Pk*<br>*Millipred® soln/tab*<br>*Orapred ®ODT*<br>*prednisolone sod phosphate ODT, soln*<br>*prednisone intensol*<br>*Rayos® DR tab*<br>*Veripred®* | **LENGTH OF AUTHORIZATIONS**: **1 year**<br>**Routine PDL edits plus**<br>***Clinical Criteria for Emflaza™**<br>• Trial and failure of all drugs does not apply to Emflaza™<br>• Indicated for the treatment of Duchenne muscular dystrophy (DMD) in members 5 years of age and older.<br>• Minimum Age Limit = 5 years of age |

| | Preferred Agents | Non-Preferred Agents | SA Criteria |
|---|---|---|---|
| | ***Growth Hormone** | | |
| | **Genotropin®**<br>**Nutropin AQ® NuSpin™** | *Humatrope® cartridge/vial*<br>*Norditropin cartridge®*<br>*Norditropin FlexPro®& Nordiflex®*<br>*Omnitrope®*<br>*Saizen® cartridge/vial*<br>*Serostim®*<br>*Tev-Tropin®*<br>*Zomacton®*<br>*Zorbtive®* | **LENGTH OF AUTHORIZATIONS**: 1 year<br><br>**ALL Growth Hormone drugs (preferred and non-preferred) require the submission of a Clinical SA. Refer to (Growth Hormone SA Fax Form)** |
| | ***Hereditary Angioedema (HAE) Agents** | | |
| | **Berinert®**<br>**Cinryze™**<br>**Kalbitor®** | *Firazyr®*<br>*Haegarda®*<br>*Ruconest®* | **LENGTH OF AUTHORIZATIONS:** Date of service<br><br>**Routine PDL edits plus**<br><br>***_ALL Hereditary Angioedema drugs (preferred and non-preferred) require the submission of a Clinical SA. Refer to (Hereditary Angioedema (HAE) SA Form)** |
| | **Pancreatic Enzymes** | | |
| | ***Creon®**<br>***Zenpep®** | *Pancreaze®*<br>*Pertzye®*<br>*Ultresa®*<br>*Viokace®* | **LENGTH OF AUTHORIZATION:** 1 year<br><br>**Routine PDL edits plus**<br><br>**Clinical Criteria for Pancreatic Enzymes**<br>***Creon®and Zenpep®:** diagnosis of pancreatic insufficiency due to cystic fibrosis or chronic pancreatitis or pancreatectomy.<br><br>• For all drugs if member has a diagnosis of Cystic Fibrosis they do not have to try and fail a preferred.<br>• If member has a feeding tube then two different pancreatic enzymes can be approved for use together. |
| | **Progestational Agents** | | |
| | **Makena Single Dose Vial (SDV)** | *Aygestin®*<br>*Crinone (Vaginal)* | **LENGTH OF AUTHORIZATIONS**: 1 year<br><br>**Routine PDL edits** |

| | Preferred Agents | Non-Preferred Agents | SA Criteria |
|---|---|---|---|
| | **medroxyprogesterone acetate (tab only)**<br>**norethindrone acetate**<br>**progesterone cap & injection** | *Depo-Provera 400 MG/ML*<br>*hydroxyprogesterone caproate IM*<br>*Makena Multi Dose Vial (MDV)*<br>*Prometrium®*<br>*Provera®* | |
| | **Progestins Used For Cachexia** | | |
| | **megestrol acetate** | *Megace®*<br>*Megace® ES*<br>*megestrol suspension ES* | **LENGTH OF AUTHORIZATIONS**: 1 year<br><br>**Routine PDL edits** |
| | **Vaginal/Oral Estrogens** | | |
| | **Premarin® Vaginal cr**<br>**Vagifem® Vaginal tab** | *Estrace ®Vaginal cr*<br>*Estring® Vaginal ring*<br>*Femring® Vaginal ring*<br>*Intrarosa™*<br>*Osphena® tab*<br>*Yuvafem®* | **LENGTH OF AUTHORIZATIONS**: 6 months<br><br>**Routine PDL edits** |
| **Gastrointestinal** | | | |
| | **G I Antibiotics** | | |
| | **metronidazole tab**<br>**vancomycin cap** | *Alinia®*<br>*Dificid®*<br>*Flagyl® cap, tab & ER*<br>*metronidazole cap*<br>*neomycin*<br>*paromomycin*<br>*Tindamax®*<br>*tinidazole*<br>*Xifaxan®*<br>*vancomycin compounded oral soln kit*<br>*Vancocin®* | **Length of authorization:** 1 year<br><br>**Routine PDL edits plus**<br><br>***All non-preferred GI Antibiotics require the submission of a Clinical SA. Refer to GI Antibiotics SA Form** |

| Preferred Agents | Non-Preferred Agents | SA Criteria |
|---|---|---|
| ***Antiemetic/Antivertigo Agents** | | |
| **Cannabinoids (delta-9THC derivatives)** | | **LENGTH OF AUTHORIZATIONS:** 6 months<br>***Dronabinol plus all non-preferred Antiemetic/Antivertigo agents require submission of a Clinical SA. Refer to (Antiemetic/Antivertigo SA form)** |
| ***dronabinol** | **Cesamet®*<br>**Marinol ®*<br>**Syndros™* | |
| **5HT3 Receptor Blockers** | | **LENGTH OF AUTHORIZATIONS:** 3 months, unless otherwise noted<br><br>**Routine PDL edits plus** |
| **ondansetron ODT/tab** | *Anzemet®*<br>*Akynzeo®*<br>*granisetron*<br>*Granisol ® soln/tab*<br>*Kytril®*<br>*ondansetron soln*<br>*Sancuso® ® patch*<br>*Zofran®*ODT/soln/tab<br>*Zuplenz® film* | |
| **NK-1 Receptor Antagonist** | | **LENGTH OF AUTHORIZATIONS:** Length of chemotherapy regimen or a maximum of 6 months |
| | *aprepitant capsule/pack*<br>*Emend® Bi Pak*<br>*Emend® cap*<br>*Emend® Tri-fold pack*<br>*Emend® susp*<br>*Varubi ™* | |
| **Other** | | **LENGTH OF AUTHORIZATIONS:** 1 year, unless otherwise noted<br><br>**Promethazine approved for members ≥ 2 years |
| **meclizine**<br>**metoclopramide**<br>**ondansetron tab & ODT**<br>**prochlorperazine**<br>****promethazine** *(AG)* | *Antivert®*<br>*Compazine® supp/tab*<br>*Compro®*<br>*Diclegis®*<br>*dimenhydrinate*<br>*hydroxyzine*<br>*Metozolv® ODT*<br>*metoclopramide ODT*<br>****Phenergan®*** | |

| | Preferred Agents | Non-Preferred Agents | SA Criteria |
|---|---|---|---|
| | | *prochlorperazine supp*<br>***promethazine 50mg supp*<br>*Reglan®*<br>*scopolamine (generic Transderm-Scop® )*<br>*Tigan®*<br>*Transderm-Scop®*<br>*trimethobenzamide*<br>*Vistaril®* | |
| | ***GI Motility, Chronic** | | |
| | **Amitiza®**<br>**Linzess™**<br>***Movantik®*** | *alosetron*<br>*Lotronex®*<br>*Relistor®*<br>*Trulance™*<br>*Viberzi™* | **LENGTH OF AUTHORIZATIONS**: 6 months<br><br>**Routine PDL edits plus**<br><br>***All GI Motility drugs (preferred and non-preferred) require the submission of a Clinical SA. Refer to (Chronic GI Motility SA form)** |
| | **H. Pylori Treatment** | | |
| | **Pylera®** | *Omeclamox®-Pak*<br>*lansoprazole/amoxicillin/ clarithromycin*<br>*Prevpac®* | **LENGTH OF AUTHORIZATIONS**: 14 days<br><br>**Routine PDL edits** |
| | **Histamine-2 Receptor Antagonists (H-2 RA)** | | |
| | **famotidine (OTC & RX)**<br>**ranitidine tab/syrup (OTC & RX)** | *cimetidine tab/syrup (OTC/RX)*<br>*famotidine oral susp (OTC/RX)*<br>*nizatidine cap/susp*<br>*Pepcid ® susp/tab (OTC/RX)*<br>*ranitidine cap (OTC/RX)*<br>*Zantac® syrup/ tab (OTC/RX)* | **LENGTH OF AUTHORIZATIONS**: 1 year<br><br>**Routine PDL edits** |
| | **Proton Pump Inhibitors** | | |
| | **omeprazole (RX & OTC)**<br>**pantoprazole** | *Aciphex® DR tab/sprinkle*<br>*Dexilant®* | **LENGTH OF AUTHORIZATIONS**: 12 weeks; unless member meets an exception; then 1 year |

| | Preferred Agents | Non-Preferred Agents | SA Criteria |
|---|---|---|---|
| | | *esomeprazole magnesium*<br>*esomeprazole strontium*<br>*lansoprazole cap*<br>*Nexium®*<br>*omeprazole/sodium bicarbonate*<br>*Prevacid® RX, OTC& Solutab*<br>*rabeprazole DR tab*<br>*Prilosec® Rx & Susp*<br>*Protonix®*<br>*Zegerid® cap, OTC & susp packet* | **Routine PDL edits plus**<br><br>***All non-preferred Proton Pump Inhibitors require submission of a Clinical SA. Refer to (Proton Pump Inhibitor SA form)** |
| | **Ulcerative Colitis Oral and Rectal Preparations (5-ASA DERIVATIVES)** | | |
| | **Ulcerative Colitis – Oral** | | **LENGTH OF AUTHORIZATIONS: 1 year**<br><br>**Routine PDL edits**<br><br>*Giazo is limited to an 8 week supply |
| | **Apriso®**<br>***Lialda®***<br>**Pentasa®**<br>**sulfasalazine DR & IR** | *Asacol ®HD*<br>*Azulfidine® IR &DR*<br>*balsalazide disodium*<br>*Colazal®*<br>*Delzicol™*<br>*Dipentum*<br>**Giazo™ (QL)*<br>*mesalamine (generic Asacol® HD)*<br>*mesalamine (generic Lialda®)*<br>*Uceris™* | |
| | **Ulcerative Colitis – Rectal** | | |
| | **Canasa® rectal supp**<br>**mesalamine enema** | *mesalamine kit*<br>*Rowasa® enema/kit*<br>*SFRowasa®*<br>*Uceris®* | |
| **Genitourinary** | | | |
| | **Alpha-Blockers and Androgen Hormone Inhibitors For Benign Prostatic Hypertrophy (BPH)** | | |
| | **Alpha-Blockers for BPH** | | **LENGTH OF AUTHORIZATIONS: 1 year**<br><br>**Routine PDL edits plus** |
| | **alfuzosin**<br>**tamsulosin HCL** | *Flomax ®*<br>*Rapaflo®*<br>*Uroxatral®* | |

| | Preferred Agents | Non-Preferred Agents | SA Criteria |
|---|---|---|---|
| | **Androgen Hormone Inhibitors for BPH** | | |
| | **dutasteride**<br>**finasteride** | *Avodart ®*<br>*Dutasteride./tamsulosin*<br>*Jalyn®*<br>*Proscar®* | |
| | **Phosphodiesterase (PDE) 5 Inhibitor for BPH** | | |
| | | **Cialis® (ST)* | ***Step edit for Cialis® -** trial and failure of Alpha Blockers and Androgen Inhibitors for BPH. Prescriber must attest that the member is not on the state's sex offenders list. Consult or evaulation by an Urologist. |
| | **Urinary Antispasmodics (Bladder Relaxant)** | | |
| | **oxybutynin tab/syrup**<br>**Toviaz™**<br>**VESIcare®** | *darifenacin ER (generic Enablex®)*<br>*Detrol® & Detrol® LA*<br>*Ditropan® & *Ditropan® XL*<br>*Enablex®*<br>*flavoxate*<br>*Gelnique™ gel, gel Pump*<br>*Myrbetriq™*<br>**oxybutynin ER*<br>*Oxytrol® transdermal*<br>*Sanctura XR*<br>*trospium IR & ER*<br>*tolterodine IR & ER* | **LENGTH OF AUTHORIZATIONS**: 1 year<br>**Routine PDL edits plus**<br>***Clinical Criteria for Oxybutynin ER, Ditropan XL®:**<br>• Allow PDL exception for children age 6-18 with a diagnosis of neurogenic bladder. |
| **Immunological Agents** | | | |
| | **Multiple Sclerosis** | | |
| | **Avonex®**<br>**Avonex® Adm Pack**<br>**Betaseron®**<br>**Copaxone 20 mg syringe®**<br>***Gilenya® *(ST)***<br>**Rebif® SQ**<br>**Rebif® Rebi dose Pen®** | ***Ampyra®*<br>*Aubagio®*<br>*Copaxone® 40 mg syringe®*<br>*Extavia® Kit*<br>*Glatopa™*<br>*Plegridy®*<br>*Tecfidera™*<br>****Zinbryta™ (QL)* | **LENGTH OF AUTHORIZATIONS**: 1 year<br>**Routine PDL edits plus**<br>***Step Edit for Gilenya®** - a trial and failure of a preferred injectable drug. In order to receive a non-preferred oral drug both an injectable preferred and Gilenya® must have been tried and failed. |

| | Preferred Agents | Non-Preferred Agents | SA Criteria |
|---|---|---|---|
| | | | ****Select non-preferred MS drugs (Amprya®, Zinbryta™) require the submission of a Clinical SA. Refer to (MS - Ampyra® SA form); and Zinbryta™ SA Form** <br><br> ******Zinbryta™*** Quantity Limit = 1 ml per 28 days (0.036 ml per day). |
| | **Cytokine and CAM Antagonists And Related Agents** | | |
| | **Enbrel®**<br>**Humira®**<br>**methotrexate tab/PF vial/vial** | *Actemra® SQ*<br>*Cimzia® & Cimzia® Syringe Kit*<br>*Cosentyx™*<br>*Kevzara®*<br>*Kineret®*<br>*Otezla®*<br>*Otrexup®*<br>*Orencia®*<br>*Rasuvo™*<br>*Siliq®*<br>*Simponi®*<br>*Taltz®*<br>*Tremfya™*<br>*Trexall®*<br>*Xatmep™ soln*<br>*Xeljanz™ & Xeljanz™ XR* | **LENGTH OF AUTHORIZATION**: 1 year <br><br> **Routine PDL edits plus** <br><br> ***All non-preferred Cytokine and CAM Antagonists require submission of a Clinical SA. Refer to Cytokine and CAM Antagonists SA form (Otrexup® SA Form); (Xeljanz™ SA Form)** |
| **Ophthalmic** | | | |
| | **Antibiotics** | | |
| | **ciprofloxacin drops**<br>**erythromycin**<br>**gentamicin drops/oint**<br>**Moxeza® drops**<br>**neomycin/polymix/gramicidin**<br>**ofloxacin drops**<br>**polymyxin/trimethoprim**<br>**sulfacetamide soln**<br>**tobramycin** | *AzaSite™ drops*<br>*bacitracin*<br>*bacitracin/polymyxin b sulfate oint*<br>*Besivance® drops*<br>*Bleph®-10*<br>*Ciloxan® drops/oint*<br>*Garamycin ®drops/oint*<br>*gatifloxacin 0.5% soln*<br>*Ilotycin®* | **LENGTH OF AUTHORIZATIONS**: Date of service only; no refills <br><br> **Routine PDL edits** |

| | Preferred Agents | Non-Preferred Agents | SA Criteria |
|---|---|---|---|
| | **Vigamox® drops** | *levofloxacin drops*<br>*moxifloxacin drops (generic Vigamox®)*<br>*Natacyn®*<br>*neomycin/bacitracin/polymyxin oint*<br>*Neosporin ®*<br>*Ocuflox® drops*<br>*Polytrim®*<br>*sulfacetamide oint*<br>*Tobrex® drops/oint*<br>*Zymaxid® drops* | |
| | **Antibiotic/Steroid Combinations** | | |
| | **neomycin/polymyxin/dexamethasone oint/susp**<br>**Tobradex® oint/susp** | *Blephamide®*<br>*Blephamide® S.O.P.*<br>*Maxitrol® oint/susp*<br>*neomycin/bacitracin/poly/HC*<br>*neomycin/polymyxin/HC*<br>*Pred-G® oint/susp*<br>*sulfacetamide/prednisolone*<br>*Tobradex® ST*<br>*tobramycin/dexamethasone susp*<br>*Zylet®* | **LENGTH OF AUTHORIZATION**: Date of service only; no refills<br><br>**Routine PDL edits** |
| | **Antihistamines/Mast Cell Stabilizers** | | |
| | **Antihistamines** | | **LENGTH OF AUTHORIZATIONS:** 1 year<br><br>**Routine PDL edits**<br><br>*Ilevro™ is limited to 1 bottle plus 1 refill |
| | **Alaway OTC®**<br>**ketotifen fumerate**<br>**Pazeo®**<br>**Zaditor® OTC drops** | *Bepreve®*<br>*Elestat® drops*<br>*Emadine® drop*<br>*epinastine 0.05% eye drops*<br>**Ilevro™ 0.3% drops(QL)*<br>*Lastacaft® drops*<br>*olopatadine*<br>*Optivar® drops*<br>*Patanol® drops*<br>*Pataday® drops* | |

| Preferred Agents | Non-Preferred Agents | SA Criteria |
|---|---|---|
| **Mast Cell Stabilizers** | | |
| **cromolyn sodium** | *Alocril® drops*<br>*Alomide® drops* | |
| **Anti-inflammatory Agents** | | |
| **NSAIDS** | | **LENGTH OF AUTHORIZATIONS**: Date of service only; no refills<br>**Routine PDL edits**<br>*Ilevro™ is limited to 1 bottle plus 1 refill |
| **diclofenac sodium**<br>**flurbiprofen sodium**<br>**ketorolac 0.4%& 0.5%** | *Acular® 0.5% & LS® 0.4%*<br>*Acuvail®*<br>*bromfenac 0.09%*<br>*BromSite ™*<br>**Ilevro™0.3% drops (QL)*<br>*Nevanac®*<br>*Ocufen®*<br>*Prolensa™* | |
| **Corticosteriods** | | |
| **Durezol®**<br>**fluorometholone**<br>**prednisolone acetate** | *Alrex™*<br>*dexamethasone*<br>*Flarex®*<br>*FML®, FML Forte® & FML® S.O.P.*<br>*Lotemax™ drops/gel/oint*<br>*Maxidex®*<br>*Omnipred®*<br>*Pred Forte® & Pred Mild®*<br>*prednisolone sod phosphate*<br>*Vexol®* | |
| **Glaucoma Agents** | | |
| **Alpha 2 Adrenergic Agents** | | **LENGTH OF AUTHORIZATIONS**: 1 year<br>**Routine PDL edits** |
| **Alphagan P® 0.1 & 0.15%**<br>**brimonidine 0.2%** | *apraclonidine 0.5% drops*<br>*brimonidine tartrate 0.15%*<br>*Iopidine® 0.5% & 1%* | |
| **Beta Blockers** | | |
| **Betoptic-S® 0.25%**<br>**carteolol 1%**<br>**Combigan®**<br>**levobunolol 0.5%** | *Betagan® 0.5%*<br>*betaxolol 0.5%*<br>*Istalol® 0.5%*<br>*Timoptic® drops 0.25% & 0.5%* | |

| | Preferred Agents | Non-Preferred Agents | SA Criteria |
|---|---|---|---|
| | **metipranolol 0.3%**<br>**timolol maleate** | *Timoptic® XE 0.25% & 0.5% sol-gel* | |
| | **Carbonic Anhydrase Inhibitors** | | |
| | **Azopt® 1%**<br>**dorzolamide**<br>**dorzolamide/timolol**<br>**Simbrinza™** | *Cosopt® 0.5%-2%*<br>*Cosopt® PF*<br>*Trusopt® 2%* | |
| | **Prostaglandin Analogs** | | |
| | **latanoprost**<br>**Travatan Z®** | *bimatoprost*<br>*Lumigan® 0.03% & 0.01%*<br>*Rescula®*<br>*travoprost 0.004%*<br>*Xalatan® 0.005%*<br>*Zioptan™* | |
| **Respiratory** | | | |
| | ***Anti-Allergens, Oral** | | |
| | | **Grastek® SL*<br>***Oralair® SL*<br>****Ragwitek™ SL* | **LENGTH OF AUTHORIZATIONS**: 1 year<br><br>***All non-preferred Anti-Allergen drugs require the submission of a Clinical SA. Refer to (Anti-Allergens, Oral SA Form)** |
| | **Antihistamines: First and Second Generation** | | |
| | **First Generation Antihistamines** | | **LENGTH OF AUTHORIZATIONS**: 1 year<br><br>**Routine PDL edits** |
| | **Generic only class** | *All Brands require a SA* | |
| | **Second Generation Antihistamines and Combinations** | | |
| | **cetirizine liquid 1mg/1mL (RX/OTC)**<br>**cetirizine tabs OTC**<br>**levocetirizine Tablets**<br>**loratadine tab/syrup OTC** | *Allegra-D®*<br>*cetirizine chew tab (OTC)*<br>*cetirizine liquid 5mg/5mL (OTC)*<br>*cetirizine D tab (OTC)*<br>*Clarinex®*<br>*Clarinex-D®*<br>*Claritin®*<br>*Claritin® D*<br>*desloratadine ODT* | |

| | *Preferred Agents* | *Non-Preferred Agents* | *SA Criteria* |
|---|---|---|---|
| | | *fexofenadine*<br>*fexofenadine/PSE ER*<br>*fexofenadine suspension*<br>*loratadine ODT*<br>*loratadine D 12 & 24 hr*<br>*Xyzal® sol & tab (RX ,OTC)* | |

## Beta-Adrenergic Agents

### Long Acting Beta Adrenergic s (LABA) MDIs or Nebulizers

| *Preferred Agents* | *Non-Preferred Agents* |
|---|---|
| **Foradil®** *(AG)*<br>**Serevent Diskus®** *(AG)* | *Arcapta DS(AG)*<br>*Brovana®(AG)*<br>*Perforomist® (AG)*<br>*Striverdi® Respimat (AG)* |

**SA Criteria:**

<u>**LENGTH OF AUTHORIZATIONS**</u>: 1 year

**Routine PDL edits plus**

<u>**Clinical Criteria for LABAs for Children**</u>
**LENGTH OF AUTHORIZATION: 3 months**
Each drug listed below will require a SA for ages less than the FDA/PI indicated age.

| Brand Name | Age where SA is required | FDA Indications |
|---|---|---|
| Advair ®Diskus2 50/50, & 500/50 | Children < 12 | Asthma & COPD |
| Advair ®HFA | Children < 12 | Asthma & COPD |
| Advair® Diskus 100/50 | Children < 4 | Asthma & COPD |
| Airduo ™ Respiclick® | Children < 12 | Asthma only |
| Anoro™ Ellipta | Children & Adolescents < 18 | COPD only |
| Arcapta® Neohaler | Children & Adolescents < 18 | COPD only |
| Bevespi Aerosphere™ | Children & Adolescents < 18 | COPD only |
| Breo®Ellipta™ | Children & Adolescents < 18 | Asthma & COPD |
| Brovana® | Children & Adolescents < 18 | COPD only |
| Dulera® | Children < 12 | Asthma only |
| fluticasone/salmeterol pow | Children < 12 | Asthma only |
| Foradil® Aerolizer | Children < 5 | Asthma & COPD |
| Perforomist® | Children & Adolescents < 18 | COPD only |
| Serevent® Diskus | Children < 4 | Asthma & COPD |
| Stiolto™ Respimat® | Children < 18 years | COPD only |
| Striverdi® Respimat | Children < 18 years | COPD only |
| Symbicort® | Children < 12 | Asthma & COPD |

| Preferred Agents | Non-Preferred Agents | SA Criteria |
|---|---|---|
| **Short Acting Metered Dose Inhalers or Devices** | | |
| **Proair® HFA**<br>**Proventil® HFA** | *levalbuterol tartrate HFA*<br>*ProAir® RespiClick*<br>*Ventolin® HFA*<br>*Xopenex® HFA* | |
| **Short Acting Nebulizers** | | |
| **albuterol sulfate (premixed)** | *levalbuterol soln*<br>*Xopenex®* | |
| **COPD: Bronchodilators and Phosphodiesterase 4 (PDE4) Inhibitors** | | |
| **Atrovent HFA®**<br>***Bevespi Aerosphere™***<br>**Combivent® Respimat**<br>**ipratropium bromide soln**<br>**ipratropium/albuterol nebs**<br>**Spiriva®** | *Anoro™ Ellipta® (AG)*<br>**Daliresp®*<br>*Incruse™ Ellipta®*<br>*Seebri Neohaler™*<br>*Spiriva® Respimat*<br>*Stiolto Respimat™ (AG)*<br>*Tudorza™*<br>*Utibron Neohaler™* | **<u>LENGTH OF AUTHORIZATION</u>**: 1 year<br><br>**Routine PDL edits plus**<br><br>***<u>Clinical Criteria for Daliresp®</u>**<br>• If the member has a diagnosis of severe COPD associated with chronic bronchitis and a history of exacerbations; **AND**<br>• Trial/failure on at least one first-line or second-line agent (inhaled anticholinergics, long acting beta agonists or inhaled corticosteroids); **AND**<br>• Adjunctive therapy (Daliresp® must be used in conjunction with first-line or second-line agent). |
| **Corticosteroids: Inhaled and Nasal Steroids** | | |
| **Inhaled Corticosteroids: Combination Drugs (Glucocorticoid and Long Acting Beta Adrenergic)** | | **<u>LENGTH OF AUTHORIZATIONS</u>**: 1 year<br><br>**Routine PDL edits** |
| ***Advair® Diskus** *(AG)*<br>***Dulera®***(AG)*<br>***Symbicort®***(AG)* | *Advair® HFA(AG)*<br>*Airduo™ Respiclick® (AG)*<br>*Breo® Ellipta™ (AG)*<br>*fluticasone/salmeterol powder (AG)* | |
| **Inhaled Corticosteroids: Metered Dose Inhalers** | | |
| **Asmanex®**<br>**Flovent® Diskus & HFA**<br>**Pulmicort Flexhaler®**<br>**QVAR®** | *Alvesco®*<br>*Aerospan™*<br>*Armonair™ Respiclick®*<br>*Arnuity™ Ellipta®*<br>*Asmanex HFA®* | |

| | *Preferred Agents* | *Non-Preferred Agents* | *SA Criteria* |
|---|---|---|---|
| | **Inhaled Corticosteroids: Nebulizer Solution** | | |
| | **Pulmicort® Respules** | *Budesonide* | |
| | **Nasal Steroids** | | |
| | **fluticasone** | *Beconase AQ®*<br>*budesonide (generic for Rhinocort® Aqua)*<br>*budesonide (generic Rhinocort® Allergy OTC)*<br>*Children's Qnasl™*<br>*Clarispray OTC*<br>*Dymista™*<br>*Flonase®*<br>*Flonase Sensimist (OTC)*<br>*flunisolide*<br>*fluticasone OTC*<br>*mometasone(generic Nasonex®)*<br>*Nasonex®*<br>*Omnaris®*<br>*Qnasl™*<br>*Rhinocort Aqua®*<br>*Rhinocort® Allergy OTC*<br>*Ticanase®*<br>*triamcinolone OTC*<br>*triamcinolone acetonide*<br>*Veramyst®*<br>*Zetonna™* | |
| | ***Cough and Cold Drugs** | | |
| | **Ala-Hist DM**<br>**benzonatate cap**<br>**codeine/ promethazine**<br>**guaifenesin/codeine phosphate**<br>**hydrocodone/ homatropine** | ***lohist-DM syrup***<br>*All other Legend cough and cold drugs are non-preferred*<br>*Tessalon ® perle* | **LENGTH OF AUTHORIZATION**: Date of Service Only<br><br>**Routine PDL edits**<br><br>*** Children under the age of 6 years are not eligible for cough and cold drugs.** |

| | *Preferred Agents* | *Non-Preferred Agents* | *SA Criteria* |
|---|---|---|---|
| | **Iophen-C NR**<br>**phenylephrine HCl/promethazine HCl**<br>**promethazine DM syrup**<br>**Tusnel® Pediatric Drops** | | |
| | **Epinephrine, Self-Injected** | | |
| | **epinephrine 0.15 mg & 0.3 mg (authorized generic EpiPen & EpiPen Jr)** | **Auvi-Q®**<br>**Epipen®**<br>**Epipen® Jr**<br>**epinephrine 0.15 mg & 0.3mg (generic Adrenaclick)** | **LENGTH OF AUTHORIZATIONS**: **1 year**<br><br>**Routine PDL edits** |
| | **Intranasal Antihistamines** | | |
| | **azelastine 0.1%**<br>**Patanase®** | *Astepro® 0.15%*<br>*olopatadine* | **LENGTH OF AUTHORIZATIONS**: 1 year<br><br>**Routine PDL edits** |
| | **Leukotriene Receptor Antagonists** | | |
| | **montelukast tabs/chew tabs** | *Accolate®*<br>*Singulair® tabs/chew tabs/granules*<br>*montelukast granules*<br>*zafirlukast*<br>*Zyflo™*<br>*Zyflo CR™*<br>*zileuton ER* | **LENGTH OF AUTHORIZATIONS**: 1 year<br><br>**Routine PDL edits** |