



Virginia Medicaid's Preferred Drug List (PDL)/ Common Core Formulary

7/1/19

Virginia Medicaid's Pharmacy Benefits Management System

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

General Information:

- Virginia Medicaid's Preferred Drug List (PDL)/ Common Core Formulary only includes select drug classes, other classes will pay such as but not limited to diuretics, many cardiac agents, many antibiotics etc.
- PDL preferred drugs do not require Service Authorizations (SA) unless subject to additional clinical criteria (e.g., long acting opioids, hepatitis C therapies, growth hormone)
- Non-preferred drugs require a SA
- Drugs not on the PDL are subject to Virginia's mandatory generic substitution requirements.
- 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.

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.

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 to 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.

**Members currently receiving aripiprazole oral solution, Geodon® (IM), Nuplazid or olanzapine/fluoxetine will be "grandfathered" for a period not to exceed one year. After that time, the prescriber will need to submit a service authorization request documenting the medical necessity of the non-preferred drug.

LEGEND

AG = age edit

CE = clinical edit

ST = step edit

QL = quantity limit

cap = capsule

cr = cream

ER = extended release

inj = injection

IR = immediate release

ODT = oral disintegrating tablet

oint = ointment

soln = solution

supp = suppository

susp = suspension

tab = tablet



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	Preferred Agents	Non-Preferred Agents	SA Criteria
Analgesics			
* Opioids – Long Acting (LAO)			
Preferred (Sch III-VI)		Non-Preferred	<p>*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)</p> <p>LENGTH OF AUTHORIZATIONS</p> <ul style="list-style-type: none"> Up to 6 months for chronic pain, (includes chronic non-malignant pain, cancer pain, palliative care, end-of-life care) Up to 1 month for severe post op pain
<p>Butrans[®] (buprenorphine) Transdermal Patch</p>	<p><i>Belbuca</i> (buprenorphine buccal film) buprenorphine (generic Butrans[®]) <i>ConZip[®]</i> (tramadol ER) <i>Ryzolt[™]</i> (tramadol ER) <i>tramadol ER</i> <i>Ultram ER[®]</i> (tramadol ER)</p>		
Preferred (Sch II)		Non-Preferred	<p>Daily dose limits have been established for all LAO. Quantity limits can be found at : Daily Dose Limits for Short & Long Acting Opioids</p>
<p>fentanyl 12, 25, 50, 75 & 100 mcg patches morphine sulfate ER tab</p>	<p><i>Arymo[™] ER</i> <i>Duragesic[®]</i> <i>Embeda</i> <i>Exalgo[®]</i> <i>fentanyl 37.5 mcg, 62.5 mcg, and 87.5 mcg patches</i> <i>hydromorphone ER</i> <i>Hysingla ER[™]</i> <i>Kadian[®] ER</i> <i>Morphabond[™] ER</i> <i>morphine ER cap (generic Avinza[®])</i> <i>morphine ER cap (generic Kadian[®])</i> <i>MS Contin[®]</i> <i>Nucynta[®] ER</i> <i>Oramorph[®] SR[®]</i> <i>oxycodone-long acting</i> <i>OxyContin[®]</i> <i>oxymorphone ER</i> <i>Xartemis[™] XR</i> <i>Xtampza ER[®]</i> <i>Zohydro ER[™]</i></p>		



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*Methadone Drugs		
	<i>Dolophine[®]</i> <i>Methadose[®] oral soln & tab</i> <i>methadone oral soln & tab</i>	*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		
	<i>Actiq[®]</i> <i>Fentora[®]</i> <i>fentanyl citrate</i> <i>Lazanda[®]</i> <i>Subsys[®]</i>	LENGTH OF AUTHORIZATIONS: <ul style="list-style-type: none"> • 1 month for severe post-surgical pain, OR • Up to 6 months for chronic pain (includes chronic non-malignant pain, active cancer pain, palliative care, end-of-life care).
Short-Acting Opioids		
codeine/APAP hydrocodone/APAP hydrocodone/ibuprofen hydromorphone morphine IR oxycodone IR oxycodone/APAP tramadol HCl tramadol HCl/APAP	<i>Abstral[®]</i> ApadazTM <i>codeine tab/soln</i> <i>butalbital comp with codeine</i> <i>butalbital/caffeine/APAP w/codeine</i> <i>butorphanol tartrate nasal</i> <i>dihydrocodeine/APAP/caffeine</i> <i>dihydrocodeine/ASA/caffeine</i> <i>hydromorphone liq/supp</i> <i>meperidine tab</i> <i>morphine supp</i> <i>Nucynta[®]</i> <i>Oxaydo[®]</i> <i>oxycodone/APAP (generic</i> <i>PrimLevTM)</i> <i>Oxycodone conc</i> <i>oxycodone/ASA</i> <i>oxycodone/ibuprofen</i> <i>oxymorphone HCl</i> <i>Panlor[®]</i> <i>pentazocine/naloxone</i> <i>PrimLevTM</i> RoxyBondTM	*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. Refer to combined short/long-acting opioid SA form (Short & Long Acting Opioid SA Form)



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	Ultracet [®] Ultram [®] Zamicet [®] soln																																									
Opioid Dependency CLOSED CLASS		<p>*All Buprenorphine Containing Drugs (non-preferred) require submission of Clinical SA. Refer to (Sublocade Form) or (Oral Buprenorphine SA Form)</p>																																								
<p>*buprenorphine SL *Suboxone[®] film *Sublocade[™] SQ</p> <p>naloxone syringe & vial naltrexone tab Narcan[®] Nasal Spray Vivitrol[®]</p>	<p>*Bunavail[™] *buprenorphine/naloxone tab SL *buprenorphine/naloxone.film.SL *Cassipa[®] *Probuphine[®] implant *Zubsolv[™]</p> <p>Evzio[®] injection</p>	<p>Quantity Limits</p> <table border="1"> <tr><td>Bunavail[™] 2.1–0.3mg buccal film</td><td>1/day</td></tr> <tr><td>Bunavail[™] 4.2–0.7mg buccal film</td><td>2/day</td></tr> <tr><td>Bunavail[™] 6.3–1mg buccal film</td><td>3/day</td></tr> <tr><td>buprenorphine SL tab 2mg</td><td>3/day</td></tr> <tr><td>buprenorphine SL tab 8mg</td><td>2/day</td></tr> <tr><td>buprenorphine/naloxone SL tab 2–0.5mg</td><td>3/day</td></tr> <tr><td>buprenorphine/naloxone SL tab 8–2mg</td><td>3/day</td></tr> <tr><td>buprenorphine/naloxone SL film 2–0.5mg</td><td>3/day</td></tr> <tr><td>buprenorphine/naloxone SL film 8–2mg</td><td>3/day</td></tr> <tr><td>Cassipa[®] 16mg-4mg</td><td>1/day</td></tr> <tr><td>Suboxone[®] SL film 2–0.5mg</td><td>3/day</td></tr> <tr><td>Suboxone[®] SL film 4–1mg</td><td>1/day</td></tr> <tr><td>Suboxone[®] SL film 8–2mg</td><td>3/day</td></tr> <tr><td>Suboxone[®] SL film 12–3mg</td><td>2/day</td></tr> <tr><td>Zubsolv[™] SL tab 0.7–0.18 mg</td><td>2/day</td></tr> <tr><td>Zubsolv[™] SL tab 1.4–0.36mg</td><td>2/day</td></tr> <tr><td>Zubsolv[™] SL tab 2.9–0.71mg</td><td>2/day</td></tr> <tr><td>Zubsolv[™] SL tab 5.7–1.4mg</td><td>2/day</td></tr> <tr><td>Zubsolv[™] SL tab 8.6–2.1mg</td><td>2/day</td></tr> <tr><td>Zubsolv[™] SL tab 11.4–2.9mg</td><td>2/day</td></tr> </table>	Bunavail [™] 2.1–0.3mg buccal film	1/day	Bunavail [™] 4.2–0.7mg buccal film	2/day	Bunavail[™] 6.3–1mg buccal film	3/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	3/day	buprenorphine/naloxone SL film 2–0.5mg	3/day	buprenorphine/naloxone SL film 8–2mg	3/day	Cassipa[®] 16mg-4mg	1/day	Suboxone [®] SL film 2–0.5mg	3/day	Suboxone [®] SL film 4–1mg	1/day	Suboxone[®] SL film 8–2mg	3/day	Suboxone[®] SL film 12–3mg	2/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
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Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)																																										
Oral NSAIDs		LENGTH OF AUTHORIZATIONS: 1 year																																								
<p>Children's Motrin[®] susp (OTC) ibuprofen cap ibuprofen tab (OTC & Rx)</p>	<p>Anaprox[®] IR & DS[®] Advil[®] Aleve[®] Arthrotec[®]</p>	<p>Routine PDL edits plus *Step edit required for Celebrex[®] and celecoxib</p>																																								



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	<p> Infant's ibuprofen drops meloxicam tab naproxen tab naproxen sodium (OTC) naproxen EC (Rx) sulindac </p>	<p> <i>Cataflam[®]</i> <i>*Celebrex[®] & *celecoxib</i> <i>Daypro[®]</i> <i>diclofenac potassium</i> <i>diclofenac sodium SR</i> <i>diclofenac sodium/misoprostol</i> <i>diflunisal</i> <i>Duexis[®]</i> <i>etodolac IR & SR</i> <i>Feldene[®]</i> <i>fenoprofen</i> <i>flurbiprofen</i> <i>ibuprofen tab chew OTC</i> <i>Indocin[®] supp</i> <i>indomethacin IR, SR & rectal</i> <i>ketoprofen IR & ER</i> <i>ketorolac</i> <i>meclofenamate</i> <i>mefenamic</i> <i>meloxicam susp</i> <i>Mobic[®]</i> <i>Motrin[®]</i> <i>nabumetone</i> <i>Nalfon[®]</i> <i>Naprelan[®]</i> <i>Naprosyn[®]</i> <i>naproxen CR (generic Naprelan[®])</i> <i>naproxen sodium (RX)</i> <i>naproxen susp</i> <i>oxaprozin</i> <i>piroxicam</i> <i>Ponstel[®]</i> <i>Prevacid Naprapac[®]</i> <i>Sprix[®] nasal spray</i> <i>Tivorbex[™]</i> <i>tolmetin sodium</i> </p>	<ul style="list-style-type: none"> • History of a trial of a minimum of two (2) different non-COX2 NSAIDs within the past year; OR • Concurrent use of anticoagulants (i.e., warfarin, heparin, etc.), methotrexate, oral corticosteroids; OR • History of previous GI bleed or conditions associated with GI toxicity risk factors (i.e., PUD, GERD, etc.); OR • Specific indication for Celebrex[®] for which preferred drugs are not indicated.



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	<p>Topical NSAIDs</p> <p>Voltaren® 1% gel</p>	<p>Vimovo® Vivlodex™ Voltaren® XR Zipsor® Zorvolex™</p> <p>*diclofenac sodium 1 % gel **diclofenac sodium 3 % gel *Flector® patch (QL) *Pennsaid® top soln, soln pkt & pump **Solaraze 3% top gel *Vopac MDS *Xrylix™ Kit</p>	<p>LENGTH OF AUTHORIZATIONS: 1 year</p> <p>Routine PDL edits plus</p> <p>Clinical Criteria for Non-Preferred Topical NSAIDs; *Flector®, Pennsaid®, Vopac MDS, & Xrylix™ Kit:</p> <ul style="list-style-type: none"> 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®. Pennsaid®, Vopac MDS, and Xrylix™ Kit can only be approved for the FDA approved indication of osteoarthritis of the knee. <p><i>Quantity limit for Flector® = 30 patches per RX</i></p> <p>**Solaraze® 3% & Diclofenac Sodium 3 % Clinical Criteria:</p> <ul style="list-style-type: none"> Approved only for the topical treatment of actinic keratosis
Antibiotic-Anti-Infective			
	<p>*Antibiotics, Inhaled</p> <p>Bethkis® (QL, AG) Kitabis™ Pak (QL, AG) **Tobi Podhaler® (QL, AG, SE) tobramycin inhalation neb soln (generic Tobi® inhalation) (QL, AG)</p>	<p>CLOSED CLASS</p> <p>***Arikayce® (amikacin liposome) Cayston® Tobi® inhalation neb soln (QL, AG) tobramycin Pak (generic Kitabis™ Pak) (QL, AG)</p>	<p>LENGTH OF AUTHORIZATIONS: 1 year</p> <p>Routine PDL edits plus</p> <p>***Clinical Criteria for Arikayce®</p> <p>Duration of Approval: 12 months</p> <p>Initial Approval Criteria</p> <ul style="list-style-type: none"> Patient is ≥ 18 years of age; AND Diagnosis of Mycobacterium avium complex (MAC) lung disease as determined by the following:



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	<i>Preferred Agents</i>	<i>Non-Preferred Agents</i>	<i>SA Criteria</i>
			<ul style="list-style-type: none"> ○ chest radiography or high-resolution computed tomography (HRCT) scan; AND ○ at least 2 positive sputum cultures; AND ○ other conditions such as tuberculosis and lung malignancy have been ruled out; AND <ul style="list-style-type: none"> ● Patient has failed a multi-drug regimen with a macrolide (clarithromycin or azithromycin), rifampin, and ethambutol. (Failure is defined as continual positive sputum cultures for MAC while adhering to a multi-drug treatment regimen for a minimum duration of 6 months); AND ● Patient has documented failure or intolerance to aerosolized administration of amikacin solution for injection, including pretreatment with a bronchodilator; AND ● Arikayce will be prescribed in conjunction with a multi-drug antimycobacterial regimen <p>*Minimum age for use is 6 years for all tobramycin inhalation nebulizer solution (Bethkis[®], Kitabis[™] Pak, Tobis[®] and Tobis Podhaler[®]) and 7 years for Cayston[®].</p> <p>**Tobis Podhaler[®]</p> <ul style="list-style-type: none"> ● Requires a clinical reason as to why one of the preferred tobramycin inhalation nebulizer solutions cannot be used (Bethkis[®] or Kitabis[™]). <p>Quantity Limits: Arikayce = 590 mg/8.4 mL(28 vials)/28 days Each carton contains a 28-day supply of medication (28 vials) Bethkis[®] = 224Ml (56 amps)/28 days Cayston[®] = 84 Ml/(56 amps)/28 days Kitabis[™] Pak = 280Ml (56 amps)/28 days Tobis Podhaler[®] = 224 capsule/28 day Tobis[®] inhalation <i>neb</i> = 280Ml (56 amps)/28 days tobramycin = 280Ml (56 amps)/28 days</p>
Antifungals, Oral			
	fluconazole tab/susp griseofulvin susp nystatin tab/susp	Ancobon [®] clotrimazole (mucous mem) Cresamba [®]	LENGTH OF AUTHORIZATIONS: Duration of the prescription (up to 12 months) Routine PDL edits plus



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terbinafine	<i>Diflucan[®] tab/susp</i> <i>flucytosine</i> <i>Gris-Peg[®]</i> <i>griseofulvin tab</i> <i>griseofulvin ultramicrosize</i> <i>itraconazole</i> <i>itraconazole solution (generic for Sporanox[®] soln)</i> <i>ketoconazole</i> <i>Lamisil[®] tab/granules</i> <i>Noxafil[®]</i> <i>*Onmel[®]</i> <i>*Sporanox[®] cap/soln</i> <i>Tolsura[™]</i> <i>Vfend[®] tab/susp</i> <i>voriconazole tab & powder for susp</i>	<p>* Clinical Criteria for all Non-Preferred oral Antifungals. Requires the submission of a Clinical SA. Refer to Antifungal Oral SA Form</p>
Cephalosporins, Oral		
Second Generation Cephalosporins		LENGTH OF AUTHORIZATIONS: Date of service only; no refills.
Cefaclor cap cefprozil tab/susp cefuroxime tab	<i>cefaclor ER</i> <i>cefaclor susp</i> <i>Ceftin[®] tab/susp</i>	Routine PDL edits plus Clinical Criteria for Non-Preferred Cephalosporins
Third Generation Cephalosporins		<ul style="list-style-type: none"> • Infection caused by an organism resistant to preferred drugs, OR • A therapeutic failure to no less than a three-day trial of one preferred cephalosporin; OR • The member is completing a course of therapy with a non-preferred drug initiated in the hospital.
cefdinir cap/susp	<i>Cedax[®] cap/susp</i> <i>ceftibuten</i> <i>cefditoren pivoxil</i> <i>cefixime suspension</i> <i>cefprozime proxetil cap/susp</i> <i>Spectracef[®]</i> <i>Suprax[®] chewable tab/cap/susp</i>	
Macrolides, Oral		
Macrolides & Ketolides		LENGTH OF AUTHORIZATIONS: Date of service only; no refills
azithromycin pack/susp/tab clarithromycin tab/susp Eryped[®] 200 susp	<i>Biaxin[®] tab</i> <i>clarithromycin ER</i> <i>Eryped[®] 400 susp</i>	Routine PDL edits plus Clinical Criteria for Non-Preferred Macrolides and Ketolides <ul style="list-style-type: none"> • Infection caused by an organism resistant to preferred drugs; OR



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E.E.S.® 200 susp erythromycin base cap DR erythromycin stearate		Ery-tab® E.E.S.® 400 tab Erythrocin® Stearate erythromycin base tab erythromycin ethylsuccinate 400mg tab (Generic E.E.S.® 400) erythromycin ethylsuccinate 200mg susp *Ketek® PCE® Zithromax® pac/tab/susp ZMAX® susp	<ul style="list-style-type: none"> A therapeutic failure to no less than a three-day trial of one preferred drug within the same class; OR The member is completing a course of therapy with a non-preferred drug which was initiated in the hospital. <p>* Ketek® Clinical Criteria</p> <ul style="list-style-type: none"> Treatment of community-acquired pneumonia (of mild to moderate severity) AND Infection is caused by one of the following microorganism: <i>Streptococcus pneumoniae</i>, <i>Haemophilus influenzae</i>, <i>Moraxella catarrhalis</i>, <i>Chlamydia pneumoniae</i>, or <i>Mycoplasma pneumoniae</i>. AND A therapeutic failure to no less than a three-day trial of one preferred drug within the same class; OR The member is completing a course of therapy with a non-preferred drug initiated in the hospital.
Otic			
Ciprodex® ofloxacin neomycin/polymyxin/hc soln/sus		Cetraxal® Cipro HC® Otovel	LENGTH OF AUTHORIZATIONS: Date of service only; no refills Routine PDL edits
Quinolones, Oral			
Second Generation Quinolones			LENGTH OF AUTHORIZATIONS: Date of service only; no refills Routine PDL edits plus: Clinical Criteria for Non-Preferred Quinolones <ul style="list-style-type: none"> Infection caused by an organism resistant to preferred drugs; OR A therapeutic failure to no less than a three-day trial of one preferred quinolone; OR The member is completing a course of therapy with a non-preferred drug initiated in the hospital.
ciprofloxacin susp/tab		Baxdela™ IV Cipro® IR & XR & susp ciprofloxacin ER Noroxin® ofloxacin	
Third Generation Quinolones			
levofloxacin tab		Avelox® Levaquin® tab/susp levofloxacin susp moxifloxacin	
Topical Antibiotics			



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mupirocin ointment		*Altabax™ (QL) Bactroban® cr/ointment Centany® Centany AT® Kit	LENGTH OF AUTHORIZATIONS: Date of service only; no refills Routine PDL edits *Quantity Limit = 15 grams per 34 days
Vaginal Antibiotics			
Cleocin® Ovules Clindesse® cr metronidazole gel Vandazole™ gel		Cleocin® cr clindamycin cr Metrogel® Nuessa®	LENGTH OF AUTHORIZATIONS: Date of Service Routine PDL edits
Antivirals			
*Hepatitis C Agents		CLOSED CLASS	
Interferon		LENGTH OF AUTHORIZATIONS: 8 weeks (initial approval)	
Peg-Intron® Peg-Intron Redipen®	Pegasys® Proclick/syringe/kit/vial	*ALL Hepatitis C Drugs (Preferred and Non-Preferred) require the submission of a Clinical SA. Refer to Hepatitis C Antivirals SA Form or Hepatitis C Mavyret and sofosbuvir/velpatasvir SA Form	
Protease Inhibitor			
		Olysio™ (discontinued)	
*Nucleotide Analog NS5A & NS5B Polymerase Inhibitors & Combinations			
sofosbuvir /velpatasvir (generic) Epclusa®	Daklinza® Epclusa® Sovaldi® Vosevi™		
*NS5A, NS3/4A Inhibitor Combinations			
Mavyret™	Technivie™ Viekira Pak™ Viekira XR™ Zepatier®		
*NS5B & Protease Inhibitor combinations			
	Harvoni® Ledipasvir/Sofosbuvir (generic) Harvoni®		



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Herpes Oral		
acyclovir cap/tab/susp famciclovir valacyclovir	Famvir® Sitavig® buccal tab Valtrex® Zovirax® tab/susp	LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edits
Herpes Topical		
Abreva OTC® Zovirax® cr	acyclovir oint Denavir® Xerese® cr Zovirax® oint	LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edits
Influenza		
amantadine cap/tab/syrup oseltamivir susp Tamiflu® cap	Flumadine® tab rimantadine oseltamivir cap Relenza Disk® Tamiflu® susp Xofluza™	LENGTH OF AUTHORIZATIONS: Date of service only Routine PDL edits
Blood Modifiers		
Bile Salts		
ursodiol mg tab	Actigal® Chenodal® Cholbam® Ocaliva® ursodiol cap Urso® Urso® Forte tab	LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edits
Phosphate Binders		
calcium acetate 667mg cap Renagel® Renvela® tablet	Auryxia™ calcium acetate 667mg tab Eliphos® Ferric citrate	LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edits



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Preferred Agents	Non-Preferred Agents	SA Criteria
	<i>Fosrenol</i> [®] chewable tab lanthanum carbonate chewable tab <i>Phoslo</i> [®] <i>Phoslyra</i> [®] <i>Renvela</i> [®] powder sevelamer carbonate powder packet <i>Velphoro</i> [®] chewable tab	
Bone Resorption Suppression and Related Agents		
Bisphosphonates		
alendronate tab	<i>Actonel</i> [®] <i>alendronate soln</i> <i>Atelvia DR</i> [®] <i>Boniva</i> [®] <i>Binosto</i> [™] <i>etidronate</i> <i>Fosamax</i> [®] tab & <i>Fosamax</i> [®] plus D <i>ibandronate</i> <i>risedronate DR</i>	LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edits
Calcitonins		
calcitonin-salmon nasal	<i>Miacalcin</i> [®]	LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edits
Others		
raloxifene	<i>Evista</i> [®] * <i>Forteo</i> [®] * <i>Tymlos</i> [™]	LENGTH OF AUTHORIZATIONS: Initial approval will be for 1 year Routine PDL edits for Evista [®] *Clinical SA must be completed for (Forteo [®] OR Tymlos [™] SA Form)
Cardiac		
Anticoagulants CLOSED CLASS		
Low Molecular Weight Heparin includes Factor XA Inhibitor		LENGTH OF AUTHORIZATIONS: 1 year
enoxaparin	<i>Arixtra</i> [®] <i>fondaparinux</i>	Routine PDL edits plus



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		<i>Fragmin[®] syringe & vial</i> <i>Lovenox[®]</i>	
Oral Anticoagulants			Clinical Criteria for Savaysa[™] <ul style="list-style-type: none"> • Diagnosis of: • Non-valvular Atrial Fibrillation, OR • deep vein thrombosis, OR • pulmonary embolism ; AND • Documentation that CrCl is NOT $\geq 95\text{mL/min}$ calculated by Cockcroft-Gault equation
Eliquis[™] Jantoven Pradaxa[®] Xarelto[®] Xarelto[®] Starter Pack warfarin	<i>Coumadin[®]</i> <i>Eliquis[™] Dose Pack</i> <i>*Savaysa[™]</i>		
Antihypertensive Agents			
ACE Inhibitors			LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edits
benazepril enalapril lisinopril ramipril	<i>Accupril[®]</i> <i>Altace[®]</i> <i>captopril</i> <i>Epaned[™] soln</i> <i>fosinopril</i> <i>Lotensin[®]</i> <i>Mavik[®]</i> <i>moexipril</i> <i>Monopril[®]</i> <i>perindopril</i> <i>Prinivil[®]</i> <i>Qbrelis[™]</i> <i>quinapril</i> <i>ramipril</i> <i>trandolapril</i> <i>Univasc[®]</i> <i>Vasotec[®]</i> <i>Zestril[®]</i>		
ACE Inhibitors + Calcium Channel Blocker Combinations			
amlodipine/ benazepril	<i>Lotrel[®]</i> <i>Tarka[®]</i> <i>trandolapril-verapamil ER</i>		



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ACE Inhibitors + Diuretic Combinations			
benazepril/HCTZ lisinopril/HCTZ enalapril/HCTZ	<i>Accuretic[®]</i> <i>captopril/HCTZ</i> <i>fosinopril/HCTZ</i> <i>Lotensin HCT[®]</i> <i>moexipril/HCTZ</i> <i>quinapril/HCTZ</i> <i>Vaseretic[®]</i> <i>Zestoretic[®]</i>		
Angiotensin Receptor Blockers			LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edits plus
*Entresto™ (QL) losartan valsartan	<i>Atacand[®]</i> <i>Avapro[®]</i> <i>Benicar[®]</i> <i>Byvalson™</i> <i>candesartan</i> <i>Cozaar[®]</i> <i>Diovan[®]</i> <i>Edarbi[®]</i> <i>eprosartan mesylate</i> <i>irbesartan</i> <i>Micardis[®]</i> <i>olmesartan</i> <i>Teveten[®]</i>		*Clinical Criteria for Entresto™ <ul style="list-style-type: none"> • Diagnosis of chronic heart failure (NYHA Class II-IV); AND • Member must be ≥ 18 years; AND • Left ventricular ejection fraction ≤ 40% <p><i>Quantity Limit = 2 per day for Entresto™</i></p>
Angiotensin Receptor Blockers + Calcium Channel Blocker Combinations			
amlodipine/ valsartan	<i>Azor[®]</i> <i>amlodipine/olmesartan</i> <i>amlodipine/olmesartan/HCTZ</i> <i>amlodipine/valsartan/HCTZ</i> <i>Exforge[®] & Exforge[®] HCT</i> <i>Tribenzor[®]</i>		



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Angiotensin Receptor Blockers + Diuretic Combinations		
losartan/HCTZ valsartan/HCTZ	<i>Atacand HCT[®]</i> <i>Avalide[®]</i> <i>Benicar HCT[®]</i> <i>candesartan/HCTZ</i> <i>Diovan HCT[®]</i> <i>Edarbyclor[®]</i> <i>Hyzaar[®]</i> <i>irbesartan/HCTZ</i> <i>Micardis HCT[®]</i> <i>olmesartan/HCTZ</i> <i>telmisartan/HCTZ</i> <i>Teveten HCT[®]</i>	
Antihypertensives, Sympatholytics		
CLOSED CLASS		
Catapres[®] -TTS clonidine tab guanfacine methyldopa reserpine	<i>Catapres[®]</i> <i>clonidine (transdermal)</i> <i>Clorpres[®]</i> <i>methyldopa/HCTZ</i> <i>Tenex[®]</i>	
Beta Blockers		
atenolol bisoprolol carvedilol labetalol metoprolol tartrate metoprolol succinate propranolol tab & ER/soln Sorine[®] sotalol AF sotalol HCL	<i>acebutaolol</i> <i>Betapace[®] IR & AF[®]</i> <i>betaxolol</i> <i>Bystolic[®]</i> <i>Carvedilol ER</i> <i>Coreg[®] IR & CR[®]</i> <i>Corgard[®]</i> <i>*Hemangeol[™]</i> <i>Inderal[®] XL</i> <i>Innopran[®] XL</i> <i>Kaspargo[™] Sprinkle</i> <i>Levatol[®]</i> <i>Lopressor[®]</i>	<p>*Clinical Criteria for Hemangeol[™]</p> <ul style="list-style-type: none"> • Diagnosis treatment of proliferating infantile hemangioma requiring systemic therapy; AND • Member's age must be between 5 weeks and 5 months.



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	<i>Preferred Agents</i>	<i>Non-Preferred Agents</i>	<i>SA Criteria</i>
		<i>nadolol</i> <i>pindolol</i> <i>propranolol LA</i> <i>Sectral®</i> <i>Sotylize™</i> <i>Tenormin®</i> <i>timolol maleate</i> <i>Toprol XL®</i> <i>Trandate®</i> <i>Zebeta®</i>	
	Beta Blockers + Diuretic Combinations		
	atenolol/chlorthalidone bisoprolol/HCTZ	<i>Corzide®</i> <i>Dutoprol®</i> <i>Lopressor HCT®</i> <i>metoprolol/HCTZ</i> <i>nadolol/bendroflumethiazide</i> <i>propranolol/HCTZ</i> <i>Tenoretic®</i> <i>Ziac®</i>	
	Calcium Channel Blockers –Dihydropyri dine		
	Afedtab CR® amlodipine Nifedical XL® nifedipine nifedipine ER	<i>Adalat CC®</i> <i>felodipine ER</i> <i>isradipine</i> <i>nisoldipine</i> <i>nicardipine</i> <i>Norvasc®</i> <i>Procardia®</i> <i>Procardia XL®</i> <i>Sular®</i>	
	Calcium Channel Blockers-Non-Dihydropyri dine		
	Cartia XT® diltiazem IR, ER q12 hr & 24 hr Taztia XT®	<i>Calan® IR & SR</i> <i>Cardizem® IR, CD & LA</i> <i>Isoptin SR®</i> <i>diltiazem LA</i>	



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verapamil tab IR & ER		Matzim LA Tiazac® verapamil 360 cap verapamil ER cap Verelan® & Verelan PM®		
Direct Renin Inhibitors (includes combination)				
		Tekamlo® Tekturna® Tekturna HCT® Twynsta® telmisartan/amlodipine		
Lipotropics				
Bile Acid Sequestrants				LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edits plus
cholestyramine powder reg & light colestipol tab Prevalite® Welchol® tab		Colestid® granule/packet/tab colesevelam tab and Pkt (generic Welchol) colestipol HCl granules Questran® powder/powder Light Welchol® packet		
Cholesterol Absorption Inhibitor (CAI)				
ezetimibe		Zetia®		
Fibric Acid Derivatives				
fenofibrate (generic Tricor® 48mg 145mg) gemfibrozil		Antara® fenofibrate (generics for Antara®, Fenoglide® & Lipofen®) fenofibrate (generics for Triglide®) fenofibric acid Fenoglide® Fibracor® Lipofen® Lofibra® Lopid®		



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	<i>Tricor</i> [®] <i>Triglide</i> [®] <i>Trilipix</i> [™]	
HMG CoA Reductase Inhibitors and Combo (High Potency Statins)		
atorvastatin rosuvastatin simvastatin	<i>amlodipine/atorvastatin</i> <i>Caduet</i> [®] <i>Crestor</i> [®] <i>Ezallor (rosuvastatin)</i> <i>Lipitor</i> [®] <i>Liptruzet</i> [®] <i>Livalo</i> [®] <i>Zypitamag</i> [™] <i>simvastatin/ezetimibe</i> <i>Vytorin</i> [®] <i>Zocor</i> [®]	
HMG CoA Reductase Inhibitors and Combinations (Statins)		
lovastatin pravastatin	<i>Advicor</i> [®] <i>Altoprev</i> [®] <i>fluvastatin</i> <i>Lescol</i> [®] and <i>Lescol XL</i> [®] <i>Mevacor</i> [®] <i>Pravachol</i> [®]	
Microsomal Triglyceride Transfer Protein Inhibitor		
	<i>*Juxtapid</i> [™]	*Clinical Criteria for Juxtapid[™]. Refer to Juxtapid[™] SA Fax Form
Niacin Derivatives		
niacin ER	<i>Niaspan</i> [®] <i>Niacor</i> [®]	
Omega 3 Fatty Acid Agent		
	***<i>Lovaza</i>[®] (ST) ***<i>omega-3 acid ethyl esters</i> (ST) <i>Vascepa</i> [®]	***Clinical Criteria for <i>Lovaza</i>[®] and omega-3 acid ethyl esters <ul style="list-style-type: none"> • Step edit requires trial and failure of any other lipotropic; OR • Documented high triglycerides of ≥ 500 mg/dL.



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Oligonucleotide Inhibitor			
		**** <i>Kynamro™</i>	**** Clinical SA for Kynamro™ . Refer to Kynamro™ SA Fax Form
*Proprotein Convertase Subtilisin Kexin Type 9 (PCSK9) Inhibitors			LENGTH OF AUTHORIZATIONS: Three months for initial approval; six months for renewal
		<i>Praluent®</i> <i>Repatha®</i>	*ALL PCSK9 Inhibitors require the submission of a Clinical SA. Refer to PCSK9 SA Form
Platelet Inhibitors			
Brilinta® clopidogrel dipyridamole prasugrel (generic Effient®) ticlopidine HCL		* <i>Aggrenox®</i> * <i>ASA/dipyridamole</i> ** <i>Durlaza ER™</i> <i>Effient®</i> <i>Persantine®</i> <i>Plavix®</i> ** <i>Yosprala® Tab</i> *** <i>Zontivity™</i>	LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edits plus Clinical Criteria for Select <u>Non-Preferred</u> Platelet Inhibitors *<u>Aggrenox® & ASA/dipyridamole</u> <ul style="list-style-type: none"> Aspirin and dipyridamole are covered as separate drugs without SA; clinical reason as to why the individual drugs cannot be used separately. **<u>Durlaza ER™ & Yosprala® Tab</u> <ul style="list-style-type: none"> Aspirin is covered without SA; clinical reason as to why aspirin cannot be used. ***<u>Zontivity™</u> <ul style="list-style-type: none"> Diagnosis of MI (myocardial infarction) or PAD (peripheral arterial disease); AND Members must not have a history of stroke, TIA, ICH, GI bleed and peptic ulcer; AND Must have concomitant therapy with clopidogrel, unless member has a contraindication to clopidogrel in which case member must have concomitant therapy with aspirin; AND Member is 18 years of age or older; AND Prescribed by or in consultation with a cardiologist.
*Pulmonary Arterial Hypertension Agents			
Inhaled Prostaglandin Analogues			LENGTH OF AUTHORIZATIONS: 1 year
Ventavis®		<i>Tyvaso®</i>	



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Oral Endothelin Receptor Antagonist			Routine PDL edits plus *Clinical Criteria for all preferred and non-preferred PDE-5 <ul style="list-style-type: none"> • Diagnosis of pulmonary hypertension in members >18 years is required; AND • The prescriber must be a pulmonary specialist or cardiologist; AND • Must have a rationale for not taking the sildenafil tablet to receive a SA for injectable Revatio®
Letairis® Tracleer® tab	Opsumit® Tracleer® susp		
*Phosphodiesterase 5 Inhibitors (PDE-5)			
Adcirca™ sildenafil tab	Alyq(tadalafil) Revatio® tab/susp/inj Tadalafil		
Prostacyclin Vasodilator and Receptor Agonist			
	Orenitram™ Uptravi®		
Soluble Guanylate Cyclase Stimulators		Adempas®	
Central Nervous System			
Alzheimer's Agents			
Cholinesterase Inhibitors			LENGTH OF AUTHORIZATIONS: Length of prescription (up to 3 months)
donepezil OTD & tab Exelon® (transderm)	Aricept® ODT, tab Exelon® cap galantamine IR, ER tab/soln Memantine ER (generic Namenda XR) Namzaric® (donepezil/memantine) Razadyne® IR, ER rivastigmine cap & patch		Routine PDL edits
NMDA Receptor Antagonist			
memantine tab	memantine Dose Pack memantine soln Namenda® Dose Pack/XR tab Namenda® tab		
Anticonvulsants			
Barbiturates			LENGTH OF AUTHORIZATIONS: 1 year

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Preferred Agents		Non-Preferred Agents	SA Criteria
phenobarbital elixir/tab primidone		Mysoline®	Routine PDL edits plus *Clinical Criteria for Onfi® <ul style="list-style-type: none"> • Patient is at least two years of age or older; AND • Patient must have a diagnosis of seizures associated with Lennox-Gastaut syndrome (LGS) AND • Using as adjunctive therapy with other anticonvulsants; AND • Prescribing physician should submit documentation of an insufficient response to another medication used for LGS *Clinical Criteria for Epidiolex® Duration of Approval: 1 year Approval Criteria: <ul style="list-style-type: none"> • Patient must be ≥ 2 years of age; AND • Patient has been diagnosed with Lennox-Gastaut syndrome (LGS) OR Dravet syndrome (DS) • Prescribing physician is or has consulted with a neurologist or epileptologist appropriate for age
Benzodiazepines			
clonazepam diazepam rectal & Device rectal		Clobazam (generic Onfi® susp/tab) clonazepam ODT Diastat® rectal Diastat® AcuDial™ rectal *Onfi® susp/tab Sympazan™ (clobazam)	
Cannabidiol			
		*Epidiolex® (cannabidiol)	
Carbamazepine Derivatives			
carbamazepine chewable tab/susp/tab carbamazepine ER carbamazepine XR oxcarbazepine susp & tab		Aptiom® Carbatrol® Equetro® cap Oxtellar™ XR Tegretol® susp/tab Tegretol® XR Trileptal® susp/tab vigabatrin powder pack	
Hydantoin			
Dilantin® cap phenytoin cap/chew tab/ susp phenytoin ext cap		Dilantin® Infatab, susp Peganone® Phenytek®	
Succinimides			



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



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



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		<p>eletriptan(generic Relpax[®]) Frova[®] frovatriptan (generic Frova[®]) Imitrex[®] cartridge/nasal/pen/tab/vial Maxali[®] tab & MLT MigranowTM Kit naratriptan OnzetraTM XsailTM sumatriptan KITS Sumavel[®] Dosepro sumatriptan/naproxen (generic Treximet[®]) Tosymra Treximet[®] ZembraceTM SymTouchTM Zomig[®] tab/nasal spray/ZMT</p>	
	Antimigraine Agents, Others Calcitonin Gene-related Peptide Antagonist (CGRP)		
	EmgalityTM Syringe EmgalityTM Pen	AimovigTM AjovyTM	All CGRPs require the submission of a Clinical SA. Refer to Antimigraine Agents, Others SA Form
*Antipsychotics (AG)			
	Atypical		LENGTH OF AUTHORIZATIONS: 1 year or 6 months for members < 18 yrs
	aripiprazole tab clozapine tab Latuda [®] olanzapine ODT,tab, IM quetiapine tab quetiapine fumarate ER risperidone ODT/soln/tab ziprasidone cap	Abilify [®] tab/IM inj ***Abilify Mycite[®] (with sensor) **aripiprazole ODT, soln Clozaril [®] clozapine ODT Fanapt [®] tab & titration pk Fazaclor [®] **Geodon [®] tab, IM Invega [®] **Nuplazid TM tab, cap (QL)(AG) **olanzapine/fluoxetine	Routine PDL edits plus *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) **Clinical Criteria NuplazidTM <ul style="list-style-type: none"> Indicated for the treatment of hallucinations and delusions associated with Parkinson's disease psychosis.

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		paliperidone ER Rexulti® tab Risperdal® ODT/soln/tab Saphris® SL Seroquel® IR Seroquel® XR Symbyax® Versacloz™ Vraylar™ Zyprexa® tab/IM/Zydis	Quantity Limit Nuplazid™ = 2 per day ***Clinical Criteria for Abilify Mycite® Initial Approval Criteria: For Three months SA Patient must: <ul style="list-style-type: none"> • Be ≥ 18 years of age; AND • Have tolerability to oral aripiprazole with suboptimal effects (as assessed by prescriber) that may be due to adherence problems; AND • Have a smart phone compatible with the device; AND • Give consent to a healthcare provider and caregiver (if applicable) to monitor the portal; AND • There is a documented intervention by prescriber if nonadherence is detected Renewal Criteria: Every 3 Months Reevaluate <ul style="list-style-type: none"> • Patient must: • Continue to meet initial criteria; AND • Have prescriber attestation that patient benefited from therapy; AND • Have prescriber attestation that there is a continued need for device (e.g., continued suboptimal effects and/or compliance); AND • Have a healthcare provider and caregiver (if applicable) agree to continue to monitor device; AND • Not have worsened target symptoms; AND • Not have had any treatment-limited adverse effects (e.g., hypersensitivity, suicidality, neuroleptic malignant syndrome, tardive dyskinesia, metabolic changes, pathological gambling and other compulsive behaviors, orthostatic hypotension, falls, seizures, cognitive and motor impairment, dysphagia, disruption in body temperature regulation, and leukopenia, neutropenia, and agranulocytosis); AND • Have a healthcare provider state reason why the patient cannot use long acting injectable atypical antipsychotic if there is continued nonadherence.
	Atypical, Long Acting Injectable	CLOSED CLASS	LENGTH OF AUTHORIZATIONS: 1 year
	Abilify Maintena® Aristada®	Perseris™ (risperidone) Zyprexa® Relprevv™	Routine PDL edits



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Preferred Agents		Non-Preferred Agents	SA Criteria
Aristada® Initio Risperdal Consta® Invega Sustenna® & Trinza®			
Typical			LENGTH OF AUTHORIZATIONS: 1 year
amitriptyline/perphenazine chlorpromazine fluphenazine decantate haloperidol decantate haloperidol lactate conc haloperidol tab loxapine perphenazine trifluoperazine thiothixene thioridazine	fluphenazine elixir/soln/tab Haldol decanoate (injection) pimozide Moban® molindone Orap®		Routine PDL edits
Neuropathic Pain			
capsaicin OTC topical duloxetine 20, 30 & 60 mg gabapentin cap/tab/soln lidocaine 5% patch *Lyrica® (ST)	Cymbalta® duloxetine 40 mg Gralise™ Horizant™ Irenka™ Lidoderm® patch Lyrica CR Lyrica® soln Neurontin® cap/tab/soln Savella™ & Savella™ Dose Pak Qutenza Kit® (Topical) Ztlido™ (lidocaine topical system)		LENGTH OF AUTHORIZATIONS: 1 year Routine PDL *Step Edit for Lyrica® <ul style="list-style-type: none"> • Trial and failure of duloxetine or gabapentin
Non-Ergot Dopamine Receptor Agonist			
pramipexole ropinirole HCl	Mirapex® IR & ER Neupro® pramipexole ER Requip® IR Requip® XR ropinirole HCl ER		LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edits



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Sedatives / Hypnotics		
temazepam 15 & 30 mg	<i>estazolam</i> <i>flurazepam</i> <i>Halcion</i> [®] <i>Restoril</i> [®] <i>temazepam</i> 7.5 mg & 22.5 mg <i>triazolam</i>	LENGTH OF AUTHORIZATIONS: Length of the prescription (up to 3 months) Routine PDL edits
Sedatives / Hypnotics (Non-Benzodiazepine)		
zolpidem	<i>Ambien</i> [®] IR & CR <i>Belsomra</i> [®] <i>Edluar</i> [™] <i>eszopiclone</i> <i>*Hetlioz</i> [™] <i>Intermezzo</i> [®] <i>Lunesta</i> [®] <i>Rozerem</i> [®] <i>Silenor</i> [®] <i>Sonata</i> [®] <i>Zaleplon</i> [®] <i>zolpidem</i> CR <i>Zolpimist</i> [™] spray <i>zolpidem</i> (generic <i>Intermezzo</i> [®])	LENGTH OF AUTHORIZATIONS: 6 months. For Renewal - must document therapeutic benefit and confirm compliance Routine PDL edits plus *Clinical Criteria for Hetlioz[™] <ul style="list-style-type: none"> For the treatment of Non-24-Hour Sleep-Wake Disorder (Non-24), AND The member is completely blind Member must be age 18 years of age or older. Quantity limit = 1 tablet per day.
Skeletal Muscle Relaxants		
baclofen chlorzoxazone cyclobenzaprine HCL dantrolene sodium methocarbamol tizanidine tab	<i>Amrix</i> [®] <i>*carisoprodol</i> <i>*carisoprodol/ASA</i> <i>*carisoprodol/ASA/codeine</i> <i>cyclobenzaprine ER</i> <i>Dantrium</i> [®] <i>Fexmid</i> [®] <i>Lorzone</i> [®] <i>metaxalone</i> <i>orphenadrine citrate</i> <i>orphenadrine/ASA/caffeine</i> <i>Parafon Forte</i> [®] DSC	LENGTH OF AUTHORIZATIONS: <ul style="list-style-type: none"> 1 year for chronic conditions Duration of prescription (up to 3 months) for acute conditions One month per every 6 months for carisoprodol drugs Routine PDL edits plus *Clinical Criteria for Carisoprodol Drugs. Refer to Soma/carisoprodol SA Fax Form



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Preferred Agents	Non-Preferred Agents	SA Criteria
	Robaxin [®] Skelaxin [®] *Soma [®] tizanidine cap Zanaflex [®]	
Smoking Cessation		
bupropion SR Chantix [®] Chantix [®] DS PK nicotine gum/lozenge/patch	Nicoderm CQ [®] Patch Nicorette [®] Gum/Lozenges Nicotrol [®] Inhaler & NS Zyban [®]	LENGTH OF AUTHORIZATIONS: 6 months Routine PDL edits
*Stimulants/ADHD Medications (AG) CLOSED CLASS		
Amphetamine Drugs		LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edits
Adderall[®] XR amphetamine salts combo <i>(generic for Adderall IR)</i> dextroamphetamine <i>(generic for Dexedrine)</i> Dyanavel[®] XR susp Vyvanse [®] cap/chewable tab <i>(lisdexamfetamine)</i>	Adderall [®] IR <i>(amphetamine salts combo)</i> Adzenys XR ODT [™] Adzenys ER [™] susp Adzenys [®] ER amphetamine salts combo XR amphetamine sulfate <i>(generic Evekeo[™])</i> Desoxyn [®] Dexedrine [®] dextroamphetamine SR & soln Evekeo [™] Evekeo[™] ODT methamphetamine Mydayis ER [™] Procentra [®] soln Zenzedi [™]	*All stimulants (preferred and non-preferred) require the submission of Clinical SA if prescribed for a child less than four or an adult eighteen years and older. Refer to Stimulant SA form (Stimulant/ADHD Medications SA Form) This does not include nonstimulant agents such as atomoxetine (generic for Strattera[®]), clonidine ER, guanfacine ER or others
Methylphenidate Drugs		
All methylphenidate IR generic Concerta[®] Daytrana [®] Transdermal Focalin [®] IR & XR QuilliChew ER [™]	Aptensio [™] XR Cotempla XR-ODT [™] dexmethylphenidate IR & XR Metadate CD [®] Metadate ER [®]	



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Preferred Agents		Non-Preferred Agents	SA Criteria
Quillivant™ XR susp		<i>Methylin ER® , soln IR</i> <i>methylphenidate chew & soln</i> <i>methylphenidate ER, LA, SR</i> <i>Ritalin® IR, LA® & SR®</i>	<p>***Nuvigil™/Provigil®/armodafinil/modafinil:</p> <p>Length of Authorizations: 1 year for sleep apnea and narcolepsy; 6 months for shift work sleep disorder.</p> <ul style="list-style-type: none"> • Approvable diagnoses include: <ul style="list-style-type: none"> ○ Sleep Apnea: Requires documentation/confirmation via sleep study or that C-PAP has been maximized; OR ○ Narcolepsy: Documentation of diagnosis via sleep study; OR ○ 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.
Miscellaneous Drugs			
atomoxetine (generic for Strattera®) clonidine ER guanfacine ER		*** <i>armodafinil (generic Nuvigil™)</i> *** <i>modafinil</i> *** <i>Nuvigil™ (AG)</i> *** <i>Provigil® (AG)</i> <i>Strattera®</i> <i>Intuniv®</i>	
Dermatologic			
*Acne Agents, Topical (AG)			
Combo Benzoyl Peroxide , Clindamycin, Erythromycin Topical			LENGTH OF AUTHORIZATIONS: 1 year
benzoyl peroxide wash/cr/gel /lot (OTC) clindamycin/benzoyl peroxide (Duac®) clindamycin phosphate soln/swab erythromycin solution Panoxyl-4 Acne Cr Wash (OTC) Panoxyl 10 OTC		<i>Acanya™ w/pump</i> <i>Acne Clearing System® (OTC)</i> <i>Aczone® Gel and Gel Pump</i> <i>Avar Cleanser, Medicated Pad</i> <i>Avar-E</i> <i>Avar-E LS</i> <i>Avar LS Cleanser, Medicated Pad</i> <i>Azelex®</i> <i>Benzaclin® & Benzaclin® Pump</i> <i>BP 10-1</i> <i>Benzefoam™ regular & Ultra™</i> <i>Benzepro</i> <i>benzoyl peroxide wash/cr/gel/ lotion/foam/towelette (RX)</i>	<p>Routine PDL edits plus</p> <p>*Clinical Criteria for Dermatologic Acne Agents</p> <ul style="list-style-type: none"> • Prescriptions for members over the age of 18 years will require the submission of a SA to evaluate treatment diagnosis; AND • Drugs are intended for acne only. SA for a cosmetic indication cannot be approved.



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	<i>Preferred Agents</i>	<i>Non-Preferred Agents</i>	<i>SA Criteria</i>
		<p>benzoyl peroxide 6%, 9% cleanser (OTC) BPO Kit Cleocin T[®] Clindacin[™] Pac Kit Clindagel[®] clindamycin phosphate (generic for Clindagel[®]) clindamycin/benzoyl peroxide (generic for Acanya[®] Pump) clindamycin/benzoyl peroxide (generics for Benzaclin[®]) clindamycin phosphate foam, el, lotion, med swab clindamycin/tretinoin (generic Veltin[®]) Delos[™] Lotion Duac[®] gel erythromycin gel/med. swab Evoclin[™] Inova[™] Lavoclen[™] Cleanser & Kit Neuac[™] topical/kit Onexton[™] gel & w/Pump Ovace[®] Wash Ovace[®] Plus shampoo/cr/lotion/foam Pacnex[®] HP & LP Panoxyl[®] 3% cr (OTC) Promiseb[®] Complete Rosula Cleanser Se BPO[®] Wash Kit & cleanser Sulfacetamide Cleanser ER Sulfacetamide Cleanser, Shampoo, Susp</p>	



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	Preferred Agents	Non-Preferred Agents	SA Criteria
		<p><i>Sulfacetamide Sodium/Sulfur Cr, Susp, Sunscreen</i> <i>SSS 10-5 Foam</i> <i>Sulfacetamide/Sulfur/Cleanser, Cleanser Kit, Lotion Med. Pad</i> <i>Sulfacetamide/Sulfur/Urea Cleanser</i> <i>Sumadan Wash, Kit</i> <i>Sumadan XLT</i> <i>Sumaxin CP Kit</i> <i>Veltin®</i></p>	
	Retinoids/Combinations, Topical		
	<p>Differin 0.1% gel (OTC) Retin® A 0.025%, 0.05, 0.1 % cr & 0.01, 0.025,% gel</p>	<p><i>Acnefree® Severe Kit (OTC)</i> <i>adapalene 0.1% cr/gel/lot</i> <i>adapalene 0.3% gel/gel w/pump</i> <i>adapalene-benzoyl peroxide (generic Epiduo®)</i> Altreno™ <i>Atralin® 0.05% gel</i> <i>Avage® 0.1% cr</i> <i>Avita® 0.025% cr/gel</i> <i>Differin® 0.1% cr/gel/lot RX</i> <i>Differin® 0.3% gel pump</i> <i>Epiduo® & Epiduo® Forte Gel</i> <i>*Fabior™01% Foam (AG)</i> <i>Renova® 0.02% cr/cr pump</i> <i>Retin® -A Micro 0.04%, 0.1% gel</i> <i>Retin® -A Micro 0.08%, 0.04%, 0.1% pump</i> <i>Tazorac® cr/gel</i> <i>tazarotene 0.1% cr</i> tretinoin 0.025, 0.1% cr & 0.01, 0.025, 0.05% gel <i>tretinoin microsphere 0.04% & 0.1% gel</i> <i>Ziana® gel</i></p>	<p>*Age Edit for Fabior™ Foam</p> <ul style="list-style-type: none"> Member must be between the ages of 12 and 18 years of age



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



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	Preferred Agents	Non-Preferred Agents	SA Criteria
		Nyata Kit [®] Nizoral A-D [®] Shampoo (OTC) nystatin-triamcinolone cr/oint oxiconazole cr (generic Oxistat [®]) Oxistat [®] cr Oxistat [®] Lotion Pediderm AF [®] PediPak [®] *Penlac [®] Tinactin [®] Aero powder/spray (OTC) tolnaftate aero powde/spray (OTC) Vusion [®]	
Immunomodulators Atopic Dermatitis			
	*Elidel [®]	*Eucrisa [™] **Dupixent [®] (QL, AG) pimecrolimus (new generic for Elidel) *Protopic [®] *tacrolimus	<p>LENGTH OF AUTHORIZATIONS: 1 year; EXCEPT Dupixent[®] 6 months</p> <p>Routine PDL edits plus</p> <p>*Clinical Criteria for Elidel[®], Eucrisa[™], Protopic[®] & tacrolimus</p> <ul style="list-style-type: none"> • Member must have a FDA approved diagnosis: <ul style="list-style-type: none"> ○ Atopic dermatitis ○ Elidel[®] & Eucrisa[™]: mild to moderate for ages > 2 years. ○ Protopic[®] 0.03%: moderate to severe for ages > 2 years. ○ Protopic[®] 0.1%: moderate to severe for ages > 18 years; AND • Failure to topical corticosteroids (i.e., desonide, fluticasone propionate, hydrocortisone butyrate, etc.) <p>**Clinical Criteria for Dupixent[®]</p> <ul style="list-style-type: none"> • ≥ 12 years of age; AND • Diagnosis of moderate to severe atopic dermatitis with ≥ 1 of the following: <ul style="list-style-type: none"> ○ Involvement of at least 10% of body surface area (BSA); OR ○ Scoring Atopic Dermatitis (SCORAD) score of 20 or more; OR ○ Investigator's Global Assessment (IGA) with a score ≥ 3; OR ○ Eczema Area and Severity Index (EASI) score of ≥ 16; OR



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	<i>Preferred Agents</i>	<i>Non-Preferred Agents</i>	<i>SA Criteria</i>
			<ul style="list-style-type: none"> ○ Incapacitation due to AD lesion location (e.g., head and neck, palms, soles, or genitalia); AND ● 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 ● Inadequant response to a 3 month minimum trial of at least 1 immunosuppressive systemic agent (e.g., cyclosporine, azathioprine, methotrexate, mycophenolate mofetil, etc.); AND ● 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 ● Is not pregnant; AND ● Is not concurrently receiving a live vaccine <p>Renewal Criteria: Member must:</p> <ul style="list-style-type: none"> ● Continue to meet above criteria; AND ● Not have documented toxicity from the agent (e.g., hypersensitivity, conjunctivitis, keratitis, immunogenicity); AND ● 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). <p>Quantity limit Dupixent® <i>2 prefilled syringes for the initial dose, then 1 single-dose syringe every 14 days</i></p>
Psoriasis, Topical			
	calcipotriene cr/oint/soln	<i>Calcitrene®</i> <i>calcitriol</i> <i>Dovonex®</i> <i>*Enstilar® Foam (AG)</i> <i>Micanol®</i> <i>Sorilux™</i> <i>Taclonex® & Taclonex® Scalp</i> <i>Vectical</i>	<p>LENGTH OF AUTHORIZATIONS: 1 year</p> <p>Routine PDL edits plus</p> <p>*Clinical Criteria for Enstilar® Foam</p> <ul style="list-style-type: none"> ● Length of Authorization: 4 weeks ● Diagnosis of plaque psoriasis; AND ● Minimum age of 18 years



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Rosacea Agents, Topical		
Metrocream® Metrogel® Metro lotion®	azelaic acid (generic for Finacea®) Finacea® foam/gel metronidazole cr/gel/lot Mirvaso® Noritate® Rosadan™ Kit Soolantra®	LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edits
Steroids		
Steroids, Topical Low Potency		
alclometasone cr/oint hydrocortisone cr/gel/lot/oint	aqua glycolic HC Capex® shampoo Derma-smoothe-FS desonate gel/cr/lot/oint Desowen® lot fluocinolone 0.01% oil Micort™ -HC Pediderm® HC Pediderm® TA Texacort®	LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edits
Steroids, Topical Medium Potency		
fluticasone propionate cr/oint hydrocortisone butyrate cr/oint/soln/ emollient mometasone furoate cr/oint/soln	betamethasone valerate foam clocortolone cr Cloderm® Cordran® tape Cutivate® cr/lot Dermatop® cr/oint Elocon® cr/oint/soln fluocinolone acetonide cr/oint/soln flurandrenolide cr/oint/tape fluticasone propionate lot hydrocortisone valerate cr/oint hydrocortisone butyrate (generic for locoid lotion) Luxiq®	



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Preferred Agents	Non-Preferred Agents	SA Criteria
	Momexin [®] Pandel [®] prednicarbate cr/oint Synalar [®] Synalar TS [®] Ticanase kit [®]	
Steroids, Topical High Potency		LENGTH OF AUTHORIZATIONS: 1 year
betamethasone valerate cr/lot/oint triamcinolone acetoneide cr/lot/oint fluocinonide soln	amcinonide cr/lot/oint betamet diprop & prop gly cr/lot/oint betamet diprop cr/foam/gel/lot/oint DermacinRx [®] SilaPak [™] DermacinRx [®] Silazone DermacinRx [®] Therazole Pak desoximetasone cr/gel/oint/spray desoximetasone (generic Topicori[®] spray) diflorasone diacetate cr/oint Diprolene [®] lot/oint DiproleneAF [®] cr Ellzia [™] Pak Kit fluocinonide cr/emollient/gel/oint/soln Halog [®] cr/oint Kenalog [®] aerosol Loprox [®] Suspension Kit *Sernivo [™] Silazone [®] II Kit Topicori [®] cr/gel/oint/spray Trianex [®] oint triamcinolone spray triamcinolone/dimethicone Vanos [®] cr Whytederm [®] Tdpak	Routine PDL edits plus *Clinical Criteria for Sernivo[™] <ul style="list-style-type: none"> Length of Authorization: 4 weeks (treatment beyond 4 weeks is not recommended). Member must have diagnosis of mild to moderate plaque psoriasis: AND At least 18 years of age



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	<i>Preferred Agents</i>	<i>Non-Preferred Agents</i>	<i>SA Criteria</i>
Steroids, Topical Very High Potency			
	clobetasol emollient clobetasol propionate cr/gel/oint/soln halobetasol propionate cr/oint	<i>Apexicon™ E</i> <i>Bryhali™ (halobetasol propionate)</i> <i>clobetasol lot/shampoo</i> <i>clobetasol propionate foam/spray</i> <i>Clobex® lot/shampoo/spray</i> <i>Clodan® kit</i> <i>Halonate®</i> <i>halobetasol propionate (generic for Lexette®)</i> <i>Olux®</i> <i>Olux® -E</i> <i>Temovate® oint</i> <i>Ultravate® cr/lotion/oint</i> <i>Ultravate® PAC & Ultravate® X</i>	
Endocrine and Metabolic Agents			
Androgenic Agents (Testosterone – Topical)			
	testosterone (generic for AndroGel®)	<i>Androderm®</i> <i>AndroGel®</i> <i>Axiron® soln</i> <i>Fortesta®</i> <i>Natesto Nasal Gel®</i> <i>Testim®</i> <i>testosterone (generic for Axiron®)</i> <i>testosterone gel/packet/pump (generic for Vogelxo™)</i> <i>testosterone (generic for Fortesta®)</i> <i>Vogelxo™ gel/packet/pump</i> <i>Xyosted™</i>	<p>LENGTH OF AUTHORIZATIONS: 1 year</p> <p>Routine PDL edits Plus</p> <p>Clinical Criteria for all preferred and non-preferred Androgenic Agents</p> <p><u>INITIAL REVIEW CRITERIA</u></p> <ul style="list-style-type: none"> • Patient is > 18 years old; AND • Patient is male; AND • Patient has a diagnosis of primary or secondary hypogonadism; AND • Patient does not have a history of prostate carcinoma or male breast carcinoma; AND • 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. • Testosterone, normal range = 300 to 1,000 ng/dL • Patients who meet criteria should be approved for the preferred agents -> androGel® gel packet or androGel® gel pump. <p><u>CONTINUATION OF THERAPY CRITERIA</u></p>



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		<ul style="list-style-type: none"> • Patient has been compliant with treatment based on refill history • 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 colchicine caps Probenecid® probenecid & colchicine	<i>colchicine tabs</i> <i>Colcrlys®</i> <i>Duzallo®</i> <i>Gloperba®</i> <i>Mitigare®</i> <i>Uloric®</i> *Zurampic® (QL, AG)	LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edits plus *Clinical Criteria for Zurampic® <ul style="list-style-type: none"> • Member has not achieved target serum uric acid levels (< 6 mg per dL; 355 µmol per L) with a xanthine oxidase inhibitor alone, AND • Member must take in combination with a xanthine oxidase inhibitor, AND • Minimum age restriction of 18 years of age • <i>Quantity limit of 1 per day</i>
Contraceptives*(long-acting IUDs & injectable)		
Kyleena™ Liletta® medroxyprogesterone 150mg Mirena® Nexplanon® Paragard® Skyla®	<i>Depo-Provera® 104 mg and 150 mg</i>	LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edits
Diabetes Hypoglycemics: Injectable Amylin Analogs		
	*SymLin® *SymLin® Pens	LENGTH OF AUTHORIZATIONS: 1 year *Clinical Criteria for Injectable Amylin Analogs <ul style="list-style-type: none"> • Member must have a history of at least a 90 day trial of insulin. • SymLin® is only indicated as adjunct therapy with insulin. • Member meeting ALL of the following criteria may be approved: <ul style="list-style-type: none"> ○ Diagnosis of Type 1 or 2 diabetes; AND ○ On insulin therapy; AND ○ Failure to achieve adequate glycemic control (HbA1c ≤ 6.5%)



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Diabetes Hypoglycemics: Injectable Incretin Mimetics CLOSED CLASS		
Byetta[®] (exenatide) Bydureon[™] (exenatide ER) Victoza[®] (liraglutide)	<i>Adlyxin[™]</i> (lixisenatide) <i>Bydureon[™] Bcise SQ</i> <i>Soliqua[®] 100/33</i> (insulin glargine & lixisenatide inj) <i>Ozempic[®]</i> <i>Tanzeum[™]</i> (albiglutide) <i>Trulicity[™]</i> (lixisenatide) <i>Xultophy[®] 100/3.6</i> (insulin glargine & lixisenatide inj)	LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edits
Diabetes Hypoglycemics: Injectable Insulins		
Insulin Mix		LENGTH OF AUTHORIZATIONS: 1 year
Humalog[®] Mix 50/50 vial Humalog[®] Mix 75/25 vial Humulin[®] 70/30 vial Novolog[®] Mix 70/30 pen/vial	<i>Humalog[®] Mix 50/50 Kwikpen</i> <i>Humalog[®] Mix 75/25 Kwikpen</i> <i>Humulin[®] 70/30 pen (OTC)</i> <i>Novolin[®] 70/30 vial (OTC)</i>	Routine PDL edits
Insulin N		
Humulin[®] N vial (OTC)	<i>Humulin[®] N pen</i> <i>Novolin[®] N vial (OTC)</i>	
Insulin R		
Humulin[®] R vial	<i>Novolin[®] R vial (OTC)</i>	
Long-Acting Insulins		
Lantus[®] Solostar[®] & vial (insulin glargine) Levemir[®] pen/vial (insulin detemir)	<i>Basaglar[®] KwikPen[®]</i> (insulin glargine) <i>Toujeo[®] Solostar[®]</i> (insulin glargine) 300 Units/mL <i>Tresiba[®] FlexTouch[®] Pen</i> (insulin degludec) 100 U/ml, 200 U/ml	
Rapid-Acting Insulins		
Humulin 500 U/M pen/vial Humalog[®] vial	<i>Admelog[®] Solostar Pen/vial</i> <i>Apidra[®] cartridge/Solostar/vial</i> <i>Fiasp[®]</i>	



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Novolog [®] cartridge/vial/ Flexpen		Humalog [®] Cartridge/Kwikpen [®] Humalog Jr. Kwikpen [®] Afrezza [®] cartridge (inhalation)	
Diabetes Oral Hypoglycemics			
Oral Hypoglycemics Alpha-Glucosidase Inhibitors			LENGTH OF AUTHORIZATIONS: 1 year
acarbose		Glyset [®] miglitol (generic Glyset [®]) Precose [®]	Routine PDL edits plus
Oral Hypoglycemics Biguanides			Metformin Step Edit for all Oral Hypoglycemics (excluding metformin)
metformin metformin ER (generic for Glucophage [®] XR)		Fortamet [®] Glucophage [®] IR & XR Glumetza [®] Riomet [®] susp metformin ER (generic Fortamet [®]) metforman ER (generic Glumetza [®]) metformin (generic Riomet [®])	<ul style="list-style-type: none"> Patients with a hemoglobin A1C < 9% must have a minimum 90 day trial of metformin (unless contraindicated*) Patients with a hemoglobin A1C ≥ 9% should be started on metformin (unless contraindicated) plus a second agent (e.g., DPP-IV, SGLT2, GLP-1 receptor agonists, TZDs, sulfonylureas). A 90 day trial of metformin is NOT required.
Oral Hypoglycemics Biguanide Combination Drugs			*Contraindications include:
glyburide/metformin		glipizide/metformin Glucovance [®]	<ul style="list-style-type: none"> severe renal impairment (eGFR below 30mL/min/1.73m2) known hypersensitivity acute or chronic metabolic acidosis including diabetic ketoacidosis
Oral Hypoglycemics DPP-IV Inhibitors & Combination CLOSED			
Janumet [®] Janumet XR [®] Januvia [®] Jentadueto [™] Tradjenta [™]		alogliptin (generic Nesina [™]) alogliptin/metformin (generic Kazano [™]) alogliptin/pioglitazone (generic Oseni [™]) Jentadueto XR [™] Kazano [™] Kombiglyze XR [™] Nesina [™] Onglyza [™] Oseni [™]	



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Preferred Agents		Non-Preferred Agents	SA Criteria
Oral Hypoglycemics Meglitinides			
repaglinide nateglinide	Prandin® PrandiMet™ repaglinide/metformin Starlix®		
Oral Hypoglycemics Second Generation Sulfonylureas			
glimepiride glipizide glipizide ER glyburide glyburide micronized	Amaryl® Diabeta® Glucotrol® Glucotrol XL® Glynase®		<u>Routine PDL Edits plus</u>
*Oral Hypoglycemics Sodium Glucose Co-Transporter 2 Inhibitor CLOSED CLASS			<u>*Clinical Criteria/Stepedit for non-preferred Sodium Glucose Co-Transporter 2 (SGLT2)</u>
Farxiga™ (AG) Glyxambi® (AG) Invokana™ (AG) Jardiance® (AG) Synjardy® (AG)	Invokamet™ (AG) Invokamet™ XR (AG) Segluromet™ (ertugliflozin/metformin) Steglatro™ Steglujan™ Synjardy® XR (AG) Xigduo™ XR (AG)		Length of Authorization: Initial approval for 6 months. Renewals for 1 year. <ul style="list-style-type: none"> Approve for Type 2 diabetics who have been compliant with and have not achieved adequate glycemic control with metformin of a HbA1c of equal to or less than 7.5% signifies control, to receive a drug in the Sodium Glucose Co-Transporter 2 Inhibitor class the HbA1c must be above 7.6% ; OR Are intolerant to metformin; AND Member must be > 18 years of age.
Oral Hypoglycemics Thiazolidinediones			
pioglitazone	Avandia® Actoplus Met® IR & XR Actos® Avandaryl® Avandamet® Duetact® pioglitazone/metformin pioglitazone/glimepiride		
Erythropoiesis Stimulating Proteins			
Epogen® Retacrit™	Aranesp® vial/syringe Procrit® Mircera®		LENGTH OF AUTHORIZATIONS: for duration of the prescription up to 6 months Routine PDL edits



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Preferred Agents	Non-Preferred Agents	SA Criteria
		<i>Omontys[®] is not PDL eligible, may be covered under medical benefit</i>
Glucocorticoids, Oral		
budesonide EC dexamethasone soln/tab hydrocortisone methylprednisolone dose pk methylprednisolone 4 mg tab prednisolone sodium phosphate soln prednisolone soln prednisone soln/tab/dose pk	Cortef [®] cortisone acetate dexamethasone elixir/intensol Dexpak [®] *Emflaza [™] (AG) Entocort [®] EC Flo-Pred [®] Medrol [®] dose pk/tab methylprednisolone 8,16 & 32mg tab Millipred DP [®] tab Does Pk Millipred [®] soln/tab Orapred [®] ODT prednisolone sod phosphate ODT/soln prednisone intensol Rayos [®] DR tab TaperDex [®] Veripred [®]	LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edits plus *Clinical Criteria for Emflaza[™] <ul style="list-style-type: none"> • Trial and failure of all drugs does not apply to Emflaza[™] • Indicated for the treatment of Duchenne muscular dystrophy (DMD) in members 5 years of age and older. • Minimum Age Limit = 5 years of age
*Growth Hormone		
CLOSED CLASS		
Genotropin [®] Nutropin AQ [®] NuSpin [™]	Humatrope [®] cartridge/vial Norditropin cartridge [®] Norditropin FlexPro [®] & Nordiflex [®] Omnitrope [®] Saizen [®] cartridge/vial Serostim [®] Tev-Tropin [®] Zomacton [®] Zorbtive [®]	LENGTH OF AUTHORIZATIONS: 1 year 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 [®] Cinryze [™] Kalbitor [®]	Firazyr [®] Haegarda [®] Ruconest [®]	LENGTH OF AUTHORIZATIONS: Date of service Routine PDL edits plus



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Preferred Agents	Non-Preferred Agents	SA Criteria
	Takhzyro™	*_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® *Zenpep®	Pancreaze® Pertzye® Ultresa® Viokace®	LENGTH OF AUTHORIZATION: 1 year Routine PDL edits plus Clinical Criteria for Pancreatic Enzymes *Creon® and Zenpep®: diagnosis of pancreatic insufficiency due to cystic fibrosis or chronic pancreatitis or pancreatectomy. <ul style="list-style-type: none"> For all drugs if member has a diagnosis of Cystic Fibrosis they do not have to try and fail a preferred. If member has a feeding tube then two different pancreatic enzymes can be approved for use together.
Progestational Agents		
Makena® Auto-injector & Single Dose Vial (SDV) medroxyprogesterone acetate (tab only) norethindrone acetate progesterone cap/inj	Aygestin® Crinone (Vaginal) Depo-Provera 400 MG/ML hydroxyprogesterone caproate SDV hydroxyprogesterone caproate (generic for Makena MDV) Makena® Multi Dose Vial (MDV) Prometrium® Provera®	LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edits
Progestins Used For Cachexia		
megestrol acetate	Megace® Megace® ES megestrol suspension ES	LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edits
Vaginal Estrogens		
Premarin® Vaginal cr Vagifem® Vaginal tab	Estrace® Vaginal cr estradiol cream (generic Estrace®) Estring® Vaginal ring Femring® Vaginal ring Imvexxy®	LENGTH OF AUTHORIZATIONS: 6 months Routine PDL edits



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	Preferred Agents	Non-Preferred Agents	SA Criteria
Gastrointestinal			
G I Antibiotics			
	Firvanq™ metronidazole tab vancomycin cap	Aemcolo™ Alinia® Difucid® Flagyl® cap/tab/ER metronidazole cap neomycin paromomycin Solosec™ Tindamax® tinidazole Xifaxan® vancomycin compounded oral soln kit Vancocin®	Length of authorization: 1 year Routine PDL edits plus
Antiemetic/Antivertigo Agents			
Cannabinoids (delta-9THC derivatives)			
	*dronabinol	*Cesamet™ *Marinol® *Syndros®	LENGTH OF AUTHORIZATIONS: 6 months *Dronabinol plus all non-preferred Antiemetic/Antivertigo agents require submission of a Clinical SA. Refer to Antiemetic/Antivertigo SA form
5HT3 Receptor Blockers			
	ondansetron ODT/tab	Aloxi® Anzemet® Akynzeo® granisetron Granisol® soln/tab Kytril® ondansetron soln palonosetron (generic Aloxi®) Sancuso® patch	LENGTH OF AUTHORIZATIONS: 3 months, unless otherwise noted Routine PDL edits plus



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Preferred Agents		Non-Preferred Agents	SA Criteria
		Zofran [®] ODT/soln/tab Zuplenz [®] film	
NK-1 Receptor Antagonist			LENGTH OF AUTHORIZATIONS: Length of chemotherapy regimen or a maximum of 6 months
		aprepitant capsule/pack Cinvanti [™] (Intraven) Emend [®] Bi Pak/cap Emend [®] Tri-fold pack/susp Varubi [™] IV, Tab	
Other			LENGTH OF AUTHORIZATIONS: 1 year, unless otherwise noted
meclizine metoclopramide ondansetron tab/ODT prochlorperazine **promethazine (AG)		Antivert [®] Bonjesta [™] Compazine [®] supp/tab Compro [®] Diclegis [®] dimenhydrinate hydroxyzine Metozolv [®] ODT metoclopramide ODT **Phenergan [®] (AG) prochlorperazine supp **promethazine 50mg supp (AG) Reglan [®] scopolamine (generic Transderm-Scop [®]) Tigan [®] Transderm-Scop [®] trimethobenzamide Vistaril [®]	**Promethazine approved for members ≥ 2 years
*GI Motility, Chronic			
Amitiza [®] Linzess [™] Movantik [®]		alosetron Lotronex [®] Relistor [®] Symproic [®]	LENGTH OF AUTHORIZATIONS: 6 months Routine PDL edits plus



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Preferred Agents		Non-Preferred Agents	SA Criteria
		Trulance™ Viberzi™	*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 lansoprazole/amoxicillin/ clarithromycin Prevpac®		LENGTH OF AUTHORIZATIONS: 14 days Routine PDL edits
Histamine-2 Receptor Antagonists (H-2 RA)			
famotidine (OTC & RX) ranitidine tab/syrup (OTC & RX)	cimetidine tab/syrup (OTC/RX) famotidine oral susp (OTC/RX) nizatidine cap/susp Pepcid® susp/tab (OTC/RX) ranitidine cap (OTC/RX) Zantac® syrup/tab (OTC/RX)		LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edits
Proton Pump Inhibitors			
omeprazole RX pantoprazole	Aciphex® DR tab/sprinkle Dexilant® esomeprazole magnesium esomeprazole strontium lansoprazole cap Nexium® Omeprazole OTC omeprazole magnesium OTC omeprazole/sodium bicarbonate Prevacid® RX, OTC & Solutab rabeprazole DR tab Prilosec® Rx & Susp Protonix® Zegerid® cap/OTC/susp packet		LENGTH OF AUTHORIZATIONS: 12 weeks; unless member meets an exception; then 1 year Routine PDL edits plus *All non-preferred Proton Pump Inhibitors require submission of a Clinical SA. Refer to Proton Pump Inhibitor SA form Preferred agents require a SA for use over 90 days
Ulcerative Colitis Oral and Rectal Preparations (5-ASA DERIVATIVES)			
Ulcerative Colitis – Oral			LENGTH OF AUTHORIZATIONS: 1 year
Apriso® Lialda®	Asacol® HD Azulfidine® IR & DR		Routine PDL edits



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Preferred Agents		Non-Preferred Agents	SA Criteria
Pentasa[®] sulfasalazine DR & IR		<i>balsalazide disodium</i> <i>budesonide ER (generic Uceris[™])</i> <i>Colazal[®]</i> <i>Delzicol[™]</i> <i>Dipentum</i> <i>*Giazo[™] (QL)</i> <i>mesalamine (generic Asacol[®] HD)</i> <i>mesalamine (generic Lialda[®])</i> <i>Uceris[™]</i>	<i>*Giazo is limited to an 8 week supply</i>
Ulcerative Colitis – Rectal			
Canasa[®] rectal supp mesalamine enema		<i>mesalamine kit</i> <i>Rowasa[®] enema/kit</i> <i>SFRowasa[®]</i> <i>Uceris[®]</i>	
Genitourinary			
Alpha-Blockers and Androgen Hormone Inhibitors For Benign Prostatic Hypertrophy (BPH)			
Alpha-Blockers for BPH			LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edits plus
alfuzosin tamsulosin HCL	<i>Flomax[®]</i> <i>Rapaflo[®]</i> <i>Sildenafil (generic Rapaflo)</i> <i>Uroxatral[®]</i>		
Androgen Hormone Inhibitors for BPH			
dutasteride finasteride	<i>Avodart[®]</i> <i>Dutasteride/tamsulosin</i> <i>Jalyn[®]</i> <i>Proscar[®]</i>		
Phosphodiesterase (PDE) 5 Inhibitor for BPH			*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 evaluation by Urologist.
	<i>*Cialis[®] (ST)</i>		
Urinary Antispasmodics (Bladder Relaxant)			
oxybutynin tab/syrup oxybutynin ER Toviaz[™] VESIcare[®]	<i>darifenacin ER (generic Enablex[®])</i> <i>Detrol[®] & Detrol[®] LA</i> <i>Ditropan[®] & *Ditropan[®] XL</i> <i>Enablex[®]</i>		



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	Preferred Agents	Non-Preferred Agents	SA Criteria
		flavoxate Gelnique™ gel/gel Pump Myrbetriq™ Oxytrol® transdermal includes for Woman OTC Sanctura XR trospium IR & ER tolterodine IR & ER	
Immunological Agents			
Multiple Sclerosis			
	Avonex® Avonex® Adm Pack Betaseron® Copaxone 20 mg syringe® *Gilenya® (ST) Rebif® SQ Rebif® Rebidose Pen®	**Ampyra® Aubagio® Copaxone® 40 mg syringe® dalfampridine ER (generic for Ampyra®) Extavia® Kit Glatopa™ Plegriby® Tecfidera™ ***Zinbryta™ (QL)	<p>LENGTH OF AUTHORIZATIONS: 1 year</p> <p>Routine PDL edits plus</p> <p>*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.</p> <p>**Select non-preferred MS drugs (Ampyra®, Zinbryta™) require the submission of a Clinical SA. Refer to MS - Ampyra® SA form; and Zinbryta™ SA Form</p> <p>***Zinbryta™ Quantity Limit = 1 ml per 28 days (0.036 ml per day).</p>
Cytokine and CAM Antagonists And Related Agents			
	Enbrel® Humira® methotrexate tab/PFvial/ MDVvial	Actemra® SQ & ACTPEN Cimzia® & Cimzia® Syringe Kit Cosentyx™ Entyvio® Ilaris® Ilumya™ Kevzara® inj, pen Kineret® Olumiant® Otezla® Otrexup® Orencia® Remicade®	<p>CLOSED CLASS</p> <p>LENGTH OF AUTHORIZATION: 1 year</p> <p>Routine PDL edits plus</p> <p>*All non-preferred Cytokine and CAM Antagonists require submission of a Clinical SA. Refer to Cytokine and CAM Antagonists and Related Agents SA Form</p> <p>For a list of Cytokine and CAM Antagonists and criteria for approval see Appendix A</p>



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	<i>Preferred Agents</i>	<i>Non-Preferred Agents</i>	<i>SA Criteria</i>
		<i>Rasuvo™</i> <i>Siliq®</i> <i>Simponi®</i> <i>Stelara® vial/syringe</i> <i>Taltz®</i> <i>Tremfya™</i> <i>Trexall®</i> <i>Xatmep™</i> <i>Xeljanz™ & Xeljanz™ XR</i>	
Ophthalmic			
Antibiotics			
	bacitracin/polymyxin b sulfate oint ciprofloxacin drops erythromycin gentamicin drops/oint Moxeza® drops ofloxacin drops polymyxin/trimethoprim tobramycin Vigamox®	<i>AzaSite™ drops</i> <i>bacitracin</i> <i>Besivance® drops</i> <i>Bleph®-10</i> <i>Ciloxan® drops/oint</i> <i>Garamycin® drops/oint</i> <i>gatifloxacin 0.5% soln</i> <i>Ilotycin®</i> <i>levofloxacin drops</i> <i>moxifloxacin drops (generic Vigamox®)</i> <i>Natacyn®</i> <i>neomycin/polymix/gramicidin</i> <i>neomycin/bacitracin/polymyxin oint</i> <i>Neosporin®</i> <i>Ocuflox® s</i> <i>Polytrim®</i> <i>sulfacetamide oint/ soln</i> <i>Tobrex® drops/oint</i> <i>Zymaxid®</i>	<u>LENGTH OF AUTHORIZATIONS:</u> Date of service only; no refills Routine PDL edits
Antibiotic/Steroid Combinations			
	neomycin/polymyxin/dexamethasone oint/susp	<i>Blephamide®</i> <i>Blephamide® S.O.P.</i>	<u>LENGTH OF AUTHORIZATION:</u> Date of service only; no refills



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Preferred Agents		Non-Preferred Agents	SA Criteria
Tobradex[®] oint/susp		<i>Maxitrol[®] oint/susp</i> <i>neomycin/bacitracin/poly/HC</i> <i>neomycin/polymyxin/HC</i> <i>Pred-G[®] oint/susp</i> <i>sulfacetamide/prednisolone</i> <i>Tobradex[®] ST</i> tobramycin/dexamethasone susp <i>Zylet[®]</i>	Routine PDL edits
Antihistamines/Mast Cell Stabilizers			
Antihistamines			LENGTH OF AUTHORIZATIONS: 1 year
Alway OTC[®] ketotifen fumerate Pazeo[®] Zaditor[®] OTC	<i>Bepreve[®]</i> <i>Elestat[®]</i> Emadine[®] <i>epinastine 0.05% eye drops</i> <i>*Ilevro[™] 0.3% (QL)</i> <i>Lastacast[®]</i> <i>olopatadine</i> <i>Optivar[®]</i> <i>Patanol[®]</i> <i>Pataday[®] s</i>	Routine PDL edits *Ilevro [™] is limited to 1 bottle plus 1 refill	
Mast Cell Stabilizers			
cromolyn sodium	<i>Alocril[®]</i> <i>Alomide[®]</i>		
Anti-inflammatory Agents			
NSAIDS			LENGTH OF AUTHORIZATIONS: Date of service only; no refills
diclofenac sodium flurbiprofen sodium ketorolac 0.4% & 0.5%	<i>Acular[®] 0.5% & LS[®] 0.4%</i> <i>Acuvail[®]</i> <i>bromfenac 0.09%</i> <i>BromSite[™]</i> <i>*Ilevro[™] 0.3% (QL)</i> Inveltys[™] (loteprednol etabonate) <i>Nevanac[®]</i> <i>Ocufen[®]</i> <i>Prolensa[™]</i>	Routine PDL edits *Ilevro [™] is limited to 1 bottle plus 1 refill	



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<i>Preferred Agents</i>		<i>Non-Preferred Agents</i>	<i>SA Criteria</i>
Corticosteroids			
Durezol® fluorometholone prednisolone acetate	Alrex™ Dexamethasone Flarex® FML®, FML Forte® & FML® S.O.P. Lotemax™ drops/gel/oint Maxidex® Omnipred® Pred Forte® & Pred Mild® prednisolone sod phosphate Vexol® Yutiq® (fluocinolone acetonide intravitreal implant)		
Glaucoma Agents			
Alpha 2 Adrenergic Agents			LENGTH OF AUTHORIZATIONS: 1 year
Alphagan P® 0.1 & 0.15% brimonidine 0.2%	apraclonidine 0.5% drops brimonidine tartrate 0.15% Iopidine® 0.5% & 1%		Routine PDL edits
Beta Blockers			
carteolol 1% Combigan® levobunolol 0.5% metipranolol 0.3% timolol maleate	Betagan® 0.5% betaxolol 0.5% Betoptic-S® 0.25% Istalol® 0.5% Timoptic® drops 0.25% & 0.5% Timoptic® XE 0.25% & 0.5% sol-gel		
Carbonic Anhydrase Inhibitors			
Azopt® 1% dorzolamide dorzolamide/timolol Simbrinza™	Cosopt® 0.5%-2% Cosopt® PF Trusopt® 2%		



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Preferred Agents		Non-Preferred Agents	SA Criteria
Rho Kinase Inhibitor			
		<i>Rhopressa[®]</i>	
Prostaglandin Analogs			
latanoprost Travatan Z[®]		<i>bimatoprost</i> <i>Lumigan[®] 0.03% & 0.01%</i> <i>Rescula[®]</i> <i>travoprost 0.004%</i> <i>Vyzulta[™]</i> <i>Xalatan[®] 0.005%</i> <i>Xelpros[®] (latanoprost)</i> <i>Zioptan[™]</i>	
Respiratory			
*Anti-Allergens, Oral			
		<i>*Grastek[®] SL</i> <i>*Oralair[®] SL</i> <i>*Ragwitek[™] SL</i> <i>*Odactra[®]</i>	LENGTH OF AUTHORIZATIONS: 1 year *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
Generic only class		<i>All Brands require a SA</i>	Routine PDL edits
Second Generation Antihistamines and Combinations			
cetirizine liquid 1mg/1mL (RX/OTC) cetirizine tabs OTC levocetirizine Tablets loratadine tab/syrup OTC		<i>Allegra-D[®]</i> <i>cetirizine chew tab (OTC)</i> <i>cetirizine liquid 5mg/5mL (OTC)</i> <i>cetirizine D tab (OTC)</i> <i>Clarinex[®]</i> <i>Clarinex-D[®]</i> <i>Claritin[®]</i> <i>Claritin[®] D</i> <i>desloratadine ODT</i> <i>fexofenadine</i>	



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Preferred Agents	Non-Preferred Agents	SA Criteria																																																									
	<i>fexofenadine/PSE ER</i> <i>fexofenadine suspension</i> <i>loratadine ODT</i> <i>loratadine D 12 & 24 hr</i> <i>Xyzal[®] soln/tab (RX, OTC)</i>																																																										
Beta-Adrenergic Agents																																																											
Long Acting Beta Adrenergic s (LABA) MDIs or Nebulizers		LENGTH OF AUTHORIZATIONS: 1 year																																																									
Foradil[®] (AG) Serevent Diskus[®] (AG)	<i>Arcapta DS(AG)</i> <i>Brovana[®] (AG)</i> <i>Perforomist[®] (AG)</i> <i>Striverdi[®] Respimat (AG)</i>	Routine PDL edits plus Clinical Criteria for LABAs for Children LENGTH OF AUTHORIZATION: 3 months Each drug listed below will require a SA for ages less than the FDA/PI indicated age. <table border="1" data-bbox="1077 722 1944 1419"> <thead> <tr> <th>Brand Name</th> <th>Age where SA is required</th> <th>FDA Indications</th> </tr> </thead> <tbody> <tr> <td>Advair[®] Diskus 250/50, & 500/50</td> <td>Children < 12</td> <td>Asthma & COPD</td> </tr> <tr> <td>Advair[®] HFA</td> <td>Children < 12</td> <td>Asthma & COPD</td> </tr> <tr> <td>Advair[®] Diskus 100/50</td> <td>Children < 4</td> <td>Asthma & COPD</td> </tr> <tr> <td>Airduo[™] Respiclick[®]</td> <td>Children < 12</td> <td>Asthma only</td> </tr> <tr> <td>Anoro[™] Ellipta</td> <td>Children & Adolescents < 18</td> <td>COPD only</td> </tr> <tr> <td>Arcapta[®] Neohaler</td> <td>Children & Adolescents < 18</td> <td>COPD only</td> </tr> <tr> <td>Bevespi Aerosphere[™]</td> <td>Children & Adolescents < 18</td> <td>COPD only</td> </tr> <tr> <td>Breo[®] Ellipta[™]</td> <td>Children & Adolescents < 18</td> <td>Asthma & COPD</td> </tr> <tr> <td>Brovana[®]</td> <td>Children & Adolescents < 18</td> <td>COPD only</td> </tr> <tr> <td>Dulera[®]</td> <td>Children < 12</td> <td>Asthma only</td> </tr> <tr> <td>Dupixent[®]</td> <td>Children < 12</td> <td>Asthma only</td> </tr> <tr> <td>fluticasone/salmeterol pow</td> <td>Children < 12</td> <td>Asthma only</td> </tr> <tr> <td>Foradil[®] Aerolizer</td> <td>Children < 5</td> <td>Asthma & COPD</td> </tr> <tr> <td>Perforomist[®]</td> <td>Children & Adolescents < 18</td> <td>COPD only</td> </tr> <tr> <td>Serevent[®] Diskus</td> <td>Children < 4</td> <td>Asthma & COPD</td> </tr> <tr> <td>Stiolto[™] Respimat[®]</td> <td>Children < 18 years</td> <td>COPD only</td> </tr> <tr> <td>Striverdi[®] Respimat</td> <td>Children < 18 years</td> <td>COPD only</td> </tr> <tr> <td>Symbicort[®] 80/4.5</td> <td>Children < 6</td> <td>Asthma & COPD</td> </tr> </tbody> </table>	Brand Name	Age where SA is required	FDA Indications	Advair [®] Diskus 250/50, & 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	Dupixent [®]	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 [®] 80/4.5	Children < 6	Asthma & COPD
Brand Name	Age where SA is required	FDA Indications																																																									
Advair [®] Diskus 250/50, & 500/50	Children < 12	Asthma & COPD																																																									
Advair [®] HFA	Children < 12	Asthma & COPD																																																									
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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																																																									
Dupixent [®]	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 [®] 80/4.5	Children < 6	Asthma & COPD																																																									



Virginia Medicaid's Preferred Drug List (PDL)/ Common Core Formulary

7/1/19

Preferred Agents		Non-Preferred Agents		SA Criteria	
			Symbicort® 160/4.5	Children < 12	Asthma & COPD
Short Acting Metered Dose Inhalers or Devices					
Proair® HFA Proventil® HFA		albuterol HFA (PROAIR) albuterol HFA (VENTOLIN) levalbuterol tartrate HFA ProAir® RespiClick Ventolin® HFA Xopenex® HFA			
Short Acting Nebulizers					
albuterol sulfate (premixed)		levalbuterol soln Xopenex®			
Biologic: Human Monoclonal IgG4 Antibody Inhibits Interleukin-4 (IL-4) and Interleukin-13 (IL-13)					
		Dupixent®		LENGTH OF AUTHORIZATION: 1 year	
				Routine PDL edits plus	
				<ul style="list-style-type: none"> • Patient must have moderate to severe asthma diagnosed as ONE of the following types: <ul style="list-style-type: none"> ○ Asthma with eosinophilic phenotype with eosinophil count greater than or equal to 300 cells/mcL; OR ○ Oral corticosteroid dependent asthma with at least 1 month of daily oral corticosteroid use within the last 3 months; AND • Patient must be 12 years of age or older; AND • Patient must have had inadequate control of asthma symptoms after a minimum of 3 months of compliant use of an inhaled corticosteroid and ONE of the following controller medications within the past 6 months: <ul style="list-style-type: none"> ○ inhaled long acting beta2 agonist ○ inhaled long acting anticholinergic 	
COPD: Bronchodilators and Phosphodiesterase 4 (PDE4) Inhibitors CLOSED CLASS					
Atrovent HFA® Anoro™ Ellipta® (AG) Bevespi Aerosphere™ Combivent® Respimat		*Daliresp® Incruse™ Ellipta® Lonhala™ Magnair™ Seebri Neohaler™		LENGTH OF AUTHORIZATION: 1 year	
				Routine PDL edits plus	
				*Clinical Criteria for Daliresp®	



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Preferred Agents		Non-Preferred Agents	SA Criteria
ipratropium bromide soln ipratropium/albuterol nebs Spiriva® Stiolto Respimat™ (AG)		<i>Spiriva® Respimat</i> <i>Tudorza™</i> <i>Utibron Neohaler™</i> <i>Wixela™ Inhub™(fluticasone/ salmeterol)</i> <i>Yupelri™ (revefenacin)</i>	<ul style="list-style-type: none"> If the member has a diagnosis of severe COPD associated with chronic bronchitis and a history of exacerbations; AND Trial/failure on at least one first-line or second-line agent (inhaled anticholinergics, long acting beta agonists or inhaled corticosteroids); AND 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) CLOSED CLASS			LENGTH OF AUTHORIZATIONS: 1 year
* Advair® Diskus (AG) * Dulera®(AG) * Symbicort®(AG)	<i>Advair® HFA(AG)</i> <i>Airduo™ Resplick® (AG)</i> <i>Breo® Ellipta™(AG)</i> <i>fluticasone/salmeterol powder (AG)</i>	Routine PDL edits	
Inhaled Corticosteroids: Metered Dose Inhalers CLOSED CLASS			
Asmanex® Flovent® Diskus & HFA Pulmicort Flexhaler®	<i>Alvesco®</i> <i>Aerospan™</i> <i>Armonair™ Resplick®</i> <i>Arnuity™ Ellipta®</i> <i>Asmanex HFA®</i> <i>QVAR® & QVAR® Redihaler</i> <i>Trelegy® Ellipta</i>		
Inhaled Corticosteroids: Nebulizer Solution CLOSED CLASS			LENGTH OF AUTHORIZATIONS: 1 year
budesonide respules	Pulmicort® Respules		
Nasal Steroids			Routine PDL edits
fluticasone	<i>Beconase AQ®</i> <i>budesonide (generic for Rhinocort® Aqua)</i> <i>budesonide (generic Rhinocort® Allergy OTC)</i> <i>Children's Qnasl™</i> <i>Clarispray OTC</i> <i>Dymista™</i> <i>Flonase®</i>		



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	<i>Preferred Agents</i>	<i>Non-Preferred Agents</i>	<i>SA Criteria</i>
		<i>Flonase Sensimist (OTC)</i> <i>flunisolide</i> <i>fluticasone OTC</i> <i>mometasone(generic Nasonex®)</i> <i>Nasonex®</i> <i>Omnaris®</i> <i>Qnasl™</i> <i>Rhinocort Aqua®</i> <i>Rhinocort® Allergy OTC</i> <i>Sinuva®</i> <i>Ticanase®</i> <i>triamcinolone OTC</i> <i>triamcinolone acetonide</i> <i>Veramyst®</i> <i>Xhance™</i> <i>Zetonna™</i>	
*Cough and Cold Drug			
	Ala-Hist DM benzonatate cap codeine/ promethazine guaifenesin/codeine phosphate hydrocodone/ homatropine Iphen-C NR phenylephrine HCl/promethazine HCl promethazine DM syrup Tusnel® Pediatric Drops	<i>lohist-DM syrup</i> <i>All other Legend cough and cold drugs are non-preferred</i> <i>Tessalon® perle</i>	LENGTH OF AUTHORIZATION: Date of Service Only Routine PDL edits * Children under the age of 6 years are not eligible for cough and cold drugs.
Epinephrine, Self-Injected			
	epinephrine 0.15 mg & 0.3 mg (authorized generic EpiPen® & EpiPen® Jr)	<i>Auvi-Q®</i> <i>Epipen®</i> <i>Epipen® Jr</i> <i>epinephrine 0.15mg & 0.3mg (generic AdrenaClick)</i>	LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edits



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	<i>Preferred Agents</i>	<i>Non-Preferred Agents</i>	<i>SA Criteria</i>
		<i>Symjepi™ (epinephrine)</i>	
Intranasal Antihistamines			
	azelastine 0.1%	<i>Astepro® 0.15%</i> <i>olopatadine</i> <i>Patanase®</i>	LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edits
Leukotriene Receptor Antagonists			
	montelukast tabs/chewable tabs	<i>Accolate®</i> <i>Singulair® tabs/chew tabs/granules</i> <i>montelukast granules</i> <i>zafirlukast</i> <i>Zyflo™</i> <i>Zyflo CR™</i> <i>zileuton ER</i>	LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edits