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

10/1/19

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***	***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)** **LENGTH OF AUTHORIZATIONS** • 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 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)* *buprenorphine (generic Butrans®)* *ConZip® (tramadol ER)* *Ryzolt™ (tramadol ER)* *tramadol ER* *Ultram ER® (tramadol ER)*	
	Preferred (Sch II)	***Non-Preferred***	
	fentanyl 12, 25, 50, 75 & 100 mcg patches **morphine sulfate ER tab**	*Arymo™ER* *Duragesic®* *Embeda* *Exalgo®* *fentanyl 37.5 mcg, 62.5 mcg, and 87.5 mcg patches* *hydromorphone ER* *Hysingla ER™* *Kadian® ER* *Morphabond™ ER* *morphine ER cap (generic Avinza®)* *morphine ER cap (generic Kadian®)* *MS Contin®* *Nucynta® ER* *Oramorph ® SR®* *oxycodone-long acting* *OxyContin®* *oxymorphone ER* *Xartemis™ XR* *Xtampza ER®* *Zohydro ER™*	

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Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
***Methadone Drugs**		
	Dolophine® *Methadose® oral soln & tab* *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:** • 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).
	Actiq® *Fentora®* *fentanyl citrate* *Lazanda®* *Subsys®*	
Short-Acting Opioids		***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)**
codeine/APAP **hydrocodone/APAP** **hydrocodone/ibuprofen** **hydromorphone** **morphine IR** **oxycodone IR** **oxycodone/APAP** **tramadol HCl** **tramadol HCl/APAP**	*Abstral®* *Apadaz™* *codeine tab/soln* *butalbital comp with codeine* *butalbital/caffeine/APAP w/codeine* *butorphanol tartrate nasal* *dihydrocodeine/APAP/caffeine* *dihydrocodeine/ASA/caffeine* *hydromorphone liq/supp* *meperidine tab* *morphine supp* *Nucynta®* *Oxaydo®* *oxycodone/APAP (generic PrimLev™)* *Oxycodone conc* *oxycodone/ASA* *oxycodone/ibuprofen* *oxymorphone HCl* *Panlor®* *pentazocine/naloxone* *PrimLev™* *RoxyBond ™*	

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Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	Ultracet® *Ultram®* *Zamicet ®soln*	
Opioid Dependency CLOSED CLASS		***All Buprenorphine Containing Drugs (non-preferred) require submission of Clinical SA. Refer to (Sublocade Form) or (Oral Buprenorphine SA Form)**
***buprenorphine SL** ***Suboxone® film** ***Sublocade™ SQ** **naloxone syringe & vial** **naltrexone tab** **Narcan® Nasal Spray** **Vivitrol®**	**Bunavail ™* **buprenorphine/naloxone tab SL* **buprenorphine/naloxone film SL* **Cassipa®* **Probuphine® implant* **Zubsolv™* *Evzio® injection*	**Quantity Limits** 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
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)		
Oral NSAIDs		**LENGTH OF AUTHORIZATIONS: 1 year**
Children's Motrin® susp (OTC) **ibuprofen cap** **ibuprofen tab (OTC & Rx)**	*Anaprox® IR & DS®* *Advil®* *Aleve®* *Arthrotec®*	**Routine PDL edits plus** ***Step edit required for Celebrex® and celecoxib**

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	Infant's ibuprofen drops **meloxicam tab** **naproxen tab** **naproxen sodium (OTC)** **naproxen EC (Rx)** **sulindac**	*Cataflam®* **Celebrex® & *celecoxib* *Daypro®* *diclofenac potassium* *diclofenac sodium SR* *diclofenac sodium/misoprostol* *diflunisal* *Duexis®* *etodolac IR & SR* *Feldene®* *fenoprofen* *flurbiprofen* *ibuprofen tab chew OTC* *Indocin® supp* *indomethacin IR, SR & rectal* *ketoprofen IR & ER* *ketorolac* *meclofenamate* *mefenamic* *meloxicam susp* *Mobic®* *Motrin®* *nabumetone* *Nalfon®* *Naprelan®* *Naprosyn®* *naproxen CR (generic Naprelan®)* *naproxen sodium (RX)* *naproxen susp* *oxaprozin* *piroxicam* *Ponstel®* *Prevacid Naprapac®* *Sprix® nasal spray* *Tivorbex™* *tolmetin sodium*	• 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.

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
		Vimovo® *Vivlodex™* *Voltaren®XR* *Zipsor®* *Zorvolex™*	
	Topical NSAIDs		**LENGTH OF AUTHORIZATIONS:** **1 year** **Routine PDL edits plus** **Clinical Criteria for Non-Preferred Topical NSAIDs; *Flector®, Pennsaid®, Vopac MDS, & Xrylix™ Kit:** • 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. ***Quantity limit for Flector® = 30 patches per RX*** **Solaraze® 3% & Diclofenac Sodium 3 % Clinical Criteria: • Approved only for the topical treatment of actinic keratosis
	Voltaren® 1% gel	**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*	
Antibiotic-Anti-Infective			
	***Antibiotics, Inhaled**	**CLOSED CLASS**	
	Bethkis® *(QL, AG)* **Kitabis™ Pak *(QL, AG)*** ****Tobi Podhaler® *(QL, AG, SE)*** tobramycin inhalation neb soln (generic Tobi® inhalation) (QL, AG)	****Arikayce®(amikacin liposome)* *Cayston®* *Tobi® inhalation neb soln (QL, AG)* *tobramycin Pak (generic Kitabis™ Pak) (QL, AG)*	**LENGTH OF AUTHORIZATIONS:** **1 year** **Routine PDL edits plus** ****Clinical Criteria for Arikayce®** Duration of Approval: 12 months **Initial Approval Criteria** • Patient is ≥ 18 years of age; AND • Diagnosis of Mycobacterium avium complex (MAC) lung disease as determined by the following:

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
			○ 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 • 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 *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®. **Tobi Podhaler® • Requires a clinical reason as to why one of the preferred tobramycin inhalation nebulizer solutions cannot be used (Bethkis® or Kitabis™). **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 Tobi Podhaler® = 224 capsule/28 day Tobi® inhalation *neb* = 280Ml (56 amps)/28 days tobramycin = 280Ml (56 amps)/28 days
	Antifungals, Oral		
	fluconazole tab/susp **griseofulvin susp** **nystatin tab/susp**	*Ancobon* ® *clotrimazole (mucous mem)* *Cresemba*®	**LENGTH OF AUTHORIZATIONS**: Duration of the prescription (up to 12 months) **Routine PDL edits plus**

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
terbinafine	*Diflucan® tab/susp* *flucytosine* *Gris-Peg®* *griseofulvin tab* *griseofulvin ultramicrosize* *itraconazole* *itraconazole solution (generic for Sporanox® soln)* *ketoconazole* *Lamisil ® tab/granules* *Noxafil®* **Onmel®* **Sporanox® cap/soln* *Tolsura™* *Vfend® tab/susp* *voriconazole tab & powder for susp*	*** 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. **Routine PDL edits plus** **Clinical Criteria for Non-Preferred Cephalosporins** • 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.
Cefaclor cap **cefprozil tab/susp** **cefuroxime tab**	*cefaclor ER* *cefaclor susp* *Ceftin® tab/susp*	
Third Generation Cephalosporins		
cefdinir cap/susp	*Cedax® cap/susp* *ceftibuten* *cefditoren pivoxil* *cefixime suspension* *cefpodoxime proxetil cap/susp* *Spectracef®* *Suprax® chewable tab/cap/susp*	
Macrolides, Oral		
Macrolides & Ketolides		**LENGTH OF AUTHORIZATIONS**: Date of service only; no refills **Routine PDL edits plus** **Clinical Criteria for Non-Preferred Macrolides and Ketolides** • Infection caused by an organism resistant to preferred drugs; **OR**
azithromycin pack/susp/tab **clarithromycin tab/susp** **Eryped® 200 susp**	*Biaxin® tab* *clarithromycin ER* *Eryped® 400 susp*	

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Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
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*	• 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. *** Ketek® Clinical Criteria** • Treatment of community-acquired pneumonia (of mild to moderate severity) **AND** • Infection is caused by one of the following microorganism: *Streptococcus pneumoniae, Haemophilus 9nfluenza, Moraxella catarrhalis, Chlamydophila pneumoniae, or Mycoplasma pneumoniae.***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** • 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	*Levaquin® tab/susp* *levofloxacin susp* *moxifloxacin*	
Topical Antibiotics		

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	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®* *Nuvessa®*	**LENGTH OF AUTHORIZATIONS**: Date of Service **Routine PDL edits**
Antivirals			
	***Hepatitis C Agents** **CLOSED CLASS**		
	Interferon		**LENGTH OF AUTHORIZATIONS**: 8 weeks (initial approval) ***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**
	Peg-Intron® **Peg-Intron Redipen®**	*Pegasys® Proclick/syringe/kit/vial*	
	Protease Inhibitor		
		Olysio™ (discontinued)	
	***Nucleotide Analog NS5A & NS5B Polymerase Inhibitors & Combinations**		
	sofosbuvir /velpatasvir (generic Epclusa®)	*Epclusa®* *Sovaldi®* *Vosevi™*	
	***NS5A, NS3/4A Inhibitor Combinations**		
	Mavyret™	*Technivie™* *Viekira Pak™* *Viekira XR™* *Zepatier®*	
	***NS5B & Protease Inhibitor combinations**		
		Harvoni® *Ledipasvir/Sofosbuvir (generic Harvoni®)*	
	Herpes Oral		
	acyclovir cap/tab/susp	*Famvir®*	**LENGTH OF AUTHORIZATIONS**: 1 year

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	famciclovir **valacyclovir**	*Sitavig®* *buccal tab* *Valtrex®* *Zovirax®* *tab/susp*	**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/** *cap*	*Flumadine® tab* *rimantadine* *Relenza Disk®* *Tamiflu® susp/cap* *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* *Fosrenol®* chewable tab lanthanum carbonate chewable tab *Phoslo®*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits**

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

Preferred Agents	Non-Preferred Agents	SA Criteria
Eliquis™ **Jantoven** **Pradaxa®** **Xarelto®** **Xarelto® Starter Pack** **warfarin**	*Coumadin®* *Eliquis™ Dose Pack* **Savaysa™*	• Diagnosis of: • Non-valvular Atrial Fibrillation, **OR** • deep vein thrombosis, **OR** • pulmonary embolism ; **AND** • Documentation that CrCl is NOT ≥ 95mL/min calculated by Cockcroft-Gault equation
Antihypertensive Agents		
ACE Inhibitors		**LENGTH OF AUTHORIZATIONS: 1 year** **Routine PDL edits**
benazepril **enalapril** **lisinopril** **ramipril**	*Accupril®* *Altace®* *captopril* *Epaned™ soln* *fosinopril* *Lotensin®* *Mavik®* *moexipril* *Monopril®* *perindopril* *Prinivil®* *Qbrelis™* *quinapril* *ramipril* *trandolapril* *Univasc®* *Vasotec®* *Zestril®*	
ACE Inhibitors + Calcium Channel Blocker Combinations		
amlodipine/benazepril	*Lotrel®* *Tarka®* *trandolapril-verapamil ER*	
ACE Inhibitors + Diuretic Combinations		
benazepril/HCTZ	*Accuretic®*	

Preferred Agents	Non-Preferred Agents	SA Criteria
lisinopril/HCTZ **enalapril/HCTZ**	*captopril/HCTZ* *fosinopril/HCTZ* *Lotensin HCT®* *moexipril/HCTZ* *quinapril/HCTZ* *Vaseretic®* *Zestoretic®*	
Angiotensin Receptor Blockers		**LENGTH OF AUTHORIZATIONS:** **1 year** **Routine PDL edits plus** ***Clinical Criteria for Entresto™** • Diagnosis of chronic heart failure (NYHA Class II-IV); **AND** • Member must be ≥ 18 years; **AND** • Left ventricular ejection fraction ≤ 40% *Quantity Limit = 2 per day for Entresto™*
Entresto™ *(QL) **losartan** **valsartan**	*Atacand®* *Avapro®* *Benicar®* *candesartan* *Cozaar®* *Diovan®* *Edarbi®* *eprosartan mesylate* *irbesartan* *Micardis®* *olmesartan* *Teveten®*	
Angiotensin Receptor Blockers + Calcium Channel Blocker Combinations		
amlodipine/valsartan	*Azor®* *amlodipine/olmesartan* *amlodipine/olmesartan/HCTZ* *amlodipine/valsartan/HCTZ* *Exforge® & Exforge® HCT* *Tribenzor®*	
Angiotensin Receptor Blockers + Diuretic Combinations		
losartan/HCTZ **valsartan/HCTZ**	*Atacand HCT®* *Avalide®* *Benicar HCT®* *candesartan/HCTZ*	

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	Diovan HCT® *Edarbyclor®* *Hyzaar®* *irbesartan/HCTZ* *Micardis HCT®* *olmesartan/HCTZ* *telmisartan/HCTZ* *Teveten HCT®*	
Antihypertensives, Sympatholytics **CLOSED CLASS**		
Catapres®-TTS **clonidine tab** **guanfacine** **methyldopa** **reserpine**	*Catapres®* *clonidine (transdermal)* *Clorpres®* *methyldopa/HCTZ* *Tenex®*	
Beta Blockers		***Clinical Criteria for Hemangeol™** • Diagnosis treatment of proliferating infantile hemangioma requiring systemic therapy; **AND** • Member's age must be between 5 weeks and 5 months.
atenolol **bisoprolol** **carvedilol** **labetalol** **metoprolol tartrate** **metoprolol succinate** **propranolol tab & ER/soln** **Sorine®** **sotalol AF** **sotalol HCL**	*acebutaolol* *Betapace®IR & AF®* *betaxolol* *Bystolic®* *Carvedilol ER* *Coreg® IR & CR®* *Corgard®* **Hemangeol™* *Inderal® XL* *Innopran® XL* *Kapspargo™ Sprinkle* *Levatol®* *Lopressor®* *nadolol* *pindolol* *propranolol LA* *Sectral®* *Sotylize ™* *Tenormin®*	

Preferred Agents	Non-Preferred Agents	SA Criteria
	timolol maleate *Toprol XL®* *Trandate®* *Zebeta®*	
Beta Blockers + Diuretic Combinations		
atenolol/chlorthalidone **bisoprolol/HCTZ**	*Corzide®* *Dutoprol®* *Lopressor HCT®* *metoprolol/HCTZ* *nadolol/bendroflumethiazide* *propranolol/HCTZ* *Tenoretic®* *Ziac®*	
Calcium Channel Blockers –Dihydropyridine		
Afeditab CR® **amlodipine** **Nifedical XL®** **nifedipine** **nifedipine ER**	*Adalat CC®* *felodipine ER* *isradipine* *nisoldipine* *nicardipine* *Norvasc®* *Procardia®* *Procardia XL®* *Sular®*	
Calcium Channel Blockers- Non-Dihydropyridine		
Cartia XT® **diltiazem IR, ER q12 hr & 24 hr** **Taztia XT®** **verapamil tab IR & ER**	*Calan® IR & SR* *Cardizem® IR, CD & LA* *Isoptin SR®* diltiazem LA *Matzim LA* *Tiazac®* *verapamil 360 cap* *verapamil ER cap* *Verelan® & Verelan PM®*	

Preferred Agents	Non-Preferred Agents	SA Criteria
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®* *Fibricor®* *Lipofen®* *Lofibra®* *Lopid®* *Tricor®* *Triglide®* *Trilipix™*	
HMG CoA Reductase Inhibitors and Combo (High Potency Statins)		
atorvastatin	*amlodipine/atorvastatin*	

Preferred Agents	Non-Preferred Agents	SA Criteria
rosuvastatin **simvastatin**	*Caduet®* *Crestor®* *Ezallor (rosuvastatin)* *Lipitor®* *Liptruzet®* *Livalo®* *Zypitamag ™* *simvastatin/ezetimibe* *Vytorin®* *Zocor®*	
HMG CoA Reductase Inhibitors and Combinations (Statins)		
lovastatin **pravastatin**	*Advicor®* *Altoprev®* *fluvastatin* *Lescol®and Lescol XL®* *Mevacor®* *Pravachol®*	
Microsomal Triglyceride Transfer Protein Inhibitor		
	**Juxtapid ™*	***Clinical Criteria for Juxtapid™. Refer to Juxtapid™ SA Fax Form**
Niacin Derivatives		
niacin ER	*Niaspan®* *Niacor®*	
Omega 3 Fatty Acid Agent		
	****Lovaza® (ST)* ****omega-3 acid ethyl esters(ST)* *Vascepa®*	***Clinical Criteria for Lovaza® and omega-3 acid ethyl esters** • Step edit requires trial and failure of any other lipotropic; **OR** • Documented high triglycerides of ≥ 500 mg/dL.
Oligonucleotide Inhibitor		
	*****Kynamro™*	*****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
	Praluent® *Repatha®*	

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
		***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**	**Aggrenox®* **ASA/dipyridamole* ***Durlaza ER™* *Effient®* *Persantine®* *Plavix®* ***Yosprala® Tab* ****Zontivity™*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits plus** **Clinical Criteria for Select Non-Preferred Platelet Inhibitors** ***Aggrenox® & ASA/dipyridamole** • Aspirin and dipyridamole are covered as separate drugs without SA; clinical reason as to why the individual drugs cannot be used separately. ****Durlaza ER™ & *Yosprala® Tab** • Aspirin is covered without SA; clinical reason as to why aspirin cannot be used. ***** Zontivity™** • 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 Prostacyclin Analogues		**LENGTH OF AUTHORIZATIONS: 1 year**
Ventavis®	*Tyvaso®*	
Oral Endothelin Receptor Antagonist		**Routine PDL edits plus**
Letairis® **Tracleer® tab**	*Opsumit®* *Tracleer® susp*	
***Phosphodiesterase 5 Inhibitors (PDE-5)**		***Clinical Criteria for all preferred and non-preferred PDE-5**
Adcirca™ **sildenafil tab**	*Alyq(tadalafil)* *Revatio® tab/susp/inj*	• Diagnosis of pulmonary hypertension in members >18 years is required; **AND** • The prescriber must be a pulmonary specialist or cardiologist; **AND**

	Preferred Agents	Non-Preferred Agents	SA Criteria
		Tadalafil	
	Prostacyclin Vasodilator and Receptor Agonist		• Must have a rationale for not taking the sildenafil tablet to receive a SA for injectable Revatio®
		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) **Routine PDL edits**
	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*	
	NMDA Receptor Antagonist		
	memantine tab	*memantine Dose Pack* memantine soln *Namenda® Dose Pack/XR tab* *Namenda® tab*	
	Anticonvulsants		
	Barbiturates		**LENGTH OF AUTHORIZATIONS:** **1 year** **Routine PDL edits plus** ***Clinicial Criteria for Onfi®** • 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
	phenobarbital elixir/tab **primidone**	*Mysoline®*	
	Benzodiazepines		
	clonazepam **diazepam rectal & Device rectal**	*Clobazam (generic Onfi®susp/tab)* *clonazepam ODT* *Diastat® rectal* *Diastat® AcuDial™ rectal*	

	Preferred Agents	Non-Preferred Agents	SA Criteria
		*Onfi®susp/tab *Sympazan* ™ *(clobazam)*	• Prescribing physician should submit documentation of an insufficient response to another medication used for LGS
	Cannabidiol		***Clinical Criteria for Epidiolex®** Duration of Approval: 1 year Approval Criteria: • 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
		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*	
	Hydantoins		
	Dilantin® cap **phenytoin cap/chew tab/ susp** **phenytoin ext cap**	*Dilantin® Infatab, susp* *Peganone®* *Phenytek®*	
	Succinimides		
	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		

	Preferred Agents	Non-Preferred Agents	SA Criteria
	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** **Routine PDL edits**
	bupropion IR, SR &XL **desvenlafaxine ER** **mirtazapine ODT/tab** **trazodone** **venlafaxine IR & ER cap**	*Aplenzin®* *Brintellix®* *bupropion XL(generic Forfivo® XL)* *Effexor® XR* *Emsam® transdermal* *Fetzima®* *Forfivo® XL* *Khedezla™* *Marplan®* *Nardil®* *nefazodone* *Oleptro® ER* *Parnate®* *phenelzine*	

	Preferred Agents	Non-Preferred Agents	SA Criteria
		Pristiq® *Remeron® ODT/tab* *tranylcypromine sulfate* *Trintellix* *venlafaxine ER tab* *Viibryd® tab/dose pk* *Wellbutrin® IR, SR & XL*	
	SSRI		
	citalopram soln/tab **escitalopram tab** **fluoxetine cap/soln** **fluvoxamine** **paroxetine tab** **sertraline tab**	*Brisdelle®* *Celexa® tab* *escitalopram soln* *fluoxetine DR cap/tab* *fluvoxamine ER* *Lexapro® soln/tab* *Luvox® CR* *paroxetine CR* *Paxil® tab/susp & Paxil® CR* *Pexeva®* *Prozac® cap/weekly* *Sarafem®* *sertraline conc* *Zoloft® conc/tab*	
	Antimigraine Agents		
	Relpax® **sumatriptan succinate tab cartridge/nasal/vial/pen** **rizatriptan tab/MLT**	*almotriptan* *Alsuma®* *Amerge®* *Axert®* *Cambia®* *eletriptan(generic Relpax®)* *Frova®* *frovatriptan (generic Frova®)* *Imitrex®* *cartridge/nasal/pen/tab/vial* *Maxalt® tab & MLT* *Migranow™ Kit*	**LENGTH OF AUTHORIZATIONS:** **1 year** **Routine PDL edits**

Preferred Agents	Non-Preferred Agents	SA Criteria
	naratriptan *Onzetra™ Xsail™* *sumatriptan KITS* *Sumavel® Dosepro* *sumatriptan/naproxen (generic Treximet®)* *Tosymra* *Treximet®* *Zembrace ™ SymTouch ™* *Zomig® tab/nasal spray/ZMT*	
Antimigraine Agents, Others **Calcitonin Gene-related Peptide Antagonist (CGRP)**		
Emgality™ Syringe **Emgality™ Pen**	*Aimovig™* *Ajovy™*	**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* *Fazaclo®* ***Geodon® tab, IM* *Invega®* ***Nuplazid™ tab, cap (QL)(AG)* ***olanzapine/fluoxetine* *paliperidone ER* *Rexulti® tab* *Risperdal® ODT/soln/tab* *Saphris® SL* *Seroquel® IR* *Seroquel® XR* *Symbyax®*	**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 Nuplazid™** • Indicated for the treatment of hallucinations and delusions associated with Parkinson's disease psychosis. *Quantity Limit Nuplazid™ = 2 per day* *****Clinical Criteria for Abilify Mycite®** **Initial Approval Criteria: For Three months SA** Patient must: • Be ≥ 18 years of age; AND

	Preferred Agents	Non-Preferred Agents	SA Criteria
		Versacloz™ *Vraylar™* *Zyprexa® tab/IM/Zydis*	• 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** • 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., • 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®** **Aristada® Initio** **Risperdal Consta®** **Invega Sustenna® &Trinza®**	*Perseris™ (risperidone)* *Zyprexa® Relprevv™*	**Routine PDL edits**
	Typical		**LENGTH OF AUTHORIZATIONS:** **1 year**
	amitriptyline/perphenazine **chlorpromazine**	*fluphenazine elixir/soln/tab* *Haldol decanoate (injection)*	**Routine PDL edits**

	Preferred Agents	Non-Preferred Agents	SA Criteria
	fluphenazine decantate **haloperidol decantate** **haloperidol lactate conc** **haloperidol tab** **loxapine** **perphenazine** **trifluoperazine** **thiothixene** **thioridazine**	*pimozide* *Moban®* *molindone* ~~*Orap®*~~	
	Neuropathic Pain		
	capsaicin OTC topical **duloxetine 20, 30 & 60 mg** **gabapentin cap/tab/soln** **lidocaine 5% patch** **pregabalin (ST)**	*Cymbalta®* *duloxetine 40 mg* *Gralise™* *Horizant ™* *Irenka™* *Lidoderm® patch* *Lyrica CR* *Lyrica® soln* *Lyrica® (ST)* *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®/pregabalin** • 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**
	Sedatives / Hypnotics		
	temazepam 15 & 30 mg	*estazolam* *flurazepam* *Halcion®* *Restoril®*	**LENGTH OF AUTHORIZATIONS**: Length of the prescription (up to 3 months) **Routine PDL edits**

Preferred Agents	Non-Preferred Agents	SA Criteria
	temazepam 7.5 mg & 22.5 mg *triazolam*	
Sedatives / Hypnotics (Non-Benzodiazepine)		
zolpidem	*Ambien® IR & CR* *Belsomra®* *Edluar™* *eszopiclone* **Hetlioz™* *Intermezzo®* *Lunesta®* *Rozerem®* *Silenor®* *Sonata®* *Zaleplon®* *zolpidem CR* *Zolpimist ™ spray* *zolpidem (generic Intermezzo®)*	**LENGTH OF AUTHORIZATIONS**: 6 months. **For Renewal -** must document therapeutic benefit and confirm compliance Routine PDL edits plus ***Clinical Criteria for Hetlioz™** • 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**	*Amrix®* *****carisoprodol* **carisoprodol/ASA* **carisoprodol/ASA/codeine* *cyclobenzaprine ER* *Dantrium®* *Fexmid®* *Lorzone®* *metaxalone* *orphenadrine citrate* *orphenadrine/ASA/caffeine* *Parafon Forte® DSC* *Robaxin®* *Skelaxin®* **Soma®* *tizanidine cap* *Zanaflex®*	**LENGTH OF AUTHORIZATIONS:** • 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**

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

10/1/19

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
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** *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**
Adderall®XR **amphetamine salts combo** *(generic for Adderall IR)* **dextroamphetamine** *(generic for Dexedrine)* **Dyanavel® XR susp** **Vyvanse® cap/chewable tab** (lisdexamfetamine)	*Adderall® IR (amphetamine salts combo)* *Adzenys XR ODT™* *Adzenys ER™ susp* *Adzenys® ER* *amphetamine salts combo XR* *amphetamine sulfate (generic Evekeo™)* *Desoxyn®* *Dexedrine®* *dextroamphetamine SR & soln* *Evekeo™* *Evekeo™ ODT* *methamphetamine* *Mydayis ER™* *Procentra® soln* *Zenzedi™*	
Methylphenidate Drugs		
All methylphenidate IR generic **Concerta®** **Daytrana® Transdermal** **Focalin® IR & XR** **QuilliChew ER™** **Quillivant™ XR susp**	*Aptensio ™ XR* *Cotempla XR-ODT™* *dexmethylphenidate IR & XR* *Metadate CD®* *Metadate ER®* *Methylin ER®, soln IR* *methylphenidate chew & soln* *methylphenidate ER, LA, SR* *Ritalin® IR, LA® & SR®*	

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	Miscellaneous Drugs		
	atomoxetine *(generic for Strattera®)* **clonidine ER** **guanfacine ER**	****armodafinil (generic Nuvigil™)* ****modafinil* ****Nuvigil ™ (AG)* ****Provigil®(AG)* *Strattera®* *Intuniv®*	*****<u>Nuvigil™/Provigil®/armodafinil/modafinil:</u>**: **Length of Authorizations:** 1 year for sleep apnea and narcolepsy; 6 months for shift work sleep disorder. • Approvable diagnoses include: ○ **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.
Dermatologic			
	***Acne Agents, Topical** *(AG)*		
	Combo Benzoyl Peroxide , Clindamycin, Erythromycin Topical		**<u>LENGTH OF AUTHORIZATIONS:</u>** <u>1 year</u> **Routine PDL edits plus** ***<u>Clinical Criteria for Dermatologic Acne Agents</u>** • 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.**
	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**	*Acanya™ w/pump* *Acne Clearing System® (OTC)* *Aczone® Gel and Gel Pump* *Avar Cleanser, Medicated Pad* *Avar-E* *Avar-E LS* *Avar LS Cleanser, Medicated Pad* *Azelex®* *Benzaclin®& Benzaclin® Pump* *BP 10-1* *Benzefoam™ regular &Ultra™* *Benzepro* *benzoyl peroxide wash/cr/gel/ lotion/foam/towelette (RX)* *benzoyl peroxide 6%, 9% cleanser (OTC)* *BPO Kit* *Cleocin T®*	

	Preferred Agents	Non-Preferred Agents		SA Criteria
		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* *Sulfacetamide Sodium/Sulfur Cr, Susp, Sunscreen* *SSS 10-5 Foam*		

Preferred Agents	Non-Preferred Agents	SA Criteria
	Sulfacetamide/Sulfur/Cleanser, Cleanser Kit, Lotion Med. Pad *Sulfacetamide/Sulfur/Urea Cleanser* *Sumadan Wash, Kit* *Sumadan XLT* *Sumaxin CP Kit* *Veltin®*	
Retinoids/Combinations, Topical		
Differin 0.1% gel (OTC) **Retin®A 0.025., 0.05, 0.1 % cr & 0.01, 0.025,% gel**	*Acnefree® Severe Kit (OTC)* *adapalene 0.1% cr/gel/lot* *adapalene 0.3% gel/gel w/pump* *adapalene-benzoyl peroxide (generic Epiduo®)* *Altreno™* *Atralin® 0.05% gel* *Avage® 0.1% cr* *Avita® 0.025% cr/gel* *Differin® 0.1% cr/gel/lot RX* *Differin® 0.3% gel pump* *Epiduo® & Epiduo® Forte Gel* **Fabior™01% Foam (AG)* *Renova® 0.02% cr/cr pump* *Retin®-A Micro 0.04%, 0.1% gel* *Retin®-A Micro 0.08%, 0.04%, 0.1% pump* *Tazorac® cr/gel* *tazarotene 0.1% cr* *tretinoin 0.025, 0.1% cr & 0.01, 0.025, 0.05% gel* *tretinoin microsphere 0.04% & 0.1% gel* *Ziana® gel*	***Age Edit for Fabior™ Foam** • Member must be between the ages of 12 and 18 years of age
Antifungal Topical		
ciclopirox soln **clotrimazole cr (OTC & RX)**	*Alevazol® OTC* *Azolen® Tincture OTC*	**LENGTH OF AUTHORIZATIONS:** **6 months**

	Preferred Agents	Non-Preferred Agents	SA Criteria
	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)**	*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* *Naftifine CR* *Nyata Kit®* *Nizoral A-D® Shampoo (OTC)* *nystatin-triamcinolone cr/oint* *oxiconazole cr (generic Oxistat®)*	**Routine PDL edits plus** **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
		Oxistat® cr *Oxistat® Lotion* *Pediaderm 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*
			LENGTH OF AUTHORIZATIONS: 1 year; EXCEPT Dupixent® 6 months
			
			Routine PDL edits plus
			
			***Clinical Criteria for Elidel®, Eucrisa™, Protopic®& tacrolimus**
			• Member must have a FDA approved diagnosis:
			  ○ Atopic dermatitis
			  ○ Elidel® & Eucisa™: 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.)
			
			****Clinical Criteria for Dupixent®**
			• ≥ 12 years of age; AND
			• Diagnosis of moderate to severe atopic dermatitis with ≥ 1 of the following:
			  ○ 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**
			  ○ 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**

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
			• 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 **Renewal Criteria:** Member must: • 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). ***Quantity limit Dupixent®*** *2 prefilled syringes for the initial dose, then 1 single-dose syringe every 14 days*
	Psoriasis, Topical		
	calcipotriene cr/oint/soln	*Calcitrene®* *calcitriol* *Dovonex®* **Enstilar ® Foam (AG)* *Micanol®* *Sorilux™* *Taclonex® & Taclonex® Scalp* *Vectical*	**LENGTH OF AUTHORIZATIONS: 1 year** **Routine PDL edits plus** ***Clinical Criteria for Enstilar ® Foam** • Length of Authorization: 4 weeks • Diagnosis of plaque psoriasis**; AND** • Minimum age of 18 years
	Rosacea Agents, Topical		

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
Metrocream® **Metrogel®** **Metrolotion®**	*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		**LENGTH OF AUTHORIZATIONS:** **1 year** **Routine PDL edits**
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* *Pediaderm® HC* *Pediaderm® TA* *Texacort®*	
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®* *Momexin®*	

Preferred Agents	Non-Preferred Agents	SA Criteria
	Pandel® *prednicarbate cr/oint* *Synalar ®* *Synalar TS®* *Ticanase kit®*	
Steroids, Topical High Potency		**LENGTH OF AUTHORIZATIONS:** **1 year** **Routine PDL edits plus** ***Clinical Criteria for Sernivo™*** • 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
betamethasone valerate cr/lot/oint **triamcinolone acetonide 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 Topicort® 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* *Topicort® cr/gel/oint/spray* *Trianex® oint* *triamcinolone spray* *triamcinolone/dimethicone* *Vanos®cr* *Whytederm®Tdpak*	
Steroids, Topical Very High Potency		

	Preferred Agents	Non-Preferred Agents	SA Criteria
	clobetasol emollient **clobetasol propionate cr/gel/oint/soln** **halobetasol propionate cr/oint**	*Apexicon™E* *Bryhali™ (halobetasol propionate)* *clobetasol lot/shampoo* *clobetasol propionate foam/spray* *Clobex® lot/shampoo/spray* *Clodan® kit* *Halonate®* *halobetasol propionate(generic for Lexette®)* *Olux®* *Olux®-E* *Temovate® oint* *Ultravate® cr/lotion/oint* *Ultravate® PAC & Ultravate® X*	
Endocrine and Metabolic Agents			
	Androgenic Agents (Testosterone – Topical)		
	testosterone (generic for AndroGel®)	*Androderm®* *AndroGel®* *Axiron® soln* *Fortesta®* *Natesto Nasal Gel ®* *Testim®* *testosterone (generic for Axiron®)* *testosterone gel/packet/pump (generic for Vogelxo™)* *testosterone (generic for Fortesta®)* *Vogelxo™ gel/packet/pump* *Xyosted™*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits Plus** **Clinical Criteria for all preferred and non-preferred** Androgenic Agents INITIAL REVIEW CRITERIA • 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. CONTINUATION OF THERAPY CRITERIA • Patient has been compliant with treatment based on refill history

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
			• 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**	*colchicine tabs* *Colcrys®* *Duzallo®* *Gloperba ®* *Mitigare®* *Uloric®* **Zurampic®(QL, AG)*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits plus** ***Clinical Criteria for Zurampic®** • 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 • *Quantity limit of 1 per day*
	Contraceptives*(long-acting IUDs & injectable)		
	Kyleena™ **Liletta®** **medroxyprogesterone 150mg** **Mirena®** **Nexplanon®** **Paragard®** **Skyla®**	*Depo-Provera® 104 mg and 150 mg*	**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**
			• 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:
			  ○ Diagnosis of Type 1 or 2 diabetes; **AND**
			  ○ On insulin therapy; **AND**
			  ○ Failure to achieve adequate glycemic control (HbA1c ≤ 6.5%)

	Diabetes Hypoglycemics: Injectable Incretin Mimetics CLOSED CLASS		
	Byetta® (exenatide)	*Adlyxin™ (lixisenatide)*	**LENGTH OF AUTHORIZATIONS**: 1 year

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

Preferred Agents	Non-Preferred Agents	SA Criteria
	Afrezza® cartridge (inhalation)	
Diabetes Oral Hypoglycemics		
Oral Hypoglycemics Alpha-Glucosidase Inhibitors		**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits plus** **Metformin Step Edit for all Oral Hypoglycemics (excluding metformin)** • 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**. ***Contraindications include:** • severe renal impairment (eGFR below 30mL/min/1.73m2) • known hypersensitivity • acute or chronic metabolic acidosis including diabetic ketoacidosis
acarbose	*Glyset®* *miglitol (generic Glyset®)* ~~*Precose®*~~	
Oral Hypoglycemics Biguanides		
metformin **metformin ER** *(generic for Glucophage® XR)*	*Fortamet®* *Glucophage® IR & XR* *Glutmetza®* *Riomet® susp* *metformin ER (generic Fortamet®)* *metforman ER (generic Glumetza®)* *metformin (generic Riomet®)*	
Oral Hypoglycemics Biguanide Combination Drugs		
glyburide/metformin	*glipizide/metformin* *Glucovance®*	
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™*	
Oral Hypoglycemics Meglitinides		
repaglinide **nateglinide**	*Prandin®* *PrandiMet™*	

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	repaglinide/metformin *Starlix®*	
Oral Hypoglycemics Second Generation Sulfonylureas		
glimepiride **glipizide** **glipizide ER** **glyburide** **glyburide micronized**	*Amaryl®* *Diabeta®* *Glucotrol®* *Glucotrol XL®* *Glynase®*	**Routine PDL Edits plus**
***Oral Hypoglycemics Sodium Glucose Co-Transporter 2 Inhibitor CLOSED CLASS**		***Clinical Criteria/Step edit for non-preferred Sodium Glucose Co-Transporter 2 (SGLT2)**
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.** • 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** *Omontys® is not PDL eligible, may be covered under medical benefit*
Glucocorticoids, Oral		
budesonide EC	*Cortef®*	**LENGTH OF AUTHORIZATIONS**: **1 year**

	Preferred Agents	Non-Preferred Agents	SA Criteria
	dexamethasone soln/tab **hydrocortisone** **methylprednisolone dose pk** **methylprednisolone 4 mg tab** **prednisolone sodium phosphate soln** **prednisolone soln** **prednisone soln/tab/dose pk**	*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®*	**Routine PDL edits plus** ***Clinical Criteria for Emflaza™** • 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®* *Takhzyro™*	**LENGTH OF AUTHORIZATIONS:** Date of service **Routine PDL edits plus** *** ALL Hereditary Angioedema drugs (preferred and non-preferred) require the submission of a Clinical SA. Refer to Hereditary Angioedema (HAE) SA Form**

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	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. • 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®* *Intrarosa™* *Osphena® tab*	**LENGTH OF AUTHORIZATIONS**: 6 months **Routine PDL edits**

	Preferred Agents	Non-Preferred Agents	SA Criteria
		Yuvafem®	
Gastrointestinal			
	G I Antibiotics		
	Firvanq™ **metronidazole tab** **vancomycin cap**	*Aemcolo™* *Alinia®* *Dificid®* *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)		**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**
	***dronabinol**	**Cesamet™* **Marinol ®* **Syndros®*	
	5HT3 Receptor Blockers		**LENGTH OF AUTHORIZATIONS:** 3 months, unless otherwise noted
	ondansetron ODT/tab	*Aloxi®* *Anzemet®* *Akynzeo®* *granisetron Granisol ® soln/tab* *Kytril®* *ondansetron soln* *palonosetron (generic Aloxi®)* *Sancuso® patch* *Zofran® ODT/soln/tab* *Zuplenz® film*	**Routine PDL edits plus**

Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
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®* *Trulance™*	**LENGTH OF AUTHORIZATIONS**: 6 months **Routine PDL edits plus** ***All GI Motility drugs (preferred and non-preferred) require the submission of a Clinical SA. Refer to Chronic GI Motility SA form**

Preferred Agents	Non-Preferred Agents	SA Criteria
	Viberzi™	
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** ***Routine PDL edits***
Apriso® **Lialda®** **Pentasa®**	*Asacol ®HD* *Azulfidine® IR &DR* *balsalazide disodium*	

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

	Preferred Agents	Non-Preferred Agents	SA Criteria
		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™* *Plegridy®* *Tecfidera™* ****Zinbryta™ (QL)*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits plus** ***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. ****Select non-preferred MS drugs (Amprya®, Zinbryta™) require the submission of a Clinical SA. Refer to MS - Ampyra® SA form; and Zinbryta™ SA Form** ****Zinbryta™* Quantity Limit = 1 ml per 28 days (0.036 ml per day).
	Cytokine and CAM Antagonists And Related Agents **CLOSED CLASS**		
	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®* *Rasuvo™*	**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edits plus** ***All non-preferred Cytokine and CAM Antagonists require submission of a Clinical SA. Refer to Cytokine and CAM Antagonists and Related Agents SA Form** For a list of Cytokine and CAM Antagonists and criteria for approval see **Appendix A**

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

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

Preferred Agents	Non-Preferred Agents	SA Criteria
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 **Routine PDL edits**
Alphagan P® 0.1 & 0.15% **brimonidine 0.2%**	*apraclonidine 0.5% drops* *brimonidine tartrate 0.15%* *Iopidine® 0.5% & 1%*	
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%*	
Rho Kinase Inhibitor		
	Rhopressa®	

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

Preferred Agents	Non-Preferred Agents	SA Criteria
	loratadine D 12 & 24 hr *Xyzal® soln/tab (RX, OTC)*	

Beta-Adrenergic Agents

Long Acting Beta Adrenergic s (LABA) MDIs or Nebulizers

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

LENGTH OF AUTHORIZATIONS: 1 year

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.

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
Symbicort® 160/4.5	Children < 12	Asthma & COPD

Preferred Agents	Non-Preferred Agents	SA Criteria
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
		• Patient must have moderate to severe asthma diagnosed as ONE of the following types:
		  ○ 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:
		  ○ 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** **ipratropium bromide soln**	**Daliresp®* *Incruse™ Ellipta®* *Lonhala™ Magnair™* *Seebri Neohaler™* *Spiriva® Respimat*	**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edits plus** ***Clinical Criteria for Daliresp®**

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	ipratropium/albuterol nebs **Spiriva®** **Stiolto Respimat™ (AG)**	*Tudorza™* *Utibron Neohaler™* *Yupelri™ (revefenacin)*	• 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
	Dulera®(AG)* **fluticasone/salmeterol powder (AG)** ***Symbicort®***(AG)*	*Advair® Diskus *(AG)* *Advair® HFA(AG)* *Airduo ™ Respiclick®(AG)* *Breo®Ellipta™ (AG)* *WixelaTM Inhub™(fluticasone/ salmeterol)*	**Routine PDL edits**
	Inhaled Corticosteroids: Metered Dose Inhalers CLOSED CLASS		
	Asmanex® **Flovent® Diskus & HFA** **Pulmicort Flexhaler®**	*Alvesco®* *Aerospan™* *Armonair™ Respiclick®* *Arnuity™ Ellipta®* *Asmanex HFA®* *QVAR® & QVAR® Redihaler* *Trelegy® Ellipta*	
	Inhaled Corticosteroids: Nebulizer Solution CLOSED CLASS		**LENGTH OF AUTHORIZATIONS**: 1 year
	budesonide respules	*Pulmicort® Respules*	
	Nasal Steroids		**Routine PDL edits**
	fluticasone	*Beconase AQ®* *budesonide (generic for Rhinocort® Aqua)* *budesonide (generic Rhinocort® Allergy OTC)* *Children's Qnasl™* *Clarispray OTC*	

	Preferred Agents	Non-Preferred Agents	SA Criteria
		Dymista™ *Flonase®* *Flonase Sensimist (OTC)* *flunisolide* *fluticasone OTC* *mometasone(generic Nasonex®)* *Nasonex®* *Omnaris®* *Qnasl™* *Rhinocort Aqua®* *Rhinocort® Allergy OTC* *Sinuva®* *Ticanase®* *triamcinolone OTC* *triamcinolone acetonide* *Veramyst®* *Xhance™* *Zetonna™*	
	***Cough and Cold Drug**		
	Ala-Hist DM **benzonatate cap** **codeine/ promethazine** **guaifenesin/codeine phosphate** **hydrocodone/ homatropine** **Iophen-C NR** **phenylephrine HCl/promethazine HCl** **promethazine DM syrup** **Tusnel® Pediatric Drops**	*lohist-DM syrup* *All other Legend cough and cold drugs are non-preferred* *Tessalon ® perle*	**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		

	Preferred Agents	*Non-Preferred Agents*	*SA Criteria*
	epinephrine 0.15 mg & 0.3 mg (authorized generic EpiPen® & EpiPen® Jr)	*Auvi-Q®* *Epipen®* *Epipen® Jr* *epinephrine 0.15mg & 0.3mg (generic Adrenaclick)* *Symjepi™ (epinephrine)*	**LENGTH OF AUTHORIZATIONS**: **1 year** **Routine PDL edits**
	Intranasal Antihistamines		
	azelastine 0.1%	*Astepro® 0.15%* *olopatadine* *Patanase®*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits**
	Leukotriene Receptor Antagonists		
	montelukast tabs/chewable tabs	*Accolate®* *Singulair® tabs/chew tabs/granules* *montelukast granules* *zafirlukast* *Zyflo™* *Zyflo CR™* *zileuton ER*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits**