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

7/1/20

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 3 months for (includes HIV/AIDS, Chronic back pain, Arthritis, Fibromyalgia, Diabetic neuropathy, Postherpetic Neuralgia). • Up to 6 months for chronic pain (includes Cancer pain, Sickle cell disease, Palliative care, End-of-Life Care, Hospice). 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™*	

***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:** • Up to 3 months for (includes HIV/AIDS, Chronic back pain, Arthritis, Fibromyalgia, Diabetic neuropathy, Postherpetic Neuralgia). • Up to 6 months for chronic pain (includes Cancer pain, Sickle cell disease, Palliative care, End-of-Life Care, Hospice).
	Actiq® *Fentora®* *fentanyl citrate* *Lazanda®* *Subsys®*	
Short-Acting Opioids		
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 oral syringe* *oxycodone/ASA* *oxycodone/ibuprofen* *oxymorphone HCl* *Panlor®* *pentazocine/naloxone PrimLev™*	***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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	RoxyBond ™ *Ultracet®* *Ultram®* *Zamicet ®soln*
Opioid Dependency **CLOSED CLASS**	
***buprenorphine SL** ***Suboxone® film** ***Sublocade™ SQ**	***Bunavail ™*** **buprenorphine/naloxone tab SL* **buprenorphine/naloxone film SL* **Cassipa®* **Probuphine® implant* **Zubsolv™*
naloxone syringe & vial **naltrexone tab** **Narcan® Nasal Spray** **Vivitrol®**	*Evzio® injection*
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)	
Oral NSAIDs	
Children's Motrin® susp (OTC)	*Anaprox® IR & DS®* *Advil®*

***All Buprenorphine Containing Drugs (non-preferred) require submission of Clinical SA. Refer to (Sublocade Form) or (Oral Buprenorphine SA Form)**

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

LENGTH OF AUTHORIZATIONS: 1 year

Routine PDL edits plus

diclofenac sodium **ibuprofen cap OTC** **ibuprofen tab/susp (OTC & Rx)** **Infant's ibuprofen drops** **meloxicam tab** **naproxen tab** **naproxen sodium (OTC)** **naproxen EC (Rx)** **sulindac**	*Aleve®* *Arthrotec®* *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™*

***Step edit required for Celebrex® and celecoxib**

- 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.

	tolmetin sodium *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)***	***Arikayce®(amikacin liposome)* *Cayston®* *Tobi® inhalation neb soln (QL, AG)* *tobramycin Pak (generic Kitabis™ Pak) (QL, AG)* tobramycin inhalation neb soln (generic Tobi® inhalation) (QL, AG)	**LENGTH OF AUTHORIZATIONS:** **1 year** **Routine PDL edits plus** ****Tobi Podhaler®** • Requires a clinical reason as to why one of the preferred tobramycin inhalation nebulizer solutions cannot be used (Bethkis® or Kitabis™). *****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: ○ 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®. **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

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Antifungals, Oral		
fluconazole tab/susp **griseofulvin susp** **nystatin tab/susp** **terbinafine**	*Ancobon ®* *clotrimazole (mucous mem)* *Cresemba®* *Diflucan® tab/susp* *flucytosine* *Gris-Peg®* *griseofulvin tab* *griseofulvin ultramicrosize* *itraconazole* *itraconazole solution (generic for Sporanox® soln)* *ketoconazole* *Lamisil ® tab/granules* *Noxafil®* **Onmel®* *posaconazole tab (generic for Noxafil)* **Sporanox® cap/soln* *Tolsura™* *Vfend® tab/susp* *voriconazole tab & powder for susp*	**LENGTH OF AUTHORIZATIONS**: Duration of the prescription (up to 12 months) **Routine PDL edits plus** *** 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**
~~**Cefaclor cap**~~ **cefprozil tab/susp** **cefuroxime tab**	*cefaclor ER* *cefaclor susp* *Ceftin® tab/susp*	
Third Generation 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.
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** • 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.
azithromycin pack/susp/tab **clarithromycin tab/susp** **Eryped® 200 susp** **E.E.S.® 200 susp** **erythromycin base cap DR** **erythromycin stearate**	*Biaxin® tab* *clarithromycin ER* *Eryped® 400 susp* *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*	
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	*Cipro® IR & XR & susp* *ciprofloxacin ER* *Noroxin®* *ofloxacin*	
Third Generation Quinolones		
levofloxacin tab	*Baxdela™ IV, tab* *Levaquin® tab/susp* *levofloxacin susp* *moxifloxacin*	
Topical Antibiotics		
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 Preferred SA Form or Hepatitis C Antivirals Non-Preferred 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 **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/ 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®**	*Auryxia™* *calcium acetate 667mg tab* *Eliphos* ~~*Ferric citrate*~~ *Fosrenol®* chewable tab *lanthanum carbonate chewable tab* ~~*Phoslo®*~~ *Phoslyra®* *Renvela® powder, tab* *sevelamer carb powder packet, tab* *Velphoro® chewable tab*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits**
Bone Resorption Suppression and Related Agents		
Bisphosphonates		
alendronate tab **ibandronate tab**	*Actonel®* *alendronate soln* *Atelvia DR®* *Boniva®* *Binosto™* *etidronate* *Fosamax®tab & Fosamax® plus D* *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™*	**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 FactorXA Inhibitor	
enoxaparin	*Arixtra®* *fondaparinux* *Fragmin® syringe & vial* *Lovenox®*

LENGTH OF AUTHORIZATIONS: 1 year

Routine PDL edits plus

Oral Anticoagulants	
Eliquis™ **Eliquis™ Dose Pack** **Jantoven** **Pradaxa®** **Xarelto®** **Xarelto® Starter Pack** **warfarin**	*Coumadin®* **Savaysa™*

Clinicial Criteria for 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	
benazepril **enalapril** **lisinopril** **ramipril**	*Accupril®* *Altace®* *captopril* *Epaned™ soln* *fosinopril* *Lotensin®* *Mavik®* *moexipril* *Monopril®* *perindopril* *Qbrelis™* *quinapril* *ramipril* *trandolapril* *Univasc®*

LENGTH OF AUTHORIZATIONS: 1 year

Routine PDL edits

	Vasotec® *Zestril*®
ACE Inhibitors + Calcium Channel Blocker Combinations	
amlodipine/benazepril	*Lotrel*® *Tarka*® *trandolapril-verapamil ER*
ACE Inhibitors + Diuretic Combinations	
benazepril/HCTZ **lisinopril/HCTZ** **enalapril/HCTZ**	*Accuretic*® *captopril/HCTZ* *fosinopril/HCTZ* *Lotensin HCT*® *moexipril/HCTZ* *quinapril/HCTZ* *Vaseretic*® *Zestoretic*®
Angiotensin Receptor Blockers	
***Entresto™ (QL)** **irbesartan** **losartan** **olmesartan** **valsartan**	*Atacand*® *Avapro*® *Benicar*® *candesartan* *Cozaar*® *Diovan*® *Edarbi*® *eprosartan mesylate* *Micardis*® *Teveten*®
Angiotensin Receptor Blockers + Calcium Channel Blocker Combinations	
amlodipine/valsartan	*Azor*® *amlodipine/olmesartan*

LENGTH OF AUTHORIZATIONS: **1 year**

Routine PDL edits plus

Quantity Limit = 2 per day for Entresto™

	amlodipine/olmesartan/HCTZ *amlodipine/valsartan/HCTZ* *Exforge® & Exforge® HCT* *Tribenzor®*
Angiotensin Receptor Blockers + Diuretic Combinations	
irbesartan/HCTZ **losartan/HCTZ** **olmesartan/HCTZ** **valsartan/HCTZ**	*Atacand HCT®* *Avalide®* *Benicar HCT®* *candesartan/HCTZ* *Diovan HCT®* *Edarbyclor®* *Hyzaar®* *Micardis HCT®* *telmisartan/HCTZ* *Teveten HCT®*
Antihypertensives, Sympatholytics CLOSED CLASS	
Catapres®-TTS **clonidine tab** **guanfacine** **methyldopa** **reserpine**	*Catapres®* *clonidine (transdermal)* *Clorpres®* *methyldopa/HCTZ* *Tenex®*
Beta Blockers	
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*

***Clinical Criteria for Hemangeol™**

- Diagnosis treatment of proliferating infantile hemangioma requiring systemic therapy

	Levatol® *Lopressor®* *nadolol* *pindolol* *propranolol LA* *Sectral®* *Sotylize ™* *Tenormin®* *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* *Katerzia™oral suspension* *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®*
Direct Renin Inhibitors (includes combination)	
	aliskiren 150 & 300mg (generic for Tekturna) *Tekamlo®* *Tekturna®* *Tekturna HCT®* *Twynsta®* *telmisartan/amlodipine*

Lipotropics

LENGTH OF AUTHORIZATIONS: 1 year

Routine PDL edits plus

Bile Acid Sequestrants	
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® ~~Chewable bar,~~ 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 **rosuvastatin** **simvastatin**	*amlodipine/atorvastatin* *Caduet®* *Crestor®* *Ezallor Sprinkle (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 ™*
Niacin Derivatives	
niacin ER	*Niaspan®* *Niacor®*

***Clinical Criteria for Juxtapid™. Refer to Juxtapid™ SA Fax Form**

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 ***ALL PCSK9 Inhibitors require the submission of a Clinical SA. Refer to PCSK9 SA Form**
	Praluent® *Repatha®*	
Platelet Inhibitors		
Brilinta® **clopidogrel** **dipyridamole** **prasugrel (generic Effient®)** ~~**ticlopidine HCL**~~	**Aggrenox®* **ASA/dipyridamole* ***ASA/omeprazole (generic Yosprala®)* ***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**	*ambrisentan (generic Letairis)* *bosentan (generic Tracleer®)* *Opsumit®* *Tracleer® susp*	
***Phosphodiesterase 5 Inhibitors (PDE-5)**		***Clinical Criteria for all preferred and non-preferred PDE-5** • Diagnosis of pulmonary hypertension in members >18 years is required; **AND** • The prescriber must be a pulmonary specialist or cardiologist; **AND**
Alyq(tadalafil) **sildenafil tab** **tadalafil 2.5 and 5 mg only**	*Adcirca™* *Revatio® tab/susp/inj*	
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)
donepezil OTD & tab **Exelon® (transderm)**	*Aricept® ODT, tab* *Exelon® cap* *galantamine IR, ER tab/soln* *Namzaric® (donepezil/memantine)* *Razadyne® IR, ER* *rivastigmine cap & patch*	**Routine PDL edits**

NMDA Receptor Antagonist		
memantine tab	*memantine Dose Pack* *memantine soln* *memantine ER (generic Namenda XR)* *Namenda® Dose Pack/XR tab* *Namenda® tab*	
Anticonvulsants		
Barbiturates		**LENGTH OF AUTHORIZATIONS:** **1 year** **Routine PDL edits plus**
phenobarbital elixir/tab **primidone**	*Mysoline®*	
Benzodiazepines		***Clinicial Criteria for Onfi® and generic clobazam tab** • 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
clobazam tab (generic Onfi®tab) **clonazepam tab** **diazepam rectal & Device rectal**	*clobazam (generic Onfi®susp)* *clonazepam ODT* *Diastat® rectal* *Diastat® AcuDial™ rectal* ***Nayzilam®* **Onfi®susp/tab* *Sympazan ™ (clobazam)*	**** Clinicial Criteria for Nayzilam®** • Patient is at least 12 years of age or older; AND • Diagnosis of acute treatment of intermittent, stereotypic episodes of frequent seizure activity that are distinct from a patient's usual seizure pattern in patients with epilepsy
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	
phenytoin cap/chew tab/ susp **phenytoin ext cap**	*Dilantin® 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*
Other Anticonvulsants	
Gabitril® **lamotrigine tab** **lamotrigine chew tab** **lamotrigine XR** **levetiracetam soln/tab** **levetiracetam ER** **Vimpat® soln/tab** **topiramate tab/sprinkle** **zonisamide**	*Banzel® susp/tab* *Briviact®* *Diacomit®* ~~*Elepsia™XR*~~ *felbamate susp/tab* *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* *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**	*Brisdelle®* *Celexa® tab* *escitalopram soln* *fluoxetine DR cap/tab*	

paroxetine tab **sertraline tab**	*fluvoxamine ER* *Lexapro® tab* *Luvox® CR* *paroxetine CR* *Paxil® tab/susp & Paxil® CR* *Pexeva®* *Prozac® cap/weekly* *Sarafem®* *sertraline conc* *Zoloft® conc/tab*	
Antimigraine Agents		
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* *naratriptan* *Onzetra™ Xsail™* *Relpax®* *sumatriptan KITS* *Sumavel® Dosepro* *sumatriptan/naproxen (generic* *Treximet®)* *Tosymra* *Treximet®* *Zembrace ™ SymTouch ™* *Zomig® tab/nasal spray/ZMT*	**LENGTH OF AUTHORIZATIONS:** **1 year** **Routine PDL edits**

Antimigraine Agents, Others Calcitonin Gene-related Peptide Antagonist (CGRP)		**LENGTH OF AUTHORIZATIONS:** 1 year **Routine PDL edits** **All CGRPs require the submission of a Clinical SA. Refer to Antimigraine Agents, Others SA Form**
Emgality™ Syringe **Emgality™ Pen**	*Aimovig™* *Ajovy™* *Reyvow* *Ubrelvy*	
***Antipsychotics** *(AG)*		
Atypical		**LENGTH OF AUTHORIZATIONS:** 1 year or 6 months for members < 18 yrs **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 • 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
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®* *Versacloz™* *Vraylar™* *Zyprexa® tab/IM/Zydis*	

		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 decantate** **haloperidol decantate** **haloperidol lactate conc** **haloperidol tab** **loxapine** **perphenazine** **trifluoperazine**	*fluphenazine elixir/soln/tab* *Haldol decanoate (injection)* *pimozide* *Moban®* *molindone* ~~*Orap®*~~	**Routine PDL edits**

thiothixene **thioridazine**		
Neuropathic Pain		
capsaicin OTC topical **duloxetine 20, 30 & 60 mg** **gabapentin cap/tab/soln** **lidocaine 5% patch** **pregabalin cap**	*Cymbalta®* *Dermacinrx® PHN Pak™ Kit* *duloxetine 40 mg (generic for Irenka™)* *Drizalma™ Sprinkle* *Gralise™* *Horizant ™* *Lidoderm® patch* *Lyrica CR* *Lyrica® soln* *Lyrica®* *Neurontin® cap/tab/soln* *pregabalin sol* *Qutenza Kit® (Topical)* *Savella™ & Savella™ Dose Pak* *Ztlido™ (lidocaine topical system)*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL**
Non-Ergot Dopamine Receptor Agonist		
pramipexole **ropinirole HCl**	*Mirapex® IR & ER* *Neupro®* *pramipexole ER* *Requip® XR* *ropinirole HCl ER*	**LENGTH OF AUTHORIZATIONS:** **1 year** **Routine PDL edits**
Sedatives / Hypnotics		
temazepam 15 & 30 mg	*estazolam* *flurazepam* *Halcion®* *Restoril®* *temazepam 7.5 mg & 22.5 mg* *triazolam*	**LENGTH OF AUTHORIZATIONS**: Length of the prescription (up to 3 months) **Routine PDL edits**
Sedatives / Hypnotics (Non-Benzodiazepine)		
zolpidem	*Ambien® IR & CR* *Belsomra®* *Edluar™*	**LENGTH OF AUTHORIZATIONS**: 6 months. **For Renewal -** must document therapeutic benefit and confirm compliance

	eszopiclone **Hetlioz™* *Intermezzo®* *Lunesta®* *Rozerem®* *Silenor®* *Sonata®* *Zaleplon®* *zolpidem CR* *Zolpimist ™ spray* *zolpidem (generic Intermezzo®)*	Routine PDL edits plus ***Clinical Criteria for Hetlioz™** • For the treatment of Non-24-Hour Sleep-Wake Disorder (Non-24), **AND** • 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**
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	
Adderall®XR **amphetamine salts combo** *(generic for Adderall IR)* **dextroamphetamine** *(generic for Dexedrine)* **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* *Dyanavel® XR susp* *Evekeo™* *Evekeo™ ODT* *methamphetamine* *Mydayis ER™* *Procentra® soln* *Zenzedi™*
Methylphenidate Drugs	
All methylphenidate IR generic **Concerta®** **Daytrana® Transdermal** **Focalin® IR & XR**	*Adhansia™XR* *Aptensio ™ XR* *Cotempla XR-ODT™* *dexmethylphenidate IR & XR* *Jornay PM* *Metadate CD®* *Metadate ER®* *Methylin ER®, soln IR* *methylphenidate chew & soln* *methylphenidate ER, LA, SR* *Ritalin® IR, LA® & SR®* *QuilliChew ER™* *Quillivant™ XR susp*

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**

Miscellaneous Drugs		
atomoxetine *(generic for Strattera®)*	***armodafinil (generic Nuvigil™)*	***Nuvigil™/Provigil®/armodafinil/modafinil:**
clonidine ER	***modafinil*	**Refer to Narcolepsy Medications SA Form**
guanfacine ER	***Nuvigil ™ (AG)*	
	***Provigil®(AG)*	
	Intuniv®	
	Sunosi™	
	Strattera®	
	Wakix®	

Dermatologic

*Acne Agents, Topical *(AG)*

Combo Benzoyl Peroxide , Clindamycin, Erythromycin Topical		
benzoyl peroxide wash/cr/gel /lot 5 % and 10%(OTC)	*Acanya™ w/pump*	**LENGTH OF AUTHORIZATIONS:** 1 year
clindamycin/benzoyl peroxide (Duac®)	*Acne Clearing System® (OTC)*	**Routine PDL edits plus**
clindamycin phosphate soln/swab	*Aczone® Gel and Gel Pump*	***Clinical Criteria for Dermatologic Acne Agents**
erythromycin solution	*Amzeeq™*	• Prescriptions for members over the age of 18 years will require the submission of a SA to evaluate treatment diagnosis; **AND**
Panoxyl-4 Acne Cr Wash (OTC)	*Avar Cleanser, Medicated Pad*	• Drugs are intended for acne **only. SA for a cosmetic indication cannot be approved.**
Panoxyl 10 OTC	*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®	
	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* *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™* *Aklief®* *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)** **clotrimazole soln (OTC)** **clotrimazole-betamethasone cr** **ketoconazole shampoo** **ketoconazole cr**	*Alevazol® OTC* *Azolen® Tincture OTC* *Bensal HP®* *Ciclodan® Kit* *ciclopirox cr/shampoo/gel* *ciclopirox kit*	**LENGTH OF AUTHORIZATIONS: 6 months** **Routine PDL edits plus**

miconazole cr/spray (OTC) **nystatin cr/oint/ powder** **terbinafine cr (OTC)** **tolnaftate cr/powder/soln (OTC)**	*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)* **Julia®* *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/ powder (OTC)* *Mentax®* *Naftin® cr/gel* *Naftifine CR* *Nyata Kit®* *Nizoral A-D® Shampoo (OTC)* *nystatin-triamcinolone cr/oint* *oxiconazole cr (generic Oxistat®)* *Oxistat® cr* *Oxistat® Lotion* *Pediaderm AF®* *PediPak®* **Penlac®*	**Select non-preferred topical Antifungals (CNL-8™, Julia®, Kerydin™, Luzu®, Penlac®) require the submission of a Clinical SA. Refer to Antifungal Topical SA Form**

	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: o Atopic dermatitis o Elidel® & Eucisa™: mild to moderate for ages > 2 years. o Protopic® 0.03%: moderate to severe for ages > 2 years. o Protopic® 0.1%: moderate to severe for ages > 18 years; **AND** • Failure to topical corticosteroids (i.e., desonide, fluticasone propionate, hydrocortisone butyrate, etc.) **** See Cytokine and CAM Antagonists Appendix A for Clinical Criteria**** **and Quantity Limits** ****Clinical Criteria for Dupixent®** ❖ **Atopic Dermatitis** • ≥ 12 years of age; **AND** • Diagnosis of moderate to severe atopic dermatitis ; **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** • Inadequate response to a 3 month minimum trial of at least 1 immunosuppressive systemic agent (e.g., cyclosporine, azathioprine, methotrexate, mycophenolate mofetil, etc.); **AND** • Inadequate 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**

		Quantity limit Dupixent® *2 prefilled syringes for the initial dose, then 1 single-dose syringe every 14 days* ❖ **Chronic Rhinosinusitis with Nasal Polyposis** • ≥ 18 years of age; AND • Diagnosis of inadequately controlled Chronic Rhinosinusitis with Nasal Polyposis (CRSwNP); AND • Is added to current maintenance treatment
Psoriasis, Topical		
calcipotriene cr/oint/soln	*Calcitrene®* *calcitriol* *Dovonex®* *Duobrii ™* **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		
Metrocream® **Metrogel®** **Metrolotion®**	*azelaic acid (generic for Finacea®)* *Finacea® foam/gel* *ivermectin (generic Soolantra)* *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**
alclometasone cr/oint	*aqua glycolic HC*	**Routine PDL edits**

hydrocortisone cr/gel/lot/oint	*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®* *Pandel®* *prednicarbate cr/oint* *Synalar ®* *Synalar TS®* *Ticanase kit®*
Steroids, Topical High Potency	
betamethasone valerate cr/lot/oint	*amcinonide cr/lot/oint* *betamet diprop & prop gly cr/lot/oint*

LENGTH OF AUTHORIZATIONS: **1 year**

Routine PDL edits plus

triamcinolone acetonide cr/lot/oint **fluocinonide soln**	*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*	***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
Steroids, Topical Very High Potency		
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 Pump (generic for AndroGel®)	*Androderm®* *AndroGel®* *Axiron® soln* *Fortesta®* *Natesto Nasal Gel ®* *Testim®* *testosterone Sol (generic for Axiron®)* *testosterone gel/packet (generic for AndroGel®)* *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 • 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®*~~ *febuxostat (generic Uloric®)* *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) **Bydureon™ (**exenatide ER) **Victoza®** (liraglutide)	*Adlyxin™ (lixisenatide)* *Bydureon™ Bcise SQ* *Soliqua® 100/33 (insulin glargine & lixisenatide inj)* *Ozempic®* *Rybelsus®* *Tanzeum™ (albiglutide)* *Trulicity™ (lixisenatide)* *Xultophy® 100/3.6 (insulin glargine & lixisenatide inj)*	**LENGTH OF AUTHORIZATIONS**: 1 year **Routine PDL edits plus** Rybelsus® Approved as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus
Diabetes Hypoglycemics: Injectable Insulins		
Insulin Mix		**LENGTH OF AUTHORIZATIONS: 1 year**
Humalog® Mix 50/50 vial **Humalog® Mix 75/25 vial** **Humulin® 70/30 pen (OTC)**	*Humalog® Mix 50/50 Kwikpen* *Humalog® Mix 75/25 Kwikpen* *Novolin® 70/30 vial (OTC)*	**Routine PDL edits**

Humulin® 70/30 vial **Novolog® Mix 70/30 pen/vial**		
Insulin N		
Humulin® N *pen* /vial (OTC)	*Novolin® N vial (OTC)*	
Insulin R		
Humulin® R pen/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** **Humalog® Cartridg/Kwikpen®** **Humalog Jr. Kwikpen®** **Novolog® cartridge/vial/ Flexpen** **insulin lispro vial**	*Admelog® Solostar Pen/vial* *Apidra® cartridge/Solostar/vial* *Fiasp®/FlexTouch® Pen/PenFill®* *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
acarbose	*Glyset®* *miglitol (generic Glyset®)*	
Oral Hypoglycemics Biguanides		
metformin **metformin ER** *(generic for Glucophage® XR)*	*Fortamet®* *Glucophage® IR & XR* *Glutmetza®* *Riomet® susp* *metformin ER (generic Fortamet®)* *metformin 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™* *repaglinide/metformin* *Starlix®*
Oral Hypoglycemics Second Generation Sulfonylureas	
glimepiride **glipizide** **glipizide ER** **glyburide** **glyburide micronized**	*Amaryl®* *Diabeta®* *Glucotrol®* *Glucotrol XL®* *Glynase®*

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

Age edit for Oral Hypoglycemics is 18 years of age or older, except Metformin which is 10 years of age.

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)** **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.
Farxiga™ (AG) **Glyxambi® (AG)** **Invokana™ (AG)** **Invokamet™ (AG)** **Invokamet™ XR (AG)** **Jardiance®(AG)** **Synjardy® (AG)** **Xigduo™ XR (AG)**	*Segluromet™ (ertugliflozin/metformin) (AG)* *Steglatro™ (AG)* *Steglujan™ (AG)* *Synjardy® XR (AG)*	
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 **dexamethasone soln/tab** **hydrocortisone** **methylprednisolone dose pk** **methylprednisolone 4 mg tab** **prednisolone sodium phosphate soln** **prednisolone soln**	*Cortef®* *cortisone acetate* *dexamethasone elixir/intensol* *Dexpak®* **Emflaza™ (AG)* *Entocort® EC* *Flo-Pred®* *Medrol ® dose pk/tab*	**LENGTH OF AUTHORIZATIONS**: **1 year** **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 2 years of age and older.

prednisone soln/tab/dose pk	*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®*	• Minimum Age Limit = 2 years of age
***Growth Hormone** **CLOSED CLASS**		
Genotropin® *Norditropin FlexPro®*	*Humatrope® cartridge/vial* *Nutropin AQ® NuSpin™* *Omnitrope® cartridge/vial* *Saizen® cartridge/vial* *Serostim® vial* *Zomacton® vial* *Zorbtive® vial*	**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®* *icatibant(generic Firazyr®)* *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**
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* *Yuvafem®*	**LENGTH OF AUTHORIZATIONS**: 6 months **Routine PDL edits**
Gastrointestinal		
G I Antibiotics		
Firvanq™ **metronidazole tab** **vancomycin cap**	*Aemcolo™* *Alinia®* *Dificid®*	**Length of authorization:** 1 year **Routine PDL edits plus**

	Flagyl® cap/tab/ER *metronidazole cap* *neomycin* *paromomycin* *Solosec™* *Tindamax®* *tinidazole* *Xifaxan®* *vancomycin compounded oral soln kit* *Vancocin®*	
Antiemetic/Antivertigo Agents		
Cannabinoids (delta-9THC derivatives)		**LENGTH OF AUTHORIZATIONS:** 6 months
***dronabinol**	**Cesamet™* **Marinol ®* **Syndros®*	***Dronabinol plus all non-preferred Antiemetic/Antivertigo agents require submission of a Clinical SA. Refer to Antiemetic/Antivertigo SA form**
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**
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** ****promethazine** *(AG)*	*Antivert®* *Bonjesta™* *Compazine®supp/tab* *Compro®* *Diclegis®* *dimenhydrinate* *doxylamine succinate/ vit B6* *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®* *Motegrity™* *Relistor®* *Symproic®* *Trulance™* *Viberzi™*	**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**
H. Pylori Treatment		
Pylera®	*Helidac®* *Omeclamox®-Pak* *lansoprazole/amoxicillin/ clarithromycin* *Prevpac®*	**LENGTH OF AUTHORIZATIONS**: 14 days **Routine PDL edits**

Histamine-2 Receptor Antagonists (H-2 RA)		
famotidine (OTC & RX) famotidine oral susp (OTC/RX) ~~**ranitidine tab/syrup (OTC & RX)**~~	*cimetidine tab/syrup (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*** **Giazo is limited to an 8-week supply*
Apriso® **Pentasa®** **sulfasalazine DR & IR**	*Asacol ®HD* *Azulfidine® IR &DR* *balsalazide disodium* *budesonide ER (generic Uceris™)* *Colazal®* *Delzicol™* *Dipentum* **Giazo™ (QL)* *Lialda®* *mesalamine (generic Asacol® HD)*	

	mesalamine (generic Lialda®) *Uceris™*	
Ulcerative Colitis – Rectal		
mesalamine rectal supp **mesalamine enema**	*Canasa® rectal supp* *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®** & tadalafil 5mg - 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)* *tadalafil 5mg (ST)*	

Urinary Antispasmodics (Bladder Relaxant)

oxybutynin tab/syrup **oxybutynin ER** **solifenacin** **Toviaz™**	*darifenacin ER (generic Enablex®)* *Detrol® & Detrol® LA* *Ditropan® & *Ditropan® XL* *Enablex®*	

	flavoxate *Gelnique™ gel/gel Pump* *Myrbetriq™* *Oxytrol® transdermal includes for Woman OTC* *Sanctura XR* *trospium IR & ER* *tolterodine IR & ER* *VESIcare®*	

Immunological Agents

Multiple Sclerosis

Avonex® **Avonex® Pen** **Betaseron® Kit** **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™* *****Mavenclad®* *****Mayzent®* *Plegridy®* *Tecfidera™* *****Vumerity™*	**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 (Ampyra®, ~~Zinbryta™~~) require the submission of a Clinical SA. Refer to MS - Ampyra® SA form; SA Form** *****Vumerity™** Approved for the treatment of relapsing forms of multiple sclerosis, to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults. *****Mayzent® or Mavenclad® SA Form**

Cytokine and CAM Antagonists And Related Agents CLOSED CLASS

Enbrel® **Humira®** **methotrexate tab/PFvial/**	*Actemra® SQ & ACTPEN* *Cimzia® & Cimzia® Syringe Kit* *Cosentyx™*	**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edits plus**

	MDVvial	*Entyvio®* ***Dupixent®* *Ilaris®* *Ilumya™* *Kevzara® inj, pen* *Kineret®* *Olumiant®* *Otezla®* *Otrexup®* *Orencia®* *Rasuvo™* *Remicade®* *Rinvoq™* *Skyrizi™* *Siliq®* *Simponi®* *Stelara® vial/syringe* *Taltz®* *Tremfya™* *Trexall®* *Xatmep™* *Xeljanz™ & Xeljanz™ XR*	***All non-preferred Cytokine and CAM Antagonists require submission of a Clinical SA. Refer to Cytokine and CAM Antagonists and Related Agents SA Form** **** See Cytokine and CAM Antagonists Appendix A for Clinical Criteria**** For a list of Cytokine and CAM Antagonists, criteria for approval and quantity limits refer to **Appendix A**
Ophthalmic			
	Antibiotics		
	bacitracin/polymyxin b sulfate oint **ciprofloxacin drops** **erythromycin** **gentamicin drops/oint** **Moxeza® drops** **ofloxacin drops** **polymyxin/trimethoprim** **tobramycin**	*AzaSite™ drops* *bacitracin* *Besivance® drops* *Bleph®-10* *Ciloxan® drops/oint* *Garamycin ®drops/oint* *gatifloxacin 0.5% soln* *Ilotycin®* *levofloxacin drops*	**LENGTH OF AUTHORIZATIONS**: Date of service only; no refills **Routine PDL edits**

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

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		
Durezol® **fluorometholone** **prednisolone acetate**	*Alrex™* *Dexamethasone* *Flarex®* *FML®, FML Forte® & FML® S.O.P.* *loteprednol etabonate (generic for Lotemax™)* *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**	*Cosopt® 0.5%-2%* *Cosopt® PF* *Simbrinza™* *Trusopt® 2%*
Rho Kinase Inhibitor	
Rhopressa® **Rocklatan ®**	
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

Grass Pollen	
	*Oralair® SL
Peanut	
	Palforzia™

LENGTH OF AUTHORIZATIONS: 1 year

***All Anti-Allergen drugs require the submission of a Clinical SA. Refer to (Anti-Allergens, Oral SA Form) (updating form)**

Initial Approval Criteria for *Palforzia™*

		▪ Patient must be 4 to 17 years of age; AND ▪ Patient must have a documented clinical history of allergy to peanuts or peanut-containing foods; AND ▪ Confirmed diagnosis of peanut allergy based on: ─ Serum immunoglobulin E (IgE) to peanut ≥ 14 kUA/L (kilos of allergen-specific units per liter) within the past 12 months; OR ─ Skin prick test (SPT) to peanut with a mean wheal diameter of ≥ 8 mm compared to control; OR ─ Clinical history of systemic reaction to peanut within the last 2 years with evidence of sensitization to peanut (serum IgE ≥ 0.35 and/or peanut SPT ≥ 3 mm); OR ─ Documented reaction to peanut upon supervised oral food challenge at a dose of ≤ 100 mg peanut protein (≤ 200 mg peanut flour); AND ▪ Patient has NOT received systemic corticosteroid therapy (oral, intramuscular, intravenous) for the treatment of asthma in any of the following manners: ─ Daily systemic corticosteroid for > 1 month during the past year; OR ─ More than 2 burst systemic corticosteroid courses in the past year with ≥ 1 week in duration; OR ─ Burst systemic corticosteroid course within 3 months prior to starting Palforzia; AND ▪ Patient has NOT been hospitalized for asthma within 1 year prior to starting Palforzia; AND ─ Patient has NOT had emergency department (ED) visit for an asthma exacerbation within 6 months prior to starting Palforzia; AND ▪ Patient does NOT have a history of eosinophilic esophagitis, and/or other eosinophilic gastrointestinal diseases; AND ▪ Patient does NOT have uncontrolled atopic dermatitis; AND Patient does NOT have a medical condition that inhibits their ability to survive anaphylaxis, such as significantly reduced lung function, severe mast cell disorder, or cardiovascular disease; AND ▪ Patient is NOT currently taking medications that can alter the effects of epinephrine (e.g., beta-blockers [oral], angiotensin-converting enzyme (ACE) inhibitor; angiotensin receptor blocker [ARB], calcium channel blocker [CCB], alpha-adrenergic blocker, ergot alkaloid); AND ▪ Patient has NOT experienced severe anaphylaxis resulting in hypotensive shock, use of > 2 doses of epinephrine, and/or intubation within the prior 60 days; AND ▪ Palforzia is being requested by or in consultation with a specialist (Allergy and Immunology specialists)

		▪ Patient has been prescribed and/or has a refill history of epinephrine auto-injector; AND ▪ Prescriber attestation for the following: ─ Patient/caregiver understand how to use injectable epinephrine; AND ─ Patient/caregiver must be able to recognize the signs and symptoms of a serious allergic reaction and anaphylaxis; AND ─ Patient/caregiver understands the importance of continual daily dosing of Palforzia to sustain desensitization and will adhere to a daily dosing regimen, including maintenance phase, of Palforzia as prescribed; AND ─ Patient/caregiver will temporarily withhold Palforzia and contact the prescriber if the patient experiences an acute asthma exacerbation; AND ─ Patient/caregiver understands dose timing considerations (e.g., strenuous exercise, hot shower/bath); AND ▪ Palforzia will be initiated at a REMS-certified healthcare facility; the initial dose escalation phase and the first dose of each of the 11 up-dosing phases will be given at a REMS-certified healthcare facility; AND ▪ Patient/caregiver will adhere to the complex up-dosing schedule that requires frequent visits to the administering healthcare facility **Renewal Criteria*** • Patient must continue to meet the above initial criteria; AND • Patient must continue to tolerate the prescribed daily doses of Palforzia; AND • Patient has not experienced recurrent asthma exacerbations; AND • Patient has not have experienced any treatment-restricting adverse effects (e.g., repeated systemic allergic reaction and/or severe anaphylaxis) Note: patients ≥ 18 years of age who met the initial approval criteria may continue maintenance treatment upon renewal
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 chew tab (OTC)* *cetirizine liquid 5mg/5mL (OTC)*	

cetirizine tabs OTC **loratadine tab/syrup OTC**	*cetirizine D tab (OTC)* *Clarinex®* *Clarinex-D®* *desloratadine ODT* *fexofenadine* *fexofenadine/PSE ER* *fexofenadine suspension* *levocetirizine tablets* *loratadine ODT* *loratadine D 12 & 24 hr* *Semprex-D®*	

Beta-Adrenergic Agents

Long Acting Beta Adrenergic s (LABA) MDIs or Nebulizers

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
Short Acting Metered Dose Inhalers or Devices				
Proair® HFA **Proventil® HFA**	*albuterol HFA (Proair)* *albuterol HFA (Ventolin)* *levalbuterol tartrate HFA* *ProAir® Digihaler™* *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** • ≥ 12 years of age; AND • Diagnosis Moderate to severe Asthma with ○ eosinophilic phenotype; OR ○ Oral corticosteroid dependent; AND • Prescribing provider is a pulmonologist or • An allergy/asthma specialist; AND • Have a diagnosis of step 5 or higher (moderate to severe) asthma; AND • Inadequately controlled asthma despite treatment with high dose inhaled or oral corticosteroid daily for at least 3 consecutive months; AND • A long-acting beta agonist (unless is not a candidate) daily for at least 3 consecutive months; AND • Is added to current maintenance treatment; AND • Is not pregnant		

COPD: Bronchodilators and Phosphodiesterase 4 (PDE4) Inhibitors CLOSED CLASS		
Atrovent HFA® **Anoro™ Ellipta®** (AG) **Bevespi Aerosphere™** **Combivent® Respimat** **ipratropium bromide soln** **ipratropium/albuterol nebs** **Spiriva®** **Stiolto Respimat™ (AG)**	**Daliresp®* *Duaklir Pressair* *Incruse™ Ellipta®* *Lonhala™ Magnair™* *Seebri Neohaler™* *Spiriva® Respimat* *Tudorza™* *Utibron Neohaler™* *Yupelri™ (revefenacin)*	**LENGTH OF AUTHORIZATION**: 1 year **Routine PDL edits plus** ***Clinical Criteria for Daliresp®** • 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 **Routine PDL edits**
Dulera®(AG)* **fluticasone/salmeterol powder (AG)** ***Symbicort®***(AG)*	*Advair® Diskus *(AG)* *Advair® HFA(AG)* *Airduo™ Respiclick®(AG)* *Breo®Ellipta™ (AG)* *Trelegy® Ellipta* *Wixela™ Inhub™(fluticasone/ salmeterol)*	
Inhaled Corticosteroids: Metered Dose Inhalers CLOSED CLASS		
Asmanex® **Flovent® Diskus & HFA** **Pulmicort Flexhaler®**	*Alvesco®* *Aerospan™* *Armonair™ Respiclick®* *Arnuity™ Ellipta®* *Asmanex HFA®* *QVAR® & QVAR® Redihaler*	
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* *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™v* *Zetonna™*	
***Cough and Cold Drug**		
Ala-Hist DM **benzonatate cap** **codeine/promethazine** **guaifenesin/codeine phosphate** **hydrocodone/ homatropine** **Iophen-C NR** **phenylephrine/promethazine** **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		
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**