MaineCare PDL

PDL Effective April 1, 2026

*** PLEASE NOTE SEARCH OPTIONS: From a computer or laptop, press "Ctrl F" for the search box; when viewing on a mobile device, search within the document using the browser search or "Find on Page" function.**

**** PLEASE NOTE: All cost effective generics applicable to DEL are considered PREFERRED Drugs. "BASIC" Covered Drugs are bolded with the Coverage Indicator of "MC / DEL".***

General Criteria for all PDL categories- For more information or help using the PDL, providers may call 1-888-445-0497; members should call 1-866-796-2463. To access PDL and PA materials via the internet: www.mainecarepdl.org

A: Preferred Drugs- Unless otherwise specified, preferred drugs are available without prior authorization. Step order may apply for preferred drugs in some drug categories as indicated on the PDL. (See item "D" below for explanation of step order.)

B: Requests for Non-preferred Drugs- Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

C: Adequate Drug Trials- 1. The minimum trial period for each preferred and step order drug is two weeks, unless otherwise stated within specific PDL drug categories; trials with less than a two week duration will be reviewed on a case-by-case basis; 2. A trial will not be considered valid if preferred or non-preferred products were readily available (by override, individual purchase, samples, etc.); 3. Certain drug trials, such as with controlled substances, may require evidence that the preferred drugs were actually tried (example: with random pill counts and with random urine drug tests, using the methods of GC/MS with no lower threshold); 4. Adequate trials require documentation of attempts to titrate dose of preferred agents toward desired clinical response. 5. Adequate trials include prevention/treatment of common adverse effects associated with preferred agents (example: antinausea, antipruritic, etc.)

D: Step Order- When numbers appear in the "step order" column, it means drugs in this category must be used in the order specified, with the lower numbers having preference over the higher numbers. Chart notes should be provided to confirm drug trials that do not appear in the member's MaineCare drug profile.

E: The Department will institute strategies to ensure cost effectiveness through the use of an enhanced Drug Benefit Preferred brand drugs will no longer be preferred in any PDL drug category where preferred generic drugs are also available. It is expected that preferred generics will be used prior to any preferred brands. This will be operated as a form of step care. Preferred brands in these categories will require prior authorization for these high utilization / high cost members.

F: Brand Name Medication Requests- (Must be submitted on the Brand Name PA request form)- According to MaineCare Benefits Manual Chapter II (80.07-5), when medically necessary covered brand-name drugs have an A-rated generic equivalent available, the most cost effective medically necessary version will be approved and reimbursed, since the brand-name and A-rated generic drugs have been determined by the FDA to be chemically and therapeutically equivalent. The Bureau does not make determinations as to whether or not a generic drug is clinically inferior or inequivalent to its brand version. This is the proper role of the FDA. Physicians should submit their reports of generic inequivalence directly to the FDA via the MEDWATCH.

G: PA requests for non- FDA Approved Indications- Decisions will be made on a case-by-case basis until the DUR committee is able to review the evidence and make a recommendation. Interim approvals and DUR recommendations for approval of a drug for a non- FDA approved indication will require a minimum of two published, peer reviewed, non contradicted, double- blind, placebo-controlled randomized clinical studies establishing both safety and efficacy.

H: Dose Consolidation Requirements- Some drugs may also be affected by dose consolidation requirements. Please see Dose Consolidation List and/or Splitting Tables provided in the PDL.

I: Trials from Multiple Drug Classes - Trial/failure/intolerance to preferred agents from multiple classes within the same category or other categories of drugs may be required prior to the approval of non-preferred agents (e.g., Cymbalta, Zofran and others).

J: Drug-specific PA Forms- Drug-specific PA forms contain medical necessity documentation requirements and/or criteria that may not be repeated in the PDL. Drug-specific PA forms may be obtained on the web at ***www.mainecarepdl.org*** .

K: PA Exemptions for Prescribers- According to MaineCare Benefits Manual Chapter II (80.07-4), providers may receive a three (3) month exemption from prior authorization requirement for certain categories of drugs when they demonstrate high compliance with the Department's PDL. The Department will notify providers in writing which drug categories are included and what dates apply to the exemption. If a provider loses his/ her exemption, members who previously were not required to obtain a PA while the prescriber was exempt will be required to do so, and criteria for approval of that medication will need to be met.

L: Drug-Drug Interactions (DDI)- The DUR Committee has implemented new drug-drug interaction edits requiring prior authorization. Several drug-drug combinations and PDL drug categories are affected by new PA requirements. These will be indicated in the PDL with DDI notation. Please see the DDI document provided in the PDL.

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
AROMATIC L-AMINO ACID DECARBOXYLASE DEFICIENCY (AADC)							
AADC DEFICIENCY AGENTS			MC		KEBILIDI (INJECTION) VIAL 280000000000 VG/0.5ML ELDOCAGENE EXUPARVOVEC-TNEQ	Use PA Form# 20420	
COVID-19 THERAPEUTICS							
COVID-19 MEDICATIONS	MC/DEL	PAXLOVID					
ASSORTED ANTIBIOTICS							
BETA-LACTAMS / CLAVULANATE COMBO'S	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC/DEL MC	AMOXICILLIN AMOXICILLIN/POTASSIUM CLA CHEW AMOXICILLIN/POTASSIUM CLA SUSR AMOXICILLIN/POTASSIUM CLA TABS AMPICILLIN BICILLIN L-A SUSP DICLOXACILLIN SODIUM CAPS OXACILLIN SODIUM SOLR PENICILLIN V POTASSIUM UNASYN SOLR	MC/DEL MC/DEL		AUGMENTIN[3] AUGMENTIN XR TB12[4]	Use PA Form# 20420 3. Chewable 125mg & 250mg and Solution 125mg/5ml and 250mg/5ml available without PA. 4. Use preferred generic amoxicillin/- clavulanate potassium alternatives.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Ampicillin will now be non-preferred and require prior authorization if it is currently being used in combination with either Prevacid, pantoprazole, Prilosec, or any currently non preferred PPI.
CEPHALOSPORINS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC	CEFADROXIL HEMIHYDRATE CEFAZOLIN SODIUM SOLR CEFDINIR CEFEPIME CEFPODOXIME **CEFPODOXIME PROXETIL SUS** **CEFPODOXIME PROXETIL TAB** CEFIXIME 400MG CAP [2] CEFPROZIL CEPHALEXIN 250MG & 500MG CAPS CEFTAZIDIME 6MG CEFTIN SUSP CEFTRIAXONE CEFUROXIME AXETIL TABS CEPHALEXIN MONOHYDRATE FORTAZ SOLR SUPRAX CHEWABLE TAZICEF 6GM	MC MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC MC/DEL MC/DEL MC MC/DEL MC		CEDAX CEFADROXIL MONOHYDRATE TABS **CEFIXIME SUS** CEPHALEXIN TABS CEFTIN FETROJA [3] FORTAZ FORTAZ SOLN KEFLEX CAPS OMNICEF ROCEPHIN SUPRAX [2] TAZICEF SOLR TEFLARO **ZEVTERA**	Use PA Form# 20420 1. Both brand and generic are clinically non-preferred. 2. Dosing limits apply, see Dosage Consolidation List. 3. Approvals will only be considered for patients 18 yrs of age or older who have limited or no alternative treatment options for the treatment of complicated urinary tract infections (cUTIs).	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Vantin will now be non-preferred and require prior authorization if it is currently being used in combination with either Prevacid, pantoprazole, Prilosec, or any currently non preferred PPI. As outlined in the US CDC Guidance on the Use of Expedited Partner Therapy (EPT) in the Treatment of Gonorrhea, MaineCare will cover a single 800 mg dose of cefixime for the treatment of gonorrhea as part of EPT.
MACROLIDES / ERYTHROMYCIN'S	MC/DEL MC/DEL MC MC MC MC MC MC/DEL	AZITHROMYCIN TABS AZITHROMYCIN SUSP E.E.S. ERYPED 200 SUSR ERYPED 400 SUSR ERY-TAB TBEC ERYTHROCIN STEARATE TABS ERYTHROMYCIN	MC/DEL MC/DEL MC/DEL MC MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		AZITHROMYCIN POW CLARITHROMYCIN SUSP CLARITHROMYCIN TABS DIFICID PCE TBEC ZITHROMAX TABS ZITHROMAX 1GM PAK ZITHROMAX TRI-PAK ZITHROMAX SUSP ZINPLAVA	Use PA Form# 20420 1. 7-Day supply per month without PA.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Preferred **Erythromycin** will now be non-preferred and require prior authorization if it is currently being used in combination with either carbamazepine, enablex 15mg or vesicare 10mg. Any non preferred formulation of erythromycin will require prior authorization and the member's drug profile will also be monitored for concurrent use with either carbamazepine, enablex 15mg or vesicare 10mg. **DDI:** Preferred **Clarithromycin** formulations (clarithromycin tablets) will now be non-preferred and require prior authorization if they are currently being used in combination with either carbamazepine, onglyza 5mg, enablex 15mg or vesicare 10mg. Any non preferred formulation of clarithromycin will require prior authorization and the member's drug profile will also be monitored for concurrent use with either carbamazepine, onglyza 5mg, enablex 15mg or vesicare 10mg. **Zinplava** will be non-preferred and require clinical prior authorization to verify it is prescribed or consulted by GI or ID specialist, diagnosis, and concurrent use of an antibacterial agent as well as limiting its use to those who have recurrent C. diff disease that has recurred despite use of guideline recommended vancomycin taper or for whom this would be contraindicated.
TETRACYCLINES	MC/DEL MC/DEL MC/DEL	DOXYCYCLINE MONOHYDRATE 100mg & 50mg CAPS MINOCYCLINE HCL CAPS TETRACYCLINE HCL CAPS	MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC/DEL		DECLOMYCIN TABS DORYX CPEP DOXYCYCLINE HYCLATE DOXYCYCLINE MONOHYDRATE 150mg & 75mg CAPS DYNACIN CAPS MINOLIRA ER NUZYRA[1] ORACEA PERIOSTAT SEYSARA[2] SOLODYN ER XIMINO	Use PA Form# 20420 1. For the treatment of patients ≥ 8 years of age 2. For the treatment of patients ≥ 9 years of age	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
FLUOROQUINOLONES	MC/DEL MC/DEL MC/DEL	CIPROFLOXACIN LEVOFLOXACIN OFLOXACIN	MC MC MC MC MC MC MC		AVELOX SOLN AVELOX ABC PACK TABS BAXDELA CIPRO LEVAQUIN TABS SOLN/INJ LEVAQUIN TABS[1] PROQUIN XR	Use PA Form# 20420 1. Dosing limits apply, see Dosage Consolidation List.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Preferred **Ofloxacin** will now be non-preferred and require prior authorization if they are currently being used in combination with amiodarone. **DDI:** Preferred **Levofloxacin** will now be non-preferred and require prior authorization if they are currently being used in combination with amiodarone. **DDI:** Preferred **Avelox** will now be non-preferred and require prior authorization if they are currently being used in combination with amiodarone. **DDI:** All preferred **Fluoroquinolones** will require clinical PA for patients over 60 that are currently on immunosuppressants or steroid therapy.
AMINO GLYCOSIDES	MC MC MC/DEL MC/DEL	GENTAMICIN KITABIS PAK NEOMYCIN SULFATE TABS **TOBRAMYCIN AMPUL-NEB**	MC/DEL MC MC/DEL MC MC/DEL MC/DEL		ARIKAYCE[1,2] BETHKIS[1] TOBI PODHALER[1,2] TOBI NEBU TOBRAMYCIN SULFATE SOLN ZEMDRI[2]	Use PA Form# 20420 1. Clinical PA to verify appropriate diagnosis 2. See Criteria section	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **TOBI Podhaler** is limited to patients with significant impairment from using nebulized version of medication **Arikayce** will require clinical PA to confirm MAC lung disease and for use in adults who have limited or no alternative treatment options. **Zemdri** will be reserved for patients with limited or no alternative treatment of care.
ANTI-MYCOBACTERIALS / ANTI-TUBERCULOSIS	MC/DEL MC/DEL MC/DEL MC/DEL	ETHAMBUTOL HCL TABS MYAMBUTOL TABS **RIFABUTIN CAPS** RIFAMPIN	MC/DEL MC/DEL MC		MYCOBUTIN CAPS **PRETOMANID** RIFADIN CAPS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Pretomanid** is indicated as part of a combination regimen with bedaquiline and linezolid for the treatment of adults with pulmonary extensively drug resistant (XDR) or treatment-intolerant or non-responsive multidrug-resistant (MDR) tuberculosis (TB). Approval of this indication is based in limited clinical safety and efficacy data. This drug is indicated for use in a limited and specific population of patients. **DDI:** Preferred **Rifampin** will be non-preferred and require prior authorization if it is currently being used in combination with either pradaxa or latuda.
ANTIMALARIAL AGENTS	MC/DEL MC MC/DEL MC/DEL	**DARAPRIM TABS** **KRINTAFEL[2]** **MEFLOQUINE HCL TABS** **QUININE SULFATE**	MC MC/DEL MC/DEL MC MC MC/DEL		ARALEN TABS **CHLOROQUINE PHOSPHATE TABS[3]** **HYDROXYCHLOROQUINE TABS[3]** ISONARIF[1] MALARONE TABS **PLAQUENIL TABS**	Use PA Form# 20420 1. Ingredients available as preferred without PA. 2. **Krintafel** is preferred for ≥ 16 years of age. 3. Established users will be grandfathered.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Avoid coadministration of **Krintafel** with Organic Cation Transporter 2 (OCT2) and Multidrug and Toxin Extrusion (MATE) substrates (e.g. dofetilide, metformin).
ANTHELMINTICS	MC/DEL MC/DEL MC/DEL	**ALBENDAZOLE** **PRAZIQUANTEL TAB** STROMECTOL TABS	MC MC MC/DEL		ALBENZA TABS EMVERM BILTRICIDE TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIBIOTICS - MISC.	MC MC MC MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL	AZACTAM SOLR COLY-MYCIN-M SOLR COLISTIMETHATE SODIUM SOLR FIRVANQ [4] FUROXONE TABS METRONIDAZOLE [1] PENTAMIDINE ISETHIONATE SOLR SOLOSEC TRIMETHOPRIM TABS VANCOMYCIN 5GM INJ. VANCOMYCIN CAPS	MC MC MC MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC MC MC/DEL MC MC/DEL		AEMCOLO BLUJEPA [6] COLISTIMETHATE SODIUM SOLR CAYSTON [3] FLAGYL CAPS FLAGYL TABS LIKMEZ METRONIDAZOLE 375MG CAPS [1] METRONIDAZOLE 750MG TABS [1] NEBUPENT SOLR **ORLYNVAH** REBYOTA [5] VANCOMYCIN 10GM INJ. [2] VOWST [5] XENLETA	Use PA Form# 20420 1. 375mg caps and 750mg tabs are non-preferred. Please use available preferred strengths (250mg & 500mg tabs) to obtain required dose without PA. 2. Please use multiple 5gm which are preferred to obtain dose without PA. 3. Clinical PA is required to establish CF diagnosis and medical necessity. Prior trial and failure of preferred **Tobi** before approval will be granted. 4. Quantity limit of one per 150ml bottle. 5. For the treatment of patients 18 years of age and older. 6. For the treatment of patients 12 years of age and older.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **For macrolide resistant infections when quinolones are inappropriate** **Cayston** is only indicated to improve respiratory symptoms in CF patients with Pseudomonas aeruginosa. Dosing limits, as should be given TID X28 days (followed by 28 days OFF Cayston therapy). A bronchodilator should be used before administration of Cayston. **Likmez**: patient has a medical necessity for a non-solid oral dosage form. **Rebyota:** For the prevention of recurrence of C. difficile infection (CDI) in individuals 18 years of age and older following antibiotic treatment for recurrent CDI. The limitation of use is that Rebyota is not indicated for treatment of CDI. **Vowst**: To prevent the recurrence of C.difficile infection (CDI) in individuals 18 years of age and older following antibacterial treatment for recurrent CDI (rCDI). **Xenleta** will be considered for the treatment of adults with community-acquired bacterial pneumonia (CABP) caused by the following susceptible microorganisms: Streptococcus pneumoniae, Staphylococcus aureus (methicillin-susceptible isolates), Hemophilus influenzae, Legionella pneumophila, Mycoplasma pneumoniae, and Chlamydophila pneumoniae.
CARBAPENEMS			MC MC MC/DEL MC/DEL		INVANZ SOLR MERREM SOLR PRIMAXIN RECARBRIO	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
LINCOSAMIDES / OXAZOLIDINONES / LEPROSTATICS	MC/DEL MC/DEL MC/DEL MC MC/DEL	CLEOCIN SOLN CLEOCIN SUSR CLINDAMYCIN HCL 150CAPS DAPSONE TABS **LINEZOLID 600mg TABS [2]**	MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL		CLEOCIN CAPS CLINDAMYCIN HCL 300CAPS [1] SIVEXTRO VIBATIV ZYVOX SUSR ZYVOX TABS	Use PA Form# 30820 for Zyvox & Vibativ Use PA Form# 20420 for all others 1. Use multiple 150's for **Clindamycin** instead of 300's. 2. Quantity limit of 14 days supply within a 60-day period.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. For **Zyvox** or **Vibativ**, please see the criteria listed in the Antibacterial Antibiotics PA form.
ANTI INFECTIVE COMBO'S - MISC.	MC/DEL MC/DEL MC/DEL	SEPTRA/DS TABS SULFAMETHOXAZOLE/TRIMETH TRIMETHOPRIM/SULFAMETHOXA	MC MC		BACTRIM DS TABS VABOMERE[1]	Use PA Form# 20420 1. For the treatment of patients ≥ 18 years of age.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
ANTIPROTOZOALS	MC/DEL	**BENZNIDAZOLE**[2]	MC		ALINIA[1]	Use PA Form# 20420 1. **Alina** is preferred for children less than 12 years of age. 2. Clinical PA required for appropriate diagnosis.	**Benznidazole** is indicated for pediatric patients 2 to 12 years of age for the treatment of Chagas disease (American trypanosomiasis) caused by trypanosoma cruzi.
	MC/DEL	LAMPIT[2]					
ANTI - FUNGALS							
ANTIFUNGALS - ASSORTED	MC/DEL	FLUCONAZOLE[1]	MC/DEL	6	LAMISIL TABS[4]	Use PA Form# 20420 See Quantity Limit table. **Non-preferred products must be used in specified step order.** Continue to use Anti-Fungal PA form for non-preferred products. Anti-Fungal PA Form# 10120 1. QL-1/every 7-day period (150mg only). 2. **Sporanox** QL 300cc/month with PA. See Quantity Limit table. 3. **Sporanox** QL 30/month with PA. 4. Quantity limit of one tablet daily. Please see Dosage Consolidation List. 5. Approved if immuno suppressed/ HIV or if the member has failed a 7-day trial of a preferred antifungal therapy. 6. **Eraxis** will be approved if submitting with documentation that it was initiated during a hospitalization and this request is to finish the hospital course. 7. Quantity limits allowing 30-day supply without PA. PA will be required if using > 30 days. 8. For children < 18, quantity limits allows 8 weeks supply without PA. PA will be required if using > than 8 weeks. If 18 and older PA will be required for any quantity. Not approving for Onychomycosis indication. 9. For patients ≥ 18 years of age.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. The other criteria are listed on the Antifungal PA form including the required proof of a non-cosmetic fungal infection. **DDI:** Any **Griseofulvin** will now be non-preferred and require prior authorization if it is currently being used in combination with either prevacid, pantoprazole, prilosec, or any currently non preferred PPI. **DDI: Sporanox** is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for current use with enablex 15mg, vesicare 10mg, prandin, prevacid, pantoprazole, prilosec, or any currently non preferred PPI, due to a significant drug-drug interaction. **DDI: Vfend** is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for concurrent use with warfarin. **DDI: Fluconazole** (except 150mg strength) will now be non-preferred and require prior authorization if it is currently being used with glimepiride (amaryl), enablex 15mg, or vesicare 10mg. **Diflucan** is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for concurrent use with either glimepiride (amaryl), enablex 15mg, or vesicare 10mg. **DDI: Fluconazole** will require prior authorization if being used in combination with plavix or warfarin. **DDI: Ketoconazole** will now be non-preferred and require prior authorization if they are currently being used in combination with any of the following medications: prevacid, pantoprazole, plavix, onglyza, enablex 15mg, vesicare 10mg, latuda, cometriq, tafinlar or omeprazole. **Rezzayo**: In patients 18 years of age or older who have limited or no alternative options for the treatment of candidemia and invasive candidiasis.
	MC/DEL	KETOCONAZOLE TABS[7]	MC/DEL	6	ITRACONAZOLE		
	MC/DEL	NYSTATIN	MC	8	BREXAFEMME		
	MC/DEL	TERBINAFINE TABS[4]	MC/DEL	8	CRESEMBA[9]		
	MC/DEL	**VORICONAZOLE TABS**	MC/DEL	8	GRIFULVIN V TABS		
			MC	8	GRISEOFULVIN SUSP		
			MC	8	GRISEOFULVIN ULTRAMICROSI TABS[8]		
			MC	8	GRIS-PEG TABS		
			MC	8	REZZAYO[9]		
			MC/DEL	8	SPORANOX SOLN[2]		
			MC/DEL	8	SPORANOX PULSEPAK CAPS[3]		
			MC/DEL	8	SPORANOX CAPS[3]		
			MC/DEL	8	DIFLUCAN		
			MC/DEL	8	ERAXIS INJ[6]		
			MC	8	GRIFULVIN SUSP		
			MC/DEL	8	ONMEL		
			MC/DEL	8	NOXAFIL[5]		
			MC/DEL	8	TOLSURA		
			MC/DEL	8	VFEND TABS		
			MC	8	VIVJOA		
ANTI - VIRALS							
ANTIRETROVIRALS - PREP	MC	APRETUDE	MC		TRUVADA [1]	Use PA Form# 20420 1. Quantity limit of one per day	**DDI:** The concomitant use of the following drugs with Descovy is not recommended: tipranavir/ritonavir, St. John's wort, and the antimycobacterials rifabutin, rifampin, or rifapentine.
	MC	DESCOVY [1]					
	MC	EMTRICITABINE-TENOFOVIR DISOP (ORAL) TAB					
	MC	YEZTUGO					
ANTIRETROVIRALS	MC/DEL	**ABACAVIR TABS**	MC/DEL		**ABACAVIR SOL**	Use PA Form# 20420 1. Quantity limit of one per day 2. Only preferred if **Norvir** script is in member's profile within the past 30 days of filling **Prezista** 3. **Isentress Chewable** will only be approved if between the age of 2-12 years old 4. Clinical PA required 5. Only preferred for post- exposure prophylaxis	**Fuzeon**: Prescriber is either an HIV specialist provider or has consulted with one. Documentation of genotype testing is supplied and shows that there is no other potent, appropriate two or three drug oral regimen available, AND patient has a positive HIV viral load within past 6 months while on his/her current antiretroviral regimen AND the drug will be prescribed with at least two other drugs that are likely to be active based on the genotype testing. **DDI:** Reyataz requires prior authorization if it is currently being used in combination with either prevacid, pantoprazole, prilosec, or any currently non preferred PPI. **DDI:** Norvir requires prior authorization if it is currently being used in combination with either enablex 15mg or vesicare 10mg. **DDI**: Preferred Crixivan caps requires prior authorization if it is currently being used in combination with either enablex 15mg or vesicare 10mg. **DDI**: Administration with the following drugs: the anticonvulsants carbamazepine, oxcarbazepine, phenobarbital, and phenytoin; the antimycobacterials rifampin and rifapentine; proton pump inhibitors such as dexlansoprazole, esomeprazole, lansoprazole, omeprazole, pantoprazole, rabeprazole; systemic dexamethasone (more than a single dose); and St. John's wort with Odefsey is contraindicated. **Stribild**: PA required; must provider rationale as to why the member's medical need cannot be met with preferred agents, particularly genvoya or combinations of preferred and agents AND must be antiretroviral treatment-naïve or virologically controlled on current therapy (HIV-1RNA < copies/ml) AND be HBV negative AND not be combined with other anti-retroviral agents. **DDI:** Tivicay will require prior authorization is used with nevirapine, oxcarbazepine, phenytoin, phenobarbital, carbamazepine, and St. John's wort. **DDI**: Aatazanavir or Darunavir and the following drugs are contraindicated (due to potential for serious and/or life-threatening events or loss of therapeutic effect): alfuzosin, dronedarone, rifampin, irinotecan, ergotamine, methylergonovine, cisapride, St. John's wort, lovastatin, simvastatin, pimozide, nevirapine, sildenafil (when given as revatio for treatment of PAH), indinavir, triazolam, or PO midazolam will be non-preferred and require prior authorization if it is currently being used in combination with tybost. **DDI:** Combined P-gp, UGT1A1 and strong CYP3A inhibitors may significantly increase plasma concentrations of Sunlenca. Concomitant administration of Sunlenca with these inhibitors is not recommended. **Sunlenca**: In combination with other antiretroviral(s) for the treatment of HIV-1 infection in heavily treatment-experienced adults with multidrug resistant HIV-1 infection failing their current antiretroviral regimen due to resistance, intolerance, or safety considerations.
	MC/DEL	**ATAZANAVIR**	MC/DEL		APTIVUS		
	MC	BIKTARVY	MC		ATRIPLA [1]		
	MC	CABENUVA	MC/DEL		CIMDUO		
	MC	COMPLERA [1]	MC/DEL		COMBIVIR TABS		
	MC/DEL	DELSTRIGO	MC/DEL		EDURANT		
	MC	DIDANOSINE	MC/DEL		FUZEON		
	MC/DEL	DOVATO	MC/DEL		INTELENCE		
	MC	EFAVIRENZ TAB	MC/DEL		ISENTRESS [3]		
	MC/DEL	**EFAVIRENZ CAP**	MC/DEL		ISENTRESS HD		
	MC	EFAVIRENZ-EMTRICITABINE-TENOFOVIR DF TAB	MC		JULUCA		
			MC		KALETRA		
	MC	EMTRIVA [1]	MC/DEL		**LAMIVUDINE SOLN**		
	MC	EPIVIR SOL	MC/DEL		NEVIRAPINE		
	MC/DEL	EVOTAZ [1]	MC		NORVIR		
	MC	GENVOYA [1,4]	MC/DEL		PIFELTRO		
	MC/DEL	ISENTRESS 400MG [5]	MC		RETROVIR		
	MC/DEL	ISENTRESS CHEW [3]	MC		REYATAZ		
	MC/DEL	ISENTRESS POWDER	MC/DEL		SELZENTRY		
	MC/DEL	**LAMIVUDINE TABS**	MC		STAVUDINE		
	MC/DEL	**LAMIVUDINE/ZIDOVUDINE**	MC		STRIBILD [1]		
	MC/DEL	**LOPINAVIR-RITONAVIR SOL**	MC/DEL		SYMFI [4]		

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
	MC	LOPINAVIR-RITONAVIR TAB	MC/DEL		SYMFI LO [4]		
	MC	ODEFSEY [1]	MC/DEL		SYMTUZA		
	MC/DEL	PREZCOBIX	MC/DEL		TRIZIVIR TABS		
	MC	PREZISTA [2]	MC/DEL		VIRACEPT TABS		
	MC/DEL	**RITONAVIR TAB 100MG**	MC		VITEKTA		
	MC	RUKOBIA [4]	MC		VIREAD TABS [1]		
	MC	SUNLENCA [4]	MC/DEL		ZIAGEN TABS		
	MC	SUSTIVA [1]	MC/DEL		ZIAGEN SOL		
	MC	TIVICAY	MC/DEL		VIRAMUNE XR		
	MC	TIVICAY PD					
	MC	TRIUMEQ [1]					
	MC	TROGARZO [4]					
	MC	TYBOST					
	MC	VIREAD POW					
	MC/DEL	ZIDOVUDINE					
CYTO-MEGALOVIRUS AGENTS	MC	CIDOFOVIR	MC		VALCYTE TABS	Use PA Form# 20420 1. Must show failure or contraindication to all the following ganciclovir, valganciclovir, cidofovir and foscarnet before **Livtencity** will be approved.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Prevymis**: Documentation that member is high-risk for CMV reactivation as defined by transplant guidelines or that there has been significant myelosuppression by one of the preferred agents. **DDI:** Livtencity is a substrate of CYP3A4. Coadministration of Livtencity with strong inducers of CYP3A4 is not recommended, except for selected anticonvulsants.
	MC	FOSCARNET SODIUM	MC		FOSCAVIR		
	MC/DEL	GANCICLOVIR	MC/DEL		LIVTENCITY [1]		
	MC/DEL	VALGANCICLOVIR	MC		PREVYMIS		
HERPES AGENTS	MC/DEL	VALACYCLOVIR HCL	MC/DEL	8	FAMCICLOVIR [1]	Use PA Form# 20420 1. Must fail **Valacyclovir** before non-preferred products in step order.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved **(in step order)**, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
			MC	8	SITAVIG		
			MC	8	VALTREX TABS [1]		
			MC/DEL	9	FAMVIR TABS [1]		
INFLUENZA AGENTS	MC	AMANTADINE CAPS	MC	8	AMANTADINE TABS	Use PA Form# 20420 1. **Tamiflu** and **Oseltamivir** 10 caps or 60cc's per month. Will be audited for presence of positive influenza tests in patient or family member.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved **(in step order)**, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC	RELENZA DISKHALER AEPB	MC	8	FLUMIST		
	MC/DEL	**OSELTAMIVIR** [1]	MC/DEL	8	RIMANTADINE HCL TABS		
			MC	8	TAMIFLU [1]		
			MC	8	TAMIFLU SUS		
			MC/DEL	8	XOFLUZA		
IMMUNE SERUMS							
IMMUNE SERUMS	MC	HYPERRHO INJ					
HEPATITIS AGENTS							
HEPATITIS C AGENTS	MC	SOFOSBUVIR/VELPATASVIR [3] (Authorized generic labeler 72626 Asegua Therapeutics)	MC	8	EPCLUSA [2]	Use PA Form #10700 1. Dosing limits apply, please see dosage consolidation list. 2. Approvals will require clinical PA. Please see the Hepatitis PA form for criteria. 3. PA is not required for simplified treatment regimens. Please see the Hepitits PA form for criteria.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved **(in step order)**, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Olysio will require a prior authorization if it is currently being used in combination with drugs known to be significant CYP3A4 inhibitors (ketoconazole, itraconazole, clarithromycin, indinavir, nefazodone, nelfinavir, ritonavir, atazanavir, saquinavir and telithromycin).
	MC	MAVYRET [3]	MC	8	HARVONI [2]		
	MC/DEL	PEGASYS KIT [1]	MC	8	SOVALDI [2]		
	MC/DEL	PEGASYS SOLN	MC	8	VOSEVI		
	MC	RIBAVIRIN	MC	8	ZEPATIER [2]		
HEPATITIS AGENTS - MISC.			MC		ACTIMMUNE	Use PA Form# 20420	Approved for chronic granulomatous disease, osteopetrosis and idiopathic pulmonary fibrosis.
HEPATITIS B ONLY	MC/DEL	**ENTECAVIR**	MC	8	BARACLUDE	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved **(in step order)**, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Baraclude** is indicated for treatment of chronic Hep B virus (HBV) in adults with: evidence of active viral replication AND either evidence of persistent elevation in serum aminotransferases (ALT or AST) or histologically active disease, Patient is 16 years of age or older. Boxed warning: Use not recommended for those co-infected with HIV and HBV who are not also receiving highly active antiretroviral therapy (HAART). **Vemlidy** remain non-preferred and require prior authorization and be available to those who have evidence of bone loss or renal insufficiency or who are unable to tolerate or who have failed on preferred medications.
	MC	TENOFOVIR	MC	8	VEMLIDY		

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
RSV PROPHYLAXIS							
RSV PROPHYLAXIS			MC		SYNAGIS [1]	Use PA Form# 30120 1. PA requests may be approved starting at the onset of RSV season for a maximum of 5 doses and a dosing interval not less than 30 days between injections. PA requests will be reviewed starting November of the current calendar year. **Synagis** dosing authorizations will extend for the recommended number of doses or until the end of epidemic RSV season as defined by CDC - whichever occurs first. Monthly prophylaxis should be discontinued for any infant or young child who experiences a breakthrough RSV hospitalization or if a child receives Nirsevimab (Beyfortus).	Please see the criteria listed on the Synagis PA form.
MS TREATMENTS							
MULTIPLE SCLEROSIS - INTERFERONS	MC	AVONEX KIT [1]	MC	8	PLEGRIDY [1]	Use PA Form# 20430 1.Clinical PA is required to establish diagnosis and medical necessity.	Non-Preferred drugs must be tried in step-order and failed due to lack of efficacy or intolerable side effects before lower ranked non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	**BETASERON SOLR [1]**					
	MC	REBIF SOLN [1]					
MULTIPLE SCLEROSIS - NON-INTERFERONS	MC	COPAXONE	MC	8	AMPYRA	Use PA Form# 20430 1. Provider must be enrolled in the TOUCH Prescribing program, a restricted distribution program. Clinical PA is required to establish diagnosis and medical necessity. 2. Clinical PA is required to establish diagnosis and medical necessity. 3. Due to safety profile, use of **Mavenclad** is generally recommended for patients who have had an inadequate response to, or are unable to tolerate, an alternate drug indicated for the treatment of MS. 4. For the treatment of patients 10 years of age and older. 5. **Approved after single step through preferred drugs**.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved **(in step order)**, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Mavenclad** will require multiple trials of preferred agents including mayzent for secondary progressive disease. **DDI:** Due to significant increases in exposure to siponimod, concomitant use of Mayzent and drugs that cause moderate CYP2C9 and moderate or strong CYP3A4 inhibition is not recommended. **Ponvory:** Before initiation of Ponvory treatment, assess the following: • Complete Blood Count (CBC) - Obtain a recent (i.e. within the last 6 months) CBC, including lymphocyte count. • Cardiac Evaluation - Obtain an electrocardiogram (ECG) to determine whether pre-existing conduction abnormalities are present. In patients with certain pre-existing conditions, advice from a cardiologist should be sought and first-dose monitoring is recommended. Determine whether patients are taking drugs that could slow heart rate of atrioventricular (AV) conduction. • Liver Function Tests - Obtain recent (i.e. within the last 6 months) transaminase and bilirubin levels. • Ophthalmic Evaluation - Obtain an evaluation of the fundus, including the macula. • Current or prior medications with immune system effects - If patients are taking anti-neoplastic, immunosuppressive, or immuno-modulating therapies, or if there is a history of prior use of these drugs, consider possible unintended additive immunosuppressive effects before starting treatment with Ponvory. • Vaccinations - Test for antibodies to varicella zoster virus (VZV) before starting Ponvory; VZV vaccination of antibody-negative patients is recommended prior to commencing treatment with Ponvory. If live attenuated vaccine immunizations are required, administer at least 1 month prior to initiation of Ponvory. **Mayzent for Relapsing forms of MS**: multiple trials of preferred agents, including an intravenous MS product. **Mayzent for Active secondary progressive disease**: prior trials of two preferred agents are required.
	MC/DEL	**DALFAMPRIDINE ER**	MC	8	AUBAGIO		
	MC/DEL	**DIMETHYL FUMARATE CAP**	MC	8	BAFIERTAM		
	MC/DEL	**FINGOLIMOD CAP [2]**	MC	8	BRIUMVI		
	MC	KESIMPTA [2,5]	MC/DEL	8	GILENYA		
	MC	TERIFLUNOMIDE TAB [2]	MC/DEL	8	**GLATOPA**		
	MC	TYSABRI [1,2]	MC/DEL	8	**MAVENCLAD [3]**		
			MC/DEL	8	**MAYZENT**		
			MC	8	OCREVUS [2]		
			MC	8	OCREVUS ZUNOVO [2]		
			MC/DEL	8	**PONVORY [2]**		
			MC	8	TASCENSO ODT [2,4]		
			MC	8	TECFIDERA		
			MC/DEL	8	TYRUKO		
			MC	8	VUMERITY		
			MC	8	ZEPOSIA		
MULTIPLE SCLEROSIS - MISC			MC		ZINBRYTA [1]	Use PA Form# 20430 1. The safety and efficacy of use in children under the age of 17 years have not been established.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ASSORTED NEUROLOGICS							
NEUROLOGICS - FIBROMYALGIA			MC		**TONMYA**		Trial failure, contra-indication, or intolerance to guideline driven care of at least two agents: amitriptyline, cyclobenzaprine, duloxetine, gabapentin, and pregabalin immediate release
NEUROLOGICS - MISC.	MC	BOTOX [2,4]	MC	8	DAXXIFY	Use PA Form# 10210 1. Approval will be limited to Cervical Dystonia. 2. Please see botulinum PA form for additional criteria. 4. Clinical PA required. 5. For adult patients who are anti-acetylcholine receptor (AChR) antibody positive. 6. For the treatment of patients between ages 4-17 years of age.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved **(in step order)**, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Failed/did not tolerate therapeutic trials of muscle relaxants, unless contraindicated, including but not limited to baclofen, cyclobenzaprine, orphenadrine, skelaxin, and tizanidine. **Migraine:** Consideration for **Botox** approvals will only be made after failures of required trials of the following preferred medications: tricyclic or venlafaxine, beta blocker, valproic acid ,topiramate. **Firdapse** is recommended for the treatment of Lambert-Eaton myasthenic syndrome (LEMS) in adults.
	MC	DYSPORT [4]	MC	8	FIRDAPSE [5]		
			MC	8	MYOBLOC [1]		
			MC	8	SKYSONA [4,6]		
			MC/DEL	8	XEOMIN [2]		
NEUROLOGICS- hATTR AGENTS			MC		AMVUTTRA [1]	Use PA Form# 20420 1. PA required for appropriate diagnosis.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Certain drugs require specific diagnoses for approval. **Tegsedi** should be non-preferred and approved for patients for whom other treatments, including Onpattro, have been ineffective. **Vyndamax** will be considered for the treatment of the cardiomyopathy of wild type or hereditary transthyretin-mediated amyloidosis (ATTR-CM) in adults to reduce cardiovascular mortality and cardiovascular-related hospitalization.
			MC		ATTRUBY		
			MC		ONPATTRO [1]		
			MC		TEGSEDI [1]		
			MC/DEL		**VYNDAMAX [1]**		
			MC/DEL		**VYNDAQEL [1]**		
			MC/DEL		WAINUA [1]		

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
NEUROLOGICS- SMA		GENE			GENE	Use PA Form# 20420 1. Clinical PA is required to establish diagnosis and medical necessity. 2. For patients 2 months of age and older. 3. For patients 2 years of age and older.	**Itvisma:** • Patients with confirmed mutation in survival motor neuron 1 (SMN1) gene. • Patients previously treated with Zolgensma should not be treated with Itvisma. • Prior to injection: 1. Assess vaccination status. 2. Assess liver function. 3. Obtain creatinine and complete blood count. 4. Perform baseline testing for presence of anti-AAV9 antibodies. • Administer to patients who are clinically stable in their overall baseline health status. Postpone in patients with active or recent infections, until the infection has resolved, and the patient is clinically stable. • One day prior to injection, begin administration of systemic corticosteroids. • Monitor liver function weekly for the month after Itvisma injection and during the corticosteroid taper period, and monitor platelet counts weekly for the first month and as clinically indicated until platelet counts return to baseline. (Monitor liver function for at least 3 months after injection). • Patients with preexisting hepatic impairment or acute hepatic viral infection may be at higher risk of liver injury. Itvisma therapy should be carefully considered in patients with liver impairment. **Zolgensma**: The patient is less than 2 years of age AND The diagnosis is spinal muscular atrophy (SMA) AND the patient has bi-allelic mutations of the SMN1 gene AND the patient does not have advanced SMA (e.g. complete paralysis of limbs or permanent ventilator dependence) AND medication is prescribed per the dosing. **Spinraza**: The diagnosis is spinal muscular atrophy (SMA) type 1, 2, or 3 (results of genetic testing must be submitted), AND the patient has at least 2 copies of the SMN2 gene, AND the prescriber is a neurologist, pulmonologist, or other physician with expertise in treatment SMA, AND baseline motor ability has been established using one of the following exams: • Hammersmith Infant Neurological Exam (HINE) • Hammersmith Functional Motor Scale Expanded (HFMSE) • Upper Limb Module Test (non-ambulatory) • Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND), AND prior to starting therapy, and prior to each dose, the following laboratory tests will be conducted: 1. Treating provider attests the member has a platelet count > 50,000/ml or greater, and 2. Treating provider agrees to do platelet count and coagulation test before each dose, and 3. Treating provider agrees to do a quantitative spot urine protein test before each dose. Concomitant use of **Spinraza** and **Zolgensma** is investigational and will not be approved, AND Use of Spinraza after gene replacement therapy, including **Zolgensma** is investigational and will not be approved **Note**: Initial approval will be granted for 4 loading doses (the first 3 loading doses should be administered at 14-day intervals; the 4th loading dose should be administered 30 days after the 3rd dose). Renewal may be granted for up to 12 months with a maximum of 3 doses approved per year (12mg (5ml) every 4 months). For therapy continuation, clinical documentation must be submitted documenting improvement or maintenance of motor ability OR slower progression of disease than would otherwise be expected.
	MC	ZOLGENSMA [1]	MC		ITVISMA [1,3]		
		NON-GENE			NON-GENE		
	MC	EVRYSDI [1,2]					
	MC	SPINRAZA [1]					
NEUROLOGICS- RETT SUNDROME			MC	8	DAYBUE [1,2]	Use PA Form# 20420 1.Clinical PA required for appropriate diagnosis 2. For the treatment of patients 2 years of age and older.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved **(in step order)**, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ALS DRUGS	MC/DEL	**RILUZOLE**	MC	8	QALSODY	Use PA Form# 20420 1. Clinical PA for indication required.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved **(in step order)**, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Qalsody**: For the treatment of amyotrophic lateral sclerosis (ALS) in adults who have a mutation in the superoxide dismutase 1 (SOD1) gene. Continued approval for this indication may be contingent upon verification of clinical benefit in confirmatory trial(s).
			MC	8	RILUTEK TABS		
			MC	8	RADICAVA [1]		
			MC	8	TIGLUTIK		
MOVEMENT DISORDERS	MC	AUSTEDO [1]	MC	8	XENAZINE	Use PA Form# 20420 1. Clinical PA required for appropriate diagnosis	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved **(in step order)**, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Avoid concomitant use of **VMAT2 inhibitors** with MAO inhibitors (e.g. isocarboxazid, phenelzine, or selegiline).Concomitant use with strong CYP3A4 inducers (e.g. rifampin, carbamazepine, phenytoin, St. John's wort) is not recommended
	MC	AUSTEDO XR [1]					
	MC	INGREZZA [1]					
	MC	TETRABENAZINE [1]					
MUSCULAR DYSTROPHY AGENTS	MC	EMFLAZA [2]	MC	8	AGAMREE [4]	Use PA Form# 20420 1. Clinical PA to verify diagnosis and use of stable dose of corticosteroid for at least 6 months. 2. For the treatment of Duchenne muscular dystrophy (DMD) in patients 2 years of age and older and a documented intolerance of oral corticosteroid. 3. Clinical prior authorization to verify diagnosis and use of stable dose of corticosteroid. 4. For the treatment of Duchenne muscular dystrophy (DMD) in patients 2 years of age and older.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved **(in step order)**, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Amondys 45, Exondys 51 and Vyondys 53:** • The prescriber is, or has consulted with, a neuromuscular disorder specialist AND • The dose does not exceed 30mg/kg once weekly AND • The patient is currently on a stable corticosteroid dose for at least 6 months (at least 3 months for Elevidy). **Amondys 45, Exondys 51, Vyondys 53** Note: Initial approval will be granted for 6 months. For re-approval after 6 months, the patient must demonstrate a response to therapy. **Duvyzat**: The patient must meet the FDA approved age AND have a diagnosis of Duchenne Muscular Dystrophy confirmed with a confirmed mutation of the DMD gene AND • The prescriber is, or has consulted with, a neuromuscular disorder specialist • The patient is ambulatory AND • The patient is currently on a stable corticosteroid dose for at least 6 months AND • Baseline platelet counts are > 150 x 109/L and baseline triglycerides are < 300 mg/dL
	MC		MC	8	AMONDYS 45 [1]		
			MC	8	DEFLAZACORT		
			MC	8	ELEVIDYS [3]		
			MC	8	DUVYZAT		
			MC	8	EXONDYS 51 [1]		
			MC	8	VILTEPSO [3]		
			MC	8	VYONDYS 53		

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
							Elevidys and Viltepso: The prescriber is, or has consulted with, a neuromuscular disorder specialist AND • The dose does not exceed dosing AND • The patient is currently on a stable corticosteroid dose for at least 3 months. **Viltepso:** For Duchenne muscular dystrophy (DMD) in patients who have a confirmed mutation of the DMD gene that is amenable to exon 53 skipping. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial.
MYASTHENIA GRAVIS	MC	PYRIDOSTIGMINE	MC	8	IMAAVY	Use PA Form# 20420 1. For the treatment of generalized myasthenia gravis (gMG) in adult patients who are anti-acetylcholine receptor (AChR) antibody positive.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved **(in step order)**, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Zilbrysq** recommended to vaccinate patients for meningococcal infection per current Advisory Committee on Immunization Practices (ACIP) recommendations at least 2 weeks prior to administering the first dose.
			MC	8	VYVGART [1]		
			MC	8	VYVGART HYTRULO [1]		
			MC/DEL	8	ZILBRYSQ [1]		
FRIEDREICH'S ATAXIA AGENTS			MC		SKYCLARYS [1,2]	Use PA Form# 20420 1. Clinical PA required for appropriate diagnosis. 2. For the treatment of patients 16 years of age and older.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
STEROIDS							
GLUCOCORTICOIDS/ MINERALOCORTICOIDS	MC/DEL	BUDESONIDE EC 3mg DR CAPS	MC		CORTEF 10 and 20 TABS	Use PA Form# 20420 1. Trial and failure, contra-indication or intolerance to Alkindi Sprinkle is required.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** All preferred steroids will require clinical PA for patients over 60 that are currently on fluoroquinolone therapy.
	MC	CELESTONE SUSP	MC		MILLIPRED		
	MC/DEL	CORTEF 5	MC/DEL		PREDNISONE INTENSOL CONC		
	MC/DEL	CORTISONE ACETATE TABS	MC		HEMADY		
	MC/DEL	DELTASONE TABS	MC		KHINDIVI [1]		
	MC/DEL	DEPO-MEDROL SUSP	MC/DEL		MEDROL TABS		
	MC/DEL	DEXAMETHASONE	MC		MEDROL DOSEPAK TABS		
	MC	DEXPAK	MC		ALKINDI SPRINKLE		
	MC/DEL	FLUDROCORTISONE ACETATE TABS	MC		ZILRETTA		
	MC/DEL	HYDROCORTISONE					
	MC	KENALOG					
	MC/DEL	METHYLPREDNISOLONE TABS					
	MC/DEL	PREDNISOLONE					
	MC/DEL	**PREDNISONE**					
	MC/DEL	SOLU-CORTEF SOLR					
	MC/DEL	SOLU-MEDROL SOLR					
HORMONE REPLACEMENT THERAPIES							
ANDROGENS / ANABOLICS	MC/DEL	ANDRODERM PT24	MC		ANADROL-50	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Additionally, laboratory evidence of a testosterone deficiency must be supplied. One of each dosage form should be tried (tablet, injection, and topical). **Oxandrolone**: Weight gain (adjunctive therapy): Adjunctive therapy to promote weight gain after weight loss following extensive surgery, chronic infections, or severe trauma, and in some patients who, without definite pathophysiologic reasons, fail to gain or to maintain normal weight. Other indications included in manufacturer labeling: Adjunctive therapy to offset protein catabolism with prolonged corticosteroid administration. Requirement for documentation of weight loss over two readings- Patient has involuntary weight loss of more than 10% of total body weight in less than four months) and, BMI < 18.5 (Normal BMI = 18.5 to 24.9).
	MC/DEL	ANDROGEL 1%	MC		ANDRO LA 200 OIL		
	MC/DEL	ANDROGEL PUMP 1.62%	MC/DEL		ANDROGEL PACKETS 1.62%		
	MC/DEL	DANAZOL CAPS	MC		ANDROID CAPS		
	MC/DEL	TESTOSTERONE CYP	MC		AXIRON		
			MC		AZMIRO		
			MC		DELATESTRYL OIL		
			MC/DEL		DEPO-TESTOSTERONE OIL		
			MC		FORTESTA		
			MC		HALOTESTIN TABS		
			MC/DEL		JATENZO		
			MC/DEL		METHITEST TAB		
			MC/DEL		**METHYLTESTOSTERONE CAP**		
			MC/DEL		**OXANDROLONE**		
			MC/DEL		STRIANT MUC ER		
			MC		TESTIM		
			MC/DEL		**TESTOSTERONE GEL PACKETS**		
			MC/DEL		**TESTOSTERONE SOL**		
			MC		TESTRED CAPS		
			MC		TLANDO		
			MC/DEL		VOGELXO		
			MC/DEL		XYOSTED		
ESTROGENS - PATCHES / TOPICAL	MC	**EVAMIST**	MC/DEL	5	**ESTRADIOL PTWK**	Use PA Form# 20420 1. **Step order drugs must be used in specified step order**.	Approved for failures on multiple oral estrogen agents after 90 day trials or if unable to swallow any oral medication.
	MC/DEL	**MINIVELLE PATCH**	MC/DEL	8	**DIVIGEL** [1]		
	MC/DEL	**VIVELLE-DOT PTTW**	MC/DEL	8	**CLIMARA PTWK**		
			MC/DEL	8	**ELESTRIN** [1]		
			MC/DEL	8	**MENOSTAR PATCH**		

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
ESTROGENS - TABS	MC/DEL MC/DEL	**ESTRADIOL** **PREMARIN TABS**	MC/DEL MC/DEL MC/DEL MC/DEL		**ESTRADIOL-NORETHINDRONE** **ESTRACE TABS** **MENEST TABS** **NORETHINDRON-ETHINYL**	Use PA Form# 20420 Must fail preferred products before non-preferred products.	Preferred drugs must be tried for at least 90 days and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ESTROGEN COMBO'S	MC/DEL MC/DEL MC/DEL MC/DEL	**ANGELIQ** **COMBIPATCH PTTW** **PREMPHASE TABS** **PREMPRO TABS**	MC/DEL MC/DEL MC MC/DEL MC/DEL		**FEMHRT 1/5 TABS** [1] **FYAVOLV** LOPREEZA TAB **ORTHO-PREFEST TABS** [1] SYNTEST H.S. TABS [1]	Use PA Form# 20420 1. Must fail **Premphase** and **Prempro** products before non preferred products.	Preferred drugs must be tried for at least 90 days and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
PROGESTINS	MC/DEL MC/DEL MC MC	MEDROXYPROGESTERONE ACETA [1] NORETHINDRONE ACETATE TABS [1] 17-ALPH HYDROXYPROGESTERONE PWDR PROGESTERONE CAPS	MC/DEL MC MC MC/DEL MC/DEL		AYGESTIN TABS CYCRIN TABS PROGESTERONE POWD PROMETRIUM CAPS PROVERA TABS	Use PA Form# 20420 1. Must fail **Medroxyprogesterone** and **Norethindrone** products before non-preferred products.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ENDOMETROSIS							
CENTRAL PRECOCIOUS PUBERTY AGENTS	MC	FENSOLVI [1]				Use PA Form# 20420 1. For pediatric patients 2 years of age and older with central precocious puberty (CPP).	
ENDOMETROSIS- NASAL	MC/DEL	SYNAREL (NASAL) SPRAY				Use PA Form# 20420	**Synarel** is also indicated for central precocious puberty.
ENDOMETROSIS/ UTERINE FIBROIDS-ORAL	MC MC MC/DEL	MYFEMBREE [1,2] ORIAHNN [1] ORILISSA [1]				Use PA Form# 20420 1. Prior treatment of NSAID and hormonal contraceptives required. 2. Limited to 24 months due to the risk of continued bone loss, which may not be reversible.	
ENDOMETROSIS- INJECTABLE	MC/DEL	DEPO-SUBQ PROVERA 104				Use PA Form# 20420	
CONTRACEPTIVES							
CONTRACEPTIVES - PROGESTIN ONLY	MC/DEL MC/DEL MC MC MC/DEL MC/DEL	CAMILA TABS ERRIN INCASSIA TAB HEATHER TAB NORETHINDRONE ACETATE 0.35MG TABS SLYND	MC/DEL MC/DEL MC		JOLIVETTE NORA-BE TABS ORTHO MICRONOR TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. If member experienced adverse reactions, consider using Oral Contraceptives from other groups. **DDI:** Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer.
CONTRACEPTIVES - INJECTABLE	MC/DEL	MEDROXYPROGESTERONE ACETATE 150mg IM	MC/DEL		DEPO-PROVERA 150 mg SUSP	Use PA Form# 20420	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
CONTRACEPTIVE - EMERGENCY	MC/DEL MC MC MC MC/DEL MC MC/DEL MC MC/DEL	ELLA ENCONTRA ONE STEP ECONTRA EZ NEW DAY OPCION OPTION 2 MY CHOICE **MY WAY** LEVONORGESTREL NEXT CHOICE [1]				Use PA Form# 20420 1. Allowed 2 tablets per 30 days without PA.	Due to the extensive list of products, any covered emergency contraceptive product preferred is and available without a PA.
CONTRACEPTIVES - PATCHES/ VAGINAL PRODUCTS	MC MC MC MC/DEL	ELURYNG[1] NUVARING RING[1] TWIRLA **XULANE**[2]	MC MC MC		ANNOVERA PHEXXI ZAFEMY	Use PA Form# 20420 1. Quantity limit allowing 1 every 28 days without PA. 2. Dose limits apply allowing 3 patches per 28 days supply.	Approved if adequate clinical reason given why patient unable to comply with other preferred agents including long acting injectable.
CONTRACEPTIVES- LONG ACTING REVERSIBLE	MC/DEL	MIRENA	MC/DEL MC MC MC/DEL MC/DEL		KYLEENA LILETTA NEXPLANON PARAGARD SKYLA	Use PA Form# 20420	

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
CONTRACEPTIVES - MONOPHASIC COMBINATION O/C'S	MC/DEL	APRI TABS	MC/DEL		BEYAZ	Use PA Form# 20420 If member experienced adverse reactions, consider using Oral Contraceptives from other groups.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. If member experienced adverse reactions, consider using Oral Contraceptives from other groups. **DDI:** Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer.
	MC/DEL	AVIANE TABS	MC/DEL		BREVICON-28 TABS		
	MC/DEL	BALZIVA	MC/DEL		LESSINA-28 TABS		
	MC/DEL	CRYSELLE-28 TABS	MC/DEL		LEVORA		
	MC	DESOGEN TABS	MC/DEL		LOESTRIN FE 1/20TABS		
	MC/DEL	ESTARYLLA TAB	MC/DEL		LOESTRIN 1.5/30-21 TABS		
	MC	HAILEY FE TAB	MC/DEL		MICROGESTIN FE TABS		
	MC/DEL	ISIBLOOM TAB	MC/DEL		LOESTRIN 1/20-21 TABS		
	MC/DEL	**JUNEL FE TAB**	MC		LO/OVRAL 21 TABS		
	MC	LARIN FE TAB	MC/DEL		LO/OVRAL 28 TABS		
	MC/DEL	**LESSINA TAB**	MC		NEXTSTELLIS		
	MC	LEVORA-28 TAB	MC/DEL		NORDETTE-28 TABS		
	MC	MILI TAB	MC/DEL		NORTREL		
	MC/DEL	NORGESTIMATE-ETHINYL ESTRADIOL TAB	MC/DEL		OCELLA		
	MC/DEL	**MIBELAS 24 FE TAB**	MC/DEL		OVRAL		
	MC/DEL	MICROGESTIN FE TAB	MC/DEL		PORTIA-28 TABS		
	MC/DEL	RECLIPSEN	MC/DEL		SAFYRAL		
	MC/DEL	SAFYRAL TAB	MC/DEL		ZOVIA		
	MC/DEL	SPRINTEC 28 TABS					
	MC/DEL	YASMIN 28 TABS					
	MC/DEL	YAZ					
CONTRACEPTIVES - BI-PHASIC COMBINATIONS	MC/DEL	AZURETTE TAB	MC/DEL		LOSEASONIQUE	Use PA Form# 20420 If member experienced adverse reactions, consider using Oral Contraceptives from other groups.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. If member experienced adverse reactions, consider using Oral Contraceptives from other groups. **DDI:** Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer.
	MC/DEL	**CAMRESE**					
	MC/DEL	**CAMRESE LO**					
	MC	DESOGESTREL/ ETH/ ESTRAD 0.15/30mcg					
	MC/DEL	KARIVA TABS					
	MC/DEL	LO LOESTRIN FE					
	MC/DEL	PIMTREA TAB					
	MC	NORETHINDRONE-ETH ESTRADIOL TAB 0.5-35/1-35					
	MC	SIMPESSE TBDSPK 3MO					
	MC/DEL	VIORELE TAB					
CONTRACEPTIVES - TRI-PHASIC COMBINATIONS	MC/DEL	ENPRESSE	MC/DEL		NORTREL 7/7/7	Use PA Form# 20420 If member experienced adverse reactions, consider using Oral Contraceptives from other groups.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. If member experienced adverse reactions, consider using Oral Contraceptives from other groups. **DDI:** Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer.
	MC/DEL	**NORGESTIMATE-ETHINYL ESTRADIOL TAB**	MC		ORTHO TRI-CYCLEN LO TABS		
	MC/DEL	TRIPHASIL 28 TABS					
	MC	TRI-LO-MILI TAB					
	MC	TRI-LO-ESTARYLLA TAB					
	MC	TRI-ESTARYLLA					
	MC/DEL	TRI-SPRINTEC TAB					
	MC/DEL	**TRI-LO-SPRINTEC**					
	MC	TRINESSA					
CONTRACEPTIVES - MULTI-PHASIC COMBINATIONS			MC		NATAZIA	Use PA Form# 20420	
VASOMOTOR SYMPTOMS AGENTS							
VASOMOTOR SYMPTOMS AGENTS	MC/DEL	**LYNKUET**	MC/DEL	8	VEOZAH	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Lynkuet:** • Diagnosis of vasomotor symptoms AND, • Member must have previously tried and failed one 30-day trial of either Hormone Replacement Therapy (HRT) or other guideline supported non-hormonal therapy for VMS (e.g., gabapentin, paroxetine, venlafaxine) AND, • Baseline liver function tests. **Veozah**: • Approval requires at least one preferred Hormone Replacement Therapy (HRT) and two preferred non-hormonal therapies (i.e., SSRIs, SNRIs, gabapentin, pregabalin, clonidine). • Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved. **DDI:** Avoid concomitant use of **Veozah** with drugs that are weak, moderate or strong CYP1A2 inhibitors.

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
DIABETES SUPPLIES							
DIABETIC- SUPPLIES		CONTINUOUS GLUCOSE MONITORING [1] DIABETIC- LANCETS DIABETIC- LANCING DEVICES DIABETIC- LANCING DEVICES DIABETIC- PEN NEEDLES DIABETIC- SYRINGES DIABETIC- TEST STRIPS DIABETIC- METERS				Use PA Form# 20420 1. Dosing limits apply. Please refer to Dose Consolidation List.	Please refer to the MaineCare Preferred Diabetic Supply List available at www.mainecarepdl.org **Continuous Glucose Monitoring Criteria**: Patient has a diagnosis of Diabetes Mellitus AND Practitioner feels patient has sufficient training to use CGM. • 2 years of age or older for Dexcom G6 and Dexcom G7, ≥ 14 years for Medtronic Guardian, or ≥ 4 years for Freestyle Libre 2. • At least one of the following are documented: o Hypoglycemic unawareness o Treated with insulin (at least 1X day) o Has history of problematic hypoglycemia with documentation of at least one recurrent level 2 hypoglycemic events, or 1 level 3 hypoglycemic event • Approval of non-preferred products will be limited to cases where the CGM is directly integrated with the patient's insulin pump. The make and model of pump must be documented on the prior authorization.
DIABETES THERAPIES							
DIABETIC - INSULIN	MC/DEL MC MC MC MC MC MC MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	**FIASP** HUMALOG KWIKPEN INJ 100/ML HUMALOG JUNIOR KWIKPEN 100/ML HUMALOG MIX 75/25 HUMALOG 50/50 VIAL HUMULIN INJ 70/30 KWIKPEN HUMULIN INJ 70/30 HUMULIN R INJ U-500 INSULIN LISPRO LANTUS SOLN LEVEMIR **NOVOLOG** **NOVOLOG MIX** NOVOLOG MIX 70/30 VIAL SEMGLEE	MC/DEL MC/DEL MC/DEL MC MC MC MC MC MC MC MC MC/DEL MC/DEL MC		APIDRA **ADMELOG** **AFREZZA** [1] BASAGLAR HUMALOG KWIKPEN U-200 HUMULIN INJ 50/50 HUMULIN N INJ U-100 HUMULIN R U-100 INSULIN DEGLUDEC KIRSTY LYUMJEV MERILOG **NOVOLIN** RELION	Use PA Form# 20420 1. Not to be as a monotherapy. Obtain lab values of pulmonary function and recent smoking history. 2. For the treatment of patients ≥ 3 years of age.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
DIABETIC - PENFILLS	MC MC MC MC MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	HUMALOG MIX KWIK 50/50 HUMALOG MIX INJ 75/25 KWP HUMALOG KWIK INJ 100/ML HUMALOG KWIK INJ 200/ML **HUMULIN R U-500 KWP** INSULIN LISPRO KWIKPEN U-100 LANTUS SOLOSTAR LEVEMIR FLEXTOUCH LEVEMIR FLEXPEN **NOVOLIN 70/30 PEN** NOVOLOG MIX PENFILL **NOVOLOG PENFILL SOLN** NOVOLOG FLEXPEN NOVOLOG MIX 70/30 FLEXPEN **TOUJEO MAX SOLOSTAR** **TOUJEO SOLOSTAR**	MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL 8 8 8 8 8 8 8 8 8	APIDRA OPTICLIK PEN MERILOG NOVOLIN 70/30 PEN REZVOGLAR KWIKPEN **TRESIBA**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved **(in step order)**, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
DIABETIC - DPP- 4 ENZYME INHIBITOR	MC/DEL MC/DEL	JANUVIA [1,2] TRADJENTA [2]	MC MC/DEL MC/DEL MC	8 8 8 8	**BRYNOVIN** **NESINA** QTERN ZITUVIO	Use PA Form# 20420 1. Preferred if therapeutic doses of metformin are seen in members drug profile for at least 60 days within the past 18 months or if phosphate binder is currently seen in the members drug profile. 2. Dosing limits apply. Please refer to Dose Consolidation List.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved **(in step order)**, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **BRYNOVIN**: In addition to tried and failed Preferred Agents, Brynovin requires tried and failed Non-Preferred Agent Zituvio.
DIABETIC - DPP- 4 ENZYME INHIBITOR-COMBO	MC/DEL MC/DEL MC/DEL	JANUMET [1,2] **JANUMET XR** [1,2] **JENTADUETO** [1]	MC/DEL MC/DEL MC/DEL MC MC	8 8 8 8 8	**JENTADUETO XR** **KAZANO** **OSENI** **ZITUVIMET** **ZITUVIMET XR**	Use PA Form# 20420 1. Preferred if therapeutic doses of metformin are seen in members drug profile for at least 60 days within the past 18 months or if phosphate binder is currently seen in the members drug profile. 2. Dosing limits apply. Please refer to Dose consolidation list.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved **(in step order)**, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Zituvimet/ Zituvimet XR:** Approvals will require trial of preferred sitagliptin/metformin products or other preferred diabetic agents.
DIABETIC - LANCET-LANCET DEVICE						Use PA Form# 20420	Please refer to the MaineCare Preferred Diabetic Supply List available at www.mainecarepdl.org
DIABETIC - SYRINGES-NEEDLES						Use PA Form# 20420	Please refer to the MaineCare Preferred Diabetic Supply List available at www.mainecarepdl.org

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
DIABETIC - OTHER			MC		SYMLIN	Use PA Form #20420	
SGLT 2 INHIBITORS	MC/DEL MC/DEL	FARXIGA JARDIANCE	MC/DEL MC/DEL		INVOKANA [1] STEGLATRO	Use PA Form# 20420 1.Dosing limits apply please refer to Dose Consolidation List.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
SGLT 2 INHIBITOR COMBINATIONS	MC/DEL MC/DEL MC/DEL	SYNJARDY SYNJARDY XR XIGDOU XR	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		GLYXAMBI INVOKAMET INVOKAMET XR SEGLUROMET STEGLUJAN TRIJARDY XR	Use PA Form# 20420	Preferred drugs must be tried for at least 3 months at full therapeutic doses and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Glyxambi /Xigduo XR-** Verify prior trials and failures or intolerance of preferred treatments from other diabetic categories. **Synjardy XR** is not recommended for patients with type 1 DM or for the treatment of diabetic ketoacidosis.
DIABETIC MONITOR	MC MC	RELION TRUE METRIX BLOOD GLUCOSE MONITORING SYSTEM TRUE METRIX BLOOD GLUCOSE MONITORING SYSTEM	MC MC MC MC MC MC MC MC MC		ACCUCHECK ASCENSIA ASSURE CONTOUR BREEZE Z EXACTECH FREESTYLE INSULINX FREESTYLE LITE SYSTEM KIT PRECISION XTRA METER PRODIGY	Use PA Form# 20420	Effective October 25th 2007, approvals for all non preferred meters/ test strips will require medical necessity documenting clinically significant features that are not available on any of the preferred meters.
DIABETIC TEST STRIPS	MC/DEL MC	RELION TRUE METRIX TRUE METRIX	MC MC MC MC MC MC MC MC MC MC		ACCUCHECK ASCENSIA ASSURE CONTOUR BREEZE Z EXACTECH FREESTYLE FREESTYLE LITE FREESTYLE INSULINX PRECISION XTRA PRODIGY	Use PA Form# 20420	Effective October 25th 2007, approvals for all non preferred meters/ test strips will require medical necessity documenting clinically significant features that are not available on any of the preferred meters. Effective October 1, 2023, a maximum of 100 blood glucose test strips every 90 days will be available without Prior Authorization for members currently utilizing continuous glucose monitors (CGM).
INCRETIN MIMETIC	MC/DEL MC MC/DEL	RYBELSUS TRULICITY VICTOZA	MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL	6 8 8 8 8 8	OZEMPIC ADLYXIN BYDUREON BCISE MOUNJARO SOLIQUA XULTOPHY	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved **(in step order)**, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Soliqua** must try both insulin and a preferred incretin mimetic and have a medical necessity for use that is not based on convenience or simply due to the fact that one injection is needed instead of two.
DIABETIC - ORAL SULFONYLUREAS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	CHLORPROPAMIDE TABS GLIMEPIRIDE GLIPIZIDE TABS GLIPIZIDE ER TABS GLYBURIDE MICRONIZED TABS GLYBURIDE TABS [1] TOLAZAMIDE TABS TOLBUTAMIDE TABS	MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL		GLUCOTROL XL TBCR	Use PA Form# 20420 1. PA required for members ≥65. Glyburide has a greater risk of severe prolonged hypoglycemia in older adults.	Preferred drugs must be tried for at least 3 months at full therapeutic doses and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** All sulfonylureas (except glyburide) will now be non-preferred and require prior authorization if it is currently being used with either ranitidine or cimetidine. **DDI: Glimepiride** will now be non-preferred and require prior authorization if it is currently being used with either fluconazole (except 150mg strength) or fluvoxamine.
DIABETIC -ORAL BIGUANIDES	MC/DEL MC/DEL	METFORMIN HCL TABS METFORMIN ER	MC		METFORMIN ER OSMOTIC	Use PA Form# 20420	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
DIABETIC - THIAZOL / BIGUANIDE COMBO			MC/DEL MC/DEL MC MC		ACTOPLUS MET [1] ACTOPLUS MET XR AVANDARYL [1] AVANDAMET TABS [1]	Use PA Form# 20420 1. Requires use of Actos, Metformin, or other preferred anti-diabetics.	**DDI: Actos, Avandia**, or any combination product with Actos or Avandia will now be non-preferred and require prior authorization if it is currently being used with gemfibrozil.
DIABETIC - / THIAZOL	MC/DEL	PIOGLITAZONE HCL [1]	MC/DEL MC		ACTOS TABS [3] AVANDIA TABS [2]	Use PA Form# 20420 1. **Pioglitazone HCL** is non-preferred as monotherapy. **Pioglitazone HCL** is preferred if therapeutic doses of metformin, sulfonylurea or insulin are seen in members drug profile for at least 60 days within the past 18 months. 2. Current users of Avandia who have tried Actos will be able to continue use of Avandia. 3. Dosing limits apply. See Dose Consolidation List.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI: Actos, Avandia**, or any combination product with Actos or Avandia will now be non-preferred and require prior authorization if it is currently being used with gemfibrozil.

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
DIABETIC - ALPHAGLUCOSIDASE			MC		**PRECOSE TABS**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
DIABETIC - SULFONYLUREA / BIGUANIDE	MC/DEL	GLYBURIDE/METFORMIN	MC MC MC/DEL		**GLUCOVANCE TABS** [1] METAGLIP TABS [1] DUETACT [2]	Use PA Form# 20420 1. Use individual ingredients. 2. Use Actos with generic glimepiride.	Approved for patients failing to achieve good diabetic control with maximal doses of individual components.
DIABETIC - MEGLITINIDES	MC	**NATEGLINIDE**	MC/DEL MC/DEL		**PRANDIN TABS** **STARLIX TABS**	Use PA Form# 20420	Preferred drugs from other diabetic sub-categories must be tried and failed due to lack of inadequate diabetic control or intolerable side effects before non-preferred drug will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI**: **Prandin** is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for current use with both sporanox and gemfibrozil, due to a significant drug-drug interaction.
GLUCOSE ELEVATING AGENTS							
GLUCOSE ELEVATING AGENTS	MC/DEL MC/DEL MC/DEL	BAQSIMI [1] **GVOKE** [2] ZEGALOGUE [3]	MC	8	GLUCAGON DIAGNOSTIC KIT	Use PA Form# 20420 1. For the treatment of patients ≥ 4 yrs of age. 2. For the treatment of patients ≥ 2 yrs of age. 3. For the treatment of patients ≥ 6 yrs of age.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved **(in step order)**, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
THYROID							
THYROID EYE DISEASE			MC		**TEPEZZA**	Use PA Form# 20420	
THYROID HORMONES	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	**ARMOUR THYROID TABS** **CYTOMEL TABS** **ERMEZA** [1] **LEVOTHROID TABS** **LEVOTHYROXINE SODIUM TABS** **LEVOXYL TABS** **UNITHROID TABS**	MC MC/DEL MC MC/DEL		LEVOTHYROXINE SODIUM SOLR LIOTHYRONINE SYNTHROID TABS THYQUIDITY	Use PA Form# 20420 1.Clinical PA is required to confirm diagnosis of dysphagia.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTITHYROID THERAPIES	MC/DEL MC/DEL	**METHIMAZOLE TABS** **PROPYLTHIOURACIL TABS**	MC/DEL		**TAPAZOLE TABS**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
CUSHING DISEASE AGENTS							
CUSHING DISEASE AGENTS			MC MC		ISTURISA [1] RECORLEV	Use PA Form #20420 1. For the treatment of adult patients with Cushing's disease for whom pituitary surgery is not an option or has not been curative.	**Recorlev** is associated with dose-related QT interval prolongation. QT interval prolongation may lead to life-threatening ventricular dysrhythmias such as Torsade de pointes.
OSTEOPOROSIS / BONE AGENTS							
OSTEOPOROSIS	MC/DEL	ALENDRONATE	MC MC MC MC MC MC MC/DEL MC/DEL MC MC MC MC MC/DEL MC MC MC MC MC MC MC/DEL MC MC/DEL	**ACTONEL TABS** BILDYOS BILPREVDA [7] BINOSTO BOMYNTRA [7] CONEXXENCE **DUAVEE** **ENOBY SOL** **EVENITY** [2] EVISTA TABS [1] FORTEO **FOSAMAX TABS AND PLUS D** [3] JUBBONTI OSENVELT [7] PROLIA SOHONOS [6] STOBOCLO STRENSIQ [5] TYMLOS WYOST [7] XGEVA **XTRENBO**	Use PA Form# 20420 1. Approval only requires failure of Alendronate. 2. Quantity limits apply, please see Dosage Consolidation List. 3. Please use Alendronate & Vitamin D. 5. Obtain baseline ophthalmology exams and renal ultrasounds and then periodically during treatment. 6. Clinical PA for indication required. 7. Previous trial of Prolia or intolerable side effects before non-preferred biosimilar will be approved.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Binosto** use preferred generic alendronate tablets**.** **Evenity** should be limited to 12 monthly doses. **Sohonos**: For the reduction in volume of new heterotopic ossification in adults and pediatric patients aged 8 years and older for females and 10 years and older for males with fibrodysplasia ossificans progressive (FOP).
FIBROBLAST GROWTH FACTOR 23 INHIBITORS	MC	CRYSVITA [1]				Use PA Form #20420 1.Preferred for patients <21 years of age for the treatment of X- linked hypophosphatemia.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
CALCIMIMETIC AGENTS							
CALCIMIMETIC AGENTS			MC		PARSABIV	Use PA Form# 30115	**Parsabiv** is for the treatment of secondary hyperparathyroidism (HPT) in adults with chronic kidney disease (CKD) on hemodialysis. Parsabiv has not been studied in adults with parathyroid carcinoma, primary hyperparathyroidism, or with chronic kidney disease who are not on hemodialysis and is not recommended for use in these populations. For **Sensipar** baseline PTH, Ca, and phosphorous levels are required and initial approvals will be limited to 3 months. Subsequent approvals will require additional levels being done to assess changes. Will not approve if baseline Ca is less than 8.4.
			MC		SENSIPAR		
GROWTH HORMONE							
GROWTH HORMONE	MC/DEL	GENOTROPIN [1]	MC	8	HUMATROPE SOLR	Use PA Form# 10710 1.Clinical PA is required to establish diagnosis and medical necessity.	See **Growth Hormone PA** form # 10710 for criteria. Step-order will still apply unless clinical contraindication supplied. Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	NORDITROPIN SOLN [1]	MC	5	NUTROPIN		
	MC	SKYTROFA [1]	MC/DEL	8	NGENLA		
			MC/DEL	5	OMNITROPE		
			MC/DEL	8	SOGROYA		
ACHONDROPLASIA TREATMENT			MC		VOXZOGO [1]	Use PA Form# 20420 1. Pediatric patients with achondroplasia who are 5 years of age and older with open epiphyses.	**Voxzogo**: To increase linear growth in pediatric patients with achondroplasia who are 5 years of age and older with open epiphyses. This indication is approved under accelerated approval based on an improvement in annualized growth velocity. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trial(s).
GROWTH HORMONE ANTAGONISTS / AGONISTS							

GH ANTAGONISTS / AGONISTS	MC	OCTREOTIDE INJ [1]	MC		LANREOTIDE	Use PA Form# 10710
						1.Clinical PA is required to establish diagnosis and medical necessity.
						2. Non-preferred products must be used in specified step order.
							Somavert: Approved for acromegaly patients failing surgery/radiation/drug therapy including bromocriptine and sandostatin.
							Criteria for all:
							• Diagnosis of acromegaly AND
							• Prescribed by or in consultation with an endocrinologist AND
							• One of the following:
							  • Patient has an inadequate response to surgery OR
							  • Patient is not a candidate for surgery

					MYCAPSSA[2]		
					PALSONIFY[2]		
					SANDOSTATIN [2]		
					SIGNIFOR [2]		
					SOMATULINE[2]		
					SOMAVERT		
VASOPRESSIN RECEPTOR ANTAGONIST							
VASOPRESSIN RECEPTOR ANTAGONIST			MC		JYNARQUE [1]	Use PA Form# 20420 1. Clinical PA required for appropriate diagnosis	**Samsca Drug Warning**- Avoid use in patients with underlying liver disease, including cirrhosis, because the ability to recover from liver injury may be impaired. Limit duration of therapy to 30 days to minimize the risk of liver injury. **DDI: Jynarque**- Concomitant use with strong CYP3A inhibitors is contraindicated. Avoid concomitant use of Jynarque with OATP1B1/B3 and OAT3 substrates (e.g. statins, bosentan, glyburide, nateglinide, repaglinide, methotrexate, furosemide).
			MC/DEL		SAMSCA		
URINARY INCONTINENCE							
VASOPRESSINS	MC/DEL	**DESMOPRESSIN TABS**	MC/DEL	5	DDAVP TABS	Use PA Form# 20420 1. **Products must be used in specified step order**. Nocturnal enuresis patients will be encouraged to periodically attempt stopping DDAVP.	Approved for central diabetes insipidus and for nocturnal enuresis. For nocturnal enuresis- must be over 6 years old, must fail an adequate trial of alarm training (higher success rate, lower relapse rate) and must periodically attempt weaning (at 6 month intervals).
	MC/DEL	DDAVP SOLN	MC/DEL	6	**DESMOPRESSIN SPRAY [1]**		
			MC	8	DESMOPRESSIN ACETATE SOLN [1]		
			MC/DEL	8	NOCDURNA [1]		
			MC	8	NOCTIVA [1]		
ANTISPASMODICS	MC/DEL	**OXYBUTYNIN**	MC/DEL	8	**DARIFENACIN ER TAB**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	**TOLTERODINE**	MC/DEL	8	**DITROPAN**		
			MC/DEL	8	**FLAVOXATE HCL TAB**		
ANTISPASMODICS - LONG ACTING	MC	FESOTERODINE	MC	8	**DITROPAN XL TBCR**	Use PA Form# 20420 1. See Criteria Section. 2. Use a preferred long acting antispasmodic. 3. For the treatment of patients ≥ 2 years of age.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. 1. **Vesicare 5mg and Enablex 7.5mg** maximum doses if given with drugs known to be significant CYP3A4 inhibitors (ketoconazole, sporanox, erythromycin, fluconazole, nefazodone, nelfinavir, and ritonavir). **DDI: Enablex** 15mg and **Vesicare** 10mg will now be non-preferred and require prior authorization if they are currently being used in combination with any of the following medications: clarithromycin, erythromycin, crixivan, norvir, ketoconazole, fluconazole (except 150mg strength), sporanox. or nefazodone.
	MC/DEL	**GELNIQUE GEL PACKET**	MC/DEL	8	ENABLEX [1,2]		
	MC/DEL	**MYRBETRIQ**	MC	8	GEMTESA [2]		
	MC/DEL	**OXYBUTYNIN ER TABS**	MC/DEL	8	**TOLTERODINE TAB**		
	MC/DEL	**OXYTROL**	MC/DEL	8	TOVIAZ		
	MC/DEL	SOLIFENACIN SUCCINATE TAB	MC	8	VESICARE [1]		
	MC/DEL	TROSPIUM	MC	8	VESICARE LS [3]		
CHOLINERGIC	MC/DEL	**BETHANECHOL**	MC/DEL			Use PA Form# 20420	
HYPERAMMONIA TREATMENTS	MC	CARBAGLU TABS	MC	8	CARGLUMIC ACID TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
UREA CYCLE DISORDER	MC	BUPHENYL TABLET	MC	8	BUPHENYL POWDER	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Olpruva**: As adjunctive therapy to standard of care, which includes dietary management, for the chronic management of adult and pediatric patients weighing 20kg or greater and with a body surface area (BSA) of 1.2m2 or greater, with urea cycle disorders (UCDs) involving deficiencies of carbamylphosphate synthetase (CPS), ornithine transcarbamylase (OTC), or argininosuccinic acid synthetase (AS).
	MC	PHEBURANE GRANULES	MC	8	RAVICTI LIQUID		
			MC	8	OLPRUVA		
			MC/DEL		**SODIUM PHENYLBUTYRATE POWDER**		
			MC/DEL		**SODIUM PHENYLBUTYRATE TAB**		
METABOLIC MODIFIER							
HERED. TYROSINEMIA			MC	6	ORFADIN	Use PA Form# 20420 1.Clinical PA is required to establish diagnosis and medical necessity.	Approved for Type 1 hereditary tyrosinemia patients. Must include laboratory evidence of dx at first PA. Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs **(in step order)** will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
			MC	6	NITYR		
			MC	8	HARLIKU [1]		

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
FABRY DISEASE AGENTS			MC MC MC	8 8 8	ELFABRIO [1] FABRAZYME [2] GALAFOLD [1]	Use PA Form# 20420 1.Clinical PA to verify appropriate diagnosis. 2.For the treatment of patients 2 years of age and older.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Elfabrio and Galfold**: For the treatment of adults with confirmed Fabry disease.
ANTIHYPERTENSIVES / CARDIAC							
CARDIAC GLYCOSIDES	MC/DEL MC/DEL MC/DEL	**DIGITEK TABS** **DIGOXIN** **LANOXIN**				Use PA Form# 20420	
CARDIAC MYOSIN INHIBITORS			MC	8	CAMZYOS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Camzyos**: For the treatment of adults with symptomatic New York Heart Association (NYHA) class II-III obstructive hypertrophic cardiomyopathy (HCM) to improve functional capacity and symptoms. **DDI:** Concomitant use of **Camzyos** with a moderate to strong CYP2C19 inhibitor or a strong CYP3A4 inhibitor is contraindicated.
CARDIAC - SINUS NODE INHIBITORS			MC	8	CORLANOR	Use PA Form#20420	In patients with stable, symptomatic chronic heart failure with left ventricular ejection fraction ≤35%, who are in sinus rhythm with resting heart rate ≥70 beats per minute (bpm) and either are on maximally tolerated doses of beta-blockers or have a contraindication to beta-blocker use.
CARDIAC- ERAs			MC	8	**TRYVIO**	Use PA Form#20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Tryvio**: In combination with other antihypertensive drugs, is indicated for the treatment of resistant hypertension, to lower blood pressure (BP) in adult patients who are not adequately controlled on other drugs. Resistant HTN is defined as a patient who takes at least 3 different class antihypertensive medications with complementary mechanisms including thiazide, ACE inhibitor, ARB, long-acting calcium channel blocker, with a trial of spironolactone, unless contra-indicated.
CARDIAC- SOLUBLE GUANYLATE CYCLASE STIMULATORS			MC	8	**VERQUVO**	Use PA Form# 20420	
CARDIOMETABOLIC HEALTH AGENTS	MC/DEL MC/DEL	WEGOVY INJ[1] WEGOVY TAB[1]	MC MC MC	8 8 8	INPEFA[2] LODOCO REZDIFFRA	Use PA Form# 20420 for REZDIFFRA Only Use PA Form #23976 for all others 1.Clinical PA is required to establish diagnosis and medical necessity. 2. To reduce the risk of cardiovascular death, hospitalization for heart failure, and urgent heart failure visit in adults with: Heart failure or Type II diabetes mellitus, chronic kidney disease, and other cardiovascular risk factors.	Other Preferred SGLT inhibitors must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Indication for use is Major Adverse Cardiac Event (MACE) Reduction:** • Patient has history of at least one of the following: o Stroke o Myocardial Infarction o Symptomatic peripheral arterial disease **Indication for use is Metabolic Dysfunction-Associated Steatohepatitis (MASH):** • Patient has metabolic dysfunction-associated steatohepatitis with moderate to advanced liver fibrosis (consistent with stages F2 or F3 fibrosis) documented by either a combination of non-invasive tests (serologic and image-based) or biopsy (NAFLD ≥ 4). • Patient does not have evidence of decompensated cirrhosis. • Medication is being prescribed or in consultation with gastroenterologist, hepatologist, or endocrinologist. **Wegovy**: Patient has BMI > 27 kg/m2, and is not being used for weight loss only **Lodoco**: Patient must have tried and failed generic colchicine due to lack of efficacy or intolerable side effects **Rezdiffra**: The patient must have a diagnosis of MASH with fibrosis Stage 2 or 3 and utilizing imaging and scanning test such as fibro scan, MRI or ultra sound AND the patient does not have evidence of decompensated cirrhosis.
ANTIANGINALS--Isosorbide Di-nitrate/ Mono-Nitrates	MC/DEL MC/DEL	**ISOSORBIDE MONONITRATE TABS** **ISOSORBIDE MONONITRATE ER**	MC/DEL MC/DEL MC/DEL		ISOSORBIDE DINITRATE CR TBCR **ISOSORBIDE DINITRATE ER TBCR** ISOSORBIDE DINITRATE TD TBCR	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
NITRO - OINTMENT/CAP/CR	MC/DEL MC/DEL MC MC	**NITROBID OINT** **NITROGLYCERIN CPCR** NITROL OINT NITRO-TIME CPCR				Use PA Form# 20420	
NITRO - PATCHES	MC/DEL MC/DEL	**NITROGLYCERIN PT24** **NITRO-DUR PT 24 0.8MG**	MC MC/DEL		NITRODISC PT24 **NITRO-DUR PT24**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
NITRO - SUBLINGUAL/ SPRAY	MC/DEL	**NITROSTAT SUBL**	MC/DEL MC MC		**NITROQUICK SUBL** **NITROLINGUAL SOLN** NITROLINGUAL TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
BETA BLOCKERS - NON SELECTIVE	MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	**CARVEDILOL** LEVATOL TABS **NADOLOL TABS** **PINDOLOL TABS** **PROPRANOLOL HCL SOLN** [1] **PROPRANOLOL HCL TABS** [1] **PROPRANOLOL HCL 60MG TABS** **PROPRANOLOL LA CAPS**	MC MC/DEL MC MC MC MC/DEL MC/DEL MC/DEL		ASPRUZYO **BETAPACE TABS** **BETAPACE AF TABS** **COREG CR** [3] **COREG TABS** **CORGARD TABS** **INDERAL TABS** **HEMANGEOL SOL**	Use PA Form# 20420 1. Recommend using BID since its effects do not last 24 hours. 2. Please use other strengths in combination to obtain this dose. 3. Dosing limits still apply. Please see dose consolidation list.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI**: Concomitant use of **Ranolazine** products with strong CYP3A inhibitors, including ketoconazole, itraconazole, clarithromycin, nefazodone, nelfinavir, ritonavir, indinavir, and saquinavir, is contraindicated.

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
	MC	RANOLAZINE ER TABS	MC		INDERAL XL CAP		
	MC/DEL	SOTALOL AF	MC		INDERAL LA CPCR		
	MC/DEL	SOTALOL HCL TABS	MC		INNOPRAN XL		
	MC/DEL	**TIMOLOL MALEATE TABS**	MC		RANEXA		
BETA BLOCKERS - CARDIO SELECTIVE	MC/DEL	**ACEBUTOLOL HCL CAPS**	MC		KERLONE TABS	Use PA Form# 20420 1. Recommend using **Atenolol** (and **Metoprolol**) BID since its effects do not last 24 hours.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	**ATENOLOL TABS** [1]	MC/DEL		**LOPRESSOR TABS**		
	MC/DEL	**BETAXOLOL HCL TABS**	MC		SECTRAL CAPS		
	MC/DEL	**BISOPROLOL FUMARATE TABS**	MC/DEL		**TENORMIN TABS**		
	MC/DEL	BYSTOLIC	MC/DEL		**TOPROL XL TB24**		
	MC/DEL	**METOPROLOL TARTRATE TABS** [1]	MC/DEL		**ZEBETA TABS**		
	MC/DEL	**METOPROLOL ER**					
	MC/DEL	**NEBIVOLOL HCL TAB**					
BETA BLOCKERS - ALPHA / BETA	MC/DEL	**LABETALOL HCL TABS**	MC		TRANDATE TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
BETA BLOCKERS & DURECTIC COMBOS	MC/DEL	**METOPROLOL-HYDROCHLOROTHIAZIDE TAB**	MC/DEL		**DUTOPROL**	Use PA Form# 20420	
CALCIUM CHANNEL BLOCKERS--Amlodipine, Felodipines, Nifedipines, Nisoldipine, and Verapamil	MC/DEL	AMLODIPINE [1]	MC/DEL		**KATERZIA**	Use PA Form# 20420 1. Dosing limits apply, see Dose Consolidation List.	
			MC		NORLIQVA		
			MC/DEL		**NORVASC TABS** [1]		
	MC	DILTIA XT CP24	MC/DEL	5	**DILACOR XR CP24** [1]	Use PA Form# 20420 1. Products must be used in specified order or PA will be required. Just write "Diltiazem 24-hour" and the pharmacy will use a preferred long acting Diltiazem that does not require PA.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved **(in step order)**, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** All preferred **Diltiazem** will now be non-preferred and require prior authorization if they are currently being used in combination with either enablex 15mg or vesicare 10mg. All non-preferred Diltiazem require prior authorization, but with any prior authorization request, the member's drug profile will also be monitored for current use with enablex 15mg or vesicare 10mg.
	MC/DEL	**DILTIAZEM HCL ER CP24**	MC/DEL	6	**TAZTIA** [1]		
	MC/DEL	**DILTIAZEM HCL XR CP24**	MC/DEL	8	**DILTIAZEM HCL TABS** [1]		
	MC/DEL	**DILTIAZEM CD 300MG CP24**	MC/DEL	8	**DILTIAZEM HCL ER CP12** [1]		
	MC	CARTIA XT CP24 [1]	MC/DEL	8	**DILTIAZEM HCL ER CP12** [1]		
	MC/DEL	**DILTIAZEM CD CP24** [1]			**DILTIAZEM CD 360MG CP24**		
	MC/DEL	**DILTIAZEM HCL ER CP24** [1]					
	MC/DEL	**DILTIAZEM XR CP24** [1]					
	MC/DEL	**TIAZAC CP24** [1]					
			MC/DEL		**PLENDIL TB24**	Use PA Form# 20420	Other Preferred calcium channel blockers must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
			MC/DEL		**FELODIPINE**		
			MC		CARDENE SR CPCR	Use PA Form# 20420	Other Preferred calcium channel blockers must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
			MC		NICARDIPINE HCL CAPS		
	MC/DEL	**NIFEDIPINE TBCR**	MC	4	**NIFEDIPINE CAPS**	Use PA Form# 20420 1. Established users of **Adalat CC** are grandfathered.	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs **in step order** will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	**NIFEDIPINE ER TBCR**	MC/DEL	8	**PROCARDIA XL TBCR**		
			MC		SULAR TB24	Use PA Form# 20420 1. Established users of 10MG and 20MG strengths are grandfathered.	
			MC		SULAR CR[1]		
	MC/DEL	**VERAPAMIL HCL CR TBCR**	MC	8	VERAPAMIL HCL ER CP24	Use PA Form# 20420 Products must be used in specified order or PA will be required. Just write "Verapamil 24-hour" and the pharmacy will use a preferred long acting generic that does not require PA.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved **(in step-order)**, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	**VERAPAMIL HCL ER TBCR**	MC	8	**VERAPAMIL HCL SR CP24**		
	MC/DEL	**VERAPAMIL HCL SR TBCR**	MC	8	**VERAPAMIL HCL TABS**		
			MC/DEL	8	**VERELAN PM CP24**		
ANTIARRHYTHMICS	MC/DEL	**AMIODARONE HCL**	MC/DEL		**CORDARONE**	Use PA Form# 20420 1. Prescription must be written by Cardiologist.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI**: **Amiodarone** will now be non-preferred and require prior authorization if it is currently being used in combination with either lovastatin (doses greater than 40mg/day) or lipitor (doses greater than 20mg/day) or levofloxacin or gemifloxacin, or moxifloxacin, or ofloxacin. **DDI: Multaq** will be preferred unless the following medications are seen in the member's drug profile within the last 35 days for brand name medications or 90 days for generic medications: erythromycin, amiodarone and other antiarrhythmics, TCA's, phenothiazine, ketoconazole, itraconazole, voriconazole, cyclosporine, telithromycin, clarithromycin, nefazodone, ritonavir.
	MC/DEL	**DISOPYRAMIDE**	MC/DEL		**DISOPYRAMIDE**		
	MC/DEL	**FLECAINIDE**	MC/DEL		MULTAQ		
	MC/DEL	**MEXILETINE HCL**	MC/DEL		**NORPACE**		
	MC/DEL	**PROCAINAMIDE**	MC/DEL		**PACERONE**		
	MC/DEL	**PROPAFENONE**	MC		QUINIDEX		
	MC	QUINAGLUTE	MC/DEL		TAMBOCOR		
	MC/DEL	**QUINIDINE GLUCONATE**	MC/DEL		TIKOSYN [1]		
	MC/DEL	**QUINIDINE SULFATE**	MC		**RYTHMOL SR**		
			MC/DEL		**RYTHMOL**		

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
ACE INHIBITORS	MC/DEL	BENAZEPRIL HCL	MC/DEL	8	ACCUPRIL TABS	Use PA Form# 20420 1. Non-preferred products must be used in specified order.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs **(in step-order)** will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Non-preferred products are subject to step-order requirements unless clinical circumstances warrant exception.
	MC/DEL	CAPTOPRIL TABS	MC/DEL	8	ALTACE CAPS [1]		
	MC/DEL	ENALAPRIL MALEATE TABS	MC	8	EPANED		
	MC/DEL	FOSINOPRIL SODIUM	MC	8	JAVADIN		
	MC/DEL	LISINOPRIL TABS	MC/DEL	8	LOTENSIN TABS [1]		
	MC/DEL	QUINAPRIL HCL	MC/DEL	8	MOEXIPRIL HCL [1]		
	MC/DEL	RAMIPRIL	MC	8	MONOPRIL HCT TABS [1]		
			MC/DEL	8	PRINIVIL TABS [1]		
			MC	8	QBRELIS		
			MC/DEL	8	UNIVASC [1]		
			MC/DEL	8	ZESTRIL TABS [1]		
ANGIOTENSIN RECEPTOR BLOCKER	MC/DEL	AMLODIPINE-OLMESARTAN TAB [3]	MC		ARBLI	Use PA Form# 20420 1. Dosing limits apply, please see Dose Consolidation List. 2. Use preferred active ingredients which are available without PA. 3. Preferred without a PA only if patient on a diabetic therapy or prior ACE therapy.	Per best practices patient should have trialed prior therapy of ACE inhibitor or currently on a diabetic therapy.
	MC/DEL	IRBESARTAN [1]	MC/DEL		ATACAND TABS		
	MC/DEL	LOSARTAN [1]	MC/DEL		AVAPRO		
	MC/DEL	MICARDIS TABS [3]	MC/DEL		BENICAR TABS		
	MC/DEL	OLMESARTAN [1]	MC/DEL		COZAAR		
	MC/DEL	TELMISARTAN [1]	MC/DEL		DIOVAN		
			MC/DEL		EDARBI		
			MC		TEVETEN TABS		
DIRECT RENIN INHIBITOR			MC/DEL		AMTURNIDE	Use PA Form# 20420 1. Must show failure of single and combination therapy from all preferred antihypertensive categories.	
			MC/DEL		TEKTURNA [1]		
			MC/DEL		TEKAMLO		
ANTIHYPERTENSIVES - CENTRAL	MC/DEL	CLONIDINE HCL TABS	MC/DEL		CLONIDINE PATCH	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	GUANFACINE HCL TABS	MC/DEL		CLONIDINE TTS		
	MC/DEL	HYDRALAZINE HCL TABS	MC		GUANABENZ ACETATE TABS		
	MC	HYLOREL TABS	MC		ISMELIN TABS		
	MC/DEL	METHYLDOPA TABS	MC/DEL		MINIPRESS CAPS		
	MC/DEL	MINOXIDIL TABS	MC		NEXICLON		
	MC/DEL	PRAZOSIN HCL CAPS	MC/DEL		TENEX TABS		
	MC/DEL	RESERPINE TABS					
ACE INHIBITORS AND CA CHANNEL BLOCKERS			MC/DEL		AMLODIPINE/BENAZEPRIL	Use PA Form# 20420 1. **Prestalia** will only be approved for patients ≥ 18 years of age. Use individual preferred generic medications.	
			MC		PRESTALIA [1]		
			MC		TARKA TBCR		
			MC/DEL		LOTREL CAPS		
ACE AND THIAZIDE COMBO'S	MC/DEL	BENAZEPRIL HCL/HYDROCHLOR	MC/DEL		ACCURETIC TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	CAPTOPRIL/HYDROCHLOROTHIA	MC		MONOPRIL HCT TABS		
	MC/DEL	ENALAPRIL MALEATE/HCTZ TABS	MC/DEL		PRINZIDE TABS		
	MC/DEL	LISINOPRIL-HCTZ TABS	MC/DEL		UNIRETIC TABS		
	MC/DEL	LOTENSIN HCT TABS	MC/DEL		ZESTORETIC TABS		
BETA BLOCKERS AND DIURETIC COMBO'S	MC/DEL	ATENOLOL/CHLORTHALIDONE	MC/DEL		CORZIDE TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	BISOPROLOL FUMARATE/HCTZ	MC/DEL		LOPRESSOR HCT TABS		
	MC/DEL	PROPRANOLOL/HCTZ	MC		TENORETIC		
			MC		TIMOLIDE 10/25 TABS		
			MC/DEL		ZIAC TABS		
ARB'S AND CA CHANNEL BLOCKERS	MC/DEL	AMLODIPINE/VALSARTAN	MC/DEL		AZOR	Use PA Form# 20420	**DDI: Byvalson** will be non-preferred and require a prior authorization if it is currently being used in combination with drugs known to be significant CYP2D6 inhibitors (e.g. quinidine, propafenone, fluoxetine, paroxetine). Per best practices, patient should have trialed prior therapy of ACE inhibitor or currently on a diabetic therapy.
	MC/DEL	AMLODIPINE/VALSARTAN HCT	MC		BYVALSON		
	MC/DEL	TRIBENZOR	MC/DEL		EXFORGE		
			MC/DEL		EXFORGE HCT		
ARB'S AND DIURETICS	MC/DEL	BENICAR HCT [1]	MC/DEL		IRBESARTAN HYDROCHLOROTHIAZIDE	Use PA Form# 20420 1. Dosing limits apply, see Dose Consolidation List.	Per best practices, patient should have trialed prior therapy of ACE inhibitor or currently on a diabetic therapy.
	MC/DEL	LOSARTAN HCT [1]	MC/DEL		ATACAND HCT TABS		
	MC/DEL	MICARDIS HCTTABS [1]	MC		AVALIDE TABS [1]		
	MC/DEL	VALSARTAN-HCT [1]	MC/DEL		DIOVAN HCT TABS [1]		
			MC/DEL		HYZAAR TABS		
			MC		TEVETEN HCT TABS		

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
ANGIOTENSIN MODULATORS-ARB COMBINATION	MC	SACUBITRIL-VALSARTAN TAB	MC/DEL		EDARBYCLOR	Use PA Form# 20420	
			MC		ENTRESTO		
			MC		ENTRESTO SPRINKLES		
ARB'S AND DIRECT RENIN INHIBITOR COMBINATION			MC/DEL		VALTURNA	Use PA Form# 20420	
DIURETICS	MC/DEL	ACETAZOLAMIDE TABS	MC/DEL		ALDACTAZIDE TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Furoscix**: The indication for use is the treatment of congestion due to fluid overload in adults with NYHA Class II or Class III chronic heart failure AND the medication is being prescribed by or in consultation with a cardiologist AND the patient is experiencing symptoms despite compliance with oral loop diuretic therapy AND oral loop diuretic therapy will be resumed as soon as practical AND medical reasoning beyond convenience is provided for not pursuing therapy in an outpatient infusion setting. PA approval will be authorized for 1 month. **Kerendia**: Patient must be on max tolerated preferred ACE-I/ARB and SGLT-2. **DDI:** The concomitant use of **Keveyis** with high dose aspirin is contraindicated.
	MC/DEL	AMILORIDE HCL	MC/DEL		ALDACTONE TABS		
	MC/DEL	BUMETANIDE	MC/DEL		BUMEX TABS		
	MC/DEL	CHLOROTHIAZIDE TABS	MC/DEL		DEMADEX TABS		
	MC/DEL	CHLORTHALIDONE TABS	MC/DEL		DIAMOX		
	MC/DEL	HYDROCHLOROTHIAZIDE	MC		DYAZIDE CAPS		
	MC/DEL	INDAPAMIDE TABS	MC		CAROSPIR		
	MC/DEL	METHAZOLAMIDE TABS	MC		ENDURON TABS		
	MC/DEL	METHYCLOTHIAZIDE TABS	MC		FUROSCIX		
	MC/DEL	SPIRONOLACTONE	MC/DEL		HEMICLOR		
	MC/DEL	SPIRONOLACTONE/HYDRO	MC/DEL		INSPRA		
	MC/DEL	TORSEMIDE TABS	MC		INZIRQO		
	MC/DEL	TRIAMTERENE/HCTZ	MC/DEL		KERENDIA		
	MC	ZAROXOLYN TABS	MC/DEL		KEVEYIS		
			MC/DEL		LASIX TABS		
			MC/DEL		MAXZIDE		
			MC/DEL		MICROZIDE CAPS		
			MC/DEL		MIDAMOR TABS		
			MC		NAQUA TABS		
CCB / LIPID			MC/DEL		CADUET	Use PA Form# 20420	
NEUROGENIC ORTHOSTATIC HYPOTENSION							
NEUROGENIC ORTHOSTATIC HYPOTENSION			MC		NORTHERA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
LIPID DRUGS							
CHOLESTEROL - BILE SEQUESTRANTS	MC/DEL	CHOLESTYRAMINE	MC/DEL		COLESTID	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	COLESTIPOL HCl	MC/DEL		PREVALITE		
			MC		QUESTRAN		
			MC/DEL		WELCHOL TABS		
CHOLESTEROL - FIBRIC ACID DERIVATIVES	MC/DEL	FENOFIBRATE TAB	MC		ANTARA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI: Fenofibrate** is preferred but will require a prior authorization requests if used concurrent with warfarin. **DDI: Gemfibrozil** will now be non-preferred and require prior authorization if it is currently being used with any of the following medications: prandin, actos, avandia, any avandia/actos combination product, any HMG-COA Reductase Inhibitors (statins), or warfarin.
	MC/DEL	GEMFIBROZIL TABS	MC/DEL		LOPID		
	MC/DEL	NIACIN ER	MC/DEL		FENOFIBRATE 120mg TAB		
			MC/DEL		FENOFIBRATE CAP		
			MC/DEL		FIBRICOR		
			MC		LIPOFEN		
			MC/DEL		LOFIBRA		
			MC/DEL		NIASPAN ER		
			MC		TRICOR		
			MC		TRIGLIDE		
CHOLESTEROL - HMG COA + ABSORB INHIBITORS MORE POTENT DRUGS/-COMBINATIONS	MC/DEL	ATORVASTATIN	MC		ATORVALIQ	Use PA Form# 20420 1. Dosing limits apply, see Dosage Consolidation List. 2. Current users grandfathered. 3. For the treatment of patients ≥ 18 years of age.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI: Lipitor** (doses greater than 20mg/day) will now be non-preferred and require prior authorization if it is currently being used in combination with amiodarone or cyclosporine. **DDI:** All preferred statins will now be non-preferred and require prior authorization if it is currently being used in combination with gemfibrozil.
	MC/DEL	EZETIM/SIMVA TAB	MC/DEL		CRESTOR		
	MC	ROSUVASTATIN	MC/DEL		EZALLOR SPRINKLES [3]		
	MC/DEL	SIMVASTATIN[1]	MC		FLOLIPID		
			MC/DEL		LIPITOR		
			MC		LIPTRUZET		
			MC/DEL		ZOCOR		
			MC/DEL		SIMVASTATIN 80MG [1,2]		
			MC		VYTORIN		

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
CHOLESTEROL - HMG COA + ABSORB INHIBITORS LESS POTENT DRUGS/-COMBINATIONS	MC/DEL MC/DEL MC/DEL	**EZETIMIBE TABS** LOVASTATIN TABS [2] PRAVASTATIN [2]	MC MC/DEL MC/DEL MC MC/DEL MC MC MC/DEL MC/DEL MC		ALTOPREV TB24 **FLUVASTATIN TAB ER** LESCOL XL TB24 LIVALO MEVACOR TABS NEXLETOL NEXLIZET **PRAVACHOL TABS** PRAVIGARD ZETIA TABS	Use PA Form# 20420 2. Dosing limits apply, please see Dosage Consolidation List.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Zetia** will be approved for patients unable to tolerate all other therapies or unable to achieve cholesterol goal with maximally tolerated dose of most potent statins. **DDI: Lescol** will now be non-preferred and require prior authorization if it is currently being used in combination with diclofenac. **DDI: Lovastatin** (doses greater than 40mg/day) will now be non-preferred and require prior authorization if it is currently being used in combination with amiodarone. **DDI: Lovastatin** (doses greater than 20mg per day) will now be non-preferred and require prior authorization if it is currently being used in combination cyclosporine. **DDI:** All preferred statins will now be non-preferred and require prior authorization if it is currently being used in combination with gemfibrozil.
CHOLESTEROL - HMG COA + ABSORB INHIBITORS STATIN/ NIACIN COMBO	MC	SIMCOR	MC		ADVICOR TBCR	Use PA Form# 20420	
FAMILIAL HYPERCHOLESTEROLEMIA	MC MC	**PRALUENT (LABLER 72733) PEN** [1,2,3,5] REPATHA [1,2,3]	MC MC MC MC		EVKEEZA [1,4] JUXTAPID KYNAMRO [1] LEQVIO	Use PA Form# 20420 1. Clinical PA required for appropriate diagnosis. 2. Quantity limits apply. 3. Documented adherence to lipid lowering medications and abstinence from tobacco for previous 90 days. 4. For treatment of patients ≥ 12 years of age. 5. Approval of Praluent NDC's with labeler code 00024 will be considered only if labeler code 72733 NDC's are on a long-term backorder and unavailable from the manufacturer.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Juxtapid** is contraindicated with strong CYP3A4 inhibitors. Juxtapid dosage should not exceed 30mg daily when it is used concomitantly with weak CYP3A4 inhibitors. **Kynamro** requires an appropriate lab testing prior to starting (ALT<AST), alkaline phosphatase and total bilirubin, monthly liver-related tests for the first year, then every three months. **Repatha and Praluent Criteria for approval:** The patient's age is FDA approved for the given indication AND • Concurrent use with statin therapy AND • Documented adherence to prescribed lipid lowering medications for the previous 90 days AND • Recommended or prescribed by a lipidologist or cardiologist AND • Inability to reach goal LDL-C despite a trial of 2 or more maximum tolerated dose of statins (one of which must be atorvastatin or rosuvastatin) and ezetimibe 10mg daily. **Additional criteria for the diagnosis of heterozygous familial hypercholesterolemia (HeFH): (both are required):** Total cholesterol > 290 mg/dL OR LDL-C > 190 mg/dL AND one of the following • Presence of tendon xanthomas OR • In 1st or 2nd degree relative-documented tendon xanthomas, MI at age ≤ 60 years or TC > 290 mg/dL. **Additional criteria for the diagnosis of clinical atherosclerotic cardiovascular disease:** History of MI, angina, coronary or other arterial revascularization, stroke, TIA, or PVD of atherosclerotic origin. **Additional criteria for the diagnosis of homozygous familial hypercholesterolemia (Repatha only):** Total cholesterol levels > 290mg/dL or LDL-C > 190mg/dL (adults) OR Total cholesterol levels > 260mg/dL or LDL-C > 155mg/dL (children < 16 years) and TG within reference range OR Confirmation of diagnosis by gene testing.
FAMILIAL HYPERCHOLESTEROLEMIA AND HYPERTRIGLYCERIDEMIA					TRYNGOLZA	Use PA Form# 20420	**Tryngolza** requires fasting triglycerides of ≥ 880 mg/dL and confirmed genetically identified familial chylomicronemia syndrome (FCS).
HYPERPHAGIA - MISC							
HYPERPHAGIA - MISC			MC		VYKAT XR		FDA approved for the treatment of hyperphagia in adults and pediatric patients 4 years of age and older with Prader-Willi syndrome (PWS).
PULMONARY ANTI-HYPERTENSIVES							
PULMONARY ANTI-HYPERTENSIVES	MC MC/DEL MC/DEL	EPOPROSTENOL INJ [3] SILDENAFIL TADALAFIL	MC/DEL MC MC/DEL MC MC MC MC MC MC/DEL MC MC MC MC MC/DEL MC	8	ADEMPAS [1,3] ADCIRCA [4] **ALYQ TAB** FLOLAN [3] LIQREV OPSUMIT [1,2] OPSYNVI [4] ORENITRAM REMODULIN [3] REVATIO [4] TADLIQ [4] TYVASO UPTRAVI VELVETRI [3] **WINREVAIR** [4] **YUTREPIA**	Use PA Form# 20420 1. Requires previous trials/failure of multiple preferred medications. 2. Dosing limits apply, see the Dose Consolidation List. 3. Require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 3 or 4. 4. Require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 2 or 3.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Sildenafil** will be preferred with clinical PA for treatment of pulmonary arterial hypotension (WHO Group 1) in adults to improve exercise ability and delay clinical worsening. Avoid concomitant use of sildenafil with moderate or strong Cyp3A inhibitors. **DDI: Uptravi** will require a prior authorization if it is currently being used in combination with strong inhibitors of CYP2C8 (gemfibrozil). **DDI: Opsumit** will require a prior authorization if it is currently being used in combination with drugs known to be significant CYP3A inhibitors (ketoconazole, itraconazole, clarithromycin, indinavir, nefazodone, nelfinavir, ritonavir, atazanavir, saquinavir and telithromycin). **DDI: Adempas** will require a prior authorization if it is currently being used in combination with drugs known to be PDE inhibitors should be avoided (including dipyridamole, adcira and tadalafil) with adempas. **Liqrev**: treatment of pulmonary arterial hypertension (WHO Group 1) in adults to improve exercise ability and delay clinical worsening. Avoid concomitant use of liqrev with moderate or strong CYP3A inhibitors.
ERA / ENDOTHELIN RECEPTOR ANTAGONIST	MC MC	LETAIRIS [1,2] TRACLEER				Use PA Form# 20420 1. Providers must be registered with LEAP Prescribing program, a restricted distribution program. 2. Clinical PA is required to establish diagnosis and medical necessity.	**Letairis** approvals will require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and functional class 2 or 3 symptoms. **Tracleer** approvals will require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 2 thru 4. **DDI:** Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with tracleer.

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
IMPOTENCE AGENTS							
IMPOTENCE AGENTS						As of January 1, 2006, per CMS (federal govt.), impotence agents are no longer covered.	As of January 1, 2006, per CMS (federal govt.), impotence agents are no longer covered.
ANTI-EMETOGENICS							
ANTIEMETIC - ANTICHOLINERGIC / DOPAMINERGIC	MC	DOXYLAMINE SUCC-PYRIDOXINE	MC		ANTIVERT TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Concomitant use of MAOIs and **Bonjesta** is contraindicated.
	MC	DOXYLAMINE SUCC-PYRIDOXINE HCL	MC		BARHEMSYS		
	MC/DEL	MECLIZINE HCL TABS	MC		BONJESTA		
	MC	PROMETHAZINE SUPP	MC		DICLEGIS		
	MC/DEL	PROMETHAZINE	MC		PHENERGAN SOLN		
		SCOPOLAMINE PATCH	MC		PROMETHAZINE 50MG SUPP		
			MC		PROMETHEGAN SUPP		
			MC		TORECAN TABS		
ANTIEMETIC - 5-HT3 RECEPTOR ANTAGONISTS/ SUBSTANCE P NEUROKININ	MC/DEL	**DRONABINOLCAPS**	MC	8	AKYNZEO [1]	Use PA Form# 20420 1. Approvals will require diagnosis of chemo-induced nausea/vomiting and failed trials of all preferred anti-emetics, including **5-HT3 class** (**Ondansetron**) and **Marinol**. 2. Clinical PA is required for members on highly emetic anti-neoplastic agents. 3. Dosing limits apply, see Dosage Consolidation List. 4. Clinical PA required for appropriate diagnosis.	Preferred drugs and step therapy must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. * **Ondansetron** limits still apply as listed on the Ondansetron PA form for covered indications including chemotherapy, radiotherapy, post operative nausea & vomiting and hyperemesis gravidarum. Other medical indications will be approved or denied on a case-by-case basis. Hyperemesis and other medical indications approved are still subject to failure of multiple preferred antiemesis drugs. **Akynzeo - C**oncomitant use should be avoided in patients who are chronically using a strong CYP3A inducer such as rifampin. **Aponvie** is for the prevention of postoperative nausea and vomiting (PONV) in adults. **Varubi** – Available to the few who are unable to tolerate or who have failed on preferred medications.
	MC/DEL	GRANISETRON TAB	MC	8	APREPITANT		
	MC/DEL	**ONDANSETRON TAB**	MC	8	ALOXI		
	MC/DEL	**ONDANSETRON ODT TBDP**	MC	8	ANZEMET TABS		
	MC/DEL	**ONDANSETRON SOL**	MC	8	APONVIE [4]		
			MC	8	CESAMET [1]		
			MC	8	CINVANTI [4]		
			MC	8	EMEND [2]		
			MC	8	FOCINVEZ [1,2]		
			MC/DEL	8	KYTRIL		
			MC/DEL	8	MARINOL CAPS		
			MC	8	SANCUSO		
			MC	8	SUSTOL		
			MC	8	SYNDROS		
			MC	8	TRIMETHOBENZAMIDE CAP		
			MC	8	VARUBI		
			MC/DEL	8	ZOFRAN ODT TBDP [3]		
			MC/DEL	8	ZOFRAN TABS [3]		
			MC/DEL	8	ZOFRAN INJ [3]		
			MC	8	ZUPLENZ		
NON-SEDATING ANTIHISTAMINES / DECONGESTANTS							
ANTIHISTIMINES - NON-SEDATING	MC	ALAVERT TABS	MC	5	CLARINEX TABS [1,5]	Use PA Form# 20530 1. Must fail preferred drugs, OTC loratadine and cetirizine before moving to non-preferred step order drugs. 2. Clarinex and Zyrtec syrup <6 yr w/o PA. 3. Must fail all step 5 drugs (clarinex, fexofenadine and zyrtec) before moving to next step product. 4. All OTC versions of Loratadine ODT are now non-preferred. 5. PA's for Clarinex RediTabs will only be approved if between the ages of 6-11 yrs old.	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved **(in step order)**, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. No combination product with decongestant will be approved since pseudoephedrine available without PA. **Pseudoephedrine** is available with prescription.
	MC/DEL	CETIRIZINE TABS	MC	5	CLARINEX SYR [1,2]		
	MC/DEL	LORATADINE	MC/DEL	5	FEXOFENADINE [1]		
	MC	TAVIST ND (OTC)	MC/DEL	5	ZYRTEC [1]		
			MC/DEL	5	ZYRTEC SYR [1,2]		
			MC/DEL	8	ALLEGRA [3]		
			MC	8	CLARITIN [3]		
			MC/DEL	8	DESLORATADIN		
			MC/DEL	8	LORATADINE ODT [4]		
			MC/DEL	8	LEVOCETIRIZINE [4]		
			MC/DEL	9	XYZAL [3]		
ANTIHISTIMINES - OTHER	MC/DEL	CLEMASTINE				Use PA Form# 20530	
	MC/DEL	CHLORPHENIRAMINE					
	MC/DEL	DIPHENHYDRAMINE					
ALLERGY / ASTHMA THERAPIES							
ANAPHYLACTIC DEVICES	MC	AUVI- Q	MC		NEFFY	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	**EPINEPHRINE**	MC		TWINJECT		
	MC/DEL	**EPIPEN**					
	MC/DEL	**EPIPEN JR**					
ALLERGEN IMMUNOTHERAPY			MC		ODACTRA	Use PA Form# 20420 1. See criteria section	Prescriber must provide the testing to show that the patient is allergic to the components in the prescribed therapy and must provide a clinically valid rationale why single agent sublingual therapy is being chosen over subcutaneous therapy. **Palforzia** is approved for use in patients with a confirmed diagnosis of peanut allergy. Initial dose escalation may be administered to patients aged 4 through 17 years. Up-dosing and maintenance may be continued in patients 4 years of age and older. **Odactra** is approved for use in persons 12 through 65 years of age. Note that Odactra is not indicated for the immediate relief of allergic symptoms. Treatment must start 12 weeks before expected onset of pollen season and only after confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for any of the 5 grass species contained in Oralair. **Oralair:** Patient age ≥10 years and ≤65 years**.** Have an auto-injectable epinephrine on-hand.
			MC		ORALAIR [1]		
			MC		PALFORZIA		
			MC		RAGWITEK		
			MC		GRASTEK		

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
ANTIASTHMATIC - ANTICHOLINERGICS - INHALER	MC MC/DEL MC/DEL	**INCRUSE ELLIPTA** [3] SPIRIVA HANDIHALER [1,2] **SPIRIVA RESPIMAT**	MC MC/DEL		LONHALA MAGNAIR **TUDORZA**	Use PA Form# 20420 1. Quantity limit of 1 inhalation daily (1 capsule for inhalation daily). **Spiriva** will require PA if Combivent or Atrovent nebulizer solution is in member's current drug profile. 2. We ask physicians to write "asthma" on the prescription whenever Spiriva is primarily being used for that condition. 3. Quantity limit of 1 inhalation daily.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIASTHMATIC - DIPEPTIDYL PEPTIDASE 1 INHIBITATORS	MC	**BRINSUPRI**				Use PA Form# 20420 1. Clinical PA is required to establish diagnosis and medical necessity.	**BRINSUPRI** required criteria include: • Imaging confirming bronchiectasis and no overlapping asthma/COPD required. • Documented airway clearance. • Greater than 2 exacerbations requiring antibiotic therapy in the last 12 months. • Must be approved by pulmonologist.
ANTIASTHMATIC - PHOSPHODIESTERASE 4 INHIBITORS	MC/DEL	ROFLUMILAST	MC/DEL MC		DALIRESP OHTUVAYRE [1]	Use PA Form# 20420 1. For the maintenance treatment of chronic obstructive pulmonary disease (COPD) in adult patients.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIASTHMATIC - ANTICHOLINERGICS - NEBULIZER	MC/DEL	**IPRATROPIUM BROMIDE SOLN**	MC/DEL		**YUPELRI**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIASTHMATIC - ANTIINFLAMMATORY AGENTS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	CROMOLYN SODIUM NEBU DUPIXENT [2,4] **FASENRA** [6] **FASENRA AUTO INJCT** [6] XOLAIR [1,4]	MC MC MC MC MC		CINQAIR [3] **EXDENSUR** [5] **NUCALA** [2] RHAPSIDO [4] TEZSPIRE [5]	Use PA Form# 20420 1. Need max inhaled steroids and written by pulmonary or allergy specialist. Must have elevated IgE and ≥ age 6. 2. For patients with severe asthma aged 12 years or older and eosinophilia. 3. For patients ≥ 18 years of age with eosinophilia. 4. Clinical PA required to establish diagnosis and medical necessity. 5. For adult and pediatric patients aged 12 years and older with severe asthma. 6. For patients ≥ 6 years of age for eosinophilia.	All will require suboptimal response to maximal doses of inhaled steroid as evidenced by asthmatic ER/Hospital admissions and Allergy/Pulmonary specialist management. **Dupixent** limited to patient with asthma not controlled on high dose ICS-LABA who have eosinophil greater than or equal to 150 cells or the patient is depend on an oral corticosteroid. **Fasenra, Nucala and Cinqair** are not indicated for treatment of other eosinophilic conditions and are not indicated for the relief of acute bronchospasm or status asthmaticus. **Rhapsido** for Chronic Spontaneous Urticaria - must have had an inadequate clinical repsonse of at least 14-days with at least two different second-generation antihistamines at 4 times standard dose. Must continue use of second-generation antihistamine. Must be prescribed by or in consultation with either allergist/- immunologist, dermatologist, pulmonologist, or otolaryngologist.
ANTIASTHMATIC - NASAL STEROIDS	MC/DEL MC/DEL MC MC/DEL MC/DEL MC	BUDESONIDE SPRAY FLUTICASONE SPR [3] OLOPATADINE SPRAY OMNARIS SPR [3] TRIAMCINOLONE NS QNASL	MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC MC MC/DEL MC MC/DEL	8 8 8 8 8 8 8 8 8 8 8 8	DYMISTA FLONASE SUSP [2,3] FLUNISOLIDE SOLN [1,3] NASONEX SUSP RHINOCORT AERO [2,3] RHINOCORT AQUA SUSP [2,3] RYALTRIS [4] TRI-NASAL SOLN [2,3] VANCENASE POCKETHALER AERS [2,3] VERAMYST [2,3] XHANCE [2] ZETONNA [3]	Use PA Form# 20420 1. All preferred drugs must be tried before moving to non preferred steps. 2. All step 5 medications need to be tried before moving to step 8's. 3. Dosing limits apply to whole category, see Dosage Consolidation List. 4. Use of individual ingredients or other preferred agents.	All preferred drugs and step therapy must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Xhance** will be considered for the treatment of nasal polyps in patients 18 years of age or older. The patient has had a documented side effect, allergy, or treatment failure of two preferred nasal glucocorticoids, one of which must be fluticasone.
ANTIASTHMATIC - NASAL MISC.	MC/DEL MC/DEL MC	AZELASTINE CROMOLYN NASAL 4% IPRATROPIUM NASAL SOL[1]	MC/DEL MC/DEL		ASTEPRO [2] PATANASE	Use PA Form# 20420 1. **Ipratropium** will be approved if submitted with documentation supporting use of CPAP machine. 2. Utilize Multiple preferred, as well as step therapy Azelastine.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Approved if patient fails on nonsedating antihistamines and steroid nasal sprays.
ANTIASTHMATIC - BETA - ADRENERGICS	MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC	**ALBUTEROL 0.63mg/3ml** **ALBUTEROL HFA** **ALBUTEROL NEB** LEVALBUTEROL TARTRATE **METAPROTERENOL** **PROAIR DIGIHALER** [4] PROAIR RESPICLICK **PROVENTIL HFA** **SEREVENT**	MC/DEL MC/DEL MC MC MC		**AIRSUPRA** **ALBUTEROL HFA (labeler 66993001968)** VOSPIRE ER TB12 **XOPENEX HFA** [3] **XOPENEX NEBU** [1,2]	Use PA Form# 20420 1. **Xopenex** users w/ prior asthma hospitalization due to albuterol nebulizer failure will be grandfathered. 2. Quantity Limit: 12 cc/day.. 3. Dosing limits apply, see Dosage Consolidation List. 4. For the treatment of patients ≥ 4 years of age.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Airsupra** has new PA criteria that include the patient is aged ≥ 18, AND the patient has had a documented side effect or allergy, AND treatment failure/intolerance or contraindication to Symbicort® and Dulera® SMART therapy, AND the patient is unable to use albuterol and budesonide separately.

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
	MC/DEL	**STRIVERDI**					
	MC/DEL	**TERBUTALINE SULFATE TABS**					
	MC	**VENTOLIN HFA AERS**					
ANTIASTHMATIC - ADRENERGIC COMBINATIONS	MC	**ADVAIR DISKUS** [1]	MC		AIRDUO DIGIHALER [2]	Use PA Form# 20420 1. Dosing limits apply, see Dosage Consolidation List. 2. For patients ≥ 12 years and older.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **AirDuo® Respiclick** be non-preferred and require prior authorization and be available to those who are unable to tolerate or who have failed on preferred medications. **DDI:** Avoid concomitant use of strong CYP3A4 inhibitors (e.g. ritonavir, atazanavir, clarithromycin, indinavir, itraconazole, nefazodone, nelfinavir, saquinavir, ketoconazole, telithromycin) with **AirDuo® Respiclick** is not recommended due to increased systemic corticosteroid and increased cardiovascular adverse effects.
	MC/DEL	**ADVAIR HFA** [1]	MC/DEL		BREYNA		
	MC	AIRDUO RESPICLICK [2]	MC/DEL		**BREZTRI AEROSPHERE**		
	MC	**BREO ELLIPTA** [1]	MC		**TRELEGY ELLIPTA** [1]		
	MC/DEL	DULERA					
	MC/DEL	FLUTICASONE-SALMETEROL					
	MC/DEL	SYMBICORT					
ANTIASTHMATIC - ADRENERGIC ANTICHOLINERGIC	MC/DEL	**ALBUTEROL/IPRATROPIUM NEB. SOLN**	MC/DEL		**BEVESPI AEROSPHERE** [2,3]	Use PA Form# 20420 1. Please use preferred individual ingredients Albuterol and Ipratropium. 2. Dosing limits apply, see Dosing Consolidation List. 3. The safety and efficacy of use in children under the age of 18 years have not been established.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Bevespi** should be used with extreme caution in patients being treated with MAO inhibitors, TCAs, or other drugs known to prolong the QTc interval. **DDI**: Avoid concomitant use of **Bevespi** with other anticholinergic-containing drugs, due to an increased risk of anticholinergic adverse events. Bevespi should be used with extreme caution in patients being treated with MAO inhibitors, TCAs, or other drugs known to prolong the QTc interval.
	MC	**ANORO ELLIPTA**	MC		**DUAKLIR PRESSAIR**		
	MC/DEL	**COMBIVENT RESPIMAT**					
	MC/DEL	**STIOLTO**					
ANTIASTHMATIC - XANTHINES	MC/DEL	**AMINOPHYLLINE TABS**	MC		**THEO-24 CP24**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	THEOCHRON TB12					
	MC/DEL	THEOLAIR-SR TB12					
	MC/DEL	**THEOPHYLLINE CR TB12**					
	MC	THEOPHYLLINE ELIX					
	MC/DEL	THEOPHYLLINE SOLN					
	MC/DEL	**THEOPHYLLINE ER CP12**					
	MC/DEL	**THEOPHYLLINE ER TB12**					
ANTIASTHMATIC - STEROID INHALANTS	MC	**ARNUITY ELLIPTA**	MC		AEROSPAN	Use PA Form# 20420 1. **Budesonide Neb** 0.25mg & 0.5mg will be preferred for members under the age of 8 years old. PA will be required for members 8 years of age and older, please consider other preferred options. 2. All preferred must be tried before moving to non preferred steps. 3. Dosing limits apply, see Dosage Consolidation List. 4. **Asmanex** 110mcg will be limited to member between the ages of 4-11 years old.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	**ASMANEX TWISTHALER** [3,4]	MC/DEL		ALVESCO [3]		
	MC/DEL	ASMANEX HFA	MC		ARMONAIR DIGIHALER		
	MC/DEL	**BUDESONIDE NEB 0.25MG & 0.5MG** [1]	MC/DEL		**BUDESONIDE NEB 1MG**		
	MC	QVAR AERS [3]	MC/DEL		**PULMICORT SUSP**		
ANTIASTHMATIC - 5-Lipoxygenase Inhibitors			MC		**ZYFLO TABS**	Use PA Form# 20420	Other Preferred asthma controller drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIASTHMATIC - LEUKOTRIENE RECEPTOR ANTAGONISTS	MC/DEL	MONTELUKAST GRANULE [1]	MC/DEL		**ACCOLATE TABS**	Use PA Form# 20420 1. **Montelukast Granules** will only be approved if between ages of 6 - 24 months. 2. **Singulair Chewable** 4mg from 2 years- 5 years and **Singulair Chewable** 5mgs from 6 years- 14 years old.	
	MC/DEL	**MONTELUKAST SODIUM TAB**	MC/DEL		**SINGULAIR** [2]		
	MC/DEL	**MONTELUKAST SODIUM CHEW TAB**	MC/DEL		**SINGULAIR GRANULES**		
ANTIASTHMATIC - ALPHA-PROTEINASE INHIBITOR			MC		ARALAST	Use PA Form# 20420	**Prolastin** and **Azemaira** will be approved for members with A1AT deficiency and clinically demonstrable panacinar emphysema.
			MC/DEL		**ZEMAIRA**		
			MC		GLASSIA		
			MC		PROLASTIN SUSR		
ANTIASTHMATIC - HYDRO-LYTIC ENZYMES			MC		PULMOZYME SOLN	Use PA Form# 20420	Will be approved for cystic fibrosis patients.
ANTIASTHMATIC - MUCOLYTICS	MC/DEL	ACETYLCYSTEINE [1]				Use PA Form# 20420 1. **Acetylcysteine** is covered with diagnosis of CF.	
ANTIASTHMATIC-CFTR POTENTIATOR AND COMBINATIONS			MC		ALYFTREK	Use PA Form# 20420 1. For the treatment of patients ≥18 years of age with CF.	**Alfytrek** will be considered for the treatment of patients 6 years and older with at least one responsive mutation, including 31 additional mutations not responsive to other CFTR modulator therapies. **Bronchitol** will be considered as add-on maintenance therapy to improve pulmonary function in adult patients 18 years and older with cystic fibrosis (CF). Use Bronchitol only for adults who have passed the Bronchitol Tolerance Test (BTT). (see Recommended Dosage section for further information). **Kalydeco** will be considered for patients with cystic fibrosis (CF) aged 1 month and older who have at least one mutation in the CFTR gene that is responsive to ivacaftor potentiation based on clinical and/or in vitro assay data. If the patient's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of a CFTR mutation followed by verification with bi-directional sequencing when recommended by the mutation test instructions for use.
			MC		BRONCHITOL [1]		
			MC		KALYDECO		
			MC		ORKAMBI		
			MC		SYMDEKO		
			MC/DEL		**TRIKAFTA**		

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
							Orkambi will be considered for patients with cystic fibrosis (CF) aged 1 year and older who are homozygous for the F508del mutation in the CFTR gene. If the patient's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of the F508del mutation on both alleles of the CFTR gene. The efficacy and safety of Orkambi have not been established in patients with CF other than those homozygous for the F508del mutation. **Symdeko** will be considered for patients with cystic fibrosis (CF) aged 6 years and older who are homozygous for the F508del mutation or who have at least one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to tezacaftor/ivacaftor based on in vitro data and/or clinical evidence. If the patient's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of a CFTR mutation followed by verification with bi-directional sequencing when recommended by the mutation test instructions for use. **Trikafta** will be considered for the treatment of cystic fibrosis (CF) in patients aged 2 years and older who have at least one F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene or mutation in the CFTE gene that is responsive based on in vitro data. If the patient's genotype is unknown, an FDA-cleared CF mutation test should be used to confirm the presence of at least one F508del mutation or a mutation that is responsive based on in vitro data.
IDIOPATHIC PULMONARY FIBROSIS	MC/DEL	**OFEV** [1]	MC		ESBRIET [1]	Use PA Form# 20420 1. Clinical PA is required to establish diagnosis and medical necessity.	**Ofev**- Avoid concomitant use with P-gp and CYPA4 inducers (e.g. carbamazepine, phenytoin, and St. John's wort. **Esbriet**- The concomitant use with strong CYP1A2 inhibitors (e.g. fluvoxamine, enoxacin) is not recommended.
	MC/DEL	PIRFENIDONE	MC/DEL		JASCAYD [1]		
COUGH/COLD							
COUGH/COLD	MC/DEL	**DEXTROMETHORPHAN CAPS** [1]				Use PA Form# 20420 1. All of cough cold preparations are not covered except these preferred products.	All non-preferred products are not covered as permitted by Federal Medicaid regulations and MaineCare Policy.
	MC/DEL	DEXTRO-GUAIF SYRP [1]					
	MC/DEL	GUAIFENESIN SYRP [1]					
	MC/DEL	PSEUDOEPHEDRINE [1]					
	MC	ROBITUSSIN DM SYRP [1]					
	MC	ROBITUSSIN SUGAR FREE SYRP [1]					
DIGESTIVE AIDS / ASSORTED GI							
GI - ANTIPERISTALTIC AGENTS	MC/DEL	DIPHENOXYLATE	MC/DEL		LOFENE TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Certain drugs require specific diagnoses for approval.
	MC/DEL	DIPHENOXYLATE/ATROPINE	MC		LONOX TABS		
	MC/DEL	LOPERAMIDE HCL CAPS/LIQ	MC		MOTOFEN TABS		
	MC/DEL	OPIUM TINCTURE TINC					
	MC	PAREGORIC TINC					
GI - ANTI-DIARRHEAL/ ANTACID - MISC.	MC	**ATROPINE SULFATE SOLN**	MC/DEL		**BELLADONNA ALKALOIDS & OP**	Use PA Form# 20420 1. Dosing limits apply, see Dose Consolidation List. 2. It is not indicated as monotherapy for treatment of peptic ulcer because effectiveness in peptic ulcer healing has not been established.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Certain drugs require specific diagnoses for approval. Preferred products that used to require diag codes still require diag codes unless indicated otherwise. **Mytesi** requires a diagnosis of non-infectious diarrhea in patients with HIV/AIDS on anti-retroviral therapy, prior trials of preferred, more cost effective anti-diarrheal.
	MC/DEL	BISMATROL	MC/DEL		BENTYL TABS		
	MC/DEL	BISMUTH SUBSALICYLATE	MC/DEL		BENTYL SYRP		
	MC/DEL	CALCIUM CARBONATE (ANTACID) CHEW	MC		CUVPOSA		
	MC/DEL	DICYCLOMINE HCL	MC		DARTISLA ODT [2]		
	MC/DEL	GLYCOPYRROLATE TABS	MC		ED-SPAZ		
	MC/DEL	HYOSCYAMINE CAPS & TABS	MC		MYTESI [1]		
	MC/DEL	HYOSCYAMINE SULFATE	MC/DEL		GLYCOPYRROLATE INJ		
	MC/DEL	KAOPECTATE	MC		LEVSIN TABS		
	MC/DEL	MAGNESIUM OXIDE TABS	MC		LEVSIN/SL SUBL		
	MC/DEL	**MAG-OX 400 TABS**	MC		NULEV TBDP		
	MC/DEL	PAMINE TABS	MC		OSCIMIN		
	MC/DEL	PROPANTHELINE BROMIDE TABS	MC		ROBINUL INJ		
	MC/DEL	SODIUM BICARBONATE TABS	MC		ROBINUL TABS		
	MC/DEL	TUMS					
GI- BILE ACID			MC		CHOLBAM [1]	Use PA Form# 20420 1. Clinical PA is required to establish diagnosis and medical necessity.	Indication of bile acid synthesis disorders due to single enzyme defects (SEDs) AND for adjunctive treatment of peroxisomal disorders (PDs).
			MC		CTEXLI [1]		
GI- EOSINOPHILIC ESOPHAGITIS	MC	EOHILIA [1]				Use PA Form# 20420 1. Approvals will not be longer than 12 weeks of treatment in adult and pediatric patients 11 years of age and older.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved **(in step order)**, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Eohilia**: Dietary modification, PPIs, and topical glucocorticoids are required as initial therapy.
GI - H2-ANTAGONISTS	MC	ACID REDUCER TABS	MC/DEL		NIZATIDINE CAPS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI: Cimetidine** will now be non-preferred and require prior authorization if it is currently being used with any sulfonylurea (except for glyburide). **DDI: Cimetidine** will require prior authorization if being used in combination with plavix.
	MC/DEL	CIMETIDINE	MC		PEPCID AC		
GI- IBAT INHIBITORS			MC		BYLVAY [1,2]	Use PA Form# 20420 1. For the treatment of patients ≥ 3 mos of age. 2. Clinical PA required for appropriate diagnosis.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Certain drugs require specific diagnoses for approval.
			MC		LIVMARLI [1,2]		
GI - PROTON PUMP INHIBITOR	MC/DEL	OMEPRAZOLE CAPS [2]	MC/DEL	6	NEXIUM CPDR [3]	Use PA Form# 20720 1. **Prevacid Solutabs** available without PA for child less than 9 years old. 2. Dosing limits apply, please see Dosage Consolidation List.	All preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved **(in step-order)**, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Please refer to the PPI PA form for additional criteria on Non-Preferred PPIs. **DDI: Omeprazole** will require prior authorization if being used in combination with plavix.
	MC/DEL	PANTOPRAZOLE [2]	MC/DEL	6	NEXIUM SUS [5]		
	MC/DEL	LANSOPRAZOLE CAPS [2]	MC	7	PRILOSEC OTC[3]		
			MC	7	ACIPHEX TBEC [3]		
			MC/DEL	8	DEXILANT (KAPIDEX) [2]		

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
			MC	8	KONVOMEP [2]	3. All preferred and step therapy must be tried and failed. 4. Payment for Prevacid SoluTabs for patients 9 and older will be considered for those patients who cannot tolerate a preferred solid oral dosage form. 5. **Nexium sus** available without PA if member is <12 yrs of age and ≤1 pack per day.	**DDI: Lansoprazole** will require prior authorization if being used in combination with plavix. **DDI: Prevacid, Omeprazole and Pantoprazole** will now be non-preferred and require prior authorization if they are currently being used in combination with any of the following medications: ampicillin, B-12, fe salts, griseofulvin, sporanox, ketoconazole, reyataz, or vantin. **DDI:** All non-preferred PPIs require prior authorization, but with any prior authorization request, the member's drug profile will also be monitored for current use with ampicillin, B-12, Fe salts, griseofulvin, itraconazole, ketoconazole, reyataz or vantin due to a significant drug-drug interaction.
			MC	8	OMEPRAZOLE-SODIUM BICARBONATE CAPS		
			MC	8	OMEPRAZOLE MAGNESIUM		
			MC/DEL	8	PREVACID CPDR [3]		
			MC/DEL	8	PREVACID SOLUTABS [1,4]		
			MC/DEL	8	PRILOSEC CPDR		
			MC/DEL	8	PROTONIX INJ		
			MC/DEL	8	PROTONIX [2]		
GI - ULCER ANTI-INFECTIVE	MC	PYLERA	MC		VOQUEZNA TABS	Use PA Form# 20420	
	MC	TALICIA	MC		VOQUEZNA DUAL PAK		
			MC		VOQUEZNA TRIPLE PAK		
GI - PROSTAGLANDINS	MC	MISOPROSTOL TABS	MC/DEL		CYTOTEC TABS	Use PA Form# 20420	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drug will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
GI - DIGESTIVE ENZYMES	MC/DEL	CREON [1]	MC/DEL		PERTZYE	Use PA Form# 20420 1. Clinical PA is required to establish CF diagnosis and medical necessity. In all cases except cystic fibrosis patients, objective evidence of pancreatic insufficiency (fat malabsorption test etc) must be supplied.	Non -Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before other non-preferred drugs will be approved **in step-order**, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC	ZENPEP [1]	MC/DEL		ULTRESA		
			MC/DEL		VIOKACE		
GI - ANTI - FLATULENTS / GI STIMULANTS	MC/DEL	AMITIZA	MC		CEPHULAC SYRP	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Certain drugs require specific diagnoses for approval.
	MC	CALULOSE SYRP	MC/DEL		INFANTS GAS RELIEF SUSP		
	MC/DEL	CONSTULOSE SYRP	MC		GIMOTI SPRAY		
	MC/DEL	ENULOSE SYRP	MC/DEL		REGLAN TABS		
	MC	GASTROCROM CONC					
	MC/DEL	GENERLAC SYRP					
	MC/DEL	LACTULOSE SYRP					
	MC/DEL	METOCLOPRAMIDE HCL					
GI - INFLAMMATORY BOWEL AGENTS	MC	MESALAMINE ENMA KIT	MC/DEL		AZULFIDINE EN-TABS TBEC	Use PA Form# 20420 1. Current users grandfathered.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Giazo** is only indicated for males, as the safety efficacy for use in females has not been established. Prior trials of preferred products.
	MC	PENTASA	MC/DEL		AZULFIDINE TABS		
	MC/DEL	**SULFAZINE EC TBEC**	MC		DIPENTUM CAPS		
	MC/DEL	**SULFASALAZINE TABS**	MC/DEL		GIAZO		
			MC		LIALDA TABS [1]		
			MC		ROWASA ENEM		
			MC/DEL		SFROWASA		
GI - IRRITABLE BOWEL SYNDROME AGENTS	MC	LOTRONEX TABS	MC		VIBERZI	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
GI- SHORT BOWL SYNDROME			MC		GATTEX	Use PA Form# 20420	**Gattex** requires a diagnosis of adult SBS who are dependent on parenteral support. Appropriate colonoscopy and lab assessments 6months prior to starting.
MISCELLANEOUS GI							
GI - MISC.	MC/DEL	BISAC-EVAC SUPP	MC/DEL		ACTIGALL CAPS	Use PA Form# 20420 2. For the treatment of carcinoid syndrome diarrhea in combination with somatostatin analog (SSA) therapy in adults inadequately controlled by SSA therapy. 3. For the treatment of Opioid Induced Constipation (OIC). 5. Dosing limits apply, see Dose Consolidation List.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Certain drugs require specific diagnoses for approval. **Iqirvo**: For the treatment of primary biliary cholangitis (PBC) in combination with ursodeoxycholic acid (UDCA) in adults who have had an inadequate response to UDCA, or as monotherapy in patients unable to tolerate UDCA. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trial(s). **Livdelzi**: Clinical PA is required for the treatment of primary biliary cholangitis (PBC) in combination with ursodeoxycholic acid (UDCA) in adults who have had an inadequate response to UDCA, or as monotherapy in patients unable to tolerate UDCA. Patients who do not have a diagnosis of decompensated cirrhosis.
	MC/DEL	BISACODYL	MC		BENEFIBER		
	MC	BISCOLAX SUPP	MC/DEL		CARAFATE		
	MC	CINOBAC CAPS	MC/DEL		CLEARLAX POW		
	MC/DEL	CITRATE OF MAGNESIA SOLN	MC/DEL		COLACE CAPS		
	MC/DEL	CITRUCEL	MC		DIOCTO-C SYRP		
	MC/DEL	CLENPIQ SOL	MC		DOC SOD /CAS CAP		
	MC/DEL	COLYTE	MC		DOC-Q-LAX CAPS		
	MC/DEL	DIOCTO SYRP	MC/DEL		DOCUSATE SODIUM/CAS CAPS		
	MC	DOCUSATE CALCIUM CAPS	MC/DEL		DOK PLUS		
	MC/DEL	DOCUSATE SODIUM	MC/DEL		DULCOLAX SUPP		
	MC/DEL	FIBER LAXATIVE TABS	MC		ENEMEEZ		
	MC	FLEET	MC		FIBER CON TABS		
	MC/DEL	GENFIBER POWD	MC/DEL		FIBER-LAX TABS		
	MC	GAVILYTE	MC/DEL		GAVILYTE-H		
	MC	GOLYTELY SOLN	MC		IBSRELA		
	MC/DEL	GLYCERIN	MC		IQIRVO		
	MC	HIPREX TABS	MC		LIVDELZI		
	MC/DEL	KRISTALOSE PACK	MC		MALTSUPEX		
	MC/DEL	LINZESS [5]	MC		MIRALAX PACKETS		
	MC	MAALOX	MC/DEL		MOTEGRITY		

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
	MC/DEL	MILK OF MAGNESIA SUSP	MC		PEG-3350 ELECTROLYTES SOLR		
	MC	MINERAL OIL	MC		PEG 3350 PACKETS		
	MC	MIRALAX BULK POWD (BRAND)	MC		PREPOPIK PAK		
	MC/DEL	MOVANTIK	MC/DEL		SENEXON TABS		
	MC	PEG 3350- ELECTROLYTE SOL	MC/DEL		SENOKOT TABS		
	MC	PEG 3350 POWDER	MC		SENOKOT S TABS		
	MC/DEL	SENNA	MC/DEL		SORBITOL		
	MC/DEL	SENOKOT GRAN	MC		STOOL SOFTENER PLUS CAPS		
	MC/DEL	SENOKOT SYRP	MC		SUPREP SOL		
	MC/DEL	SENOKOT CHILDRENS SYRP	MC		SUTAB		
	MC	SENOKOT XTRA TABS	MC/DEL		SYMPROIC [3]		
	MC/DEL	STOOL SOFTENER CAPS	MC/DEL		UNI-CENNA TABS		
	MC/DEL	SUCRALFATE TABS	MC		UNI-EASE PLUS CAPS		
	MC	SUFLAVE	MC		V-R NATURAL SENNA LAXATIV TABS		
	MC	UNI-EASE CAPS	MC		URSO 250		
	MC	URSO FORTE	MC		XERMELO [2]		
	MC/DEL	URSODIOL					
MISC. UROLOGICAL							
UROLOGICAL - MISC.	MC	ACETIC ACID 0.25% SOLN	MC		CITRIC ACID/SODIUM CITRAT SOLN	Use PA Form# 20420 1. **Elmiron** requires adequate proof of Dx with supportive testing.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC	CYTRA-K SOLN	MC/DEL		CYTRA-2 SOLN		
	MC	FOSFOMYCIN (NDC 82036427401 ONLY)	MC/DEL		ELMIRON CAPS [1]		
	MC	K-PHOS MF TABS	MC		FURADANTIN SUSP		
	MC/DEL	METHENAMINE MANDELATE TABS	MC/DEL		MACROBID CAPS		
	MC/DEL	NEOSPORIN GU IRRIGANT SOLN	MC/DEL		MACRODANTIN CAPS		
	MC/DEL	NITROFURANTOIN MONO CAPS	MC/DEL		NITROFURANTOIN MACR SUSP		
	MC/DEL	PHENAZOPYRIDINE HCL TABS	MC		POTASSIUM CITRATE/CITRIC SOLN		
	MC/DEL	PHENAZOPYRIDINE PLUS	MC/DEL		PYRIDIUM PLUS TABS		
	MC	POT CITRATE TAB	MC		PYRIDIUM TABS		
	MC/DEL	PROSED/DS TABS	MC/DEL		RENACIDIN SOLN		
	MC	TRICITRATES SYRP	MC		UROCIT-K		
	MC/DEL	URELIEF PLUS					
	MC	UREX TABS					
	MC/DEL	URISED TABS					
	MC/DEL	UROQID #2 TABS					
PHOSPHATE BINDERS							
PHOSPHATE BINDERS	MC/DEL	CALCIUM ACETATE CAP [1]	MC		AURYXIA [1]	Use PA Form# 20420 1. Diagnosis required.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before less preferred drugs will be approved **in step-order**, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Xphozah** to reduce serum phosphorus in adults with chronic kidney disease (CKD) on dialysis as add-on therapy in patients who have an inadequate response to phosphate binders or who are intolerant of any dose of phosphate binder therapy.
	MC/DEL	FOSRENOL CHEW [1]	MC/DEL		CALCIUM ACETATE TAB [1]		
	MC/DEL	MAGNEBIND - 400 [1]	MC/DEL		ELIPHOS [1]		
	MC	PHOSLYRA [1]	MC/DEL		FOSRENOL PWDR [1]		
	MC/DEL	RENVELA [1]	MC		VELPHORO [1]		
			MC		XPHOZAH		
INTRA-VAGINALS							
VAGINAL - ANTIBACTERIALS	MC/DEL	CLEOCIN CREA	MC/DEL		METROGEL VAGINAL GEL [1]	Use PA Form# 20420 1. Dosing limits apply, see Dosage Consolidation List.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before less preferred drugs will be approved **in step-order**, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	CLEOCIN SUPP	MC/DEL		VANDAZOLE		
	MC	CLINDESSE CREA	MC		XACIATO		
	MC/DEL	NUVESSA					
VAGINAL - ANTI FUNGALS	MC/DEL	CLOTRIMAZOLE CREA	MC		AVC CREA	Use PA Form# 20420 1. Quantity limit: 1/script/2 weeks.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI: Miconazole** will require prior authorization if being used in combination with warfarin.
	MC/DEL	CLOTRIMAZOLE-3 CREA	MC		CLOTRIMAZOLE 3 DAY CREA		
	MC/DEL	GYNE-LOTRIMIN CREA	MC		GYNAZOLE-1 CREA		
	MC	MICONAZOLE CREA	MC		GYNE-LOTRIMIN 3 TABS		
	MC	MICONAZOLE 3 KIT CREA OTC	MC/DEL		MICONAZOLE 3 COMBO PACK KIT[1]		
	MC/DEL	MICONAZOLE 7 CREA	MC/DEL		MICONAZOLE 3 SUPP		
	MC/DEL	MICONAZOLE NITRATE CREA	MC		TERAZOL 3 CREA		
	MC	NYSTATIN TABS	MC		TERAZOL 7 CREA		
	MC/DEL	TERCONAZOLE CREAM	MC/DEL		TERCONAZOLE SUPP		
	MC	VAGITROL					
	MC	V-R MICONAZOLE-7 CREA					
VAGINAL - ESTROGENS	MC/DEL	**ESTRING RING**	MC/DEL		ESTRACE CREA [1]	Use PA Form# 20420 1. Must fail all preferred products before non-preferred.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	**PREMARIN CREA**	MC/DEL		VAGIFEM TABS [1]		
VAGINAL - OTHER	MC/DEL	ACID JELLY GEL	MC		AMINO ACID CERVICAL CREA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC	ACI-JEL GEL					
	MC	CERVICAL AMINO ACID CREA					

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
BENIGN PROSTATIC HYPERPLASIA (BPH)							
BPH	MC/DEL	**DOXAZOSIN MESYLATE TABS**	MC/DEL	5	**FLOMAX CP24**	Use PA Form# 20420 1. There will be dosing limits of 1 tab per day with out PA. 2. Prior use of preferred agent prior to any approvals. 3. Use of preferred (Tamsulosin and Finasteride) and (Tamsulosin and non-preferred Avodart). 4. Non-preferred products must be used in specified order. 5. Use of individual ingredients preferred (Finasteride and Tadalafil). 6. Entadfi is not recommended for more than 26 weeks.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Approval of a non-preferred 5-alpha reductase inhibitor requires objective clinical evidence of a very enlarged prostate rather than just the presence of obstructive urinary outflow symptoms along with adequate trial of preferred proscar.
	MC/DEL	FINASTERIDE[1] 5mg	MC/DEL	8	ALFUZOSIN		
	MC/DEL	TERAZOSIN HCL CAPS	MC	8	AVODART [2,4]		
	MC/DEL	**TAMSULOSIN HCL**	MC/DEL	8	**CARDURA TABS** [4]		
			MC	8	ENTADFI [5,6]		
			MC	8	JALYN [3,4]		
			MC/DEL	8	PROSCAR TABS [4]		
			MC/DEL	8	RAPAFLO [4]		
			MC	8	**TEZRULY**		
			MC/DEL	8	UROXATRAL [4]		
ANXIOLYTICS							
ANXIOLYTICS - BENZODIAZEPINES	MC/DEL	ALPRAZOLAM TABS	MC/DEL		ALPRAZOLAM ER	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	CHLORDIAZEPOXIDE HCL CAPS	MC		LOREEV XR		
	MC/DEL	CLORAZEPATE DIPOTASSIUM TABS	MC/DEL		NIRAVAM		
	MC/DEL	DIAZEPAM	MC/DEL		TRANXENE		
	MC/DEL	OXAZEPAM CAPS	MC/DEL		XANAX TABS		
			MC/DEL		XANAX XR		
ANXIOLYTICS - MISC.	MC/DEL	BUSPIRONE HCL TABS	MC		BUSPAR TABS	Use PA Form# 20420 1. Dosing limits apply, see Dose Consolidation List.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC	HYDROXYZINE HCL SOLN	MC		DROPERIDOL SOLN		
	MC	HYDROXYZINE HCL SYRP	MC/DEL		DROPERIDOL SOLN		
	MC/DEL	HYDROXYZINE HCL TABS [1]	MC/DEL		DROPERIDOL SOLN		
	MC/DEL	HYDROXYZINE PAMOATE CAPS					
	MC/DEL	MEPROBAMATE TABS					
ANTI-DEPRESSANTS							
ANTIDEPRESSANTS - MAO INHIBITORS	MC/DEL	NARDIL TABS	MC/DEL		**TRANYLCYPROMIINE**	Use PA Form# 20420	
ANTIDEPRESSANTS - MAO INHIBITORS TOPICAL			MC/DEL		EMSAM [1]	Use PA Form# 20420 1. Dosing limits apply, see Dose Consolidation List.	Preferred drugs (including a preferred SSRI, a non-SSRI, and venlafaxine ER) must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIDEPRESSANTS - SELECTED SSRI's AND OTHERS	MC/DEL	BUPROPION SR	MC	8	AUVELITY [11]	Use PA Form# 20420 1. Strong caution with pediatric population. 2. Max daily dose allowed is 120mg, combination of multiple strengths require PA. 4. Dosing limits allowing 2 tabs/day and a max daily limit of 200mg / day applies. See Dose Consolidation List. 5. Dosing limits apply, see Dose Consolidation List and max daily dose applies. Max daily dose allowed is 375mg. 6. **Non-preferred products must be used in specified step order.** 7. Requires previous trials/failure of multiple preferred medications. Dosing limits apply, see Dose Consolidation List. Max daily dose of 80mg if used concomitantly with strong CYP3A4 inhibitor. 8. Psychiatry recommended. Please see criteria secti 9. Please use multiples of the 20mg; the 40mg is still non-preferred. 10. For the treatment of patients ≥ 18 years of age. 11. Use individual ingredients separately. 12. Approval will be limited to a 14-day treatment course.	Preferred drugs (including failure of at least one preferred SSRI, one SNRI and one non-SSRI/SNRI) must be tried for at least 4 weeks each and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **CYMBALTA:** Fibromyalgia diagnosis- prior use and failure of preferred generics (amitriptyline or cyclobenzaprine) and gabapentin prior to approval. **SAVELLA:** Fibromyalgia diagnosis and trial of a preferred generic amitriptyline, cyclobenzaprine, duloxetine and gabapentin prior to approval. **Zulresso** is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS) called the Zulresso REMS. **Spravato:** Treatment Resistant Depression: • Must be 18 years of age or older; and medication must be administered under the direct, on site, supervision of a licensed healthcare provider with post-administration observation of a minimum of least 2-hours. The medication must be prescribed by or in consultation with a psychiatrist and prescriber must be enrolled in the REMS program. • Approval is based upon failure of at least two antidepressants and failure of an antidepressant used adjunctively with one recognized augmentation strategy such as lithium, an atypical antipsychotic, thyroid hormone, etc. • Ongoing use of Spravato beyond 3 months is based upon a positive response as evidenced by at least a 30 % reduction from baseline as measured by a standardized rating scale including PHQ 9, Hamilton Depression Rating Scale, or QIDS). **Spravato:** MDD with Suicidal Ideation. Approval for this indication only if it is started in an inpatient unit, given adjunctively with an optimized antidepressant regimen, and with an 8-12 week initial approval with ongoing use dependent upon documentation of ongoing benefit. **DDI: Drizalma Sprinkle** avoid the concomitant use of duloxetine with potent CYP1A2 inhibitors (e.g. fluvoxamine, cimetidine, ciprofloxacin, enoxacin). **DDI: Fluvoxamine** will require prior authorization if being used in combination with plavix. **DDI: Fluvoxamine** will now be non-preferred and require prior authorization if it is currently being used with glimepiride (amaryl). **DDI: Fluoxetine** will require prior authorization if being used in combination with plavix. **DDI:** Preferred **Nefazodone** will now be non-preferred and require prior authorization if it is currently being used in combination with either onglyza 5mg, enablex 15mg or vesicare 10mg. **DDI:** Reduce the **Zurzuvae** dosage when used with a strong CYP3A4 inhibitor.
	MC/DEL	BUPROPION XL 150mg and 300mg	MC/DEL	8	BUPROPION XL 450mg		
	MC/DEL	CITALOPRAM	MC/DEL	8	CELEXA		
	MC/DEL	DULOXETINE [2,9]	MC	8	CYMBALTA [2]		
	MC/DEL	ESCITALOPRAM	MC/DEL	8	DRIZALMA SPRINKLES		
	MC/DEL	FLUOXETINE 10mg AND 20mg CAPS	MC/DEL	8	EFFEXOR TABS		
	MC/DEL	FLUOXETINE 10mg AND 20mg TABS	MC/DEL	8	EFFEXOR XR CP24		
	MC/DEL	FLUOXETINE HCL LIQD	MC	8	EXXUA [10]		
	MC/DEL	FLUVOXAMINE MALEATE TABS	MC/DEL	8	FETZIMA [7]		
	MC/DEL	MIRTAZAPINE	MC	8	FORFIVO XL		
	MC/DEL	NEFAZODONE	MC/DEL	8	IRENKA		
	MC/DEL	PAROXETINE [1]	MC/DEL	8	KHEDEZLA		
	MC/DEL	SERTRALINE HCL	MC/DEL	8	LEXAPRO TABS		
	MC/DEL	TRAZODONE HCL TABS	MC	8	LUVOX TABS		
	MC/DEL	VENLAFAXINE ER CAPS [5]	MC	8	MAPROTILINE HCL TABS		
	MC/DEL	VENLAFAXINE TABS [5]	MC/DEL	8	MIRTAZAPINE ODT		
			MC	8	OLEPTRO		
			MC/DEL	8	PAROXETINE CR [1]		
			MC/DEL	8	PAXIL [1]		
			MC/DEL	8	PAXIL CR [1]		
			MC/DEL	8	PRISTIQ		
			MC	8	PROZAC		
			MC	8	PROZAC CAPS		
			MC	8	PROZAC WEEKLY CPDR		
			MC	8	RALDESY		
			MC/DEL	8	REMERON TABS		
			MC/DEL	8	REMERON SOLTAB TBDP		
			MC/DEL	8	SARAFEM CAPS		
			MC/DEL	8	SAVELLA [4]		
			MC/DEL	8	SPRAVATO [8]		

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
			MC/DEL	8	TRAZODONE HCL 300MG TABS		
			MC/DEL	8	TRINTELLIX		
			MC/DEL	8	VENLAFAXINE ER TABS [5]		
			MC	8	WELLBUTRIN TABS		
			MC	8	WELLBUTRIN SR TBCR		
			MC/DEL	8	ZOLOFT		
			MC/DEL	8	ZULRESSO [10]		
			MC	8	ZURZUVAE [12]		
			MC/DEL	9	FLUOXETINE 90mg TABS [6]		
			MC/DEL	9	VIIBRYD [6]		
ANTIDEPRESSANTS - TRI-CYCLICS	MC/DEL	**AMITRIPTYLINE HCL TABS** [1]	MC/DEL		**AMOXAPINE TABS**	Use PA Form# 20420 Use PA Form# 10220 for Brand Name requests 1. Users over the age of 65 require a PA. 2. Use multiples of 50mg.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	**CLOMIPRAMINE HCL CAPS** [1]	MC/DEL		**ANAFRANIL CAPS**		
	MC/DEL	**DESIPRAMINE HCL TABS** [1]	MC/DEL		**DOXEPIN HCL 150 MG** [2]		
	MC/DEL	**DOXEPIN HCL** [1] **(not generic Silenor)**	MC/DEL		**DOXEPIN (generic Silenor)**		
	MC/DEL	**IMIPRAMINE HCL TABS** [1]	MC/DEL		**NORPRAMIN TABS**		
	MC/DEL	**NORTRIPTYLINE HCL** [1]	MC/DEL		**PAMELOR**		
	MC	PROTRIPTYLINE HCL TABS [1]	MC		TOFRANIL		
	MC	SURMONTIL CAPS [1]	MC		VIVACTIL TABS		
SEDATIVE / HYPNOTICS							
SEDATIVE/HYPNOTICS - BARBITURATE	MC	BUTISOL SODIUM TABS [1]	MC		LUMINAL SOLN	Use PA Form# 20420 1. PA required for new users of preferred products if over 65 years.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	CHLORAL HYDRATE SYRP [1]	MC/DEL		SOMNOTE CAPS		
	MC	MEBARAL TABS [1]					
	MC/DEL	PHENOBARBITAL [1]					
SEDATIVE/HYPNOTICS - BENZODIAZEPINES	MC/DEL	DORAL TABS [1]	MC		HALCION TABS [1]	Use PA Form# 30110 1. Dosing limits apply, see Dosing Consolidation List.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Benzodiazepines** do cause dependence with continued use and usage should be limited to 7-10 days at a time. Chronic intermittent use (2-3 days per week max) is the standard of care.
	MC/DEL	ESTAZOLAM TABS [1]	MC		MIDAZOLAM HCL SYRP		
	MC/DEL	FLURAZEPAM HCL CAPS [1]	MC/DEL		RESTORIL CAPS [1]		
	MC/DEL	TEMAZEPAM CAPS 15 & 30MG [1]	MC/DEL		TEMAZEPAM 7.5MG [1]		
	MC/DEL	TRIAZOLAM TABS [1]					
SEDATIVE/HYPNOTICS - Non-Benzodiazepines	MC/DEL	MIRTAZAPINE	MC/DEL		AMBIEN [1]	Use PA Form# 30110 1. Quantity Limit of 12 per 34 days. 2. Quantity limits will be allowed up to 30/30, but intermittent therapy is recommended. 3. Only Zolpidem trial/failure will be required to obtain Zaleplon. 4. Must fail all preferred products before non-preferred.	All preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Ambien, Ambien CR, Lunesta, Sonata, Zaleplon and Zolpidem** may cause dependence with continued use and as with benzodiazepines, usage should be limited to 7-10 days at a time. Chronic intermittent use (2-3 days per week max) is the standard of care. Please refer to Sedative/Hypnotic PA form. **DDI: Belsomra** with strong CYP3A inhibitors (e.g. ketoconazole, itraconazole, posaconazole, clarithromycin, nefazodone, ritonavir, saquinavir, nelfinavir, indinavir, boceprevir, telaprevir, telithromycin, and conivaptan) is not recommended.
	MC	TRAZODONE	MC/DEL		**ESZOPICLONE**		
	MC/DEL	ZOLPIDEM [2]	MC/DEL		**ZOLPIDEM ER**		
	MC/DEL	ZALEPLON [2,3]	MC/DEL		AMBIEN CR [1]		
			MC/DEL		BELSOMRA [1]		
			MC		DAYVIGO [1]		
			MCDEL		EDLUAR		
			MC		HETLIOZ		
			MC/DEL		INTERMEZZO		
			MC/DEL		LUNESTA [1]		
			MC/DEL		SONATA CAPS [1]		
			MC/DEL		ROZEREM		
			MC		QUVIVIQ		
			MC/DEL		ZOLPIMIST		
ANTI-PSYCHOTICS							
ANTIPSYCHOTICS - ATYPICALS	MC	ABILIFY ASIMTUFII	MC/DEL	8	ABILIFY DISC TAB, INJ and SOL [1]	Use PA form# 20440 for Multiple Antipsychotic requests Use PA form# 10130 for non-preferred single therapy atypical requests If prescribing 2 or more antipsychotics, PA will be required for both drugs, except if one is **Clozapine**. This includes combination of **Seroquel** with **Seroquel XR**. 1. Established users of single therapy atypicals were grandfathered. 2. Prior Authorization will be required for preferred medications for members under the age of 5. 3. Dosing limits apply, refer to the Dose Consolidation List.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Non preferred atypicals will be approved for patients with FDA-approved indications, and for specific conditions supported by at least two published peer-reviewed double-blinded, placebo-controlled randomized trials that are not contradicted by other studies of similar quality and as long as all first line preferred therapies have been tried and failed at full therapeutic doses for adequate durations (at least two weeks). **Quetiapine** prescriptions for are limited to a maximum daily dose of 800mg. **Uzedy**: Establish tolerability with oral risperidone prior to initiating Uzedy. **Atypicals:** Prior Authorization will be required for preferred medication to assure indication is in accordance with FDA approved or literature supported evidence-based best practices. The approved indications are: • **schizophrenia** • **bipolar disorder** • **agitation related to autism** • **adjunct in major depressive disorder** **Lybalvi**: Step through aripiprazole and latuda. If criteria is met then initial approval for 3 months. Subsequent approvals will be based on evidence of not gaining >= 10% baseline body weight for ongoing approval. If weight gain >= 10% of initial body weight, then criteria for ongoing use not met.
	MC	ABILIFY MAINTENA	MC	8	ABILIFY TABS [2]		
	MC/DEL	**ARIPIPRAZOLE SOL**	MC/DEL	8	ARIPIPRAZOLE ODT		
	MC/DEL	ARIPIPRAZOLE TAB [3]	MC	8	COBENFY		
	MC	ARISTADA	MC	8	ERZOFRI		
	MC	ARISTADA INITIO	MC	8	FANAPT		
	MC	CAPLYTA [5]	MC/DEL	8	GEODON		
	MC/DEL	**OLANZAPINE** [2,3]	MC	8	INVEGA		
	MC/DEL	**OLANZAPINE** [2,3] **ODT**	MC	8	IGALMI		
	MC/DEL	INVEGA HAFYERA	MC	8	LATUDA		
	MC	INVEGA SUSTENNA	MC	8	LYBALVI		
	MC/DEL	INVEGA TRINZA INJ	MC	8	NUPLAZID		
	MC/DEL	**LURASIDONE TAB**	MC	8	OPIPZA		
	MC/DEL	**PALIPERIDONE ER**	MC	8	REXULTI		
	MC/DEL	PERSERIS	MC	8	RISPERDAL TAB		

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
	MC	RISPERDAL CONSTA	MC	8	RISPERDAL M TAB [1]	4. Requires step through one (1) preferred drug for all indications except AMDD. AMDD requires insufficient response from two antidepressants. 5. Will require a step through one (1) preferred drug for all indications. Prior Auth required for < 18 years of age.	**Cobenfy**: Patient must be 18–65 years old AND meet criteria for the diagnosis of schizophrenia, AND trial of 2 prior preferred second generation antipsychotics showing minimal response in control of symptoms of schizophrenia OR trial of SGA that have yielded side effects of weight gain which has not been responsive to lifestyle & medication augmentation AND patient must have baseline tests including heart rate, liver enzymes, kidney function tests, and bilirubin prior to starting treatment. **Invega Hafyera**: The patient is started and stabilized on the medication OR the patient has been adequately treated with Invega Sustenna (paliperidone palmitate 1-month) for at least four months or Invega Trinza (paliperidone palmitate 3- month) following at least one 3-month injection cycle. **DDI**: It is recommended to reduce the Vraylar dose if it is used concomitantly with a strong CYP3A inhibitor (such as itraconazole, ketoconazole). The concomitant use of Vraylar with a CYP3A4 inducer (such as rifampin, carbamazepine) is not recommended. **DDI**: The concomitant use of Nuplazid with other drugs known to prolong the QT interval (e.g. Class IA antiarrhythmics, Class 3 antiarrhythmics, antipsychotics, and antibiotics such as gatifloxacin and moxifloxacin).
	MC/DEL	RISPERIDONE ODT	MC	8	RISPERDAL SOLN		
	MC/DEL	RISPERIDONE TAB [2,3]	MC	8	RYKINDO		
	MC/DEL	RISPERIDONE SOLN [2]	MC/DEL	8	SAPHRIS [1]		
	MC/DEL	QUETIAPINE [2,3]	MC	8	SECUADO		
	MC/DEL	QUETIAPINE XR	MC/DEL	8	SEROQUEL TABS		
	MC	UZEDY	MC	8	ZYPREXA TABS		
	MC	VRAYLAR [4]	MC	8	ZYPREXA RELPREVV		
	MC/DEL	**ZIPRASIDONE** [2,3]	MC	8	ZYPREXA ZYDIS TBDP [1]		
			MC/DEL	9	SEROQUEL XR		
ANTIPSYCHOTICS - SPECIAL ATYPICALS	MC/DEL	CLOZAPINE TABS	MC/DEL		CLOZAPINE ODT	Use PA Form# 20420	Preferred generic drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred brand will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Patients previously stabilized on brand name drug will be approved.
			MC		CLOZARIL TABS		
			MC/DEL		VERSACLOZ SUSP		
ANTIPSYCHOTICS - TYPICAL	MC/DEL	CHLORPROMAZINE HCL	MC/DEL		COMPAZINE	Use PA Form# 20420 If prescribing 2 or more antipsychotics, PA will be required for both drugs, except if one is **Clozapine**.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. If prescribing 2 or more antipsychotics, PA will be required for both drugs, except if one is **Clozapine**.
	MC/DEL	FLUPHENAZINE DECANOATE	MC/DEL		COMPRO SUPP		
	MC/DEL	FLUPHENAZINE HCL	MC/DEL		FLUPHENAZINE HCL CONC		
	MC	HALDOL	MC		HALDOL DECANOATE		
	MC/DEL	HALOPERIDOL	MC/DEL		LOXITANE CAPS		
	MC	HALOPERIDOL DECANOATE SOLN	MC		MELLARIL		
	MC	HALOPERIDOL LACTATE SOLN	MC/DEL		NAVANE CAPS		
	MC/DEL	LOXAPINE SUCCINATE CAPS	MC		PROLIXIN		
	MC/DEL	LOXITANE-C CONC	MC		STELAZINE TABS		
	MC	MOBAN TABS					
	MC/DEL	PERPHENAZINE					
	MC/DEL	PROCHLORPERAZINE					
	MC/DEL	THIORIDAZINE HCL					
	MC/DEL	THIOTHIXENE					
	MC/DEL	TRIFLUOPERAZINE HCL TABS					
LITHIUM							
LITHIUM	MC/DEL	LITHIUM CARBONATE	MC/DEL		ESKALITH CAPS	Use PA Form# 20420	
	MC/DEL	LITHIUM CITRATE SYRP	MC/DEL		ESKALITH CR TBCR		
COMBINATION - PSYCHOTHERAPEUTIC							
PSYCHOTHERPEUTIC COMBINATION			MC/DEL		CHLORDIAZEPOXIDE/AMITRIPT	Use PA Form# 20420	
			MC/DEL		PERPHENAZINE/AMITRIPTYLIN		
STIMULANTS							
STIMULANT - AMPHETAMINES -SHORT ACTING	MC/DEL	AMPHETAMINE SALT COMBO [1,3,4]	MC/DEL		ADDERALL TABS [1,2,3]	Use PA Form# 20420 1. Preferred stimulants will be available without PA if diagnosis of ADHD or Narcolepsy. 2. As per recent FDA alert, Adderall & Dexedrine should not be used in patients with underlying heart defects since they may be at increased risk for sudden death. 3. Dosing limits apply, see Dosing Consolidation List. 4. Max daily dose of 50mg.	
	MC/DEL	DEXTROAMPHET SULF TABS [1,2,3]	MC		EVEKEO		
	MC	PROCENTRA [1,3]	MC/DEL		METHAMPHETAMINE HCL		
			MC		ZENZEDI		
STIMULANT - LONG ACTING AMPHETAMINES SALT	MC	ADDERALL XR CP24 [1,3,4,7]	MC		MYDAYIS [5]	Use PA Form# 20420 1. As per recent FDA alert, **Adderall** should not be used in patients with underlying heart defects since they may be at increased risk for sudden death. 2. FDA approval is currently for adults and children 6 or older. Will be available without PA for this age group if within dosing limits. Limit of one capsule daily. Max dose of 70MG daily. 3. Preferred stimulants will be available without PA if diagnosis of ADHD. 4. Dosing limits apply, see Dosing Consolidation List. 5. For the treatment of Attention Deficit Hyperactivity Disorder (ADHD) in patients 13 years and older.	**DDI**: The concomitant use of **Mydayis** is contraindicated with monoamine oxidase inhibitors (MAOIs) or within 14 days after discontinuing MAOI treatment, as concomitant use can increase hypertensive crisis.
	MC/DEL	AMPHETAMINE/DEXTROAMPHET ER [3,4,7]	MC		VYVANSE CHEW [4]		
		LISDEXAMFETAMINE CAP	MC		XELSTRYM [8]		
	MC	VYVANSE [2,3,4]					

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
						7. FDA approval is currently for adults and children 6 or older. Will be available without PA for this age group if within dosing limits. Max dose of 50MG daily without a PA. 8. For the treatment of patients 6 years of age and older.	
LONG ACTING AMPHETAMINES	MC MC/DEL MC	DEXTROAMPHET SULF CPSR [1,3] **DEXTROAMPHETAMINE ER** DYANAVEL XR SUS	MC/DEL MC MC MC MC		ADZENYS ER [3] ADZENYS XR- ODT ADZENYS XR [3] DEXEDRINE CAP SR [2,3] DYANAVEL XR TAB	Use PA Form# 20420 1. Preferred stimulants will be available without PA if diagnosis of ADHD. 2. As per recent FDA alert, Adderall & Dexedrine should not be used in patients with underlying heart defects since they may be at increased risk for sudden death. 3. Dosing limits apply, see Dosing Consolidation List.	**DDI:** The concomitant use of **Adzenys XR** is contraindicated with monoamine oxidase inhibitors (MAOIs) or within 14 days after discontinuing MAOI treatment.
STIMULANT - METHYLPHENIDATE	MC/DEL MC/DEL MC/DEL MC/DEL	DEXMETHYLPHENIDATE IR TABS METHYLPHENIDATE SOL **METHYLPHENIDATE TAB** METHYLIN TABS [1,2]	MC/DEL MC/DEL MC MC MC/DEL MC/DEL		FOCALIN IR TABS METADATE ER METHYLPHENIDATE HCL CHEW METHYLIN CHEWABLES METHYLIN SOL RITALIN	Use PA Form# 20420 1. Preferred stimulants will be available without PA if diagnosis of ADHD. 2. Dosing limits apply, see Dosing Consolidation List. Maximum daily doses are as follows: 72mg daily for **Methylphenidate** and 36mg daily for **Dexmethylphenidate**.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Please refer to General Criteria category E.
STIMULANT - METHYLPHENIDATE - LONG ACTING	MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC MC/DEL	CONCERTA TBCR **DEXMETHYLPHENIDATE CAP ER 50/50** FOCALIN XR METHYLPHENIDATE LA CAPS METHYLPHENIDATE ER CAPS 50/50 METHYLPHENIDATE ER CAPS 40/60 METHYLPHENIDATE CD CAPS 30-70 QUILLICHEW ER [5,1] QUILLIVANT XR SUS [1,5] RITALIN LA [4]	MC MC/DEL MC MC MC MC MC/DEL MC/DEL MC/DEL MC/DEL	5 8 8 8 8 8 8 8 8 8	METADATE CD CPCR ADHANSIA XR [2,6] APTENSIO XR [2] AZSTARYS [6] COTEMPLA XR [2] COTEMPLA XR ODT [2] DAYTRANA [2,3] JORNAY PM [2,6] METHYLPHENIDATE ER CAPS [2,4]	Use PA Form# 20420 1. Preferred stimulants will be available without PA if diagnosis of ADHD. 2. **Non-preferred products must be used in specified step order.** 3. FDA approval currently only for ages 6-16. Limit of one patch daily. Max dose of 30MG daily. 4. Dosing limits apply, see Dosing Consolidation List. 5. Quillivant XR and Quillichew ER are only indicated for use in patients ≥ 6 yrs of age. 6. For the treatment of patients ≥ 6 ys of age.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
STIMULANT - STIMULANT LIKE	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC	**ATOMOXETINE HCL** ARMODAFINIL CLONIDINE ER **GUANFACINE ER** MODAFINIL TABS QELBREE[6,7]	MC/DEL MC MC MC/DEL MC MC MC/DEL MC MC MC MC/DEL MC MC	7 7 8 8 8 8 8 8 8 8 9 9 9	PROVIGIL TABS[3] STRATTERA[1, 2] CAFCIT SOLN[3] INTUNIV KAPVAY ONYDA XR[6] SUNOSI WAKIX XYREM SOL XYWAV[5] NUVIGIL[3] DESOXYN TABS[3] DESOXYN CR[3]	Use PA Form# 20710 for Provigil, Nuvigil and Xyrem Use PA Form# 20420 for all others 1. Failure of both an amphetamine and methylphenidate is required for consideration for approval of **Strattera**, unless history of substance abuse without current use of abusable medication(s). Additionally, for patients <17 years of age, a trial of **Guanfacine** required before approval of **Strattera**. 2. Strattera currently has dosing limitations allowing one tablet per day for all strengths if obtain approval. Max daily dose of Strattera is 100mg. Please see Dosing Consolidation List. 3. **Non-preferred products must be used in specified step order**. 4. Please use generic Guanfacine. 5. For patients 7 years of age and older with narcolepsy. 6. For pediatric patients 6 years of age or older. 7. Preferred with a trial and fail either Atomoxetine OR any 2 preferred ADHD agents.	**Provigil** requests require diagnosis of Narcolepsy, ADHD, or Obstructive Sleep Apnea. Previous failures of methylphenidate and amphetamine is required for Narcolepsy and ADHD diagnosis, with additional Strattera trial needed with ADHD diagnosis. Please refer to detailed criteria on Provigil PA form. **Sunsosi** is non-preferred and is indicated for to improve wakefulness in adult patients with excessive daytime sleepiness associated with narcolepsy or obstructive sleep apnea (OSA). **Wakix** is non-preferred and is indicated for the treatment of excessive daytime sleepiness (EDS) in adults with narcolepsy. Xywav: Diagnosis of cataplexy associated with narcolepsy OR excessive daytime sleepiness associated with narcolepsy. Diagnosis must be confirmed by submission of supporting documentation to include the specialist's interpretation of the Polysomnography (PSG) and Multiple Sleep Latency Test (MSLT) results. FDA reminded healthcare professionals and patients that the combined use of **Xyrem** (sodium oxalate) with alcohol or central nervous system (CNS) depressant drugs can markedly impair consciousness and may lead to severe breathing problems (respiratory depression). **DDI: Sunosi** is contraindicated with MAO inhibitors or within 14 days after discontinuing the MAO inhibitor. **DDI:** Concomitant use of **Qelbree** with an MAO inhibitor or within 2 weeks after discontinuing an MAO inhibitor is contraindicated. **DDI**: Concomitant use of **Qelbree** significantly increases the total exposure, but not peak exposure, of sensitive CYP1A2 substates, which may increase the risk of adverse reactions associated with these CYP1A2 substrates. Coadministration of Qelbree with sensitive CYP1A2 substrates or CYP1A2 substrates with a narrow therapeutic range (e.g. alosetron, duloxetine, ramelteon, tasimelteon, tizanidine, theophylline), is contraindicated.
ANTI-CATAPLECTIC AGENTS							
PSYCHOTHERAPEUTIC AGENTS - MISC.			MC MC		NUEDEXTA XENAZINE	Use PA Form# 20710 for Xenazine	

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
WEIGHT LOSS							
WEIGHT LOSS						No longer covered: Phentermine,Xenical, Didrex, and Meridia	Weight loss drugs are not covered as permitted by Federal Medicaid regulations and Maine Medicaid (MaineCare) Policy.
ALZHEIMER DISEASE							
ALZHEIMER - Cholinomimetics/Others	MC/DEL	DONEPEZIL HYDROCHLORIDE TABS [1]	MC	6	ARICEPT TABS [2]	Use PA Form# 20420 1. PA is required to establish dementia diagnosis and baseline mental status score. 2. Must fail all preferred products before moving to non-preferred. 3. Approvals will require trials and failure or clinical rationale why preferred patches can't be used.	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs **(in step-order)** will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Kisunla and Leqembi**: Testing to rule out reversible causes of dementia (CBC, CMP, TSH, B12, urine drug screen, RPR/VDRL, (folate if alcohol abuse is present), HIV (if risk present) and an assessment including a review of current medications as a cause of intellectual decline - Prescribed by or in consultation with a neurologist or geriatrician or geriatric psychiatrist. Diagnosis of Alzheimer's disease defined as: • Confirmed presence of amyloid pathology and mild cognitive impairment or mild dementia stage of disease, consistent with Stage 3 and Stage 4 Alzheimer's disease OR • Confirmed presence of amyloid pathology and prodromal or mild dementia stage of disease, consistent with Stage 3 & Stage 4 Alzheimer's disease Testing: • Clinical Dementia Rating (CDR) global score of 0.5 or 1.0 OR • Repeatable Battery for Assessment of Neuropsychological Status (RBANS) delayed memory index score ≤ 85 OR • Mini-Mental State Examination (MMSE) score of 20-30 OR • Montreal Cognitive Assessment (MoCA) score ≤ 22 – Member is age 50 or older – Obtain recent (within one year) brain magnetic resonance imaging (MRI) prior to initiating treatment – Provider attestation to obtain MRIs prior to the 7th infusion (first dose of 10 mg/kg) and 12th infusion (sixth dose of 10 mg/kg) – Member does NOT have history or increased risk of amyloid related imaging abnormalities-edema (ARIA-E), which includes brain edema or sulcal effusions and amyloid related imaging abnormalities hemosiderin deposition (ARIA-H), which includes microhemorrhage and superficial siderosis – Member does NOT have hypersensitivity to any components of these drugs
	MC/DEL	DONEPEZIL HYDROCHLORIDE ODT [1]	MC	6	ARICEPT ODT [2]		
	MC/DEL	EXELON DIS [1]	MC/DEL	7	DONEPEZIL HYDROCHLORIDE TABS 23MG		
	MC/DEL	**GALANTAMINE CAPS** [1]	MC	8	ADLARITY [3]		
	MC/DEL	**GALANTAMINE TAB** [1]	MC/DEL	8	EXELON CAP		
	MC/DEL	MEMANTINE [1]	MC/DEL	8	GALANTAMINE HYDROBROMIDE SOL		
	MC/DEL	RIVASTIGMINE TARTRATE CAPS [1]	MC	8	KISUNLA [1]		
			MC	8	LEQEMBI [1]		
			MC/DEL	8	MEMANTINE HCL SOL		
			MC/DEL	8	NAMENDA		
			MC/DEL	8	NAMENDA XR CAPS		
			MC/DEL	8	NAMZARIC		
			MC	8	RAZADYNE [2]		
			MC	8	ZUNVEYL		
			MC	9	COGNEX CAPS [2]		
SMOKING CESSATION							
NICOTINE PATCHES / TABLETS	MC/DEL	CHANTIX TAB [1]	MC/DEL		NICODERM CQ PT24 [1]	Use PA Form# 20420 1. See criteria section for exemptions	As of July 1, 2014 per MaineCare policy, smoking cessation products will be covered without a copay (including MEDEL). No annual or lifetime limits, must follow FDA approved indications and therapy guidelines. Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Note:** MaineCare policy, smoking cessation product were "not covered" except for during pregnancy between 9/1/12 and 1/1/14, between 1/1/2014 and 7/1/14 smoking cessation products were covered with limitations. Patients may qualify for the medication through The Maine Tobacco Helpline if they do not have MaineCare or MEDEL. Patients are encouraged to call The Maine Tobacco helpline at 1-800-207-1230.
	MC/DEL	CHANTIX STARTER PACK					
	MC/DEL	NICOTINE DIS PT24 [1]					
	MC/DEL	**VARENICLINE TAB**					
NICOTINE REPLACEMENT - OTHER	MC/DEL	NICOTINE POLACRILEX GUM [1]	MC/DEL	8	NICOTROL INHALER [1,2]	Use PA Form# 20420 1. See criteria section for exemptions. 2. **Must use non-preferred products in specified step order.**	As of July 1, 2014 per MaineCare policy, smoking cessation products will be covered without a copay (including MEDEL). No annual or lifetime limits, must follow FDA approved indications and therapy guidelines. Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Note:** MaineCare policy, smoking cessation product were "not covered" except for during pregnancy between 9/1/12 and 1/1/14, between 1/1/2014 and 7/1/14 smoking cessation products were covered with limitations. Patients may qualify for the medication through The Maine Tobacco Helpline if they do not have MaineCare or MEDEL. Patients are encouraged to call The Maine Tobacco helpline at 1-800-207-1230.
	MC/DEL	NICOTINE LOZENGE MINI	MC/DEL	8	NICOTROL NASAL SPRAY [1,2]		
	MC/DEL	NICOTINE LOZENGE	MC/DEL	8	NICORETTE GUM [1,2]		
			MC	8	NICORETTE LOZENGES		
ALCOHOL DETERRENTS							
ALCOHOL DETERRENTS	MC/DEL	**ACAMPROSATE**	MC/DEL		**ACAMPRO** [1]	Use PA Form# 20420 1. Should only be used in conjunction with formal structured outpatient detoxification program.	Preferred generic drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC	ANTABUSE TABS					
	MC	DISULFIRAM TABS					
	MC/DEL	NALTREXONE HCL TABS					
MISCELLANEOUS ANALGESICS							
ANALGESICS - MISC.	MC/DEL	ACETAMINOPHEN	MC		AXOCET CAPS	Use PA Form# 20420 1. QL: No greater than 14-day supply within 90 days.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Journavx** requires patient must have documented clinical reason as to why they are unable to use acetaminophen and NSAIDS (which can include Cox-II inhibitors). Journavx is FDA approved for moderate to severe ***ACUTE*** pain in adults.
	MC/DEL	**ASPIRIN**	MC/DEL		ESGIC-PLUS		
	MC/DEL	ASPRIN/ APAP/ CAFF TAB	MC/DEL		FIORICET TABS		
	MC/DEL	BUTAL/ASA/CAFF	MC		FIORINAL CAPS		
	MC/DEL	BUTALBITAL COMPOUND	MC		FIORTAL CAPS		
	MC/DEL	BUTALBITAL/ACET TABS	MC/DEL		FORTABS TABS		
	MC/DEL	BUTALBITAL/APAP CAPS	MC		JOURNAVX [1]		
	MC/DEL	BUTALBITAL/APAP/CAFFEINE TABS	MC		PHRENILIN TABS		
	MC/DEL	**CHOLINE MAGNESIUM TRISALI**	MC		PHRENILIN FORTE CAPS		
	MC/DEL	**DIFLUNISAL TABS**	MC		TRILISATE LIQD		
	MC	EXCEDRIN	MC		TRILISATE TABS		
	MC/DEL	**SALSALATE TABS**	MC		ZEBUTAL CAPS		
			MC		ZORPRIN TBCR		

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
LONG ACTING NARCOTICS							
NARCOTICS - LONG ACTING	MC/DEL	FENTANYL PATCH [4]	MC	8	ARYMO ER	Use PA Form# 20510 Use PA Form #10300 for PAs over the opiate limit 1. **Oxycontin** will be available without PA for patients treated for or dying from cancer or hospice patients. CA (cancer) or HO (hospice) diag code may be used but store must verify since all scripts will be audited and stores will be liable. 3. **Oxycodone ER** allowed only 2 per day for all strengths except 80 mg, where 4 are allowed to achieve max total daily dose of 320mg. 4. 25mcg, 50mcg, 75mcg, 100mcg. Dosing limits apply, see Dose Consolidation List. 5. **Non-preferred products must be used in specific order.** 6. **Methadone** will be available without PA for patients treated for or dying from cancer or hospice patients or similar conditions as supported by clinical documentation. CA (cancer) or HO (hospice) diag code may be used but store must verify since all scripts will be audited and stores will be liable.	Preferred drugs (Fentanyl Patch, Morphine Sulfate ER tab, and Butrans) must be tried for at least 2 weeks each & failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug & the preferred drug(s) exists. Adequate trials include prevention/treatment of common adverse effects associated w/ narcotics (antinausea, antipruritic, etc.) as well as adequate equianalgesic dosing when converting from one narcotic to another. Also, adequate documentation of attempts to titrate dose of preferred agents to achieve adequate pain relief & desired clinical response must be provided. Member's drug regimen for additions &/or discontinuations of medications that may affect absorption &/or metabolism of preferred agents must be monitored. Approvals will not be granted if patient had access to either non-preferred products or high doses of short acting narcotics during the trial period. Non-preferred drugs will not be approved for patients showing evidence of usage patterns consistent w/ controlled substance abuse such as: 1.Frequent or persistent early refills of controlled drugs; 2.Multiple instances of early refill overrides due to reports of misplacement, stolen, dropped in toilet or sink, distant travel, etc. 3.Breaches of narcotic contracts with any provider; 4.Failure to comply with patient responsibilities in attached opioid documentation (see PA form) including but not limited to failing to submit to and pass 5.Failing to take or pass random drug testing; 6.Failing to provide old records regarding prior use of narcotics; 7.Receiving controlled substances from other prescribers that the provider submitting the PA is unaware of; 8.Documented history of substance abuse. Substance abuse evaluations may be required for patients with medical records displaying documented substance abuse or potential signs of narcotic misuse and abuse such as chronic early refills, short dosing intervals, frequent dose increases, multiple lost/stolen etc scripts and intolerance or "allergy" to all products but Oxycontin. 9. Circumventing MaineCare prior authorization requirements for narcotics by paying cash for affected narcotics (prescribers failed to submit prior authorization prior to cash narcotic scripts being filled by member). 10. Requests for any Brand name controlled substance, considered by authorities to be highly abused and diverted (Oxycontin, Percocet, Tylox, Vicodin, Dilaudid, Ultracet...) with an available AB rated generic equivalent will be denied unless it will be provided in a setting that virtually eliminates the risk of diversion. 11. Allergic reactions to any product within a specific narcotic class will justify and preclude use of any other product in the same class due to the risk of cross-hypersensitivity. **Hysingla ER**- Concomitant use should be avoided with mixed agonist/antagonist analgesics, partial agonist analgesics, and MAOIs. Verify prior trials and failures or intolerance of preferred treatments. **Methadone** – Established users must have a trial and failure of at least 2preferred drugs for least 2 weeks. Otherwise they will be allowed 180 days to transition to a preferred product.
	MC/DEL	TRAMADOL HCL TABS 50 mg [2]	MC	8	BUPRENEX SOLN		
	MC/DEL	BUTRANS [4]	MC	8	AVINZA		
	MC/DEL	MORPHINE SULFATE ER TB12	MC	8	BELBUCA		
			MC	8	EXALGO		
			MC/DEL	8	HYSINGLA ER		
			MC	8	KADIAN		
			MC/DEL	8	METHADONE [6]		
			MC/DEL	8	METHADOSE [6]		
			MC/DEL	8	MORPHABOND ER		
			MC/DEL	8	MORPHINE SULFATE ER CAP		
			MC/DEL	8	MORPHINE SULFATE SUPP		
			MC/DEL	8	MS CONTIN TB12		
			MC/DEL	8	ORAMORPH SR TB12		
			MC/DEL	8	OXYCONTIN TB12 [1]		
			MC	8	XARTEMIS ER		
			MC	8	ZOHYDRO ER		
			MC	8	OXYCODONECONC		
			MC/DEL	9	OXYCODONE ER [3,5]		
NARCOTICS - SELECTED	MC/DEL	TRAMADOL HCL TABS 50 mg [2]	MC	8	BUPRENEX SOLN	Use PA Form# 20420 Use PA form #10300 for PAs over the opiate limit 1. Only available if component ingredients are unavailable. 2. Dosing limits apply, please see Dosing Consolidation List.	Preferred drugs from this and other narcotic classes must be tried for at least 2 weeks each and failed due to lack of efficacy or intolerable side effects before non-preferred drugs from this class will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Approvals will not be granted if patient had access to either non-preferred products or high doses of short acting narcotics during the trial period. Substance abuse evaluations may be required for patients with medical records displaying potential signs of narcotic misuse and abuse such as chronic early refills, short dosing intervals, frequent dose increases, multiple lost/stolen etc scripts and intolerance or "allergy" to all products but desired product. Allergic reactions to any product within a specific narcotic class will justify and preclude use of any other product in the same class due to the risk of cross-hypersensitivity. Non-preferred drugs will not be approved for patients showing evidence of usage patterns consistent with controlled substance abuse such as: 1. frequent or persistent early refills of controlled drugs; 2. multiple instances of early refill overrides due to reports of misplacement, stolen, dropped in toilet or sink, distant travel; 3. breaches of narcotic contracts with any provider; 4. failure to comply with patient responsibilities in attached opioid documentation (see PA form) including but not limited to failing to submit to and pass pill counts; 5. failing to take or pass random drug testing; 6. failing to provide old records regarding prior use of narcotics; 7. receiving controlled substances from other prescribers that the provider submitting the PA is unaware of. Substance abuse evaluations may be required for patients with medical records displaying potential signs of narcotic misuse and abuse such as chronic early refills, short dosing intervals, frequent dose increases, multiple lost/stolen etc scripts and intolerance or "allergy" to all products but Oxycontin. Allergic reactions to any product within a specific narcotic class will justify and preclude use of any other product in the same class due to the risk of cross-hypersensitivity. Beginning January 2017, all current opiate users who are above the maximum combined daily dose of 100 MME must titrate their total daily dose of opioid medications below 30 MME. Also, the maximum daily supply of an opiate prescription for acute pain will be limited to 7-day supplies. The maximum day supply of an opiate prescription for chronic pain will be limited to 30-day supplies. As of July 1, 2017 all users of opioid medications must comply with the maximum combined daily dose of 100 MME. However, for MaineCare members, effective January 1, 2017, opioid prescription(s) for more than a 7-day supply and/or more than 30 MME/ day will require a prior authorization. Please note that MaineCare implemented a 30 MME limit January 1, 2013 that is still effective. Post-surgical members may receive prior authorizations for opiates up to 60 days in length if medical necessity is provided by the surgical provider. An MME conversion chart is available at www.mainecarepdl.org. Click on "General Pharmacy Info." **Please see the Pain Management Policy tab for the complete criteria.**
	MC/DEL	TRAMADOL/APAP TABS	MC/DEL	8	BUTORPHANOL		
			MC	8	NALBUPHINE HCL SOLN		
			MC	8	QDOLO SOLN		
			MC	8	SEGLENTIS [1]		
			MC	8	STADOL NS SOLN		
			MC	8	TRAMADOL ER		
			MC	8	ULTRACET TABS [1]		
MISCELLANEOUS NARCOTICS							
NARCOTICS - MISC.	MC/DEL	ACETAMINOPHEN/CODEINE	MC/DEL	8	ABSTRAL	Use PA Form# 20420 Use PA form #10300 for PAs over the opiate limit	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Please refer to General Criteria category E.
	MC/DEL	ASPIRIN/CODEINE TABS	MC/DEL	8	APADAZ		
	MC/DEL	BUTAL/ASA/CAFF/COD CAPS	MC/DEL	8	ASCOMP/CODEINE CAPS		

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
	MC	BUTALBITAL/ASPIRIN/CAFFEI CAPS	MC/DEL	8	BUTALBITAL/APAP/CAFFEINE/ CAPS	1. **Fentanyl OT loz** (Barr) and **Capital and Codeine Suspension** products require PA for users over 18 years of age. PA is not required if under 18 years of age. 2. Oxycodone/Acet 10/650 is 8 times more expensive. Use twice as many of Oxycodone/Acet 5/325 instead. You can mix and match preferred strengths of Oxycodone and Oxycodone/Acet to minimize Acet dose similar to certain non-preferred drugs. 3. Only preferred manufacturer's products will be available without prior authorization.	Beginning January 2017, all current opiate users who are above the maximum combined daily dose of 100 MME must titrate their total daily dose of opioid medications below 30 MME. Also, the maximum daily supply of an opiate prescription for acute pain will be limited to 7-day supplies. The maximum day supply of an opiate prescription for chronic pain will be limited to 30-day supplies. As of July 1, 2017 all users of opioid medications must comply with the maximum combined daily dose of 100 MME. However, for MaineCare members, effective January 1, 2017, opioid prescription(s) for more than a 7-day supply and/or more than 30 MME/ day will require a prior authorization. Please note that MaineCare implemented a 30 MME limit January 1, 2013 that is still effective. Post-surgical members may receive prior authorizations for opiates up to a 60 days in length if medical necessity is provided by the surgical provider. An MME conversion chart is available at www.mainecarepdl.org. Click on “General Pharmacy Info.” **Please see the Pain Management Policy for the complete criteria**
	MC	CAPITAL AND CODEINE SUSP [1]	MC/DEL	8	BUTALBITAL COMPOUND- CODEINE CAP		
	MC/DEL	CODEINE PHOSPHATE SOLN	MC	8	DEMEROL		
	MC/DEL	CODEINE SULFATE TABS	MC/DEL	8	DILAUDID		
	MC/DEL	ENDOCET TABS [3]	MC	8	DILAUDID-HP SOLN		
	MC/DEL	ENDODAN TABS	MC	8	FENTANYL CITRATE SOLN		
	MC/DEL	FENTANYL OT LOZ [1]	MC/DEL	8	FENTORA		
	MC/DEL	HYDROCODONE/ACETAMINOPHEN	MC/DEL	8	FIORICET/CODEINE CAPS		
	MC/DEL	HYDROMORPHONE HCL [3]	MC	8	FIORINAL/CODEINE #3 CAPS		
	MC	LORTAB ELX	MC	8	FIORTAL/CODEINE CAPS		
	MC/DEL	MEPERIDINE SOL	MC/DEL	8	HYDROCODONE/IBUPROFEN		
	MC/DEL	OXYCODONE TAB	MC/DEL	8	HYDROMORPHONE ER		
	MC/DEL	OXYCODONE/ACETAMINOPHEN [2,3]	MC/DEL	8	HYDROMORPHONE RECTAL SUPP		
	MC/DEL	ROXICET	MC	8	IBUDONE		
	MC	ROXIPRIN TABS	MC/DEL	8	**LEVORPHANOL TARTRATE TAB**		
			MC/DEL	8	LORCET		
			MC	8	LORTAB		
			MC	8	MAXIDONE TABS		
			MC/DEL	8	MEPERIDINE TABS		
			MC/DEL	8	NORCO TABS		
			MC/DEL	8	ONSOLIS		
			MC/DEL	8	OXECTA		
			MC/DEL	8	OXYCODONE CAP		
			MC/DEL	8	OXYCODONE/APAP 10/650		
			MC/DEL	8	OXYCODONE/APAP 7.5/500		
			MC/DEL	8	PENTAZOCINE/ACET TABS		
			MC/DEL	8	PENTAZOCINE/NALOXONE TABS		
			MC	8	PERCOCET TABS		
			MC	8	PHRENILIN W/CAFFEINE/CODE CAPS		
			MC/DEL	8	ROXICET 5/500 TABS		
			MC	8	ROXICODONE TABS		
			MC/DEL	8	ROXYBOND		
			MC	8	SYNALGOS-DC CAPS		
			MC	8	TALACEN TABS		
			MC	8	TREZIX		
			MC	8	TYLENOL/CODEINE #3 TABS		
			MC	8	TYLOX CAPS		
			MC	8	XOLOX		
			MC	8	VICODIN		
			MC	8	VICOPROFEN TABS		
			MC	8	ZYDONE TABS		
			MC	9	ACTIQ LPOP		
			MC	9	CONZIP		
			MC	9	OPANA		
OPIOID DEPENDENCE TREATMENTS	MC	SUBOXONE FILM [2]	MC/DEL		BUPRENORPHINE [1]	Use PA form #20200 for Buprenorphine Extended Release Use PA Form #20100 for all others 1. **Buprenorphine** will only be approved for use during pregnancy. 2. See Criteria Section.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Members will continue to be required to follow the criteria listed below: 1. Being used for the treatment of OUD (rather than pain or any other non-FDA approved indication) 2. Induction period for 30 days 3. Max dose of 32 mg for induction 4. Max dose of 24 mg for maintenance 5. There is not more than one opioid fill in member’s drug profile between current fill of **Buprenorphine** and a prior **Buprenorphine** fill within the past 90 days 6. Should provide evidence of monthly monitoring including random pill counts, urine drug tests and use of Maine Prescription Monitoring Program reports. 7. **Buprenorphine** monotherapy is preferred if member is pregnant and dose not > 24 mg day and pregnancy diagnosis is noted on the prescription.
	MC/DEL	BUPRENORPHINE/NALOXONE TABS [2]	MC		ZUBSOLV		
EXTENDED RELEASE BUPRENORPHINE	MC	BRIXADI [1]				Use PA form #20200 for Buprenorphine Extended Release 1. Clinical PA required.	**Brixadi and Sublocade:** The prescriber can attest (and medical record should document) that: −member has a documented history of opioid use disorder (OUD), −XRB is being used for the treatment of OUD (rather than pain or any other non-FDA approved indication) and −member’s total daily dose of sublingual buprenorphine is less than or equal to 24 mg daily. AND at least one of the following is true:
	MC	SUBLOCADE [1]					

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
							−The member's previous use of sublingual buprenorphine has included misuse, overuse, or diversion. −The member is at high risk of overdose (e.g., individuals leaving incarceration or abstinence-based treatment programs; individuals who are unhoused; or those facing potential gaps in care due to delays in care or geographically limited treatment access). −The member has experienced significant medical complications of OUD and/or of injection drug use. Occurrence should be in the last 5 years, or it should be clearly documented that the risk indicated by this infection or complication is ongoing (Examples of medical complications of OUD include: threatened the function of organs or life or limb threatening and required medical and/or surgical therapy. Examples of medical complications of injection drug use include osteomyelitis, endocarditis, renal failure, joint infection or other serious medical complications directly related to OUD.) −The member has treatment-resistant OUD, including those with ongoing illicit substance use in the context of sublingual buprenorphine treatment as documented by positive urine drug screens or other clear objective evidence, and/or further functional decline with explicit documentation of the functional decline. −The member has a significant intolerance of, or documented allergy to, sublingual buprenorphine (either buprenorphine monotherapy or buprenorphine/naloxone combination therapy) that has resulted in the patient's inability to comply with continued treatment using the sublingual product. (A true allergy is usually accompanied by rash, respiratory symptoms, or anaphylaxis. Other complaints such as bad taste, mouth tingling, etc. do not constitute evidence of allergy or significant intolerance. Formulation preference or convenience are not, in and of themselves, indications for using XRB.) −The member is in ongoing treatment with XRB and would like to continue the medication.
OPIOID WITHDRAWAL AGENTS			MC		LUCEMYRA [1]	Use PA Form#20420 1. Clinical PA for appropriate approved use and patient has documented contraindication to **Clonidine**.	
NARCOTIC ANTAGONISTS							
NARCOTIC - ANTAGONISTS	MC/DEL MC MC MC MC MC	NALTREXONE HCL TABS NALOXONE INJ NARCAN NS NALOXONE SPRAY OTC VIVITROL INJ ZIMHI	MC MC MC/DEL		OPVEE [2] KLOXXADO ZURNAI [2]	Use PA Form# 20420 2. For the treatment of adult and pediatric patients 12 years of age and older.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
COX 2 / NSAIDS							
COX 2 INHIBITORS - SELECTIVE / HIGHLY SELECTIVE	MC/DEL MC/DEL MC/DEL MC/DEL	**CELECOXIB [4,5]** KETOROLAC TROMETHAMINE [2,3,5] NABUMETONE TABS [5] MELOXICAM TABS [1,5]	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC		CELEBREX CAPS [4,5] MELOXICAM CAPS [5] **MOBIC [5]** MOBIC SUSP [5] **RELAFEN TABS [5]** **QMIIZ ODT** **VIVLODEX** **VYSCOXA** XIFYRM [5]	Use PA Form# 20420 **1. Meloxicam and Xifyrm have dosing limits allowing one tablet daily of all strengths without PA.** 2. **Ketorolac Tromethamine** is indicated for the short term (up to 5 days) management of moderately severe acute pain that requires analgesic at the opioid level in adults. Not indicated for minor or chronic pain conditions. 3. Ketorolac has dosing limits allowing 24 tablets for a 5-day supply every 30 days. 4. Dosing limits will be set at a maximum of 400mg daily. 5. The FDA has issued a Public Health Advisory warning of the potential for increased cardiovascular risk & GI bleeding with NSAID use.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
NSAIDS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	**CHILDRENS IBUPROFEN** **DICLOFENAC POTASSIUM TABS** **DICLOFENAC SODIUM TABS** **DICLOFENAC SODIUM 1% GEL [1]** **ETODOLAC** **FENOPROFEN CALCIUM TABS** **FLURBIPROFEN TABS** **IBUPROFEN** **INDOMETHACIN** **KETOPROFEN** **MECLOFENAMATE SODIUM CAPS** NAPROSYN SUSP NAPROXEN SUSP **NAPROXEN TABS** **NAPROXEN SODIUM TABS** **NAPROXEN SODIUM CAPS** **NAPROXEN DR TBEC** **OXAPROZIN TABS** **SULINDAC TABS**	MC MC MC MC MC/DEL MC MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC MC/DEL MC	 x **x** x x	ADVIL TABS ANAPROX TABS ANAPROX DS TABS CAMBIA **CATAFLAM TABS** CHILDRENS ADVIL SUSP CHILD'S IBUPROFEN SUSP CHILDREN'S MOTRIN SUSP **CLINORIL TABS** **DAYPRO TABS** **DICLOFENAC GEL** **EC-NAPROSYN TBEC** **ETODOLAC ER 600MG** FELDENE CAPS FLECTOR PATCH INDOCIN LICART **LODINE** LOFENA	Use PA Form# 20420 The FDA has issued a Public Health Advisory warning of the potential for increased cardiovascular risk & GI bleeding with NSAID use. 1. Dosing limits apply, see Dosage Consolidation List.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Approvals will be granted for other requests based on failure of at least one generic NSAID from at least 3 different NSAID classes as described in the COX-II PA form. The FDA has issued a Public Health Advisory warning of the potential for increased cardiovascular risk & GI bleeding with NSAID use. **DDI: Diclofenac** will now be non-preferred and require prior authorization if it is currently being used in combination with lescol.

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
	MC/DEL	**TOLMETIN SODIUM**	MC/DEL		**MOTRIN**		
	MC/DEL	VOLTAREN GEL	MC		NALFON CAPS		
			MC/DEL		NAPRELAN TBCR		
			MC/DEL		NAPROSYN TABS		
			MC/DEL		**NAPROXEN SODIUM TBCR**		
			MC		PENNSAID		
			MC/DEL		**PIROXICAM CAPS**		
			MC		PONSTEL CAPS		
			MC		RELAFEN DS		
			MC		SB IBUPROFEN TABS		
			MC		SPRIX		
			MC		TIVORBEX		
			MC		TOLECTIN		
			MC		V-R IBUPROFEN TABS		
			MC		ZORVOLEX		
NSAID - PPI			MC		PREVACID NAPRA-PAC	Use PA Form# 20420	
			MC/DEL		VIMOVO [1]	1. Use a preferred NSAID and PPI separately.	
RHEUMATOID ARTHRITIS							
RHEUMATOID ARTHRITIS	MC/DEL	ACTEMRA VIALS	MC		AMJEVITA	Use PA Form# 20900	See criteria as listed on Rheumatoid Arthritis PA form.
	MC/DEL	ACTEMRA SYRINGES	MC/DEL		**ARAVA**	1. Dosing limits apply, see Dosage Consolidation List.	Preferred injectable products allowed without PA if trial of a preferred oral agents (azathioprine, hydroxychloroquine, leflunomide, methotrexate, sulfasalazine tabs) are seen in the members drug profile. Dosing limits apply.
	MC/DEL	**ADALIMUMAB-FKJP** [7]	MC		AVTOZMA	2. Established users will be grandfathered.	**Jylamvo** will require using preferred methotrexate if unable please provide clinical rational as why inappropriate.
	MC	AVSOLA	MC/DEL		CIMZIA	3. Clinical PA is required to establish diagnosis and medical necessity.	**Xeljanz** is limited to adults with moderate to severe RA and UC who have had an inadequate response or intolerance to methotrexate. Should not be used concomitantly with biologic DMARDs or potent immunosuppressants.
	MC/DEL	**AZATHIOPRINE**	MC		**COXANTO**	4. Verification of age for appropriate indication.	**Zymfentra**: In adults for maintenance treatment of:
	MC	**ENBREL** [2]	MC/DEL		**CYLTEZO**	5. Treatment failure or intolerance to other forms of preferred methotrexate.	Moderately to severely active ulcerative colitis following treatment with an infliximab product administered intravenously.
	MC	ENBREL SURECLICK [2]	MC/DEL		ENTYVIO	6. See criteria section.	Moderately to severely active Crohn's disease following treatment with an infliximab product administered intravenously.
	MC	**HUMIRA** [1,2,7]	MC		HADLIMA	7. Will not require a PA if at least one systemic drug such as azathioprine, hydroxychloroquine, leflunomide, methotrexate, sulfasalazine tabs) are seen in the members drug profile. Dosing limits apply. 8. See additional criteria on the RA PA form.	**DDI**: The concomitant use of **Xeljanz XR** with biologic DMARDs or potent immunosuppressants such as azathioprine and cyclosporine are not recommended. The concomitant use of **Xeljanz XR** with potent CYP3A4 inducers (e.g. rifampin) is not recommended.
	MC	**KINERET SOLN**	MC/DEL		**HULIO**		
	MC/DEL	LEFLUNOMIDE	MC/DEL		**HYDROXYCHLOROQUINE** [2]		
	MC/DEL	METHOTREXATE	MC/DEL		**HYRIMOZ**		
	MC	ORENCIA	MC/DEL		**ILARIS** [1,3,4]		
	MC/DEL	**RENFLEXIS**	MC/DEL		INFLECTRA		
	MC/DEL	**RINVOQ** [3]	MC		INFLIXIMAB VIAL		
	MC	SIMLANDI [7]	MC		JYLAMVO		
	MC	SIMPONI PEN	MC/DEL		**KEVZARA**		
	MC	SIMPONI AUTOINJECTOR	MC		OLUMIANT		
	MC/DEL	**SULFASALAZINE TABS**	MC		OMVOH		
	MC	**TYENNE** [7,8]	MC		OTREXUP		
	MC/DEL	**XELJANZ** [3,6]	MC		RASUVO [6]		
	MC/DEL	**XELJANZ XR**	MC		**REMICADE**		
			MC		TOFIDENCE		
			MC		VELSIPITY		
			MC/DEL		**XELJANZ XR SOL**		
			MC		XATMEP [5]		
			MC		YUFLYMA		
			MC		YUSIMRY		
			MC		ZYMFENTRA		
ALOPECIA AREATA AGENTS							
ALOPECIA AREATA AGENTS			MC	7	OLUMIANT	Use PA Form# 20420	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved **(in step order)**, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
			MC/DEL	8	LITFULO	1. Clinical PA is required to establish diagnosis and medical necessity.	
			MC	8	LEQSELVI [1]		
MISCELLANEOUS ARTHRITIS							
ARTHRITIS - MISC.	MC	RIDAURA CAPS	MC/DEL		**ARTHROTEC** [1]	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. The individual components of Arthrotec are available without PA.
	MC	MYOCHRYSINE SOLN				1. The individual components of Arthrotec are available without PA.	
LUPUS-SLE							
LUPUS-SLE			MC		BENLYSTA [1]	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved **(in step order)**, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI: Lupkynis** is a sensitive CYP3A4 substrate. Co-administration with strong or moderate CYP3A4 inhibitors increases voclosporin exposure, which may increase the risk of Lupkynis adverse reactions. Co-administration of Lupkynis with strong CYP3A4 inhibitors (e.g. ketoconazole, itraconazole, clarithromycin) is contraindicated. Reduce Lupkynis dosage when co-administered with moderate CYP3A4 inhibitors (e.g. verapamil, fluconazole, diltiazem).
			MC		LUPKYNIS	1. Approvals will require previous trial of corticosteroids, antimalarials, NSAIDS and immunosuppressives.	
			MC		SAPHNELO		

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
PIK3CA-Related Overgrowth Spectrum (PROS)							
PIK3CA-Related Overgrowth Spectrum (PROS)			MC		VIJOICE [1]	Use PA Form# 20420 1. PA required to confirm FDA approved indication.	Preferred drugs must be tried and failed due to lack of efficacy (failure to reach target IOP reduction) or intolerable side effects before non-preferred drugs will be approved **in step-order** unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
MIGRAINE THERAPIES							
MIGRAINE - ERGOTAMINE DERIVATIVES			MC MC MC		BREKIYA D.H.E. 45 SOLN **DIHYDROERGOTAMINE MESYLATE INJ** TRUDHESA	Use PA Form# 10110	Preferred drugs must be tried within the Migraine therapy category and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
MIGRAINE - CARBOXYLIC ACID DERIVATIVES	MC	DIVALPROEX ER TB24	MC		DEPAKOTE ER TB24	Use PA Form# 10110	
MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)--Tabs/Nasal	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	RELPAX [1] **RIZATRIPTAN ODT** **RIZATRIPTAN TABS** SUMATRIPTAN TABS [1] **ZOLMITRIPTAN TAB** [1] NARATRIPTAN HCl TABS [1]	MC MC MC/DEL MC MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		AMERGE TABS [1,2] AXERT TABS [1,2] FROVA TABS [1,2] IMITREX NASAL SPRAY [1] IMITREX TABS [1,2] MAXALT [1,2,3] MAXALT MLT [1,2,3] ONZETRA XSAIL [2] SUMATRIPTAN NASAL SPRAY [1] **ZOLMITRIPTAN ODT** **ZOLMITRIPTAN SPRAY** ZOMIG TABS [1,2] ZOMIG NASAL SPARY [1,2] ZOMIG ZMT TBDP [1,2]	Use PA Form# 10110 1. All drugs in this category have dosing limits. Refer to Dose Consolidation Table. 2. Must fail all preferred products before non-preferred. 3. Established users will be grandfathered.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Quantity limit exceptions will require ongoing therapy with therapeutic doses of highly effective prophylactic medication as listed on the Triptan PA form.
MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)--Injectables	MC MC/DEL MC/DEL	IMITREX CARTRIDGE [1] SUMATRIPTAN SYRINGE [1] SUMATRIPTAN PEN INJCTR [1]	MC/DEL MC MC		TOSYMRA ZEMBRACE [1] IMITREX PEN INJCTR [1]	Use PA Form# 10110 1. Dosing limits apply, see Dosage Consolidation List.	
MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)--Combinations			MC/DEL		TREXIMET [1,2]	Use PA Form# 10110 1. Dosing limits apply, see Dosage Consolidation List. 2. Use preferred **Sumatriptan** and **Naproxen** separately. **Treximet** only available if component ingredients of **Sumatriptan** and **Naproxen** are unavailable.	
MIGRAINE - SELECTIVE SEROTONIN AGONISTS--Combinations			MC		SYMBRAVO [1]	1. Dosing limits apply, see Dosage Consolidation List.	
MIGRAINE - PREVENTATIVE TREATMENT	MC MC/DEL MC/DEL MC/DEL MC/DEL	AIMOVIG [1] AJOVY [1] AJOVY AUTO INJCT [1] EMGALITY SYRINGE [1] 120mg/ml EMGALITY PEN [1] 120mg/ml	MC MC MC		NURTEC ODT QULIPTA VYEPTI [2]	Use PA Form# 10110 1. See criteria section. 2. Dosing limits apply, see Dosage Consolidation List.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Aimovig, Ajovy and Emgality:** The patient is 18 years of age or older AND patient has a diagnosis of episodic migraine (4-14 headache days per month with migraine lasting 4 hours or more) or chronic migraine (≥ 15 headache days per month, of which ≥ 8 are migraine days, for at least 3 months) AND patient has failed or has a contraindication to an adequate trial (≥ 60 days) of at least 2 medications for migraine prophylaxis from at least 2 different classes.
MIGRAINE - ACUTE TREATMENT	MC MC MC	NURTEC ODT [1] SPASTRIN TABS UBRELVY [1]	MC MC MC/DEL MC/DEL MC		BELCOMP-PB SUPP ELYXYB MIGRAZONE CAPS MIGERGOT SUP REYVOW	Use PA Form# 10110 1. Dosing limits apply, see Dosage Consolidation List.	**Nurtec ODT will be preferred after 2 adequate trails of at least two preferred triptans.** **Reyvow** is non-preferred and is indicated for the acute treatment of migraine with or without aura in adults. Reyvow is not indicated for the preventive treatment of migraine. **Ubrelvy** is preferred after 2 adequate trials of at least two preferred triptans for the acute treatment of migraine with or without aura in adults. It is not indicated for migraine prevention. **Zavzpret**: The patient must have a documented side effect, allergy, or treatment failure to preferred oral CGRP Inhibitor and two non-preferred oral CGRP Inhibitors.
GOUT							
GOUT	MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL	**ALLOPURINOL TABS** COLCHICINE TAB **FEBUXOSTAT TAB** MITIGARE **PROBENECID TABS** **PROBENECID/COLCHICINE TABS**	MC/DEL MC MC MC/DEL MC		**COLCHICINE CAP** COLCRYS GLOPERBA ULORIC [1] ZYLOPRIM TABS	Use PA Form# 20420 1. Failure of therapeutic (300mg) dose of **Allopurinol** (failure define as not being able to get uric acid levels below 6mg/dl) or severe renal disease.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** The concomitant use of Gloperba and CYP3A4 inhibitors (e.g. clarithromycin, ketoconazole, grapefruit juice, erythromycin, verapamil, etc.) should be avoided due to the potential for serious and life-threatening toxicity.
MISC.							
ACID SPHINGOMYELINASE DEFICIENCY (ASMD)			MC		XENPOZYME [1,2]	Use PA Form# 20420 1. For treatment of non-central nervous system manifestations of acid sphingomyelinase deficiency (ASMD) in adult & pediatric patients.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
						2. Clinical PA required for appropriate diagnosis and clinical parameters.	
ANESTHETICS - MISC.	MC MC MC	BUPIVACAINE HCL SOLN LIDOCAINE HCL SOLN MARCAINE SOLN	MC MC/DEL MC		SENSORCAINE-MPF SOLN SYNVISC INJ XYLOCAINE SOLN	Use PA Form# 30130	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
COLD AGGLUTININ DISEASE (CAD)			MC		ENJAYMO [1]	Use PA Form# 20420 1. Indicated to decrease the need for red blood cell transfusion due to hemolysis in adults with cold agglutinin disease (CAD).	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
CONGENITAL ADRENAL HYPERPLASIA			MC		CRENESSITY	Use PA Form# 30130	**Crenessity** - As adjunctive treatment to glucocorticoid replacement to control androgens in adults and pediatric patients 4 years of age and older with classic congenital adrenal hyperplasia (CAH).
PRIMARY HYPEROXALURIA TYPE 1 (PH1)			MC MC/DEL		OXLUMO [1] RIVFLOZA	Use PA Form# 20420 1. PA is required to establish diagnosis and medical necessity.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Rivfloza:** The patient has a diagnosis of Primary Hyperoxaluria Type I (PH1) confirmed via genetic testing (identification of alanine: glyoxylate aminotransferase gene (AGXT) mutation) AND urinary oxalate excretion > 0.5mmol/1.73 m2 or urinary oxalate: creatinine ratio is above the upper limit of normal for age AND is at least 9 years of age AND medication is being prescribed by, or in consultation, with a nephrologist or urologist.
SICKLE CELL DISEASE	MC MC MC/DEL MC	DROXIA CASGEVY [2,3] **HYDROXYUREA** LYFGENIA [2,3]	MC MC MC/DEL MC		ADAKVEO ENDARI [1] SIKLOS XROMI	Use PA Form# 20420 1. Evidence of other preferred L-glutamine products utilization and reason for failure. 2. For the treatment of patients ≥ 12 years of age. 3. PA required to confirm FDA approved indication.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
HUTCHINSON- GILFORD PROGERIA SYNDROME (HGPS)			MC		ZOKINVY [1,2]	Use PA Form# 20420 1. In patients 12 months of age and older with a body surface area (BSA) of 0.39m2 and above. 2. PA required to confirm FDA approved indication.	**ZOKINVY**: To reduce the risk of mortality in Hutchinson-Gilford Progeria Syndrome (HGPS). For the treatment of processing-deficient Progeroid Laminopathies with either: Heterozygous LMNA mutation with progerin-like protein accumulation OR Homozygous or compound heterozygous ZMPSTE24 mutations.
OBSTRUCTIVE SLEEP APNEA			MC		ZEPBOUND	Use PA Form# 20420	**Zepbound** for adults with a BMI ≥ 30 mg/kg2 and diagnosis of moderate to severe OSA, confirmed by sleep study within the last 3 years documenting AHI ≥ 15, AND in which CPAP is ineffective (AHI > 5 during therapeutic section of sleep study) or patient is unable to tolerate CPAP for at least 90 days AND for whom lifestyle modifications have been attempted for at least 3 months with failure to achieve weight loss. **Note**: Not for patients with T1DM, T2DM.
VACCINES	MC/DEL MC MC/DEL MC MC/DEL	ABRYSVO AREXVY GARDASIL 9 MRESVIA SHINGRIX				Use PA Form# 20420	**Gardasil** 9 will be preferred by MaineCare for ages 19-45 for FDA approved indications. Under the Maine Immunization Program Gardasil 9 is covered under the Vaccine for Children Program for ages 9-18. Please contact 1-800-867-4775 or 207-287-3746 for assistance. **Abrysvo, Arexvy, and Mresvia** are preferred vaccines for respiratory syncytial virus (RSV) for members aged 50-74 who are at high risk of infection and members aged 75 and older . **Abrysvo** is preferred for immunization of pregnant individuals at 32 through 36 weeks gestational age for the prevention of RSV in infants from birth through 6 months of age. **Shingrix** is preferred for prevention of shingles for immunocopetent members aged 50 and older.
APDS			MC		JOENJA [1,2,3]	Use PA Form# 20420 1. Clinical PA required for appropriate diagnosis. 2. For the treatment of patients ≥ 2 years of age. 3. Avoid CYP3A drug interaction.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ALPHA- MANNOSIDOSIS			MC		LAMZEDE	Use PA Form# 20420 1. Clinical PA required for appropriate diagnosis.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTI-CONVULSANTS							
ANTICONVULSANTS	MC/DEL MC/DEL MC MC MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL	BRIVIACT CARBAMAZEPINE CARBAMAZEPINE ER CAP CARBAMAZEPINE SUS CARBATROL CP12 CELONTIN CAPS **CLOBAZAM** CLONAZEPAM TABS DEPAKOTE SPRINKLES CPSP DIAZEPAM GEL [1] DILANTIN	MC MC MC MC MC MC/DEL MC MC MC/DEL MC/DEL MC/DEL	8 8 8 8 8 8 8 8 8 8 8	APTIOM BANZEL DEPAKOTE DEPAKOTE ER DIACOMIT DIVALPROEX SODIUM SPRINKLE CAPS ELEPSIA XR [9] EPRONTIA SOLN [10] FELBATOL FELBATOL SUS FELBAMATE SUS	Use PA Form# 20420 **All non-preferred meds must be used in specified order.** 1. Quantity limit: 5/month 2. Dosing limits apply, see Dosage Consolidation List. 3. Dosing limits apply per strength as well as a maximum daily dose of 600mg. Please see Dose Consolidation List. 4. Adjunctive therapy 17 and older. 5. Max dose 2400mg.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Approvals will be for patients with a variety of drug-specific FDA-approved indications and for specific conditions supported by at least two published peer-reviewed double-blinded, placebo-controlled randomized trials that are not contradicted by other studies of similar quality after recommendation by the DUR Committee and as long as all first line therapies have been tried and failed at full therapeutic doses for adequate durations (at least two weeks). **Topamax and Neurontin** - Second line therapy for migraine prophylaxis after trial of at least three preferred preventive medications from Group 1 listed on page 2 of the Acute Migraine PA form. **All non-preferred meds must be used in specified order.** **Diacomit** is for the treatment of seizures associated with Dravet syndrome (DS) in patients 6 months of age and older and weighing 7kg or more There are no clinical data to support the use of Diacomit as monotherapy in DS.

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
	MC/DEL	DIVALPROEX SODIUM	MC	8	FINTEPLA [8]	6. Clinical PA required for appropriate diagnosis. 7. **Epidiolex** is for the treatment of seizures associated with Lennox-Gastaut syndrome (LGS), Dravet syndrome (DS) or TS (Tuberous Sclerosis Complex) in patients 1 years of age and older. 8. For seizures associated with Dravet syndrome in patients 2 years of age and older. 9. Adjunctive therapy 12 and older. 10. Initial monotherapy for the treatment of partial-onset or primary generalized tonic-clonic seizures in patients 2 years of age and older. Adjunctive therapy for the treatment of partial-onset seizures, primary generalized tonic-clonic seizures, and seizures associated with Lennox Gastaut syndrome in patients 2 years of age and older. The preventive treatment of migraine in patients 12 years and older. Will require a step though **Topiramate**.	**Xcopri** criteria: History of trials with at least 4 AEDs (2 generic, 2 branded) or Uncontrolled seizures on three AEDs; or Uncontrolled on 2 AEDs given along with VNS. Uncontrolled defined as 3 or more TC seizures per year (increases risk of SUDEP); > 6 disabling seizures per year. Any patient who has gone to the ED 2 or more times in the prior 12 months (who has also tried and failed at least 3 other drugs). Ongoing use requires 50 percent reduction in seizure frequency after three months. **Motpoly XR:** pediatric patient weight must be > 50kg and requires multiple preferred medication trials including generic lacosamide. **Libervant:** For the acute treatment of intermittent, stereotypic episodes of frequent seizure activity (i.e., seizure clusters, acute repetitive seizures) that are distinct from a patient's usual seizure pattern in patients with epilepsy 2 to 5 years of age as long as all preferred therapies have been tried and failed at full therapeutic doses. **Vigafyde:** Indicated as monotherapy for the treatment of infantile spasms in pediatric patients 1 month to 2 years of age for whom the potential benefits outweigh the potential risk of vision loss. **Epidiolex** Criteria for Lennox-Gastaut syndrome (LGS) and Dravet: a trial of two drugs (clobazam, levetiracetam, valproate derivatives, lamotrigine, topiramate, rufinamide, or felbamate). **Please use Drug-Drug Interaction PA form #10400 for this combination.** ***** SEE CHART AT END OF DOCUMENT ***** **DDI**: Concomitant use of **Diacomit** with other CNS depressants, including alcohol, may increase the risk of sedation and somnolence. Concomitant use of strong inducers (CYP1A2, CYP3A4, or CYP2C19 inducers, such as rifampin, phenytoin, phenobarbital, and carbamazepine) should be avoided, or dosage adjustments should be made. **DDI:** Avoid concomitant use of **Nayzilam** with moderate or strong CYP3A inhibitors.
	MC	DIVALPROEX SPRINKLE CAP	MC	8	FYCOMPA [2]		
	MC/DEL	EPIDIOLEX [7]	MC/DEL	8	HORIZANT		
	MC/DEL	EPITOL TABS	MC	8	GRALISE		
	MC/DEL	ETHOSUXIMIDE SYRP	MC/DEL	8	KEPPRA TABS		
	MC/DEL	EQUETRO	MC/DEL	8	KEPPRA SOLN		
	MC/DEL	GABAPENTIN CAP [2]	MC/DEL	8	KLONOPIN TABS		
	MC/DEL	GABAPENTIN TAB [2]	MC	8	LAMICTAL IR		
	MC/DEL	GABAPENTIN SOL	MC	8	LAMICTAL ODT		
	MC/DEL	GABITRIL TABS	MC	8	LAMICTAL XR		
	MC/DEL	**LACOSAMIDE SOL**	MC/DEL	8	**LEVETIRACETAM INJ**		
	MC/DEL	**LACOSAMIDE TAB**	MC	8	LIBERVANT		
	MC	LAMICTAL CHEW	MC/DEL	8	LYRICA CR		
	MC/DEL	LAMOTRIGINE ER ODT	MC	8	MOTPOLY XR		
	MC/DEL	LAMOTRIGINE IR [2]	MC	8	ONFI		
	MC/DEL	LAMOTRIGINE XR	MC	8	OXTELLAR XR [5]		
	MC/DEL	LEVETIRACETAM SOLN	MC/DEL	8	PHENYTEK CAPS		
	MC/DEL	LEVETIRACETAM TABS	MC/DEL	8	POTIGA		
	MC/DEL	**LEVETIRACETAM ER TABS**	MC/DEL	8	PREGABALIN (ORAL) SOL		
	MC/DEL	LYRICA [3]	MC	8	ROWEEPRA TAB		
	MC/DEL	LYRICA SOL [3]	MC	8	SABRIL		
	MC/DEL	NAYZILAM [1]	MC	8	SEZABY		
	MC/DEL	OXCARBAZEPINE	MC	8	SPRITAM		
	MC/DEL	OXCARBAZEPINE SUS	MC	8	SYMPAZAN		
	MC/DEL	PREGABALIN CAPS	MC/DEL	8	TEGRETOL TAB		
	MC/DEL	PHENYTOIN	MC/DEL	8	TIAGABINE		
	MC/DEL	QUDEXY XR	MC	8	TOPAMAX		
	MC/DEL	TEGRETOL SUS	MC/DEL	8	TOPIRAMATE ER CAPS		
	MC/DEL	TOPIRAMATE	MC	8	TOPAMAX SPRINKLE ER CAPS [2]		
	MC/DEL	TOPIRAMATE SPRINKLE IR CAPS	MC	8	TOPAMAX SPRINKLE IR CAPS [2]		
	MC/DEL	TRILEPTAL SUS	MC/DEL	8	TOPIRAMATE SPRINKLE ER CAPS [2]		
	MC/DEL	VALPROIC ACID TABS	MC	8	TROKENDI [2,6]		
	MC/DEL	VALPROIC ACID SOL	MC	8	VIGAFYDE		
	MC	VALTOCO [2]	MC/DEL	8	VIMPAT [4]		
	MC/DEL	ZONISAMIDE	MC/DEL	8	VIMPAT SOL [4]		
			MC	8	XCOPRI		
			MC/DEL	8	ZARONTIN SYRP		
			MC/DEL	8	ZARONTIN CAP		
			MC/DEL	8	ZARONTIN SOL		
			MC	8	ZONISADE		
			MC	8	ZTALMY		
			MC/DEL	9	KEPPRA XR		
			MC/DEL	9	NEURONTIN		
			MC/DEL	9	TEGRETOL-XR TB12		

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
					BIPOLAR DISORDER: STEP ORDER	**SEE ANTICONVULSANT INDICATION CHART AT THE END OF THIS DOCUMENT**	
				M ~ A			
				4 ~ 4	LAMICTAL	M= Monotherapy A= Adjunctive 9= No Evidence The step orders show the relative strength of evidence for use in bi-polar and will guide prior authorization determinations. Step 4 drugs-no PA required.	
				4 ~ 4	LITHIUM		
				4 ~ 4	CARBAMAZEPINE		
				4 ~ 4	VALPROATE		
				4 ~ 4	ATYPICAL ANTIPSYCHOTICS EXC. CLOZAPINE		
				5 ~ 5	TRILEPTAL		
				9 ~ 6	TOPAMAX		
				9 ~ 7	KEPPRA TABS		
				9 ~ 8	GABITRIL TABS		
				9 ~ 9	NEURONTIN		
					PEDIATRIC BIPOLAR1 DISORDER: STEP ORDER		
				M ~ A	(6-18 YEARS WITH OR WITHOUT PSYCHOSIS)	Two-step 1 preferred drugs must be tried before **Trileptal**. The step orders show the relative strength of evidence for use in bi-polar and will guide prior authorization determinations. Step 4 drugs-no PA required.	
				4 ~ 4	LITHIUM		
				4 ~ 4	CARBAMAZEPINE		
				4 ~ 4	VALPROATE		
				4 ~ 4	ATYPICAL ANTIPSYCHOTICS EXC.CLOZAPINE		
				4 ~ 4	LAMICTAL		
				5 ~ 5	TRILEPTA		
ANTI-PARKINSON DRUGS							
PARKINSONS - ANTICHOLINERGICS	MC/DEL MC MC/DEL	BENZTROPINE MESYLATE TABS COGENTIN SOLN **TRIHEXYPHENIDYL**				Use PA Form# 20420	
PARKINSONS - ADENOSINE RECEPTOR ANTAGONIST			MC/DEL		**NOURIANZ**	Use PA Form# 20420	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Avoid use of **Nourianz** with strong CYP3A4 inducers (e.g. carbamazepine, rifampin, phenytoin, St. John's wort).
PARKINSONS - COMT INHIBITORS			MC/DEL MC		**COMTAN TABS** ONGENTYS	Use PA Form# 20420	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
PARKINSONS - SELECTED DOPAMIN AGONISTS	MC/DEL MC/DEL	**PRAMIPEXOLE** **ROPINIROLE** **NEUPRO PATCH**	MC/DEL MC MC/DEL	5 8 8	**MIRAPEX TABS** [1] **REQUIP TABS** **MIRAPEX ER**	Use PA Form# 20420 1. As of 12/08 users of Mirapex will be grandfathered if diagnosis is Parkinson's.	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved **in step-order**, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
PARKINSONS- MAOIS			MC		XADAGO	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
PARKINSONS - DOPAMINERGICS/ CARBII/ LEVO	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL	**AMANTADINE HCL CAPS** **AMANTADINE HCL TABS** **BROMOCRIPTINE MESYLATE TABS** **BROMOCRIPTINE MESYLATE CAPS** **CARBIDOPA/LEVODOPA TABS** [3] **CARBIDOPA/LEVODOPA ER** **CARBIDOPA/LEVO/ENTACAPONE TAB** LARODOPA TABS **SELEGILINE CAPS HCL**	MC/DEL MC MC/DEL MC MC MC MC/DEL MC MC MC MC/DEL MC/DEL MC MC MC MC		**APOKYN** AZILECT [2] **CARBIDOPA/LEVODOPA RAPDIS** CREXONT [4] ELDEPRYL CAPS GOCOVRI **INBRIJA** KYNMOBI ONAPGO OSMOLEX ER **PARLODEL CAPS** **PARLODEL TABS** RYTARY SINEMET TABS SINEMET TBCR VYALEV	Use PA Form# 20420 1. Approvals will require concurrent therapy with **Levodopa** and failed trials of **Comtan** and **Stalevo**. 2. Approvals will require trials of Carbidopa/-Levodopa, Comtan, and Stalevo. 3. Only preferred manufacturer's products will be available without prior authorization. 4. Approvals will require trials of preferred medications including extended-release levodopa/carbidopa tablets.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Inbrija** is recommended for the intermittent treatment of OFF episodes in patients with Parkinson's disease treated with carbidopa/levodopa.
PARKINSONS - COMBO.			MC/DEL MC		STALEVO [1] CARBIDOPA/LEVODOPA/ENTACA [1]	Use PA Form# 20420 1. Clinical PA is required to establish diagnosis and medical necessity.	

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
MUSCLE RELAXANTS							
MUSCLE RELAXANTS	MC/DEL	**BACLOFEN TABS**	MC/DEL	7	**ORPHENADRINE CITRATE**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. At least 4 preferred drugs (including tizanidine) must be tried for at least 2 weeks and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the PA form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Elderly patients, over 65, will require written notice of the increased sedative risks and impaired driving. Prior Authorization will not be given for: 1. frequent or persistent early refills of controlled drugs; 2. multiple instances of early refill overrides due to reports of misplacement, stolen, dropped in toilet or sink, distant travel, etc. **Non-preferred products must be used in specified step order.** Non-preferred drugs will not be approved if members circumventing MaineCare prior authorization requirements by paying (prescribers failed to submit prior authorization prior to cash narcotic scripts being filled by member). **Lorzone** is non preferred and requires at least 4 preferred drugs (including tizanidine) and step care therapy (orphenadrine), as well as reasons for why chlorzoxazone is not acceptable.
	MC/DEL	**CHLORZOXAZONE TABS**	MC/DEL	8	**CARISOPRODOL 350MG TABS**		
	MC/DEL	**CYCLOBENZAPRINE HCL 5mg & 10mg TABS**	MC/DEL	8	AMRIX		
			MC/DEL	8	DANTRIUM CAPS		
	MC	LIORESAL INTRATHECAL KIT	MC	8	FLEQSUVY		
	MC/DEL	**METHOCARBAMOL TABS**	MC	8	LIORESAL TABS		
	MC/DEL	**TIZANIDINE HCL TABS**	MC	8	LORZONE		
			MC	8	LYVISPAH		
			MC/DEL	8	**METAXALONE**		
			MC	8	NORFLEX TBCR		
			MC	8	OZOBAX		
			MC	8	ROBAXIN-750 TABS		
			MC	8	VECUROMIUM INJ		
			MC/DEL	8	**ZANAFLEX TABS**		
			MC/DEL	9	**CARISOPRODOL 250MG TABS**		
			MC/DEL	9	**CHLORZOXAZONE 250mg TABS**		
			MC/DEL	9	**SKELAXIN TAB**		
			MC/DEL	9	**SOMA TABS**		
			MC	9	**TANLOR**		
MUSCLE RELAXANT - COMBO.			MC/DEL		CARISOPRODOL/ASPIRIN TABS	Use PA Form# 20420	Individual components are available with PA described in the section above. 1. frequent or persistent early refills of non-controlled drugs; 2. multiple instances of early refill overrides due to reports of misplacement stolen, dropped in toilet or sink, distant travel, etc.
			MC/DEL		CARISOPRODOL/ASPIRIN/CODE		
			MC		NORGESIC TABS		
			MC/DEL		ORPHENADRINE COMPOUND		
			MC/DEL		ORPHENADRINE/ASA/CAFF		
			MC		ORPHENGESIC		
PARATHYROID HORMONE							
PARATHYOID HORMONE			MC		NATPARA [1]	Use PA Form# 20420 1. Recommended only for those who cannot be well-controlled on calcium supplements and active forms of vitamin D alone.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
			MC		YORVIPATH [1]		
VITAMINS							
VITAMINS	MC	CYANOCOBALAMIN SOLN	MC		AQUASOL E SOLN	Use PA Form# 20420 **Please refer to OTC list for covered products.** Click here for the OTC List	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Certain drugs require specific diagnoses for approval. **DDI:** B-12 will now be non-preferred and require prior authorization if it is currently being used in combination with either prevacid, pantoprazole, prilosec, or any currently non preferred PPI. Please refer to OTC List for covered products. Preferred products that used to require diag codes still require diag codes unless indicated otherwise.
	MC	FERIVA CAP	MC		AQUAVIT-E SOLN		
	MC	FERIVAFA CAP	MC		DHT SOLN		
	MC/DEL	FOLIC ACID TABS	MC		FUSION PLUS CAP		
	MC/DEL	MEPHYTON TABS	MC		HEMOCYTE PLU CAP		
	MC/DEL	NIACIN	MC		INTEGRA CAP		
	MC	NIACOR TABS	MC		INTEGRA F CAP		
	MC/DEL	NICOTINIC ACID SR CPCR	MC		INTEGRA PLUS CAP		
	MC	PYRIDOXINE HCL TABS	MC		NASCOBAL GEL		
	MC	TANDEM CAP	MC		TANDEM PLUS CAP		
	MC/DEL	THIAMINE HCL SOLN					
	MC/DEL	VITAMIN B-1 TABS					
	MC/DEL	VITAMIN B-12					
	MC	VITAMIN B-6 TABS					
	MC/DEL	VITAMIN C					
	MC/DEL	VITAMIN E CAPS					
	MC/DEL	VITAMIN E/D-ALPHA CAPS					
	MC	VITAMIN K1 SOLN					
	MC	V-R VITAMIN E CAPS					
VITAMIN D's	MC/DEL	**CALCITRIOL CAPS** [1]	MC		CALCIJEX	Use PA Form# 20420 1. Diagnosis of dialysis (renal failure) required. 2. Only specific NDCs available.	Preferred products require dialysis/renal failure diagnosis. **Rayaldee** requires clinical PA to verify stage 3 or 4 CKD.
	MC/DEL	**ROCALTROL**	MC/DEL		**DOXERCALCIF CAP**		
	MC/DEL	**VITAMIN D2** [2]	MC/DEL		**DOXERCALCIF INJ**		
	MC/DEL	**VITAMIN D3** [2]	MC/DEL		**PARICALCITROL CAP**		
	MC/DEL	**VITAMIN DROPS**	MC/DEL		**PARICALCITROL INJ**		
	MC	PARICALCITOL CAPS	MC/DEL		HECTOROL (ORAL)		
			MC/DEL		HECTOROL (PARENTERAL)		
			MC		RAYALDEE		
			MC		ZEMPLAR INJ		
			MC		ZEMPLAR CAPS		

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
EMZYMES							
POMPE DISEASE AGENTS			MC		NEXVIAZYME [1]	Use PA Form# 20420 1. For patients 1 year of age and older with late-onset Pompe disease (lysosomal acid alpha-glucosidase [GAA] deficiency).	All preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved **(in step-order)**, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Pombiliti and Opfolda** are for the treatment of adult patients with late-onset Pompe disease (lysosomal acid alpha-glucosidase [GAA] deficiency) weighing ≥40kg and who are not improving on their current enzyme replacement therapy (ERT).
			MC		LUMIZYME		
			MC		OPFOLDA		
			MC		POMBILITI		
MISC MULTI-VITAMINS							
VITAMINS - MISC.	MC	CENTRUM TABS	MC		ADEKS	Use PA Form# 20420 1. Diag codes are no longer required on prenatal vitamins. Click here for the OTC List	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Certain drugs require specific diagnoses for approval. Please refer to OTC List for covered products. Preferred products that used to require diag codes still require diag codes unless indicated otherwise.
	MC	CENTRUM JR/IRON CHEW	MC/DEL		ADVANCED NATALCARE TABS		
	MC	CENTRUM-LUTEIN TABS	MC		AQUADEKS		
	MC	CEROVITE ADVANCED FO TABS	MC		CENTRUM JR/EXTRA C CHEW		
	MC/DEL	CHEWABLE MULTIVIT/FL CHEW	MC		CENTRUM PERFORMANCE TABS		
	MC	COD LIVER OIL CAPS	MC		CENTRUM SILVER TABS		
	MC/DEL	COMPLETE NATAL DHA (ORAL) COMBO PKG	MC		DALYVITE LIQD		
			MC		EMBREX 600 MISC		
	MC	COMPLETE SENIOR TABS	MC		FERRALET 90		
	MC	DAILY MULTI VIT/IRON	MC		IBERET		
	MC/DEL	DIALYVITE 1MG	MC		MATERNA TABS		
	MC/DEL	DIALYVITE 800MG	MC		MAXARON		
	MC/DEL	FULL SPECTRUM B	MC		MULTIRET FOLIC -500 TBCR		
	MC	M.V.I.-12 INJ	MC/DEL		NATAFORT TABS		
	MC	MULTI-VIT/FLUORIDE	MC/DEL		NATALCARE CFE 60 TABS [1]		
	MC/DEL	NATALCARE RX TABS	MC/DEL		NATALCARE GLOSS TABS [1]		
	MC/DEL	NEPHRONEX	MC		NATALCARE PIC TABS [1]		
	MC/DEL	NIVA-PLUS (ORAL) TABLET	MC		NATALCARE PIC FORTE TABS [1]		
	MC/DEL	ONE DAILY TABS	MC/DEL		NATALCARE PLUS TABS [1]		
	MC/DEL	ONE-DAILY MULTIVITAMINS	MC		NATALCARE THREE TABS [1]		
	MC/DEL	ONE-TABLET-DAILY	MC/DEL		NATACHEW CHEW		
	MC/DEL	POLY-VIT/IRON/FLUORID SOLN	MC		NATALFIRST TABS		
	MC/DEL	POLY-VITAMIN/FLUORIDE SOLN	MC		NATATAB RX TABS		
	MC/DEL	POLY-VITAMINS/IRON SOLN	MC/DEL		NEPHPLEX RX TABS		
	MC	PRENATA (ORAL) TAB CHEW	MC/DEL		NEPHROCAPS CAPS		
	MC/DEL	PRENATAL TABS [1]	MC/DEL		NEPHRO-VITE TABS		
	MC/DEL	PRENATAL FORMULA 3 TABS [1]	MC		NESTABS RX TABS		
	MC/DEL	PRENATAL PLUS TABS [1]	MC/DEL		NIFEREX		
	MC/DEL	PRENATAL PLUS NF TABS [1]	MC/DEL		OCUVITE TABS		
	MC	PRENATAL PLUS/27MG IRON [1]	MC		POLY-VI-FLOR SOLN		
	MC	PRENATAL PLUS/IRON TABS [1]	MC		POLY-VI-SOL SOLN		
	MC	PRENATAL VITAMIN PLUS LOW IRON (ORAL) TABLET	MC		POLY-VI-SOL/IRON SOLN		
			MC		POLY-VITAMIN DROPS SOLN		
	MC/DEL	PRENATAL RX/BETA-CAROTENE [1]	MC		PRECARE		
	MC/DEL	PREPLUS (ORAL) TABLET	MC		PREFERA OB		
	MC/DEL	RENAL CAPS	MC		PREMESIS RX TABS		
	MC/DEL	RENAPHRO CAPS	MC		PRENATABS CBF TABS [1]		
	MC	STRESS TAB NF TABS	MC		PRENATAL CARE TABS [1]		
	MC	THERAPEUTIC-M TABS	MC		PRENATAL MR 90 TBCR [1]		
	MC	THERAVITE LIQD	MC/DEL		PRENATAL MTR/SELENIUM TABS [1]		
	MC/DEL	TRINATAL RX 1 (ORAL) TABLET	MC		PRENATAL OPTIMA ADVANCE TABS [1]		
	MC/DEL	TRIVEEN-DUO DHA (ORAL) COMBO. PKG	MC		PRENATAL PC 40 TABS [1]		
	MC/DEL	TRI-VITAMIN/FLUORIDE SOLN	MC/DEL		PRENATAL RX TABS [1]		
	MC	VITA CON FORTE CAPS	MC		PRENATE [1]		
	MC	VITAPLEX PLUS TABS	MC		PRENATE ELITE [1]		
			MC		PRIMACARE MISC		
			MC		PROTEGRA CAPS		
			MC		STUARTNATAL PLUS 3 TABS [1]		
			MC		TRI-VI-SOL SOLN		
			MC		TRI-VI-SOL/IRON SOLN		
			MC/DEL		ULTRA NATALCARE TABS		
			MC		ULTRA-NATAL TABS [1]		
			MC		VICON FORTE CAPS		
			MC		VINATAL FORTE TABS [1]		
			MC		VINATE [1]		
			MC/DEL		VINATE ADVANCED TABS [1]		

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
MISCELLANEOUS MINERALS							
MINERALS	MC	CALCARB	MC		ANEMAGEN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Certain drugs require specific diagnoses for approval.
	MC	CALCI-MIX CAPSULE CAPS	MC		CALCET TABS	**Please refer to OTC list for covered products.**	
	MC	CALCIQUID SYRP	MC/DEL		**CALCIUM 600-D TABS**		**DDI:** Fe salts will now be non-preferred and require prior authorization if it is currently being used in combination with either prevacid, pantoprazole, prilosec, or any currently non preferred PPI.
	MC	CALCITRATE/VITAMIN D TABS	MC		CALCIUM/VITAMIN D TABS		
	MC/DEL	CALCIUM	MC		CALTRATE 600 PLUS/VIT D TABS		
	MC/DEL	CALCIUM CARBONATE	MC		CALTRATE PLUS TABS		
	MC/DEL	CALCIUM CITRATE TABS	MC		CHROMAGEN		
	MC/DEL	CALCIUM GLUCONATE TABS	MC		CITRACAL PLUS TABS	Click here for the OTC List	Please refer to OTC List for covered products.
	MC/DEL	CALCIUM LACTATE TABS	MC		CONTRIN CAPS		Preferred products that used to require diag codes still require diag codes unless indicated otherwise.
	MC	CALCIUM/MAGNESIUM TABS	MC		FEOGEN FORTE CAPS		
	MC/DEL	**CALCIUM/VITAMIN D TABS**	MC		FEROCON CAPS		
	MC	CALTRATE 600 TABS	MC/DEL		FERREX 150 CAPS		
	MC/DEL	CHEWABLE CALCIUM CHEW	MC		FERRO-SEQUELS TBCR		
	MC	CITRACAL TABS	MC		FE-TINIC CAPS		
	MC	CITRACAL + D TABS	MC		FE-TINIC 150 FORTE CAPS		
	MC	CITRUS CALCIUM TABS	MC/DEL		FLUOR-A-DAY SOLN		
	MC	CITRUS CALCIUM 1500 + D TABS	MC		HEMOCYTE TABS		
	MC	EFFERVESCENT POTASSIUM TBEF	MC/DEL		K-DUR TBCR		
	MC/DEL	FEOSTAT CHEW	MC		KLOR-CON PACK		
	MC	FERATAB TABS	MC		K-LYTE		
	MC/DEL	FER-GEN-SOL SOLN	MC/DEL		K-PHOS TABS NEUTRAL		
	MC	FER-IRON SOLN	MC		K-TABS TBCR		
	MC	FERRONATE TABS	MC		K-VESCENT PACK		
	MC/DEL	FERROUS SULFATE	MC		MICRO-K 10 MEG CPCR		
	MC/DEL	FLUOR-A-DAY CHEW	MC		NU-IRON 150 CAPS		
	MC	FLUORIDE CHEW	MC/DEL		**OYSTER SHELL CALCIUM/VITA TABS**		
	MC	FLUORIDE SODIUM CHEW	MC/DEL		POLY-IRON 150 CAPS		
	MC	FLUORITAB CHEW	MC/DEL		POLYSACCHARIDE IRON CAPS		
	MC	HM CALCIUM TABS	MC/DEL		POTASSIUM BICARB/CHLORIDE		
	MC	K+ POTASSIUM PACK	MC/DEL		POTASSIUM CHLORIDE 10MEQ CAPS		
	MC	KAON ELIX	MC/DEL		POTASSIUM CHLORIDE 8MEQ CAPS		
	MC	KAON-CL-10 TBCR	MC		TUMS 500 CHEW		
	MC	KCL 0.075% / D5W / NACL 0.2% SOLN	MC		VIACTIV CHEW		
	MC	K-EFFERVESCENT TBEF					
	MC	KLOR-CON					
	MC	KLOTRIX TBCR					
	MC/DEL	K-PHOS TABS					
	MC/DEL	K-VESCENT TBEF					
	MC/DEL	LURIDE CHEW					
	MC/DEL	MAGNESIUM GLUCONATE TABS					
	MC/DEL	MAGNESIUM SULFATE SOLN					
	MC	MAGTABS					
	MC	MICRO-K 8 MEG					
	MC/DEL	OS-CAL TABS					
	MC/DEL	**OS-CAL 500 + D TABS**					
	MC/DEL	**OYSCO**					
	MC/DEL	OYST-CAL TABS					
	MC/DEL	**OYST-CAL D TABS**					
	MC/DEL	**OYST-CAL/VITAMIN D TABS**					
	MC/DEL	OYSTER CALCIUM TABS					
	MC/DEL	OYSTER SHELL					
	MC	PHARMA FLUR					
	MC/DEL	PHOSPHA 250 NEUTRAL TABS					
	MC	POTASSIUM BICARBONATE TBEF					
	MC/DEL	POTASSIUM CHLORIDE 8MEQ					
	MC	POTASSIUM EFFERVESCENT					
	MC/DEL	SELENIUM TABS					
	MC	SLOW-MAG TBCR					
	MC/DEL	SODIUM FLUORIDE					
	MC	V-R CALCIUM					
	MC	V-R OYSTER SHELL CALCIUM					
	MC	ZINC SULFATE CAPS					

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
PHENYLKETONURIA (PKU) TREATMENT AGENTS							
PHENYLKETONURIA (PKU) TREATMENT AGENTS- INJECTABLES			MC		PALYNZIQ [1]	Use PA Form# 20420 1. For the treatment of patients ≥ 18 yrs of age.	**Palynziq** is not to be used in combination with kuvan.
PHENYLKETONURIA (PKU) TREATMENT AGENTS- ORAL			MC		CYSTADANE (ORAL) POWDER 1G/SCOOP	Use PA Form# 20420 1. Clinical PA is required to establish diagnosis and medical necessity. 2. For adults and pediatric patients one (1) month of age and older who have tried and failed or have a contraindication or intolerance to Sapropterin Dihydrochloride products.	
			MC		JAVYGTOR (ORAL) TABLET SOL 100 MG		
			MC		JAVYGTOR (ORAL) POWD PACK 100 MG		
			MC		JAVYGTOR (ORAL) POWD PACK 500 MG		
			MC		KUVAN		
			MC/DEL		SAPROPTERIN DIHYDROCHLORIDE (ORAL) TABLET SOL 100 MG		
			MC/DEL		SAPROPTERIN DIHYDROCHLORIDE (ORAL) POWD PACK 100 MG		
			MC		SAPROPTERIN DIHYDROCHLORIDE (ORAL) POWD PACK 500 MG		
			MC		SEPHIENCE [1,2]		
MISC. ELECTROLYTES/NUTRITIONALS							
ELECTROLYTES/ NUTRITIONALS	MC	INTRALIPID EMUL [1]	MC		BOOST [1]	Use PA Form# 20420 & SGA Form 1. This list of nutritionals is incomplete. All nutritionals still require a PA except for the miscellaneous products listed as preferred. SGA form required for nutritionals unless member has a G/I tube. 2. Formerly known as **Omacor**.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Certain drugs require specific diagnoses for approval. Medical foods are not to be authorized solely for the purpose of enhancing nutrient intake or managing body weight if the participant is able to eat conventional foods adequately. Medical foods may be approved if the member has a medical condition which precludes or restricts the use of conventional foods and necessitates the use of a formula. Concurrent Stimulant therapy is not an acceptable medical reason/condition for use of medical foods for enhancing nutrient intake or managing body weight. For children under the age of 5, MaineCare will not provide milk- or soy-based standard infant formulas. Regular formulas may be sought through your nearest WIC office. MaineCare will continue to cover medical food for all participants in MaineCare when medical necessity is met. **Vascepa** requires adjunct therapy for specific indication to reduce TG in those with severe hypertriglyceridemia (500mg per deciliter or more). Proper indication per lab values is required before approval.
	MC	P.T.E. -5 SOLN [1]	MC		CASEC POWD [1]		
	MC	SEA-OMEGA CAPS [1]	MC		CHOICE DM LIQD [1]		
			MC		DELIVER 2.0 LIQD [1]		
			MC		DOJOLVI		
			MC		ENFAMIL [1]		
			MC		ENSURE [1]		
			MC		GLUCERNA [1]		
			MC		ISOCAL LIQD [1]		
			MC		KINDERCAL TF LIQD [1]		
			MC		KINDERCAL TF/FIBER LIQD [1]		
			MC		L-CARNITINE CAPS [1]		
			MC		LIPISORB LIQD [1]		
			MC		LOVAZA [1,2]		
			MC		MODULEN IBD POWD [1]		
			MC		NUTRAMIGEN POWD [1]		
			MC		NUTREN [1]		
			MC		NUTRITIONAL SUPPLEMENT LIQD [1]		
			MC		NUTRIVENT 1.5 LIQD [1]		
			MC		PEPTAMEN [1]		
			MC		PHENYLADE [1]		
			MC		PHENYL-FREE [1]		
			MC		PKU 3 POWD [1]		
			MC		PREGESTIMIL POWD [1]		
			MC		PROBALANCE LIQD [1]		
			MC		PROSOBEE [1]		
			MC		SCANDISHAKE PACK [1]		
			MC		VASCEPA		
ERYTHROPOEITINS	MC	EPOGEN SOLN	MC	8	ARANESP SOLN [1]	Use PA Form# 10520 1. Clinical PA is required to establish medical necessity and that appropriate lab monitoring is being done.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs **in step-order** will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Please see the EPO PA form for other approval and renewal criteria.
	MC	MIRCERA SYRINGE	MC	8	PROCRIT SOLN [1]		
	MC	RETACRIT					
GRANULOCYTE CSF							
GRANULOCYTE CSF	MC	FULPHILA	MC	8	FYLNETRA	Use PA Form# 20520 1. **Must be used in specified step order.**	See approval criteria detailed on Granulocyte Colony Stimulating Factor PA form.
	MC	NEUPOGEN SYRINGE	MC	8	GRANIX SYRINGE		
	MC	NEUPOGEN VIAL	MC	8	GRANIX VIAL		
	MC/DEL	**NYVEPRIA SYRINGE**	MC	8	LEUKINE		
			MC/DEL	8	NIVESTYM		
			MC	8	ROLVEDON		
			MC	8	RYZNEUTA		
			MC	8	STIMUFEND		
			MC/DEL	8	ZARXIO		
			MC/DEL	8	ZIEXTENZO		
			MC	9	NEULASTA [1]		

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
GAUCHER DISEASE							
GAUCHER DISEASE			MC		CERDELGA [1]	Use PA Form# 20420 1. Clinical PA for indication required.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Exceeding days supply limits for LMWH class requires PA. **Yargesa**: As monotherapy for the treatment of adult patients with mild to moderate type 1 Gaucher disease for whom enzyme replacement therapy is not a therapeutic option (e.g., due to allergy, hypersensitivity, or poor venous access).
			MC		YARGESA [1]		
NIEMANN-PICK DISEASE AGENTS							
NIEMANN-PICK DISEASE AGENTS			MC		AQNEURSA [1]	Use PA Form# 20420 1. Clinical PA required for appropriate diagnosis.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
			MC		MIPLYFFA [1]		
ANTICOAGULANTS / PLATELET AGENTS							
ANTICOAGULANTS	MC	COUMADIN TABS	MC		ARIXTRA SOLN	Use PA form# 20420 1. **Enoxaparin** therapy durations greater than 7 days every 30 days require PA. 2. Use other strengths available to obtain desired dose. 3. Diagnosis required. 4. For the treatment of patients aged 3 months to less than 12 years of age.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Exceeding days supply limits for LMWH class requires PA. **DDI: Warfarin** will require prior authorization if being used in combination with fluconazole, miconazole, or voriconazole. **DDI: Warfarin** will require prior authorization if being used in conjunction with gemfibrozil or fenofibrate. **DDI: Rifampin** will require prior authorization if being used in combination with savaysa.
	MC/DEL	ENOXAPARIN [1]	MC/DEL		FONDAPARINUX		
	MC	ELIQUIS	MC/DEL		FRAGMIN INJ		
	MC	ELIQUIS STARTER PACK	MC/DEL		FRAGMIN VIAL		
	MC	HEPARIN SODIUM/NACL 0.9% SOLN	MC/DEL		**LOVENOX SOLN**		
	MC	HEP-LOCK SOLN	MC/DEL		LOVENOX 300 [2]		
	MC	**INNOHEP**	MC/DEL		LOVENOX SUBQ SYRINGE		
	MC	HEPARIN LOCK SOLN	MC/DEL		PRADAXA ORAL PELLETS [4]		
	MC/DEL	HEPARIN LOCK FLUSH SOLN	MC		IPRIVASK		
	MC/DEL	HEPARIN SODIUM SOLN	MC/DEL		SAVAYSAS [3]		
	MC/DEL	HEPARIN SODIUM LOCK FLUSH SOLN					
	MC/DEL	PRADAXA					
	MC/DEL	JANTOVEN					
	MC/DEL	**WARFARIN SODIUM TABS**					
	MC/DEL	XARELTO					
	MC/DEL	XARELTO STARTER PACK					
ANTIHEMOPHILIC AGENTS	MC	ALPHANATE	MC/DEL		ADYNOVATE VIAL	Use PA Form# 20420 1. Only if other products unavailable. 2. **Advate** may be available with PA in cases of large volume dosing in patients with poor venous access. 3. Not indicated for use in children <12 years of age due to greater risk for hypersensitivity reactions and is not indicated for use in previously untreated patients. 4. Clinical PA required for appropriate diagnosis. 5. Established users will be grandfathered.	Non-preferred will only be approved if other preferred products are unavailable. **Beqvez** - FDA Approved Indication: An adeno-associated virus vector-based gene therapy indicated for the treatment of adults with moderate to severe hemophilia B (congenital factor IX deficiency) who: • Currently use factor IX prophylaxis therapy, or • Have current or historical life-threatening hemorrhage, or • Have repeated, serious spontaneous bleeding episodes, and, • Do not have neutralizing antibodies to adeno-associated virus serotype Rh74var (AAVRh74var) capsid as detected by an FDA-approve test. **Hemgenix** is an adeno-associated viral vector-based gene therapy for IV infusion after dilution. For treatment of adults with Hemophilia B (congenital Factor IX deficiency) who: Currently use Factor IX prophylaxis therapy, or have current or historical life-threatening hemorrhage, or have repeated, serious spontaneous bleeding episodes. **Altuviiio** is a von Willebrand Factor (VWF) independent recombinant DNA-derived, Factor VIII concentrate indicated for use in adults and children with hemophilia A (congenital factor VIII deficiency) for: Routine prophylaxis to reduce the frequency of bleeding episodes, On-demand treatment and control of bleeding episodes, Perioperative management of bleeding. **Roctavian**: For the treatment of adults with severe hemophilia A (congenital factor VIII deficiency with factor VIII activity <1 IU/dL) without antibodies to adeno-associated virus serotype 5 (AAV5) detected by an FDA-approved test. Inclusion: • Severe factor VIII deficiency (less than 1% native factor VIII). Exclusion Criteria: • Antibodies to the virus AAV5 • Factor VIII inhibitors (or history of) • Known significant fibrosis of cirrhosis of the liver, or unexplained elevated LFTs • History of inadequate compliance with prophylaxis, or regular bleeds despite adequate prophylaxis • Conditions in which high-dose steroids are contraindicated. • Inability to abstain from alcohol for one year • Plan to impregnate a partner within 6 months of infusion • Hypersensitivity to mannitol • Active infections, either acute or uncontrolled chronic • HIV infection (limited information on use in this population)
	MC/DEL	BEBULIN VIAL	MC/DEL		AFSTYLA		
	MC/DEL	BENEFIX SOLR	MC/DEL		BEQVEZ		
	MC/DEL	HELIXATE FS KIT	MC/DEL		ESPEROCT		
	MC	HEMOFIL - M	MC/DEL		ELOCTATE		
	MC	HUMATE-P SOLR	MC/DEL		HEMGENIX		
	MC/DEL	IXINITY VIAL	MC/DEL		IDELVION		
	MC/DEL	JIVI [3]	MC/DEL		KOGENATE FS [5]		
	MC	KOATE-DVI	MC		RECOMBINATE VIAL [5]		
	MC	KONYNE - 80	MC		ROCTAVIAN [4]		
	MC/DEL	KOVALTRY	MC		SEVENFACT		
	MC/DEL	REBINYN					
	MC	MONARC - M					
	MC	MONOCLATE - P					
	MC	MONONINE					
	MC/DEL	NOVOEIGHT					
	MC	NOVOSEVEN SOLR					
	MC	NUWIQ					
	MC/DEL	PROFILNINE					
	MC	RECOMBINATE SOLR					
	MC	REFACTO					
	MC/DEL	RIXUBIS VIAL					
	MC	WILATE INJ					
	MC/DEL	XYNTHA					
NON-FACTOR REPLACEMENT THERAPY	MC	HEMLIBRA	MC/DEL		ALHEMO	Use PA Form# 20420	Subsequent changes made to Antihemophilic Agents: Factor Therapy to move Hemlibra to Non-Factor Therapy
			MC/DEL		HYMPAVZI		
			MC		QFITLIA		
			MC		QFITLIA PEN		

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
PLATELET AGGREGATION INHIBITORS	MC/DEL	ASPIRIN	MC/DEL		TICLOPIDINE HCL TABS	Use PA Form# 20715 for Plavix, Effient & Brilinta Use PA form# 20420 for other requests 1. Dosing limits apply, see Dose Consolidation List.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. A special PA may be obtained at the pharmacy for members scheduled for "stent" placement or have had placement if in the last 12months. Please indicate on prescription date of stent placement. **Brilinta**- Concomitant use with strong CYP3A4 inhibitors should be avoided (including ketoconazole, itraconazole, atazanavir, and telithromycin). Doses of simvastatin and lovastatin >40mg should be avoided. **DDI:** exists for using maintenance ASA dose >100mg, as it reduces the effectiveness of Brilinta. **DDI: Plavix** will require prior authorization if being used in combination with omeprazole, esomeprazole, cimetidine, fluconazole, ketoconazole, intelence, fluoxetine, ticlopidine, and fluvoxamine.
	MC	ASPIRIN-DIPYRIDAMOLE ER CPMP 12HR	MC/DEL		BRILINTA 60mg		
	MC/DEL	BRILINTA 90mg	MC		DURLAZA		
	MC/DEL	**DIPYRIDAMOLE TABS**	MC		EFFIENT		
	MC/DEL	**CLOPIDOGREL 75MG**	MC/DEL		PERSANTINE TABS		
	MC/DEL	**PRASUGREL HCL TAB**	MC/DEL		PLAVIX TABS		
			MC/DEL		**ZONTIVITY**		
PLATELET AGGR. INHIBITORS / COMBO'S - MISC.	MC/DEL	**CILOSTAZOL**	MC/DEL		**AGRYLIN CAPS**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	PENTOXIFYLLINE ER TBCR	MC/DEL		**ANAGRELIDE CAPS**		
			MC/DEL		**PLETAL TABS**		
			MC		TRENTAL TBCR		
			MC		YOSPRALA		
HEMATOLOGICALS							
MONOCLONAL ANTIBODY			MC		BKEMV	Use PA Form# 20420	A diagnosis of Paroxysmal nocturnal hemoglobinuria (PNH) using the HAM test or flow cytometry is required. In addition, the patient must show evidence of having received a meningitis vaccine at least 2 weeks prior to the start of therapy. **Gamifant** is recommended for the treatment of adult and pediatric (newborn and older) patients with primary hemophagocytic lymphohistiocytosis (HLH) with refractory, recurrent, or progressive disease or intolerance with conventional HLH therapy. **Fabhalta** and **Ultomiris** are recommended for the treatment of adults with paroxysmal nocturnal hemoglobinuria (PNH). **Bkemv** and **Epysqli** have updated criteria for a diagnosis of generalized myasthenia gravis (gMG): must have confirmation that patients are anti-acetylcholine receptor (AChR) antibody positive.
			MC		EMPAVELI		
			MC/DEL		ENSPRYNG		
			MC		EPYSQLI		
			MC		FABHALTA		
			MC/DEL		GAMIFANT		
			MC		PIASKY		
			MC		SOLIRIS		
			MC/DEL		ULTOMIRIS		
			MC		UPLIZNA		
			MC		VOYDEYA		
IMMUNE GLOBULIN	MC	BIVIGAM [1]	MC		ALYGLO	Use PA Form# 20420 1. Clinical PA required. 2. For the treatment of patients between 12 to 17 years of age.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Alyglo** is indicated for treatment of primary humoral immunodeficiency in adults ages 17 or older. **Cutaquig** is indicated as replacement therapy for primary humoral immunodeficiency (PI) in adults. **Xembify** is indicated for treatment of primary humoral immunodeficiency (PI) in patients 2 years of age and older. **Asceniv** indicated for the treatment of primary humoral immunodeficiency (PI) in adults and adolescents (12 to 17 years of age). PI includes but is not limited to the humoral immune defect in congenital agammaglobulinemia, common variable immunodeficiency (CVID), X-linked agammaglobulinemia, Wiskott-Aldrich syndrome, and severe combined immunodeficiencies (SCID).
	MC/DEL	CUTAQUIG [1]	MC		ASCENIV [2]		
	MC	GAMMAGARD S-D [1]	MC/DEL		CUVITRU		
	MC/DEL	HIZENTRA [1]	MC		GAMMAPLEX INJ		
	MC/DEL	PANZYGA [1]	MC/DEL		HYQVIA		
	MC	PRIVIGEN [1]	MC		OCTAGAM INJ [1]		
			MC/DEL		XEMBIFY		
HEREDITARY ANGIOEDEMA		**PROPHYLAXIS**			**PROPHYHLAXIS**		
	MC	CINRYZE [1]	MC		ANDEMBRY	Use PA Form# 20420 1. Clinical PA is required to establish diagnosis and medical necessity. 2. For the treatment of patients ≥ 12 years of age.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Haegarda** is indicated for routine prophylaxis to prevent Hereditary Angioedema (HAE) attacks in adolescent and adult patients
	MC	HAEGARDA [1]	MC		DAWNZERA [2]		
	MC	ORLADEYO [1,2]					
	MC/DEL	TAKHZYRO [1]					
		TREATMENT			**TREATMENT**		
	MC/DEL	BERINERT KIT [1]	MC/DEL	8	KALBITOR VIAL	Use PA Form# 20420 1. Clinical PA is required to establish diagnosis and medical necessity. 2. For the treatment of patients ≥ 12 yrs of age.	
	MC	FIRAZYR [1]	MC	8	EKTERLY [2]		
	MC/DEL	RUCONEST VIAL [1]					
HEMATOLOGICAL AGENTS-THROMBOPOIETIN RECEPTOR AGONISTS	MC	PROMACTA [1]	MC		ALVAIZ	Use PA Form# 20420 1. Clinical PA required. Must see prior trial with insufficient response to corticosteroids and immunoglobulins.	**Doptelet** and **Mulpelta**: For the treatment of thrombocytopenia in adults with chronic liver disease who are scheduled to undergo a procedure.
	MC	NPLATE [1]	MC/DEL		DOPTELET		
			MC/DEL		MULPLETA		
HEMATOLOGICAL AGENTS-IgAN			MC/DEL	8	FILSPARI [1]	Use PA Form# 20420 1. Clinical PA is required to establish diagnosis and medical necessity.	All preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs **(in step-order)** will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. PA required to confirm FDA-approved indication. **Vanrafia** is for adults with biopsy proven primary IgAN AND eGFR>=30 cc/min/1.73m3 AND urine protein >=1 g/day AND on stable dose of maximally tolerated renin-angiotensin system inhibitor. Additional criteria for all: • Diagnosis of primary immunoglobulin A nephropathy (IgAN) AND • Patients at risk for disease progression (e.g., proteinuria) of at least 0.5 g/day, or by other criteria as clinical risk scoring using the International IgAN prediction tool, AND • Patient has been on a minimum 90-day trial or maximally tolerated dose and will continue to receive: an angiotensin converting enzyme (ACE) inhibitor or angiotensin II receptor blocker (ARB), AND • Prescribed in consultation or by a nephrologist
			MC	8	TARPEYO [1]		
			MC	8	VANRAFIA [1]		
			MC	8	**VOYXACT** [1]		

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
ANEMIA - ALPHA or BETA THALASSEMIA			MC		AQVESME [1]	Use PA Form# 20420	**Aqvesme** requires a diagnosis of anemia in adults with alpha or beta thalassemia, AND prescribed in consultation with or by a hematologist.
			MC		REBLOZYL	1. Clinical PA is required to establish diagnosis and medical necessity.	**Reblozyl** is indicated for three (3) treatments of anemia in adults: 1. in adult patients with beta thalassemia who require regular red blood cell (RBC) transfusions; 2. without previous erythropoiesis stimulating agent use (ESA-naïve) in adult patients with very low- to intermediate-risk myelodysplastic syndromes (MDS) who may require regular RBC transfusions; and 3. failing an ESA and requiring 2 or more RBC units over 8 weeks in adult patients with very low- to intermediate-risk MDS with ring sideroblasts (MDS-RS) or with myelodysplastic/myeloproliferative neoplasm with ring sideroblasts and thrombocytosis (MDS/MPN-RS-T). **It is not indicated for use as a substitute for RBC transfusions in patients who require immediate correction of anemia.**
			MC		ZYNTEGLO		**Zynteglo** is indicated for the treatment of adult and pediatric patients with β-thalassemia who require regular red blood cell (RBC) transfusions.
HEMATOLOGIC DISORDER TREATMENT AGENTS			MC/DEL		CABLIVI	Use PA Form# 20420	**Tavalisse** is recommended for patients at risk of bleeding when one line of therapy (steroids, IVIG, splenectomy) has failed.
			MC		WAYRILZ [1]	1. Clinical PA is required to establish diagnosis and medical necessity.	**Cablivi** is recommended for the treatment of adult patients with acquired thrombotic thrombocytopenic purpura (aTTP), in combination with plasma exchange and immunosuppressive therapy.
			MC		TAVALISSE		**Wayrilz**: Baseline platelet count is less than 30,000/mcL and prescribed in consultation or by a hemotologist/oncologist.
COMPLEMENT RECEPTOR ANTAGONIST			MC		TAVNEOS	Use PA Form# 20420	
WHIM SYNDROME AGENTS			MC		XOLREMDI	Use PA Form# 20420	**Xolremdi**: In patients 12 years of age and older with WHIM syndrome (warts, hypogammaglobulinemia, infections, and myelokathexis) to increase the number of circulating mature neutrophils and lymphocytes.
HEMOSTATIC							
HEMOSTATIC	MC/DEL	AMICAR	MC		FIBRYGA	Use PA Form# 20420	**Fibryga** and **Riastap** are indicated for the treatment of acute bleeding episodes in adults and adolescents with congenital fibrinogen deficiency, including afibrinogenemia and hypofibrinogenemia. Fibryga is not indicated for dysfibrinogenemia.
	MC	AMINOCAPROIC ACID	MC		RIASTAP		
ACUTE HEPATIC PORPHYRIA (AHP)							
ACUTE HEPATIC PORPHYRIA (AHP)			MC		GIVLAARI	Use PA Form# 20420	**Givlaari** is indicated for the treatment of adults with acute hepatic porphyria (AHP).
PYRUVATE KINASE DEFICIENCY AGENTS							
PYRUVATE KINASE DEFICIENCY AGENTS			MC		PYRUKYND [1]	Use PA Form# 20420 1. PA required to confirm FDA approved indication.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s).
OP. - ANTIBIOTICS	MC	AK-SPORE OINT	MC		AK-POLY-BAC OINT	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC	BACITRACIN/NEOMYCIN/POLYM	MC		AK-SULF OINT		
	MC/DEL	BACITRACIN/POLYMYXIN B OINT	MC		AK-TOB SOLN		
	MC	CHLOROPTIC SOLN	MC		AZASITE		
	MC/DEL	ERYTHROMYCIN OINT	MC		BACITRACIN OINT		
	MC	NEOSPORIN SOLN	MC		BLEPH-10 SOLN		
	MC	POLYSPORIN	MC/DEL		**GATIFLOXACIN DROPS**		
	MC/DEL	TRIMETHOPRIM SULFATE/POLY	MC/DEL		GENTAMICIN SULFATE		
	MC/DEL	TOBRAMYCIN SULFATE SOLN	MC		GENTAK		
			MC		ILOTYCIN OINT		
			MC/DEL		**LEVOFLOXACIN DROPS**		
			MC/DEL		NEOMYCIN/BACI/POLYM OINT		
			MC/DEL		NEOMYCIN/POLYMYXIN/GRAMIC		
			MC		NEOSPORIN OINT		
			MC		OCUSULF-10 SOLN		
			MC		OCUTRICIN SOLN		
			MC/DEL		POLYTRIM DROPS		
			MC/DEL		SULFACETAMIDE SODIUM DROPS		
			MC/DEL		SULFACETAMIDE SODIUM OINT		
			MC		TERAK OINT		
OP. - ANTI-PARASITIC			MC		XDEMVY [1]	Use PA Form# 20420 1. For the treatment of Demodex blepharitis.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
OP. - RHO KINASE INHIBITORS	MC	RHOPRESSA				Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
OP. - QUINOLONES	MC/DEL	CILOXAN OINT	MC/DEL		BESIVANCE	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	CIPROFLOXACIN SOL 0.3%	MC/DEL		CILOXAN SOLN		
	MC/DEL	OFLOXACIN	MC		OCUFLOX SOLN		
	MC/DEL	QUIXIN SOLN					
OP. - QUINOLONES-4TH GENERATION	MC/DEL	**MOXIFLOXACIN 0.5% SOLN (Generic Vigamox)**	MC		ZYMAXID	Use PA Form# 20420	
OP. - ARTIFICIAL TEARS AND LUBRICANTS	MC/DEL	ARTIFICIAL TEARS OINT	MC/DEL		ARTIFICIAL TEARS SOLN OP	Use PA Form# 20420 1. Dosing limits apply, see Dose Consolidation List.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	ARTIFICIAL TEARS SOLN	MC		BION TEARS SOLN		
	MC	CELLUVISC SOLN	MC		DRY EYES OINT		
	MC	EYE LUBRICANT OINT	MC		DURATEARS OINT		
	MC/DEL	GENTEAL	MC/DEL		HYPO TEARS		

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
	MC	LIQUITEARS SOLN	MC/DEL		ISOPTO TEARS SOLN		
	MC	MAJOR TEARS SOLN	MC		LACRI-LUBE		
	MC	PURALUBE OINT	MC		LUBRIFRESH P.M. OINT		
	MC	PURALUBE TEARS SOLN	MC		MURINE SOLN		
	MC	REFRESH SOLN OP	MC/DEL		MUROCEL SOLN		
	MC	REFRESH PLUS SOLN [1]	MC/DEL		NATURE'S TEARS SOLN		
	MC	REFRESH PM OINT	MC		REFRESH SOLN		
			MC		REFRESH TEARS SOLN [1]		
			MC		TEARGEN SOLN		
			MC		TEARISOL SOLN		
			MC/DEL		TEARS NATURALE		
			MC/DEL		TEARS PURE SOLN		
			MC		TEARS RENEWED OINT		
			MC/DEL		THERATEARS SOLN		
			MC		V-R ARTIFICIAL TEARS SOLN		
OP. - BETA - BLOCKERS	MC/DEL	**BETOPTIC-S SUSP**	MC		BETAGAN SOLN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	**CARTEOLOL HCL SOLN**	MC/DEL		**BETAXOLOL HCL SOLN**		
	MC/DEL	**LEVOBUNOLOL HCL SOLN**	MC		ISTALOL		
	MC/DEL	METIPRANOLOL SOLN	MC/DEL		**OCUPRESS SOLN**		
			MC		OPTIPRANOLOL SOLN		
			MC/DEL		**TIMOPTIC SOLN**		
			MC		TIMOLOL DROP		
			MC/DEL		**TIMOLOL SOL-GEL**		
			MC/DEL		**TIMOPTIC-XE SOLG**		
OP. - ANTI-INFLAMMATORY / STEROIDS OPHTH.	MC	AK-SPORE HC OINT	MC		AK-TROL SUSP	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	ALREX SUSP	MC		BAC/POLY/NEOMY/HC OINT		
	MC/DEL	DEXAMETH SOD PHOS SOLN	MC		BLEPHAMIDE S.O.P. OINT		
	MC/DEL	FLUOROMETHOLONE SUSP	MC		BLEPHAMIDE SUSP		
	MC	FML DROPS SUSP 1%	MC		BROMDAY		
	MC	FML FORTE SUSP	MC		EFLONE SUSP		
	MC	FML S.O.P. OINT	MC/DEL		FLAREX SUSP		
	MC/DEL	**LOTEMAX OINT**	MC		FLUOR-OP SUSP		
	MC/DEL	**LOTEMAX GEL**	MC/DEL		**ILUVIEN IMPLANT**		
	MC/DEL	LOTEMAX SUSP	MC/DEL		**INVELTYS**		
	MC/DEL	NEO/POLY/DEXAMETH OINT	MC/DEL		**LOTEMAX SM DROPS GEL 0.38%**		
	MC	NEO/POLY/DEXAMETH SUSP	MC		MAXITROL OPTH OINT 0.1%		
	MC	PRED-G SUSP	MC		NEO/POLY/BAC/HC OINT		
	MC	PRED FORTE SUSP 1%	MC/DEL		NEOM/POLY/DEX OPTH OINT 0.1%		
	MC	PRED MILD SUSP	MC/DEL		**OMNIPRED DROPS SUSP**		
	MC/DEL	PREDNISOLONE	MC/DEL		OZURDEX		
	MC/DEL	TOBRADEX OINT	MC		PRED-G S.O.P. OINT		
	MC/DEL	TOBREX OINT	MC/DEL		PREDNISOLONE SODIUM PHOSHATE SOL		
	MC	SULFACETAMIDE/PREDNISOLONE	MC/DEL		**RETISERT IMPLANT**		
	MC/DEL	ZYLET SUSP	MC/DEL		SULFACET SOD/PRED SOLN		
			MC/DEL		**TRIESENCE VIAL**		
			MC/DEL		TOBRADEX ST		
			MC/DEL		TOBRAMYCIN SUSP DEXAMETHASONE		
			MC		VASOCIDIN SOLN		
			MC/DEL		VEXOL SUSP		
			MC		XIPERE		
OP. - PROSTAGLANDINS	MC/DEL	**LATANOPROST SOL 0.005%**	MC/DEL	7	**ZIOPTAN**	Use PA Form# 20420 1. All preferred must be tried. 2. Dosing limits apply, see Dosing Consolidation List. 3. Clinical PA is required to establish diagnosis and medical necessity.	Preferred drugs must be tried and failed due to lack of efficacy (failure to reach target IOP reduction) or intolerable side effects before non-preferred drugs, **in step-order**, will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC	LUMIGAN SOLN	MC/DEL	8	**BIMATOPROST 0.03% DROPS**		
	MC/DEL	ROCKLATAN	MC	8	DURYSTA		
	MC/DEL	**TRAVATAN-Z**	MC	8	IYUZEH		
			MC	8	RESCULA [1,2,3]		
			MC/DEL	8	**TRAVATAN SOLN**		
			MC/DEL	8	**TRAVOPROST**		
			MC/DEL	**8**	**VYZULTA**		

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
			MC/DEL	8	XALATAN SOLN [1]		
			MC/DEL	8	**XELPROS**		
OP. - CYCLOPLEGICS	MC	AK-PENTOLATE SOLN	MC/DEL		CYCLOGYL SOLN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	ATROPINE SULFATE	MC		ISOPTO ATROPINE SOLN		
	MC/DEL	CYCLOPENTOLATE HCL SOLN	MC/DEL		ISOPTO HOMATROPINE SOLN		
	MC/DEL	ISOPTO HYOSCINE SOLN	MC		MUROCOLL-2 SOLN		
OP. - MIOTICS - DIRECT ACTING	MC/DEL	**ISOPTO CARBACHOL SOLN**				Use PA Form# 20420	
	MC	ISOPTO CARPINE SOLN					
	MC	PILOCAR SOLN					
	MC/DEL	**PILOCARPINE HCL SOLN**					
	MC/DEL	**PILOPINE HS GEL**					
OP. - SELECTIVE ALPHA ADRENERGIC AGONISTS	MC	ALPHAGAN SOLN	MC/DEL		**BRIMONIDINE TARTRATE DROPS 0.15 %**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC	ALPHAGAN P 0.1% SOLN	MC/DEL		**IOPIDINE SOLN**		
	MC	ALPHAGAN P 0.15% SOLN					
	MC/DEL	BRIMONIDINE DROPS 0.2 %					
	MC/DEL	SIMBRINZA					
OP. - ANTI-ALLERGICS	MC/DEL	AZELASTINE HCL DROPS	MC		ALOCRIL SOLN	Use PA Form# 20420	All preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC	BEPREVE	MC/DEL		ALOMIDE SOLN		
	MC/DEL	CROMOLYN SODIUM DROPS	MC/DEL		EMADINE SOLN		
	MC/DEL	**KETOTIFEN FUMARATE DROPS**	MC		OPTICROM SOLN		
	MC	LASTACAFT	MC/DEL		PATANOL SOLN		
	MC/DEL	**OLOPATADINE HCL 0.1%**	MC		ZERVIATE		
	MC/DEL	**OLOPATADINE HCL 0.2%**	MC/DEL		EPINASTINE		
	MC/DEL	ZADITOR SOLN					
OP. ANTI-ALLERGICS- MASTCELL STABILIZER CLASS			MC/DEL		ALAMAST SOLN	Use PA Form# 20420	
OP. - CARBONIC ANHYDRASE INHIBITORS/COMBO	MC/DEL	**AZOPT SUSP**	MC/DEL		**COSOPT SOLN PF**	Use PA Form# 20420	
	MC	COMBIGAN					
	MC/DEL	DORZOLAMIDE					
	MC/DEL	DORZOLAMIDE/TIMOLOL					
OP. - NSAID'S	MC	ACULAR SOLN [1]	MC		ACULAR LS [1]	Use PA Form# 20420 1. Must fail all preferred products before non-preferred.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	**DUREZOL**	MC		BROMSITE [1]		
	MC/DEL	KETOROLAC OPTH 0.4%	MC/DEL		DEXAMETHASONE DROPS		
	MC/DEL	KETOROLAC OPTH 0.5%	MC/DEL		DICLOFENAC OPTH 0.1%		
	MC/DEL	**MAXIDEX SUSP**	MC		FLURBIPROFEN SODIUM SOLN		
	MC/DEL	NEVANAC	MC/DEL		ILEVRO		
	MC/DEL	PREDNISOLONE DROPS	MC/DEL		**LOTEMAX SM DROPS GEL 0.38%**		
			MC/DEL		PROLENSA		
			MC		OCUFEN SOLN [1]		
			MC		XIBROM [1]		
			MC		VOLTAREN SOLN [1]		
			MC		ACUVAIL [1]		
			MC/DEL		BROMFENAC		
OP. - OF INTEREST	MC	EYSUVIS [2]	MC		BYOOVIZ	Use PA Form# 20420 1. PA required to confirm appropriate diagnosis and clinical parameters for use. 2. For the short-term (up to two weeks) treatment of the signs and symptoms of dry eye disease.	Must fail adequate trials of multi agents from artificial tears and lubricant category. **Beovu** is non-preferred and indicated for the treatment of Neovascular (wet) Age-Related Macular Degeneration (AMD) **Eylea** is non-preferred and indicated for the treatment of: Neovascular (wet) Age-Related Macular Degeneration (AMD), Macular Edema following Retinal Vein Occlusion (RVO), Diabetic Macular Edema (DME), Diabetic Retinopathy (DR) **Luxturna** will be considered for the treatment of patients with confirmed biallelic RPE65 mutation-associated retinal dystrophy. Patients must have viable retinal cells as determined by the treating physician(s). **Miebo** is non-preferred and is indicated for the treatment of the signs and symptoms of dry eye disease (DED). **Oxervate** is non-preferred and is indicated for the treatment of neurotrophic keratitis. **Pavblu**: Clinical rationale for why eylea cannot be used **Syfovre** is non-preferred and is indicated for the treatment of geographic atrophy (GA) secondary to age-related macular degeneration (AMD). **Vevye** - Must fail adequate trials of multi agents from artificial tears and lubricant category and a preferred cyclosporine alternative.
	MC	LUCENTIS	MC		BEOVU		
	MC	RESTASIS DROPPERETTE	MC		BOTOX SOLR		
	MC	XIIDRA	MC/DEL		CEQUA		
			MC		CIMERLI		
			MC		CYCLOSPORINE DROPERETTE		
			MC		CYSTADROPS [1]		
			MC		CYSTARAN [1]		
			MC		EYLEA		
			MC		EYLEA HD [1]		
			MC		IZERVAY [1]		
			MC		LUCENTIS		
			MC		LUXTURNA		
			MC/DEL		MIEBO		
			MC/DEL		OXERVATE		
			MC		PAVBLU		
			MC/DEL		RESTASIS MULTIDOSE DROPS		
			MC		SUSVIMO		
			MC		SYFOVRE		
			MC		TRYPTYR [1]		

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
			MC		TYRVAYA		
			MC		VABYSMO		
			MC		VERKAZIA		
			MC		VEVYE		
DERMATOLOGICAL							
ISOTRETINION, ACNE	MC	AMNESTEEM [1]	MC		ABSORICA	Use PA Form# 20420 1. Users 24 or under, PA will not be required.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC	CLARAVIS [1]	MC		ABSORICA LD		
	MC	MYORISAN [1]					
	MC	ZENATANE [1]					
TOPICAL - ACNE PREPARATIONS	MC/DEL	ERY/BENZOYL GEL	MC/DEL		AKLIEF [6]	Use PA Form# 10220 for Brand Name requests Use PA Form# 20420 for all other requests 1. Users 24 or under, PA will not be required. 2. Dosing limits allow one package per month. Refer to Dose Consolidation List. 3. Only available if component ingredients are unavailable. 4. Dosing limits apply, see Dosing Consolidation List. 5. Not approved for use in children <12 years of age. 6. For the treatment of patients ≥ 9 years of age.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC	ERYDERM SOLN	MC		ALTINAC CREA		
	MC/DEL	ERYTHROMYCIN GEL	MC		AMZEEQ [6]		
	MC/DEL	ERYTHROMYCIN SOLN	MC		AVITA CREA		
	MC/DEL	EVOCLIN	MC		BENZAC		
	MC	ISOTRETINOIN	MC/DEL		BENZACLIN GEL [3]		
	MC	METRONIDAZOLE GEL [2]	MC/DEL		BENZAGEL-10 GEL		
	MC	METRONIDAZOLE LOTN [2]	MC		BENZEFOAM		
	MC/DEL	TRETINOIN .025%, .01% GEL [1]	MC		BREVOXYL		
	MC	TRETINOIN CREA [1,2]	MC/DEL		CLEOCIN-T [2]		
			MC		CLINAC BPO GEL		
			MC		CLINDETS SWAB		
			MC		DESQUAM-E GEL		
			MC		DESQUAM-X		
			MC		DIFFERIN 0.3% GEL		
			MC		DIFFERIN		
			MC		EMGEL GEL		
			MC		EPIDUO		
			MC		EPSOLAY		
			MC		ERYCETTE PADS		
			MC		FINEVIN CREA		
			MC		METROCREAM CREA [2]		
			MC		METROGEL GEL [2]		
			MC		METROLOTION LOTN [2]		
			MC		NEOBENZ MICRO		
			MC/DEL		PLIXDA		
			MC		RHOFADE		
			MC/DEL		SODIUM SULFACET/SULF LOTN		
			MC		SOOLANTRA [4]		
			MC/DEL		TRIAZ		
			MC		TWYNEO		
			MC		VELTIN		
			MC		WINLEVI [5]		
			MC		ZENCIA WASH		
			MC		ZETACET		
			MC		ZILXI		
TOPICAL- ATOPIC DERMATITIS	MC/DEL	PIMECROLIMUS	MC		**ANZUPGO**	Use PA Form# 20420 1. Avoid live vaccines if treated with Dupixent. 2. Clinical PA required. 3. For the treatment of patients ≥ 12 years of age. 4. Preferred only after a trial and failure of TCI. 5. Clinical PA is required to establish diagnosis and medical necessity.	Preferred drugs also indicated for this condition, including topical steroids, cyclosporin AND calcineurin inhibitors must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Note: If unable to use TCIs then a trial of Eucrisa could be recommended before Dupixent. **ANZUPGO**: use of Anzupgo in combination with other JAK inhibitors or potent immunosuppressants is not recommended.
	MC/DEL	PROTOPIC OINT	MC/DEL		CIBINQO		
	MC/DEL	TACROLIMUS OINT	MC		NEMLUVIO		
	MC	ADBRY [2,4]					
	MC	EBGLYSS [2,3,4]					
	MC/DEL	DUPIXENT [1,2,4]					
	MC	EUCRISA [2,4]					
	MC	OPZELURA [2,3,4]					
	MC	RINVOQ [5]					
TOPICAL - ANTIBIOTIC	MC	BACIT/NEOMYCIN/POLYM OINT	MC/DEL		CENTANY OINT 2% [1]	Use PA Form# 20420 1. Dosing limits apply, see Dosing Consolidation List.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	BACITRACIN OINT	MC/DEL		MUPIROCIN CREA [1]		
	MC/DEL	GENTAMICIN SULFATE	MC/DEL		TRIPLE ANTIBIOTIC OINT		
	MC/DEL	MUPIROCIN OINT [1]	MC		XEPI		
TOPICAL - ANTIFUNGALS	MC/DEL	BETAMETHASONE CLOTRIMAZOLE CREA	MC/DEL		CICLOPIROX SOLN	Use PA Form# 10120 1. Diagnosis required.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	BETAMETHASONE CLOTRIMAZOLE LOT	MC		EXELDERM		
	MC	CICLOPIROX 0.77 CREA	MC		FUNGIZONE CREA		

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
	MC	CICLOPIROX 0.77 SUSP	MC/DEL		HYDROCORT/IODOQ CREA		**Kerydin**- Verify prior trials and failures or intolerance of preferred treatments, including both topical and oral agents **DDI: Ketoconazole** will now be non-preferred and require prior authorization if they are currently being used in combination with any of the following medications: prevacid, pantoprazole, onglyza or omeprazole.
	MC/DEL	CLOTRIMAZOLE	MC		KERYDIN [1]		
	MC	ECONAZOLE NITRATE CREA	MC/DEL		LOPROX 0.77 LOTN		
	MC/DEL	KETOCONAZOLE CREA	MC/DEL		LOPROX 0.77 CREA		
	MC/DEL	KETOCONAZOLE SHAM	MC/DEL		LOPROX 0.77 SUSP		
	MC/DEL	LOPROX 1.0 CREA	MC/DEL		LOPROX SHAMPOO SHAM		
	MC/DEL	LOPROX 1.O LOTN	MC		LOTRIMIN		
	MC/DEL	LOPROX GEL	MC/DEL		LOTRISONE LOT		
	MC/DEL	LOPROX TS LOTN	MC/DEL		LOTRISONE CREA		
	MC/DEL	MICONAZOLE NITRATE CREA	MC/DEL		MENTAX CREA		
	MC	MYCO-TRIACET II CREA	MC		MYCOGEN II CREA		
	MC/DEL	NYSTATIN	MC		NAFTIN		
	MC/DEL	NYSTATIN/TRIAMCINOLONE CREA	MC		NIZORAL SHAM		
	MC/DEL	NYSTOP POWD	MC/DEL		NYSTATIN/TRIAMCINOLONE OINT		
	MC	TRI-STATIN II CREA	MC		NYSTAT-RX POWD		
			MC/DEL		OXISTAT		
			MC/DEL		PENLAC NAIL LACQUER SOLN		
TOPICAL - ANTIPRURITICS	MC	ZONALON CREA	MC		KORSUVA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
			MC		PRUDOXIN CREA		
TOPICAL - ANTIPSORIATICS	MC/DEL	CALCIP/BETAMETHASONE SUS	MC/DEL		TACLONEX [1]	Use PA Form# 20420 1. Must fail all preferred products before non-preferred.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
			MC		ENSTILAR		
			MC		OXSORALEN ULTRA CAPS [1]		
			MC		PSORIATEC CREA [1]		
			MC/DEL		SORIATANE CK KIT [1]		
			MC		VECTICAL [1]		
			MC		VTAMA		
			MC		ZORYVE		
TOPICAL - ANTISEBORRHEICS	MC/DEL	SELENIUM SULFIDE SHAM	MC		CARMOL SCALP TREATMENT KIT	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Zoryve Foam**: For the treatment of seborrheic dermatitis in adult and pediatric patients 9 years of age and older.
			MC		ZNP BAR		
			MC		ZORYVE FOAM		
TOPICAL - ANTIVIRALS			MC/DEL		DENAVIR CREA [1, 3]	Use PA Form# 20420 1. Must fail oral treatment with **Valacyclovir**. 2. Approvals limited to 1 tube per 180 days. 3. Dosing limits apply, see Dosing Consolidation List. 4. For the topical treatment of molluscum contagiosum in adult and pediatric patients 1 year of age and older.	
			MC		YCANTH		
			MC		ZELSUVMI [4]		
TOPICAL - ANTINEOPLASTICS	MC/DEL	FLUOROURACIL 5% CREA	MC		SOLARAZE GEL	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - BURN PRODUCTS	MC	FURACIN CREA	MC/DEL		SILVADENE CREA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	SILVER SULFADIAZINE CREA					
	MC	SSD AF CREA					
	MC	SSD CREA					
	MC/DEL	THERMAZENE CREA					
TOPICAL - CORTICOSTEROIDS		**LOW POTENCY**			**LOW POTENCY**	Use PA Form# 20420 1. Dosing limits apply, see Dosing Consolidation List. 2. Treatment beyond 4 weeks is not recommended. 3. For the treatment of patients ≥ 12 yrs of age. 4. For the treatment of patients ≥ 18 yrs of age.	At least 1 drug from each potency of preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC	DERMA-SMOOTHE- FS BODY	MC/DEL		ACLOVATE		
	MC/DEL	HYDROCORTISONE CREA	MC		DESONATE GEL		
	MC	HYDROCORTISONE LOTN	MC/DEL		**FLUOCINOLONE ACETONIDE**		
	MC	HYDROCORTISONE LOTN	MC/DEL		**FLUOCINOLONE**		
	MC	TEXACORT SOLN	MC		HALOG		
			MC		HYDROCORTISONE POWD		
			MC		LIDA MANTLE HC CREA		
			MC		PROCTOCORT CREA		
			MC/DEL		VERDESO		

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
		MEDIUM POTENCY			**MEDIUM POTENCY**		
	MC/DEL	DESOXIMETASONE 0.05% CREA/GEL	MC/DEL		**BESER LOTION** [3]		
	MC	FLUTICASONE PROPIONATE CREA/OINT	MC		CLODERM CREA		
	MC	HYDROCORTISONE BUTYRATE	MC/DEL		CORDRAN		
	MC	HYDROCORTISONE OINT	MC/DEL		CUTIVATE CREA / OINT		
	MC	HYDROCORTISONE VALERATE	MC/DEL		CUTIVATE LOTN		
	MC	MOMETASONE FUROATE OINT	MC/DEL		DERMATOP		
	MC	TRIAMCINOLONE ACETONIDE .025-.1%	MC		ELOCON OINT		
			MC		KENALOG AERS		
			MC/DEL		LOCOID		
			MC/DEL		LUXIQ FOAM		
			MC		PANDEL CREA		
			MC		TOPICORT		
			MC		TOPICORT LP CREA		
			MC/DEL		TOVET FOAM [3]		
			MC		WESTCORT		
		HIGH POTENCY			**HIGH POTENCY**		
	MC/DEL	DESONIDE [1]	MC		AMCINONIDE CREA		
	MC	TRIAMCINOLONE ACETONIDE .5%	MC		BETAMETHASONE DIPROPIONATE		
			MC/DEL		**DESOXIMETASONE 0.25% CREA/OINT**		
		VERY HIGH POTENCY			**VERY HIGH POTENCY**		
	MC/DEL	AUGMENTED BETA DIP	MC/DEL		**CLOBETASOL PROPINATE LOTN**		
	MC/DEL	BETAMETHASONE VALERATE	MC/DEL		CLOBETASOL PROPINATE SHAMPOO 0.05%		
	MC	DIFLORASONE DIACETATE	MC/DEL		CORMAX		
			MC/DEL		DIPROLENE		
			MC/DEL		IMPEKLO [4]		
			MC/DEL		LEXETTE		
			MC/DEL		OLUX FOAM		
			MC/DEL		PSORCON		
			MC/DEL		PSORCON E		
			MC		SERNIVO SPRAY [2]		
			MC/DEL		TEMOVATE		
			MC		ULTRAVATE		
		MISCELLANEOUS					
	MC	PROCTO-KIT CREA 1%					
TOPICAL - STEROID LOCAL ANESTHETICS			MC		EPIFOAM FOAM	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - STEROID COMBINATIONS	MC	DERMA-SMOOTHE-FS SCALP	MC		CARMOL-HC CREA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - EMOLLIENTS	MC/DEL	AMMONIUM LACTATE CREA [1]	MC		LAC-HYDRIN CREA [1]	Use PA Form# 20420 1. Dosing limits still apply, see Dose Consolidation List.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC	AMMONIUM LACTATE LOTN 12% [1]	MC		LAC-HYDRIN LOTN 12%		
	MC	VITAMIN A & D MEDICATED OINT	MC		MEDERMA GEL		
			MC		MIMYX		
			MC		RENOVA CREA		
TOPICAL - ENZYMES / KERATOLYTICS / UREA			MC		CARMOL 40 CREA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Ziox, Panafil and Papain** products have been removed from the PDL due to FDA safety concerns regarding drugs containing Papain.
			MC		SALEX CREA		
			MC		SALEX LOTN		
TOPICAL - GENITAL WARTS	MC/DEL	IMIQUIMOD 5% [2]	MC/DEL	5	PODOFILOX SOLN	Use PA Form# 20420 1. **Non-preferred products must be used in specified order.** 2. Dosing limits still apply, see Dose Consolidation List.	
			MC/DEL	8	CONDYLOX [1]		
			MC/DEL	8	ALDARA [1]		
			MC	8	PICATO		
			MC	8	VEREGEN [1]		

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
TOPICAL - LOCAL ANESTHETICS	MC	AF CAPSICUM OLEORESIN CREA	MC/DEL		EMLA PADS	Use PA Form# 20420 1. **Lidocaine/Prilocaine cream** and **Ela-Max** products require PA for users over 18 yrs of age. 2. Dosing limits still apply, see Dose Consolidation List.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	CAPSAICIN CREA	MC/DEL		EMLA CREA		
	MC/DEL	CAPSAICIN PATCH	MC		LIDA MANTLE CREA		
	MC/DEL	**DIBUCAINE OINT**	MC		PONTOCAINE SOLN		
	MC	ELA-MAX [1]	MC		SYNERA		
	MC/DEL	LIDOCAINE/PRILOCAINE CREA [1]	MC		ZOSTRIX		
	MC/DEL	LIDOCAINE CREAM	MC/DEL		ZTLIDO [2]		
	MC/DEL	LIDOCAINE GEL					
	MC/DEL	**LIDOCAINE PTCH 5%**					
TOPICAL - DEPIGMENTING AGENTS			MC		ALUSTRA CREA	Use PA Form# 20420	As per Medicaid Policy, cosmetic drugs are not covered. Non-cosmetic clinical applications will be considered by prior authorization on a case-by-case basis.
			MC		EPIQUIN MICRO		
			MC		GLYQUIN CREA		
			MC/DEL		HYDROQUINONE CREA		
			MC/DEL		HYDROQUINONE/SUNSCREENS		
			MC		SOLAQUIN FORTE CREA		
			MC		TRI-LUMA CREA		
			MC		ELDOQUIN		
TOPICAL - SCABICIDES AND PEDICULICIDES	MC/DEL	ACTICIN CREA	MC		ELIMITE CREA	Use PA Form# 20420 1. Dosing limits apply, see Dosage Consolidation List.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC	LICE KILLING SHAM	MC		EURAX		
	MC/DEL	LICE TREATMENT CREME RINS LIQD	MC/DEL		LINDANE		
	MC/DEL	PERMETHRIN LOTN	MC		MALATHION		
	MC	NATROBA [1]	MC		OVIDE LOTN		
			MC/DEL		**SPINOSAD SUSP**		
TOPICAL - WOUND / DECUBITUS CARE			MC		FILSUVEZ	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Regranex** will be approved for diabetic patients in good control (hgba1c <8), who are not smoking, with a stage III or IV WOCN AND NPUAP lower extremity diabetic ulcer and with an adequate blood supply (Tcp 02 >30, ABI>0.7 or ASP> 70), and where the underlying cause has been corrected. The wound must be free of infection and have been previously treated with preferred standard therapies for at least 2 months. Maximum approval for 20 weeks. **Accuzyme and Ethezyme** products have been removed from the PDL due to FDA concerns regarding drugs containing papain. **Filsuvez**: The patient has a diagnosis of dystrophic or junctional epidermolysis bullosa. The patient is at least 6 months old and does not have current evidence or history of squamous cell carcinoma or active infection in the area requiring filsuvez application. The patient has used standard wound care treatments, including silicone or foam dressings without wound resolution **Vyjuvek**: For the treatment of wounds in patients 6 months of age and older with dystrophic epidermolysis bullosa (DEB) with mutation(s) in the collagen type VII alpha 1 chain (COL7A1) gene.
			MC		REGRANEX GEL		
			MC		VYJUVEK		
TOPICAL - ASTRINGENTS / PROTECTANTS			MC		MOISTURIN DRY SKIN CREA	Use PA Form# 20420 1. Dosing limits apply, see Dosage Consolidation List.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
			MC		PROSHIELD PLUS SKIN PROTE CREA		
			MC		SURGILUBE GEL		
HYPERHIDROSIS THERAPY - AXILLARY	MC	XERAC AC SOLN	MC		SOFDRA [1, 2]	1. Clinical PA is required to establish diagnosis and medical necessity. 2. For adults and pediatric patients 9 yrs of age and older.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **SOFDRA**: prescribed by a dermatologist.
TOPICAL - ANTISEPTICS / DISINFECTANTS	MC/DEL	POVIDONE-IODINE SOLN	MC		BETADINE OINT	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
			MC		FORMALYDE-10 AERS		
			MC		IODOSORB		
			MC		LAZERFORMALYDE SOLUTION SOLN		
MISCELLANEOUS EYE							
OP. - EYE	MC	AK-DILATE SOLN	MC		LENS PLUS REWETTING DROPS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC	EYE WASH SOLN	MC/DEL		MURO 128		
	MC	NAPHAZOLINE HCL SOLN	MC		NEO-SYNEPHRINE SOLN		
	MC	PHENYLEPHRINE HCL SOLN					
	MC	PONTOCAINE SOLN					
	MC/DEL	SODIUM CHLORIDE					
MISCELLANEOUS EAR							
EAR	MC/DEL	A/B OTIC SOLN	MC		ANTIBIOTIC EAR SOLN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC	ACETASOL SOLN	MC		ANTIBIOTIC EAR SUSP		
	MC/DEL	ACETASOL HC SOLN	MC/DEL		CIPRODEX		
	MC/DEL	ACETIC ACID	MC/DEL		**CIPROFLOXACIN HCL**		
	MC/DEL	ACETIC ACID/HYDROCORTISON	MC/DEL		DEBROX SOLN		
	MC/DEL	ALLERGEN SOLN	MC		DERMOTIC		
	MC	CARBAMIDE PEROXIDE 6.5% OTIC SOLN	MC		FLOXIN		
	MC/DEL	CIPRO HC SUSP	MC		OTIPRIO		
	MC/DEL	CORTISPORIN-TC SUSP	MC		OTOVEL		

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
	MC/DEL	CORTOMYCIN					
	MC	COLY-MYCIN-S SUSP					
	MC	EAR DROPS SOLN					
	MC	EAR DROPS RX SOLN					
	MC/DEL	EAR WAX REMOVAL DROPS					
	MC	FLUOCINOLONE ACETONIDE OIL DROPS 0.01%					
	MC/DEL	NEOMYCIN/POLYMYXIN/HC					
	MC/DEL	OFLOXACIN 0.3% OTIC					
MOUTH ANTISEPTICS							
MOUTH ANTI-INFECTIVES	MC	NILSTAT SUSP	MC		MYCELEX TROC	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	NYSTATIN SUSP	MC		ORAVIG		
MOUTH ANTISEPTICS	MC/DEL	CHLORHEXIDINE GLUCONATE	MC		APHTHASOL PSTE [1]	Use PA Form# 20420 1. Must fail all preferred products before non-preferred.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	LIDOCAINE VISCOUS SOLN	MC		PERIOGARD SOLN [1]		
	MC	TRIAMCINOLONE IN ORABASE PSTE	MC		TRIAMCINOLONE ACETONIDE PSTE [1]		
	MC	TRIAMCINOLONE ORADENT PSTE					
DENTAL PRODUCTS							
DENTAL PRODUCTS	MC/DEL	ETHEDENT CREA	MC0MC		APF GEL	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	GEL-KAM CONC	MC/DEL		DENTAGEL GEL		
	MC/DEL	GEL-KAM GEL 0.4%	MC/DEL		PHOS-FLUR GEL		
	MC/DEL	PHOS FLUR SOLN	MC		THERA-FLUR-N GEL		
	MC/DEL	SF 5000 PLUS CREA					
	MC/DEL	SF GEL					
	MC	STANNOUS FLUORIDE ORAL RI CONC					
ARTIFICIAL SALIVA/STIMULANTS							
ARTIFICIAL SALIVA/ STIMULANTS	MC	SALIVA SUBSTITUTE SOLN	MC		EVOXAC CAPS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
			MC		RADIACARE SOLR		
			MC		SALAGEN TABS		
MISCELLANEOUS ANORECTAL							
ANORECTAL - MISC.	MC	CORTENEMA ENEM	MC/DEL		CORTIFOAM FOAM	Use PA Form# 20420	
	MC	ELA-MAX 5 CREA	MC/DEL		PROCTOFOAM HC FOAM		
	MC/DEL	PROCTOSOL HC CREA	MC/DEL		PROCTO-KIT CREA 2.5%		
	MC/DEL	PROCTOZONE-HC CREA	MC		RECTIV OINT		
T-CELL ACTIVATION INHIBITOR							
PSORIASIS BIOLOGICALS		ADALIMUMAB-FKJP [5,7]	MC		AMJEVITA	Use PA Form# 20910 1. Dosing limits apply, see Dosage Consolidation List. 2. Clinical PA required and will be preferred for the indication of plaque psoriasis, psoriatic arthritis and ankylosing spondylitis. 3. For the treatment of adults with moderate-to-severe plaque psoriasis who are candidates for systemic therapy or phototherapy. 4. Please see Criteria section. 5. Will not require a PA if at least one systemic drug such as methotrexate, cyclosporine, methoxsalen or acitretin is in members drug profile. 6. Clinical PA required and will be preferred for the indication of plaque psoriasis, psoriatic arthritis, Crohn's disease and ulcerative colitis. 7. Clinical PA required.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Cosentyx** approvals for 300mg dose(s) must use "300DOSE" package (containing 2 x 150mg pens or syringes). **Taltz**: It is recommended to assess for TB infection prior to starting treatment with **Taltz**. **Stelara** will require using preferred trial of **Skyrizi** if unable please provide clinical rational as why inappropriate.
	MC	ENBREL [1,5]	MC/DEL		BIMZELX [3]		
	MC	ENBREL SURECLICK [1]	MC		**COSENTYX [4]**		
	MC	HUMIRA [1,5]	MC/DEL		CYLTEZO		
	MC	OTEZLA	MC		HADLIMA		
	MC/DEL	PYZCHIVA [5,7]	MC/DEL		HULIO		
	MC	SELARSDI [5,7]	MC/DEL		HYRIMOZ		
	MC	SIMLANDI [5]	MC/DEL		ILUMYA [3]		
	MC/DEL	SKYRIZI [6]	MC		IMULDOSA		
	MC	TALTZ [2]	MC		OTEZLA XR [3,4]		
	MC	TREMFYA [5,7]	MC		OTULFI		
			MC		SOTYKTU		
			MC/DEL		SPEVIGO		
			MC/DEL		**STARJEMZA**		
			MC		STELARA		
			MC		STEQEYMA		
			MC		YESINTEK		
			MC		YUFLYMA		
			MC		YUSIMRY		
ALTERNATIVE MEDICINES							
ALTERNATIVE MEDICINES	MC	DIMETHYL SULFOXIDE SOLN	MC/DEL		CO-ENZYME Q-10	Use PA Form# 20420	Will only be approved for specific conditions supported by at least two double-blinded, placebo-controlled randomized trials that are not contradicted by other studies of similar quality.
	MC	MELATONIN					
CHELATING AGENTS							
CHELATING AGENTS			MC		CLOVIQUE	Use PA Form# 20420 1. FDA indication of treatment of chronic iron overload due to blood transfusions in members 2 years of age and older is required for approval of **Exjade**.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved **(in step order)**, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Clovique** should be used when continued treatment with penicillamine is no longer possible because of intolerable or life endangering side effects.
			MC		DEPEN TITRATABS TABS		
			MC/DEL		EXJADE [1]		

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
ANTILEPROTIC							
ANTILEPROTIC			MC		THALOMID CAPS [1]	Use PA Form# 20420 1. All PA requests for 150mg dosing will require use of **Thalomid** 100mg and 50mg capsules.	Approved for indications of leprosy, treatment-resistant multiple myeloma and AIDS.
ANTINEOPLASTIC AGENTS							
ANTINEOPLASTIC AGENTS - ANTIADNDROGENS	MC/DEL	BICALUTAMIDE	MC/DEL		CASODEX	Use PA Form# 20420	
ANTINEOPLASTIC AGENTS- LHRH ANALOGS	MC/DEL MC/DEL MC/DEL MC/DEL	LUPRON DEPOTSYRINGEKIT [1] LUPRON DEPOT- PED KIT(1-month) [1] LUPRON DEPOT-PED SYRINGEKIT (3-month) TRIPTODUR VIAL	MC/DEL MC/DEL MC/DEL MC		FIRMAGON [2] SUPPRELIN LA (IMPLANT) KIT TRELSTAR VANTAS [2]	Use PA Form# 20420 1. Dosing limits apply, please refer to Dosage Consolidation List. 2. PA required to confirm FDA approved indication.	
ANTINEOPLASTIC AGENTS - TYROSINE KINASE INHIBITORS			MC MC/DEL MC		SPRYCEL [1] TYKERB [2] GLEEVEC [1]	Use PA Form# 20420 1. Verification of diagnosis is required. 2. PA required to confirm FDA approved indication and to monitor for potential drug-drug interactions.	
ANTINEOPLASTICS-MISCELLANEOUS	MC MC/DEL MC/DEL	AMIFOSTINE MERCAPTOPURINE **OXALIPLATIN**	MC MC/DEL MC/DEL MC MC/DEL MC/DEL		DOCEFREZ ELOXATIN ETHYOL LEUPROLIDE PURINETHOL ZOLINZA	Use PA Form# 20420	
ANTINEOPLASTICS- MONOCLONAL ANTIBODIES	MC/DEL	TRAZIMERA	MC/DEL MC/DEL MC MC.DEL MC MC MC/DEL		ENHERTU HERCEPTIN HERCESSI HERZUMA KANJINTI OGIVRI ONTRUZANT	Use PA Form# 20420	
CANCER							
CANCER	MC MC/DEL MC MC MC/DEL MC MC/DEL MC	ALIMTA ANASTROZOLE TABS ERBITUX **IMATINIB MESYLATE** LETROZOLE RUXIENCE VIDAZA ZIRABEV	MC MC MC MC/DEL MC MC MC/DEL MC MC MC MC MC/DEL MC/DEL MC MC MC MC/DEL MC/DEL MC MC MC MC MC/DEL MC MC MC MC		ABECMA AKEEGA ALECENSA ALIQOPA [3] ALUNBRIG [1] ALYMSYS ARIMIDEX AUCATZYL AUGTYRO AVMAPKI-FAKZYNJA AYVAKIT AVASTIN BALVERSA BAVENCIO [1,8] BEIZRAY BENDEKA [3] BESPONSA [3] BESREMI [1] BIZENGRI BLENREP BOSULIF BRAFTOVI [1] BREYANZI BRUKINSA CABOMETYX [3] CAMCEVI CALQUENCE [3] COMETRIQ [3,4,5] COTELLIC COPIKTRA DANZITEN DARZALEX [3]	Use PA Form# 20420 1. PA required to confirm appropriate diagnosis and testing. 2. Avoid CYP3A drug interaction. 3. Clinical PA required for appropriate diagnosis. 4. Re-approval will require documentation of response without disease progression and tolerance to treatment. 5. Dosing limits apply, see Dosage Consolidation List. 6. Max daily dose of 300mg. 7. Monitor liver enzymes periodically and stop treatment upon Grade 3 or higher elevation of liver enzymes approved indication. 8. For patients ≥ 12 years of age. 9. For the treatment of patients up to 25 years of age with B-cell acute lymphoblastic leukemia (ALL) that is refractory or in second or later relapse.	All non-preferred: A clinical PA is required to confirm appropriate clinical indication for the individual drug request. Specific to each drug all age, clinical testing requirements, previous step therapies, adjunctive drug therapy requirements, and response without disease progression will be also be evaluated for clinical appropriateness. The standard for the appropriate indication will include the FDA label as well as current NCCN guidelines. **Scemblix** is for the treatment of adult patients with: Philadelphia chromosome-positive chronic myeloid leukemia (Ph+ CML) in chronic phase (CP), previously treated with two or more tyrosine kinase inhibitors (TKIs).

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
			MC/DEL		DATROWAY		
			MC/DEL		DAURISMO		
			MC/DEL		ELREXFIO		
			MC/DEL		EMPLICITI(IV) [8]		
			MC		EMRELIS		
			MC		EPKINLY		
			MC/DEL		**ERLEADA**		
			MC/DEL		ERIVEDGE		
			MC		EXKIVITY		
			MC		FARYDAK		
			MC/DEL		FEMARA		
			MC		FOLOTYN		
			MC		FOTIVDA		
			MC		FRUZAQLA		
			MC		GAVRETO		
			MC/DEL		GILOTRIF [4,5]		
			MC		GOMEKLI		
			MC		GRAFAPEX		
			MC/DEL		HERNEXEOS		
			MC/DEL		**HYRNUO**		
			MC/DEL		IBRANCE		
			MC		IBTROZI		
			MC		ICLUSIG [3]		
			MC/DEL		IDHIFA [3]		
			MC		IMBRUVICA		
			MC		IMDELLTRA		
			MC/DEL		IMFINZI		
			MC/DEL		IMJUDO		
			MC		IMKELDI		
			MC		IMLYGIC		
			MC		INLURIYO		
			MC/DEL		INLYTA		
			MC/DEL		INREBIC		
			MC		INQOVI		
			MC		ITOVEBI		
			MC		IWILFIN		
			MC		JAKAFI		
			MC		JAYPIRCA [1,2]		
			MC		JEMPERLI		
			MC		JOBEVNE		
			MC/DEL		KEYTRUDA [1]		
			MC		KEYTRUDA QLEX		
			MC		KIMMTRAK		
			MC		KISQALI [1]		
			MC/DEL		KOSELUGO		
			MC		KRAZATI [3]		
			MC		KYMRIAH [3,9]		
			MC		KYPROLIS [1]		
			MC		LARTRUVO [1]		
			MC		LAZCLUZE		
			MC		LENVIMA		
			MC/DEL		LIBTAYO [1]		
			MC		LONSURF		
			MC/DEL		LORBRENA		
			MC		LOQTORZI		
			MC		LUMAKRAS		
			MC/DEL		LUMOXITI [1]		
			MC		LUNSUMIO [1]		
			MC		LYNOZYFIC		
			MC		LYNPARZA [1]		
			MC		LYTGOBI		
			MC		NEXAVAR [1]		
			MC		NERLYNX [3]		

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
			MC		NINLARO(PO)		
			MC/DEL		NUBEQA		
			MC		MARGENZA		
			MC/DEL		MEKINIST [3,4]		
			MC/DEL		MEKTOVI [1]		
			MC		MODEYSO		
			MC		MONJUVI		
			MC/DEL		MYLOTARG [3]		
			MC/DEL		MVASI		
			MC		ODOMZO [1,2,5]		
			MC		OGSIVEO		
			MC		OJEMDA		
			MC		OJJAARA		
			MC		OMISIRGE		
			MC		ONUREG		
			MC/DEL		OPDIVO [3]		
			MC		OPDIVO QVANTIG		
			MC		OPDUALAG		
			MC		ORGOVYX		
			MC		ORSERDU [2,3]		
			MC		PADCEV		
			MC		PEMAZYRE		
			MC		PEPAXTO		
			MC		PHESGO		
			MC		PHYRAGO		
			MC/DEL		PIQRAY		
			MC		POLIVY		
			MC		POMALYST		
			MC		PORTRAZZA [3]		
			MC		QINLOCK		
			MC		RETEVMO		
			MC		REVUFORJ		
			MC/DEL		ROMVIMZA		
			MC		REZLIDHIA		
			MC/DEL		ROZLYTREK		
			MC		RUBRACA		
			MC		RITUXAN		
			MC		RYBREVANT		
			MC		RYDAPT		
			MC		RYLAZE		
			MC		RYTELO		
			MC/DEL		SARCLISA		
			MC		SCEMBLIX [1]		
			MC/DEL		STIVARGA		
			MC/DEL		SUTENT [1,2]		
			MC/DEL		SYLATRON		
			MC		TABRECTA		
			MC		TALVEY		
			MC/DEL		TAFINLAR [3,4,5,6]		
			MC		TAZVERIK		
			MC/DEL		TALZENNA [1]		
			MC/DEL		TAGRISSO		
			MC		TECARTUS		
			MC		TECELRA		
			MC		TECENTRIQ [1]		
			MC		TECENTRIQ HYBREZA		
			MC		TEPMETKO		
			MC		TEVIMBRA		
			MC/DEL		TIBSOVO [1]		
			MC		TIVDAK		
			MC		TRODELVY		
			MC		TRUSELTIQ		
			MC/DEL		TRUXIMA		

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
			MC/DEL		TRUQAP		
			MC		TUKYSA		
			MC		UKONIQ		
			MC/DEL		VANFLYTA		
			MC		VEGZELMA		
			MC		VENCLEXTA [3]		
			MC		VERZENIO [3]		
			MC/DEL		VITRAKVI		
			MC/DEL		VIZIMPRO [1]		
			MC		VONJO		
			MC		VORANIGO		
			MC/DEL		VYLOY		
			MC/DEL		WELIREG		
			MC/DEL		XALKORI		
			MC/DEL		XPOVIO		
			MC/DEL		XOSPATA		
			MC/DEL		XTANDI		
			MC/DEL		YERVOY		
			MC		YESCARTA [3]		
			MC/DEL		ZALTRAP		
			MC		ZEJULA [1]		
			MC/DEL		ZELBORAF		
			MC		ZEPZELCA		
			MC		ZIIHERA		
			MC		ZYDELIG		
			MC/DEL		ZYKADIA		
			MC		ZYNLONTA		
			MC		ZYNYZ [1]		
			MC		ZYTIGA		
IMMUNOSUPPRESSANTS							
IMMUNOSUPPRESSANTS	MC	GENGRAF CAPS	MC/DEL		CELLCEPT	Use PA Form# 20420 1. For the treatment of adult and pediatric patients 12 years and older with chronic graft-versus-host disease (chronic GVHD) after failure of at least 2 prior lines of systemic therapy. 2.Clinical PA is required.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Myhibbin:** For the prophylaxis of organ rejection, in adult and pediatric recipients 3 months of age and older of allogeneic kidney, heart, or liver transplants, in combination with other immunosuppressants. **DDI:** All preferred immunosuppressants will require clinical PA for patients over 60 that are currently on fluoroquinolone therapy. **DDI: Cyclosporine** will now be non-preferred and require prior authorization if it is currently being used in combination with either Lipitor (doses greater than 20mg/day), crestor, or lovastatin (doses greater than 20mg). **DDI: Cyclosporine** will require prior authorization when used with livalo.
	MC/DEL	MYCOPHENOLATE	MC/DEL		CYCLOSPORINE CAPS		
	MC/DEL	MYCOPHENOLIC ACID TAB DR	MC/DEL		CYCLOSPORINE SOL. MODIFIED		
	MC/DEL	NEORAL SOL	MC		ENVARSUS XR		
	MC/DEL	SANDIMMUNE	MC		MYFORTIC		
	MC/DEL	**TACROLIMUS CAPS**	MC		MYHIBBIN [2]		
			MC/DEL		NEORAL CAP		
			MC		PROGRAF CAPS		
			MC		REZUROCK [1]		
			MC/DEL		ZORTRESS		
IMMUNOSUPPRESSANTS- Misc.			MC		HYFTOR [1,2]	Use PA Form# 20420 1. For the treatment of patients ≥ 6 years 2. Clinical PA required for appropriate diagnosis and clinical parameters.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
PURINE ANALOG							
PURINE ANALOG	MC	AZASAN TABS	MC/DEL		**IMURAN TABS**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL	**AZATHIOPRINE TABS**					
K REMOVING RESINS							
K REMOVING RESINS	MC/DEL	LOKELMA	MC/DEL		SPS SUSP	Use PA Form# 20420	
	MC/DEL	SODIUM POLYSTYRENE SULFON	MC/DEL		SPS 30GM/120ML ENEMA SUSP		
			MC		VELTASSA		

New drugs are initially non-preferred until reviewed by the DUR Committee and the State. According to State policy, any drug requiring specific diagnosis still requires the specific diagnosis unless otherwise noted within this document.

PDL DOSAGE CONSOLIDATION LIST - EFFECTIVE 4/1/2026

Tabs / Caps / Patches: Quantities in Units
Sprays / Inhalers / Nebulizers: Quantities in GM, ML, or MCG
Injectibles: Quantities in ML
Multi-Dose Vial: MDV

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PREFERRED			
Drug Name	Strength	Limit/Day	Limit/Days
ACTOS	All Strengths	1	35/35
ADVAIR HFA	All Strengths	4	120/30
ALAVERT-NON DROW	TAB	1	96/96
ALENDRONATE	All Strengths	1/WK	35/35
AMLODIPINE	2.5MG	1.5	53/35 DAYS
AMLODIPINE	5MG	1.5	53/35 DAYS
AMMONIUM LACTATE LOTN	12%		1TUBE/8
AMPHETAMINE/DEXTROAMPHET ER	5MG	3	90/30
AMPHETAMINE/DEXTROAMPHET ER	10MG	3	90/30
AMPHETAMINE/DEXTROAMPHET ER	15MG	3	90/30
AMPHETAMINE/DEXTROAMPHET ER	20MG	2	60/30
AMPHETAMINE/DEXTROAMPHET ER	30MG	1	90/90
AMPHETAMINE SALT	5,10,15MG	3	105/35
AMPHETAMINE SALT	20MG	2	70/35
AMPHETAMINE SALT	30MG	1	35/35
ANDRODERM	2.5MG	2	60/30
ANDRODERM	5MG	1	30/30
ARICEPT	5MG	1	35/35
ARICEPT	10MG	1	35/35
ARIPIPRAZOLE	2MG	2	180/90
ARIPIPRAZOLE	5MG	2	180/90
ARIPIPRAZOLE	10MG	2	180/90
ARIPIPRAZOLE	15MG	2	180/90
ARIPIPRAZOLE	20MG	1.5	135/90
ARIPIPRAZOLE	30MG	1	90/90
ARIXTRA INJECTION	2.5MG/0.5ML		7/30
ARIXTRA INJECTION	5MG/0.4ML		7/30
ARIXTRA INJECTION	7.5MG/0.6ML		7/30
ARIXTRA INJECTION	10MG/0.8ML		7/30
ARMONAIR	All Strengths	I INHALATION	60U/30
ASMANEX 30 UNITS	220MCG	1 INHALATION	30U/30
ASMANEX 60 UNITS	220MCG	2 INHALATIONS	60U/30
ASMANEX 120 UNITS	220MCG	4 INHALATIONS	120U/30
ATOMOXETINE	All Strengths	1	90/90
ATRIPLA	600MG	1	35/35
ATROVENT HFA	17MCG	12 INHALATIONS	25.8/34
AVAPRO	75MG	1.5	53/35
AVAPRO	150MG	1	35/35
AZELEX	20%		1 TUBE/18
BENAZEPRIL	5MG	1	35/35
BENAZEPRIL	10MG	1.5	53/35
BENAZEPRIL	20MG	1	35/35
BENAZEP/HCTZ	5-6.25	1	35/35
BENAZEP/HCTZ	10/12.5	1	35/35
BENICAR-HCT	All Strengths	1	30/30
CARTIA XT	120MG	1	90/90
CARTIA XT	180MG	1	90/90
CARTIA XT	240MG	1	90/90
CARTIA XT	300MG	1	90/90
CATAPRES-TTS1	0.1 MG/24HR		5/35
CATAPRES- TTS2	0.2 MG/24HR		5/35
CATAPRES- TTS3	0.3 MG/24HR		5/35
CEFIXIME	400MG	2	2/7
CITALOPRAM	10MG	2	180/90
CITALOPRAM	20MG	2	180/90
CITALOPRAM	40MG	1	90/90
COMBIVENT	103-18MCG	12 INHALATIONS	30/35
CONCERTA	18MG	1	30/30
CONCERTA	27MG	1	30/30
CONCERTA	36MG	2	60/30
COPAXONE INJ	20MG		1/32
COPAXONE KIT	20MG/ML		1/30
DAYTRANA	10mg/9hr (27.5mg)	1	34/34
DAYTRANA	15mg/9hr (41.3mg)	1	34/34
DAYTRANA	20mg/9hr (55.0mg)	1	34/34
DAYTRANA	30mg/9hr (82.5mg)	1	34/34
DEPO-TESTOSTERONE	200MG/ML		20/90
DESMOPRESSIN	0.1MG	12	420/35
DESMOPRESSIN	0.2MG	6	210/35

NON-PREFERRED			
Drug Name	Strength	Limit/Day	Limit/Days
ABILIFY SOLUTION	1MG/ML	30ML	1020/34
ACCUPRIL	5MG	1	35/35
ACCUPRIL	10MG	1	35/35
ACCUPRIL	20MG	1	35/35
ACTONEL	5MG	1	35/35
ACTONEL	35MG	1/WK	5/35
ADDERALL XR	5MG	3	90/30
ADDERALL XR	10MG	3	90/30
ADDERALL XR	15MG	3	90/30
ADDERALL XR	20MG	2	60/30
ADDERALL XR	30MG	1	35/35
ADEMPAS	All Strengths	1	35/35
ADVAIR DISKUS	All Strengths	2	60/30
ADZENYS XR	All Strengths	1	30/30
AEROBID	250MCG	8 INHALATIONS	21/35
AEROBID-M	250MCG	8 INHALATIONS	21/35
ALTABAX	5GM		1 TUBE/30
ALTABAX	15GM		1 TUBE/30
ALTABAX	30GM		1 TUBE/30
ALTACE	1.25MG	1	35/35
ALTACE	2.5MG	1	35/35
ALTACE	5MG	1	35/35
AMBIEN	5MG		12/34
AMBIEN	10MG		12/34
AMBIEN CR	6.25MG		12/34
AMBIEN CR	12.5MG		12/34
AMERGE (Step 8)	1MG		12/30
AMERGE (Step 8)	2.5MG	2.5MG	12/30
AMMONIUM LACTATE CREA	12%		1 TUBE/10
ARAVA	10MG	1	35/35
ARCAPTA	75MCG	1 INHALATION	35/35
ATACAND	4MG	1.5	53/35
ATACAND	8MG	1.5	53/35
ATACAND	16MG	1	35/35
AVANDIA	2MG	1.5	53/35
AVANDIA	4MG	1	35/35
AXERT (Step 8)	6.25MG		12/30
AXERT (Step 8)	12.5MG		12/30
AZILECT	All Strengths	1	35/35
BACTROBAN CREAM			1 TUBE/30
BECONASE AQ	42MCG	8 INHALATIONS	50/30
BEVESPI AERO		4 INHALATIONS	120/30
BOTOX (ADULTS)	100U/ML	1 session/84 days	600U/84
BOTOX (CHILDREN>12)	100U/ML	1 session/84 days	400U/84
BREO ELLIPTA	100/25MCG	1 INHALATIONS	60/60
BRILINTA	All Strengths	2	70/35
BRINTELLIX	All Strengths	1	35/35
BUTRANS		1 patch/WK	4/28
BYETTA	5mcg inj	0.04ML	1.2ML/30
BYETTA	10mcg inj	0.08ML	2.4ML/30
CARDIZEM CD	120MG/24	1	35/35
CARDIZEM CD	180MG/24	1	35/35
CARDIZEM CD	240MG/24	1	35/35
CARDIZEM CD	300MG/24	1	35/35
CARDIZEM CD	360MG/24	1	35/35
CARDIZEM LA	120MG/24	1	35/35
CARDIZEM LA	180MG/24	1	35/35
CARDIZEM LA	240MG/24	1	35/35
CARDIZEM LA	300MG/24	1	35/35
CARDIZEM LA	360MG/24	1	35/35
CARDURA	1MG	1	35/35
CARDURA	2MG	1.5	53/35
CARDURA	4MG	1.5	53/35
CELEBREX	100MG	1	35/35
CELEBREX	200MG	2	70/35
CELEBREX	400MG	1	35/35
CELEXA	20mg	0.5	17/34
CELEXA	40mg	1	51/34
CLARINEX	REDI TAB	1	35/35

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PREFERRED			
Drug Name	Strength	Limit/Day	Limit/Days
DESONIDE	0.05%		2 TUBES/30
DESOWEN	0.05%		2 TUBES/30
DEXEDRINE	All Strengths	3	90/30
DEXILANT	All Strengths	1	35/35
DEXTROAMPHETAMINE	All Strengths	3	90/30
DICLOFENAC 1% GEL	1% GEL		2 TUBES/30
DILTIA - XT	120MG/24	1	90/90
DILTIA - XT	180MG	1	90/90
DILTIA - XT	240MG/24	1	90/90
DILTIAZEM CAP ER	120MG	1	90/90
DILTIAZEM CAP XR	120MG	1	90/90
DILTIAZEM CAP	120MG/24	1	90/90
DILTIAZEM CAP	180MG/24	1	90/90
DILTIAZEM CAP ER	240MG	1	90/90
DILTIAZEM CAP XR	240MG	1	90/90
DILTIAZEM XR CAP	240MG/24	1	90/90
DILTIAZEM CAP	240MG/24	1	90/90
DILTIAZEM CAP	300MG/24	1	90/90
DIOVAN	80MG	1	35/35
DIOVAN - HCT	80 - 12.5	1	35/35
DORAL	7.5MG		10/30
DOXAZOSIN	1MG	1	90/90
DOXAZOSIN	2MG	1.5	135/90
DOXAZOSIN	4MG	1.5	135/90
DRYSOL SOL	20%		1 BOTTLE/30DAYS
DULOXETINE	20MG	3	270/90
DULOXETINE	30MG	3	270/90
DULOXETINE	60MG	2	180/90
ENALAPR/HCTZ	5-12.5	1	90/90
ENALAPRIL	2.5	1	90/90
ENALAPRIL	5MG	1.5	135/90
ENALAPRIL	10MG	1.5	135/90
ENBREL	25MG/ML		8/28
ENBREL SURECLICK			8/28
ESTAZOLAM	1MG		10/30
ESTAZOLAM	2MG		10/30
ESTRING MIS	2MG		1/90
FENTANYL	25MCG/HR		11/33
FENTANYL	50MCG/HR		11/33
FENTANYL	75MCG/HR		11/33
FENTANYL	100MCG/HR		22/33
FINASTERIDE	5MG	1	90/90
FLOVENT DISKUS	50MCG, 100MCG	4 INHALATIONS	60/30
FLOVENT DISKUS	250MCG	3 INHALATIONS	120/30
FLOVENT HFA 44MCG	44MCG	4 INHALATIONS	10.6/30
FLOVENT HFA 110MCG	110MCG	4 INHALATIONS	12/30
FLOVENT HFA 220MCG	220MCG	8 INHALATIONS	24/30
FLUCONAZOLE	150MG		1/7
FLUOXETINE CAP	10MG	3	270/90
FLUOXETINE CAP	20MG	4	360/90
FLUOXETINE CAP	40MG	2	180/90
FLURAZEPAM	15MG		10/30
FLURAZEPAM	30MG		10/30
FLUTICASONE SPR		4 SPRAYS	48/90
FLUVOXAMINE	25MG	3	270/90
FLUVOXAMINE	50MG	3	270/90
FOCALIN	All Strengths	3	105/35
FOCALIN XR	All Strengths	1	35/35
FOSINOPRIL	10MG	1.5	135/90
FOSINOPRIL	20MG	2	180/90
FRAGMIN INJ	10000U/ML	2ML	14/7
FRAGMIN INJ	2500U/.2ML	0.4ML	2.80/7
FRAGMIN INJ	25000U/ML	0.8ML	5.6/7
FRAGMIN INJ	5000U/.2ML	0.4ML	2.80/7
FRAGMIN INJ	7500U/.3ML	0.6ML	4.2/7
GABAPENTIN	300MG	9	810/90
GABAPENTIN	400MG	9	810/90
GABAPENTIN	600MG	6	540/90
GABAPENTIN	800MG	4	360/90

NON-PREFERRED			
Drug Name	Strength	Limit/Day	Limit/Days
CLEOCIN-T		1 PACKAGE	1/30
CLINDAMYCIN PHOSPHATE		1 PACKAGE	1/30
COMETRIQ	80MG	1	35/35
COMETRIQ	20MG	3	105/35
COREG CR	All Strengths	1	34/34
COSENTYX	150MG	1	1/30
CRESTOR	5MG	1	35/35
CRESTOR	10MG	1	35/35
CRESTOR	20MG	1	35/35
CRESTOR	40MG	1	35/35
CYMBALTA	All Strengths	1	35/35
DALMANE	15MG		10/30
DALMANE	30MG		10/30
DAYPRO	600MG	2	70/35
DDAVP	5ML		15/34
DENAVIR CREAM			2gm/30
DEPO-PROVERA	150MG/ML		1/90
DEPO-PROVERA	400MG/ML		2.5/90
DETROL LA	2MG	1	35/35
DIFLUCAN	150MG		1/7
DILACOR XR	240MG/24	1	35/35
DILACOR XR	120MG/24	1	35/35
DILACOR XR	180MG/24	1	35/35
DILTIAZEM CAP	360MG/24	1	90/90
DITROPAN XL	5MG	1	35/35
DITROPAN XL	10MG	2	70/35
DURAGESIC PATCHES	12.5MCG/HR		11/33
DURAGESIC PATCHES	25MCG/HR		11/33
DURAGESIC PATCHES	50MCG/HR		11/33
DURAGESIC PATCHES	75MCG/HR		11/33
DURAGESIC PATCHES	100MCG/HR		22/33
EDEX	All Strengths		1/30
EFFEXOR XR	37.5MG	1	35/35
EFFEXOR XR	75MG	1	35/35
EMSAM	All Strengths	1	34/34
EVENITY		12 DOSES/LIFETIME	12 DOSES/LIFETIME
EVOTAZ	All Strengths	1	30/30
FELODIPINE	2.5MG	1	90/90
FELODIPINE	5MG	1.5	135/90
FETZIMA	All Strengths	1	35/35
FLONASE	50MCG	4 SPRAYS	32/34
FLUNISOLIDE SOLN	0.025%	16 SPRAYS	75/30
FORFIVO XL	All Strengths	1	35/35
FOSAMAX	5MG	1	35/35
FOSAMAX	10MG	1	35/35
FOSAMAX	70MG	1/WK	5/35
FOSAMAX	40MG	2/WK	10/35
FROVA TAB (Step 8)	2.5MG		12/30
FULYZAQ	125MG	2	70/35
FUZEON	KIT	1	1/30
FYCOMPA	All Strengths	1	35/35
GILOTRIF	All Strengths	1	35/35
GLUCOSE TES STRP		12	420/35
GLUCAGEN INJ. HYPOKIT			2/30
HALCION	0.125MG		10/35
HALCION	0.25		10/35
HYTRIN	1MG	1	35/35
HYTRIN	5MG	1	35/35
HYZAAR	50-12.5	1	35/35
ILARIS			2/28
IMDUR	30MG	1.5	53/35
IMDUR	60MG	1.5	53/35
IMITREX (step 8)	25MG		12/30
IMITREX (step 8)	50MG		12/30
IMITREX (step 8)	100MG		12/30
IMITREX VIAL	All Strengths		6 boxes/30
IMITREX CARTRIDGE	All Strengths		12/30
IMITREX NASAL SPRAY	All Strengths		12/30
IMITREX PEN INJCTR	All Strengths		12/30

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PREFERRED			
Drug Name	Strength	Limit/Day	Limit/Days
GEODON	20MG	2	70/35
GEODON	40MG	2	70/35
GEODON	60MG	2	70/35
GEODON	80MG	2	70/35
GEODON	INJ	2	70/35
GLIMEPIRIDE	1MG	1	90/90
GLIMEPIRIDE	2MG	1	90/90
GLYCOLAX[1]	255GM		255GM/90
HUMIRA	40mg/0.8ml		4/28
HYDROXYZINE TAB	All Strengths	3	270/90
IMIQUIMOD	5%		12/28
INTAL	800MCG	8 INHALATIONS	28.4/34
IRBESARTAN	All Strengths	1	90/90
ISOSORBIDE MONO	30MG	2	180/90
ISOSORBIDE MONO	60 MG	1.5	135/90
JANUMET	All Strengths	2	70/35
JANUVIA	All Strengths	1	35/35
JUVISYNC	All Strengths	1	35/35
KETOPROFEN	100MG	2	180/90
KETOPROFEN	200MG	1	90/90
KETOROLAC	10MG	4.8	24/30
LAC-HYDRIN CREAM	12%		1TUBE/30
LAMOTRIGINE	25MG	6	540/90
LAMOTRIGINE	100MG	2	180/90
LANSOPRAZOLE CAPS	All Strengths	2	180/90
LATUDA	All Strengths	1	17/34
LEFLUNOMIDE	10MG	1	90/90
LESCOL	20MG	1	35/35
LEXAPRO	5MG	0.5	15/30
LIPITOR	10MG	1	35/35
LIPITOR	20MG	1	35/35
LIPITOR	40MG	1.5	53/35
LISINOP/HCTZ	10/12.5MG	1	90/90
LINEZOLID	600mg		28/60
LINZESS	All Strengths	1	35/35
LOSARTAN	All Strengths	1	90/90
LOSARTAN- HCT	All Strengths	1	90/90
LOTENSIN - HCT	5 - 6.25	1	35/35
LOTENSIN - HCT	10 - 12.5	1	35/35
LOVASTATIN	10MG	1.5	135/90
LOVASTATIN	20MG	1.5	135/90
LOVENOX INJ	30MG/.3ML	0.6	14 injections/7
LOVENOX INJ	40MG/.4ML	0.8	14 injections/7
LOVENOX INJ	60MG/.6ML	1.2	14 injections/7
LOVENOX INJ	80MG/.8ML	1.6	14 injections/7
LOVENOX INJ	100MG/ML	2	14 injections/7
LOVENOX INJ	120MG/.8ML	1.6	14 injections/7
LOVENOX INJ	150MG/ML	2	14 injections/7
LUPRON DEPOT INJ	11.25MG	KIT	1/90
LUPRON DEPOT INJ	30MG		1/90
LUPRON DEPOT INJ	30MG	KIT	1/90
MAXAIR AUTO	200MCG	12 INHALATIONS	14/30
MAXALT (step 8)	10MG		12/30
MAXALT MLT (step 1)	5MG		12/30
MAXALT MLT (step 1)	10MG		12/30
MEDROXYPR AC	150MG/ML		1/90
METADATE ER	10,20MG	3	90/30
METFORMIN ER	500MG	4	360/90
METHYLIN	All Strengths	3	90/30
METHYLPHENIDATE ER	36mg	2	180/90
METHYLPHENIDATE	All Strengths	3	90/30
METRONIDAZOLE GEL		1 PACKAGE	1/30
METRONIDAZOLE LOTION		1 PACKAGE	1/30
MIACALCIN		3.75ml	1 bottle/34
MICARDIS	All Strengths	1	30/30
MICARDIS-HCT	All Strengths	1	30/30
MIRTAZAPINE	15mg	3	270/90
MUPIROCIN			1 TUBE/30
NABUMETONE	500MG	2	180/90

NON-PREFERRED			
Drug Name	Strength	Limit/Day	Limit/Days
INVOKANA	All Strengths	1	35/35
IPRATROPIUM 15ML	0.06%	16 SPRAYS	135/90
IPRATROPIUM 30ML	0.03%	12 SPRAYS	90/90
KHEDEZLA	All Strengths	1	35/35
LAMICTAL	25MG	6	210/35
LAMICTAL	25MG CHW	6	210/35
LAMICTAL	100MG	2	70/35
LAMISIL	250MG	1	35/35
LOTENSIN	5MG	1	35/35
LOTENSIN	10MG	1.5	35/35
LOTENSIN	20MG	1	53/35
LUNESTA	1MG		12/34
LUNESTA	2MG		12/34
LUNESTA	3MG		12/34
LYRICA	25,50,75MG	3	102/35
LYRICA	100,150,200MG	3	102/35
LYRICA	225,300MG	2	70/35
MAXALT (step 8)	5MG		12/30
MELOXICAM TABS	All Strengths	1	90/90
METROCREAM		1 PACKAGE	1/30
METROGEL		1 PACKAGE	1/30
METROLOTION		1 PACKAGE	1/30
MEVACOR	10MG	1.5	53/35
MEVACOR	20MG	1.5	53/35
MIGRANAL NASAL SPRAY	All Strengths		12/30
MIRALAX	255G	8.5G	1 bottle/30
MIRALAX	17G/PACKET	0.5 packet	15 packets/30
MOBIC	7.5 MG	1	35/35
MOBIC	15MG	1	35/35
MOEXIPRIL	7.5	1.5	135/90
MONOPRIL	10MG	1.5	53/35
MONOPRIL	20MG	2	70/35
NASACORT AERS	55 MCG	4 SPRAYS	9.3/25
NASACORT AQ	55MCG	4 SPRAYS	17/30
NATROBA		120ML	1 bottle/30
NAYZILAM	All Strengths		5/30
NEUPOGEN INJ	300MCG/ML		10/30
NEUPOGEN INJ	480MCG/1.6		16/30
NEUPOGEN INJ	300MCG/.5ML		5/30
NEUPOGEN INJ	480MCG/.8ML		8/30
NEURONTIN	300MG	9	315/35
NEURONTIN	600MG	9	315/35
NEXIUM	20MG	1	35/35
NEXIUM	40MG	2	70/35
NEXIUM SUS	All Strengths	1	30/30
NORVASC	2.5MG	1.5	53/35 DAYS
NORVASC	5MG	1.5	53/35 DAYS
ODOMZO	200mg	1	30/30
OPSUMIT	All Strengths	1	35/35
ORUVAIL	200MG	1	35/35
OXYCODONE ER	10,20,40MG	2	70/35
OXYCODONE ER	80MG	4	140/35
OXYCONTIN[1]	10,20,30,40MG	2	70/35
OXYCONTIN[1]	80MG	4	140/35
PAXIL	10MG	1.5	53/35
PAXIL	20MG	1	35/35
PLAN B			2/15 or 4/30
PLENDIL	2.5MG	1	35/35
PLENDIL	5MG	1.5	53/35
PRAVACHOL	10MG	1	35/35
PRAVACHOL	20MG	1	35/35
PRAVACHOL	40MG	1	35/35
PRAVACHOL	80MG	1	35/35
PREVPAC MIS	500MG-30MG		14/30
PRILOSEC OTC	20MG	2	168/84
PRINIVIL	2.5MG	1	35/35
PRINIVIL	5MG	1	35/35
PRINIVIL	10MG	1.5	53/35
PRINIVIL	20MG	1.5	53/35

PDL DOSAGE CONSOLIDATION LIST - EFFECTIVE 4/1/2026

Tabs / Caps / Patches: Quantities in Units
Sprays / Inhalers / Nebulizers: Quantities in GM, ML, or MCG
Injectibles: Quantities in ML
Multi-Dose Vial: MDV

Shaded areas are non-preferred agents - Quantities of these non-preferred agents are available up to the limit only with prior authorization.

PREFERRED			
Drug Name	Strength	Limit/Day	Limit/Days
NABUMETONE	750MG	2	180/90
NARATRIPTAN			12/30
NASONEX	50MCG	4 SPRAYS	17/30
NIFEDIPINE CR	90MG	1	90/90
NIFEDIPINE ER	30MG	1	90/90
NIFEDIPINE ER	60MG	1	90/90
NIFEDIPINE ER	90MG	1	90/90
NIFEDIPINE ER,CR	30MG	1	90/90
NURTEC ODT	All Strengths		8/30
NUVARING		1/MO	1/28
OLMESARTAN	All Strengths	1	90/90
OLANZAPINE	2.5MG	3	270/90
OLANZAPINE	5MG	3	270/90
OLANZAPINE	7.5MG	3	270/90
OLANZAPINE	10MG	3	270/90
OLANZAPINE	15MH	2	180/90
OLANZAPINE	20MG	1.5	135/90
OLANZAPINE ODT	All Strengths	1	90/90
OMEPRAZOLE	10MG	2	180/90
OMEPRAZOLE	20MG	2	180/90
OMEPRAZOLE	40MG	2	180/90
OMNARIS	50MCG	4 sprays	12.5/30
OXAPROZIN	600MG	2	180/90
PANTOPRAZOLE	All Strengths	2	180/90
PAROXETINE	10MG	2	180/90
PAROXETINE	20MG	2	180/90
PEGASYS KIT		KIT	1/28
PRAVASTATIN	10MG	1	35/35
PRAVASTATIN	20MG	1	35/35
PRAVASTATIN	40MG	2	180/90
PRAVASTATIN	80MG	1	35/35
PROAIR HFA	90mcg	12 INHALATIONS	17/34
QUETIAPINE	25MG	3	270/90
QUETIAPINE	50MG	3	270/90
QUETIAPINE	100MG	3	270/90
QUETIAPINE	200MG	3	270/90
QUINAPRIL	5MG	1	90/90
QUINAPRIL	10MG	1	90/90
QUINAPRIL	20MG	1	90/90
QVAR AERS	All Strengths	8 Inhalations	14.6/25
RANITIDINE SYRUP [2]	15MG/ML	20ML	700ML/35
REFRESH PLUS		15 ML	1 bottle/30
REFRESH PLUS		30 ML	2 bottles/30
RELPAX	All Strengths		12/30
REYATAZ	All Strengths	1	35/35
RISPERIDONE	0.25MG	3	270/90
RISPERIDONE	0.5MG	3	270/90
RISPERIDONE	1MG	3	270/90
RISPERIDONE	2MG	3	270/90
RISPERIDONE	3MG	2	180/90
RISPERIDONE	4MG	2	180/90
RISPERIDONE SOL.	1MG/ML	8ML	280/35
RITALIN LA	All Strengths	1	35/35
RITALIN LA	30mg	2	70/35
SEREVENT DISKUS	50MCG	2 INHALATIONS	60/30
SEROQUEL	100MG		45/30
SERTRALINE	25MG	3	270/90
SERTRALINE	50MG	3	270/90
SERTRALINE	100MG	3	270/90
SIMVASTATIN	5MG	1	35/35
SIMVASTATIN	10MG	1.5	53/35
SIMVASTATIN	20MG	1.5	53/35
SIMVASTATIN	40MG	1.5	53/35
SINGULAIR	4MG	1	35/35
SINGULAIR	5MG	1	35/35
SINGULAIR	10MG	1	35/35
SPIRIVA	HANDIHLR	1 INHALTION	30/30
SUMATRIPTAN NASAL SPRAY	All Strengths		12/30
SUMATRIPTAN PEN INJ	All Strengths		12/30

NON-PREFERRED			
Drug Name	Strength	Limit/Day	Limit/Days
PRINZIDE	10-12.5	1	35/35
PROTONIX	20MG	2	70/35
PROTONIX	40MG	2	70/35
PROZAC	10MG	1.5	53/35
REFRESH TEARS		15 ML	1 bottle/30
REFRESH TEARS		30 ML	2 bottles/30
RELAFEN	500MG	2	70/35
RELAFEN	750MG	2	70/35
REMERON	15MG	1.5	53/35
REMODULIN	All Strengths		1 MDV/30
RESCULA			2 bottles/35
RESTORIL	7.5MG		10/30
RESTORIL	15MG		10/30
RESTORIL	30MG		10/30
REVLIMID	All Strengths	1	35/35
REYVOW	All Strengths		4/30
RHINOCORT AQ	32MCG	8 SPRAYS	18/30
RISPERDAL	0.5MG	1.5	53/35
RISPERDAL	0.25MG	1.5	53/35
RISPERDAL	1MG	1.5	53/35
RISPERDAL	2MG	1.5	53/35
RISPERDAL	3MG	2	70/35
RISPERDAL	4MG	2	70/35
RISPERDAL INJ	25MG		2/28
RISPERDAL INJ	37.5		2/28
RISPERDAL INJ	50MG		2/28
RISPERDAL M-TAB	0.5MG	1.5	53/35
RISPERDAL M-TAB	1MG	1.5	53/35
RISPERDAL M-TAB	2MG	4	140/35
RISPERDAL SOL.	1MG/ML	8ML	280/35
SAVELLA	All Strengths	2	70/35
SEROQUEL XR	150MG	1	35/35
SEROQUEL XR	200MG	1	35/35
SEROQUEL XR	300MG	2	70/35
SEROQUEL XR	400MG	2	70/35
SIMVASTATIN	80MG	1	35/35
SONATA	5MG		12/34
SONATA	10MG		12/34
SPORANOX SOL	10MG/ML	10ML/ML	300cc/30
SPORANOX PULSEPAK	F		30/30
SPORANOX	100MG		30/30
STADOL INJ	1MG/ML		9/35
STADOL INJ	2MG/ML		9/35
STRATTERA	All Strengths	1	35/35
SULAR	10MG	1.5	53/35
SULAR	20MG	1	35/35
SYNVISC INJ	8MG/ML		2/30
TAFINLAR	50MG	6	210/35
TAFINLAR	75MG	4	140/35
TAZTIA XT CAP	120MG/24	1	90/90
TAZTIA XT CAP	180MG/24	1	90/90
TAZTIA XT CAP	240MG/24	1	90/90
TAZTIA XT CAP	300MG/24	1	90/90
TAZTIA XT CAP	360MG/24	1	90/90
TEMAZEPAM	7.5MG		10/30
TEQUIN	200MG	1	35/35
TIAZAC	120MG/24	1	35/35
TIAZAC	180MG/24	1	35/35
TIAZAC	240MG/24	1	35/35
TIAZAC	300MG/24	1	35/35
TIAZAC	360MG/24	1	35/35
TIAZAC	420MG/24	1	35/35
TOPAMAX SPRINKLES	All Strengths	1	35/35
TOPROL XL	25MG	1.5	53/35
TOPROL XL	50MG	1.5	53/35
TRAMADOL/ APAP	37.5/325MG	8	720/90
TRELEGY ELLIPTA	All Strengths	1INHALATION	30U/30
TREXIMET	85/500	2.5	12/30
TROKENDI XR	25MG	1	35/35

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PREFERRED			
Drug Name	Strength	Limit/Day	Limit/Days
SUMATRIPTAN SYRINGE	All Strengths		12/30
SUMATRIPTAN TAB	All Strengths		12/30
SUPRAX	400MG	1	1/7
SYRINGES		10	1000/100
TELMISARTAN	All Strengths	1	90/90
TEMAZEPAM	15MG		10/30
TEMAZEPAM	30MG		10/30
TERAZOSIN	1MG	1	90/90
TERAZOSIN	5MG	1	90/90
TERBINAFINE	250MG	1	35/35
TEST STRIPS	Blood Glucose	12	420/35
TILADE	1.75MG	8 INHALATIONS	48.6/35
TRADJENTA	All Strengths	1	35/35
TRAMADOL	50MG	8	720/90
TRIAZOLAM	0.125MG		10/30
TRIAZOLAM	0.25MG		10/30
VALSARTAN-HCT	All Strengths	1	90/90
VALTOCO	All Strengths		10/30
VENLAFAXINE TABS	25	3	270/90
VENLAFAXINE TABS	37.5	3	270/90
VENLAFAXINE TABS	100	3	270/90
VENLAFAXINE ER CAPS	37.5	3	270/90
VENLAFAXINE ER CAPS	75	3	270/90
VENLAFAXINE ER	150	2	180/90
VENTOLIN HFA	90MCG	12 INHALATIONS	36/34
VERAPAMIL ER, SR	120MG	1	90/90
VERAPAMIL ER, CR, SR	180MG	2	90/90
VERAPAMIL ER, CR, SR	240MG	2	90/90
VYVANSE	All Strengths	1	35/35
VYVANSE CHEW	All Strengths	1	35/35
ZALEPLON	All Strengths		30/30
ZIPRASIDONE	20MG	3	270/90
ZIPRASIDONE	40MG	3	270/90
ZOLMITRIPTAN TAB	All Strengths		12/30
ZOLPIDEM (step 1)	5MG		30/30
ZOLPIDEM (step 1)	10MG		30/30
ZTLIDO	All Strengths	3	90/30
ZYPREXA	2.5MG	1.5	53/35
ZYPREXA	5MG	1	35/35
ZYPREXA	7.5MG	1	35/35
ZYPREXA	10MG	1	35/35
ZYPREXA	15MG	1	35/35
ZYPREXA	20MG	1	35/35

NON-PREFERRED			
Drug Name	Strength	Limit/Day	Limit/Days
TROKENDI XR	50MG	1	35/35
TROKENDI XR	100MG	1	35/35
TROKENDI XR	200MG	2	70/35
UBRELVY	All Strengths		10/30
UNIVASC	7.5MG	1.5	53/35 DAYS
UTIBRON	27.5mcg/15.6mcg	2 INHALATIONS	60/30
VASERETIC	5-12.5MG	1	35/35
VASOTEC	2.5MG	1	35/35
VASOTEC	5MG	1.5	53/35
VASOTEC	10MG	1.5	53/35
VERAMYST	27.5MCG	4 sprays	10/30
VERELAN	180MG	1	35/35
VERELAN SR	120MG	1	35/35
VERELAN SR	180MG	1	35/35
VERELAN SR	240MG	2	70/35
VYEPTI	All Strengths		4/30
XIFYRM	All Strengths	1	90/90
XOPENEX HFA		12 INHALATIONS	2 INHALERS/34
XOPENEX NEB		12CC	408/34
ZECUITY	6.5		4/28
ZEMBRACE	All Strengths		3boxes/30
ZESTORETIC	10-12.5	1	35/35
ZESTRIL	2.5MG	1	35/35
ZESTRIL	5MG	1	35/35
ZESTRIL	10MG	1.5	53/35
ZESTRIL	20MG	1.5	53/35
ZETONNA	37MCG	2	60/30
ZOCOR	5MG	1	35/35
ZOCOR	10MG	1.5	53/35
ZOCOR	20MG	1.5	53/35
ZOCOR	40MG	1.5	53/35
ZOFRAN [2]	4MG	3	90/30
ZOFRAN [2]	8MG	1.5	45/30
ZOFRAN [2]	24MG	0.5	15/30
ZOFRAN [2]	4MG/5ML	15ML	450/30
ZOLOFT	25MG	0.5	18/35
ZOLOFT	50MG	0.5	18/35
ZOLOFT	100MG	3	105/35
ZOMIG (Step 8)	5MG		12/30
ZYPREXA ZYDIS	5MG	1	35/35
ZYPREXA ZYDIS	10MG	1	35/35
ZYPREXA ZYDIS	15MG	1	35/35
ZYPREXA ZYDIS	20MG	1	35/35

PREFERRED

1. GLYCOLAX: Available for once daily dosing to members under the age of 18 years.

2. RANITIDINE SYRUP: Available without PA to users less than 6 years old.

NON-PREFERRED

1. OXYCONTIN: Available without PA with CA and HO diag.

2. ZOFRAN: Cancer diagnosis with non-daily chemotherapy required.

Pain Management Policy

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Beginning January 2017, all current opiate users who are above the maximum combined daily dose of 100 MME must titrate their total daily dose of opioid medications below 30 MME. Also, the maximum daily supply of an opiate prescription for acute pain will be limited to 7-day supplies. The maximum day supply of an opiate prescription for chronic pain will be limited to 30-day supplies. As of July 1, 2017 all users of opioid medications must comply with the maximum combined daily dose of 100 MME.

However, for MaineCare members, effective January 1, 2017, opioid prescription(s) for more than a 7-day supply and/or more than 30 MME/ day will require a prior authorization. Please note that MaineCare implemented a 30 MME limit January 1, 2013 that is still effective.

The following are general exceptions: pain associated with cancer treatment, end-of-life and hospice care, palliative care, and symptoms related to HIV/AIDS. Per MaineCare criteria, the diagnosis of cancer must be written on the prescription. A palliative care exception for any MaineCare opioid prescription will require prior authorization (PA) with appropriate clinical documentation.

Post-surgical members may receive prior authorizations for opiates up to a 60 days in length if medical necessity is provided by the surgical provider.

An MME conversion chart is available at www.mainecarepdl.org. Click on “General Pharmacy Info.”

Updated July 1, 2025