

## MaineCare PDL

**PDL Effective October 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.mainearepdl.org](http://www.mainearepdl.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.mainearepdl.org](http://www.mainearepdl.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<br>PA Required                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                             | Criteria                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
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| AROMATIC L-AMINO ACID DECARBOXYLASE DEFICIENCY (AADC) |                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                          |            |                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| AADC DEFICIENCY AGENTS                                |                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                       | MC                                                                                                                       |            | KEBILIDI (INJECTION) VIAL 280000000000 VG/0.5ML<br>ELDOCEGENE EXUPARVOVEC-TNEQ                                                                                                                                                        | <a href="#">Use PA Form# 20420</a>                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| COVID-19 THERAPEUTICS                                 |                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                          |            |                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| COVID-19 MEDICATIONS                                  | MC/DEL                                                                                                                                                                 | PAXLOVID                                                                                                                                                                                                                                                                                                                                                                              | MC                                                                                                                       |            | XOCOVA <sup>1</sup>                                                                                                                                                                                                                   | 1. Clinical PA required for the treatment of adults and adolescents 12 years of age and older who have been exposed to someone with COVID-19 who are at high risk for progression to severe COVID-19 including hospitalization or death. Treatment must be initiated within 72 hours of first-known contact with an individual with confirmed COVID-19.     | XOCOVA: for post-exposure prophylaxis of COVID-19 in adults and adolescents 12 years of age and older following contact with an individual who has COVID-19, who are at high risk for progression to severe COVID-19 including hospitalization or death. The member must have at least one risk factor associated with severe disease, such as 65 years of age or older, chronic lung disease, significant cardiovascular disease, diabetes mellitus, chronic kidney disease, or an immunocompromising condition or receipt of immunosuppressive therapy. Treatment must be initiated within 72 hours of first-known contact with an individual with confirmed COVID-19.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| ASSORTED ANTIBIOTICS                                  |                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                          |            |                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| BETA-LACTAMS / CLAVULANATE COMBO'S                    | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC<br>MC/DEL<br>MC                                                                                             | AMOXICILLIN<br>AMOXICILLIN/POTASSIUM CLA CHEW<br>AMOXICILLIN/POTASSIUM CLA SUSR<br>AMOXICILLIN/POTASSIUM CLA TABS<br>AMPICILLIN<br>BICILLIN L-A SUSP<br>DICLOXACILLIN SODIUM CAPS<br>OXACILLIN SODIUM SOLR<br>PENICILLIN V POTASSIUM<br>UNASYN SOLR                                                                                                                                   | MC/DEL<br>MC/DEL<br>MC                                                                                                   |            | AUGMENTIN <sup>1</sup><br>AUGMENTIN XR TB12 <sup>2</sup><br>PIVYA                                                                                                                                                                     | <a href="#">Use PA Form# 20420</a><br>1. Chewable 125mg & 250mg and Solution 125mg/5ml and 250mg/5ml available without PA.<br>2. 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.<br><br>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<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC | CEFADROXIL HEMIHYDRATE<br>CEFAZOLIN SODIUM SOLR<br>CEFDINIR<br>CEFEPIME<br>CEFPODOXIME<br>CEFPODOXIME PROXETIL SUS<br>CEFPODOXIME PROXETIL TAB<br>CEFIXIME 400MG CAP <sup>2</sup><br>CEFPROZIL<br>CEPHALEXIN 250MG & 500MG CAPS<br>CEFTAZIDIME 6MG<br>CEFTIN SUSP<br>CEFTRIAXONE<br>CEFUROXIME AXETIL TABS<br>CEPHALEXIN MONOHYDRATE<br>FORTAZ SOLR<br>SUPRAX CHEWABLE<br>TAZICEF 6GM | MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC<br>MC<br>MC/DEL<br>MC<br>MC<br>MC/DEL<br>MC<br>MC<br>MC/DEL<br>MC |            | CEDAX<br>CEFADROXIL MONOHYDRATE TABS<br>CEFIXIME SUS<br>CEPHALEXIN TABS<br>CEFTIN<br>FETROJA <sup>3</sup><br>FORTAZ<br>FORTAZ SOLN<br>KEFLEX CAPS<br>OMNICEF<br>ROCEPHIN<br>SUPRAX <sup>2</sup><br>TAZICEF SOLR<br>TEFLARO<br>ZEVTERA | <a href="#">Use PA Form# 20420</a><br>1. Both brand and generic are clinically non-preferred.<br>2. Dosing limits apply, see Dosage Consolidation List.<br>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.<br><br>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.<br><br>As outlined in the <a href="#">US CDC Guidance on the Use of Expedited Partner Therapy (EPT) in the Treatment of Gonorrhea</a> , MaineCare will cover a single 800 mg dose of cefixime for the treatment of gonorrhea as part of EPT.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| MACROLIDES / ERYTHROMYCIN'S                           | MC/DEL<br>MC/DEL<br>MC<br>MC<br>MC<br>MC<br>MC<br>MC/DEL                                                                                                               | AZITHROMYCIN TABS<br>AZITHROMYCIN SUSP<br>E.E.S.<br>ERYPED 200 SUSR<br>ERYPED 400 SUSR<br>ERY-TAB TBEC<br>ERYTHROCIN STEARATE TABS<br>ERYTHROMYCIN                                                                                                                                                                                                                                    | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL                       |            | AZITHROMYCIN POW<br>CLARITHROMYCIN SUSP<br>CLARITHROMYCIN TABS<br>DIFICID<br>PCE TBEC<br>ZITHROMAX TABS<br>ZITHROMAX 1GM PAK<br>ZITHROMAX TRI-PAK<br>ZITHROMAX SUSP<br>ZINPLAVA                                                       | <a href="#">Use PA Form# 20420</a><br>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.<br><br>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.<br><br>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.<br><br>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<br>MC/DEL<br>MC/DEL                                                                                                                                             | DOXYCYCLINE MONOHYDRATE 100mg & 50mg CAPS<br>MINOCYCLINE HCL CAPS<br>TETRACYCLINE HCL CAPS                                                                                                                                                                                                                                                                                            | MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC<br>MC/DEL<br>MC<br>MC/DEL<br>MC                                   |            | DECLOMYCIN TABS<br>DORYX CPEP<br>DOXYCYCLINE HYCLATE<br>DOXYCYCLINE MONOHYDRATE 150mg & 75mg CAPS<br>DYNACIN CAPS<br>MINOLIRA ER<br>NUZYRA <sup>1</sup><br>ORACEA<br>PERIOSTAT<br>SEYSARA <sup>2</sup><br>SOLODYN ER<br>XIMINO        | <a href="#">Use PA Form# 20420</a><br>1. For the treatment of patients ≥ 8 years of age<br>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<br>PA Required                                                                                                                                                                                                                                                                                                          | Criteria                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
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| FLUOROQUINOLONES                             | MC/DEL<br>MC/DEL<br>MC/DEL                                                       | CIPROFLOXACIN<br>LEVOFLOXACIN<br>OFLOXACIN                                                                                                                                                                                                       | MC<br>MC<br>MC<br>MC<br>MC<br>MC                                                                   |            | AVELOX SOLN<br>AVELOX ABC PACK TABS<br>BAXDELA<br>CIPRO<br>LEVAQUIN TABS SOLN/INJ<br>LEVAQUIN TABS <sup>1</sup><br>PROQUIN XR                                                                                                                                                                                                               | <a href="#">Use PA Form# 20420.</a><br>1. Dosing limits apply, see Dosage Consolidation List.<br><br>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.<br><br>DDI: Preferred <b>Ofloxacin</b> will now be non-preferred and require prior authorization if they are currently being used in combination with amiodarone.<br>DDI: Preferred <b>Levofloxacin</b> will now be non-preferred and require prior authorization if they are currently being used in combination with amiodarone.<br>DDI: Preferred <b>Avelox</b> will now be non-preferred and require prior authorization if they are currently being used in combination with amiodarone.<br>DDI: All preferred <b>Fluoroquinolones</b> will require clinical PA for patients over 60 that are currently on immunosuppressants or steroid therapy.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| AMINO GLYCOSIDES                             | MC<br>MC<br>MC/DEL<br>MC/DEL                                                     | GENTAMICIN<br>KITABIS PAK<br>NEOMYCIN SULFATE TABS<br>TOBRAMYCIN AMPUL-NEB                                                                                                                                                                       | MC/DEL<br>MC<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL                                                   |            | ARIKAYCE <sup>1,2</sup><br>BETHKIS <sup>1</sup><br>TOBI PODHALER <sup>1,2</sup><br>TOBI NEBU<br>TOBRAMYCIN SULFATE SOLN<br>ZEMDRI <sup>2</sup>                                                                                                                                                                                              | <a href="#">Use PA Form# 20420.</a><br>1. Clinical PA to verify appropriate diagnosis<br>2. See Criteria section<br><br>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.<br><br><b>TOBI Podhaler</b> is limited to patients with significant impairment from using nebulized version of medication<br><b>Arikayce</b> will require clinical PA to confirm MAC lung disease and for use in adults who have limited or no alternative treatment options.<br><b>Zemdri</b> will be reserved for patients with limited or no alternative treatment of care.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| ANTI-MYCOBACTERIALS / ANTI-TUBERCULOSIS      | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL                                             | ETHAMBUTOL HCL TABS<br>MYAMBUTOL TABS<br>RIFABUTIN CAPS<br>RIFAMPIN                                                                                                                                                                              | MC/DEL<br>MC/DEL<br>MC<br>MC                                                                       |            | MYCOBUTIN CAPS<br>PRETOMANID<br>RIFADIN CAPS                                                                                                                                                                                                                                                                                                | <a href="#">Use PA Form# 20420.</a><br><br>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.<br><br><b>Pretomanid</b> 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.<br><br>DDI: Preferred <b>Rifampin</b> will be non-preferred and require prior authorization if it is currently being used in combination with either praxadax or latuda.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| ANTIMALARIAL AGENTS                          | MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL                                       | DARAPRIM TABS<br>HYDROXYCHLOROQUINE TABS<br>KRINTAFEL <sup>2</sup><br>MEFLOQUINE HCL TABS<br>QUININE SULFATE                                                                                                                                     | MC<br>MC/DEL<br>MC<br>MC<br>MC/DEL                                                                 |            | ARALEN TABS<br>CHLOROQUINE PHOSPHATE TABS <sup>3</sup><br>ISONARIF <sup>1</sup><br>MALARONE TABS<br>PLAQUENIL TABS                                                                                                                                                                                                                          | <a href="#">Use PA Form# 20420.</a><br>1. Ingredients available as preferred without PA.<br>2. <b>Krintafel</b> is preferred for ≥ 16 years of age.<br>3. Established users will be grandfathered.<br><br>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.<br><br>DDI: Avoid coadministration of <b>Krintafel</b> with Organic Cation Transporter 2 (OCT2) and Multidrug and Toxin Extrusion (MATE) substrates (e.g. dofetilide, metformin).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| ANTHELMINTICS                                | MC/DEL<br>MC/DEL<br>MC/DEL                                                       | ALBENDAZOLE<br>PRAZIQUANTEL TAB<br>STROMECTOL TABS                                                                                                                                                                                               | MC<br>MC<br>MC/DEL                                                                                 |            | ALBENZA TABS<br>EMVERM<br>BILTRICIDE TABS                                                                                                                                                                                                                                                                                                   | <a href="#">Use PA Form# 20420</a><br><br>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<br>MC<br>MC<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL | AZACTAM SOLR<br>COLY-MYCIN-M SOLR<br>COLISTIMETHATE SODIUM SOLR<br>FIRVANQ <sup>4</sup><br>FUROXONE TABS<br>METRONIDAZOLE <sup>1</sup><br>PENTAMIDINE ISETHIONATE SOLR<br>SOLOSEC<br>TRIMETHOPRIM TABS<br>VANCOMYCIN 5GM INJ.<br>VANCOMYCIN CAPS | MC<br>MC<br>MC<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC<br>MC<br>MC/DEL<br>MC/DEL |            | AEMCOLO<br>BLUJEP A <sup>6</sup><br>COLISTIMETHATE SODIUM SOLR<br>CAYSTON <sup>3</sup><br>FLAGYL CAPS<br>FLAGYL TABS<br>LIKMEZ<br>METRONIDAZOLE 375MG CAPS <sup>1</sup><br>METRONIDAZOLE 750MG TABS <sup>1</sup><br>NEBUPENT SOLR<br>ORLYNVAH<br>REBYOTA <sup>5</sup><br>VANCOMYCIN 10GM INJ. <sup>2</sup><br>VOWST <sup>5</sup><br>XENLETA | <a href="#">Use PA Form# 20420</a><br><br>1. 375mg caps and 750mg tabs are non-preferred. Please use available preferred strengths (250mg & 500mg tabs) to obtain required dose without PA.<br>2. Please use multiple 5gm which are preferred to obtain dose without PA.<br>3. Clinical PA is required to establish CF diagnosis and medical necessity. Prior trial and failure of preferred Tobl before approval will be granted.<br>4. Quantity limit of one per 150ml bottle.<br>5. For the treatment of patients 18 years of age and older.<br>6. For the treatment of patients 12 years of age and older.<br><br>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.<br><br><b>For macrolide resistant infections when quinolones are inappropriate</b><br><b>Cayston</b> is only indicated to improve respiratory symptoms in CF patients with <i>Pseudomonas aeruginosa</i> . 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.<br><b>Likmez</b> : patient has a medical necessity for a non-solid oral dosage form.<br><b>Rebyota</b> : For the prevention of recurrence of <i>C. difficile</i> 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.<br><b>Vowst</b> : To prevent the recurrence of <i>C. difficile</i> infection (CDI) in individuals 18 years of age and older following antibacterial treatment for recurrent CDI (rCDI).<br><b>Xenleta</b> will be considered for the treatment of adults with community-acquired bacterial pneumonia (CABP) caused by the following susceptible microorganisms: <i>Streptococcus pneumoniae</i> , <i>Staphylococcus aureus</i> (methicillin-susceptible isolates), <i>Hemophilus influenzae</i> , <i>Legionella pneumophila</i> , <i>Mycoplasma pneumoniae</i> , and <i>Chlamydia pneumoniae</i> . |
| CARBAPENEMS                                  |                                                                                  |                                                                                                                                                                                                                                                  | MC<br>MC<br>MC/DEL<br>MC/DEL                                                                       |            | INVANZ SOLR<br>MERREM SOLR<br>PRIMAXIN<br>RECARBRIO                                                                                                                                                                                                                                                                                         | <a href="#">Use PA Form# 20420</a><br><br>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<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL                                       | CLEOCIN SOLN<br>CLEOCIN SUSR<br>CLINDAMYCIN HCL 150CAPS<br>DAPSONE TABS<br>LINEZOLID 600mg TABS <sup>2</sup>                                                                                                                                     | MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL                                                         |            | CLEOCIN CAPS<br>CLINDAMYCIN HCL 300CAPS <sup>1</sup><br>SIVEXTRO<br>VIBATIV<br>ZYVOX SUSR<br>ZYVOX TABS                                                                                                                                                                                                                                     | <a href="#">Use PA Form# 30820 for Zyvox &amp; Vibativ</a><br><a href="#">Use PA Form# 20420 for all others</a><br>1. Use multiple 150's for <b>Cindamycin</b> instead of 300's.<br>2. Quantity limit of 14 days supply within a 60-day period.<br><br>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 <b>Zyvox</b> or <b>Vibativ</b> , please see the criteria listed in the Antibacterial Antibiotics PA form.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| ANTI INFECTIVE COMBO'S - MISC.               | MC/DEL<br>MC/DEL<br>MC/DEL                                                       | SEPTRA/DS TABS<br>SULFAMETHOXAZOLE/TRIMETH<br>TRIMETHOPRIM/SULFAMETHOXA                                                                                                                                                                          | MC<br>MC<br>MC                                                                                     |            | BACTRIM DS TABS<br>VABOMERE <sup>1</sup>                                                                                                                                                                                                                                                                                                    | <a href="#">Use PA Form# 20420</a><br>1. For the treatment of patients ≥ 18 years of age.<br><br>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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| ANTIPROTOZOALS                               | MC/DEL<br>MC/DEL                                                                 | BENZNIDAZOLE <sup>2</sup><br>LAMPIT <sup>2</sup>                                                                                                                                                                                                 | MC                                                                                                 |            | ALINIA <sup>1</sup>                                                                                                                                                                                                                                                                                                                         | <a href="#">Use PA Form# 20420</a><br>1. <b>Alina</b> is preferred for children less than 12 years of age.<br>2. Clinical PA required for appropriate diagnosis.<br><br><b>Benznidazole</b> is indicated for pediatric patients 2 to 12 years of age for the treatment of Chagas disease (American trypanosomiasis) caused by <i>trypanosoma cruzi</i> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |

| CATEGORY               | Coverage Indicator | PREFERRED DRUGS                          | Coverage Indicator | Step Order | NON-PREFERRED DRUGS<br>PA Required          |                                                                                                                                                                                                                        | Criteria                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
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| ANTI - FUNGALS         |                    |                                          |                    |            |                                             |                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| ANTIFUNGALS - ASSORTED | MC/DEL             | FLUCONAZOLE <sup>1</sup>                 | MC/DEL             | 6          | LAMISIL TABS <sup>4</sup>                   | <a href="#">Use PA Form# 20420</a>                                                                                                                                                                                     | 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.<br><br><b>DDI:</b> Any <b>Griseofulvin</b> 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.<br><br><b>DDI:</b> <b>Sporanox</b> 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.<br><br><b>DDI:</b> <b>Viend</b> is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for concurrent use with warfarin.<br><br><b>DDI:</b> <b>Fluconazole</b> (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. <b>Diflucan</b> 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.<br><br><b>DDI:</b> <b>Fluconazole</b> will require prior authorization if being used in combination with plavix or warfarin.<br><br><b>DDI:</b> <b>Ketoconazole</b> 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, tafinar or omeprazole.<br><br><b>Rezzayo:</b> 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 <sup>7</sup>           | MC/DEL             | 6          | ITRACONAZOLE                                | See Quantity Limit table.                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                        | MC/DEL             | NYSTATIN                                 | MC                 | 8          | BREXAFEMME                                  | <b>Non-preferred products must be used in specified step order.</b>                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                        | MC/DEL             | TERBINAFINE TABS <sup>4</sup>            | MC/DEL             | 8          | CRESEMBA <sup>9</sup>                       | Continue to use Anti-Fungal PA form for non-preferred products.                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                        | MC/DEL             | VORICONAZOLE TABS                        | MC/DEL             | 8          | GRIFULVIN V TABS                            |                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                        |                    |                                          | MC                 | 8          | GRISEOFULVIN SUSP                           |                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                        |                    |                                          | MC                 | 8          | GRISEOFULVIN ULTRAMICROSI TABS <sup>8</sup> | <a href="#">Anti-Fungal PA Form# 10120</a>                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                        |                    |                                          | MC                 | 8          | GRIS-PEG TABS                               | 1. QL-1/every 7-day period (150mg only).                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                        |                    |                                          | MC                 | 8          | REZZAYO <sup>9</sup>                        | 2. Sporanox QL 300cc/month with PA. See Quantity Limit table.                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                        |                    |                                          | MC/DEL             | 8          | SPORANOX SOLN <sup>2</sup>                  | 3. Sporanox QL 30/month with PA.                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                        |                    |                                          | MC/DEL             | 8          | SPORANOX PULSEPAK CAPS <sup>3</sup>         | 4. Quantity limit of one tablet daily. Please see Dosage Consolidation List.                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                        |                    |                                          | MC/DEL             | 8          | SPORANOX CAPS <sup>3</sup>                  | 5. Approved if immuno suppressed/ HIV or if the member has failed a 7-day trial of a preferred antifungal therapy.                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                        |                    |                                          | MC/DEL             | 8          | DIFLUCAN                                    | 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.                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                        |                    |                                          | MC/DEL             | 8          | ERAXIS INU <sup>6</sup>                     | 7. Quantity limits allowing 30-day supply without PA. PA will be required if using > 30 days.                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                        |                    |                                          | MC                 | 8          | GRIFULVIN SUSP                              | 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. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                        |                    |                                          | MC/DEL             | 8          | ONMEL                                       | 9. For patients ≥ 18 years of age.                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                        |                    |                                          | MC/DEL             | 8          | NOXAFIL <sup>5</sup>                        |                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                        |                    |                                          | MC/DEL             | 8          | TOLSURA                                     |                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                        |                    |                                          | MC/DEL             | 8          | VFEND TABS                                  |                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                        |                    |                                          | MC                 | 8          | VIVJOA                                      |                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| ANTI - VIRALS          |                    |                                          |                    |            |                                             |                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| ANTIRETROVIRALS - PREP | MC                 | APRETUDE                                 | MC                 |            | TRUVADA <sup>1</sup>                        | <a href="#">Use PA Form# 20420</a>                                                                                                                                                                                     | <b>DDI:</b> 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 <sup>1</sup>                     |                    |            |                                             | 1. Quantity limit of one per day                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                        | MC                 | EMTRICITABINE-TENOFOVIR DISOP (ORAL) TAB |                    |            |                                             |                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                        | MC                 | YEZTUGO                                  |                    |            |                                             |                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| ANTIRETROVIRALS        | MC/DEL             | ABACAVIR TABS                            | MC/DEL             |            | ABACAVIR SOL                                | <a href="#">Use PA Form# 20420</a>                                                                                                                                                                                     | 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.<br><br><b>Fuzeon:</b> 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.<br><br><b>DDI:</b> Reyataz requires prior authorization if it is currently being used in combination with either prevacid, pantoprazole, prilosec, or any currently non preferred PPI.<br><br><b>DDI:</b> Norvir requires prior authorization if it is currently being used in combination with either enablex 15mg or vesicare 10mg.<br><br><b>DDI:</b> Preferred Crixivan caps requires prior authorization if it is currently being used in combination with either enablex 15mg or vesicare 10mg.<br><br><b>DDI:</b> 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.<br><br><b>Stribild:</b> PA required; must provide rationale as to why the member's medical need cannot be met with preferred agents, particularly genovoya 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 antiretroviral agents.<br><br><b>DDI:</b> Tivicay will require prior authorization is used with nevirapine, oxcarbazepine, phenytoin, phenobarbital, carbamazepine, and St. John's wort.<br><br><b>DDI:</b> 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 reavatio 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.<br><br><b>DDI:</b> 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.<br><br><b>Sunlenca:</b> 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                                     | 1. Quantity limit of one per day                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                        | MC                 | BIKTARVY                                 | MC                 |            | ATRIPLA <sup>1</sup>                        | 2. Only preferred if Norvir script is in member's profile within the past 30 days of filing <b>Prezista</b>                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                        | MC                 | CABENUVA                                 | MC/DEL             |            | CIMDUO                                      | 3. Isentress Chewable will only be approved if between the age of 2-12 years old                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                        | MC                 | COMPLERA <sup>1</sup>                    | MC/DEL             |            | COMBIVIR TABS                               | 4. Clinical PA required                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                        | MC/DEL             | DARUNAVIR <sup>2</sup>                   | MC/DEL             |            | EDURANT                                     | 5. Only preferred for post- exposure prophylaxis                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                        | MC/DEL             | DELSTRIGO                                | MC/DEL             |            | FUZEON                                      |                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                        | MC                 | DIDANOSINE                               | MC                 |            | IDVYNZO                                     |                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                        | MC/DEL             | DOVATO                                   | MC/DEL             |            | INTELENCE                                   |                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                        | MC                 | EFAVIRENZ TAB                            | MC/DEL             |            | ISENTRESS <sup>3</sup>                      |                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                        | MC/DEL             | EFAVIRENZ CAP                            | MC/DEL             |            | ISENTRESS HD                                |                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                        | MC                 | EFAVIRENZ-EMTRICITABINE-TENOFOVIR DF TAB | MC                 |            | JULUCA                                      |                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                        |                    |                                          | MC                 |            | KALETRA                                     |                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                        | MC                 | EMTRIVA <sup>1</sup>                     | MC/DEL             |            | LAMIVUDINE SOLN                             |                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                        | MC                 | EPVIR SOL                                | MC/DEL             |            | NEVIRAPINE                                  |                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                        | MC/DEL             | EVOTAZ <sup>1</sup>                      | MC                 |            | NORVIR                                      |                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                        | MC                 | GENVOYA <sup>1,4</sup>                   | MC/DEL             |            | PIFELTRO                                    |                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                        | MC/DEL             | ISENTRESS 400MG <sup>5</sup>             | MC                 |            | PREZISTA                                    |                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                        | MC/DEL             | ISENTRESS CHEW <sup>3</sup>              | MC                 |            | RETROVIR                                    |                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                        | MC/DEL             | ISENTRESS POWDER                         | MC                 |            | REYATAZ                                     |                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                        | MC/DEL             | LAMIVUDINE TABS                          | MC/DEL             |            | SELZENTRY                                   |                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                        | MC/DEL             | LAMIVUDINE/ZIDOVUDINE                    | MC                 |            | STAVUDINE                                   |                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                        | MC/DEL             | LOPINAVIR-RITONAVIR SOL                  | MC                 |            | STRIBILD <sup>1</sup>                       |                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                        | MC                 | LOPINAVIR-RITONAVIR TAB                  | MC/DEL             |            | SYMFI <sup>4</sup>                          |                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                        | MC                 | ODEFSEY <sup>1</sup>                     | MC/DEL             |            | SYMFI LO <sup>4</sup>                       |                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                        | MC/DEL             | PREZCOBIX                                | MC/DEL             |            | SYM TUZA                                    |                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                        | MC/DEL             | RITONAVIR TAB 100MG                      | MC/DEL             |            | TRIZIVIR TABS                               |                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                        | MC                 | RUKOBIA <sup>4</sup>                     | MC/DEL             |            | VIRACEPT TABS                               |                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                        | MC                 | SUNLENCA <sup>4</sup>                    | MC                 |            | VITEKTA                                     |                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                        | MC                 | SUSTIVA <sup>1</sup>                     | MC                 |            | VIREAD TABS <sup>1</sup>                    |                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                        | MC                 | TIVICAY                                  | MC/DEL             |            | ZIAGEN TABS                                 |                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                        | MC                 | TIVICAY PD                               | MC/DEL             |            | ZIAGEN SOL                                  |                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                        | MC                 | TRIUMEQ <sup>1</sup>                     | MC/DEL             |            | VIRAMUNE XR                                 |                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                        | MC                 | TROGARZO <sup>4</sup>                    |                    |            |                                             |                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| MC                     | TYBOST             |                                          |                    |            |                                             |                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| MC                     | VIREAD POW         |                                          |                    |            |                                             |                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| MC/DEL                 | ZIDOVUDINE         |                                          |                    |            |                                             |                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |

| CATEGORY                             | Coverage Indicator                                 | PREFERRED DRUGS                                                                                                                                                             | Coverage Indicator                                 | Step Order                      | NON-PREFERRED DRUGS<br>PA Required                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Criteria                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|--------------------------------------|----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|---------------------------------|---------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| CYTO-MEGALOVIRUS AGENTS              | MC<br>MC<br>MC/DEL<br>MC/DEL                       | CIDOFOVIR<br>FOSCARNET SODIUM<br>GANCICLOVIR<br>VALGANCICLOVIR                                                                                                              | MC<br>MC<br>MC/DEL<br>MC                           |                                 | VALCYTE TABS<br>FOSCAVIR<br>LIVTENCITY <sup>1</sup><br>PREVYMIS                                         | <a href="#">Use PA Form# 20420.</a><br><br>1. Must show failure or contraindication to all the following ganciclovir, valganciclovir, cidofovir and foscarnet before <b>Livtencity</b> 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.<br><b>Prevymis:</b> 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.<br><b>DDI:</b> Livtency is a substrate of CYP3A4. Coadministration of Livtency with strong inducers of CYP3A4 is not recommended, except for selected anticonvulsants.                                                                                                                                                                                                                                                                                                                            |
| HERPES AGENTS                        | MC/DEL                                             | VALACYCLOVIR HCL                                                                                                                                                            | MC/DEL<br>MC<br>MC<br>MC/DEL                       | 8<br>8<br>8<br>9                | FAMCICLOVIR <sup>1</sup><br>SITAVIG<br>VALTREX TABS <sup>1</sup><br>FAMVIR TABS <sup>1</sup>            | <a href="#">Use PA Form# 20420.</a><br><br>1. Must fail <b>Valacyclovir</b> 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 ( <b>in step order</b> ), 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| INFLUENZA AGENTS                     | MC<br>MC<br>MC/DEL                                 | AMANTADINE CAPS<br>RELENZA DISKHALER AEPB<br>OSELTAMIVIR <sup>1</sup>                                                                                                       | MC<br>MC<br>MC/DEL<br>MC<br>MC<br>MC/DEL           | 8<br>8<br>8<br>8<br>8<br>8      | AMANTADINE TABS<br>FLUMIST<br>RIMANTADINE HCL TABS<br>TAMIFLU <sup>1</sup><br>TAMIFLU SUS<br>XOFLUZA    | <a href="#">Use PA Form# 20420</a><br><br>1. <b>Tamiflu</b> and <b>Osetamivir</b> 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 ( <b>in step order</b> ), 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| IMMUNE SERUMS                        |                                                    |                                                                                                                                                                             |                                                    |                                 |                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| IMMUNE SERUMS                        | MC                                                 | HYPERRHO INJ                                                                                                                                                                |                                                    |                                 |                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| HEPATITIS AGENTS                     |                                                    |                                                                                                                                                                             |                                                    |                                 |                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| HEPATITIS C AGENTS                   | MC<br>MC<br>MC/DEL<br>MC/DEL<br>MC                 | SOFOSBUVIR/VELPATASVIR <sup>1</sup> (Authorized generic labeler 72626 Asegua Therapeutics)<br>MAVYRET <sup>3</sup><br>PEGASYS KIT <sup>1</sup><br>PEGASYS SOLN<br>RIBAVIRIN | MC<br>MC<br>MC<br>MC<br>MC                         | 8<br>8<br>8<br>8<br>8           | EPCLUSA <sup>2</sup><br>HARVONI <sup>2</sup><br>SOVALDI <sup>2</sup><br>VOSEVI<br>ZEPATIER <sup>2</sup> | <a href="#">Use PA Form #10700</a><br><br>1. Dosing limits apply, please see dosage consolidation list.<br>2. Approvals will require clinical PA. Please see the Hepatitis PA form for criteria.<br>3. PA is not required for simplified treatment regimens. Please see the Hepatitis 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 ( <b>in step order</b> ), 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.<br><b>DDI:</b> 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).                                                                                                                                                                                                                                                                                                                                                                                 |
| HEPATITIS AGENTS - MISC.             | MC                                                 |                                                                                                                                                                             | MC<br>MC                                           |                                 | ACTIMMUNE<br>HEPCLUDEX <sup>1</sup>                                                                     | <a href="#">Use PA Form# 20420.</a><br><br>1. Clinical PA required                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Approved for chronic granulomatous disease, osteopetrosis and idiopathic pulmonary fibrosis.<br><b>Hepcludex:</b> Diagnosis of chronic HDV infection with detectable HDV RNA within 6 months, active liver disease, no HIV diagnosis, and no decompensated liver disease. Prescriber must attest to adherence and discontinuation monitoring counseling. Must be prescribed by or in consultation with hepatology, gastroenterology, or infectious disease specialist.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| HEPATITIS B ONLY                     | MC/DEL<br>MC                                       | ENTECAVIR<br>TENOFOVIR                                                                                                                                                      | MC<br>MC                                           | 8<br>8                          | BARACLUDE<br>VEMLIDY                                                                                    | <a href="#">Use PA Form# 20420.</a>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved ( <b>in step order</b> ), 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.<br><b>Baraclude</b> 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).<br><b>Vemlidy</b> 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. |
| RSV PROPHYLAXIS                      |                                                    |                                                                                                                                                                             |                                                    |                                 |                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| RSV PROPHYLAXIS                      |                                                    |                                                                                                                                                                             | MC                                                 |                                 | SYNAGIS <sup>1</sup>                                                                                    | <a href="#">Use PA Form# 30120</a><br><br>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. <b>Synagis</b> 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<br>MC/DEL<br>MC                                 | AVONEX KIT <sup>1</sup><br>BETASERON SOLR <sup>1</sup><br>REBIF SOLN <sup>1</sup>                                                                                           | MC                                                 | 8                               | PLEGRIDY <sup>1</sup>                                                                                   | <a href="#">Use PA Form# 20430.</a><br><br>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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| MULTIPLE SCLEROSIS - NON-INTERFERONS | MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC<br>MC | COPAXONE<br>DALFAMPRIDINE ER<br>DIMETHYL FUMARATE CAP<br>FINGOLIMOD CAP <sup>2</sup><br>KESIMPTA <sup>2,5</sup><br>TERIFLUNOMIDE TAB <sup>2</sup><br>TYSABRI <sup>1,2</sup> | MC<br>MC<br>MC<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL | 8<br>8<br>8<br>8<br>8<br>8<br>8 | AMPYRA<br>AUBAGIO<br>BAFIERTAM<br>BRIUMVI<br>GILENYA<br>GLATOPIA<br>MAVENCLAD <sup>3</sup>              | <a href="#">Use PA Form# 20430.</a><br><br>1. Provider must be enrolled in the TOUCH Prescribing program, a restricted distribution program. Clinical PA is required to establish diagnosis and medical necessity.<br>2. Clinical 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 ( <b>in step order</b> ), 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.<br><b>Mavenclad</b> will require multiple trials of preferred agents including mayzent for secondary progressive disease.<br><b>DDI:</b> 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.<br><b>Ponvory:</b> Before initiation of Ponvory treatment, assess the following:                                                                                                                                                                                                                                                                    |

| CATEGORY                   | Coverage Indicator | PREFERRED DRUGS                                 | Coverage Indicator                                             | Step Order                                | NON-PREFERRED DRUGS<br>PA Required                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                   | Criteria                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
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|                            |                    |                                                 | MC/DEL<br>MC<br>MC<br>MC/DEL<br>MC<br>MC<br>MC/DEL<br>MC<br>MC | 8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8 | MAYZENT<br>OCREVUS <sup>2</sup><br>OCREVUS ZUNOVO <sup>2</sup><br>PONVORY <sup>2</sup><br>TASCENSO ODT <sup>2,4</sup><br>TECFIDERA<br>TYRUKO<br>VUMERITY<br>ZEPOSIA | 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.<br>4. For the treatment of patients 10 years of age and older.<br>5. Approved after single step through preferred drugs. | <ul style="list-style-type: none"> <li>Complete Blood Count (CBC) - Obtain a recent (i.e. within the last 6 months) CBC, including lymphocyte count.</li> <li>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.</li> <li>Liver Function Tests - Obtain recent (i.e. within the last 6 months) transaminase and bilirubin levels.</li> <li>Ophthalmic Evaluation - Obtain an evaluation of the fundus, including the macula.</li> <li>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.</li> <li>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.</li> </ul> <p><b>Mayzent for Relapsing forms of MS:</b> multiple trials of preferred agents, including an intravenous MS product.</p> <p><b>Mayzent for Active secondary progressive disease:</b> prior trials of two preferred agents are required.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| MULTIPLE SCLEROSIS - MISC  |                    |                                                 | MC                                                             |                                           | ZINBRYTA <sup>1</sup>                                                                                                                                               | Use PA Form# 20430.<br>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<br>MC           | BOTOX <sup>2,4</sup><br>DYSPORT <sup>4</sup>    | MC<br>MC<br>MC<br>MC<br>MC/DEL                                 | 8<br>8<br>8<br>8<br>8                     | DAXXIFY<br>FIRDAPSE <sup>5</sup><br>MYOBLOC <sup>1</sup><br>SKYSONA <sup>4,6</sup><br>XEOMIN <sup>2</sup>                                                           | Use PA Form# 10210.<br>1. Approval will be limited to Cervical Dystonia.<br>2. Please see botulinum PA form for additional criteria.<br>4. Clinical PA required.<br>5. For adult patients who are anti-acetylcholine receptor (AChR) antibody positive.<br>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 ( <b>in step order</b> ), 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.<br><b>Failed/did not tolerate therapeutic trials of muscle relaxants, unless contraindicated, including but not limited to baclofen, cyclobenzaprine, orphenadrine, skelaxin, and tizanidine.</b><br><b>Migraine:</b> Consideration for Botox approvals will only be made after failures of required trials of the following preferred medications: triicyclic or venlafaxine, beta blocker, valproic acid, topiramate.<br><b>Firdapse</b> is recommended for the treatment of Lambert-Eaton myasthenic syndrome (LEMS) in adults.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| NEUROLOGICS- hATTR AGENTS  |                    |                                                 | MC<br>MC<br>MC<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL             |                                           | AMVUTTRA <sup>1</sup><br>ATTRUBY<br>ONPATTRO <sup>1</sup><br>TEGSEDI <sup>1</sup><br>VYNDAMAX <sup>1</sup><br>VYNDAQEL <sup>1</sup><br>WAINJUA <sup>1</sup>         | Use PA Form# 20420.<br>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.<br><br><b>Tegsedi</b> should be non-preferred and approved for patients for whom other treatments, including Onpatro, have been ineffective.<br><b>Vyndamax</b> 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| NEUROLOGICS- SMA           |                    | GENE                                            |                                                                |                                           | GENE                                                                                                                                                                | Use PA Form# 20420.<br>1. Clinical PA is required to establish diagnosis and medical necessity.<br>2. For patients 2 months of age and older.<br>3. For patients 2 years of age and older.                                                                                                                                        | <p><b>Itvisma:</b></p> <ul style="list-style-type: none"> <li>Patients with confirmed mutation in survival motor neuron 1 (SMN1) gene.</li> <li>Patients previously treated with Zolgensma should not be treated with Itvisma.</li> <li>Prior to injection:               <ol style="list-style-type: none"> <li>Assess vaccination status.</li> <li>Assess liver function.</li> <li>Obtain creatinine and complete blood count.</li> <li>Perform baseline testing for presence of anti-AAV9 antibodies.</li> </ol> </li> <li>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.</li> <li>One day prior to injection, begin administration of systemic corticosteroids.</li> <li>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).</li> <li>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.</li> </ul> <p><b>Zolgensma:</b> 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.</p> <p><b>Spinraza:</b> 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:</p> <ul style="list-style-type: none"> <li>Hammersmith Infant Neurological Exam (HINE)</li> <li>Hammersmith Functional Motor Scale Expanded (HFMSSE)</li> <li>Upper Limb Module Test (non-ambulatory)</li> <li>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:               <ol style="list-style-type: none"> <li>Treating provider attests the member has a platelet count &gt; 50,000/ml or greater, and</li> <li>Treating provider agrees to do platelet count and coagulation test before each dose, and</li> <li>Treating provider agrees to do a quantitative spot urine protein test before each dose.</li> </ol> </li> </ul> <p>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.</p> <p>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.</p> |
|                            | MC                 | ZOLGENSMA <sup>1</sup>                          | MC                                                             |                                           | ITVISMA <sup>1,3</sup>                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|                            |                    | NON-GENE                                        |                                                                |                                           | NON-GENE                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|                            | MC<br>MC           | EVRYSDI <sup>1,2</sup><br>SPINRAZA <sup>1</sup> |                                                                |                                           |                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |

| CATEGORY                               | Coverage Indicator                                                                                                                                               | PREFERRED DRUGS                                                                                                                                                                                                                                                                                                  | Coverage Indicator                                                                                                             | Step Order                           | NON-PREFERRED DRUGS<br>PA Required                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Criteria                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
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| NEUROLOGICS- RETT SYNDROME             |                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                  | MC                                                                                                                             | 8                                    | DAYBUE <sup>1,2</sup>                                                                                                                                                   | <a href="#">Use PA Form# 20420</a><br>1. Clinical PA required for appropriate diagnosis<br>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 ( <b>in step order</b> ), 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<br>MC<br>MC<br>MC                                                                                                           | 8<br>8<br>8<br>8                     | QALSODY<br>RILUTEK TABS<br>RADICAVA <sup>1</sup><br>TIGLUTIK                                                                                                            | <a href="#">Use PA Form# 20420</a><br>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 ( <b>in step order</b> ), 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.<br><b>Qalsody:</b> 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).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| MOVEMENT DISORDERS                     | MC<br>MC<br>MC<br>MC                                                                                                                                             | AUSTEDO <sup>1</sup><br>AUSTEDO XR <sup>1</sup><br>INGREZZA <sup>1</sup><br>TETRABENAZINE <sup>1</sup>                                                                                                                                                                                                           | MC                                                                                                                             | 8                                    | XENAZINE                                                                                                                                                                | <a href="#">Use PA Form# 20420</a><br>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 ( <b>in step order</b> ), 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.<br><b>DDI:</b> Avoid concomitant use of <b>VMAT2 inhibitors</b> 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                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| MUSCULAR DYSTROPHY AGENTS              | MC                                                                                                                                                               | EMFLAZA <sup>2</sup>                                                                                                                                                                                                                                                                                             | MC<br>MC<br>MC<br>MC<br>MC<br>MC<br>MC<br>MC                                                                                   | 8<br>8<br>8<br>8<br>8<br>8<br>8<br>8 | AGAMREE <sup>4</sup><br>AMONDYS 45 <sup>1</sup><br>DEFLAZACORT<br>ELEVIDYS <sup>3</sup><br>DUVYZAT<br>EXONDYS 51 <sup>1</sup><br>VILTEPSO <sup>3</sup><br>VYONDYS 53    | <a href="#">Use PA Form# 20420</a><br>1. Clinical PA to verify diagnosis and use of stable dose of corticosteroid for at least 6 mos.<br>2. For the treatment of Duchenne muscular dystrophy (DMD) in patients 2 years of age and older and a documented intolerance of oral corticosteroid.<br>3. Clinical prior authorization to verify diagnosis and use of stable dose of corticosteroid.<br>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 ( <b>in step order</b> ), 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.<br><b>Amondys 45, Exondys 51 and Vyondys 53:</b><br>• The prescriber is, or has consulted with, a neuromuscular disorder specialist AND<br>• The dose does not exceed 30mg/kg once weekly AND<br>• The patient is currently on a stable corticosteroid dose for at least 6 months (at least 3 months for Elevidy).<br><b>Amondys 45, Exondys 51, Vyondys 53 Note:</b> Initial approval will be granted for 6 months. For re-approval after 6 months, the patient must demonstrate a response to therapy.<br><b>Duvyzat:</b> 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<br>• The prescriber is, or has consulted with, a neuromuscular disorder specialist<br>• The patient is ambulatory AND<br>• The patient is currently on a stable corticosteroid dose for at least 6 months AND<br>• Baseline platelet counts are > 150 x 10 <sup>9</sup> /L and baseline triglycerides are < 300 mg/dL.<br><b>Elevidys and Viltepsos:</b> The prescriber is, or has consulted with, a neuromuscular disorder specialist AND<br>• The dose does not exceed dosing AND<br>• The patient is currently on a stable corticosteroid dose for at least 3 months.<br><b>Viltepsos:</b> 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<br>MC<br>MC<br>MC/DEL                                                                                                       | 8<br>8<br>8<br>8                     | IMAAVY<br>VYVGART <sup>1</sup><br>VYVGART HYTRULO <sup>1</sup><br>ZILBRYSO <sup>1</sup>                                                                                 | <a href="#">Use PA Form# 20420</a><br>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 ( <b>in step order</b> ), 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.<br><b>Zilbrysq</b> recommended to vaccinate patients for meningococcal infection per current Advisory Committee on Immunization Practices (ACIP) recommendations at least 2 weeks prior                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| FRIEDREICH'S ATAXIA AGENTS             |                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                  | MC                                                                                                                             |                                      | SKYCLARYS <sup>1,2</sup>                                                                                                                                                | <a href="#">Use PA Form# 20420</a><br>1. Clinical PA required for appropriate diagnosis.<br>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/<br>MINERALOCORTICOIDS | MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL | BUDESONIDE EC 3mg DR CAPS<br>CELESTONE SUSP<br>CORTEF 5<br>CORTISONE ACETATE TABS<br>DELTASONE TABS<br>DEPO-MEDROL SUSP<br>DEXAMETHASONE<br>DEXPAK<br>FLUDROCORTISONE ACETATE TABS<br>HYDROCORTISONE<br>KENALOG<br>METHYLPREDNISOLONE TABS<br>PREDNISOLONE<br>PREDNISONE<br>SOLU-CORTEF SOLR<br>SOLU-MEDROL SOLR | MC<br>MC<br>MC/DEL<br>MC<br>MC<br>MC/DEL<br>MC<br>MC<br>MC<br>MC<br>MC<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL |                                      | CORTEF 10 and 20 TABS<br>MILLIPRED<br>PREDNISONE INTENSOL CONC<br>HEMADY<br>KHINDIVI <sup>1</sup><br>MEDROL TABS<br>MEDROL DOSEPAK TABS<br>ALKINDI SPRINKLE<br>ZILRETTA | <a href="#">Use PA Form# 20420</a><br>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.<br><b>DDI:</b> All preferred steroids will require clinical PA for patients over 60 that are currently on fluoroquinolone therapy.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| HORMONE REPLACEMENT THERAPIES          |                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                  |                                                                                                                                |                                      |                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| ANDROGENS / ANABOLICS                  | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL                                                                                                                   | ANDRODERM PT24<br>ANDROGEL 1%<br>ANDROGEL PUMP 1.62%<br>DANAZOL CAPS<br>TESTOSTERONE CYP                                                                                                                                                                                                                         | MC<br>MC<br>MC/DEL<br>MC<br>MC<br>MC<br>MC/DEL                                                                                 |                                      | ANADROL-50<br>ANDRO LA 200 OIL<br>ANDROGEL PACKETS 1.62%<br>ANDROID CAPS<br>AXIRON<br>AZMIRO<br>DELATESTRYL OIL<br>DEPO-TESTOSTERONE OIL                                | <a href="#">Use PA Form# 20420</a>                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 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).<br><b>Oxandrolone:</b> 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).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |

| CATEGORY                                 | Coverage Indicator                                                       | PREFERRED DRUGS                                                                                                                                      | Coverage Indicator                                                                                         | Step Order       | NON-PREFERRED DRUGS<br>PA Required                                                                                                                                                                                           |                                                                                                                                                                                                             | Criteria                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
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|                                          |                                                                          |                                                                                                                                                      | MC<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC<br>MC<br>MC/DEL<br>MC/DEL |                  | FORTESTA<br>HALOTESTIN TABS<br>JATENZO<br>METHITEST TAB<br>METHYLTESTOSTERONE CAP<br>OXANDROLONE<br>STRIANT MUC ER<br>TESTIM<br>TESTOSTERONE GEL PACKETS<br>TESTOSTERONE SOL<br>TESTRED CAPS<br>TLANDO<br>VOGELXO<br>XYOSTED |                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| ESTROGENS - PATCHES /<br>TOPICAL         | MC<br>MC/DEL<br>MC/DEL<br>MC/DEL                                         | EVAMIST<br>ESTRADIOL PTTK<br>MINIVELLE PATCH<br>VIVELLE-DOT PTTW                                                                                     | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL                                                                       | 8<br>8<br>8<br>8 | DIVIGEL <sup>1</sup><br>CLIMARA PTWK<br>ELESTRIN <sup>1</sup><br>MENOSTAR PATCH                                                                                                                                              | <a href="#">Use PA Form# 20420</a><br><br><b>1. Step order drugs must be used in specified step order.</b>                                                                                                  | Approved for failures on multiple oral estrogen agents after 90 day trials or if unable to swallow any oral medication.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| ESTROGENS - TABS                         | MC/DEL<br>MC/DEL                                                         | ESTRADIOL<br>PREMARIN TABS                                                                                                                           | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL                                                                       |                  | ESTRADIOL-NORETHINDRONE<br>ESTRACE TABS<br>MENEST TABS<br>NORETHINDRON-ETHINYL                                                                                                                                               | <a href="#">Use PA Form# 20420</a><br><br>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<br>MC/DEL<br>MC/DEL<br>MC/DEL                                     | ANGELIQ<br>COMBIPATCH PTTW<br>PREMPHASE TABS<br>PREMPRO TABS                                                                                         | MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL                                                                 |                  | FEMHRT 1/5 TABS <sup>1</sup><br>FYAVOLV<br>LOPREEZA TAB<br>ORTHO-PREFEST TABS <sup>1</sup><br>SYNTEST H.S. TABS <sup>1</sup>                                                                                                 | <a href="#">Use PA Form# 20420</a><br><br>1. Must fail <b>Premphase</b> and <b>Prempro</b> 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<br>MC/DEL<br>MC<br>MC                                             | MEDROXYPROGESTERONE ACETA <sup>1</sup><br>NORETHINDRONE ACETATE TABS <sup>1</sup><br>17-ALPH HYDROXYPROGESTERONE PWDR<br>PROGESTERONE CAPS           | MC/DEL<br>MC<br>MC<br>MC/DEL                                                                               |                  | AYGESTIN TABS<br>CYCRIN TABS<br>PROGESTERONE POWD<br>PROMETRIUM CAPS<br>PROVERA TABS                                                                                                                                         | <a href="#">Use PA Form# 20420</a><br><br>1. Must fail <b>Medroxyprogesterone</b> and <b>Norethindrone</b> 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.                                                                                                                                                                                                                                                                          |
| ENDOMETRIOSIS                            |                                                                          |                                                                                                                                                      |                                                                                                            |                  |                                                                                                                                                                                                                              |                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| CENTRAL PRECOCIOUS PUBERTY<br>AGENTS     | MC                                                                       | FENSOLVI <sup>1</sup>                                                                                                                                |                                                                                                            |                  |                                                                                                                                                                                                                              | <a href="#">Use PA Form# 20420</a><br><br>1. For pediatric patients 2 years of age and older with central precocious puberty (CPP).                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| ENDOMETRIOSIS- NASAL                     | MC/DEL                                                                   | SYNAREL (NASAL) SPRAY                                                                                                                                |                                                                                                            |                  |                                                                                                                                                                                                                              | <a href="#">Use PA Form# 20420</a>                                                                                                                                                                          | <b>Synarel</b> is also indicated for central precocious puberty.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| ENDOMETRIOSIS/ UTERINE FIBROIDS-<br>ORAL | MC<br>MC<br>MC/DEL                                                       | MYFEMBREE <sup>1,2</sup><br>ORIAHNN <sup>1</sup><br>ORILISSA <sup>1</sup>                                                                            |                                                                                                            |                  |                                                                                                                                                                                                                              | <a href="#">Use PA Form# 20420</a><br><br>1. Prior treatment of NSAID and hormonal contraceptives required.<br>2. Limited to 24 months due to the risk of continued bone loss, which may not be reversible. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| ENDOMETRIOSIS- INJECTABLE                | MC/DEL                                                                   | DEPO-SUBQ PROVERA 104                                                                                                                                |                                                                                                            |                  |                                                                                                                                                                                                                              | <a href="#">Use PA Form# 20420</a>                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| CONTRACEPTIVES                           |                                                                          |                                                                                                                                                      |                                                                                                            |                  |                                                                                                                                                                                                                              |                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| CONTRACEPTIVES - PROGESTIN ONLY          | MC/DEL<br>MC/DEL<br>MC<br>MC<br>MC/DEL<br>MC/DEL                         | CAMILA TABS<br>ERRIN<br>INCASSIA TAB<br>HEATHER TAB<br>NORETHINDRONE ACETATE 0.35MG TABS<br>SLYND                                                    | MC/DEL<br>MC/DEL<br>MC                                                                                     |                  | JOLIVETTE<br>NORA-BE TABS<br>ORTHO MICRONOR TABS                                                                                                                                                                             | <a href="#">Use PA Form# 20420</a>                                                                                                                                                                          | 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.<br><br>If member experienced adverse reactions, consider using Oral Contraceptives from other groups.<br><b>DDI:</b> 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<br>150mg IM                                                                                                              | MC/DEL                                                                                                     |                  | DEPO-PROVERA 150 mg SUSP                                                                                                                                                                                                     | <a href="#">Use PA Form# 20420</a>                                                                                                                                                                          | 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<br>MC<br>MC<br>MC<br>MC<br>MC/DEL<br>MC<br>MC/DEL<br>MC<br>MC/DEL | ELLA<br>ENCONTRA ONE STEP<br>ECONTRA EZ<br>NEW DAY<br>OPCION<br>OPTION 2<br>MY CHOICE<br><b>MY WAY</b><br>LEVONORGESTREL<br>NEXT CHOICE <sup>1</sup> |                                                                                                            |                  |                                                                                                                                                                                                                              | <a href="#">Use PA Form# 20420</a><br><br>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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |

| CATEGORY                                      | Coverage Indicator                                                                                                                                                           | PREFERRED DRUGS                                                                                                                                                                                                                                                                                                                                                 | Coverage Indicator                                                                                                                                                                                     | Step Order | NON-PREFERRED DRUGS<br>PA Required                                                                                                                                                                                                                                                                       |                                                                                                                          | Criteria                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|-----------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| CONTRACEPTIVES - PATCHES/ VAGINAL PRODUCTS    | MC<br>MC<br>MC<br>MC/DEL                                                                                                                                                     | ELURYNG <sup>1</sup><br>NUVARING RING <sup>1</sup><br>TWIRLA<br>XULANE <sup>2</sup>                                                                                                                                                                                                                                                                             | MC<br>MC<br>MC<br>MC                                                                                                                                                                                   |            | ANNOVERA<br>PHEXXI<br>ZAFEMY                                                                                                                                                                                                                                                                             | 1. Quantity limit allowing 1 every 28 days without PA.<br>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<br>MC<br>MC/DEL<br>MC/DEL                                                                                                                                                                       |            | KYLEENA<br>LILETTA<br>NEXPLANON<br>PARAGARD<br>SKYLA                                                                                                                                                                                                                                                     | Use PA Form# 20420                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| CONTRACEPTIVES - MONOPHASIC COMBINATION O/C'S | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC<br>MC<br>MC/DEL<br>MC<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL | APRI TABS<br>AVIANE TABS<br>BALZIVA<br>CRYSELLE-28 TABS<br>DESOGEN TABS<br>ESTARYLLA TAB<br>HAILEY FE TAB<br>ISIBLOOM TAB<br>JUNEL FE TAB<br>LARIN FE TAB<br>LESSINA TAB<br>LEVORA-28 TAB<br>MILI TAB<br>NORGESTIMATE-ETHINYL ESTRADIOL TAB<br>MIBELAS 24 FE TAB<br>MICROGESTIN FE TAB<br>RECLIPSEN<br>SAFYRAL TAB<br>SPRINTEC 28 TABS<br>YASMIN 28 TABS<br>YAZ | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL |            | BEYAZ<br>BREVICON-28 TABS<br>LESSINA-28 TABS<br>LEVORA<br>LOESTRIN FE 1/20TABS<br>LOESTRIN 1.5/30-21 TABS<br>MICROGESTIN FE TABS<br>LOESTRIN 1/20-21 TABS<br>LO/OVRAL 21 TABS<br>LO/OVRAL 28 TABS<br>NEXTSTELLIS<br>NORDETTE-28 TABS<br>NORTREL<br>OCELLA<br>OVRAL<br>PORTIA-28 TABS<br>SAFYRAL<br>ZOVIA | Use PA Form# 20420<br><br>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.<br><br>If member experienced adverse reactions, consider using Oral Contraceptives from other groups.<br><br>DDI: Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| CONTRACEPTIVES - BI-PHASIC COMBINATIONS       | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC<br>MC/DEL                                                                                         | AZURETTE TAB<br>CAMRESE<br>CAMRESE LO<br>DESOGESTREL/ ETH/ ESTRAD 0.15/30mcg<br>KARIVA TABS<br>LO LOESTRIN FE<br>PIMTREA TAB<br>NORETHINDRONE-ETH ESTRADIOL TAB 0.5-35/1-35<br>SIMPESE TBDSFK 3MO<br>VIORELE TAB                                                                                                                                                | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC<br>MC/DEL                                                                                                                   |            | LOSEASONIQUE                                                                                                                                                                                                                                                                                             | Use PA Form# 20420<br><br>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.<br><br>If member experienced adverse reactions, consider using Oral Contraceptives from other groups.<br><br>DDI: Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| CONTRACEPTIVES - TRI-PHASIC COMBINATIONS      | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC<br>MC<br>MC/DEL<br>MC/DEL<br>MC                                                                                                       | ENPRESSE<br>NORGESTIMATE-ETHINYL ESTRADIOL TAB<br>TRIPHASIL 28 TABS<br>TRI-LO-MILI TAB<br>TRI-LO-ESTARYLLA TAB<br>TRI-ESTARYLLA<br>TRI-SPRINTEC TAB<br>TRI-LO-SPRINTEC<br>TRINESSA                                                                                                                                                                              | MC/DEL<br>MC<br>MC/DEL<br>MC<br>MC<br>MC<br>MC/DEL<br>MC/DEL<br>MC                                                                                                                                     |            | NORTREL 7/7/7<br>ORTHO TRI-CYCLEN LO TABS                                                                                                                                                                                                                                                                | Use PA Form# 20420<br><br>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.<br><br>If member experienced adverse reactions, consider using Oral Contraceptives from other groups.<br><br>DDI: Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| 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.<br><br>Lynkuet:<br>• Diagnosis of vasomotor symptoms AND,<br>• 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,<br>• Baseline liver function tests.<br><br>Veoza:<br>• Approval requires at least one preferred Hormone Replacement Therapy (HRT) and two preferred non-hormonal therapies (i.e., SSRIs, SNRIs, gabapentin, pregabalin, clonidine).<br>• Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved.<br><br>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<br>PA Required                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                | Criteria                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|-------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| DIABETES SUPPLIES                         |                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                        |                                                                                                  |                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| DIABETIC- SUPPLIES                        |                                                                                                                                                                        | CONTINUOUS GLUCOSE MONITORING <sup>1</sup><br>DIABETIC- LANCETS<br>DIABETIC- LANCING DEVICES<br>DIABETIC- LANCING DEVICES<br>DIABETIC- PEN NEEDLES<br>DIABETIC- SYRINGES<br>DIABETIC- TEST STRIPS<br>DIABETIC- METERS                                                                                                                                                                     |                                                                                                                                                                                        |                                                                                                  |                                                                                                                                                                                                                        | <a href="#">Use PA Form# 20420</a><br>1. Dosing limits apply. Please refer to Dose Consolidation List.                                                                                                                                                                                                         | <b>Please refer to the MaineCare Preferred Diabetic Supply List available at <a href="http://www.mainearepdl.org">www.mainearepdl.org</a></b><br><b>Continuous Glucose Monitoring Criteria:</b> Patient has a diagnosis of Diabetes Mellitus AND Practitioner feels patient has sufficient training to use CGM.<br>• 2 years of age or older for Dexcom G6 and Dexcom G7, ≥ 14 years for Medtronic Guardian, or ≥ 4 years for Freestyle Libre 2.<br>• At least one of the following are documented:<br>o Hypoglycemic unawareness<br>o Treated with insulin (at least 1X day)<br>o Has history of problematic hypoglycemia with documentation of at least one recurrent level 2 hypoglycemic events, or 1 level 3 hypoglycemic event<br>• 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<br>MC<br>MC<br>MC<br>MC<br>MC<br>MC<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL                                                                     | FIASP<br>HUMALOG KWIKPEN INJ 100/ML<br>HUMALOG JUNIOR KWIKPEN 100/ML<br>HUMALOG MIX 75/25<br>HUMALOG 50/50 VIAL<br>HUMULIN INJ 70/30 KWIKPEN<br>HUMULIN INJ 70/30<br>HUMULIN R INJ U-500<br>INSULIN LISPRO<br>LANTUS SOLN<br>LEVEMIR<br>NOVOLOG<br>NOVOLOG MIX<br>NOVOLOG MIX 70/30 VIAL                                                                                                  | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC<br>MC<br>MC<br>MC<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC                                                                           |                                                                                                  | APIDRA<br>ADMELOG<br>AFREZZA <sup>1</sup><br>BASAGLAR<br>HUMALOG KWIKPEN U-200<br>HUMULIN INJ 50/50<br>HUMULIN N INJ U-100<br>HUMULIN R U-100<br>INSULIN DEGLUDEC<br>KIRSTY<br>LYUMJEV<br>MERILOG<br>NOVOLIN<br>RELION | <a href="#">Use PA Form# 20420</a><br>1. Not to be as a monotherapy. Obtain lab values of pulmonary function and recent smoking history.<br>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<br>MC<br>MC<br>MC<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL | HUMALOG MIX KWIK 50/50<br>HUMALOG MIX INJ 75/25 KWP<br>HUMALOG KWIK INJ 100/ML<br>HUMALOG KWIK INJ 200/ML<br>HUMULIN R U-500 KWP<br>INSULIN LISPRO KWIKPEN U-100<br>LANTUS SOLOSTAR<br>LEVEMIR FLEXTOUCH<br>LEVEMIR FLEXPEN<br>NOVOLIN 70/30 PEN<br>NOVOLOG MIX PENFILL<br>NOVOLOG PENFILL SOLN<br>NOVOLOG FLEXPEN<br>NOVOLOG MIX 70/30 FLEXPEN<br>TOUJEO MAX SOLOSTAR<br>TOUJEO SOLOSTAR | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL | 8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8 | APIDRA OPTICLIK PEN<br>AWIQLI<br>MERILOG<br>NOVOLIN 70/30 PEN<br>REZVOGLAR KWIKPEN<br>TRESIBA                                                                                                                          | <a href="#">Use PA Form# 20420</a>                                                                                                                                                                                                                                                                             | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in <b>step order</b> ), 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<br>MC/DEL                                                                                                                                                       | JANUVIA <sup>1,2</sup><br>TRADJENTA <sup>2</sup>                                                                                                                                                                                                                                                                                                                                          | MC<br>MC/DEL<br>MC/DEL<br>MC                                                                                                                                                           | 8<br>8<br>8<br>8                                                                                 | BRYNOVIN<br>NESINA<br>QTERN<br>ZITUVIO                                                                                                                                                                                 | <a href="#">Use PA Form# 20420</a><br>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.<br>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 <b>step order</b> ), 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.<br><b>Brynovin:</b> 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<br>MC/DEL<br>MC/DEL                                                                                                                                             | JANUMET <sup>1,2</sup><br>JANUMET XR <sup>1,2</sup><br>JENTADUETO <sup>1</sup>                                                                                                                                                                                                                                                                                                            | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC                                                                                                                                                 | 8<br>8<br>8<br>8<br>8                                                                            | JENTADUETO XR<br>KAZANO<br>QSENI<br>ZITUVIMET<br>ZITUVIMET XR                                                                                                                                                          | <a href="#">Use PA Form# 20420</a><br>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.<br>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 <b>step order</b> ), 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.<br><b>Zituvimet / Zituvimet XR:</b> Approvals will require trial of preferred sitagliptin/metformin products or other preferred diabetic agents.                                                                                                                                                                                                                                                                                                                                                               |
| DIABETIC - LANCET-LANCET DEVICE           |                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                        |                                                                                                  |                                                                                                                                                                                                                        | <a href="#">Use PA Form# 20420</a>                                                                                                                                                                                                                                                                             | Please refer to the MaineCare Preferred Diabetic Supply List available at <a href="http://www.mainearepdl.org">www.mainearepdl.org</a>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| DIABETIC - SYRINGES-NEEDLES               |                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                        |                                                                                                  |                                                                                                                                                                                                                        | <a href="#">Use PA Form# 20420</a>                                                                                                                                                                                                                                                                             | Please refer to the MaineCare Preferred Diabetic Supply List available at <a href="http://www.mainearepdl.org">www.mainearepdl.org</a>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| DIABETIC - OTHER                          |                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                           | MC                                                                                                                                                                                     |                                                                                                  | SYMLIN                                                                                                                                                                                                                 | <a href="#">Use PA Form #20420</a>                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| SGLT 2 INHIBITORS                         | MC/DEL<br>MC/DEL                                                                                                                                                       | FARXIGA<br>JARDIANCE                                                                                                                                                                                                                                                                                                                                                                      | MC/DEL<br>MC/DEL                                                                                                                                                                       |                                                                                                  | INVOKANA <sup>1</sup><br>STEGLATRO                                                                                                                                                                                     | <a href="#">Use PA Form# 20420</a><br>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<br>MC/DEL<br>MC/DEL                                                                                                                                             | SYNJARDY<br>SYNJARDY XR<br>XIGDOU XR                                                                                                                                                                                                                                                                                                                                                      | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL                                                                                                                               |                                                                                                  | GLYXAMBI<br>INVOKAMET<br>INVOKAMET XR<br>SEGLUROMET<br>STEGLUJAN<br>TRIJARDY XR                                                                                                                                        | <a href="#">Use PA Form# 20420</a>                                                                                                                                                                                                                                                                             | 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.<br><b>Glyxambi /Xigduo XR-</b> Verify prior trials and failures or intolerance of preferred treatments from other diabetic categories.<br><b>Synjardy XR</b> is not recommended for patients with type 1 DM or for the treatment of diabetic ketoacidosis.                                                                                                                                                                                                                             |

| CATEGORY                             | Coverage Indicator                                                 | PREFERRED DRUGS                                                                                                                                                              | Coverage Indicator                                       | Step Order            | NON-PREFERRED DRUGS<br>PA Required                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                               | Criteria                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|--------------------------------------|--------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|-----------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| DIABETIC MONITOR                     | MC<br>MC<br>MC                                                     | ACCU-CHEK GUIDE<br>RELION TRUE METRIX BLOOD GLUCOSE MONITORING SYSTEM<br>TRUE METRIX BLOOD GLUCOSE MONITORING SYSTEM                                                         | MC<br>MC<br>MC<br>MC<br>MC<br>MC<br>MC                   |                       | ASCENSIA<br>ASSURE<br>CONTOUR BREEZE Z<br>EXACTECH<br>FREESTYLE INSULINX<br>FREESTYLE LITE SYSTEM KIT<br>PRECISION XTRA METER<br>PRODIGY          | <a href="#">Use PA Form# 20420</a>                                                                                                                                                                                                                                                                                                                                                                                            | 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<br>MC                                                       | RELION TRUE METRIX<br>TRUE METRIX                                                                                                                                            | MC<br>MC<br>MC<br>MC<br>MC<br>MC<br>MC<br>MC<br>MC<br>MC |                       | ACCUCHECK<br>ASCENSIA<br>ASSURE<br>CONTOUR BREEZE Z<br>EXACTECH<br>FREESTYLE<br>FREESTYLE LITE<br>FREESTYLE INSULINX<br>PRECISION XTRA<br>PRODIGY | <a href="#">Use PA Form# 20420</a>                                                                                                                                                                                                                                                                                                                                                                                            | 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.<br><br>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<br>MC<br>MC/DEL                                             | RYBELSUS<br>TRULICITY<br>VICTOZA                                                                                                                                             | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL           | 6<br>8<br>8<br>8<br>8 | OZEMPIC<br>ADLYXIN<br>BYDUREON BCISE<br>SOLQUA<br>XULTOPHY                                                                                        | <a href="#">Use PA Form# 20420</a>                                                                                                                                                                                                                                                                                                                                                                                            | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved ( <b>in step order</b> ), 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.<br><br><b>Soliqua</b> 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<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL | CHLORPROPAMIDE TABS<br>GLIMEPIRIDE<br>GLIPIZIDE TABS<br>GLIPIZIDE ER TABS<br>GLYBURIDE MICRONIZED TABS<br>GLYBURIDE TABS <sup>1</sup><br>TOLAZAMIDE TABS<br>TOLBUTAMIDE TABS | MC/DEL                                                   |                       | GLUCOTROL XL TBCR                                                                                                                                 | <a href="#">Use PA Form# 20420</a><br><br>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.<br><br>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.<br>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<br>MC/DEL                                                   | METFORMIN HCL TABS<br>METFORMIN ER                                                                                                                                           | MC                                                       |                       | METFORMIN ER OSMOTIC                                                                                                                              | <a href="#">Use PA Form# 20420</a>                                                                                                                                                                                                                                                                                                                                                                                            | 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<br>MC/DEL<br>MC<br>MC                             |                       | ACTOPLUS MET <sup>1</sup><br>ACTOPLUS MET XR<br>AVANDARYL <sup>1</sup><br>AVANDAMET TABS <sup>1</sup>                                             | <a href="#">Use PA Form# 20420</a><br><br>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 <sup>1</sup>                                                                                                                                                | MC/DEL<br>MC                                             |                       | ACTOS TABS <sup>2</sup><br>AVANDIA TABS <sup>2</sup>                                                                                              | <a href="#">Use PA Form# 20420</a><br><br>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.<br>2. Current users of Avandia who have tried Actos will be able to continue use of Avandia.<br>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.<br><br>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 - ALPHAGLUCOSIDASE          |                                                                    |                                                                                                                                                                              | MC                                                       |                       | PRECOSE TABS                                                                                                                                      | <a href="#">Use PA Form# 20420</a>                                                                                                                                                                                                                                                                                                                                                                                            | 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<br>MC<br>MC/DEL                                       |                       | GLUCOVANCE TABS <sup>1</sup><br>METAGLIP TABS <sup>1</sup><br>DUETACT <sup>2</sup>                                                                | <a href="#">Use PA Form# 20420</a><br><br>1. Use individual ingredients.<br>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<br>MC/DEL                                         |                       | PRANDIN TABS<br>STARLIX TABS                                                                                                                      | <a href="#">Use PA Form# 20420</a>                                                                                                                                                                                                                                                                                                                                                                                            | 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.<br><br>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<br>MC/DEL<br>MC/DEL                                         | BAQSIMI <sup>1</sup><br>GVOKE <sup>2</sup><br>ZEGALOGUE <sup>3</sup>                                                                                                         | MC                                                       | 8                     | GLUCAGON DIAGNOSTIC KIT                                                                                                                           | <a href="#">Use PA Form# 20420</a><br><br>1. For the treatment of patients ≥ 4 yrs of age.<br>2. For the treatment of patients ≥ 2 yrs of age.<br>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 ( <b>in step order</b> ), 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<br>PA Required                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Criteria                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|----------------------------------------|--------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| THYROID                                |                                                                    |                                                                                                                                              |                                                                                                                                      |            |                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| THYROID EYE DISEASE                    |                                                                    |                                                                                                                                              | MC                                                                                                                                   |            | TEPEZZA                                                                                                                                                                                                                                                                                                                                                                         | <a href="#">Use PA Form# 20420</a>                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| THYROID HORMONES                       | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL | ARMOUR THYROID TABS<br>CYTOMEL TABS<br>ERMEZA <sup>1</sup><br>LEVOTHROID TABS<br>LEVOTHYROXINE SODIUM TABS<br>LEVOXYL TABS<br>UNITHROID TABS | MC<br>MC/DEL<br>MC<br>MC/DEL                                                                                                         |            | LEVOTHYROXINE SODIUM SOLR<br>LIOTHYRONINE<br>SYNTHROID TABS<br>THYQUIDITY                                                                                                                                                                                                                                                                                                       | <a href="#">Use PA Form# 20420</a><br>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<br>MC/DEL                                                   | METHIMAZOLE TABS<br>PROPYLTHIOURACIL TABS                                                                                                    | MC/DEL                                                                                                                               |            | TAPAZOLE TABS                                                                                                                                                                                                                                                                                                                                                                   | <a href="#">Use PA Form# 20420</a>                                                                                                                                                                                                                                                                                                                                                                                                                                   | 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<br>MC                                                                                                                             |            | ISTURISA <sup>1</sup><br>RECORLEV                                                                                                                                                                                                                                                                                                                                               | <a href="#">Use PA Form #20420</a><br>1. For the treatment of adult patients with Cushing's disease for whom pituitary surgery is not an option or has not been curative.                                                                                                                                                                                                                                                                                            | <b>Recorelv</b> 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<br>MC/DEL<br>MC/DEL<br>MC/DEL                               | ALENDRONATE<br>ENOBY <sup>6</sup><br>JUBBONTI <sup>6</sup><br>WYOST <sup>6,7</sup><br>XTRENBO <sup>6</sup>                                   | MC<br>MC<br>MC<br>MC<br>MC<br>MC<br>MC/DEL<br>MC<br>MC<br>MC<br>MC<br>MC<br>MC<br>MC<br>MC<br>MC<br>MC<br>MC<br>MC<br>MC<br>MC<br>MC |            | ACTONEL TABS<br>AUKELSO<br>BILDYOS<br>BILPREVDA <sup>7</sup><br>BINOSTO<br>BOMYNTRA <sup>7</sup><br>BOSAYA<br>CONEXENCE<br>DUAVEE<br>EVENTY <sup>2</sup><br>EVISTA TABS <sup>1</sup><br>FORTEO<br>FOSAMAX TABS AND PLUS D <sup>3</sup><br>JUBEREQ<br>OSENVELT <sup>7</sup><br>OSVYRTI<br>PROLIA<br>SOHONOS <sup>6</sup><br>STOBOCLO<br>STRENSIO <sup>5</sup><br>TYMLOS<br>XGEVA | <a href="#">Use PA Form# 20420</a><br>1. Approval only requires failure of Alendronate.<br>2. Quantity limits apply, please see Dosage Consolidation List.<br>3. Please use Alendronate & Vitamin D.<br>5. Obtain baseline ophthalmology exams and renal ultrasounds and then periodically during treatment.<br>6. Clinical PA for indication required.<br>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.<br><br><b>Binosto</b> use preferred generic alendronate tablets.<br><b>Eventy</b> should be limited to 12 monthly doses.<br><b>Sohonos:</b> 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 <sup>1</sup>                                                                                                                        |                                                                                                                                      |            |                                                                                                                                                                                                                                                                                                                                                                                 | <a href="#">Use PA Form #20420</a><br>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.                                                                                                                                                                                                                                                                                                                                                                |
| CALCIMIMETIC AGENTS                    |                                                                    |                                                                                                                                              |                                                                                                                                      |            |                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| CALCIMIMETIC AGENTS                    |                                                                    |                                                                                                                                              | MC<br>MC                                                                                                                             |            | PARSABIV<br>SENSIPAR                                                                                                                                                                                                                                                                                                                                                            | <a href="#">Use PA Form# 30115</a>                                                                                                                                                                                                                                                                                                                                                                                                                                   | <b>Parsabiv</b> 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.<br><b>For Sensipar baseline</b> PTH, Ca, and phosphorus 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.                                                                                                                                                  |
| GROWTH HORMONE                         |                                                                    |                                                                                                                                              |                                                                                                                                      |            |                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| GROWTH HORMONE                         | MC/DEL<br>MC/DEL<br>MC                                             | GENOTROPIN <sup>1</sup><br>NORDITROPIN SOLN <sup>1</sup><br>SKYTROFA <sup>1</sup>                                                            | MC<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL                                                                                               |            | HUMATROPE SOLR<br>NUTROPIN<br>NGENLA<br>OMNITROPE<br>SOGROYA                                                                                                                                                                                                                                                                                                                    | <a href="#">Use PA Form# 10710</a><br>1.Clinical PA is required to establish diagnosis and medical necessity.                                                                                                                                                                                                                                                                                                                                                        | See <b>Growth Hormone PA form # 10710</b> for criteria. Step-order will still apply unless clinical contraindication supplied.<br><br>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.                                                                                                                                                                                                                          |
| ACHONDROPLASIA TREATMENT               |                                                                    |                                                                                                                                              | MC<br>MC                                                                                                                             |            | VOXZOGO <sup>1</sup><br>YUWIVEL <sup>2</sup>                                                                                                                                                                                                                                                                                                                                    | <a href="#">Use PA Form# 20420</a><br>1. Pediatric patients with achondroplasia who are 5 years of age and older with open epiphyses.<br>2. Clinical PA is required to establish diagnosis and medical necessity.                                                                                                                                                                                                                                                    | <b>Voxzogo:</b> 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).                                                                                                                                                                                                                                                                                                                                                                              |

| CATEGORY                              | Coverage Indicator                                             | PREFERRED DRUGS                                                                                                            | Coverage Indicator                                     | Step Order                 | NON-PREFERRED DRUGS PA Required                                                                                                                           |                                                                                                                                                                                          | Criteria                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|---------------------------------------|----------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|----------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| GROWTH HORMONE ANTAGONISTS / AGONISTS |                                                                |                                                                                                                            |                                                        |                            |                                                                                                                                                           |                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| GH ANTAGONISTS / AGONISTS             | MC                                                             | OCTREOTIDE INJ <sup>1</sup>                                                                                                | MC                                                     |                            | LANREOTIDE<br>MYCAPSSA <sup>2</sup><br>PALSONIFY <sup>2</sup><br>SANDOSTATIN <sup>2</sup><br>SIGNIFOR <sup>2</sup><br>SOMATULINE <sup>2</sup><br>SOMAVERT | <a href="#">Use PA Form# 10710</a><br>1. Clinical PA is required to establish diagnosis and medical necessity.<br>2. Non-preferred products must be used in specified step order.        | <b>Somavert:</b> Approved for acromegaly patients failing surgery/radiation/drug therapy including bromocriptine and sandostatatin.<br><b>Criteria for all:</b> <ul style="list-style-type: none"> <li>Diagnosis of acromegaly AND</li> <li>Prescribed by or in consultation with an endocrinologist AND</li> <li>One of the following:               <ul style="list-style-type: none"> <li>Patient has an inadequate response to surgery OR</li> <li>Patient is not a candidate for surgery</li> </ul> </li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| VASOPRESSIN RECEPTOR ANTAGONIST       |                                                                |                                                                                                                            |                                                        |                            |                                                                                                                                                           |                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| VASOPRESSIN RECEPTOR ANTAGONIST       |                                                                |                                                                                                                            | MC<br>MC/DEL                                           |                            | JYNARQUE <sup>1</sup><br>SAMSCA                                                                                                                           | <a href="#">Use PA Form# 20420</a><br>1. Clinical PA required for appropriate diagnosis                                                                                                  | <b>Samsca Drug Warning:</b> 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.<br><b>DDI: Jynarque-</b> 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).                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| URINARY INCONTINENCE                  |                                                                |                                                                                                                            |                                                        |                            |                                                                                                                                                           |                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| VASOPRESSINS                          | MC/DEL<br>MC/DEL                                               | DESMOPRESSIN TABS<br>DDAVP SOLN                                                                                            | MC/DEL<br>MC/DEL<br>MC<br>MC<br>MC/DEL<br>MC           | 5<br>6<br>8<br>8<br>8<br>8 | DDAVP TABS<br>DESMOPRESSIN SPRAY <sup>1</sup><br>DESMODA<br>DESMOPRESSIN ACETATE SOLN <sup>1</sup><br>NOCDURNA <sup>1</sup><br>NOCTIVA <sup>1</sup>       | <a href="#">Use PA Form# 20420</a><br><b>1. Products must be used in specified step order.</b><br>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).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| ANTISPASMODICS                        | MC/DEL<br>MC/DEL                                               | OXYBUTYNIN<br>TOLTERODINE                                                                                                  | MC/DEL<br>MC/DEL<br>MC/DEL                             |                            | DARIFENACIN ER TAB<br>DITROPAN<br>FLAVOXATE HCL TAB                                                                                                       | <a href="#">Use PA Form# 20420</a>                                                                                                                                                       | 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| ANTISPASMODICS - LONG ACTING          | MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL | FESOTERODINE<br>GELNIQUE GEL PACKET<br>MYRBETRIQ<br>OXYBUTYNIN ER TABS<br>OXYTROL<br>SOLIFENACIN SUCCINATE TAB<br>TROSPIUM | MC<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL |                            | DITROPAN XL TBCR<br>ENABLEX <sup>1,2</sup><br>GEMTESA <sup>2</sup><br>TOLTERODINE TAB<br>TOVIAZ<br>VESICARE <sup>1</sup><br>VESICARE LS <sup>3</sup>      | <a href="#">Use PA Form# 20420</a><br>1. See Criteria Section.<br>2. Use a preferred long acting antispasmodic.<br>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.<br><b>1. Vesicare 5mg and Enablex 7.5mg</b> maximum doses if given with drugs known to be significant CYP3A4 inhibitors (ketoconazole, sporanox, erythromycin, fluconazole, nefazodone, nelfinavir, and ritonavir).<br><b>DDI: Enablex 15mg and Vesicare 10mg</b> 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. |
| CHOLINERGIC                           | MC/DEL                                                         | BETHANECHOL                                                                                                                | MC/DEL                                                 |                            |                                                                                                                                                           | <a href="#">Use PA Form# 20420</a>                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| HYPERAMMONIA TREATMENTS               | MC                                                             | CARBAGLU TABS                                                                                                              | MC                                                     |                            | CARGLUMIC ACID TABS                                                                                                                                       | <a href="#">Use PA Form# 20420</a>                                                                                                                                                       | 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<br>MC                                                       | BUPHENYL TABLET<br>PHEBURANE GRANULES                                                                                      | MC<br>MC<br>MC<br>MC/DEL<br>MC/DEL                     |                            | BUPHENYL POWDER<br>RAVICTI LIQUID<br>OLPRUVA<br>SODIUM PHENYLBUTYRATE POWDER<br>SODIUM PHENYLBUTYRATE TAB                                                 | <a href="#">Use PA Form# 20420</a>                                                                                                                                                       | 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.<br><b>Olpruva:</b> 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 1.2m <sup>2</sup> or greater, with urea cycle disorders (UCDs) involving deficiencies of carbamylphosphate synthetase (CPS), ornithine transcarbamylase (OTC), or argininosuccinic acid synthetase (AS).                                                                                                            |
| METABOLIC MODIFIER                    |                                                                |                                                                                                                            |                                                        |                            |                                                                                                                                                           |                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| HERED. TYROSINEMIA                    |                                                                |                                                                                                                            | MC<br>MC<br>MC                                         | 6<br>6<br>8                | ORFADIN<br>NITYR<br>HARLIKU <sup>1</sup>                                                                                                                  | <a href="#">Use PA Form# 20420</a><br>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.<br><br>Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs ( <b>in step order</b> ) 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.                                                                                                                                                                                                                                                                                                                                                                                                       |
| FABRY DISEASE AGENTS                  |                                                                |                                                                                                                            | MC<br>MC<br>MC                                         |                            | ELFABRIO <sup>1</sup><br>FABRAZYME <sup>2</sup><br>GALAFOLD <sup>1</sup>                                                                                  | <a href="#">Use PA Form# 20420</a><br>1. Clinical PA to verify appropriate diagnosis.<br>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.<br><br>Elfabrio and Galfold: For the treatment of adults with confirmed Fabry disease.                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| ANTIHYPERTENSIVES / CARDIAC           |                                                                |                                                                                                                            |                                                        |                            |                                                                                                                                                           |                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| CARDIAC GLYCOSIDES                    | MC/DEL<br>MC/DEL<br>MC/DEL                                     | DIGITEK TABS<br>DIGOXIN<br>LANOXIN                                                                                         |                                                        |                            |                                                                                                                                                           | <a href="#">Use PA Form# 20420</a>                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| CARDIAC MYOSIN INHIBITORS             |                                                                |                                                                                                                            | MC<br>MC                                               |                            | CAMZYOS <sup>1</sup><br>MYQORZO <sup>1</sup>                                                                                                              | <a href="#">Use PA Form# 20420</a><br>1. 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.<br><br><b>Camzyos and Myqorzo:</b> 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.<br><br><b>DDI:</b> Concomitant use of <b>Camzyos</b> or <b>Myqorzo</b> with a moderate to strong CYP2C19 inhibitor or a strong CYP3A4 inhibitor is contraindicated.                                                                                                                                                  |
| CARDIAC - SINUS NODE INHIBITORS       |                                                                |                                                                                                                            | MC                                                     |                            | CORLANOR                                                                                                                                                  | <a href="#">Use PA Form#20420</a>                                                                                                                                                        | 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |

| CATEGORY                                           | Coverage Indicator                                                                                 | PREFERRED DRUGS                                                                                                                                                                                                                                                           | Coverage Indicator                                                                   | Step Order | NON-PREFERRED DRUGS<br>PA Required                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                           | Criteria                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
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| CARDIAC- ERAs                                      |                                                                                                    |                                                                                                                                                                                                                                                                           | MC/DEL<br>MC                                                                         |            | BAXFENDY<br>TRYVIO                                                                                                                                                                                  | <a href="#">Use PA Form#20420</a>                                                                                                                                                                                                                                                                                                                                                                                                         | <b>Baxfendy and Tryvio:</b> Clinical PA required. Member must have a diagnosis of uncontrolled hypertension or resistant hypertension, and the requested drug must be used in combination with other antihypertensive medications.<br><br><b>Baxfendy:</b> Patient has not achieved BP control after treatment with two non-MRA antihypertensive medications from different classes at target doses, including a thiazide-type or thiazide diuretic and a calcium channel blocker. Trial and inadequate response, contraindication, or intolerance to an MRA, such as spironolactone or eplerenone, is required. Should be prescribed by or in consultation with a cardiologist or nephrologist.<br><br><b>Tryvio:</b> Indicated, in combination with other antihypertensive drugs, for the treatment of resistant hypertension to lower BP in adult patients who are not adequately controlled on other drugs. Resistant hypertension is defined as use of at least three antihypertensive medication classes with complementary mechanisms, including a thiazide or thiazide-type diuretic, ACE inhibitor or ARB, and long-acting calcium channel blocker, with a trial of spironolactone unless contraindicated. Should be prescribed in consultation with a cardiologist or nephrologist.                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| CARDIAC- SOLUBLE GUANYLATE CYCLASE STIMULATORS     |                                                                                                    |                                                                                                                                                                                                                                                                           | MC                                                                                   |            | VERQUVO                                                                                                                                                                                             | <a href="#">Use PA Form# 20420</a>                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| CARDIOMETABOLIC HEALTH AGENTS                      | MC/DEL<br>MC/DEL                                                                                   | WEGOVY INJ <sup>1</sup><br>WEGOVY TAB <sup>1</sup>                                                                                                                                                                                                                        | MC<br>MC<br>MC                                                                       |            | INPEFA <sup>2</sup><br>LODOCO<br>REZDIFFRA                                                                                                                                                          | <a href="#">Use PA Form# 20420 for REZDIFFRA Only</a><br><a href="#">Use PA Form #23976 for all others</a><br><br>1. Clinical PA is required to establish diagnosis and medical necessity.<br>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.<br><b>Indication for use is Major Adverse Cardiac Event (MACE) Reduction:</b><br>• Patient has history of at least one of the following: <ul style="list-style-type: none"><li>o Stroke</li><li>o Myocardial Infarction</li><li>o Symptomatic peripheral arterial disease</li></ul> <b>Indication for use is Metabolic Dysfunction-Associated Steatohepatitis (MASH):</b><br>• 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).<br>• Patient does not have evidence of decompensated cirrhosis.<br>• Medication is being prescribed or in consultation with gastroenterologist, hepatologist, or endocrinologist.<br><b>Wegovy:</b> Patient has BMI > 27 kg/m2, and is not being used for weight loss only<br><b>Lodoco:</b> Patient must have tried and failed generic colchicine due to lack of efficacy or intolerable side effects<br><b>Rezdiffra:</b> 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<br>MC/DEL                                                                                   | ISOSORBIDE MONONITRATE TABS<br>ISOSORBIDE MONONITRATE ER                                                                                                                                                                                                                  | MC/DEL<br>MC/DEL<br>MC/DEL                                                           |            | ISOSORBIDE DINITRATE CR TBGR<br>ISOSORBIDE DINITRATE ER TBGR<br>ISOSORBIDE DINITRATE TD TBGR                                                                                                        | <a href="#">Use PA Form# 20420</a>                                                                                                                                                                                                                                                                                                                                                                                                        | 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<br>MC/DEL<br>MC<br>MC                                                                       | NITROBID OINT<br>NITROGLYCERIN CPCPR<br>NITROL OINT<br>NITRO-TIME CPCPR                                                                                                                                                                                                   |                                                                                      |            |                                                                                                                                                                                                     | <a href="#">Use PA Form# 20420</a>                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| NITRO - PATCHES                                    | MC/DEL<br>MC/DEL                                                                                   | NITROGLYCERIN PT24<br>NITRO-DUR PT 24 0.8MG                                                                                                                                                                                                                               | MC<br>MC/DEL                                                                         |            | NITRODISC PT24<br>NITRO-DUR PT24                                                                                                                                                                    | <a href="#">Use PA Form# 20420</a>                                                                                                                                                                                                                                                                                                                                                                                                        | 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<br>MC<br>MC                                                                   |            | NITROQUICK SUBL<br>NITROLINGUAL SOLN<br>NITROLINGUAL TABS                                                                                                                                           | <a href="#">Use PA Form# 20420</a>                                                                                                                                                                                                                                                                                                                                                                                                        | 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<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL | CARVEDILOL<br>LEVATOL TABS<br>NADOLOL TABS<br>PINDOLOL TABS<br>PROPRANOLOL HCL SOLN <sup>1</sup><br>PROPRANOLOL HCL TABS <sup>1</sup><br>PROPRANOLOL HCL 60MG TABS<br>PROPRANOLOL LA CAPS<br>RANOLAZINE ER TABS<br>SOTALOL AF<br>SOTALOL HCL TABS<br>TIMOLOL MALEATE TABS | MC<br>MC/DEL<br>MC<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC<br>MC<br>MC<br>MC |            | ASPRUZO<br>BETAPACE TABS<br>BETAPACE AF TABS<br>COREG CR <sup>1</sup><br>COREG TABS<br>CORCARD TABS<br>INDERAL TABS<br>HEMANGEOL SOL<br>INDERAL XL CAP<br>INDERAL LA CPCPR<br>INNOPRAN XL<br>RANEXA | <a href="#">Use PA Form# 20420</a><br><br>1. Recommend using BID since its effects do not last 24 hours.<br>2. Please use other strengths in combination to obtain this dose.<br>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.<br><br><b>DDI:</b> Concomitant use of <b>Ranolazine</b> products with strong CYP3A inhibitors, including ketoconazole, itraconazole, clarithromycin, nefazodone, nelfinavir, ritonavir, indinavir, and saquinavir, is contraindicated.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| BETA BLOCKERS - CARDIO SELECTIVE                   | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL                                 | ACEBUTOLOL HCL CAPS<br>ATENOLOL TABS <sup>1</sup><br>BETAXOLOL HCL TABS<br>BISOPROLOL FUMARATE TABS<br>BYSTOLIC<br>METOPROLOL TARTRATE TABS <sup>1</sup><br>METOPROLOL ER<br>NEBIVOLOL HCL TAB                                                                            | MC<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL                           |            | KERLONE TABS<br>LOPRESSOR TABS<br>SECTRAL CAPS<br>TENORMIN TABS<br>TOPROL XL TB24<br>ZEBETA TABS                                                                                                    | <a href="#">Use PA Form# 20420</a><br><br>1. Recommend using <b>Atenolol</b> (and <b>Metoprolol</b> ) 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| BETA BLOCKERS - ALPHA / BETA                       | MC/DEL                                                                                             | LABETALOL HCL TABS                                                                                                                                                                                                                                                        | MC                                                                                   |            | TRANDATE TABS                                                                                                                                                                                       | <a href="#">Use PA Form# 20420</a>                                                                                                                                                                                                                                                                                                                                                                                                        | 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                                                                                                                                                                                            | <a href="#">Use PA Form# 20420</a>                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |

| CATEGORY                                                                                       | Coverage Indicator                                                       | PREFERRED DRUGS                                                                                                                                                                                                            | Coverage Indicator                                                                             | Step Order                                               | NON-PREFERRED DRUGS<br>PA Required                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                    | Criteria                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|----------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| CALCIUM CHANNEL BLOCKERS--<br>Amlodipine, Felodipines, Nifedipines, Nisoldipine, and Verapamil | MC/DEL                                                                   | AMLODIPINE <sup>1</sup>                                                                                                                                                                                                    | MC/DEL<br>MC<br>MC/DEL                                                                         |                                                          | KATERZIA<br>NORLIQVA<br>SDAMLO<br>NORVASC TABS <sup>1</sup>                                                                                                                                                                                                | <a href="#">Use PA Form# 20420.</a><br>1. Dosing limits apply, see Dose Consolidation List.                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                                                                                                | MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL     | DILTIA XT CP24<br>DILTIAZEM HCL ER CP24<br>DILTIAZEM HCL XR CP24<br>DILTIAZEM CD 300MG CP24<br>CARTIA XT CP24 <sup>1</sup><br>DILTIAZEM CD CP24 <sup>1</sup><br>DILTIAZEM XR CP24 <sup>1</sup><br>TIAZAC CP24 <sup>1</sup> | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL                                       | 5<br>6<br>8<br>8<br>8                                    | DILACOR XR CP24 <sup>1</sup><br>TAZTIA <sup>1</sup><br>DILTIAZEM HCL TABS <sup>1</sup><br>DILTIAZEM HCL ER CP12 <sup>1</sup><br>DILTIAZEM CD 360MG CP24                                                                                                    | <a href="#">Use PA Form# 20420.</a><br>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 ( <b>in step order</b> ), 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.<br><br><b>DDI:</b> All preferred <b>Diltiazem</b> 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<br>MC/DEL                                                                               |                                                          | FELODIPINE<br>PLENDIL TB24                                                                                                                                                                                                                                 | <a href="#">Use PA Form# 20420.</a>                                                                                                                                                                                                                                | 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                                                                                             |                                                          | NICARDIPINE HCL CAPS                                                                                                                                                                                                                                       | <a href="#">Use PA Form# 20420.</a>                                                                                                                                                                                                                                | 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 ( <b>in step order</b> ), 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<br>MC/DEL                                                         | NIFEDIPINE TBCR<br>NIFEDIPINE ER TBCR                                                                                                                                                                                      | MC<br>MC/DEL                                                                                   | 4<br>8                                                   | NIFEDIPINE CAPS<br>PROCARDIA XL TBCR                                                                                                                                                                                                                       | <a href="#">Use PA Form# 20420.</a><br>1. Established users of <b>Adalat CC</b> are grandfathered.                                                                                                                                                                 | Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs <b>in step order</b> 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<br>MC                                                                                       |                                                          | SULAR TB24<br>SULAR CR <sup>1</sup>                                                                                                                                                                                                                        | <a href="#">Use PA Form# 20420.</a><br>1. Established users of 10MG and 20MG strengths are grandfathered.                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                                                                                                | MC/DEL<br>MC/DEL<br>MC/DEL                                               | VERAPAMIL HCL CR TBCR<br>VERAPAMIL HCL ER TBCR<br>VERAPAMIL HCL SR TBCR                                                                                                                                                    | MC<br>MC<br>MC<br>MC/DEL                                                                       | 8<br>8<br>8<br>8                                         | VERAPAMIL HCL ER CP24<br>VERAPAMIL HCL SR CP24<br>VERAPAMIL HCL TABS<br>VERELAN PM CP24                                                                                                                                                                    | <a href="#">Use PA Form# 20420.</a><br>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 ( <b>in step-order</b> ), 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<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL | AMIODARONE HCL<br>DISOPYRAMIDE<br>FLECAINIDE<br>MEXILETINE HCL<br>PROCAINAMIDE<br>PROPAFENONE<br>QUINAGLUTE<br>QUINIDINE GLUCONATE<br>QUINIDINE SULFATE                                                                    | MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL |                                                          | CARDAMYST<br>CORDARONE<br>DISOPYRAMIDE<br>MULTAQ<br>NORPACE<br>PACERONE<br>QUINIDEX<br>TAMBOCOR<br>TIKOSYN <sup>1</sup><br>RYTHMOL SR<br>RYTHMOL                                                                                                           | <a href="#">Use PA Form# 20420.</a><br>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.<br><br><b>DDI: Amiodarone</b> 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.<br><br><b>DDI:</b> 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<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL       | BENAZEPRIL HCL<br>CAPTOPRIL TABS<br>ENALAPRIL MALEATE TABS<br>FOSINOPRIL SODIUM<br>LISINAPRIL TABS<br>QUINAPRIL HCL<br>RAMIPRIL                                                                                            | MC/DEL<br>MC/DEL<br>MC<br>MC<br>MC/DEL<br>MC/DEL<br>MC<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL     | 8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8 | ACCUPRIL TABS<br>ALTACE CAPS <sup>1</sup><br>EPANED<br>JAVADIN<br>LOTENSIN TABS <sup>1</sup><br>MOEXIPRIL HCL <sup>1</sup><br>MONOPRIL HCT TABS <sup>1</sup><br>PRINIVIL TABS <sup>1</sup><br>QBRELIS<br>UNIVASC <sup>1</sup><br>ZESTRIL TABS <sup>1</sup> | <a href="#">Use PA Form# 20420.</a><br>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 ( <b>in step-order</b> ) 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<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL                           | AMLODIPINE-OLMESARTAN TAB <sup>3</sup><br>IRBESARTAN <sup>1</sup><br>LOSARTAN <sup>1</sup><br>MICARDIS TABS <sup>3</sup><br>OLMESARTAN <sup>1</sup><br>TELMISARTAN <sup>1</sup>                                            | MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC                                     |                                                          | ARBLI<br>ATACAND TABS<br>AVAPRO<br>BENICAR TABS<br>COZAAR<br>DIOVAN<br>EDARBI<br>TEVETEN TABS                                                                                                                                                              | <a href="#">Use PA Form# 20420.</a><br>1. Dosing limits apply, please see Dose Consolidation List.<br>2. Use preferred active ingredients which are available without PA.<br>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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| DIRECT RENIN INHIBITOR                                                                         |                                                                          |                                                                                                                                                                                                                            | MC/DEL                                                                                         |                                                          | TEKAMLO                                                                                                                                                                                                                                                    | <a href="#">Use PA Form# 20420.</a>                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |

| CATEGORY                               | Coverage Indicator | PREFERRED DRUGS               | Coverage Indicator | Step Order | NON-PREFERRED DRUGS<br>PA Required                 |                                                                                                 | Criteria                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|----------------------------------------|--------------------|-------------------------------|--------------------|------------|----------------------------------------------------|-------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| ANTIHYPERTENSIVES - CENTRAL            | MC/DEL             | CLONIDINE HCL TABS            | MC/DEL             |            | CLONIDINE PATCH                                    | <a href="#">Use PA Form# 20420.</a>                                                             | 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                                         |                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| ACE INHIBITORS AND CA CHANNEL BLOCKERS |                    |                               | MC/DEL MC          |            | AMLODIPINE/BENAZEPRIL<br>TARKA TBCR<br>LOTREL CAPS | <a href="#">Use PA Form# 20420.</a><br><br>Use individual preferred generic medications.        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| ACE AND THIAZIDE COMBO'S               | MC/DEL             | BENAZEPRIL HCL/HYDROCHLOR     | MC/DEL             |            | ACCURETIC TABS                                     | <a href="#">Use PA Form# 20420</a>                                                              | 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             | CAPTROPRIl/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             | ATENOloLi/ChlorThaliDonE      | MC/DEL             |            | CORziDE TABS                                       | <a href="#">Use PA Form# 20420.</a>                                                             | 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<br><br>TIMOLide 10/25 TABS               |                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| ARB'S AND CALCIUM CHANNEL BLOCKERS     | MC/DEL             | AMLoDiPiNE/VAlSaRTAN          | MC/DEL             |            | Azor                                               | <a href="#">Use PA Form# 20420.</a>                                                             | Per best practices, patient should have trialed prior therapy of ACE inhibitor or currently on a diabetic therapy.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|                                        | MC/DEL             | AmLoDiPiNe/vAlSaRtAN hCT      | MC/DEL             |            | Exforge                                            |                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                        | MC/DEL             | TriBenzor                     | MC/DEL             |            | Exforge HCT                                        |                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| ARB'S AND DIURETICS                    | MC/DEL             | Benicar HCT <sup>1</sup>      | MC/DEL             |            | iRBESARTAN HYDROCHLOROThiazide                     | <a href="#">Use PA Form# 20420.</a><br><br>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 <sup>1</sup>     | MC/DEL             |            | ATAcAND HCT TABS                                   |                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                        | MC/DEL             | MicARDIS HcTTAbS <sup>1</sup> | MC                 |            | AVALIde TABS <sup>1</sup>                          |                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                        | MC/DEL             | VAlSaRTAN-hCT <sup>1</sup>    | MC/DEL             |            | DioVAN HCT TABS <sup>1</sup>                       |                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                        |                    |                               | MC/DEL             |            | HYZAR TABS                                         |                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                        |                    |                               | MC                 |            | TEVETEN HCT TABS                                   |                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| ANGIOTENSIN MODULATORS-ARB COMBINATION | MC                 | SACUBitril-VAlSaRTAN TAB      | MC/DEL MC MC       |            | EDArBYclOR<br>ENTRESTO<br>ENTRESTO SPRINKLES       | <a href="#">Use PA Form# 20420</a>                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| DIURETICS                              | MC/DEL             | AcETAzOLAmiDE TABS            | MC/DEL             |            | ALDACTAziDE TABS                                   | <a href="#">Use PA Form# 20420</a>                                                              | 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.<br><br><b>Furoscix:</b> 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.<br><br><b>Kerendia:</b> Patient must be on max tolerated preferred ACE-I/ARB and SGLT-2.<br><b>DDI:</b> The concomitant use of Keveyis with high dose aspirin is contraindicated. |
|                                        | MC/DEL             | AMILORIDe HCL                 | MC/DEL             |            | ALDACTIONE 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             | Methylclothiazide TABS        | MC                 |            | FUROScIX                                           |                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                        | MC/DEL             | Spironolactone                | MC/DEL             |            | HEMIClOR                                           |                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                        | MC/DEL             | SPIRONOlACTONE/hydro          | MC/DEL             |            | InSPRA                                             |                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                        | MC/DEL             | TORSEMiDE TABS                | MC                 |            | INZIROQ                                            |                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                        | MC/DEL             | TRIAMTERENE/HCTZ              | MC/DEL             |            | KERENDIA                                           |                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                        | MC                 | ZAROXLYN TABS                 | MC/DEL             |            | KEVEyiS                                            |                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                        |                    |                               | MC/DEL             |            | LASIX TABS                                         |                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                        |                    |                               | MC/DEL             |            | MAXziDE                                            |                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                        |                    |                               | MC/DEL             |            | MICROziDE CAPS                                     |                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                        |                    |                               | MC                 |            | MIdAMOR TABS                                       |                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                        |                    |                               | MC/DEL             |            | NAQUA TABS                                         |                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| CCB / LIPID                            |                    |                               | MC/DEL             |            | CADUET                                             | <a href="#">Use PA Form# 20420</a>                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| NEUROGENIC ORTHOSTATIC HYPOTENSION     |                    |                               |                    |            |                                                    |                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| NEUROGENIC ORTHOSTATIC HYPOTENSION     |                    |                               | MC                 |            | NORTHERA                                           | <a href="#">Use PA Form# 20420</a>                                                              | 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 SEQUESTANTS         | MC/DEL             | CHOlestyrAMine                | MC/DEL             |            | COLESTiD                                           | <a href="#">Use PA Form# 20420.</a>                                                             | 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 HCI                | MC/DEL             |            | PREVALITE                                          |                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                        |                    |                               | MC                 |            | QUESTRAN                                           |                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                        |                    |                               | MC/DEL             |            | WeLCHol TABS                                       |                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| CHOLESTEROL - FIBRIC ACID DERIVATIVES  | MC/DEL             | FENOfIBRATE TAB               | MC                 |            | AntARA                                             | <a href="#">Use PA Form# 20420.</a>                                                             | 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             | GEMFiBrozil TABS              | MC/DEL             |            | LIPOD                                              |                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                        | MC/DEL             | NIACIN ER                     | MC/DEL             |            | FENOFIBRATE 120mg TAB                              |                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |

| CATEGORY                                                                   | Coverage Indicator               | PREFERRED DRUGS                                                              | Coverage Indicator                                                                                                     | Step Order | NON-PREFERRED DRUGS<br>PA Required                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Criteria                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|----------------------------------------------------------------------------|----------------------------------|------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                            |                                  |                                                                              | MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC<br>MC                                                                 |            | FENOFIBRATE CAP<br>FIBRICOR<br>LIPOFEN<br>LOFIBRA<br>NIASPAN ER<br>TRICOR<br>TRIGLIDE                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | DDI: Fenofibrate is preferred but will require a prior authorization requests if used concurrent with warfarin.<br>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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| CHOLESTEROL - HMG COA + ABSORB INHIBITORS MORE POTENT DRUGS/- COMBINATIONS | MC/DEL<br>MC/DEL<br>MC<br>MC/DEL | ATORVASTATIN<br>EZETIM/SIMVA TAB<br>ROSUVASTATIN<br>SIMVASTATIN <sup>1</sup> | MC<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC                                                 |            | ATORVALIQ<br>CRESTOR<br>EZALLOR SPRINKLES <sup>3</sup><br>FLOLIPID<br>LIPITOR<br>LIPTRUZET<br>ZOCOR<br>SIMVASTATIN 80MG <sup>1,2</sup><br>VYTORIN                                                                                                                                                                       | <a href="#">Use PA Form# 20420.</a><br><br>1. Dosing limits apply, see Dosage Consolidation List.<br>2. Current users grandfathered.<br>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.<br>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.<br>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 LESS POTENT DRUGS/- COMBINATIONS | MC/DEL<br>MC/DEL<br>MC/DEL       | EZETIMIBE TABS<br>LOVASTATIN TABS <sup>2</sup><br>PRAVASTATIN <sup>2</sup>   | MC<br>MC/DEL<br>MC/DEL<br>MC<br>MC<br>MC<br>MC/DEL<br>MC/DEL<br>MC                                                     |            | ALTOPREV TB24<br>FLUVASTATIN TAB ER<br>LESCOL XL TB24<br>LIVALO<br>MEVACOR TABS<br>NEXLETOL<br>NEXLIZET<br>PRAVACHOL TABS<br>PRAVIGARD<br>ZETIA TABS                                                                                                                                                                    | <a href="#">Use PA Form# 20420.</a><br><br>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.<br><br>DDI: Lescol will now be non-preferred and require prior authorization if it is currently being used in combination with diclofenac.<br>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.<br>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.<br>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                                                                                                                                                                                                                                                                                                            | <a href="#">Use PA Form# 20420.</a>                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| FAMILIAL HYPERCHOLESTEROLEMIA                                              | MC<br>MC                         | PRALUENT (LABLER 72733) PEN <sup>1,2,3</sup><br>REPATHA <sup>1,2,3</sup>     | MC<br>MC<br>MC<br>MC                                                                                                   |            | EVKEEZA <sup>1,4</sup><br>JUXTAPID<br>KYNAMRO <sup>1</sup><br>LEQVIO                                                                                                                                                                                                                                                    | <a href="#">Use PA Form# 20420.</a><br><br>1. Clinical PA required for appropriate diagnosis.<br>2. Quantity limits apply.<br>3. Documented adherence to lipid lowering medications and abstinence from tobacco for previous 90 days.<br>4. For treatment of patients ≥ 12 years of age.<br>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.<br>Juxtapid is contraindicated with strong CYP3A4 inhibitors. Juxtapid dosage should not exceed 30mg daily when it is used concomitantly with weak CYP3A4 inhibitors.<br>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.<br>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.<br>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.<br><b>Additional criteria for the diagnosis of clinical atherosclerotic cardiovascular disease:</b> History of MI, angina, coronary or other arterial revascularization, stroke, TIA, or PVD of atherosclerotic origin.<br><b>Additional criteria for the diagnosis of homozygous familial hypercholesterolemia (Repatha only):</b> 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                     |                                  |                                                                              | MC<br>MC                                                                                                               |            | REDEMPIO <sup>1</sup><br>TRYNGOLZA <sup>1</sup>                                                                                                                                                                                                                                                                         | <a href="#">Use PA Form# 20420</a><br><br>1. Clinical PA required for appropriate diagnosis and clinical parameters.                                                                                                                                                                                                                                                                                                                                                      | Tryngolza and Redempio require fasting triglycerides of ≥ 880 mg/dL and confirmed genetically identified familial chylomicronemia syndrome (FCS).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| HYPERPHAGIA - MISC                                                         |                                  |                                                                              |                                                                                                                        |            |                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| HYPERPHAGIA - MISC                                                         |                                  |                                                                              | MC                                                                                                                     |            | YVKAT 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<br>MC/DEL<br>MC/DEL           | EPOPROSTENOL INJ <sup>3</sup><br>SILDENAFIL<br>TADALAFIL                     | MC/DEL<br>MC<br>MC/DEL<br>MC<br>MC<br>MC<br>MC<br>MC<br>MC/DEL<br>MC<br>MC<br>MC<br>MC<br>MC/DEL<br>MC<br>MC/DEL<br>MC |            | ADEMPAS <sup>1,3</sup><br>ADCIRCA <sup>4</sup><br>ALYO TAB<br>FLOLAN <sup>3</sup><br>LIQREV<br>OPSUMIT <sup>1,2</sup><br>OPSYNVI <sup>4</sup><br>ORENITRAM<br>REMODULIN <sup>3</sup><br>REVATIO <sup>4</sup><br>TADLIQ <sup>4</sup><br>TYVASO<br>UPTRAVI<br>VELVETRI <sup>3</sup><br>WINREVAIR <sup>4</sup><br>YUTREPIA | <a href="#">Use PA Form# 20420</a><br><br>1. Requires previous trials/failure of multiple preferred medications.<br>2. Dosing limits apply, see the Dose Consolidation List.<br>3. Require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 3 or 4.<br>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.<br>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 Cyp3A4 inhibitors.<br>DDI: Uptravi will require a prior authorization if it is currently being used in combination with strong inhibitors of CYP2C8 (gemfibrozil).<br>DDI: Opsumit 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).<br>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, adcirca and tadalafil) with adempas.<br>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 CYP3A4 inhibitors.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |

| CATEGORY                                                        | Coverage Indicator                             | PREFERRED DRUGS                                                                                                                              | Coverage Indicator                                                                                                     | Step Order                                          | NON-PREFERRED DRUGS<br>PA Required                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Criteria                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
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| ERA / ENDOTHELIN RECEPTOR ANTAGONIST                            | MC<br>MC                                       | LETAIRIS <sup>1,2</sup><br>TRACLEER                                                                                                          |                                                                                                                        |                                                     |                                                                                                                                                                                                                                                                                                                                                                                      | <a href="#">Use PA Form# 20420</a><br>1. Providers must be registered with LEAP Prescribing program, a restricted distribution program.<br>2. Clinical PA is required to establish diagnosis and medical necessity.                                                                                                                                                                                                                                                   | <b>Letairis</b> approvals will require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and functional class 2 or 3 symptoms.<br><b>Tracleer</b> approvals will require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 2 thru 4.<br><b>DDI:</b> Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with tracleer.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| 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<br>MC<br>MC/DEL<br>MC<br>MC/DEL             | DOXYLAMINE SUCC-PYRIDOXINE<br>DOXYLAMINE SUCC-PYRIDOXINE HCL<br>MECLIZINE HCL TABS<br>PROMETHAZINE SUPP<br>PROMETHAZINE<br>SCOPOLAMINE PATCH | MC<br>MC<br>MC<br>MC<br>MC<br>MC<br>MC<br>MC                                                                           |                                                     | ANTIVERT TABS<br>BARHEMSYS<br>BONJESTA<br>DICLEGIS<br>NEREUS<br>PHENERGAN SOLN<br>PROMETHAZINE 50MG SUPP<br>PROMETHEGAN SUPP<br>TORECAN TABS                                                                                                                                                                                                                                         | <a href="#">Use PA Form# 20420</a>                                                                                                                                                                                                                                                                                                                                                                                                                                    | 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.<br><b>DDI:</b> Concomitant use of MAOIs and Bonjesta is contraindicated.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| ANTIEMETIC - 5-HT3 RECEPTOR ANTAGONISTS/ SUBSTANCE P NEUROKININ | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL | DRONABINOLCAPS<br>GRANISETRON TAB<br>ONDANSETRON TAB<br>ONDANSETRON ODT TBDP<br>ONDANSETRON SOL                                              | MC<br>MC<br>MC<br>MC<br>MC<br>MC<br>MC<br>MC/DEL<br>MC/DEL<br>MC<br>MC<br>MC<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC |                                                     | AKYNZEO <sup>1</sup><br>APREPITANT<br>ALOXI<br>ANZEMET TABS<br>APONVIE <sup>4</sup><br>CESAMET <sup>1</sup><br>CINVANTI <sup>4</sup><br>EMEND <sup>2</sup><br>FOCINVEZ <sup>1,2</sup><br>KYTRIL<br>MARINOL CAPS<br>SANCUSO<br>SUSTOL<br>SYNDROS<br>TRIMETHOBENZAMIDE CAP<br>VARUBI<br>ZOFRAN ODT TBDP <sup>3</sup><br>ZOFRAN TABS <sup>3</sup><br>ZOFRAN INJ <sup>3</sup><br>ZUPLENZ | <a href="#">Use PA Form# 20420</a><br>1. Approvals will require diagnosis of chemo-induced nausea/vomiting and failed trials of all preferred anti-emetics, including 5-HT3 class ( <b>Ondansetron</b> ) and <b>Marinol</b> .<br>2. Clinical PA is required for members on highly emetic anti-neoplastic agents.<br>3. Dosing limits apply, see Dosage Consolidation List.<br>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. * <b>Ondansetron</b> 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.<br><br><b>Akynzeo</b> - Concomitant use should be avoided in patients who are chronically using a strong CYP3A inducer such as rifampin.<br><b>Aponvie</b> is for the prevention of postoperative nausea and vomiting (PONV) in adults.<br><b>Varubi</b> – Available to the few who are unable to tolerate or who have failed on preferred medications. |
| NON-SEDATING ANTIHISTAMINES / DECONGESTANTS                     |                                                |                                                                                                                                              |                                                                                                                        |                                                     |                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| ANTIHISTIMINES - NON-SEDATING                                   | MC<br>MC/DEL<br>MC/DEL<br>MC                   | ALAVERT TABS<br>CETIRIZINE TABS<br>LORATADINE<br>TAVIST ND (OTC)                                                                             | MC<br>MC<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL                                       | 5<br>5<br>5<br>5<br>5<br>8<br>8<br>8<br>8<br>8<br>9 | CLARINEX TABS <sup>1,5</sup><br>CLARINEX SYR <sup>1,2</sup><br>FEXOFENADINE <sup>1</sup><br>ZYRTEC <sup>1</sup><br>ZYRTEC SYR <sup>1,2</sup><br>ALLEGRA <sup>3</sup><br>CLARITIN <sup>3</sup><br>DESLORATADIN<br>LORATADINE ODT <sup>4</sup><br>LEVOCETIRIZINE <sup>4</sup><br>XYZAL <sup>3</sup>                                                                                    | <a href="#">Use PA Form# 20530</a><br>1. Must fail preferred drugs, OTC loratadine and cetirizine before moving to non-preferred step order drugs.<br>2. Clarinex and Zyrtec syrup <6 yr w/o PA.<br>3. Must fail all step 5 drugs (clarinex, fexofenadine and zyrtec) before moving to next step product.<br>4. All OTC versions of Loratadine ODT are now non-preferred.<br>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 ( <b>in step order</b> ), 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.<br><b>Pseudoephedrine</b> is available with prescription.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| ANTIHISTIMINES - OTHER                                          | MC/DEL<br>MC/DEL<br>MC/DEL                     | CLEMASTINE<br>CHLORPHENIRAMINE<br>DIPHENHYDRAMINE                                                                                            |                                                                                                                        |                                                     |                                                                                                                                                                                                                                                                                                                                                                                      | <a href="#">Use PA Form# 20530</a>                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| ALLERGY / ASTHMA THERAPIES                                      |                                                |                                                                                                                                              |                                                                                                                        |                                                     |                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| ANAPHYLACTIC DEVICES                                            | MC<br>MC/DEL<br>MC/DEL<br>MC/DEL               | AUVI- Q<br>EPINEPHRINE<br>EPIPEN<br>EPIPEN JR                                                                                                | MC<br>MC                                                                                                               |                                                     | NEFFY<br>TWINJECT                                                                                                                                                                                                                                                                                                                                                                    | <a href="#">Use PA Form# 20420</a>                                                                                                                                                                                                                                                                                                                                                                                                                                    | 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<br>PA Required                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Criteria                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|-----------------------------------------------------|----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|----------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| ALLERGEN IMMUNOTHERAPY                              |                                                          |                                                                                                                                      | MC<br>MC<br>MC<br>MC<br>MC                                                             |                                                          | ODACTRA <sup>1</sup><br>ORALAIR <sup>1</sup><br>PALFORZIA<br>RAGWITEK<br>GRASTEK                                                                                                                                                                                                                                                                  | <a href="#">Use PA Form# 20420</a><br><br>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.<br><b>Palforzia</b> 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.<br><b>Odactra</b> is approved for patients between the ages of age ≥ 5 years and ≤ 65 years who have been confirmed by positive in vitro testing for IgE antibodies to Dermatophagoides farinae or Dermatophagoides pteronyssinus house dust mites or by positive skin testing to licensed house dust mite allergen extracts. Note: Odactra is not indicated for the immediate relief of allergic symptoms.<br><b>Oralair</b> is approved for patients between the ages of age ≥ 5 years and ≤ 65 years. 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 these 5 grass species: Sweet Vernal, Orchard, Perennial Rye, Timothy, and Kentucky Bluegrass.<br><b>Have an auto-injectable epinephrine on-hand.</b> |
| ANTIASTHMATIC - ANTICHOLINERGICS - INHALER          | MC<br>MC/DEL<br>MC/DEL                                   | INCRUSE ELLIPTA <sup>3</sup><br>SPIRIVA HANDIHALER <sup>1,2</sup><br>SPIRIVA RESPIMAT                                                | MC<br>MC/DEL                                                                           |                                                          | LONHALA MAGNAIR<br>TUDORZA                                                                                                                                                                                                                                                                                                                        | <a href="#">Use PA Form# 20420</a><br><br>1. Quantity limit of 1 inhalation daily (1 capsule for inhalation daily). <b>Spiriva</b> will require PA if Combivent or Atrovent nebulizer solution is in member's current drug profile.<br>2. We ask physicians to write "asthma" on the prescription whenever Spiriva is primarily being used for that condition.<br>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 <sup>1</sup>                                                                                                               |                                                                                        |                                                          |                                                                                                                                                                                                                                                                                                                                                   | <a href="#">Use PA Form# 20420</a><br><br>1. Clinical PA is required to establish diagnosis and medical necessity.                                                                                                                                                                                                                                                                                                                                                                                                  | <b>BRINSUPRI</b> required criteria include attestation of the following:<br><ul style="list-style-type: none"> <li>Imaging confirming bronchiectasis</li> <li>Physician attestation of need for airway clearance</li> <li>History of pulmonary exacerbations in the last 12 months based on age: <ul style="list-style-type: none"> <li>Members 18 years of age or older: ≥ 2 exacerbations requiring antibiotic therapy</li> <li>Members 12 to 17 years of age: ≥ 1 exacerbation requiring antibiotic therapy</li> </ul> </li> <li>Must be prescribed by, or in consultation with, a pulmonary or infectious disease specialist</li> <li>Prescriber attests that underlying causes of NCFB have been adequately addressed, if applicable</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| ANTIASTHMATIC - PHOSPHODIESTERASE 4 INHIBITORS      | MC/DEL                                                   | ROFLUMILAST                                                                                                                          | MC/DEL<br>MC                                                                           |                                                          | DALIRESP<br>OHTUVAYRE <sup>1</sup>                                                                                                                                                                                                                                                                                                                | <a href="#">Use PA Form# 20420</a><br><br>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                                                                                                                                                                                                                                                                                                                                           | <a href="#">Use PA Form# 20420</a>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 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<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL | CROMOLYN SODIUM NEBU<br>DUPIXENT <sup>2,4</sup><br>FASENRA <sup>6</sup><br>FASENRA AUTO INJECT <sup>6</sup><br>XOLAIR <sup>1,4</sup> | MC<br>MC<br>MC<br>MC<br>MC<br>MC                                                       |                                                          | CINQAIR <sup>3</sup><br>EXDENSUR <sup>5</sup><br>NUCALA <sup>2</sup><br>RHAPSIDO <sup>4</sup><br>TEZSPIRE <sup>5</sup>                                                                                                                                                                                                                            | <a href="#">Use PA Form# 20420</a><br><br>1. Need max inhaled steroids and written by pulmonary or allergy specialist. Must have elevated IgE and ≥ age 6.<br>2. For patients with severe asthma aged 12 years or older and eosinophilia.<br>3. For patients ≥ 18 years of age with eosinophilia.<br>4. Clinical PA required to establish diagnosis and medical necessity.<br>5. For adult and pediatric patients aged 12 years and older with severe asthma.<br>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.<br><b>Dupixent</b> 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.<br><b>Fasenra, Nucala and Cinqair</b> are not indicated for treatment of other eosinophilic conditions and are not indicated for the relief of acute bronchospasm or status asthmaticus.<br><b>Rhapsido for Chronic Spontaneous Urticaria</b> - must have had an inadequate clinical response 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<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC         | BUDESONIDE SPRAY<br>FLUTICASONE SPR <sup>3</sup><br>OLOPATADINE SPRAY<br>OMNARIS SPR <sup>3</sup><br>TRIAMCINOLONE NS<br>QNASL       | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC<br>MC<br>MC<br>MC/DEL<br>MC<br>MC/DEL | 8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8 | DYMISTA<br>FLONASE SUSP <sup>2,3</sup><br>FLUNISOLIDE SOLN <sup>1,3</sup><br>NASONEX SUSP<br>RHINOCORT AERO <sup>2,3</sup><br>RHINOCORT AQUA SUSP <sup>2,3</sup><br>RYALTRIS <sup>4</sup><br>TRI-NASAL SOLN <sup>2,3</sup><br>VANCENASE POCKETHALER AERS <sup>2,3</sup><br>VERAMYST <sup>2,3</sup><br>XHANCE <sup>2</sup><br>ZETONNA <sup>3</sup> | <a href="#">Use PA Form# 20420</a><br><br>1. All preferred drugs must be tried before moving to non preferred steps.<br>2. All step 5 medications need to be tried before moving to step 6's.<br>3. Dosing limits apply to whole category, see Dosage Consolidation List.<br>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.<br><br><b>Xhance</b> 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<br>MC/DEL<br>MC                                   | AZELASTINE<br>CROMOLYN NASAL 4%<br>IPRATROPIUM NASAL SOL <sup>1</sup>                                                                | MC/DEL<br>MC/DEL<br>MC/DEL                                                             |                                                          | ASTEPRO <sup>2</sup><br>PATANASE                                                                                                                                                                                                                                                                                                                  | <a href="#">Use PA Form# 20420</a><br><br>1. <b>Ipratropium</b> will be approved if submitted with documentation supporting use of CPAP machine.<br>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.<br>Approved if patient fails on non-sedating antihistamines and steroid nasal sprays.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |

| CATEGORY                                         | Coverage Indicator                                                         | PREFERRED DRUGS                                                                                                                                                                     | Coverage Indicator                     | Step Order | NON-PREFERRED DRUGS<br>PA Required                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Criteria                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|--------------------------------------------------|----------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|------------|-------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| ANTIASTHMATIC - BETA - ADRENERGICS               | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC | ALBUTEROL 0.63mg/3ml<br>ALBUTEROL HFA<br>ALBUTEROL NEB<br>LEVALBUTEROL TARTRATE<br>METAPROTERENOL<br>PROAIR DIGIHALER <sup>4</sup><br>PROAIR RESPICLIK<br>PROVENTIL HFA<br>SEREVENT | MC/DEL<br>MC/DEL<br>MC<br>MC<br>MC     |            | AIRSUPRA<br>ALBUTEROL HFA (labeler 66993001968)<br>VOSPIRE ER TB12<br>XOPENEX HFA <sup>3</sup><br>XOPENEX NEBU <sup>1,2</sup> | <a href="#">Use PA Form# 20420.</a><br><br>1. Xopenex users w/ prior asthma hospitalization due to albuterol nebulizer failure will be grandfathered.<br>2. Quantity Limit: 12 cc/day.<br>3. Dosing limits apply, see Dosage Consolidation List.<br>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.<br><b>Airsupra</b> 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.                                                                                                                                                                                                      |
|                                                  | MC/DEL<br>MC/DEL<br>MC                                                     | STRIVERDI<br>TERBUTALINE SULFATE TABS<br>VENTOLIN HFA AERS                                                                                                                          |                                        |            |                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| ANTIASTHMATIC - ADRENERGIC COMBINATIONS          | MC<br>MC<br>MC<br>MC<br>MC/DEL<br>MC/DEL                                   | ADVAIR DISKUS <sup>1</sup><br>ADVAIR HFA <sup>1</sup><br>AIRDUO RESPICLIK <sup>2</sup><br>BREQ ELLIPTA <sup>1</sup><br>DULERA<br>FLUTICASONE-SALMETEROL<br>SYMBICORT                | MC<br>MC/DEL<br>MC/DEL<br>MC           |            | AIRDUO DIGIHALER <sup>2</sup><br>BREYNA<br>BRETTRI AEROSPHERE<br>TRELEGY ELLIPTA <sup>1</sup>                                 | <a href="#">Use PA Form# 20420.</a><br><br>1. Dosing limits apply, see Dosage Consolidation List.<br>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.<br><b>AirDuo® Resplick</b> be non-preferred and require prior authorization and be available to those who are unable to tolerate or who have failed on preferred medications.<br><b>DDI:</b> Avoid concomitant use of strong CYP3A4 inhibitors (e.g. ritonavir, atazanavir, clarithromycin, indinavir, itraconazole, nefazodone, nefinavir, saquinavir, ketoconazole, telithromycin) with AirDuo® Resplick is not recommended due to increased systemic corticosteroid and increased cardiovascular adverse effects. |
| ANTIASTHMATIC - ADRENERGIC ANTICHOLINERGIC       | MC/DEL<br>MC<br>MC/DEL<br>MC/DEL                                           | ALBUTEROL/IPRATROPIUM NEB. SOLN<br>ANORO ELLIPTA<br>COMBIVENT RESPIMAT<br>STIOLTO                                                                                                   | MC/DEL<br>MC                           |            | BEVESPI AEROSPHERE <sup>2,3</sup><br>DUAKLIR PRESSAIR                                                                         | <a href="#">Use PA Form# 20420.</a><br><br>1. Please use preferred individual ingredients Albuterol and Ipratropium.<br>2. Dosing limits apply, see Dosage Consolidation List.<br>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.<br><b>Beyespi</b> should be used with extreme caution in patients being treated with MAO inhibitors, TCAs, or other drugs known to prolong the QTc interval.<br><b>DDI:</b> 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.                                             |
| ANTIASTHMATIC - XANTHINES                        | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL             | AMINOPHYLLINE TABS<br>THEOCHRON TB12<br>THEOLAIR-SR TB12<br>THEOPHYLLINE CR TB12<br>THEOPHYLLINE ELIX<br>THEOPHYLLINE SOLN<br>THEOPHYLLINE ER CP12<br>THEOPHYLLINE ER TB12          | MC                                     |            | THEO-24 CP24                                                                                                                  | <a href="#">Use PA Form# 20420.</a>                                                                                                                                                                                                                                                                                                                                                                                                                                    | 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 - STEROID INHALANTS                | MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC                                     | ARNUITY ELLIPTA<br>ASMANEX TWISTHALER <sup>1,4</sup><br>ASMANEX HFA<br>BUDESONIDE NEB 0.25MG & 0.5MG <sup>1</sup><br>QVAR AERS <sup>3</sup>                                         | MC<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL |            | AEROSPAN<br>ALVESCO <sup>3</sup><br>ARMONAIR DIGIHALER<br>BUDESONIDE NEB 1MG<br>PULMICORT SUSP                                | <a href="#">Use PA Form# 20420.</a><br><br>1. <b>Budesonide Neb</b> 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.<br>2. All preferred must be tried before moving to non preferred steps.<br>3. Dosing limits apply, see Dosage Consolidation List.<br>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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| ANTIASTHMATIC - 5-Lipoxygenase Inhibitors        |                                                                            |                                                                                                                                                                                     | MC                                     |            | ZYFLO TABS                                                                                                                    | <a href="#">Use PA Form# 20420.</a>                                                                                                                                                                                                                                                                                                                                                                                                                                    | 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<br>MC/DEL<br>MC/DEL                                                 | MONTELUKAST GRANULE <sup>1</sup><br>MONTELUKAST SODIUM TAB<br>MONTELUKAST SODIUM CHEW TAB                                                                                           | MC/DEL<br>MC/DEL<br>MC/DEL             |            | ACCOLATE TABS<br>SINGULAIR <sup>2</sup><br>SINGULAIR GRANULES                                                                 | <a href="#">Use PA Form# 20420.</a><br><br>1. <b>Montelukast Granules</b> will only be approved if between ages of 6 - 24 months.<br>2. <b>Singulair Chewable</b> 4mg from 2 years- 5 years and <b>Singulair Chewable</b> 5mgs from 6 years- 14 years old.                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| ANTIASTHMATIC - ALPHA-PROTEINASE INHIBITOR       |                                                                            |                                                                                                                                                                                     | MC<br>MC<br>MC<br>MC/DEL               |            | ARALAST<br>GLASSIA<br>PROLASTIN SUSR<br>ZEMAIRA                                                                               | <a href="#">Use PA Form# 20420.</a>                                                                                                                                                                                                                                                                                                                                                                                                                                    | <b>Prolastin</b> and <b>Azemaira</b> will be approved for members with A1AT deficiency and clinically demonstrable panacinar emphysema.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| ANTIASTHMATIC - HYDRO-LYTIC ENZYMES              |                                                                            |                                                                                                                                                                                     | MC                                     |            | PULMOZYME SOLN                                                                                                                | <a href="#">Use PA Form# 20420.</a>                                                                                                                                                                                                                                                                                                                                                                                                                                    | Will be approved for cystic fibrosis patients.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| ANTIASTHMATIC - MUCOLYTICS                       | MC/DEL                                                                     | ACETYL CYSTEINE <sup>1</sup>                                                                                                                                                        |                                        |            |                                                                                                                               | <a href="#">Use PA Form# 20420.</a><br><br>1. <b>Acetylcysteine</b> is covered with CF diagnosis.                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |

| CATEGORY                                        | Coverage Indicator                                                                                                                                                                                                                                                       | PREFERRED DRUGS                                                                                                                                                                                                                                                                                                                              | Coverage Indicator                                                                                                                                                                                                                        | Step Order | NON-PREFERRED DRUGS<br>PA Required                                                                                                                                                                                                                |                                                                                                                                                                                                                                                | Criteria                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
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| ANTIASTHMATIC-CFTR POTENTIATOR AND COMBINATIONS |                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                              | <b>MC</b><br><b>MC</b><br><b>MC</b><br><b>MC</b><br><b>MC/DEL</b>                                                                                                                                                                         |            | ALYFTREK<br>BRONCHITOL <sup>1</sup><br>KALYDECO<br>ORKAMBI<br>SYMDEKO<br>TRIKAFTA                                                                                                                                                                 | <a href="#">Use PA Form# 20420.</a><br><br>1. For the treatment of patients ≥18 years of age with CF.                                                                                                                                          | <b>Alftytrek</b> 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.<br><b>Bronchitol</b> 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).<br><b>Kalydeco</b> 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.<br><b>Orkambi</b> 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.<br><b>Symdeko</b> 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.<br><b>Trikafta</b> 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                   | <b>MC/DEL</b><br><b>MC</b>                                                                                                                                                                                                                                               | OFEV <sup>1</sup><br>PIRFENIDONE                                                                                                                                                                                                                                                                                                             | <b>MC</b><br><b>MC/DEL</b>                                                                                                                                                                                                                |            | ESBRIET <sup>1</sup><br>JASCAVD <sup>1</sup>                                                                                                                                                                                                      | <a href="#">Use PA Form# 20420.</a><br><br>1. Clinical PA is required to establish diagnosis and medical necessity.                                                                                                                            | <b>Ofev</b> - Avoid concomitant use with P-gp and CYP4A inducers (e.g. carbamazepine, phenytoin, and St. John's wort).<br><b>Esbriet</b> - The concomitant use with strong CYP1A2 inhibitors (e.g. fluvoxamine, enoxacin) is not recommended.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| COUGH/COLD                                      |                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                           |            |                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| COUGH/COLD                                      | <b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC</b><br><b>MC</b>                                                                                                                                                                               | DEXTROMETHORPHAN CAPS <sup>1</sup><br>DEXTRO-GUAIF SYRP <sup>1</sup><br>GUAIFENESIN SYRP <sup>1</sup><br>PSEUDOEPHEDRINE <sup>1</sup><br>ROBITUSSIN DM SYRP <sup>1</sup><br>ROBITUSSIN SUGAR FREE SYRP <sup>1</sup>                                                                                                                          |                                                                                                                                                                                                                                           |            |                                                                                                                                                                                                                                                   | <a href="#">Use PA Form# 20420.</a><br><br>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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| DIGESTIVE AIDS / ASSORTED GI                    |                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                           |            |                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| GI - ANTIPERISTALTIC AGENTS                     | <b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC</b>                                                                                                                                                                                            | DIPHENOXYLATE<br>DIPHENOXYLATE/ATROPINE<br>LOPERAMIDE HCL CAPS/LIQ<br>OPIUM TINCTURE TINC<br>PAREGORIC TINC                                                                                                                                                                                                                                  | <b>MC/DEL</b><br><b>MC</b><br><b>MC</b>                                                                                                                                                                                                   |            | LOFENE TABS<br>LONOX TABS<br>MOTOFEN TABS                                                                                                                                                                                                         | <a href="#">Use PA Form# 20420.</a>                                                                                                                                                                                                            | 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| GI - ANTI-DIARRHEAL/ ANTACID - MISC.            | <b>MC</b><br><b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC/DEL</b> | ATROPINE SULFATE SOLN<br>BISMATROL<br>BISMUTH SUBSALICYLATE<br>CALCIUM CARBONATE (ANTACID) CHEW<br>DICYCLOMINE HCL<br>GLYCOPYRRROLATE TABS<br>HYOSCYAMINE CAPS & TABS<br>HYOSCYAMINE SULFATE<br>KAOPECTATE<br>MAGNESIUM OXIDE TABS<br><b>MAG-OX 400 TABS</b><br>PAMINE TABS<br>PROPANTHELINE BROMIDE TABS<br>SODIUM BICARBONATE TABS<br>TUMS | <b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC</b><br><b>MC</b><br><b>MC</b><br><b>MC</b><br><b>MC/DEL</b><br><b>MC</b><br><b>MC</b><br><b>MC</b><br><b>MC</b><br><b>MC</b><br><b>MC</b><br><b>MC</b><br><b>MC</b><br><b>MC</b> |            | BELLADONNA ALKALOIDS & OP<br>BENTYL TABS<br>BENTYL SYRP<br>CUVPOSA<br>DARTISLA ODT <sup>2</sup><br>ED-SPAZ<br>MYTESI <sup>1</sup><br>GLYCOPYRRROLATE INJ<br>LEVSIN TABS<br>LEVSIN/SL SUBL<br>NULEV TBDP<br>OSCIMIN<br>ROBINUL INJ<br>ROBINUL TABS | <a href="#">Use PA Form# 20420.</a><br><br>1. Dosing limits apply, see Dose Consolidation List.<br>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.<br>Preferred products that used to require diag codes still require diag codes unless indicated otherwise.<br><b>Mytesi</b> 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| GI- BILE ACID                                   |                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                              | <b>MC</b><br><b>MC</b>                                                                                                                                                                                                                    |            | CHOLBAM <sup>1</sup><br>CTECLI <sup>1</sup>                                                                                                                                                                                                       | <a href="#">Use PA Form# 20420.</a><br><br>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).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| GI- EOSINOPHILIC ESOPHAGITIS                    | <b>MC</b>                                                                                                                                                                                                                                                                | EOHILIA <sup>1</sup>                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                           |            |                                                                                                                                                                                                                                                   | <a href="#">Use PA Form# 20420.</a><br><br>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 ( <b>in step order</b> ), 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.<br><b>Eohilia</b> : Dietary modification, PPIs, and topical glucocorticoids are required as initial therapy.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| GI- H2-ANTAGONISTS                              | <b>MC</b><br><b>MC/DEL</b>                                                                                                                                                                                                                                               | ACID REDUCER TABS<br>CIMETIDINE                                                                                                                                                                                                                                                                                                              | <b>MC/DEL</b><br><b>MC</b>                                                                                                                                                                                                                |            | NIZATIDINE CAPS<br>PEPCID AC                                                                                                                                                                                                                      | <a href="#">Use PA Form# 20420.</a>                                                                                                                                                                                                            | 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.<br><b>DDI: Cimetidine</b> will now be non-preferred and require prior authorization if it is currently being used with any sulfonylurea (except for glyburide).<br><b>DDI: Cimetidine</b> will require prior authorization if being used in combination with plavix.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |

| CATEGORY                               | Coverage Indicator                                                                                                 | PREFERRED DRUGS                                                                                                                                                                                                  | Coverage Indicator                                                                           | Step Order                                                         | NON-PREFERRED DRUGS<br>PA Required                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Criteria                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
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| GI- IBAT INHIBITORS                    |                                                                                                                    |                                                                                                                                                                                                                  | MC<br>MC<br>MC                                                                               |                                                                    | BYLVAY <sup>1,2</sup><br>LIVMARLJ <sup>1,2</sup><br>LYNAVOY <sup>3</sup>                                                                                                                                                                                                                                                                                                             | <a href="#">Use PA Form# 20420.</a><br>1. For the treatment of patients ≥ 3 mos of age.<br>2. Clinical PA required for appropriate diagnosis.<br>3. Clinical PA required to confirm appropriate diagnosis and clinical parameters for the treatment of cholestatic pruritus associated with primary biliary cholangitis (PBC) 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. Certain drugs require specific diagnoses for approval.<br><br><b>LYNAVOY:</b> FDA approved indication for the treatment of cholestatic pruritus associated with primary biliary cholangitis (PBC) in adult patients.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| GI - PROTON PUMP INHIBITOR             | MC/DEL<br>MC/DEL<br>MC/DEL                                                                                         | OMEPRAZOLE CAPS <sup>2</sup><br>PANTOPRAZOLE <sup>2</sup><br>LANSOPRAZOLE CAPS <sup>2</sup>                                                                                                                      | MC/DEL<br>MC/DEL<br>MC<br>MC<br>MC<br>MC<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC | 6<br>6<br>7<br>7<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8 | NEXIUM CPDR <sup>3</sup><br>NEXIUM SUS <sup>5</sup><br>PRILOSEC OTC <sup>3</sup><br>ACIPHEX TBEC <sup>3</sup><br>DEXILANT (KAPIDEX) <sup>2</sup><br>KONVOMEF <sup>2</sup><br>OMEPRAZOLE-SODIUM BICARBONATE CAPS<br>OMEPRAZOLE MAGNESIUM<br>PREVACID CPDR <sup>3</sup><br>PREVACID SOLUTABS <sup>1,4</sup><br>PRILOSEC CPDR<br>PROTONIX INJ<br>PROTONIX <sup>2</sup><br>VOQUEZNA TABS | <a href="#">Use PA Form# 20720</a><br>1. <b>Prevacid Solutabs</b> available without PA for child less than 9 years old.<br>2. Dosing limits apply, please see Dosage Consolidation List.<br>3. All preferred and step therapy must be tried and failed<br>4. Payment for <b>Prevacid SoluTabs</b> for patients 9 and older will be considered for those patients who cannot tolerate a preferred solid oral dosage form.<br>5. <b>Nexium sus</b> available without PA if member is <12 yrs of age and ≤1 pack per day. | All preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved ( <b>in step-order</b> ), 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.<br>Please refer to the <b>PPI PA</b> form for additional criteria on Non-Preferred PPIs.<br><b>DDI: Omeprazole</b> will require prior authorization if being used in combination with plavix.<br><b>DDI: Lansoprazole</b> will require prior authorization if being used in combination with plavix.<br><b>DDI: Prevacid, Omeprazole and Pantoprazole</b> 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.<br><b>DDI:</b> 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. |
| GI - ULCER ANTI-INFECTION              | MC<br>MC                                                                                                           | PYLERA<br>TALICIA                                                                                                                                                                                                | MC<br>MC                                                                                     |                                                                    | VOQUEZNA DUAL PAK<br>VOQUEZNA TRIPLE PAK                                                                                                                                                                                                                                                                                                                                             | <a href="#">Use PA Form# 20420.</a>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| GI - PROSTAGLANDINS                    | MC                                                                                                                 | MISOPROSTOL TABS                                                                                                                                                                                                 | MC/DEL                                                                                       |                                                                    | CYTOTEC TABS                                                                                                                                                                                                                                                                                                                                                                         | <a href="#">Use PA Form# 20420.</a>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 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<br>MC                                                                                                       | CREON <sup>1</sup><br>ZENPEP <sup>1</sup>                                                                                                                                                                        | MC/DEL<br>MC                                                                                 | 8<br>8                                                             | PERTZYE<br>VIOKACE                                                                                                                                                                                                                                                                                                                                                                   | <a href="#">Use PA Form# 20420.</a><br>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 <b>in step-order</b> , 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 - ANTI - FLATULENTS / GI STIMULANTS | MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL                                         | AMITIZA<br>CALULOSE SYRP<br>CONSTULOSE SYRP<br>ENULOSE SYRP<br>GASTROCRON CONC<br>GENERLAC SYRP<br>LACTULOSE SYRP<br>LUBIPROSTONE<br>METOCLOPRAMIDE HCL                                                          | MC<br>MC/DEL<br>MC<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL                       |                                                                    | CEPHULAC SYRP<br>INFANTS GAS RELIEF SUSP<br>GIMOTI SPRAY<br>REGLAN TABS                                                                                                                                                                                                                                                                                                              | <a href="#">Use PA Form# 20420.</a>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| GI - INFLAMMATORY BOWEL AGENTS         | MC<br>MC<br>MC/DEL<br>MC/DEL                                                                                       | MESALAMINE ENMA KIT<br>PENTASA<br>SULFAZINE EC TBEC<br>SULFASALAZINE TABS                                                                                                                                        | MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC<br>MC<br>MC/DEL                                       |                                                                    | AZULFIDINE EN-TABS TBEC<br>AZULFIDINE TABS<br>DIPENTUM CAPS<br>GIAZO<br>LIALDA TABS <sup>1</sup><br>ROWASA ENEM<br>SFROWASA                                                                                                                                                                                                                                                          | <a href="#">Use PA Form# 20420.</a><br>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.<br><b>Glazo</b> is only indicated for males, as the safety efficacy for use in females has not been established. Prior trials of preferred products.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| GI - IRRITABLE BOWEL SYNDROME AGENTS   | MC                                                                                                                 | LOTIRONEX TABS                                                                                                                                                                                                   | MC                                                                                           |                                                                    | VIBERZI                                                                                                                                                                                                                                                                                                                                                                              | <a href="#">Use PA Form# 20420.</a>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 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                                                                                                                                                                                                                                                                                                                                                                               | <a href="#">Use PA Form# 20420.</a>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <b>Gattex</b> 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<br>MC/DEL<br>MC<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL | BISAC-EVAC SUPP<br>BISACODYL<br>BISCOLAX SUPP<br>CINOBAC CAPS<br>CITRATE OF MAGNESIA SOLN<br>CITRUCEL<br>CLENPIQ SOL<br>COLYTE<br>DIOCTO SYRP<br>DOCUSATE CALCIUM CAPS<br>DOCUSATE SODIUM<br>FIBER LAXATIVE TABS | MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC<br>MC<br>MC<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC |                                                                    | ACTIGALL CAPS<br>BENEFIBER<br>CARAFATE<br>CLEARLAX POW<br>COLACE CAPS<br>DIOCTO-C SYRP<br>DOC SOD /ICAS CAP<br>DOC-Q-LAX CAPS<br>DOCUSATE SODIUM/ICAS CAPS<br>DOK PLUS<br>DULCOLAX SUPP<br>ENEMEEZ                                                                                                                                                                                   | <a href="#">Use PA Form# 20420.</a><br>2. For the treatment of carcinoid syndrome diarrhea in combination with somatostatin analog (SSA) therapy in adults inadequately controlled by SSA therapy.<br>3. For the treatment of Opioid Induced Constipation (OIC).<br>5. 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. Certain drugs require specific diagnoses for approval.<br><b>Iqirvo:</b> 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).<br><b>Livdelzi:</b> 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.                                                                                                                                                                             |

| CATEGORY                 | Coverage Indicator                                                                                                                                                                                                                                                                                                                                           | PREFERRED DRUGS                                                                                                                                                                                                                                                                                                                                                                                                                                              | Coverage Indicator                                                                                                                                                                                                                                                                                                                      | Step Order            | NON-PREFERRED DRUGS<br>PA Required                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                         | Criteria                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                          | <b>MC</b><br><b>MC/DEL</b><br><b>MC</b><br><b>MC</b><br><b>MC/DEL</b><br><b>MC</b><br><b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC</b><br><b>MC/DEL</b><br><b>MC</b><br><b>MC/DEL</b><br><b>MC</b><br><b>MC</b><br><b>MC</b><br><b>MC/DEL</b><br><b>MC</b><br><b>MC/DEL</b><br><b>MC</b><br><b>MC/DEL</b><br><b>MC</b><br><b>MC</b><br><b>MC</b><br><b>MC/DEL</b> | FLEET<br>GENFIBER POWD<br>GAVILYTE<br>GOLYTELY SOLN<br>GLYCERIN<br>HIPREX TABS<br>KRISTALOSE PACK<br>LINZESS <sup>1</sup><br>MAALOX<br>MILK OF MAGNESIA SUSP<br>MINERAL OIL<br>MIRALAX BULK POWD (BRAND)<br>MOVANTIK<br>PEG 3350- ELECTROLYTE SOL<br>PEG 3350 POWDER<br>SENNA<br>SENOKOT GRAN<br>SENOKOT SYRP<br>SENOKOT CHILDRENS SYRP<br>SENOKOT XTRA TABS<br>STOOL SOFTENER CAPS<br>SUCRALFATE TABS<br>SUFLAVE<br>UNI-EASE CAPS<br>URSO FORTE<br>URSODIOL | <b>MC</b><br><b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC</b><br><b>MC</b><br><b>MC</b><br><b>MC</b><br><b>MC</b><br><b>MC/DEL</b><br><b>MC</b><br><b>MC/DEL</b><br><b>MC</b><br><b>MC/DEL</b><br><b>MC</b><br><b>MC</b><br><b>MC</b><br><b>MC/DEL</b><br><b>MC</b><br><b>MC/DEL</b><br><b>MC</b><br><b>MC</b><br><b>MC</b><br><b>MC/DEL</b> |                       | FIBER CON TABS<br>FIBER-LAX TABS<br>GAVILYTE-H<br>IBSRELA<br>IQIRVO<br>LIVDELZI<br>MALTSUPEX<br>MIRALAX PACKETS<br>MOTEGRITY<br>PEG-3350 ELECTROLYTES SOLR<br>PEG 3350 PACKETS<br>PREPOPIK PAK<br>SENEXON TABS<br>SENOKOT TABS<br>SENOKOT S TABS<br>SORBITOL<br>STOOL SOFTENER PLUS CAPS<br>SUPREP SOL<br>SUTAB<br>SYMPROIC <sup>2</sup><br>UNI-CENNA TABS<br>UNI-EASE PLUS CAPS<br>V-R NATURAL SENNA LAXATIV TABS<br>URSO 250<br>XERMELO <sup>2</sup> |                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| MISC. UROLOGICALS        |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                         |                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| UROLOGICAL - MISC.       | <b>MC</b><br><b>MC</b><br><b>MC</b><br><b>MC</b><br><b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC</b><br><b>MC/DEL</b><br><b>MC</b><br><b>MC/DEL</b><br><b>MC</b><br><b>MC</b><br><b>MC/DEL</b><br><b>MC/DEL</b>                                                                                                | ACETIC ACID 0.25% SOLN<br>CYTRA-K SOLN<br>FOSFOMYCIN (NDC 82036427401 ONLY)<br>K-PHOS MF TABS<br>METHENAMINE MANDELATE TABS<br>NEOSPORIN GU IRRIGANT SOLN<br>NITROFURANTOIN MONO CAPS<br>PHENAZOPYRIDINE HCL TABS<br>PHENAZOPYRIDINE PLUS<br>POT CITRATE TAB<br>PROSED/DS TABS<br>TRICITRATES SYRP<br>URELIEF PLUS<br>UREX TABS<br>URISED TABS<br>UROQID #2 TABS                                                                                             | <b>MC</b><br><b>MC</b><br><b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC</b><br><b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC</b><br><b>MC/DEL</b><br><b>MC</b><br><b>MC/DEL</b><br><b>MC</b><br><b>MC/DEL</b><br><b>MC</b><br><b>MC</b><br><b>MC/DEL</b>                                                                                            |                       | CITRIC ACID/SODIUM CITRAT SOLN<br><b>CONTEPO</b><br>CYTRA-2 SOLN<br>ELMIRON CAPS <sup>1</sup><br>FURADANTIN SUSP<br>MACROBID CAPS<br>MACRODANTIN CAPS<br>NITROFURANTOIN MACR SUSP<br>POTASSIUM CITRATE/CITRIC SOLN<br>PYRIDIUM PLUS TABS<br>PYRIDIUM TABS<br>RENACIDIN SOLN<br>UROCIT-K                                                                                                                                                                | <a href="#">Use PA Form# 20420</a><br>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.                                                                                                                                                                                                                                                                                   |
| PHOSPHATE BINDERS        |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                         |                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| PHOSPHATE BINDERS        | <b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC</b><br><b>MC/DEL</b>                                                                                                                                                                                                                                                                                | CALCIUM ACETATE CAP <sup>1</sup><br>FOSRENOL CHEW <sup>1</sup><br>MAGNEBIND - 400 <sup>1</sup><br>PHOSLYRA <sup>1</sup><br>RENVELA <sup>1</sup>                                                                                                                                                                                                                                                                                                              | <b>MC</b><br><b>MC</b><br><b>MC/DEL</b><br><b>MC</b><br><b>MC</b>                                                                                                                                                                                                                                                                       | 8<br>8<br>8<br>8<br>8 | AURYXIA <sup>1</sup><br>CALCIUM ACETATE TAB <sup>1</sup><br>FOSRENOL PWDR <sup>1</sup><br>VELPHORO <sup>1</sup><br>XPHOZAH                                                                                                                                                                                                                                                                                                                             | <a href="#">Use PA Form# 20420</a><br>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 <b>in step-order</b> , 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.<br><br><b>Xphozah</b> 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. |
| INTRA-VAGINALS           |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                         |                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| VAGINAL - ANTIBACTERIALS | <b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC</b><br><b>MC/DEL</b>                                                                                                                                                                                                                                                                                                 | CLEOCIN CREA<br>CLEOCIN SUPP<br>CLINDESSE CREA<br>NUVESSA                                                                                                                                                                                                                                                                                                                                                                                                    | <b>MC</b><br><b>MC/DEL</b><br><b>MC</b><br><b>MC</b>                                                                                                                                                                                                                                                                                    | 8<br>8<br>8<br>8      | METROGEL VAGINAL GEL <sup>1</sup><br>VANDAZOLE<br>XACIATO                                                                                                                                                                                                                                                                                                                                                                                              | <a href="#">Use PA Form# 20420</a><br>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 <b>in step-order</b> , 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.                                                                                                                                                                                                                                                            |
| VAGINAL - ANTI FUNGALS   | <b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC</b><br><b>MC</b><br><b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC</b><br><b>MC/DEL</b><br><b>MC</b><br><b>MC</b><br><b>MC</b>                                                                                                                                                            | CLOTRIMAZOLE CREA<br>CLOTRIMAZOLE-3 CREA<br>GYNE-LOTRIMIN CREA<br>MICONAZOLE CREA<br>MICONAZOLE 3 KIT CREA OTC<br>MICONAZOLE 7 CREA<br>MICONAZOLE NITRATE CREA<br>NYSTATIN TABS<br>TERCONAZOLE CREAM<br>VAGITROL<br>V-R MICONAZOLE-7 CREA                                                                                                                                                                                                                    | <b>MC</b><br><b>MC</b><br><b>MC</b><br><b>MC</b><br><b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC</b><br><b>MC</b><br><b>MC/DEL</b><br><b>MC</b><br><b>MC</b><br><b>MC</b><br><b>MC/DEL</b>                                                                                                                                                   |                       | AVC CREA<br>CLOTRIMAZOLE 3 DAY CREA<br>GYNAZOLE-1 CREA<br>GYNE-LOTRIMIN 3 TABS<br>MICONAZOLE 3 COMBO PAK KIT <sup>1</sup><br>MICONAZOLE 3 SUPP<br>TERAZOL 3 CREA<br>TERAZOL 7 CREA<br>TERCONAZOLE SUPP                                                                                                                                                                                                                                                 | <a href="#">Use PA Form# 20420</a><br>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.<br><br><b>DDI: Miconazole</b> will require prior authorization if being used in combination with warfarin.                                                                                                                                                                        |

[illegible]

| CATEGORY                                 | Coverage Indicator                                                                                                                                                                 | PREFERRED DRUGS                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Coverage Indicator                                                                                                                               | Step Order                                                                                            | NON-PREFERRED DRUGS<br>PA Required                                                                                                                                                                                                                                                                                                                         | Criteria                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                          |                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL                                                   | 8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>9<br>9                                         | SPRAVATO <sup>8</sup><br>TRAZODONE HCL 300MG TABS<br>TRINTELLIX<br>VENLAFAXINE ER TABS <sup>5</sup><br>WELLBUTRIN TABS<br>WELLBUTRIN SR TBCR<br>ZOLOFT<br>ZULRESSO <sup>10</sup><br>ZURZUVAE <sup>12</sup><br>FLUOXETINE 90mg TABS <sup>6</sup><br>VIBRYD <sup>6</sup>                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| ANTIDEPRESSANTS - TRI-CYCLICS            | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC                                                                                                                         | AMITRIPTYLINE HCL TABS <sup>1</sup><br>CLOMIPRAMINE HCL CAPS <sup>1</sup><br>DESIPRAMINE HCL TABS <sup>1</sup><br>DOXEPIN HCL <sup>1</sup> (not generic Silenor)<br>IMIPRAMINE HCL TABS <sup>1</sup><br>NORTRIPTYLINE HCL <sup>1</sup><br>PROTRIPTYLINE HCL TABS <sup>1</sup><br>SURMONTIL CAPS <sup>1</sup>                                                                                                                                                                            | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC                                                                                       |                                                                                                       | AMOXAPINE TABS<br>ANAFRANIL CAPS<br>DOXEPIN HCL 150 MG <sup>2</sup><br>DOXEPIN (generic Silenor)<br>NORPRAMIN TABS<br>PAMELOR<br>TOFRANIL<br>VIVACTIL TABS                                                                                                                                                                                                 | <a href="#">Use PA Form# 20420.</a><br><br><a href="#">Use PA Form# 10220 for Brand Name requests</a><br><br>1. Users over the age of 65 require a PA.<br>2. Use multiples of 50mg.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| SEDATIVE / HYPNOTICS                     |                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                  |                                                                                                       |                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| SEDATIVE/HYPNOTICS - BARBITURATE         | MC<br>MC/DEL<br>MC<br>MC/DEL                                                                                                                                                       | BUTISOL SODIUM TABS <sup>1</sup><br>CHLORAL HYDRATE SYRP <sup>1</sup><br>MEBARAL TABS <sup>1</sup><br>PHENOBARBITAL <sup>1</sup>                                                                                                                                                                                                                                                                                                                                                        | MC<br>MC/DEL                                                                                                                                     |                                                                                                       | LUMINAL SOLN<br>SOMNOTE CAPS                                                                                                                                                                                                                                                                                                                               | <a href="#">Use PA Form# 20420.</a><br><br>1. PA required for new users of preferred products if over 65 years.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| SEDATIVE/HYPNOTICS - BENZODIAZEPINES     | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL                                                                                                                                     | DORAL TABS <sup>1</sup><br>ESTAZOLAM TABS <sup>1</sup><br>FLURAZEPAM HCL CAPS <sup>1</sup><br>TEMAZEPAM CAPS 15 & 30MG <sup>1</sup><br>TRIAZOLAM TABS <sup>1</sup>                                                                                                                                                                                                                                                                                                                      | MC<br>MC<br>MC/DEL<br>MC/DEL                                                                                                                     |                                                                                                       | HALCION TABS <sup>1</sup><br>MIDAZOLAM HCL SYRP<br>RESTORIL CAPS <sup>1</sup><br>TEMAZEPAM 7.5MG <sup>1</sup>                                                                                                                                                                                                                                              | <a href="#">Use PA Form# 30110</a><br><br>1. Dosing limits apply, see Dosing Consolidation List.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| SEDATIVE/HYPNOTICS - Non-Benzodiazepines | MC/DEL<br>MC<br>MC/DEL<br>MC/DEL                                                                                                                                                   | MIRTAZAPINE<br>TRAZODONE<br>ZOLPIDEM <sup>2</sup><br>ZALEPLON <sup>2,3</sup>                                                                                                                                                                                                                                                                                                                                                                                                            | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL                                         |                                                                                                       | AMBIEN <sup>1</sup><br>ESZOPICLONE<br>ZOLPIDEM ER<br>AMBIEN CR <sup>1</sup><br>BELSOMRA <sup>1</sup><br>DAYVIGO <sup>1</sup><br>EDLUAR<br>HETLIOZ<br>INTERMEZZO<br>LUNESTA <sup>1</sup><br>SONATA CAPS <sup>1</sup><br>ROZEREM<br>QUVIVIQ<br>ZOLPIMIST                                                                                                     | <a href="#">Use PA Form# 30110</a><br><br>1. Quantity Limit of 12 per 34 days.<br>2. Quantity limits will be allowed up to 30/30, but intermittent therapy is recommended.<br>3. Only Zolpidem trial/failure will be required to obtain Zaleplon.<br>4. Must fail all preferred products before non-preferred.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| ANTI-PSYCHOTICS                          |                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                  |                                                                                                       |                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| ANTI-PSYCHOTICS - ATYPICALS              | MC<br>MC<br>MC/DEL<br>MC/DEL<br>MC<br>MC<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC | ABILIFY ASIMTUFII<br>ABILIFY MAINTENA<br>ARIPRAZOLE SOL<br>ARIPRAZOLE TAB <sup>3</sup><br>ARISTADA<br>ARISTADA INITIO<br>CAPLYTA <sup>5</sup><br>OLANZAPINE <sup>2,3</sup><br>OLANZAPINE <sup>2,3</sup> ODT<br>INVEGA HAFYERA<br>INVEGA SUSTENNA<br>INVEGA TRINZA INJ<br>LURASIDONE TAB<br>PALIPERIDONE ER<br>PERSERIS<br>RISPERDAL CONSTA<br>RISPERIDONE ODT<br>RISPERIDONE TAB <sup>2,3</sup><br>RISPERIDONE SOLN <sup>2</sup><br>QUETIAPINE <sup>2,3</sup><br>QUETIAPINE XR<br>UZEDY | MC/DEL<br>MC<br>MC/DEL<br>MC<br>MC<br>MC<br>MC/DEL<br>MC<br>MC<br>MC<br>MC<br>MC/DEL<br>MC<br>MC<br>MC<br>MC<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL | 8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8 | ABILIFY DISC TAB, INJ and SOL <sup>1</sup><br>ABILIFY TABS <sup>2</sup><br>ARIPRAZOLE ODT<br>BY-SANTI<br>COBENFY<br>ERZOFRI<br>FANAPT<br>GEODON<br>INVEGA<br>IGALMI<br>LATUDA<br>LYBALVI<br>NUPLAZID<br>OPIZA<br>REXULTI<br>RISPERDAL TAB<br>RISPERDAL M TAB <sup>1</sup><br>RISPERDAL SOLN<br>RYKINDO<br>SAPHRIS <sup>1</sup><br>SECUADO<br>SEROQUEL TABS | <a href="#">Use PA form# 20440 for Multiple Antipsychotic requests</a><br><br><a href="#">Use PA form# 10130 for non-preferred single therapy atypical requests</a><br><br>If prescribing 2 or more antipsychotics, PA will be required for both drugs, except if one is <b>Clozapine</b> . This includes combination of <b>Seroquel</b> with <b>Seroquel XR</b> .<br><br>1. Established users of single therapy atypicals were grandfathered.<br>2. Prior Authorization will be required for preferred medications for members under the age of 5.<br>3. Dosing limits apply, refer to the Dose Consolidation List.<br>4. Requires step through one (1) preferred drug for all indications except AMDD. AMDD requires insufficient response from two antidepressants.<br>5. Will require a step through one (1) preferred drug for all indications. Prior Auth required for < 18 years of age. |

| CATEGORY                                  | Coverage Indicator                                                                                                                 | PREFERRED DRUGS                                                                                                                                                                                                                                                                                                    | Coverage Indicator                                                                                                             | Step Order       | NON-PREFERRED DRUGS<br>PA Required                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|-------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                           | MC<br>MC/DEL                                                                                                                       | VRAYLAR <sup>4</sup><br>ZIPRASIDONE <sup>2,3</sup>                                                                                                                                                                                                                                                                 | MC<br>MC<br>MC<br>MC/DEL                                                                                                       | 8<br>8<br>8<br>9 | ZYPREXA TABS<br>ZYPREXA RELPREV<br>ZYPREXA ZYDIS TBP <sup>1</sup><br>SEROQUEL XR                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| ANTIPSYCHOTICS - SPECIAL ATYPICALS        | MC/DEL                                                                                                                             | CLOZAPINE TABS                                                                                                                                                                                                                                                                                                     | MC/DEL<br>MC<br>MC/DEL                                                                                                         |                  | CLOZAPINE ODT<br>CLOZARIL TABS<br>VERSACLOZ SUSP                                                                                                | <a href="#">Use PA Form# 20420.</a>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 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.                                              |
| ANTIPSYCHOTICS - TYPICAL                  | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC<br>MC<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL | CHLORPROMAZINE HCL<br>FLUPHENAZINE DECANOATE<br>FLUPHENAZINE HCL<br>HALDOL<br>HALOPERIDOL<br>HALOPERIDOL DECANOATE SOLN<br>HALOPERIDOL LACTATE SOLN<br>LOXAPINE SUCCINATE CAPS<br>LOXITANE-C CONC<br>MOBAN TABS<br>PERPHENAZINE<br>PROCHLORPERAZINE<br>THIORIDAZINE HCL<br>THIOTHIXENE<br>TRIFLUOPERAZINE HCL TABS | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC<br>MC<br>MC/DEL<br>MC<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL |                  | COMPazine<br>COMPRO SUPP<br>FLUPHENAZINE HCL CONC<br>HALDOL DECANOATE<br>LOXITANE CAPS<br>MELLARIL<br>NAVANE CAPS<br>PROLIXIN<br>STELAZINE TABS | <a href="#">Use PA Form# 20420.</a><br><br>If prescribing 2 or more antipsychotics, PA will be required for both drugs, except if one is <b>Clozapine</b> .                                                                                                                                                                                                                                                                                                                                                                                        | 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.<br><br>If prescribing 2 or more antipsychotics, PA will be required for both drugs, except if one is <b>Clozapine</b> . |
| LITHIUM                                   |                                                                                                                                    |                                                                                                                                                                                                                                                                                                                    |                                                                                                                                |                  |                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| LITHIUM                                   | MC/DEL<br>MC/DEL                                                                                                                   | LITHIUM CARBONATE<br>LITHIUM CITRATE SYRP                                                                                                                                                                                                                                                                          | MC/DEL<br>MC/DEL                                                                                                               |                  | ESKALITH CAPS<br>ESKALITH CR TBCR                                                                                                               | <a href="#">Use PA Form# 20420.</a>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| COMBINATION - PSYCHOTHERAPEUTIC           |                                                                                                                                    |                                                                                                                                                                                                                                                                                                                    |                                                                                                                                |                  |                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| PSYCHOTHERPEUTIC COMBINATION              |                                                                                                                                    |                                                                                                                                                                                                                                                                                                                    | MC/DEL<br>MC/DEL                                                                                                               |                  | CHLORDIAZEPOXIDE/AMITRIPT<br>PERPHENAZINE/AMITRIPTYLIN                                                                                          | <a href="#">Use PA Form# 20420.</a>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| STIMULANTS                                |                                                                                                                                    |                                                                                                                                                                                                                                                                                                                    |                                                                                                                                |                  |                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| STIMULANT - AMPHETAMINES -SHORT ACTING    | MC/DEL<br>MC/DEL<br>MC                                                                                                             | AMPHETAMINE SALT COMBO <sup>1,3,4</sup><br>DEXTROAMPHET SULF TABS <sup>1,2,3</sup><br>PROCENTRA <sup>1,3</sup>                                                                                                                                                                                                     | MC/DEL<br>MC<br>MC/DEL<br>MC                                                                                                   |                  | ADDERALL TABS <sup>1,2,3</sup><br>EVEKEO<br>METHAMPHETAMINE HCL<br>ZENZED                                                                       | <a href="#">Use PA Form# 20420.</a><br><br>1. Preferred stimulants will be available without PA if diagnosis of ADHD or Narcolepsy.<br>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.<br>3. Dosing limits apply, see Dosing Consolidation List.<br>4. Max daily dose of 50mg.                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| STIMULANT - LONG ACTING AMPHETAMINES SALT | MC<br>MC/DEL<br>MC/DEL<br>MC                                                                                                       | ADDERALL XR CP24 <sup>1,3,4,7</sup><br>AMPHETAMINE/DEXTROAMPHET ER <sup>3,4,7</sup><br>LISDEXAMFETAMINE CAP<br>VYVANSE <sup>2,3,4</sup>                                                                                                                                                                            | MC/DEL<br>MC<br>MC<br>MC<br>MC                                                                                                 |                  | AMPHETAMINE-DEXTROAMPHETAMINE<br>3-BEAD CAP ER 24HR<br><br>ARYNTA<br>MYDAYIS <sup>5</sup><br>VYVANSE CHEW <sup>4</sup><br>XELSTRYM <sup>8</sup> | <a href="#">Use PA Form# 20420.</a><br><br>1. As per recent FDA alert, <b>Adderall</b> should not be used in patients with underlying heart defects since they may be at increased risk for sudden death.<br>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.<br>3. Preferred stimulants will be available without PA if diagnosis of ADHD.<br>4. Dosing limits apply, see Dosing Consolidation List. | DDI: The concomitant use of <b>Mydayis</b> is contraindicated with monoamine oxidase inhibitors (MAOIs) or within 14 days after discontinuing MAOI treatment, as concomitant use can increase hypertensive crisis.                                                                                                                                                                                                                                                                                                                     |
| LONG ACTING AMPHETAMINES                  | MC<br>MC/DEL<br>MC                                                                                                                 | DEXTROAMPHET SULF CPSR <sup>1,3</sup><br>DEXTROAMPHETAMINE ER<br>DYANAVEL XR SUS                                                                                                                                                                                                                                   | MC/DEL<br>MC<br>MC<br>MC<br>MC                                                                                                 |                  | ADZENYS ER <sup>3</sup><br>ADZENYS XR- ODT<br>ADZENYS XR <sup>3</sup><br>DEXEDRINE CAP SR <sup>2,3</sup><br>DYANAVEL XR TAB                     | <a href="#">Use PA Form# 20420.</a><br><br>1. Preferred stimulants will be available without PA if diagnosis of ADHD.<br>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.<br>3. Dosing limits apply, see Dosing Consolidation List.                                                                                                                                                                                             | DDI: The concomitant use of <b>Adzenys XR</b> is contraindicated with monoamine oxidase inhibitors (MAOIs) or within 14 days after discontinuing MAOI treatment.                                                                                                                                                                                                                                                                                                                                                                       |
| STIMULANT - METHYLPHENIDATE               | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL                                                                                               | DEXMETHYLPHENIDATE IR TABS<br>METHYLPHENIDATE SOL<br>METHYLPHENIDATE TAB<br>METHYLIN TABS <sup>1,2</sup>                                                                                                                                                                                                           | MC/DEL<br>MC/DEL<br>MC<br>MC<br>MC/DEL<br>MC/DEL                                                                               |                  | FOCALIN IR TABS<br>METADATE ER<br>METHYLPHENIDATE HCL CHEW<br>METHYLIN CHEWABLES<br>METHYLIN SOL<br>RITALIN                                     | <a href="#">Use PA Form# 20420.</a><br><br>1. Preferred stimulants will be available without PA if diagnosis of ADHD.<br>2. Dosing limits apply, see Dosing Consolidation List.<br>Maximum daily doses are as follows: 72mg daily for <b>Methylphenidate</b> and 36mg daily for <b>Dexmethylphenidate</b> .                                                                                                                                                                                                                                        | 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.                                                                            |

| CATEGORY                                  | Coverage Indicator                                                         | PREFERRED DRUGS                                                                                                                                                                                                                                                                             | Coverage Indicator                                                                                           | Step Order                                                    | NON-PREFERRED DRUGS<br>PA Required                                                                                                                                                                                                                                                                                                              | Criteria                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|-------------------------------------------|----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| STIMULANT - METHYLPHENIDATE - LONG ACTING | MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC<br>MC/DEL | CONCERTA TBCR<br>DEXMETHYLPHENIDATE CAP ER 50/50<br>FOCALIN XR<br>METHYLPHENIDATE LA CAPS<br>METHYLPHENIDATE ER CAPS 50/50<br>METHYLPHENIDATE ER CAPS 40/60<br>METHYLPHENIDATE CD CAPS 30-70<br>QUILLICHEW ER <sup>5,1</sup><br>QUILLIVANT XR SUS <sup>1,5</sup><br>RITALIN LA <sup>4</sup> | MC<br>MC/DEL<br>MC<br>MC<br>MC<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL                                           | 5<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8                     | METADATE CD CPCR<br>ADHANSIA XR <sup>2,5</sup><br>APTENSIO XR <sup>2</sup><br>AZSTARYS <sup>4</sup><br>COTEMPLA XR <sup>2</sup><br>COTEMPLA XR ODT <sup>2</sup><br>DAYTRANA <sup>2,3</sup><br>JORNAY PM <sup>2,6</sup><br>METHYLPHENIDATE ER CAPS <sup>2,4</sup>                                                                                | <a href="#">Use PA Form# 20420.</a><br>1. Preferred stimulants will be available without PA if diagnosis of ADHD.<br>2. <b>Non-preferred products must be used in specified step order.</b><br>3. FDA approval currently only for ages 6-16. Limit of one patch daily. Max dose of 30MG daily.<br>4. Dosing limits apply. see Dosing Consolidation List.<br>5. Quilivant XR and Quilichew ER are only indicated for use in patients ≥ 6 yrs of age.<br>6. For the treatment of patients ≥ 6 ys of age.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| STIMULANT - STIMULANT LIKE                | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC                                 | ATOMOXETINE HCL<br>ARMODAFINIL<br>CLONIDINE ER<br>GUANFACINE ER<br>MODAFINIL TABS<br>QELBREE <sup>6,7</sup>                                                                                                                                                                                 | MC/DEL<br>MC<br>MC<br>MC<br>MC/DEL<br>MC<br>MC<br>MC<br>MC<br>MC<br>MC/DEL<br>MC<br>MC<br>MC/DEL<br>MC<br>MC | 7<br>7<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>9<br>9<br>9 | PROVIGIL TABS <sup>3</sup><br>STRATTERA <sup>1,2</sup><br>ATONCY <sup>4</sup><br>CAFCIT SOLN <sup>3</sup><br>INTUNIV<br>KAPVAY<br>ONVDA XR <sup>8</sup><br>SUNOSI<br>WAKIX<br>XYREM SOL<br>XYWAV <sup>6</sup><br>NUVIGIL <sup>3</sup><br>DESOXYN TABS <sup>3</sup><br>DESOXYN CR <sup>3</sup>                                                   | <a href="#">Use PA Form# 20710 for Provigil, Nuvigil and Xyrem</a><br><a href="#">Use PA Form# 20420 for all others</a><br>1. Failure of both an amphetamine and methylphenidate is required for consideration for approval of <b>Strattera</b> , unless history of substance abuse without current use of abusable medication(s). Additionally, for patients <17 years of age, a trial of <b>Guanfacine</b> required before approval of <b>Strattera</b> .<br>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.<br>3. <b>Non-preferred products must be used in specified step order.</b><br>4. Please use generic Guanfacine.<br>5. For patients 7 years of age and older with narcolepsy.<br>6. For pediatric patients 6 years of age or older.<br>7. Preferred with a trial and fail either Atomoxetine OR any 2 preferred ADHD agents.                                                                                                                                                                                        |
| ANTI-CATALECTIC AGENTS                    |                                                                            |                                                                                                                                                                                                                                                                                             |                                                                                                              |                                                               |                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| PSYCHOTHERAPEUTIC AGENTS - MISC.          |                                                                            |                                                                                                                                                                                                                                                                                             | MC<br>MC                                                                                                     |                                                               | NUDEXTA<br>XENAZINE                                                                                                                                                                                                                                                                                                                             | <a href="#">Use PA Form# 20710 for Xenazine</a>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| 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<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL         | DONEPEZIL HYDROCHLORIDE TABS <sup>1</sup><br>DONEPEZIL HYDROCHLORIDE ODT <sup>1</sup><br>EXELON DIS <sup>1</sup><br>GALANTAMINE CAPS <sup>1</sup><br>GALANTAMINE TAB <sup>1</sup><br>MEMANTINE <sup>1</sup><br>RIVASTIGMINE TARTRATE CAPS <sup>1</sup>                                      | MC<br>MC<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC<br>MC<br>MC/DEL<br>MC/DEL<br>MC<br>MC<br>MC<br>MC<br>MC   | 6<br>6<br>7<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>9 | ARICEPT TABS <sup>2</sup><br>ARICEPT ODT <sup>2</sup><br>DONEPEZIL HYDROCHLORIDE TABS 23MG<br>ADLARTY <sup>3</sup><br>EXELON CAP<br>GALANTAMINE HYDROBROMIDE SOL<br>KISUNLA <sup>1</sup><br>LEQEEMI <sup>1</sup><br>MEMANTINE HCL SOL<br>NAMENDA<br>NAMENDA XR CAPS<br>NAMZARIC<br>RAZADYNE <sup>2</sup><br>ZUNVEYL<br>COGNEX CAPS <sup>2</sup> | <a href="#">Use PA Form# 20420.</a><br>1. PA is required to establish dementia diagnosis and baseline mental status score.<br>2. Must fail all preferred products before moving to non-preferred.<br>3. Approvals will require trials and failure or clinical rationale why preferred patches can't be used.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| SMOKING CESSATION                         |                                                                            |                                                                                                                                                                                                                                                                                             |                                                                                                              |                                                               |                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| NICOTINE PATCHES / TABLETS                | MC/DEL<br>MC/DEL                                                           | NICOTINE DIS PT24 <sup>1</sup><br>VARENICLINE TAB                                                                                                                                                                                                                                           | MC/DEL                                                                                                       |                                                               | NICODERM CQ PT24 <sup>1</sup>                                                                                                                                                                                                                                                                                                                   | <a href="#">Use PA Form# 20420.</a><br>1. See criteria section for exemptions<br><br>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.<br><br>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.<br><br><b>Note:</b> 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. |

| CATEGORY                     | Coverage Indicator                                                                                               | PREFERRED DRUGS                                                                                                                                                                                                                                            | Coverage Indicator                                                                                                           | Step Order                                                                        | NON-PREFERRED DRUGS PA Required                                                                                                                                                                                                                                                                                                             |                                                        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| NICOTINE REPLACEMENT - OTHER | MC/DEL<br>MC/DEL<br>MC/DEL                                                                                       | NICOTINE POLACRILEX GUM <sup>1</sup><br>NICOTINE LOZENGE MINI<br>NICOTINE LOZENGE                                                                                                                                                                          | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC                                                                                             | 8<br>8<br>8<br>8                                                                  | NICOTROL INHALER <sup>1,2</sup><br>NICOTROL NASAL SPRAY <sup>1,2</sup><br>NICORETTE GUM <sup>1,2</sup><br>NICORETTE LOZENGES                                                                                                                                                                                                                | <a href="#">Use PA Form# 20420.</a><br><br>1. See criteria section for exemptions.<br><br>2. <b>Must use non-preferred products in specified step order.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 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.<br><br>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.<br><br><b>Note:</b> 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.<br>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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| ALCOHOL DETERRENTS           |                                                                                                                  |                                                                                                                                                                                                                                                            |                                                                                                                              |                                                                                   |                                                                                                                                                                                                                                                                                                                                             |                                                        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| ALCOHOL DETERRENTS           | MC/DEL<br>MC<br>MC<br>MC/DEL                                                                                     | ACAMPROSATE<br>ANTABUSE TABS<br>DISULFIRAM TABS<br>NALTREXONE HCL TABS                                                                                                                                                                                     | MC/DEL                                                                                                                       |                                                                                   | ACAMPRO <sup>1</sup>                                                                                                                                                                                                                                                                                                                        | <a href="#">Use PA Form# 20420.</a><br><br>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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| MISCELLANEOUS ANALGESICS     |                                                                                                                  |                                                                                                                                                                                                                                                            |                                                                                                                              |                                                                                   |                                                                                                                                                                                                                                                                                                                                             |                                                        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| ANALGESICS - MISC.           | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL | ACETAMINOPHEN<br>ASPIRIN<br>ASPRIN/ APAP/ CAFF TAB<br>BUTAL/ASA/CAFF<br>BUTALBITAL COMPOUND<br>BUTALBITAL/ACET TABS<br>BUTALBITAL/APAP CAPS<br>BUTALBITAL/APAP/CAFFEINE TABS<br>CHOLINE MAGNESIUM TRISALI<br>DIFLUNISAL TABS<br>EXCEDRIN<br>SALSALATE TABS | MC<br>MC/DEL<br>MC/DEL<br>MC<br>MC<br>MC/DEL<br>MC<br>MC<br>MC<br>MC<br>MC<br>MC<br>MC                                       |                                                                                   | AXOCET CAPS<br>ESGIC-PLUS<br>FIORICET TABS<br>FIORINAL CAPS<br>FIORTAL CAPS<br>FORTABS TABS<br>JOURNAVX <sup>1</sup><br>PHRENILIN TABS<br>PHRENILIN FORTE CAPS<br>TRILISATE LIQD<br>TRILISATE TABS<br>ZEBUTAL CAPS<br>ZORPRIN TBCR                                                                                                          | <a href="#">Use PA Form# 20420.</a><br><br>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.<br><br><b>Journavx</b> 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 <b>ACUTE</b> pain in adults.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| LONG ACTING NARCOTICS        |                                                                                                                  |                                                                                                                                                                                                                                                            |                                                                                                                              |                                                                                   |                                                                                                                                                                                                                                                                                                                                             |                                                        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| NARCOTICS - LONG ACTING      | MC/DEL<br>MC/DEL<br>MC/DEL                                                                                       | FENTANYL PATCH <sup>1</sup><br>BUTRANS <sup>4</sup><br>MORPHINE SULFATE ER TB12                                                                                                                                                                            | MC<br>MC<br>MC<br>MC<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC<br>MC<br>MC/DEL | 8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>9 | ARYMO ER<br>AVINZA<br>BELBUCA<br>EXALGO<br>HYSINGLA ER<br>KADIAN<br>METHADONE <sup>5</sup><br>METHADOSE <sup>6</sup><br>MORPHABOND ER<br>MORPHINE SULFATE ER CAP<br>MORPHINE SULFATE SUPP<br>MS CONTIN TB12<br>ORAMORPH SR TB12<br>OXYCONTIN TB12 <sup>1</sup><br>XARTEMIS ER<br>ZOHYDRO ER<br>OXYCODONECONC<br>OXYCODONE ER <sup>3,5</sup> | <a href="#">Use PA Form# 20510</a><br><br><a href="#">Use PA Form #10300 for PAs over the opiate limit</a><br><br>1. <b>Oxycontin</b> 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.<br>2. Oxycontin will be available without PA for patients treated for or dying from cancer or hospice patients or similar conditions as supported by clinical<br>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.<br>4. 25mcg, 50mcg, 75mcg, 100mcg. Dosing limits apply, see Dose Consolidation List.<br>5. <b>Non-preferred products must be used in specific order.</b><br>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 | 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:<br>1. Frequent or persistent early refills of controlled drugs;<br>2. Multiple instances of early refill overrides due to reports of misplacement, stolen, dropped in toilet or sink, distant travel, etc.<br>3. Breaches of narcotic contracts with any provider;<br>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;<br>5. Failing to take or pass random drug testing;<br>6. Failing to provide old records regarding prior use of narcotics;<br>7. Receiving controlled substances from other prescribers that the provider submitting the PA is unaware of;<br>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.<br>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).<br>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.<br>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.<br><b>Hysingla ER</b> - 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.<br><b>Methadone</b> - Established users must have a trial and failure of at least 2 preferred drugs for least 2 weeks. Otherwise they will be allowed 180 days to transition to a preferred product. |
| NARCOTICS - SELECTED         | MC/DEL<br>MC/DEL                                                                                                 | TRAMADOL HCL TABS 50 mg <sup>2</sup><br>TRAMADOL/APAP TABS                                                                                                                                                                                                 | MC<br>MC/DEL<br>MC<br>MC<br>MC<br>MC<br>MC<br>MC                                                                             | 8<br>8<br>8<br>8<br>8<br>8<br>8<br>8                                              | BUPRENEX SOLN<br>BUTORPHANOL<br>NALBUPHINE HCL SOLN<br>QDOLO SOLN<br>SEGLENTIS <sup>1</sup><br>STADOL NS SOLN<br>TRAMADOL ER<br>ULTRACET TABS <sup>1</sup>                                                                                                                                                                                  | <a href="#">Use PA Form# 20420.</a><br><br><a href="#">Use PA form #10300 for PAs over the opiate limit</a><br><br>1. Only available if component ingredients are unavailable.<br>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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |

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| NARCOTICS - MISC. |        |                                        |        |                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                   | MC/DEL | ACETAMINOPHEN/CODEINE                  | MC/DEL | ABSTRAL                          | <a href="#">Use PA Form# 20420.</a>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                   | MC/DEL | ASPIRIN/CODEINE TABS                   | MC/DEL | APADAZ                           | <a href="#">Use PA form #10300 for PAs over the opiate limit</a>                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                   | MC/DEL | BUTAL/ASA/CAFF/COD CAPS                | MC/DEL | ASCOMP/CODEINE CAPS              | 1. <b>Fentanyl OT loz</b> (Barr) and <b>Capital and Codeine Suspension</b> products require PA for users over 18 years of age. PA is not required if under 18 years of age.<br>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.<br>3. Only preferred manufacturer's products will be available without prior authorization. | 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.<br><br>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.<br>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.<br>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.<br>An MME conversion chart is available at <a href="http://www.mainearepdl.org">www.mainearepdl.org</a> . Click on "General Pharmacy Info."<br>Please see the Pain Management Policy for the complete criteria. |
|                   | MC     | BUTALBITAL/ASPIRIN/CAFFEI CAPS         | MC/DEL | BUTALBITAL/APAP/CAFFEINE/ CAPS   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                   | MC     | CAPITAL AND CODEINE SUSP <sup>1</sup>  | MC/DEL | BUTALBITAL COMPOUND- CODEINE CAP |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                   | MC/DEL | CODEINE PHOSPHATE SOLN                 | MC     | DEMEROL                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                   | MC/DEL | CODEINE SULFATE TABS                   | MC/DEL | DILAUDID                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                   | MC/DEL | ENDOCET TABS <sup>3</sup>              | MC     | DILAUDID-HP SOLN                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                   | MC/DEL | ENDODAN TABS                           | MC     | FENTANYL CITRATE SOLN            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                   | MC/DEL | FENTANYL OT LOZ <sup>1</sup>           | MC/DEL | FENTORA                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                   | MC/DEL | HYDROCODONE/ACETAMINOPHEN              | MC/DEL | FIORICET/CODEINE CAPS            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                   | MC/DEL | HYDROMORPHONE HCL <sup>3</sup>         | MC     | FIORINAL/CODEINE #3 CAPS         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                   | MC     | LORTAB ELX                             | MC     | FIORTAL/CODEINE CAPS             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                   | MC/DEL | MEPERIDINE SOL                         | MC/DEL | HYDROCODONE/IBUPROFEN            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                   | MC/DEL | OXYCODONE TAB                          | MC/DEL | HYDROMORPHONE ER                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                   | MC/DEL | OXYCODONE/ACETAMINOPHEN <sup>2,3</sup> | MC/DEL | HYDROMORPHONE RECTAL SUPP        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                   | MC/DEL | ROXICET                                | MC     | IBUDONE                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                   | MC     | ROXIPRIN TABS                          | MC/DEL | <b>LEVORPHANOL TARTRATE TAB</b>  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                   |        |                                        | MC/DEL | LORCET                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                   |        |                                        | MC     | LORTAB                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                   |        |                                        | MC     | MAXIDONE TABS                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                   |        |                                        | MC/DEL | MEPERIDINE TABS                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                   |        |                                        | MC/DEL | NORCO TABS                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                   |        |                                        | MC/DEL | ONSOLIS                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                   |        |                                        | MC/DEL | OXYCTA                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                   |        |                                        | MC/DEL | OXYCODONE CAP                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                   |        |                                        | MC/DEL | OXYCODONE/APAP 10/650            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                   |        |                                        | MC/DEL | OXYCODONE/APAP 7.5/500           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                   |        |                                        | MC/DEL | PENTAZOCINE/ACET TABS            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                   |        |                                        | MC/DEL | PENTAZOCINE/NALOXONE TABS        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                   |        |                                        | MC     | PERCOCET TABS                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                   |        |                                        | MC     | PHRENILIN W/CAFFEINE/CODE CAPS   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                   |        |                                        | MC/DEL | ROXICET 5/500 TABS               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                   |        |                                        | MC     | ROXICODONE TABS                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                   |        |                                        | MC/DEL | ROXYBOND                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                   |        |                                        | MC     | SYNALGOS-DC CAPS                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                   |        |                                        | MC     | TALACEN TABS                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                   |        |                                        | MC     | TREZIX                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                   |        |                                        | MC     | TYLENOL/CODEINE #3 TABS          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                   |        |                                        | MC     | TYLOX CAPS                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                   |        |                                        | MC     | XOLOX                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                   |        |                                        | MC     | VICODIN                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                   |        |                                        | MC     | VICOPROFEN TABS                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                   |        |                                        | MC     | ZYDONE TABS                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                   |        |                                        | MC     | ACTIQ LPOP                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                   |        |                                        | MC     | CONZIP                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                   |        |                                        | MC     | OPANA                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |

| CATEGORY                                        | Coverage Indicator                                                                                         | PREFERRED DRUGS                                                                                                                                                                                                                                         | Coverage Indicator                                                                 | Step Order | NON-PREFERRED DRUGS PA Required                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Criteria                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|-------------------------------------------------|------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| OPIOID DEPENDENCE TREATMENTS                    | MC<br>MC/DEL                                                                                               | SUBOXONE FILM <sup>2</sup><br>BUPRENORPHINE/NALOXONE TABS <sup>2</sup>                                                                                                                                                                                  | MC/DEL<br>MC                                                                       |            | BUPRENORPHINE <sup>1</sup><br>ZUBSOLV                                                                                                                                                                        | <a href="#">Use PA form #20200 for Buprenorphine Extended Release</a><br><a href="#">Use PA Form #20100 for all others</a><br>1. <b>Buprenorphine</b> will only be approved for use during pregnancy.<br>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.<br><br>Members will continue to be required to follow the criteria listed below: <ol style="list-style-type: none"> <li>Being used for the treatment of OUD (rather than pain or any other non-FDA approved indication)</li> <li>Induction period for 30 days</li> <li>Max dose of 32 mg for induction</li> <li>Max dose of 24 mg for maintenance</li> <li>There is not more than one opioid fill in member's drug profile between current fill of <b>Buprenorphine</b> and a prior <b>Buprenorphine</b> fill within the past 90 days</li> <li>Should provide evidence of monthly monitoring including random pill counts, urine drug tests and use of Maine Prescription Monitoring Program reports.</li> <li><b>Buprenorphine</b> monotherapy is preferred if member is pregnant and dose not &gt; 24 mg day and pregnancy diagnosis is noted on the prescription.</li> </ol>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| EXTENDED RELEASE BUPRENORPHINE                  | MC<br>MC                                                                                                   | BRIXADI <sup>1</sup><br>SUBLOCADE <sup>1</sup>                                                                                                                                                                                                          |                                                                                    |            |                                                                                                                                                                                                              | <a href="#">Use PA form #20200 for Buprenorphine Extended Release</a><br>1. Clinical PA required.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <b>Brixadi and Sublocade:</b><br>The prescriber can attest (and medical record should document) that:<br>-member has a documented history of opioid use disorder (OUD).<br>-XRB is being used for the treatment of OUD (rather than pain or any other non-FDA approved indication) and<br>-member's total daily dose of sublingual buprenorphine is less than or equal to 24 mg daily.<br>AND at least one of the following is true:<br>-The member's previous use of sublingual buprenorphine has included misuse, overuse, or diversion.<br>-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).<br>-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.)<br>-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.<br>-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.)<br>-The member is in ongoing treatment with XRB and would like to continue the medication. |
| OPIOID WITHDRAWAL AGENTS                        |                                                                                                            |                                                                                                                                                                                                                                                         | MC                                                                                 |            | LUCEMYRA <sup>1</sup>                                                                                                                                                                                        | <a href="#">Use PA Form#20420</a><br>1. Clinical PA for appropriate approved use and patient has documented contraindication to <b>Clonidine</b> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| NARCOTIC ANTAGONISTS                            |                                                                                                            |                                                                                                                                                                                                                                                         |                                                                                    |            |                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| NARCOTIC - ANTAGONISTS                          | MC/DEL<br>MC<br>MC<br>MC<br>MC<br>MC                                                                       | NALTREXONE HCL TABS<br>NALOXONE INJ<br>NARCAN NS<br>NALOXONE SPRAY OTC<br>VIVITROL INJ<br>ZIMHI                                                                                                                                                         | MC<br>MC<br>MC<br>MC/DEL                                                           |            | OPVEE <sup>2</sup><br>KLOXXADO<br>REZENOPY<br>ZURNAL <sup>2</sup>                                                                                                                                            | <a href="#">Use PA Form# 20420</a><br>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<br>MC/DEL<br>MC/DEL<br>MC/DEL                                                                       | CELECOXIB <sup>4,5</sup><br>KETOROLAC TROMETHAMINE <sup>2,3,5</sup><br>NABUMETONE TABS <sup>5</sup><br>MELOXICAM TABS <sup>1,5</sup>                                                                                                                    | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC<br>MC                   |            | CELEBREX CAPS <sup>4,5</sup><br>MELOXICAM CAPS <sup>5</sup><br>MOBIC <sup>5</sup><br>MOBIC SUSP <sup>5</sup><br>RELAFEN TABS <sup>5</sup><br>QMIIZ ODT<br>VIVLODEX<br>VYSCOX<br>XIFYRM <sup>5</sup><br>ZYBIC | <a href="#">Use PA Form# 20420</a><br>1. <b>Meloxicam</b> and <b>Xifyrm</b> have dosing limits allowing one tablet daily of all strengths without PA.<br>2. <b>Ketorolac Tromethamine</b> 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.<br>3. <b>Ketorolac</b> has dosing limits allowing 24 tablets for a 5-day supply every 30 days.<br>4. Dosing limits will be set at a maximum of 400mg daily.<br>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<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL | CHILDRENS IBUPROFEN<br>DICLOFENAC POTASSIUM TABS<br>DICLOFENAC SODIUM TABS<br>DICLOFENAC SODIUM 1% GEL <sup>1</sup><br>ETODOLAC<br>FENOPROFEN CALCIUM TABS<br>FLURBIPROFEN TABS<br>IBUPROFEN<br>INDOMETHACIN<br>KETOPROFEN<br>MECLOFENAMATE SODIUM CAPS | MC<br>MC<br>MC<br>MC<br>MC/DEL<br>MC<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL |            | ADVIL TABS<br>ANAPROX TABS<br>ANAPROX DS TABS<br>CAMBIA<br>CATAFLAM TABS<br>CHILDRENS ADVIL SUSP<br>CHILD'S IBUPROFEN SUSP<br>CHILDRENS MOTRIN SUSP<br>CLINORIL TABS<br>DAYPRO TABS<br>DICLOFENAC GEL        | <a href="#">Use PA Form# 20420</a><br>The FDA has issued a Public Health Advisory warning of the potential for increased cardiovascular risk & GI bleeding with NSAID use.<br><br>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.<br><br>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.<br><br>The FDA has issued a Public Health Advisory warning of the potential for increased cardiovascular risk & GI bleeding with NSAID use.<br><b>DDI: Diclofenac</b> will now be non-preferred and require prior authorization if it is currently being used in combination with Ilescol.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |



| CATEGORY                                                   | Coverage Indicator                                       | PREFERRED DRUGS                                                                                                                                                   | Coverage Indicator                                                                               | Step Order  | NON-PREFERRED DRUGS<br>PA Required                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | Criteria                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|------------------------------------------------------------|----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|-------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| LUPUS-SLE                                                  |                                                          |                                                                                                                                                                   |                                                                                                  |             |                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| LUPUS-SLE                                                  |                                                          |                                                                                                                                                                   | MC<br>MC<br>MC/DEL                                                                               | 8<br>8<br>8 | BENLYSTA <sup>1</sup><br>LUPKYNIS<br>SAPHNELO                                                                                                                                                                                                                                                                                                                                                                                      | <a href="#">Use PA Form# 20420.</a><br><br>1. Approvals will require previous trial of corticosteroids, antimalarials, NSAIDs and immunosuppressives.                                                                                                                                  | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved ( <b>in step order</b> ), 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.<br><br><b>DDI: Lukynis</b> is a sensitive CYP3A4 substrate. Co-administration with strong or moderate CYP3A4 inhibitors increases voclosporin exposure, which may increase the risk of Lukynis adverse reactions. Co-administration of Lukynis with strong CYP3A4 inhibitors (e.g. ketoconazole, itraconazole, clarithromycin) is contraindicated. Reduce Lukynis dosage when co-administered with moderate CYP3A4 inhibitors (e.g. verapamil, fluconazole, diltiazem). |
| PIK3CA-Related Overgrowth Spectrum (PROS)                  |                                                          |                                                                                                                                                                   |                                                                                                  |             |                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| PIK3CA-Related Overgrowth Spectrum (PROS)                  |                                                          |                                                                                                                                                                   | MC                                                                                               | 8           | VJOICE <sup>1</sup>                                                                                                                                                                                                                                                                                                                                                                                                                | <a href="#">Use PA Form# 20420.</a><br><br>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 <b>step-order</b> 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<br>MC<br>MC<br>MC                                                                             |             | BREKIYA<br>D.H.E. 45 SOLN<br>DIHYDROERGOTAMINE MESYLATE INJ<br>TRUDHESA                                                                                                                                                                                                                                                                                                                                                            | <a href="#">Use PA Form# 10110</a>                                                                                                                                                                                                                                                     | 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                                                                                                                                                                                                                                                                                                                                                                                                                   | <a href="#">Use PA Form# 10110</a>                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)–Tabs/Nasal   | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL | RELPAX <sup>1</sup><br>RIZATRIPTAN ODT<br>RIZATRIPTAN TABS<br>SUMATRIPTAN TABS <sup>1</sup><br>ZOLMITRIPTAN TAB <sup>1</sup><br>NARATRIPTAN HCI TABS <sup>1</sup> | MC<br>MC<br>MC/DEL<br>MC<br>MC<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL |             | AMERGE TABS <sup>1,2</sup><br>AXERT TABS <sup>1,2</sup><br>FROVA TABS <sup>1,2</sup><br>IMITREX NASAL SPRAY <sup>1</sup><br>IMITREX TABS <sup>1,2</sup><br>MAXALT <sup>1,2,3</sup><br>MAXALT MLT <sup>1,2,3</sup><br>ONZETRA XSAIL <sup>2</sup><br>SUMATRIPTAN NASAL SPRAY <sup>1</sup><br>ZOLMITRIPTAN ODT<br>ZOLMITRIPTAN SPRAY<br>ZOMIG TABS <sup>1,2</sup><br>ZOMIG NASAL SPARY <sup>1,2</sup><br>ZOMIG ZMT TBP <sup>1,2</sup> | <a href="#">Use PA Form# 10110</a><br><br>1. All drugs in this category have dosing limits. Refer to Dose Consolidation Table.<br>2. Must fail all preferred products before non-preferred.<br>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<br>MC/DEL<br>MC/DEL                                   | IMITREX CARTRIDGE <sup>1</sup><br>SUMATRIPTAN SYRINGE <sup>1</sup><br>SUMATRIPTAN PEN INJECT <sup>1</sup>                                                         | MC/DEL<br>MC<br>MC                                                                               |             | TOSYMRA<br>ZEMBRACE <sup>1</sup><br>IMITREX PEN INJECT <sup>1</sup>                                                                                                                                                                                                                                                                                                                                                                | <a href="#">Use PA Form# 10110</a><br><br>1. Dosing limits apply, see Dosage Consolidation List.                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)–Combinations |                                                          |                                                                                                                                                                   | MC/DEL                                                                                           |             | TREXIMET <sup>1,2</sup>                                                                                                                                                                                                                                                                                                                                                                                                            | <a href="#">Use PA Form# 10110</a><br><br>1. Dosing limits apply, see Dosage Consolidation List.<br>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 <sup>1</sup>                                                                                                                                                                                                                                                                                                                                                                                                              | 1. Dosing limits apply, see Dosage Consolidation List.                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| MIGRAINE - PREVENTATIVE TREATMENT                          | MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL               | AIMOVIG <sup>1</sup><br>AJOVY <sup>1</sup><br>AJOVY AUTO INJECT <sup>1</sup><br>EMGALITY SYRINGE <sup>1</sup> 120mg/ml<br>EMGALITY PEN <sup>1</sup> 120mg/ml      | MC<br>MC<br>MC<br>MC                                                                             |             | NURTEC ODT<br>QULIPTA<br>VYEPTI <sup>2</sup>                                                                                                                                                                                                                                                                                                                                                                                       | <a href="#">Use PA Form# 10110</a><br><br>1. See criteria section.<br>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.<br><br><b>Aimovig, Ajovy and Emgality:</b> 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<br>MC<br>MC                                           | NURTEC ODT <sup>1</sup><br>SPASTRIN TABS<br>UBRELVY <sup>1</sup>                                                                                                  | MC<br>MC<br>MC/DEL<br>MC/DEL<br>MC                                                               |             | BELCOMP-PB SUPP<br>ELYXYB<br>MIGRAZONE CAPS<br>MIGERGOT SUP<br>REYVOW                                                                                                                                                                                                                                                                                                                                                              | <a href="#">Use PA Form# 10110</a><br><br>1. Dosing limits apply, see Dosage Consolidation List.                                                                                                                                                                                       | <b>Nurtec ODT will be preferred after 2 adequate trials of at least two preferred triptans.</b><br><b>Reyvow</b> 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.<br><b>Ubrelyv</b> 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.<br><b>Zavzpret:</b> 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<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL     | ALLOPURINOL TABS<br>COLCHICINE TAB<br>FEBUXOSTAT TAB<br>MITIGARE<br>PROBENECID TABS<br>PROBENECID/COLCHICINE TABS                                                 | MC/DEL<br>MC<br>MC<br>MC/DEL<br>MC                                                               |             | COLCHICINE CAP<br>COLCRYS<br>GLOPERBA<br>ULORIC <sup>1</sup><br>ZYLOPRIM TABS                                                                                                                                                                                                                                                                                                                                                      | <a href="#">Use PA Form# 20420.</a><br><br>1. Failure of therapeutic (300mg) dose of <b>Allopurinol</b> (failure define as not being able to get uric acid levels below 6mg/dl) or severe renal disease.<br>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.<br><br><b>DDI:</b> 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 <sup>1,2</sup>                                                                                                                                                                                                                                                                                                                                                                                                           | <a href="#">Use PA Form# 20420</a><br><br>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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |

[illegible]



| CATEGORY                                | Coverage Indicator                                                                     | PREFERRED DRUGS                                                                                                                                                                                                                                        | Coverage Indicator                                                                                                                                           | Step Order                                                                                       | NON-PREFERRED DRUGS<br>PA Required                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Criteria                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
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| PARKINSONS - COMT INHIBITORS            |                                                                                        |                                                                                                                                                                                                                                                        | MC/DEL<br>MC                                                                                                                                                 |                                                                                                  | COMTAN TABS<br>ONGENTYS                                                                                                                                                                                                                                                                                                                           | <a href="#">Use PA Form# 20420</a>                                                                                                                                                                                                                                                                                                                                                                                                                                  | 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<br>MC/DEL<br>MC/DEL                                                             | PRAMIPEXOLE<br>ROPINIROLE<br>NEUPRO PATCH                                                                                                                                                                                                              | MC/DEL<br>MC<br>MC/DEL                                                                                                                                       | 5<br>8<br>8                                                                                      | MIRAPEX TABS <sup>1</sup><br>REQUIP TABS<br>MIRAPEX ER                                                                                                                                                                                                                                                                                            | <a href="#">Use PA Form# 20420</a><br><br>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                                                                                                                                                                                                                                                                                                                                            | <a href="#">Use PA Form# 20420</a>                                                                                                                                                                                                                                                                                                                                                                                                                                  | 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/ CARBI/ LEVO | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br><br>MC<br>MC/DEL | AMANTADINE HCL CAPS<br>AMANTADINE HCL TABS<br>BROMOCRIPTINE MESYLATE TABS<br>BROMOCRIPTINE MESYLATE CAPS<br>CARBIDOPA/LEVODOPA TABS <sup>1</sup><br>CARBIDOPA/LEVODOPA ER<br>CARBIDOPA/LEVO/ENTACAPONE TAB<br><br>LARODOPA TABS<br>SELEGILINE CAPS HCL | MC/DEL<br>MC<br>MC/DEL<br>MC<br>MC<br>MC<br>MC/DEL<br>MC<br>MC<br>MC/DEL<br>MC<br>MC<br>MC<br>MC<br>MC<br>MC                                                 |                                                                                                  | APOKYN<br>AZILECT <sup>2</sup><br>CARBIDOPA/LEVODOPA RAPDIS<br>CREXONT <sup>4</sup><br>ELDEPRYL CAPS<br>GOCOVRI<br>INBRIJA<br>KYNMOBI<br>ONAPGO<br>OSMOLEX ER<br>PARLODEL CAPS<br>PARLODEL TABS<br>RYTARY<br>SINEMET TABS<br>SINEMET TBCR<br>VYALEV                                                                                               | <a href="#">Use PA Form# 20420</a><br><br>1. Approvals will require concurrent therapy with <b>Levodopa</b> and failed trials of <b>Comtan</b> and <b>Stalevo</b> .<br>2. Approvals will require trials of Carbidopa/Levodopa, Comtan, and Stalevo.<br>3. Only preferred manufacturer's products will be available without prior authorization.<br>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.<br><br><b>Inbrija</b> is recommended for the intermittent treatment of OFF episodes in patients with Parkinson's disease treated with carbidopa/levodopa.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| PARKINSONS - COMBO.                     |                                                                                        |                                                                                                                                                                                                                                                        | MC/DEL<br>MC                                                                                                                                                 |                                                                                                  | STALEVO <sup>1</sup><br>CARBIDOPA/LEVODOPA/ ENTACA <sup>1</sup>                                                                                                                                                                                                                                                                                   | <a href="#">Use PA Form# 20420</a><br><br>1. Clinical PA is required to establish diagnosis and medical necessity.                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| MUSCLE RELAXANTS                        |                                                                                        |                                                                                                                                                                                                                                                        |                                                                                                                                                              |                                                                                                  |                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| MUSCLE RELAXANTS                        | MC/DEL<br>MC/DEL<br>MC/DEL<br><br>MC<br>MC/DEL<br>MC/DEL                               | BACLOFEN TABS<br>CHLORZOXAZONE TABS<br>CYCLOBENZAPRINE HCL<br>5mg & 10mg TABS<br><br>LIORESAL INTRATHECAL KIT<br>METHOCARBAMOL TABS<br>TIZANIDINE HCL TABS                                                                                             | MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC<br>MC/DEL<br>MC<br>MC<br>MC<br>MC/DEL<br>MC<br>MC<br>MC<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC | 7<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>9<br>9<br>9<br>9<br>9 | ORPHENADRINE CITRATE<br>CARISOPRODOL 350MG TABS<br>ATMEKSI<br>AMRIX<br>DANTRIUM CAPS<br>FLEQSUVY<br>LIORESAL TABS<br>LORZONE<br>LYVISPAN<br>METAXALONE<br>NORFLEX TBCR<br>ONTRALFY<br>OZOBAX<br>ROBAXIN-750 TABS<br>VECUROMIUM INJ<br>ZANAFLEX TABS<br>CARISOPRODOL 250MG TABS<br>CHLORZOXAZONE 250mg TABS<br>SKELAXIN TAB<br>SOMA TABS<br>TANLOR | <a href="#">Use PA Form# 20420</a>                                                                                                                                                                                                                                                                                                                                                                                                                                  | 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.<br><br>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.<br><br><b>Non-preferred products must be used in specified step order.</b><br><br>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).<br><b>Lorzone</b> 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. |
| MUSCLE RELAXANT - COMBO.                |                                                                                        |                                                                                                                                                                                                                                                        | MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC                                                                                                             |                                                                                                  | CARISOPRODOL/ASPIRIN TABS<br>CARISOPRODOL/ASPIRIN/CODE<br>NORGESIC TABS<br>ORPHENADRINE COMPOUND<br>ORPHENADRINE/ASA/CAFF<br>ORPHENGESIC                                                                                                                                                                                                          | <a href="#">Use PA Form# 20420</a>                                                                                                                                                                                                                                                                                                                                                                                                                                  | 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| PARATHYROID HORMONE                     |                                                                                        |                                                                                                                                                                                                                                                        |                                                                                                                                                              |                                                                                                  |                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| PARATHYROID HORMONE                     |                                                                                        |                                                                                                                                                                                                                                                        | MC<br>MC                                                                                                                                                     |                                                                                                  | NATPARA <sup>1</sup><br>YORVIPATH <sup>1</sup>                                                                                                                                                                                                                                                                                                    | <a href="#">Use PA Form# 20420</a><br><br>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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| VITAMINS                                |                                                                                        |                                                                                                                                                                                                                                                        |                                                                                                                                                              |                                                                                                  |                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| VITAMINS                                | MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC                                                 | CYANOCOBALAMIN SOLN<br>FOLIC ACID TABS<br>MEPHYTON TABS<br>NIACIN<br>NIACOR TABS                                                                                                                                                                       | MC<br>MC<br>MC<br>MC<br>MC                                                                                                                                   |                                                                                                  | AQUASOL E SOLN<br>AQUAVIT-E SOLN<br>DHT SOLN<br>FERIVA CAP<br>FUSION PLUS CAP                                                                                                                                                                                                                                                                     | <a href="#">Use PA Form# 20420</a><br><br>Please refer to OTC list for covered products.<br><br><a href="#">Click here for the OTC List</a>                                                                                                                                                                                                                                                                                                                         | 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.<br><br>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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |



[illegible]

[illegible]

| CATEGORY                         | Coverage Indicator                                                                                                                                                                                             | PREFERRED DRUGS                                                                                                                                                                                                                                                                                                                                                                               | Coverage Indicator                                                                                                                                                                                       | Step Order                                               | NON-PREFERRED DRUGS<br>PA Required                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Criteria                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
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| GRANULOCYTE CSF                  |                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                          |                                                          |                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| GRANULOCYTE CSF                  | MC<br>MC<br>MC<br>MC/DEL                                                                                                                                                                                       | FULPHILA<br>NEUPOGEN SYRINGE<br>NEUPOGEN VIAL<br>NYVEPRIA SYRINGE                                                                                                                                                                                                                                                                                                                             | MC<br>MC<br>MC<br>MC<br>MC/DEL<br>MC<br>MC<br>MC<br>MC/DEL<br>MC/DEL<br>MC                                                                                                                               | 8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>9 | FILKRI<br>FYLNETRA<br>GRANIX SYRINGE<br>GRANIX VIAL<br>LEUKINE<br>NIVESTYM<br>ROLVEDON<br>RYZNEUTA<br>STIMUFEND<br>ZARXIO<br>ZIENTENZO<br>NEULASTA <sup>1</sup>                                                                              | <a href="#">Use PA Form# 20520</a><br><br>1. <b>Must be used in specified step order.</b>                                                                                                                                                                                                                                                                                                                                                                                   | See approval criteria detailed on Granulocyte Colony Stimulating Factor PA form.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| GAUCHER DISEASE                  |                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                          |                                                          |                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| GAUCHER DISEASE                  |                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                               | MC<br>MC                                                                                                                                                                                                 |                                                          | CERDELGA <sup>1</sup><br>YARGESA <sup>1</sup>                                                                                                                                                                                                | <a href="#">Use PA Form# 20420</a><br><br>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.<br><br><b>Yargesa:</b> 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).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| NIEMANN-PICK DISEASE AGENTS      |                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                          |                                                          |                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| NIEMANN-PICK DISEASE AGENTS      |                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                               | MC<br>MC                                                                                                                                                                                                 |                                                          | AONEURSA <sup>1</sup><br>MIPLYFFA <sup>1</sup>                                                                                                                                                                                               | <a href="#">Use PA Form# 20420</a><br><br>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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| ANTICOAGULANTS / PLATELET AGENTS |                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                          |                                                          |                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| ANTICOAGULANTS                   | MC<br>MC/DEL<br>MC<br>MC<br>MC<br>MC<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL                                                       | COUMADIN TABS<br>ENOXAPARIN <sup>1</sup><br>ELIQUIS<br>ELIQUIS STARTER PACK<br>HEPARIN SODIUM/NACL 0.9% SOLN<br>HEP-LOCK SOLN<br>INNOHEP<br>HEPARIN LOCK SOLN<br>HEPARIN LOCK FLUSH SOLN<br>HEPARIN SODIUM SOLN<br>HEPARIN SODIUM LOCK FLUSH SOLN<br>PRADAXA<br>JANTOVEN<br>WARFARIN SODIUM TABS<br>XARELTO<br>XARELTO STARTER PACK                                                           | MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL                                     |                                                          | ARIXTRA SOLN<br>FONDAPARINUX<br>FRAGMIN INJ<br>FRAGMIN VIAL<br>LOVENOX SOLN<br>LOVENOX 300 <sup>2</sup><br>LOVENOX SUBQ SYRINGE<br>PRADAXA ORAL PELLETS <sup>4</sup><br>IPRIVASK<br>SAVAYSAS <sup>3</sup>                                    | <a href="#">Use PA form# 20420</a><br><br>1. <b>Enoxaparin</b> therapy durations greater than 7 days every 30 days require PA.<br>2. Use other strengths available to obtain desired dose.<br>3. Diagnosis required.<br>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.<br><br><b>DDI: Warfarin</b> will require prior authorization if being used in combination with fluconazole, miconazole, or voriconazole.<br><b>DDI: Warfarin</b> will require prior authorization if being used in conjunction with gemfibrozil or fenofibrate.<br><b>DDI: Rifampin</b> will require prior authorization if being used in combination with savaysa.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| ANTHEMOPHILIC AGENTS             | MC<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC<br>MC/DEL<br>MC/DEL<br>MC<br>MC<br>MC<br>MC<br>MC/DEL<br>MC<br>MC<br>MC<br>MC/DEL<br>MC<br>MC<br>MC/DEL<br>MC<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL | ALPHANATE<br>ALPHANINE SD<br>ALPROLIX VIAL<br>BEBULIN VIAL<br>BENEFIX SOLR<br>HELIXATE FS KIT<br>HEMOFIL - M<br>HUMATE-P SOLR<br>IXINITY VIAL<br>JIVI <sup>3</sup><br>KOATE-DVI<br>KONYNE - 80<br>KOVALTRY<br>REBINYN<br>MONARC - M<br>MONOCLATE - P<br>MONONINE<br>NOVOEIGHT<br>NOVOSEVEN SOLR<br>NUWIQ<br>PROFILNINE<br>RECOMBINATE SOLR<br>REFACTO<br>RIXUBIS VIAL<br>WILATE INJ<br>XYNTHA | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC<br>MC<br>MC<br>MC/DEL<br>MC<br>MC<br>MC<br>MC/DEL<br>MC<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL |                                                          | ADYNOVATE VIAL<br>ADVATE <sup>1,2,5</sup><br>ALTUVIIIO <sup>4</sup><br>AFSTYLA<br>BEQVEZ<br>ESPEROCT<br>ELOCTATE<br>HEMGENIX<br>IDELVION<br>KOGENATE FS <sup>5</sup><br>RECOMBINATE VIAL <sup>5</sup><br>ROCTAVIAN <sup>4</sup><br>SEVENFACT | <a href="#">Use PA Form# 20420</a><br><br>1. Only if other products unavailable.<br>2. Advate may be available with PA in cases of large volume dosing in patients with poor venous access.<br>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.<br>4. Clinical PA required for appropriate diagnosis.<br>5. Established users will be grandfathered. | Non-preferred will only be approved if other preferred products are unavailable.<br><b>Beqvez</b> - 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:<br>• Currently use factor IX prophylaxis therapy, or<br>• Have current or historical life-threatening hemorrhage, or<br>• Have repeated, serious spontaneous bleeding episodes, and,<br>• Do not have neutralizing antibodies to adeno-associated virus serotype Rh74var (AAV/Rh74var) capsid as detected by an FDA-approved test.<br><b>Hemgenix</b> 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.<br><b>Altuviiio</b> 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.<br><b>Roctavian:</b> 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.<br><b>Inclusion:</b><br>• Severe factor VIII deficiency (less than 1% native factor VIII).<br><b>Exclusion Criteria:</b><br>• Antibodies to the virus AAV5<br>• Factor VIII inhibitors (or history of)<br>• Known significant fibrosis of cirrhosis of the liver, or unexplained elevated LFTs<br>• History of inadequate compliance with prophylaxis, or regular bleeds despite adequate prophylaxis<br>• Conditions in which high-dose steroids are contraindicated.<br>• Inability to abstain from alcohol for one year<br>• Plan to impregnate a partner within 6 months of infusion<br>• Hypersensitivity to mannitol<br>• Active infections, either acute or uncontrolled chronic |

| CATEGORY                                                  | Coverage Indicator                                   | PREFERRED DRUGS                                                                                                                                       | Coverage Indicator                                                         | Step Order       | NON-PREFERRED DRUGS<br>PA Required                                                                                                              |                                                                                                                                                                                           | Criteria                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|-----------------------------------------------------------|------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| NON-FACTOR REPLACEMENT THERAPY                            | MC                                                   | HEMLIBRA                                                                                                                                              | MC/DEL<br>MC/DEL<br>MC<br>MC                                               |                  | ALHEMO<br>HYMPAVZI<br>QFILTIA<br>QFILTIA PEN                                                                                                    | <a href="#">Use PA Form# 20420</a>                                                                                                                                                        | Subsequent changes made to Antithemophilic Agents: Factor Therapy to move Hemlibra to Non-Factor Therapy                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| PLATELET AGGREGATION INHIBITORS                           | MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL | ASPIRIN<br>ASPIRIN-DIPYRIDAMOLE ER CPMP 12HR<br>BRILINTA 90mg<br>DIPYRIDAMOLE TABS<br>CLOPIDOGREL 75MG<br>PRASUGREL HCL TAB                           | MC/DEL<br>MC/DEL<br>MC<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL                 |                  | TICLOPIDINE HCL TABS<br>BRILINTA 60mg<br>DURLAZA<br>EFFIENT<br>PERSANTINE TABS<br>PLAVIX TABS<br>ZONTIVITY                                      | <a href="#">Use PA Form# 20715</a><br>for Plavix, Effient & Brilinta<br><br><a href="#">Use PA form# 20420</a> for other requests<br>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.<br>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.<br><b>Brilinta</b> - Concomitant use with strong CYP3A4 inhibitors should be avoided (including ketoconazole, itraconazole, atazanavir, and telithromycin). Doses of simvastatin and lovastatin >40mg should be avoided.<br><b>DDI</b> : exists for using maintenance ASA dose >100mg, as it reduces the effectiveness of Brilinta.<br><b>DDI</b> : Plavix will require prior authorization if being used in combination with omeprazole, esomeprazole, cimetidine, fluconazole, ketoconazole, itenelence, fluoxetine, ticlopidine, and fluvoxamine.                                                                                        |
| PLATELET AGGR. INHIBITORS / COMBO'S MISC.                 | MC/DEL<br>MC/DEL                                     | CILOSTAZOL<br>PENTOXIFYLLINE ER TBCR                                                                                                                  | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC                                     |                  | AGRYLIN CAPS<br>ANAGRELIIDE CAPS<br>PLETAL TABS<br>TRENTAL TBCR<br>YOSPRALA                                                                     | <a href="#">Use PA Form# 20420</a>                                                                                                                                                        | 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| HEMATOLOGICALS                                            |                                                      |                                                                                                                                                       |                                                                            |                  |                                                                                                                                                 |                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| MONOCLONAL ANTIBODY                                       |                                                      |                                                                                                                                                       | MC<br>MC<br>MC/DEL<br>MC<br>MC<br>MC/DEL<br>MC<br>MC<br>MC/DEL<br>MC<br>MC |                  | BKEMV<br>EMPAVELI<br>ENSPRYNG<br>EPYSQI<br>FABHALTA<br>GAMIFANT<br>PIASKY<br>SOLIRIS<br>ULTOMIRIS<br>UPLIZNA<br>VOYDEYA                         | <a href="#">Use PA Form# 20420</a>                                                                                                                                                        | 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.<br><br><b>Gamifant</b> is recommended for the treatment of adult and pediatric (newborn and older) patients with primary hemaphagocytic lymphohistiocytosis (HLH) with refractory, recurrent, or progressive disease or intolerance with conventional HLH therapy.<br><br><b>Fabhalta</b> and <b>Ultomiris</b> are recommended for the treatment of adults with paroxysmal nocturnal hemoglobinuria (PNH).<br><b>Bkemv</b> and <b>Epysqli</b> have updated criteria for a diagnosis of generalized myasthenia gravis (gMG): must have confirmation that patients are anti-acetylcholine receptor (AChR) antibody positive.                                                                                                                                                                                                                                                                                                                                                                                      |
| IMMUNE GLOBULIN                                           | MC<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC         | BIVIGAM <sup>1</sup><br>CUTAQUIG <sup>1</sup><br>GAMMAGARD S-D <sup>1</sup><br>HIZENTRA <sup>1</sup><br>PANZYGA <sup>1</sup><br>PRIVIGEN <sup>1</sup> | MC<br>MC<br>MC/DEL<br>MC<br>MC/DEL<br>MC<br>MC<br>MC/DEL                   |                  | ALYGLO<br>ASCENIV <sup>2</sup><br>CUVITRU<br>GAMMAPLEX INJ<br>HYQVIA<br>OCTAGAM INJ <sup>1</sup><br>QIVIGY <sup>1</sup><br>XEMBIFY <sup>1</sup> | <a href="#">Use PA Form# 20420</a><br><br>1. Clinical PA required.<br>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.<br><br><b>Alyglo</b> is indicated for treatment of primary humoral immunodeficiency in adults ages 17 or older.<br><b>Cutaquig</b> is indicated as replacement therapy for primary humoral immunodeficiency (PI) in adults.<br><b>Xembify</b> is indicated for treatment of primary humoral immunodeficiency (PI) in patients 2 years of age and older.<br><b>Asceniv</b> 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).                                                                                                  |
| HEREDITARY ANGIOEDEMA                                     |                                                      | <b>PROPHYLAXIS</b>                                                                                                                                    |                                                                            |                  | <b>PROPHYLAXIS</b>                                                                                                                              |                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                                           | MC<br>MC<br>MC<br>MC/DEL                             | CINRYZE <sup>1</sup><br>HAEGARDA <sup>1</sup><br>ORLADEYO <sup>1,2</sup><br>TAKHZYRO <sup>1</sup>                                                     | MC<br>MC<br>MC<br>MC                                                       |                  | ANDEMBRY<br>DAWNZERA <sup>2</sup><br>ORLADEYO SPRINKLES                                                                                         | <a href="#">Use PA Form# 20420</a><br><br>1. Clinical PA is required to establish diagnosis and medical necessity.<br>2. For the treatment of patients ≥ 12 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, 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.<br><br><b>Haegarda</b> is indicated for routine prophylaxis to prevent Hereditary Angioedema (HAE) attacks in adolescent and adult patients                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                                                           | MC/DEL<br>MC<br>MC/DEL                               | <b>TREATMENT</b><br>BERINERT KIT <sup>1</sup><br>FIRAZYR <sup>1</sup><br>RUCONEST VIAL <sup>1</sup>                                                   | MC/DEL<br>MC<br>MC                                                         |                  | <b>TREATMENT</b><br>KALBITOR VIAL<br>EKTERLY <sup>2</sup>                                                                                       | <a href="#">Use PA Form# 20420</a><br><br>1. Clinical PA is required to establish diagnosis and medical necessity.<br>2. For the treatment of patients ≥ 12 yrs of age.                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| HEMATOLOGICAL AGENTS-<br>THROMBOPOIETIN RECEPTOR AGONISTS | MC<br>MC                                             | PROMACTA <sup>1</sup><br>NPLATE <sup>1</sup>                                                                                                          | MC<br>MC/DEL<br>MC/DEL                                                     |                  | ALVAIZ<br>DOPTLEET<br>MULPLETA                                                                                                                  | <a href="#">Use PA Form# 20420</a><br><br>1. Clinical PA required. Must see prior trial with insufficient response to corticosteroids and immunoglobulins.                                | <b>Doptelet</b> and <b>Mulpeita</b> : For the treatment of thrombocytopenia in adults with chronic liver disease who are scheduled to undergo a procedure.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| HEMATOLOGICAL AGENTS-IgAN                                 |                                                      |                                                                                                                                                       | MC/DEL<br>MC<br>MC<br>MC                                                   | 8<br>8<br>8<br>8 | FILSPARI <sup>1</sup><br>TARPEYO <sup>1</sup><br>VANRAFIA <sup>1</sup><br>VOYXACT <sup>1</sup>                                                  | <a href="#">Use PA Form# 20420</a><br><br>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 ( <b>in step-order</b> ) 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.<br><br>PA required to confirm FDA-approved indication. <b>Vanrafia</b> 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.<br>Additional criteria for all:<br>• Diagnosis of primary immunoglobulin A nephropathy (IgAN) AND<br>• 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<br>• 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<br>• Prescribed in consultation or by a nephrologist |

| CATEGORY                              | Coverage Indicator                                                           | PREFERRED DRUGS                                                                                                                                                                                           | Coverage Indicator                                                                                                             | Step Order | NON-PREFERRED DRUGS<br>PA Required                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                              | Criteria                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|---------------------------------------|------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| ANEMIA - ALPHA or BETA THALASSEMIA    |                                                                              |                                                                                                                                                                                                           | MC<br>MC<br>MC                                                                                                                 |            | AQVESME <sup>1</sup><br>REBLOZYL<br>ZYNTEGLO                                                                                                                                                                                                                                                                                                                                                           | <a href="#">Use PA Form# 20420</a><br>1. Clinical PA is required to establish diagnosis and medical necessity.               | Aqvesme requires a diagnosis of anemia in adults with alpha or beta thalassemia, AND prescribed in consultation with or by a hematologist.<br>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.<br>Zynteglo is indicated for the treatment of adult and pediatric patients with $\beta$ -thalassemia who require regular red blood cell (RBC) transfusions. |
| HEMATOLOGIC DISORDER TREATMENT AGENTS |                                                                              |                                                                                                                                                                                                           | MC/DEL<br>MC<br>MC                                                                                                             |            | CABLIVI<br>WAYRILZ <sup>1</sup><br>TAVALISSE                                                                                                                                                                                                                                                                                                                                                           | <a href="#">Use PA Form# 20420</a><br>1. Clinical PA is required to establish diagnosis and medical necessity.               | Tavalisse is recommended for patients at risk of bleeding when one line of therapy (steroids, IVIG, splenectomy) has failed.<br>Cablivi is recommended for the treatment of adult patients with acquired thrombotic thrombocytopenic purpura (aTTP), in combination with plasma exchange and immunosuppressive therapy.<br>Wayrilz: Baseline platelet count is less than 30,000/mcL and prescribed in consultation or by a hematologist/oncologist.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| COMPLEMENT RECEPTOR ANTAGONIST        |                                                                              |                                                                                                                                                                                                           | MC                                                                                                                             |            | TA/NEOS                                                                                                                                                                                                                                                                                                                                                                                                | <a href="#">Use PA Form# 20420</a>                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| WHIM SYNDROME AGENTS                  |                                                                              |                                                                                                                                                                                                           | MC                                                                                                                             |            | XOLREMDI                                                                                                                                                                                                                                                                                                                                                                                               | <a href="#">Use PA Form# 20420</a>                                                                                           | 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<br>MC                                                                 | AMICAR<br>AMINOCAPROIC ACID                                                                                                                                                                               | MC<br>MC<br>MC                                                                                                                 |            | FIBRYGA<br>FESILTY <sup>1</sup><br>RIASTAP                                                                                                                                                                                                                                                                                                                                                             | <a href="#">Use PA Form# 20420</a><br>1. Clinical Prior Authorization required to establish diagnosis and medical necessity. | 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.<br>Fesilty: For the treatment of acute bleeding episodes in pediatric and adult patients with congenital fibrinogen deficiency, including hypo- or afibrinogenemia. Fesilty is not indicated for dysfibrinogenemia.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| ACUTE HEPATIC PORPHYRIA (AHP)         |                                                                              |                                                                                                                                                                                                           |                                                                                                                                |            |                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| ACUTE HEPATIC PORPHYRIA (AHP)         |                                                                              |                                                                                                                                                                                                           | MC                                                                                                                             |            | GIVLAARI                                                                                                                                                                                                                                                                                                                                                                                               | <a href="#">Use PA Form# 20420</a>                                                                                           | Givlaari is indicated for the treatment of adults with acute hepatic porphyria (AHP).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| PYRUVATE KINASE DEFICIENCY AGENTS     |                                                                              |                                                                                                                                                                                                           |                                                                                                                                |            |                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| PYRUVATE KINASE DEFICIENCY AGENTS     |                                                                              |                                                                                                                                                                                                           | MC                                                                                                                             |            | PYRUKYND <sup>1</sup>                                                                                                                                                                                                                                                                                                                                                                                  | <a href="#">Use PA Form# 20420</a><br>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                     |                                                                              |                                                                                                                                                                                                           |                                                                                                                                |            |                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| OP. - ANTIBIOTICS                     | MC<br>MC<br>MC/DEL<br>MC<br>MC/DEL<br>MC<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL | AK-SPORE OINT<br>BACITRACIN/NEOMYCIN/POLYM<br>BACITRACIN/POLYMYXIN B OINT<br>CHLOROPTIC SOLN<br>ERYTHROMYCIN OINT<br>NEOSPORIN SOLN<br>POLYSPORIN<br>TRIMETHOPRIM SULFATE/POLY<br>TOBRAMYCIN SULFATE SOLN | MC<br>MC<br>MC<br>MC<br>MC<br>MC/DEL<br>MC/DEL<br>MC<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC<br>MC/DEL<br>MC/DEL<br>MC |            | AK-POLY-BAC OINT<br>AK-SULF OINT<br>AK-TOB SOLN<br>AZASITE<br>BACITRACIN OINT<br>BLEPH-10 SOLN<br>GATIFLOXACIN DROPS<br>GENTAMICIN SULFATE<br>GENTAK<br>ILOTYCIN OINT<br>LEVOFLOXACIN DROPS<br>NEOMYCIN/BACI/POLYM OINT<br>NEOMYCIN/POLYMYXIN/GRAMIC<br>NEOSPORIN OINT<br>OCUSULF-10 SOLN<br>OCUTRICIN SOLN<br>POLYTRIM DROPS<br>SULFACETAMIDE SODIUM DROPS<br>SULFACETAMIDE SODIUM OINT<br>TERAK OINT | <a href="#">Use PA Form# 20420</a>                                                                                           | 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. - ANTI-PARASITIC                  |                                                                              |                                                                                                                                                                                                           | MC                                                                                                                             |            | XDEMIVY <sup>1</sup>                                                                                                                                                                                                                                                                                                                                                                                   | <a href="#">Use PA Form# 20420</a><br>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                                                                                                                                                                                                 |                                                                                                                                |            |                                                                                                                                                                                                                                                                                                                                                                                                        | <a href="#">Use PA Form# 20420</a>                                                                                           | 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<br>MC/DEL<br>MC/DEL<br>MC/DEL                                         | CILOXAN OINT<br>CIPROFLOXACIN SOL 0.3%<br>OFLOXACIN<br>QUIXIN SOLN                                                                                                                                        | MC/DEL<br>MC/DEL<br>MC<br>MC                                                                                                   |            | BESIVANCE<br>CILOXAN SOLN<br>OCUFLOX SOLN                                                                                                                                                                                                                                                                                                                                                              | <a href="#">Use PA Form# 20420</a>                                                                                           | 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-4TH GENERATION       | MC/DEL                                                                       | MOXIFLOXACIN 0.5% SOLN<br>(Generic Vigamox)                                                                                                                                                               | MC                                                                                                                             |            | ZYMAXID                                                                                                                                                                                                                                                                                                                                                                                                | <a href="#">Use PA Form# 20420</a>                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| OP. - ARTIFICIAL TEARS AND LUBRICANTS | MC/DEL<br>MC/DEL<br>MC<br>MC<br>MC/DEL<br>MC<br>MC<br>MC                     | ARTIFICIAL TEARS OINT<br>ARTIFICIAL TEARS SOLN<br>CELLUVISC SOLN<br>EYE LUBRICANT OINT<br>GENTEAL<br>LIQUITEARS SOLN<br>MAJOR TEARS SOLN<br>PURALUBE OINT                                                 | MC/DEL<br>MC<br>MC<br>MC<br>MC/DEL<br>MC/DEL<br>MC<br>MC                                                                       |            | ARTIFICIAL TEARS SOLN OP<br>BION TEARS SOLN<br>DRY EYES OINT<br>DURATEARS OINT<br>HYPO TEARS<br>ISOPTO TEARS SOLN<br>LACRI-LUBE<br>LUBRIFRESH P.M. OINT                                                                                                                                                                                                                                                | <a href="#">Use PA Form# 20420</a><br>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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |

| CATEGORY                                     | Coverage Indicator                                                                                                                                                                         | PREFERRED DRUGS                                                                                                                                                                                                                                                                                                                                                                                  | Coverage Indicator                                                                                                                                                                               | Step Order                                          | NON-PREFERRED DRUGS<br>PA Required                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                 | Criteria                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|----------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                              | MC<br>MC<br>MC<br>MC                                                                                                                                                                       | PURALUBE TEARS SOLN<br>REFRESH SOLN OP<br>REFRESH PLUS SOLN <sup>1</sup><br>REFRESH PM OINT                                                                                                                                                                                                                                                                                                      | MC<br>MC/DEL<br>MC<br>MC<br>MC<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC                                                                                                                         |                                                     | MURINE SOLN<br>MUROCEL SOLN<br>NATURE'S TEARS SOLN<br>REFRESH SOLN<br>REFRESH TEARS SOLN <sup>1</sup><br>TEARGEN SOLN<br>TEARISOL SOLN<br>TEARS NATURELE<br>TEARS PURE SOLN<br>TEARS RENEWED OINT<br>THERATEARS SOLN<br>V-R ARTIFICIAL TEARS SOLN                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| OP. - BETA - BLOCKERS                        | MC/DEL<br>MC/DEL<br>MC/DEL                                                                                                                                                                 | BETOPTIC-S SUSP<br>CARTEOLOL HCL SOLN<br>LEVOBUNOLOL HCL SOLN<br>METIPRANOLOL SOLN                                                                                                                                                                                                                                                                                                               | MC<br>MC/DEL<br>MC<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL                                                                                                                                           |                                                     | BETAGAN SOLN<br>BETAXOLOL HCL SOLN<br>ISTALOL<br>OCUPRESS SOLN<br>OPTIPRANOLOL SOLN<br>TIMOPTIC SOLN<br>TIMOLOL DROP<br>TIMOLOL SOL-GEL<br>TIMOPTIC-XE SOLG                                                                                                                                                                                                                                                                                                                                                                                         | <a href="#">Use PA Form# 20420</a>                                                                                                                                                                              | 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. - ANTH-INFLAMMATORY / STEROIDS<br>OPHTH. | MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC<br>MC<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL | AK-SPORE HC OINT<br>ALREX SUSP<br>DEXAMETH SOD PHOS SOLN<br>FLUOROMETHOLONE SUSP<br>FML DROPS SUSP 1%<br>FML FORTE SUSP<br>FML S.O.P. OINT<br>LOTEMAX OINT<br>LOTEMAX GEL<br>LOTEMAX SUSP<br>NEO/POLY/DEXAMETH OINT<br>NEO/POLY/DEXAMETH SUSP<br>PRED-G SUSP<br>PRED FORTE SUSP 1%<br>PRED MILD SUSP<br>PREDNISOLONE<br>TOBRADEX OINT<br>TOBREX OINT<br>SULFACETAMIDE/PREDNISOLONE<br>ZYLET SUSP | MC<br>MC<br>MC<br>MC<br>MC<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL |                                                     | AK-TROL SUSP<br>BAC/POLYNEOMY/HC OINT<br>BLEPHAMIDE S.O.P. OINT<br>BLEPHAMIDE SUSP<br>BROMDAY<br>EFLONE SUSP<br>FLAREX SUSP<br>FLUOR-OP SUSP<br>ILUVIEN IMPLANT<br>INVELTYS<br>LOTEMAX SM DROPS GEL 0.38%<br>MAXITROL OPTH OINT 0.1%<br>NEO/POLY/BAC/HC OINT<br>NEOM/POLY/DEX OPTH OINT 0.1%<br>OMNIPRED DROPS SUSP<br>OZURDEX<br>PRED-G S.O.P. OINT<br>PREDNISOLONE SODIUM PHOSPHATE SOL<br>RETISERT IMPLANT<br>SULFACET SODIPRED SOLN<br>TRIESENCE VIAL<br>TOBRADEX ST<br>TOBRAMYCIN SUSP DEXAMETHASONE<br>VASOCIDIN SOLN<br>VEXOL SUSP<br>XIPERE | <a href="#">Use PA Form# 20420</a>                                                                                                                                                                              | 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. - PROSTAGLANDINS                         | MC/DEL<br>MC<br>MC/DEL<br>MC/DEL                                                                                                                                                           | LATANOPROST SOL 0.005%<br>LUMIGAN SOLN<br>ROCKLATAN<br>TRAVATAN-Z                                                                                                                                                                                                                                                                                                                                | MC/DEL<br>MC/DEL<br>MC<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC                                                                                                   | 7<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8<br>8 | ZIOPTAN<br>BIMATOPROST 0.03% DROPS<br>DURYSTA<br>IYUZEH<br>RESCULA <sup>1,2,3</sup><br>TRAVATAN SOLN<br>TRAVOPROST<br>VYZULTA<br>XALATAN SOLN <sup>1</sup><br>XELPROS<br>ZOLYMBUS                                                                                                                                                                                                                                                                                                                                                                   | <a href="#">Use PA Form# 20420</a><br><br>1. All preferred must be tried.<br>2. Dosing limits apply. see Dosing Consolidation List.<br>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, <b>in step-order</b> , 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. - CYCLOPLEGICS                           | MC<br>MC/DEL<br>MC/DEL<br>MC/DEL                                                                                                                                                           | AK-PENTOLATE SOLN<br>ATROPINE SULFATE<br>CYCLOPENTOLATE HCL SOLN<br>ISOPTO HYOSCINE SOLN                                                                                                                                                                                                                                                                                                         | MC/DEL<br>MC<br>MC/DEL<br>MC                                                                                                                                                                     |                                                     | CYCLOGYL SOLN<br>ISOPTO ATROPINE SOLN<br>ISOPTO HOMATROPINE SOLN<br>MUROCOLL-2 SOLN                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <a href="#">Use PA Form# 20420</a>                                                                                                                                                                              | 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. - MIOTICS - DIRECT ACTING                | MC/DEL<br>MC<br>MC<br>MC/DEL<br>MC/DEL                                                                                                                                                     | ISOPTO CARBACHOL SOLN<br>ISOPTO CARPINE SOLN<br>PILOCAR SOLN<br>PILOCARPINE HCL SOLN<br>PILOPINE HS GEL                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                  |                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <a href="#">Use PA Form# 20420</a>                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |

| CATEGORY                                      | Coverage Indicator                                                   | PREFERRED DRUGS                                                                                                                                                   | Coverage Indicator                                                                                                                                                             | Step Order | NON-PREFERRED DRUGS<br>PA Required                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                | Criteria                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|-----------------------------------------------|----------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| OP. - SELECTIVE ALPHA ADRENERGIC AGONISTS     | MC<br>MC<br>MC<br>MC/DEL<br>MC/DEL                                   | ALPHAGAN SOLN<br>ALPHAGAN P 0.1% SOLN<br>ALPHAGAN P 0.15% SOLN<br>BRIMONIDINE DROPS 0.2 %<br>SIMBRINZA                                                            | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL                                                                                                                                 |            | BRIMONIDINE TARTRATE DROPS 0.15 %<br>LOPIDINE SOLN                                                                                                                                                                                                                                                                                                                                              | <a href="#">Use PA Form# 20420.</a>                                                                                                                                                                                            | 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. - ANTI-ALLERGICS                          | MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL | AZELASTINE HCL DROPS<br>BEPREVE<br>CROMOLYN SODIUM DROPS<br>KETOTIFEN FUMARATE DROPS<br>LASTACAFT<br>OLOPATADINE HCL 0.1%<br>OLOPATADINE HCL 0.2%<br>ZADITOR SOLN | MC<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC<br>MC/DEL                                                                                                                         |            | ALOCRIL SOLN<br>ALOMIDE SOLN<br>EMADINE SOLN<br>OPTICROM SOLN<br>PATANOL SOLN<br>ZERVIAE<br>EPINASTINE                                                                                                                                                                                                                                                                                          | <a href="#">Use PA Form# 20420.</a>                                                                                                                                                                                            | 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| OP. ANTI-ALLERGICS- MASTCELL STABILIZER CLASS |                                                                      |                                                                                                                                                                   | MC/DEL                                                                                                                                                                         |            | ALAMAST SOLN                                                                                                                                                                                                                                                                                                                                                                                    | <a href="#">Use PA Form# 20420.</a>                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| OP. - CARBONIC ANHYDRASE INHIBITORS/COMBO     | MC/DEL<br>MC<br>MC/DEL<br>MC/DEL                                     | AZOPT SUSP<br>COMBIGAN<br>DORZOLAMIDE<br>DORZOLAMIDE/TIMOLOL                                                                                                      | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL                                                                                                                                           |            | COSOPT SOLN PF                                                                                                                                                                                                                                                                                                                                                                                  | <a href="#">Use PA Form# 20420.</a>                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| OP. - NSAID'S                                 | MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL       | ACULAR SOLN <sup>1</sup><br>DUREZOL<br>KETOROLAC OPTH 0.4%<br>KETOROLAC OPTH 0.5%<br>MAXIDEX SUSP<br>NEVANAC<br>PREDNISOLONE DROPS                                | MC<br>MC<br>MC/DEL<br>MC<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC<br>MC<br>MC                                                                       |            | ACULAR LS <sup>1</sup><br>ACUVAIL <sup>1</sup><br>BROMFENAC<br>BROMSITE <sup>1</sup><br>BYQLLOVI<br>DEXAMETHASONE DROPS<br>DICLOFENAC OPTH 0.1%<br>FLURBIPROFEN SODIUM SOLN<br>ILEVRO<br>LOTEMAX SM DROPS GEL 0.38%<br>PROLENSA<br>OCUFEN SOLN <sup>1</sup><br>XIBROM <sup>1</sup><br>VOLTAREN SOLN <sup>1</sup>                                                                                | <a href="#">Use PA Form# 20420.</a><br><br>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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| OP. - OF INTEREST                             | MC<br>MC<br>MC<br>MC                                                 | EYSUVIS <sup>2</sup><br>LUCENTIS<br>RESTASIS DROPPERETTE<br>XIIDRA                                                                                                | MC<br>MC<br>MC<br>MC/DEL<br>MC<br>MC<br>MC<br>MC<br>MC<br>MC<br>MC<br>MC/DEL<br>MC<br>MC/DEL<br>MC<br>MC<br>MC/DEL<br>MC<br>MC<br>MC<br>MC<br>MC<br>MC<br>MC<br>MC<br>MC<br>MC |            | BYOOVIZ<br>BEOVU<br>BOTOX SOLR<br>CEQUA<br>CIMERLI<br>CYCLOSPORINE DROPPERETTE<br>CYSTADROPS <sup>1</sup><br>CYSTARAN <sup>1</sup><br>EYLEA<br>EYLEA HD <sup>1</sup><br>IZERVAY <sup>1</sup><br>LUCENTIS<br>LUXTURNA<br>MIEBO<br>NUFYMC0<br>OXERVATE<br>PAVBLU<br>RESTASIS MULTIDOSE DROPS<br>SUSVIMO<br>SYFOVRE<br>TRYPTYR <sup>1</sup><br>TYRVAYA<br>VABYSMO<br>VERKAZIA<br>VEVYE<br>YESAFILI | <a href="#">Use PA Form# 20420.</a><br><br>1. PA required to confirm appropriate diagnosis and clinical parameters for use.<br>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.<br><br><b>Beovu</b> is non-preferred and indicated for the treatment of Neovascular (wet) Age-Related Macular Degeneration (AMD)<br><b>Eylea</b> 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)<br><br><b>Luxturna</b> 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).<br><br><b>Miebo</b> is non-preferred and is indicated for the treatment of the signs and symptoms of dry eye disease (DED).<br><br><b>Oxervate</b> is non-preferred and is indicated for the treatment of neurotrophic keratitis.<br><br><b>Pavblu</b> : Clinical rationale for why eylea cannot be used<br><br><b>Syfovre</b> is non-preferred and is indicated for the treatment of geographic atrophy (GA) secondary to age-related macular degeneration (AMD).<br><br><b>Vevye</b> - Must fail adequate trials of multi agents from artificial tears and lubricant category and a preferred cyclosporine alternative. |
| DERMATOLOGICAL                                |                                                                      |                                                                                                                                                                   |                                                                                                                                                                                |            |                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| ISOTRETINION, ACNE                            | MC<br>MC<br>MC<br>MC                                                 | AMNESTEEM <sup>1</sup><br>CLARAVIS <sup>1</sup><br>MYORISAN <sup>1</sup><br>ZENATANE <sup>1</sup>                                                                 | MC<br>MC<br>MC<br>MC                                                                                                                                                           |            | ABSORICA<br>ABSORICA LD                                                                                                                                                                                                                                                                                                                                                                         | <a href="#">Use PA Form# 20420.</a><br><br>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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| TOPICAL - ACNE PREPARATIONS                   | MC/DEL<br>MC<br>MC/DEL                                               | ERY/BENZOYL GEL<br>ERYDERM SOLN<br>ERYTHROMYCIN GEL                                                                                                               | MC/DEL<br>MC<br>MC                                                                                                                                                             |            | AKLIEF <sup>5</sup><br>ALTINAC CREA<br>AVITA CREA                                                                                                                                                                                                                                                                                                                                               | <a href="#">Use PA Form# 10220</a> for Brand Name requests<br><br><a href="#">Use PA Form# 20420</a> for all other requests                                                                                                    | 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<br>PA Required                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                           | Criteria                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
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|                             | <b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC</b><br><b>MC</b><br><b>MC</b><br><b>MC/DEL</b><br><b>MC</b>                                                                                                                                                                                                                                                                         | ERYTHROMYCIN SOLN<br>EVOCLIN<br>ISOTRETINOIN<br>METRONIDAZOLE GEL <sup>2</sup><br>METRONIDAZOLE LOTN <sup>2</sup><br>TRETINOLIN .025%, .01% GEL <sup>1</sup><br>TRETINOLIN CREA <sup>1,2</sup>                                                                                                                                                                                                                 | <b>MC</b><br><b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC</b><br><b>MC</b><br><b>MC/DEL</b><br><b>MC</b><br><b>MC</b><br><b>MC</b><br><b>MC</b><br><b>MC</b><br><b>MC</b><br><b>MC</b><br><b>MC</b><br><b>MC</b><br><b>MC</b><br><b>MC</b><br><b>MC</b><br><b>MC</b><br><b>MC/DEL</b><br><b>MC</b><br><b>MC/DEL</b><br><b>MC</b><br><b>MC/DEL</b><br><b>MC</b><br><b>MC</b><br><b>MC</b><br><b>MC</b><br><b>MC</b><br><b>MC</b><br><b>MC</b> |            | BENZAC<br>BENZACLIN GEL <sup>3</sup><br>BENZAGEL-10 GEL<br>BENZEFOAM<br>BREVOXYL<br>CLEOCIN-T <sup>2</sup><br>CLINAC BPO GEL<br>CLINETS SWAB<br>DESQUAM-E GEL<br>DESQUAM-X<br>DIFFERIN 0.3% GEL<br>DIFFERIN<br>EMGEL GEL<br>EPIDUO<br>EPSOLAY<br>ERYCETTE PADS<br>FINEVIN CREA<br>METROCREAM CREA <sup>2</sup><br>METROGEL GEL <sup>2</sup><br>METROLOTION LOTN <sup>2</sup><br>NEOBENZ MICRO<br>PLUXDA<br>RHOFAGE<br>SODIUM SULFACET/SULF LOTN<br>SOOLANTRA <sup>4</sup><br>TRIAZ<br>TWYNEO<br>VELTIN<br>WINLEVI <sup>5</sup><br>ZENCIA WASH<br>ZETACET | 1. Users 24 or under, PA will not be required.<br>2. Dosing limits allow one package per month. Refer to Dose Consolidation List.<br>3. Only available if component ingredients are unavailable.<br>4. Dosing limits apply, see Dosing Consolidation List.<br>5. Not approved for use in children <12 years of age.<br>6. For the treatment of patients ≥ 9 years of age. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| TOPICAL - ATOPIC DERMATITIS | <b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC</b><br><b>MC</b><br><b>MC/DEL</b><br><b>MC</b><br><b>MC</b><br><b>MC</b>                                                                                                                                                                                                                                           | PIMECROLIMUS<br>PROTOPIC OINT<br>TACROLIMUS OINT<br>ADBRY <sup>2,4</sup><br>EBGLYSS <sup>2,3,4</sup><br>DUPIXENT <sup>1,2,4</sup><br>EUCRISA <sup>2,4</sup><br>OPZELURA <sup>2,3,4</sup><br>RINVOO <sup>5</sup>                                                                                                                                                                                                | <b>MC</b><br><b>MC/DEL</b><br><b>MC</b>                                                                                                                                                                                                                                                                                                                                                                                                 |            | <b>ANZUPGO</b><br>CIBINQO<br>NEMLUVIO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <a href="#">Use PA Form# 20420</a><br>1. Avoid live vaccines if treated with Dupixent.<br>2. Clinical PA required.<br>3. For the treatment of patients ≥ 12 years of age.<br>4. Preferred only after a trial and failure of TCI.<br>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.<br><b>ANZUPGO:</b> use of Anzupgo in combination with other JAK inhibitors or potent immunosuppressants is not recommended.                                   |
| TOPICAL - ANTIBIOTIC        | <b>MC</b><br><b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC/DEL</b>                                                                                                                                                                                                                                                                                                                | BACIT/NEOMYCIN/POLYM OINT<br>BACITRACIN OINT<br>GENTAMICIN SULFATE<br>MUPIROCI OINT <sup>1</sup>                                                                                                                                                                                                                                                                                                               | <b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC</b>                                                                                                                                                                                                                                                                                                                                                                            |            | CENTANY OINT 2% <sup>1</sup><br>MUPIROCI CREA <sup>1</sup><br>TRIPLE ANTIBIOTIC OINT<br>XEPI                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <a href="#">Use PA Form# 20420</a><br>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.                                                                                                                                                                                                                                                                                                                                                               |
| TOPICAL - ANTIFUNGALS       | <b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC</b><br><b>MC</b><br><b>MC/DEL</b><br><b>MC</b><br><b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC</b><br><b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC</b><br><b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC</b> | BETAMETHASONE CLOTRIMAZOLE CREA<br>BETAMETHASONE CLOTRIMAZOLE LOT<br>CICLOPIROX 0.77 CREA<br>CICLOPIROX 0.77 SUSP<br>CLOTRIMAZOLE<br>ECONAZOLE NITRATE CREA<br>KETOCONAZOLE CREA<br>KETOCONAZOLE SHAM<br>LOPROX 1.0 CREA<br>LOPROX 1.0 LOTN<br>LOPROX GEL<br>LOPROX TS LOTN<br>MICONAZOLE NITRATE CREA<br>MYCO-TRIACET II CREA<br>NYSTATIN<br>NYSTATIN/TRIAMCINOLONE CREA<br>NYSTOP POWD<br>TRI-STATIN II CREA | <b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC</b><br><b>MC</b><br><b>MC/DEL</b><br><b>MC</b><br><b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC</b><br><b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC</b><br><b>MC/DEL</b><br><b>MC/DEL</b><br><b>MC/DEL</b>                                                         |            | CICLOPIROX SOLN<br>EXELDERM<br>FUNGIZONE CREA<br>HYDROCORT/10DOOQ CREA<br>KERYDIN <sup>1</sup><br>LOPROX 0.77 LOTN<br>LOPROX 0.77 CREA<br>LOPROX 0.77 SUSP<br>LOPROX SHAMPOO SHAM<br>LOTRIMIN<br>LOTRISONE LOT<br>LOTRISONE CREA<br>MENTAX CREA<br>MYCOGEN II CREA<br>NAFTIN<br>NIZORAL SHAM<br>NYSTATIN/TRIAMCINOLONE OINT<br>NYSTAT-RX POWD<br>OXISTAT<br>PENLAC NAIL LACQUER SOLN                                                                                                                                                                     | <a href="#">Use PA Form# 10120</a><br>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.<br><b>Keydin:</b> Verify prior trials and failures or intolerance of preferred treatments, including both topical and oral agents<br><b>DDI: Ketoconazole</b> 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. |
| TOPICAL - ANTIPRURITICS     | <b>MC</b>                                                                                                                                                                                                                                                                                                                                                                   | ZONALON CREA                                                                                                                                                                                                                                                                                                                                                                                                   | <b>MC</b><br><b>MC</b>                                                                                                                                                                                                                                                                                                                                                                                                                  |            | KORSUVA<br>PRUDOXIN CREA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <a href="#">Use PA Form# 20420</a>                                                                                                                                                                                                                                                                                                                                        | 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<br>PA Required                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                               | Criteria                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|---------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| TOPICAL - ANTIPSORIATICS  | MC/DEL                                                                                 | CALCIP/BETAMETHASONE SUS                                                                                                                                                                                     | MC/DEL<br><br>MC<br>MC<br>MC/DEL<br>MC<br>MC<br>MC                                                 |            | TACLONEX <sup>1</sup><br>ENSTILAR<br>OXSORALEN ULTRA CAPS <sup>1</sup><br>PSORiatec CREA <sup>1</sup><br>SORIATANE CK KIT <sup>1</sup><br>VECTICAL <sup>1</sup><br>VTAMA<br>ZORYVE                                                                     | <a href="#">Use PA Form# 20420.</a><br><br>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.                                                                                                                                 |
| TOPICAL - ANTISEBORRHEICS | MC/DEL                                                                                 | SELENIUM SULFIDE SHAM                                                                                                                                                                                        | MC<br>MC<br>MC                                                                                     |            | CARMOL SCALP TREATMENT KIT<br>ZNP BAR<br>ZORYVE FOAM                                                                                                                                                                                                   | <a href="#">Use PA Form# 20420.</a>                                                                                                                                                                                                                                                                                           | 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.<br><br><b>Zoryve Foam:</b> For the treatment of seborrheic dermatitis in adult and pediatric patients 9 years of age and older. |
| TOPICAL - ANTIVIRALS      |                                                                                        |                                                                                                                                                                                                              | MC/DEL<br>MC<br>MC                                                                                 |            | DENAVIR CREA <sup>1,3</sup><br>YCANTH<br>ZELSUVIM <sup>4</sup>                                                                                                                                                                                         | <a href="#">Use PA Form# 20420.</a><br><br>1. Must fail oral treatment with <b>Valacyclovir</b> .<br>2. Approvals limited to 1 tube per 180 days.<br>3. Dosing limits apply, see Dosing Consolidation List.<br>4. For the topical treatment of molluscum contagiosum in adult and pediatric patients 1 year of age and older. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| TOPICAL - ANTINEOPLASTICS | MC/DEL                                                                                 | FLUOROURACIL 5% CREA                                                                                                                                                                                         | MC                                                                                                 |            | SOLARAZE GEL                                                                                                                                                                                                                                           | <a href="#">Use PA Form# 20420.</a>                                                                                                                                                                                                                                                                                           | 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<br>MC/DEL<br>MC<br>MC<br>MC/DEL                                                     | FURACIN CREA<br>SILVER SULFADIAZINE CREA<br>SSD AF CREA<br>SSD CREA<br>THERMAZONE CREA                                                                                                                       | MC/DEL                                                                                             |            | SILVADENE CREA                                                                                                                                                                                                                                         | <a href="#">Use PA Form# 20420.</a>                                                                                                                                                                                                                                                                                           | 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 - CORTICOSTEROIDS |                                                                                        | <b>LOW POTENCY</b>                                                                                                                                                                                           |                                                                                                    |            | <b>LOW POTENCY</b>                                                                                                                                                                                                                                     | <a href="#">Use PA Form# 20420.</a>                                                                                                                                                                                                                                                                                           | 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<br>MC/DEL<br>MC<br>MC<br>MC                                                         | DERMA-SMOOTHIE FS BODY<br>HYDROCORTISONE CREA<br>HYDROCORTISONE LOTN<br>HYDROCORTISONE LOTN<br>TEXACORT SOLN                                                                                                 | MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC<br>MC<br>MC<br>MC/DEL                                       |            | ACLOVATE<br>DESONATE GEL<br>FLUCINOLONE ACETONIDE<br>FLUCINOLONE<br>HALOG<br>HYDROCORTISONE POWD<br>LIDA MANTLE HC CREA<br>PROCTOCORT CREA<br>VERDESO                                                                                                  | 1. Dosing limits apply, see Dosing Consolidation List.<br>2. Treatment beyond 4 weeks is not recommended.<br>3. For the treatment of patients ≥ 12 yrs of age.<br>4. For the treatment of patients ≥ 18 yrs of age.                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                           |                                                                                        | <b>MEDIUM POTENCY</b>                                                                                                                                                                                        |                                                                                                    |            | <b>MEDIUM POTENCY</b>                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                           | MC/DEL<br>MC<br>MC<br>MC<br>MC<br>MC<br>MC<br>MC/DEL<br>MC<br>MC<br>MC<br>MC/DEL<br>MC | DESOXIMETASONE 0.05% CREA/GEL<br>FLUTICASONE PROPIONATE CREA/OINT<br>HYDROCORTISONE BUTYRATE<br>HYDROCORTISONE OINT<br>HYDROCORTISONE VALERATE<br>MOMETASONE FUROATE OINT<br>TRIAMCINOLONE ACETONIDE .025-1% | MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC<br>MC/DEL<br>MC<br>MC<br>MC<br>MC/DEL<br>MC |            | BESER LOTION <sup>3</sup><br>CLODERM CREA<br>CORDRAN<br>CUTIVATE CREA / OINT<br>CUTIVATE LOTN<br>DERMATOP<br>ELOCON OINT<br>KENALOG AERS<br>LOCOID<br>LUXIQ FOAM<br>PANDEL CREA<br>TOPICORT<br>TOPICORT LP CREA<br>TOVET FOAM <sup>3</sup><br>WESTCORT |                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                           |                                                                                        | <b>HIGH POTENCY</b>                                                                                                                                                                                          |                                                                                                    |            | <b>HIGH POTENCY</b>                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                           | MC/DEL<br>MC                                                                           | DESONIDE <sup>1</sup><br>TRIAMCINOLONE ACETONIDE .5%                                                                                                                                                         | MC<br>MC<br>MC/DEL                                                                                 |            | AMCINONIDE CREA<br>BETAMETHASONE DIPROPIONATE<br>DESOXIMETASONE 0.25% CREA/OINT                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                           |                                                                                        | <b>VERY HIGH POTENCY</b>                                                                                                                                                                                     |                                                                                                    |            | <b>VERY HIGH POTENCY</b>                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                           | MC/DEL<br>MC/DEL<br>MC                                                                 | AUGMENTED BETA DIP<br>BETAMETHASONE VALERATE<br>DIFLORASONE DIACETATE                                                                                                                                        | MC/DEL<br>MC/DEL<br>MC/DEL                                                                         |            | CLOBETASOL PROPINATE LOTN<br>CLOBETASOL PROPINATE SHAMPOO 0.05%<br>CORMAX<br>DIPROLENE                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |

| CATEGORY                                | Coverage Indicator                                                             | PREFERRED DRUGS                                                                                                                                                                                              | Coverage Indicator                                         | Step Order            | NON-PREFERRED DRUGS<br>PA Required                                                                                                                |                                                                                                                                                                                                        | Criteria                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
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|                                         |                                                                                |                                                                                                                                                                                                              | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC |                       | IMPEKLO <sup>4</sup><br>LEXETTE<br>OLUX FOAM<br>PSORCON<br>PSORCON E<br>SERNIVO SPRAY <sup>2</sup><br>TEMOVATE<br>ULTRAVATE                       |                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|                                         | MC                                                                             | MISCELLANEOUS<br>PROCTO-KIT CREA 1%                                                                                                                                                                          |                                                            |                       |                                                                                                                                                   |                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| TOPICAL - STEROID LOCAL ANESTHETICS     |                                                                                |                                                                                                                                                                                                              | MC                                                         |                       | EPIFOAM FOAM                                                                                                                                      | <a href="#">Use PA Form# 20420</a>                                                                                                                                                                     | 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-SMOOTHES FS SCALP                                                                                                                                                                                      | MC                                                         |                       | CARMOL HC CREA                                                                                                                                    | <a href="#">Use PA Form# 20420</a>                                                                                                                                                                     | 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<br>MC<br>MC                                                             | AMMONIUM LACTATE CREA <sup>1</sup><br>AMMONIUM LACTATE LOTN 12% <sup>1</sup><br>VITAMIN A & D MEDICATED OINT                                                                                                 | MC<br>MC<br>MC<br>MC<br>MC                                 |                       | LAC-HYDRIN CREA <sup>1</sup><br>LAC-HYDRIN LOTN 12%<br>MEDERMA GEL<br>MIMYX<br>RENOVA CREA                                                        | <a href="#">Use PA Form# 20420</a><br>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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| TOPICAL - ENZYMES / KERATOLYTICS / UREA |                                                                                |                                                                                                                                                                                                              | MC<br>MC<br>MC                                             |                       | CARMOL 40 CREA<br>SALEX CREA<br>SALEX LOTN                                                                                                        | <a href="#">Use PA Form# 20420</a>                                                                                                                                                                     | 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.<br><b>Ziox, Panafil and Papain</b> products have been removed from the PDL due to FDA safety concerns regarding drugs containing Papain.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| TOPICAL - GENITAL WARTS                 | MC/DEL                                                                         | IMQUIMOD 5% <sup>2</sup>                                                                                                                                                                                     | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC                     | 5<br>8<br>8<br>8<br>8 | PODOFILOX SOLN<br>CONDYLOX <sup>1</sup><br>ALDARA <sup>1</sup><br>PICATO<br>VEREGEN <sup>1</sup>                                                  | <a href="#">Use PA Form# 20420</a><br>1. <b>Non-preferred products must be used in specified order.</b><br>2. Dosing limits still apply, see Dose Consolidation List.                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| TOPICAL - LOCAL ANESTHETICS             | MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL | AF CAPSICUM OLEORESIN CREA<br>CAPSAICIN CREA<br>CAPSAICIN PATCH<br>DIBUCAINE OINT<br>ELA-MAX <sup>1</sup><br>LIDOCAINE/PRILOCAINE CREA <sup>1</sup><br>LIDOCAINE CREAM<br>LIDOCAINE GEL<br>LIDOCAINE PTCH 5% | MC/DEL<br>MC/DEL<br>MC<br>MC<br>MC<br>MC<br>MC/DEL         |                       | EMLA PADS<br>EMLA CREA<br>LIDA MANTLE CREA<br>PONTOCAINE SOLN<br>SYNERA<br>ZOSTRIX<br>ZTLIDO <sup>2</sup>                                         | <a href="#">Use PA Form# 20420</a><br>1. <b>Lidocaine/Prilocaine cream and Ela-Max</b> products require PA for users over 18 yrs of age.<br>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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| TOPICAL - DEPIGMENTING AGENTS           |                                                                                |                                                                                                                                                                                                              | MC<br>MC<br>MC<br>MC/DEL<br>MC/DEL<br>MC<br>MC<br>MC       |                       | ALUSTRA CREA<br>EPIQUIN MICRO<br>GLYQUIN CREA<br>HYDROQUINONE CREA<br>HYDROQUINONE/SUNSCREENS<br>SOLAQUIN FORTE CREA<br>TRI-LUMA CREA<br>ELDOQUIN | <a href="#">Use PA Form# 20420</a>                                                                                                                                                                     | 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| TOPICAL - SCABICIDES AND PEDICULICIDES  | MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC                                         | ACTICIN CREA<br>LICE KILLING SHAM<br>LICE TREATMENT CREME RINS LIQD<br>PERMETHRIN LOTN<br>NATROBA <sup>1</sup>                                                                                               | MC<br>MC<br>MC/DEL<br>MC<br>MC<br>MC/DEL                   |                       | ELIMITE CREA<br>EURAX<br>LINDANE<br>MALATHION<br>OVIDE LOTN<br>SPINOSAD SUSP                                                                      | <a href="#">Use PA Form# 20420</a><br>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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| TOPICAL - WOUND / DECUBITUS CARE        |                                                                                |                                                                                                                                                                                                              | MC<br>MC<br>MC                                             |                       | FILSUEVZ<br>REGRANEX GEL<br>VYJUEVK                                                                                                               | <a href="#">Use PA Form# 20420</a>                                                                                                                                                                     | 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. <b>Regranex</b> will be approved for diabetic patients in good control (HgbA1c <8), who are not smoking, with a stage III or IV WOUN AND NPUAP lower extremity diabetic ulcer and with an adequate blood supply (Tc p 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.<br><br><b>Accuzyme and Ethezyme</b> products have been removed from the PDL due to FDA concerns regarding drugs containing papain.<br><b>Filsuvez:</b> 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.<br><b>Vyjuvek:</b> 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. |

| CATEGORY                              | Coverage Indicator                                                                                                                   | PREFERRED DRUGS                                                                                                                                                                                                                                                                                                                                                                         | Coverage Indicator                                                                                                   | Step Order | NON-PREFERRED DRUGS<br>PA Required                                                                                                    |                                                                                                                                          | Criteria                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|---------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|------------|---------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| TOPICAL - ASTRINGENTS / PROTECTANTS   |                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                         | MC<br>MC<br>MC                                                                                                       |            | MOISTURIN DRY SKIN CREA<br>PROSHIELD PLUS SKIN PROTE CREA<br>SURGILUBE GEL                                                            | <a href="#">Use PA Form# 20420.</a><br>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.                                                      |
| HYPERHIDROSIS THERAPY - AXILLARY      | MC                                                                                                                                   | XERAC AC SOLN                                                                                                                                                                                                                                                                                                                                                                           | MC                                                                                                                   |            | SOFDRA <sup>1,2</sup>                                                                                                                 | 1. Clinical PA is required to establish diagnosis and medical necessity.<br>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.<br><br><b>Sofdra:</b> prescribed by a dermatologist. |
| TOPICAL - ANTISEPTICS / DISINFECTANTS | MC/DEL                                                                                                                               | POVIDONE-IODINE SOLN                                                                                                                                                                                                                                                                                                                                                                    | MC<br>MC<br>MC<br>MC                                                                                                 |            | BETADINE OINT<br>FORMALYDE-10 AERS<br>IODOSORB<br>LAZERFORMALYDE SOLUTION SOLN                                                        | <a href="#">Use PA Form# 20420.</a>                                                                                                      | 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.                                                      |
| MISCELLANEOUS EYE                     |                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                      |            |                                                                                                                                       |                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| OP. - EYE                             | MC<br>MC<br>MC<br>MC<br>MC<br>MC/DEL                                                                                                 | AK-DILATE SOLN<br>EYE WASH SOLN<br>NAPHAZOLINE HCL SOLN<br>PHENYLEPHRINE HCL SOLN<br>PONTOCAINE SOLN<br>SODIUM CHLORIDE                                                                                                                                                                                                                                                                 | MC<br>MC/DEL<br>MC                                                                                                   |            | LENS PLUS REWETTING DROPS<br>MURO 128<br>NEO-SYNEPHRINE SOLN                                                                          | <a href="#">Use PA Form# 20420.</a>                                                                                                      | 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.                                                      |
| MISCELLANEOUS EAR                     |                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                      |            |                                                                                                                                       |                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| EAR                                   | MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC<br>MC<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL | A/B OTIC SOLN<br>ACETASOL SOLN<br>ACETASOL HC SOLN<br>ACETIC ACID<br>ACETIC ACID/HYDROCORTISON<br>ALLERGEN SOLN<br>CARBAMIDE PEROXIDE 6.5% OTIC SOLN<br>CIPRO HC SUSP<br>CORTISPORIN-TC SUSP<br>CORTOMYCIN<br>COLY-MYCIN-S SUSP<br>EAR DROPS SOLN<br>EAR DROPS RX SOLN<br>EAR WAX REMOVAL DROPS<br>FLUOCINOLONE ACETONIDE OIL DROPS 0.01%<br>NEOMYCIN/POLYMYXINH<br>OFLOXACIN 0.3% OTIC | MC<br>MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC<br>MC<br>MC<br>MC<br>MC<br>MC<br>MC<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL |            | ANTIBIOTIC EAR SOLN<br>ANTIBIOTIC EAR SUSP<br>CIPRODEX<br>CIPROFLOXACIN HCL<br>DEBROX SOLN<br>DERMOTIC<br>FLOXIN<br>OTIPRIO<br>OTOVEL | <a href="#">Use PA Form# 20420.</a>                                                                                                      | 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.                                                      |
| MOUTH ANTISEPTICS                     |                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                      |            |                                                                                                                                       |                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| MOUTH ANTI-INFECTIVES                 | MC<br>MC/DEL                                                                                                                         | NILSTAT SUSP<br>NYSTATIN SUSP                                                                                                                                                                                                                                                                                                                                                           | MC<br>MC                                                                                                             |            | MYCELEX TROC<br>ORAVIG                                                                                                                | <a href="#">Use PA Form# 20420.</a>                                                                                                      | 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.                                                      |
| MOUTH ANTISEPTICS                     | MC/DEL<br>MC/DEL<br>MC<br>MC                                                                                                         | CHLORHEXIDINE GLUCONATE<br>LIDOCAINE VISCOUS SOLN<br>TRIAMCINOLONE IN ORABASE PSTE<br>TRIAMCINOLONE ORADENT PSTE                                                                                                                                                                                                                                                                        | MC<br>MC<br>MC<br>MC                                                                                                 |            | APHTHASOL PSTE <sup>1</sup><br>PERIOGARD SOLN <sup>1</sup><br>TRIAMCINOLONE ACETONIDE PSTE <sup>1</sup>                               | <a href="#">Use PA Form# 20420.</a><br>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.                                                      |
| DENTAL PRODUCTS                       |                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                      |            |                                                                                                                                       |                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| DENTAL PRODUCTS                       | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC                                                             | ETHEDENT CREA<br>GEL-KAM CONC<br>GEL-KAM GEL 0.4%<br>PHOS FLUR SOLN<br>SF 5000 PLUS CREA<br>SF GEL<br>STANNOUS FLUORIDE ORAL RI CONC                                                                                                                                                                                                                                                    | MC/MC<br>MC/DEL<br>MC/DEL<br>MC<br>MC<br>MC<br>MC                                                                    |            | APF GEL<br>DENTAGEL GEL<br>PHOS-FLUR GEL<br>THERA-FLUR-N GEL                                                                          | <a href="#">Use PA Form# 20420.</a>                                                                                                      | 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.                                                      |
| ARTIFICIAL SALIVA/STIMULANTS          |                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                      |            |                                                                                                                                       |                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| ARTIFICIAL SALIVA/<br>STIMULANTS      | MC                                                                                                                                   | SALIVA SUBSTITUTE SOLN                                                                                                                                                                                                                                                                                                                                                                  | MC<br>MC<br>MC                                                                                                       |            | EVOXAC CAPS<br>RADIACARE SOLR<br>SALAGEN TABS                                                                                         | <a href="#">Use PA Form# 20420.</a>                                                                                                      | 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.                                                      |
| MISCELLANEOUS ANORECTAL               |                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                      |            |                                                                                                                                       |                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| ANORECTAL - MISC.                     | MC<br>MC<br>MC/DEL<br>MC/DEL                                                                                                         | CORTENEMA ENEM<br>ELA-MAX 5 CREA<br>PROCTOSOL HC CREA<br>PROCTOZONE-HC CREA                                                                                                                                                                                                                                                                                                             | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC                                                                                     |            | CORTIFOAM FOAM<br>PROCTOFOAM HC FOAM<br>PROCTO-KIT CREA 2.5%<br>RECTIV OINT                                                           | <a href="#">Use PA Form# 20420.</a>                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |

| CATEGORY                                           | Coverage Indicator                                                     | PREFERRED DRUGS                                                                                                                                                                                                                                                                     | Coverage Indicator                                                                                           | Step Order  | NON-PREFERRED DRUGS<br>PA Required                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Criteria                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|----------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|-------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| T-CELL ACTIVATION INHIBITOR                        |                                                                        |                                                                                                                                                                                                                                                                                     |                                                                                                              |             |                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| PSORIASIS BIOLOGICALS                              | MC<br>MC<br>MC<br>MC<br>MC<br>MC/DEL<br>MC<br>MC<br>MC/DEL<br>MC<br>MC | ADALIMUMAB-FKJP <sup>5,7</sup><br>ENBREL <sup>1,5</sup><br>ENBREL SURECLICK <sup>1</sup><br>HUMIRA <sup>1,5</sup><br>OTEZLA<br>PYZCHIVA <sup>5,7</sup><br>SELARSDI <sup>5,7</sup><br>SIMLANDI <sup>5</sup><br>SKYRIZI <sup>6</sup><br>TALTZ <sup>2</sup><br>TREMIFYA <sup>5,7</sup> | MC<br>MC/DEL<br>MC<br>MC/DEL<br>MC<br>MC/DEL<br>MC<br>MC<br>MC/DEL<br>MC<br>MC<br>MC<br>MC<br>MC<br>MC<br>MC |             | AMJEVITA<br>BIMZELX <sup>3</sup><br>COSENTYX <sup>4</sup><br>CYLTEZO<br>HADLIMA<br>HULIO<br>HYRIMOZ<br>ICOTYDE<br>ILUMYA <sup>3</sup><br>IMULDOSA<br>OTEZLA XR <sup>3,4</sup><br>OTULFI<br>SOTYKTU<br>SPEVIGO<br>STARJEMZA<br>STELARA<br>STEQEYMA<br>YESINTEK<br>YUFLYMA<br>YUSIMRY | <a href="#">Use PA Form# 20910.</a><br>1. Dosing limits apply, see Dosage Consolidation List.<br>2. Clinical PA required and will be preferred for the indication of plaque psoriasis, psoriatic arthritis and ankylosing spondylitis.<br>3. For the treatment of adults with moderate-to-severe plaque psoriasis who are candidates for systemic therapy or phototherapy.<br>4. Please see Criteria section.<br>5. Will not require a PA if at least one systemic drug such as methotrexate, cyclosporine, methoxsalen or acitretin is in members drug profile.<br>6. Clinical PA required and will be preferred for the indication of plaque psoriasis, psoriatic arthritis, Crohn's disease and ulcerative colitis.<br>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.<br><b>Cosentyx</b> approvals for 300mg dose(s) must use "300DOSE" package (containing 2 x 150mg pens or syringes).<br><b>Taltz</b> : It is recommended to assess for TB infection prior to starting treatment with <b>Taltz</b> .<br><b>Stelara</b> will require using preferred trial of <b>Skyrizi</b> if unable please provide clinical rational as why inappropriate. |
| ALTERNATIVE MEDICINES                              |                                                                        |                                                                                                                                                                                                                                                                                     |                                                                                                              |             |                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| ALTERNATIVE MEDICINES                              | MC<br>MC                                                               | DIMETHYL SULFOXIDE SOLN<br>MELATONIN                                                                                                                                                                                                                                                | MC/DEL                                                                                                       |             | CO-ENZYME Q-10                                                                                                                                                                                                                                                                      | <a href="#">Use PA Form# 20420.</a>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| ULTRA-RARE DISEASE AGENTS                          |                                                                        |                                                                                                                                                                                                                                                                                     |                                                                                                              |             |                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| ULTRA-RARE DISEASE AGENTS                          |                                                                        |                                                                                                                                                                                                                                                                                     | MC<br>MC<br>MC<br>MC                                                                                         |             | FORZINITY <sup>1</sup><br><b>IMCIVREE</b> <sup>1</sup><br><b>KYGEVVI</b> <sup>1</sup><br><b>LOARGYS</b> <sup>1</sup><br><b>YARTEMLEA</b> <sup>1</sup>                                                                                                                               | <a href="#">Use PA Form# 20420.</a><br>1. Clinical PA required for appropriate diagnosis and clinical parameters.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <b>IMCIVREE</b> : Clinical PA required for acquired hypothalamic obesity in patients 4 years and older, or BBS or genetically confirmed POMC, PCSK1, or LEPR deficiency in patients 2 years and older. Genetic variants must be pathogenic, likely pathogenic, or VUS. Not indicated for benign or likely benign variants, other obesity syndromes, or general polygenic obesity.                                                                                                                                                                                                                                                                                                                                                                                                        |
| CHELATING AGENTS                                   |                                                                        |                                                                                                                                                                                                                                                                                     |                                                                                                              |             |                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| CHELATING AGENTS                                   |                                                                        |                                                                                                                                                                                                                                                                                     | MC<br>MC/DEL<br>MC                                                                                           | 8<br>8<br>8 | CLOVIQUE<br>DEPEN TITRATABS TABS<br>EXJADE <sup>1</sup>                                                                                                                                                                                                                             | <a href="#">Use PA Form# 20420.</a><br>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 <b>Exjade</b> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved ( <b>in step order</b> ), 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.<br><b>Clovique</b> should be used when continued treatment with penicillamine is no longer possible because of intolerable or life endangering side effects.                                                                                                                                                                                     |
| ANTILEPTIC                                         |                                                                        |                                                                                                                                                                                                                                                                                     |                                                                                                              |             |                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| ANTILEPTIC                                         |                                                                        |                                                                                                                                                                                                                                                                                     | MC                                                                                                           |             | THALOMID CAPS <sup>1</sup>                                                                                                                                                                                                                                                          | <a href="#">Use PA Form# 20420.</a><br>1. All PA requests for 150mg dosing will require use of <b>Thalomid</b> 100mg and 50mg capsules.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Approved for indications of leprosy, treatment-resistant multiple myeloma and AIDS.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| ANTINEOPLASTIC AGENTS                              |                                                                        |                                                                                                                                                                                                                                                                                     |                                                                                                              |             |                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| ANTINEOPLASTIC AGENTS - ANTIANDROGENS              | MC/DEL                                                                 | BICALUTAMIDE                                                                                                                                                                                                                                                                        | MC/DEL                                                                                                       |             | CASODEX                                                                                                                                                                                                                                                                             | <a href="#">Use PA Form# 20420.</a>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| ANTINEOPLASTIC AGENTS- LHRH ANALOGS                | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL                                   | LUPRON DEPOTSYPHINGKIT <sup>1</sup><br>LUPRON DEPOT- PED KIT(1-month) <sup>1</sup><br>LUPRON DEPOT-PED SYRINGEKIT (3-month)<br>TRIPTODUR VIAL                                                                                                                                       | MC/DEL<br>MC/DEL<br>MC/DEL<br>MC                                                                             |             | FIRMAGON <sup>2</sup><br>SUPPRELIN LA (IMPLANT) KIT<br>TRELSTAR<br>VANTAS <sup>2</sup>                                                                                                                                                                                              | <a href="#">Use PA Form# 20420.</a><br>1. Dosing limits apply, please refer to Dosage Consolidation List.<br>2. PA required to confirm FDA approved indication.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| ANTINEOPLASTIC AGENTS - TYROSINE KINASE INHIBITORS |                                                                        |                                                                                                                                                                                                                                                                                     | MC<br>MC/DEL<br>MC                                                                                           |             | SPRYCEL <sup>1</sup><br>TYKERB <sup>2</sup><br>GLEEVEC <sup>1</sup>                                                                                                                                                                                                                 | <a href="#">Use PA Form# 20420.</a><br>1. Verification of diagnosis is required.<br>2. PA required to confirm FDA approved indication and to monitor for potential drug-drug interactions.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| ANTINEOPLASTICS-MISCELLANEOUS                      | MC<br>MC/DEL<br>MC/DEL                                                 | AMIFOSTINE<br>MERCAPTOPYRINE<br>OXALIPLATIN                                                                                                                                                                                                                                         | MC<br>MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC/DEL                                                             |             | DOCEFREZ<br>ELOXATIN<br>ETHYOL<br>LEUPROLIDE<br>PURINETHOL<br>ZOLINZA                                                                                                                                                                                                               | <a href="#">Use PA Form# 20420.</a>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| ANTINEOPLASTICS- MONOCLONAL ANTIBODIES             | MC/DEL                                                                 | TRAZIMERA                                                                                                                                                                                                                                                                           | MC/DEL<br>MC/DEL<br>MC<br>MC/DEL<br>MC<br>MC<br>MC/DEL                                                       |             | ENHERTU<br>HERCEPTIN<br>HERCESSI<br>HERZUMA<br>KANJINTI<br>OGIVRI<br>ONTRUZANT                                                                                                                                                                                                      | <a href="#">Use PA Form# 20420.</a>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |

| CATEGORY | Coverage Indicator | PREFERRED DRUGS   | Coverage Indicator | Step Order | NON-PREFERRED DRUGS<br>PA Required | Criteria                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
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| CANCER   |                    |                   |                    |            |                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| CANCER   | MC                 | ALIMTA            | MC                 |            | ABECMA                             | <p><a href="#">Use PA Form# 20420</a></p> <p>1. PA required to confirm appropriate diagnosis and testing.</p> <p>2. Avoid CYP3A drug interaction.</p> <p>3. Clinical PA required for appropriate diagnosis.</p> <p>4. Re-approval will require documentation of response without disease progression and tolerance to treatment.</p> <p>5. Dosing limits apply, see Dosage Consolidation List.</p> <p>6. Max daily dose of 300mg.</p> <p>7. Monitor liver enzymes periodically and stop treatment upon Grade 3 or higher elevation of liver enzymes approved indication.</p> <p>8. For patients ≥ 12 years of age.</p> <p>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.</p> <p>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 also be evaluated for clinical appropriateness. The standard for the appropriate indication will include the FDA label as well as current NCCN guidelines.</p> <p><b>Scemblix</b> 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).</p> |
|          | MC/DEL             | ANASTROZOLE TABS  | MC                 |            | AKEEGA                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|          | MC                 | ERBITUX           | MC                 |            | ALECENSA                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|          | MC                 | IMATINIB MESYLATE | MC/DEL             |            | ALIQUOPA <sup>3</sup>              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|          | MC/DEL             | LETROZOLE         | MC                 |            | ALUNBRIG <sup>1</sup>              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|          | MC                 | RUXIENCE          | MC                 |            | ALYMSYS                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|          | MC/DEL             | VIDAZA            | MC/DEL             |            | ARIMIDEX                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|          | MC                 | ZIRABEV           | MC                 |            | AUCATZYL                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|          |                    |                   | MC                 |            | AUGTYRO                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|          |                    |                   | MC                 |            | AVMAPKI-FAKZYNJA                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|          |                    |                   | MC                 |            | AYVAKIT                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|          |                    |                   | MC/DEL             |            | AVASTIN                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|          |                    |                   | MC/DEL             |            | BALVERSA                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|          |                    |                   | MC                 |            | BAVENCIO <sup>1,8</sup>            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|          |                    |                   | MC                 |            | BEIZRAY                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|          |                    |                   | MC/DEL             |            | BENDEKA <sup>3</sup>               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|          |                    |                   | MC/DEL             |            | BESPONSA <sup>3</sup>              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|          |                    |                   | MC                 |            | BESREMI <sup>1</sup>               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|          |                    |                   | MC                 |            | BIZENGRI                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|          |                    |                   | MC                 |            | BLNREP                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|          |                    |                   | MC/DEL             |            | BOSULIF                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|          |                    |                   | MC/DEL             |            | BRAFTOVI <sup>1</sup>              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|          |                    |                   | MC                 |            | BREYANZI                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|          |                    |                   | MC                 |            | BRUKINSA                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|          |                    |                   | MC                 |            | CABOMETYX <sup>3</sup>             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|          |                    |                   | MC                 |            | CAMCEVI                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|          |                    |                   | MC/DEL             |            | CALQUENCE <sup>3</sup>             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|          |                    |                   | MC                 |            | CAVHANZA                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|          |                    |                   | MC                 |            | COMETRIQ <sup>3,4,5</sup>          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|          |                    |                   | MC                 |            | COTELLIC                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|          |                    |                   | MC/DEL             |            | COPIKTRA                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|          |                    |                   | MC                 |            | DANZITEN                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|          |                    |                   | MC                 |            | DARZALEX <sup>3</sup>              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|          |                    |                   | MC/DEL             |            | DATROWAY                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|          |                    |                   | MC/DEL             |            | DAURISMO                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|          |                    |                   | MC/DEL             |            | ELREXFIO                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|          |                    |                   | MC/DEL             |            | EMPLICITI(IV) <sup>8</sup>         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|          |                    |                   | 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 <sup>4,5</sup>            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|          |                    |                   | MC                 |            | GOMEKLI                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|          |                    |                   | MC                 |            | GRAFAPEX                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|          |                    |                   | MC/DEL             |            | HERNEXEOS                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|          |                    |                   | MC/DEL             |            | HYRNUO                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|          |                    |                   | MC/DEL             |            | IBRANCE                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|          |                    |                   | MC                 |            | IBTROZI                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|          |                    |                   | MC                 |            | ICLUSIG <sup>3</sup>               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|          |                    |                   | MC/DEL             |            | IDHIFA <sup>3</sup>                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|          |                    |                   | MC                 |            | IMBRUVICA                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|          |                    |                   | MC                 |            | IMDELLTRA                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|          |                    |                   | MC/DEL             |            | IMFINZI                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|          |                    |                   | MC/DEL             |            | IMJUDO                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|          |                    |                   | MC                 |            | IMKELDI                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|          |                    |                   | MC                 |            | IMLYGIC                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|          |                    |                   | MC                 |            | INLURIYO                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|          |                    |                   | MC/DEL             |            | INLYTA                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|          |                    |                   | MC/DEL             |            | INREBIC                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |

| CATEGORY | Coverage<br>Indicator | PREFERRED DRUGS | Coverage<br>Indicator | Step Order | NON-PREFERRED DRUGS<br>PA Required |  | Criteria |
|----------|-----------------------|-----------------|-----------------------|------------|------------------------------------|--|----------|
|          |                       |                 | MC                    |            | INQOVI                             |  |          |
|          |                       |                 | MC                    |            | ITOVEBI                            |  |          |
|          |                       |                 | MC                    |            | IWILFIN                            |  |          |
|          |                       |                 | MC                    |            | JAKAFI                             |  |          |
|          |                       |                 | MC                    |            | JAYPIRCA <sup>1,2</sup>            |  |          |
|          |                       |                 | MC                    |            | JEMPERLI                           |  |          |
|          |                       |                 | MC                    |            | JOBEVNE                            |  |          |
|          |                       |                 | MC/DEL                |            | KEYTRUDA <sup>1</sup>              |  |          |
|          |                       |                 | MC                    |            | KEYTRUDA QLEX                      |  |          |
|          |                       |                 | MC                    |            | KIMMTRAK                           |  |          |
|          |                       |                 | MC                    |            | KISOALI <sup>1</sup>               |  |          |
|          |                       |                 | MC                    |            | KOMZIFTI                           |  |          |
|          |                       |                 | MC/DEL                |            | KOSELUGO                           |  |          |
|          |                       |                 | MC                    |            | KRAZATI <sup>3</sup>               |  |          |
|          |                       |                 | MC                    |            | KYMRIAH <sup>3,9</sup>             |  |          |
|          |                       |                 | MC                    |            | KYPROLIS <sup>1</sup>              |  |          |
|          |                       |                 | MC                    |            | LARTRUVO <sup>1</sup>              |  |          |
|          |                       |                 | MC                    |            | LAZCLUZE                           |  |          |
|          |                       |                 | MC                    |            | LENVIMA                            |  |          |
|          |                       |                 | MC/DEL                |            | LIBTAYO <sup>1</sup>               |  |          |
|          |                       |                 | MC                    |            | LIFYORLI                           |  |          |
|          |                       |                 | MC                    |            | LONSURF                            |  |          |
|          |                       |                 | MC/DEL                |            | LORBRENA                           |  |          |
|          |                       |                 | MC                    |            | LOQTORZI                           |  |          |
|          |                       |                 | MC                    |            | LUMAKRAS                           |  |          |
|          |                       |                 | MC/DEL                |            | LUMOXITI <sup>1</sup>              |  |          |
|          |                       |                 | MC                    |            | LUNSUMIO <sup>1</sup>              |  |          |
|          |                       |                 | MC                    |            | LYNOZYFIC                          |  |          |
|          |                       |                 | MC                    |            | LYNPARZA <sup>1</sup>              |  |          |
|          |                       |                 | MC                    |            | LYTGOBI                            |  |          |
|          |                       |                 | MC                    |            | NEXAVAR <sup>1</sup>               |  |          |
|          |                       |                 | MC                    |            | NERLYNX <sup>3</sup>               |  |          |
|          |                       |                 | MC                    |            | NINLARO(PO)                        |  |          |
|          |                       |                 | MC/DEL                |            | NUBEQA                             |  |          |
|          |                       |                 | MC                    |            | MARGENZA                           |  |          |
|          |                       |                 | MC/DEL                |            | MEKINIST <sup>3,4</sup>            |  |          |
|          |                       |                 | MC/DEL                |            | MEKTOVI <sup>1</sup>               |  |          |
|          |                       |                 | MC                    |            | MODEYSO                            |  |          |
|          |                       |                 | MC                    |            | MONJUVI                            |  |          |
|          |                       |                 | MC/DEL                |            | MYLOTARG <sup>3</sup>              |  |          |
|          |                       |                 | MC/DEL                |            | MVASI                              |  |          |
|          |                       |                 | MC                    |            | ODOMZO <sup>1,2,5</sup>            |  |          |
|          |                       |                 | MC                    |            | OGSIVEO                            |  |          |
|          |                       |                 | MC                    |            | OJEMDA                             |  |          |
|          |                       |                 | MC                    |            | OJJAARA                            |  |          |
|          |                       |                 | MC                    |            | OMISIRGE                           |  |          |
|          |                       |                 | MC                    |            | ONUREG                             |  |          |
|          |                       |                 | MC/DEL                |            | OPDIVO <sup>1</sup>                |  |          |
|          |                       |                 | MC                    |            | OPDIVO QVANTIG                     |  |          |
|          |                       |                 | MC                    |            | OPDUALAG                           |  |          |
|          |                       |                 | MC                    |            | ORGOVYX                            |  |          |
|          |                       |                 | MC                    |            | ORSERDU <sup>2,3</sup>             |  |          |
|          |                       |                 | MC                    |            | PADCEV                             |  |          |
|          |                       |                 | MC                    |            | PEMAZYRE                           |  |          |
|          |                       |                 | MC                    |            | PEPAXTO                            |  |          |
|          |                       |                 | MC                    |            | PHESGO                             |  |          |
|          |                       |                 | MC                    |            | PHYRAGO                            |  |          |
|          |                       |                 | MC/DEL                |            | PIQRAY                             |  |          |
|          |                       |                 | MC                    |            | POLIVY                             |  |          |
|          |                       |                 | MC                    |            | POMALYST                           |  |          |
|          |                       |                 | MC                    |            | PORTRAZZA <sup>3</sup>             |  |          |
|          |                       |                 | MC                    |            | QINLOCK                            |  |          |
|          |                       |                 | MC                    |            | RETEVMO                            |  |          |
|          |                       |                 | MC                    |            | REVUFORJ                           |  |          |
|          |                       |                 | MC/DEL                |            | ROMVIMZA                           |  |          |
|          |                       |                 | MC                    |            | REZLIDHIA                          |  |          |
|          |                       |                 | MC/DEL                |            | ROZLYTREK                          |  |          |

| CATEGORY | Coverage<br>Indicator | PREFERRED DRUGS | Coverage<br>Indicator | Step Order | NON-PREFERRED DRUGS<br>PA Required | Criteria |
|----------|-----------------------|-----------------|-----------------------|------------|------------------------------------|----------|
|          |                       |                 | MC                    |            | RUBRACA                            |          |
|          |                       |                 | MC                    |            | RITUXAN                            |          |
|          |                       |                 | MC                    |            | RYBREVA NT                         |          |
|          |                       |                 | MC                    |            | RYDAPT                             |          |
|          |                       |                 | MC                    |            | RYLAZE                             |          |
|          |                       |                 | MC                    |            | RYTELO                             |          |
|          |                       |                 | MC/DEL                |            | SARCLISA                           |          |
|          |                       |                 | MC                    |            | SCEMBLIX <sup>1</sup>              |          |
|          |                       |                 | MC/DEL                |            | STIVARGA                           |          |
|          |                       |                 | MC/DEL                |            | SUTENT <sup>1,2</sup>              |          |
|          |                       |                 | MC/DEL                |            | SYLATRON                           |          |
|          |                       |                 | MC                    |            | TABRECTA                           |          |
|          |                       |                 | MC                    |            | TALVEY                             |          |
|          |                       |                 | MC/DEL                |            | TAFINLAR <sup>3,4,5,6</sup>        |          |
|          |                       |                 | MC                    |            | TAZVERIK                           |          |
|          |                       |                 | MC/DEL                |            | TALZENNA <sup>1</sup>              |          |
|          |                       |                 | MC/DEL                |            | TAGRISSO                           |          |
|          |                       |                 | MC                    |            | TECARTUS                           |          |
|          |                       |                 | MC                    |            | TECELRA                            |          |
|          |                       |                 | MC                    |            | TECENTRIQ <sup>1</sup>             |          |
|          |                       |                 | MC                    |            | TECENTRIQ HYBREZA                  |          |
|          |                       |                 | MC                    |            | TEPMETKO                           |          |
|          |                       |                 | MC                    |            | TEVIMBRA                           |          |
|          |                       |                 | MC/DEL                |            | TIBSOVO <sup>1</sup>               |          |
|          |                       |                 | MC                    |            | TIVDAK                             |          |
|          |                       |                 | MC                    |            | TRODELVY                           |          |
|          |                       |                 | MC                    |            | TRUSELTIQ                          |          |
|          |                       |                 | MC/DEL                |            | TRUXIMA                            |          |
|          |                       |                 | MC/DEL                |            | TRUOAP                             |          |
|          |                       |                 | MC                    |            | TUKYSA                             |          |
|          |                       |                 | MC                    |            | UKONIQ                             |          |
|          |                       |                 | MC/DEL                |            | VANFLYTA                           |          |
|          |                       |                 | MC                    |            | VEGZELMA                           |          |
|          |                       |                 | MC                    |            | VENCLEXTA <sup>3</sup>             |          |
|          |                       |                 | MC                    |            | VEPPANU                            |          |
|          |                       |                 | MC                    |            | VERZENIO <sup>3</sup>              |          |
|          |                       |                 | MC/DEL                |            | VITRAKVI                           |          |
|          |                       |                 | MC/DEL                |            | VIZIMPRO <sup>1</sup>              |          |
|          |                       |                 | 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 <sup>3</sup>              |          |
|          |                       |                 | MC                    |            | YULITHIRA                          |          |
|          |                       |                 | MC/DEL                |            | ZALTRAP                            |          |
|          |                       |                 | MC                    |            | ZEJULA <sup>1</sup>                |          |
|          |                       |                 | MC/DEL                |            | ZELBORAF                           |          |
|          |                       |                 | MC                    |            | ZEPZELCA                           |          |
|          |                       |                 | MC                    |            | ZIHERA                             |          |
|          |                       |                 | MC                    |            | ZYDELIG                            |          |
|          |                       |                 | MC/DEL                |            | ZYKADIA                            |          |
|          |                       |                 | MC                    |            | ZYNLONTA                           |          |
|          |                       |                 | MC                    |            | ZYNYZ <sup>1</sup>                 |          |
|          |                       |                 | MC                    |            | ZYTIGA                             |          |

| CATEGORY                                                                                                                                                                                                                                     | Coverage Indicator                                   | PREFERRED DRUGS                                                                                                                                 | Coverage Indicator                                                 | Step Order | NON-PREFERRED DRUGS<br>PA Required                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                            | Criteria                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| IMMUNOSUPPRESSANTS                                                                                                                                                                                                                           |                                                      |                                                                                                                                                 |                                                                    |            |                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| IMMUNOSUPPRESSANTS                                                                                                                                                                                                                           | MC<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL<br>MC/DEL | GENGRAF CAPS<br>MYCOPHENOLATE <sup>3</sup><br>MYCOPHENOLIC ACID TAB DR <sup>3</sup><br>NEORAL SOL<br>SANDIMMUNE<br>TACROLIMUS CAPS <sup>3</sup> | MC/DEL<br>MC/DEL<br>MC<br>MC<br>MC<br>MC/DEL<br>MC<br>MC<br>MC/DEL |            | CELLCEPT<br>CYCLOSPORINE CAPS<br>CYCLOSPORINE SOL. MODIFIED<br>ENVARUSUS XR<br>MYFORTIC TAB DR<br>MYHIBBIN <sup>2</sup><br>NEORAL CAP<br>PROGRAF CAPS<br>REZUROCK <sup>1</sup><br>ZORTRESS | <a href="#">Use PA Form# 20420.</a><br>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.<br>2. Clinical PA is required.<br>3. 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.<br><br><b>Myhibbin:</b> 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.<br><b>DDI:</b> All preferred immunosuppressants will require clinical PA for patients over 60 that are currently on fluoroquinolone therapy.<br><b>DDI:</b> 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).<br><b>DDI:</b> Cyclosporine will require prior authorization when used with livalo. |
| IMMUNOSUPPRESSANTS- Misc.                                                                                                                                                                                                                    |                                                      |                                                                                                                                                 | MC                                                                 |            | HYFTOR <sup>1,2</sup>                                                                                                                                                                      | <a href="#">Use PA Form# 20420.</a><br>1. For the treatment of patients ≥ 6 years of age.<br>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<br>MC/DEL                                         | AZASAN TABS<br>AZATHIOPRINE TABS                                                                                                                | MC/DEL                                                             |            | IMURAN TABS                                                                                                                                                                                | <a href="#">Use PA Form# 20420.</a>                                                                                                                                                                                                                                                                                        | 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| K REMOVING RESINS                                                                                                                                                                                                                            |                                                      |                                                                                                                                                 |                                                                    |            |                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| K REMOVING RESINS                                                                                                                                                                                                                            | MC/DEL<br>MC/DEL                                     | LOKELMA<br>SODIUM POLYSTYRENE SULFON                                                                                                            | MC/DEL<br>MC/DEL<br>MC                                             |            | SPS SUSP<br>SPS 30GM/120ML ENEMA SUSP<br>VELTASSA                                                                                                                                          | <a href="#">Use PA Form# 20420.</a>                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| 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 10/1/2026

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.

| Drug Name                   | PREFERRED         |                |            |
|-----------------------------|-------------------|----------------|------------|
|                             | 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      |
| ARIPIRAZOLE                 | 2MG               | 2              | 180/90     |
| ARIPIRAZOLE                 | 5MG               | 2              | 180/90     |
| ARIPIRAZOLE                 | 10MG              | 2              | 180/90     |
| ARIPIRAZOLE                 | 15MG              | 2              | 180/90     |
| ARIPIRAZOLE                 | 20MG              | 1.5            | 135/90     |
| ARIPIRAZOLE                 | 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     | 1 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      |
| BENAZEPI/HCTZ               | 5-6.25            | 1              | 35/35      |
| BENAZEPI/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     |

| Drug Name             | NON-PREFERRED |                   |            |
|-----------------------|---------------|-------------------|------------|
|                       | 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      |

# PDL DOSAGE CONSOLIDATION LIST - **EFFECTIVE 10/1/2026**

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.

| Drug Name          | PREFERRED     |               |            |
|--------------------|---------------|---------------|------------|
|                    | 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     |
| 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     |
| GEODON             | 20MG          | 2             | 70/35      |

| Drug Name             | NON-PREFERRED |                   |                   |
|-----------------------|---------------|-------------------|-------------------|
|                       | 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             |

# PDL DOSAGE CONSOLIDATION LIST - EFFECTIVE 10/1/2026

Tabs / Caps / Patches: Quantities in Units

Sprays / Inhalers / Nebulizers: Quantities in GM, ML, or MCG

Injectibles: Quantities in ML

Multi-Dose Vial: MDV

| Drug Name                | PREFERRED     |                |                 |
|--------------------------|---------------|----------------|-----------------|
|                          | Strength      | Limit/Day      | Limit/Days      |
| 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 <sup>1</sup>    | 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         | 22.5          | KIT            | 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       |
| MYCOPHENOLATE TAB        | All Strengths | 1              | 105/105         |
| MYCOPHENOLIC ACID TAB DR | All Strengths | 1              | 105/105         |

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

| Drug Name              | NON-PREFERRED |            |               |
|------------------------|---------------|------------|---------------|
|                        | 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 <sup>1</sup> | 10,20,30,40MG | 2          | 70/35         |
| OXYCONTIN <sup>1</sup> | 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 10/1/2026**

Tabs / Caps / Patches: Quantities in Units

Sprays / Inhalers / Nebulizers: Quantities in GM, ML, or MCG

Injectibles: Quantities in ML

Multi-Dose Vial: MDV

| Drug Name                     | PREFERRED     |                |              |
|-------------------------------|---------------|----------------|--------------|
|                               | Strength      | Limit/Day      | Limit/Days   |
| NABUMETONE                    | 500MG         | 2              | 180/90       |
| 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 <sup>2</sup> | 15MG/ML       | 20ML           | 700ML/35     |
| REFRESH PLUS                  |               | 15 ML          | 1 bottle/30  |
| REFRESH PLUS                  |               | 30 ML          | 2 bottles/30 |
| RELPAK                        | 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        |

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

| Drug Name         | NON-PREFERRED |             |              |
|-------------------|---------------|-------------|--------------|
|                   | 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        |

# PDL DOSAGE CONSOLIDATION LIST - EFFECTIVE 10/1/2026

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 |
| SUMATRIPTAN PEN INJ  | All Strengths |                | 12/30      |
| SUMATRIPTAN SYRINGE  | All Strengths |                | 12/30      |
| SUMATRIPTAN TAB      | All Strengths |                | 12/30      |
| SUPRAX               | 400MG         | 1              | 1/7        |
| SYRINGES             |               | 10             | 1000/100   |
| TACROLIMUS CAP       | All Strengths | 1              | 105/105    |
| 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  | 100MG         | 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      |

## 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       |                 |                |               |
|---------------------|-----------------|----------------|---------------|
| 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 <sup>2</sup> | 4MG             | 3              | 90/30         |
| ZOFRAN <sup>2</sup> | 8MG             | 1.5            | 45/30         |
| ZOFRAN <sup>2</sup> | 24MG            | 0.5            | 15/30         |
| ZOFRAN <sup>2</sup> | 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         |

## NON-PREFERRED

1. OXYCONTIN: Available without PA with CA and HO diag.
2. ZOFRAN: Cancer diagnosis with non-daily chemotherapy required.

## **Pain Management Policy**

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.maineicarepdl.org](http://www.maineicarepdl.org). Click on "General Pharmacy Info."

Updated July 1, 2025