

MaineCare PDL

PDL Effective October 1, 2026 - Amended to include GAHT Effective October 9, 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

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.

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

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

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

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

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
ANTI - FUNGALS							
ANTIFUNGALS - ASSORTED	MC/DEL	FLUCONAZOLE ¹	MC/DEL	6	LAMISIL TABS ⁴	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. The other criteria are listed on the Antifungal PA form including the required proof of a non-cosmetic fungal infection. DDI: Any Griseofulvin will now be non-preferred and require prior authorization if it is currently being used in combination with either prevacid, pantoprazole, prilosec, or any currently non preferred PPI. DDI: Sporanox is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for current use with enablex 15mg, vesicare 10mg, prandin, prevacid, pantoprazole, prilosec, or any currently non preferred PPI, due to a significant drug-drug interaction. DDI: Vfend is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for concurrent use with warfarin. DDI: Fluconazole (except 150mg strength) will now be non-preferred and require prior authorization if it is currently being used with glimepiride (amaryl), enablex 15mg, or vesicare 10mg. Diflucan is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for concurrent use with either glimepiride (amaryl), enablex 15mg, or vesicare 10mg. DDI: Fluconazole will require prior authorization if being used in combination with plavix or warfarin. DDI: Ketoconazole will now be non-preferred and require prior authorization if they are currently being used in combination with any of the following medications: prevacid, pantoprazole, plavix, onglyza, enablex 15mg, vesicare 10mg, latuda, cometriq, tafilar or omeprazole. Rezzayo : In patients 18 years of age or older who have limited or no alternative options for the treatment of candidemia and invasive candidiasis.
	MC/DEL	KETOCONAZOLE TABS ⁷	MC/DEL	6	ITRACONAZOLE	See Quantity Limit table.	
	MC/DEL	NYSTATIN	MC	8	BREXAFEMME	Non-preferred products must be used in specified step order.	
	MC/DEL	TERBINAFINE TABS ⁴	MC/DEL	8	CRESEMBA ⁸	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 ⁴	Anti-Fungal PA Form# 10120	
			MC	8	GRIS-PEG TABS	1. QL-1/every 7-day period (150mg only).	
			MC	8	REZZAYO ⁹	2. Sporanox QL 300cc/month with PA. See Quantity Limit table.	
	MC/DEL		MC/DEL	8	SPORANOX SOLN ²	3. Sporanox QL 30/month with PA.	
	MC/DEL		MC/DEL	8	SPORANOX PULSEPAK CAPS ³	4. Quantity limit of one tablet daily. Please see Dosage Consolidation List.	
	MC/DEL		MC/DEL	8	SPORANOX CAPS ²	5. Approved if immuno suppressed/ HIV or if the member has failed a 7-day trial of a preferred antifungal therapy.	
	MC/DEL		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	8	ERAXIS IN ⁶	7. Quantity limits allowing 30-day supply without PA. PA will be required if using > 30 days.	
			MC/DEL	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 ⁵		
			MC/DEL	8	TOLSURA		
			MC/DEL	8	VFEND TABS		
			MC	8	VIVJOA		
ANTI - VIRALS							
ANTIRETROVIRALS - PREP	MC	APRETUDE	MC		TRUVADA ¹	Use PA Form# 20420	DDI: The concomitant use of the following drugs with Descovy is not recommended: tipranavir/ritonavir, St. John's wort, and the antimycobacterials rifabutin, rifampin, or rifapentine.
	MC	DESCOVY ¹				1. Quantity limit of one per day	
	MC	EMTRICITABINE-TENOFOVIR DISOP (ORAL) TAB					
	MC	YEZTUGO					
ANTIRETROVIRALS	MC/DEL	ABACAVIR TABS	MC/DEL		ABACAVIR SOL	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. Fuzeon : Prescriber is either an HIV specialist provider or has consulted with one. Documentation of genotype testing is supplied and shows that there is no other potent, appropriate two or three drug oral regimen available, AND patient has a positive HIV viral load within past 6 months while on his/her current antiretroviral regimen AND the drug will be prescribed with at least two other drugs that are likely to be active based on the genotype testing. DDI: Reyataz requires prior authorization if it is currently being used in combination with either prevacid, pantoprazole, prilosec, or any currently non preferred PPI. DDI: Norvir requires prior authorization if it is currently being used in combination with either enablex 15mg or vesicare 10mg. DDI: Preferred Crixivan caps requires prior authorization if it is currently being used in combination with either enablex 15mg or vesicare 10mg. DDI: Administration with the following drugs: the anticonvulsants carbamazepine, oxcarbazepine, phenobarbital, and phenytoin; the antimycobacterials rifampin and rifapentine; proton pump inhibitors such as dexlansoprazole, esomeprazole, lansoprazole, omeprazole, pantoprazole, rabeprazole; systemic dexamethasone (more than a single dose); and St. John's wort with Odefsey is contraindicated. Stribild : PA required; must provider rationale as to why the member's medical need cannot be met with preferred agents, particularly genvoia or combinations of preferred and agents AND must be antiretroviral treatment-naïve or virologically controlled on current therapy (HIV-1RNA < copies/ml) AND be HBV negative AND not be combined with other anti-retroviral agents. DDI: Tivicay will require prior authorization is used with nevirapine, oxcarbazepine, phenytoin, phenobarbital, carbamazepine, and St. John's wort. DDI: Aatazanavir or Darunavir and the following drugs are contraindicated (due to potential for serious and/or life-threatening events or loss of therapeutic effect): alfuzosin, dronedarone, rifampin, ritonavir, ergotamine, methylethergonine, cisapride, St. John's wort, lovastatin, simvastatin, pimozide, nevirapine, sildenafil (when given as revatio for treatment of PAH), indinavir, triazolam, or PO midazolam will be non-preferred and require prior authorization if it is currently being used in combination with tybost. DDI: Combined P-gp, UGT1A1 and strong CYP3A inhibitors may significantly increase plasma concentrations of Sunlenca. Concomitant administration of Sunlenca with these inhibitors is not recommended. Sunlenca : In combination with other antiretroviral(s) for the treatment of HIV-1 infection in heavily treatment-experienced adults with multidrug resistant HIV-1 infection failing their current antiretroviral regimen due to resistance, intolerance, or safety considerations.
	MC/DEL	ATAZANAVIR	MC/DEL		APTIVUS	1. Quantity limit of one per day	
	MC	BIKTARVY	MC		ATRIPLA ¹	2. Only preferred if Norvir script is in member's profile within the past 30 days of filling Prezista	
	MC	CABENUVA	MC/DEL		CIMDUO		
	MC	COMPLERA ¹	MC/DEL		COMBIVIR TABS		
	MC/DEL	DARUNAVIR ²	MC/DEL		EDURANT	3. Isentress Chewable will only be approved if between the age of 2-12 years old	
	MC/DEL	DELSTRIGO	MC/DEL		FUZEON	4. Clinical PA required	
	MC	DIDANOSINE	MC/DEL		IDVNSO	5. Only preferred for post-exposure prophylaxis	
	MC/DEL	DOVATO	MC/DEL		INTELENCE		
	MC	EFAVIRENZ TAB	MC/DEL		ISENTRESS ³		
	MC/DEL	EFAVIRENZ CAP	MC/DEL		ISENTRESS HD		
	MC	EFAVIRENZ-EMTRICITABINE-TENOFOVIR DF TAB	MC		JULUCA		
	MC	EMTRIVA ¹	MC/DEL		KALETRA		
	MC	EPIVIR SOL	MC/DEL		LAMIVUDINE SOLN		
	MC/DEL	EVOTAZ ¹	MC		NEVIRAPINE		
	MC	GENVOYA ¹⁴	MC/DEL		NORVIR		
	MC/DEL	ISENTRESS 400MG ⁵	MC		PIFELTRO		
	MC/DEL	ISENTRESS CHEW ³	MC		PREZISTA		
	MC/DEL	ISENTRESS POWDER	MC		RETROVIR		
	MC/DEL	LAMIVUDINE TABS	MC/DEL		REYATAZ		
	MC/DEL	LAMIVUDINE/ZIDOVUDINE	MC		SELZENTRY		
	MC/DEL	LOPINAVIR-RITONAVIR SOL	MC		STAVUDINE		
	MC	LOPINAVIR-RITONAVIR TAB	MC/DEL		STRIBILD ¹		
	MC	ODEFSEY ¹	MC/DEL		SYMFI ⁴		
	MC/DEL	PREZCOBIX	MC/DEL		SYMFI LO ⁴		
	MC/DEL	RITONAVIR TAB 100MG	MC/DEL		SYMTOZA		
	MC	RUKOBIA ⁴	MC/DEL		TRIZIVIR TABS		
	MC	SUNLENCA ⁴	MC		VIRACEPT TABS		
	MC	SUSTIVA ¹	MC		VITEKTA		
	MC	TIVICAY	MC/DEL		VIREAD TABS ¹		
MC	TIVICAY PD	MC/DEL		ZIAGEN TABS			
MC	TRIUMEQ ¹	MC/DEL		ZIAGEN SOL			
MC	TROGARZO ⁴	MC/DEL		VIRAMUNE XR			
MC	TYBOST						
MC	VIREAD POW						
MC/DEL	ZIDOVUDINE						

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required	Criteria
CYTO-MEGALOVIRUS AGENTS	MC MC MC/DEL MC/DEL	CIDOFOVIR FOSCARNET SODIUM GANCICLOVIR VALGANCICLOVIR	MC MC MC/DEL MC		VALCYTE TABS FOSCAVIR LIVTENCITY ¹ PREVYMIS	Use PA Form# 20420 1. Must show failure or contraindication to all the following ganciclovir, valganciclovir, cidofovir and foscarnet before Livtency will be approved. Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Prevymis: Documentation that member is high-risk for CMV reactivation as defined by transplant guidelines or that there has been significant myelosuppression by one of the preferred agents. DDI: 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 MC MC MC/DEL	8 8 8 9	FAMCICLOVIR ¹ SITAVIG VALTREX TABS ¹ FAMVIR TABS ¹	Use PA Form# 20420 1. Must fail Valacyclovir before non-preferred products in step order. Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
INFLUENZA AGENTS	MC MC MC/DEL	AMANTADINE CAPS RELENZA DISKHALER AEPB OSELTAMIVIR ¹	MC MC MC/DEL MC MC/DEL	8 8 8 8 8 8	AMANTADINE TABS FLUMIST RIMANTADINE HCL TABS TAMIFLU ¹ TAMIFLU SUS XOFLUZA	Use PA Form# 20420 1. Tamiflu and Osetamivir 10 caps or 60cc's per month. Will be audited for presence of positive influenza tests in patient or family member. Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
IMMUNE SERUMS						
IMMUNE SERUMS	MC	HYPERRHO INJ				
HEPATITIS AGENTS						
HEPATITIS C AGENTS	MC MC MC/DEL MC/DEL MC	SOFOSBUVIR/VELPATASVIR ¹ (Authorized generic labeler 72626 Asegua Therapeutics) MAVYRET ³ PEGASYS KIT ¹ PEGASYS SOLN RIBAVIRIN	MC MC MC MC MC	8 8 8 8 8	EPCLUSA ² HARVONI ² SOVALDI ² VOSEVI ZEPATIER ²	Use PA Form #10700 1. Dosing limits apply, please see dosage consolidation list. 2. Approvals will require clinical PA. Please see the Hepatitis PA form for criteria. 3. PA is not required for simplified treatment regimens. Please see the 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 (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. DDI: Olysio will require a prior authorization if it is currently being used in combination with drugs known to be significant CYP3A4 inhibitors (ketoconazole, itraconazole, clarithromycin, indinavir, nefazodone, nelfinavir, ritonavir, atazanavir, saquinavir and telithromycin).
HEPATITIS AGENTS - MISC.	MC		MC MC		ACTIMMUNE HEPCLUDEX ¹	Use PA Form# 20420 1. Clinical PA required Approved for chronic granulomatous disease, osteopetrosis and idiopathic pulmonary fibrosis. Hepcludex: 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 MC	ENTECAVIR TENOFVIR	MC MC	8 8	BARACLUDE VEMLIDY	Use PA Form# 20420 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Baraclude is indicated for treatment of chronic Hep B virus (HBV) in adults with: evidence of active viral replication AND either evidence of persistent elevation in serum aminotransferases (ALT or AST) or histologically active disease, Patient is 16 years of age or older. Boxed warning: Use not recommended for those co-infected with HIV and HBV who are not also receiving highly active antiretroviral therapy (HAART). Vemlidy remain non-preferred and require prior authorization and be available to those who have evidence of bone loss or renal insufficiency or who are unable to tolerate or who have failed on preferred medications.
RSV PROPHYLAXIS						
RSV PROPHYLAXIS			MC		SYNAGIS ¹	Use PA Form# 30120 1. PA requests may be approved starting at the onset of RSV season for a maximum of 5 doses and a dosing interval not less than 30 days between injections. PA requests will be reviewed starting November of the current calendar year. Synagis dosing authorizations will extend for the recommended number of doses or until the end of epidemic RSV season as defined by CDC - whichever occurs first. Monthly prophylaxis should be discontinued for any infant or young child who experiences a breakthrough RSV hospitalization or if a child receives Nirsevimab (Beyfortus). Please see the criteria listed on the Synagis PA form.
MS TREATMENTS						
MULTIPLE SCLEROSIS - INTERFERONS	MC MC/DEL MC	AVONEX KIT ¹ BETASERON SOLR ¹ REBIF SOLN ¹	MC	8	PLEGRIDY ¹	Use PA Form# 20430 1. Clinical PA is required to establish diagnosis and medical necessity. Non-Preferred drugs must be tried in step-order and failed due to lack of efficacy or intolerable side effects before lower ranked non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
MULTIPLE SCLEROSIS - NON-INTERFERONS	MC MC/DEL MC/DEL MC/DEL MC MC MC	COPAXONE DALFAMPRIDINE ER DIMETHYL FUMARATE CAP FINGOLIMOD CAP ² KESIMPTA ^{2,5} TERIFLUNOMIDE TAB ² TYSABRI ^{1,2}	MC MC MC MC MC/DEL MC/DEL MC/DEL	8 8 8 8 8 8 8	AMPYRA AUBAGIO BAFIERTAM BRIUMVI GILENYA GLATOPIA MAVENCLAD ³	Use PA Form# 20430 1. Provider must be enrolled in the TOUCH Prescribing program, a restricted distribution program. Clinical PA is required to establish diagnosis and medical necessity. 2. Clinical PA is required to establish diagnosis and medical necessity. Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Mavenclad will require multiple trials of preferred agents including mayzent for secondary progressive disease. DDI: Due to significant increases in exposure to siponimod, concomitant use of Mayzent and drugs that cause moderate CYP2C9 and moderate or strong CYP3A4 inhibition is not recommended. Ponvory: Before initiation of Ponvory treatment, assess the following:

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
			MC/DEL MC MC MC/DEL MC MC MC/DEL MC MC	8 8 8 8 8 8 8 8 8	MAYZENT OCREVUS ² OCREVUS ZUNOVO ² PONVORY ² TASCENSO ODT ^{2,4} TECFIDERA TYRUKO VUMERITY 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. 4. For the treatment of patients 10 years of age and older. 5. Approved after single step through preferred drugs.	- Complete Blood Count (CBC) - Obtain a recent (i.e. within the last 6 months) CBC, including lymphocyte count. - Cardiac Evaluation - Obtain an electrocardiogram (ECG) to determine whether pre-existing conduction abnormalities are present. In patients with certain pre-existing conditions, advice from a cardiologist should be sought and first-dose monitoring is recommended. Determine whether patients are taking drugs that could slow heart rate of atrioventricular (AV) conduction. - Liver Function Tests - Obtain recent (i.e. within the last 6 months) transaminase and bilirubin levels. - Ophthalmic Evaluation - Obtain an evaluation of the fundus, including the macula. - Current or prior medications with immune system effects - If patients are taking anti-neoplastic, immunosuppressive, or immuno-modulating therapies, or if there is a history of prior use of these drugs, consider possible unintended additive immunosuppressive effects before starting treatment with Ponvory. - Vaccinations - Test for antibodies to varicella zoster virus (VZV) before starting Ponvory; VZV vaccination of antibody-negative patients is recommended prior to commencing treatment with Ponvory. If live attenuated vaccine immunizations are required, administer at least 1 month prior to initiation of Ponvory. Mayzent for Relapsing forms of MS: multiple trials of preferred agents, including an intravenous MS product. Mayzent for Active secondary progressive disease: prior trials of two preferred agents are required.
MULTIPLE SCLEROSIS - MISC			MC		ZINBRYTA ¹	Use PA Form# 20430. 1. The safety and efficacy of use in children under the age of 17 years have not been established.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ASSORTED NEUROLOGICS							
NEUROLOGICS - FIBROMYALGIA			MC		TONMYA		Trial failure, contra-indication, or intolerance to guideline driven care of at least two agents: amitriptyline, cyclobenzaprine, duloxetine, gabapentin, and pregabalin immediate release
NEUROLOGICS - MISC.	MC MC	BOTOX ^{2,4} DYSPORT ⁴	MC MC MC MC MC/DEL	8 8 8 8 8	DAXXIFY FIRDAPSE ⁵ MYOBLOC ¹ SKYSONA ^{4,6} XEOMIN ²	Use PA Form# 10210 1. Approval will be limited to Cervical Dystonia. 2. Please see botulinum PA form for additional criteria. 4. Clinical PA required. 5. For adult patients who are anti-acetylcholine receptor (AChR) antibody positive. 6. For the treatment of patients between ages 4-17 years of age.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Failed/did not tolerate therapeutic trials of muscle relaxants, unless contraindicated, including but not limited to baclofen, cyclobenzaprine, orphenadrine, skelaxin, and tizanidine. Migraine: Consideration for Botox approvals will only be made after failures of required trials of the following preferred medications: tricyclic or venlafaxine, beta blocker, valproic acid, topiramate. Firdapse is recommended for the treatment of Lambert-Eaton myasthenic syndrome (LEMS) in adults.
NEUROLOGICS- hATTR AGENTS			MC MC MC MC/DEL MC/DEL MC/DEL		AMVUTTRA ¹ ATTRUBY ONPATTRO ¹ TEGSEDI ¹ VYNDAMAX ¹ VYNDAQEL ¹ WAINJUA ¹	Use PA Form# 20420. 1. PA required for appropriate diagnosis.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Certain drugs require specific diagnoses for approval. Tegsedi should be non-preferred and approved for patients for whom other treatments, including Onpatro, have been ineffective. Vyndamax will be considered for the treatment of the cardiomyopathy of wild type or hereditary transthyretin-mediated amyloidosis (ATTR-CM) in adults to reduce cardiovascular mortality and cardiovascular-related hospitalization.
NEUROLOGICS- SMA		GENE			GENE	Use PA Form# 20420.	Itivisma: - Patients with confirmed mutation in survival motor neuron 1 (SMN1) gene. - Patients previously treated with Zolgensma should not be treated with Itivisma. - Prior to injection: - Assess vaccination status. - Assess liver function. - Obtain creatinine and complete blood count. - Perform baseline testing for presence of anti-AAV9 antibodies. - Administer to patients who are clinically stable in their overall baseline health status. Postpone in patients with active or recent infections, until the infection has resolved, and the patient is clinically stable. - One day prior to injection, begin administration of systemic corticosteroids. - Monitor liver function weekly for the month after Itivisma injection and during the corticosteroid taper period, and monitor platelet counts weekly for the first month and as clinically indicated until platelet counts return to baseline. (Monitor liver function for at least 3 months after injection). - Patients with preexisting hepatic impairment or acute hepatic viral infection may be at higher risk of liver injury. Itivisma therapy should be carefully considered in patients with liver impairment. Zolgensma: The patient is less than 2 years of age AND The diagnosis is spinal muscular atrophy (SMA) AND the patient has bi-allelic mutations of the SMN1 gene AND the patient does not have advanced SMA (e.g. complete paralysis of limbs or permanent ventilator dependence) AND medication is prescribed per the dosing. Spinraza: The diagnosis is spinal muscular atrophy (SMA) type 1, 2, or 3 (results of genetic testing must be submitted), AND the patient has at least 2 copies of the SMN2 gene, AND the prescriber is a neurologist, pulmonologist, or other physician with expertise in treatment SMA, AND baseline motor ability has been established using one of the following exams: - Hammersmith Infant Neurological Exam (HINE) - Hammersmith Functional Motor Scale Expanded (HFMSE) - Upper Limb Module Test (non-ambulatory) - Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND), AND prior to starting therapy, and prior to each dose, the following laboratory tests will be conducted: - Treating provider attests the member has a platelet count > 50,000/ml or greater, and - Treating provider agrees to do platelet count and coagulation test before each dose, and - Treating provider agrees to do a quantitative spot urine protein test before each dose. Concomitant use of Spinraza and Zolgensma is investigational and will not be approved, AND Use of Spinraza after gene replacement therapy, including Zolgensma is investigational and will not be approved. Note: Initial approval will be granted for 4 loading doses (the first 3 loading doses should be administered at 14-day intervals; the 4th loading dose should be administered 30 days after the 3rd dose). Renewal may be granted for up to 12 months with a maximum of 3 doses approved per year (12mg (5ml) every 4 months). For therapy continuation, clinical documentation must be submitted documenting improvement or maintenance of motor ability OR slower progression of disease than would otherwise be expected.
	MC	ZOLGENSMA ¹	MC		ITIVISMA ^{1,3}	1. Clinical PA is required to establish diagnosis and medical necessity. 2. For patients 2 months of age and older. 3. For patients 2 years of age and older.	
		NON-GENE			NON-GENE		
	MC MC	EVRYSDI ^{1,2} SPINRAZA ¹					

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
NEUROLOGICS- RETT SYNDROME			MC	8	DAYBUE ^{1,2}	Use PA Form# 20420 1. Clinical PA required for appropriate diagnosis 2. For the treatment of patients 2 years of age and older.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ALS DRUGS	MC/DEL	RILUZOLE	MC MC MC MC	8 8 8 8	QALSODY RILUTEK TABS RADICAVA ¹ TIGLUTIK	Use PA Form# 20420 1. Clinical PA for indication required.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Qalsody: For the treatment of amyotrophic lateral sclerosis (ALS) in adults who have a mutation in the superoxide dismutase 1 (SOD1) gene. Continued approval for this indication may be contingent upon verification of clinical benefit in confirmatory trial(s).
MOVEMENT DISORDERS	MC MC MC MC	AUSTEDO ¹ AUSTEDO XR ¹ INGREZZA ¹ TETRABENAZINE ¹	MC	8	XENAZINE	Use PA Form# 20420 1. Clinical PA required for appropriate diagnosis	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. DDI: Avoid concomitant use of VMAT2 inhibitors with MAO inhibitors (e.g. isocarboxazid, phenelzine, or selegiline). Concomitant use with strong CYP3A4 inducers (e.g. rifampin, carbamazepine, phenytoin, St. John's wort) is not recommended
MUSCULAR DYSTROPHY AGENTS	MC	EMFLAZA ²	MC MC MC MC MC MC MC MC MC	8 8 8 8 8 8 8 8 8	AGAMREE ⁴ AMONDYS 45 ¹ DEFLAZACORT ELEVIDYS ³ DUVYZAT EXONDYS 51 ¹ VLITEPSO ³ VYONDYS 53	Use PA Form# 20420 1. Clinical PA to verify diagnosis and use of stable dose of corticosteroid for at least 6 months. 2. For the treatment of Duchenne muscular dystrophy (DMD) in patients 2 years of age and older and a documented intolerance of oral corticosteroid. 3. Clinical prior authorization to verify diagnosis and use of stable dose of corticosteroid. 4. For the treatment of Duchenne muscular dystrophy (DMD) in patients 2 years of age and older.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Amondys 45, Exondys 51 and Vyondys 53: • The prescriber is, or has consulted with, a neuromuscular disorder specialist AND • The dose does not exceed 30mg/kg once weekly AND • The patient is currently on a stable corticosteroid dose for at least 6 months (at least 3 months for Elevidys). Amondys 45, Exondys 51, Vyondys 53 Note: Initial approval will be granted for 6 months. For re-approval after 6 months, the patient must demonstrate a response to therapy. Duvyzat: The patient must meet the FDA approved age AND have a diagnosis of Duchenne Muscular Dystrophy confirmed with a confirmed mutation of the DMD gene AND • The prescriber is, or has consulted with, a neuromuscular disorder specialist • The patient is ambulatory AND • The patient is currently on a stable corticosteroid dose for at least 6 months AND • Baseline platelet counts are > 150 x 109/L and baseline triglycerides are < 300 mg/dL Elevidys and Vlitepsos: The prescriber is, or has consulted with, a neuromuscular disorder specialist AND • The dose does not exceed dosing AND • The patient is currently on a stable corticosteroid dose for at least 3 months. Vlitepsos: 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 MC MC MC/DEL	8 8 8 8	IMAAVY VYVGART ¹ VYVGART HYTRULO ¹ ZILBRYSQ ¹	Use PA Form# 20420 1. For the treatment of generalized myasthenia gravis (gMG) in adult patients who are anti-acetylcholine receptor (AChR) antibody positive.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Zilbrysq recommended to vaccinate patients for meningococcal infection per current Advisory Committee on Immunization Practices (ACIP) recommendations at least 2 weeks prior to administering the first dose.
FRIEDREICH'S ATAXIA AGENTS			MC		SKYCLARYS ^{1,2}	Use PA Form# 20420 1. Clinical PA required for appropriate diagnosis. 2. For the treatment of patients 16 years of age and older.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
STEROIDS							
GLUCOCORTICOIDS/ MINERALOCORTICOIDS	MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	BUDESONIDE EC 3mg DR CAPS CELESTONE SUSP CORTEF 5 CORTISONE ACETATE TABS DELTASONE TABS DEPO-MEDROL SUSP DEXAMETHASONE DEXPAK FLUDROCORTISONE ACETATE TABS HYDROCORTISONE KENALOG METHYLPREDNISOLONE TABS PREDNISOLONE PREDNISOLONE SOLU-CORTEF SOLR SOLU-MEDROL SOLR	MC MC MC/DEL MC MC MC/DEL MC MC MC MC		CORTEF 10 and 20 TABS MILLIPRED PREDNISONE INTENSOL CONC HEMADY KHINDVI ¹ MEDROL TABS MEDROL DOSEPAK TABS ALKINDI SPRINKLE ZILRETTA	Use PA Form# 20420 1. Trial and failure, contra-indication or intolerance to Alkindi Sprinkle is required.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. DDI: All preferred steroids will require clinical PA for patients over 60 that are currently on fluoroquinolone therapy.

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
HORMONE REPLACEMENT THERAPIES							
ANDROGENS / ANABOLICS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	ANDRODERM PT24 ¹ ANDROGEL 1% ANDROGEL PUMP 1.62% ¹ DANAZOL CAPS TESTOSTERONE CYP ¹	MC MC MC/DEL MC MC MC/DEL MC MC MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC/DEL		ANADROL-50 ANDRO LA 200 OIL ANDROGEL PACKETS 1.62% ANDROID CAPS AXIRON AZMIRO DELATESTRYL OIL DEPO-TESTOSTERONE OIL ¹ FORTESTA ¹ HALOTESTIN TABS JATENZO METHITEST TAB METHYLTESTOSTERONE CAP OXANDROLONE STRIANT MUC ER TESTIM ¹ TESTOSTERONE GEL PACKETS ¹ TESTOSTERONE SOL ¹ TESTRED CAPS TLANDO ¹ VOGELXO ¹ XYOSTED ¹	Use PA Form# 20420 For GAHT - Use PA Form 30900.pdf 1. Clinical PA required for patients <19 years of age. Use PA Form #30900	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Additionally, laboratory evidence of a testosterone deficiency must be supplied. One of each dosage form should be tried (tablet, injection, and topical). Oxandrolone: Weight gain (adjunctive therapy): Adjunctive therapy to promote weight gain after weight loss following extensive surgery, chronic infections, or severe trauma, and in some patients who, without definite pathophysiologic reasons, fail to gain or to maintain normal weight. Other indications included in manufacturer labeling: Adjunctive therapy to offset protein catabolism with prolonged corticosteroid administration. Requirement for documentation of weight loss over two readings- Patient has involuntary weight loss of more than 10% of total body weight in less than four months) and, BMI < 18.5 (Normal BMI = 18.5 to 24.9).
ESTROGENS - PATCHES / TOPICAL	MC MC/DEL MC/DEL MC/DEL	EVAMIST ESTRADIOL PTTK MINIVELLE PATCH VIVELLE-DOT PTTW	MC/DEL MC/DEL MC/DEL MC/DEL	8 8 8 8	DIVIGEL ¹ CLIMARA PTTWK ELESTRIN ¹ MENOSTAR PATCH	Use PA Form# 20420 1. Step order drugs must be used in specified step order.	Approved for failures on multiple oral estrogen agents after 90 day trials or if unable to swallow any oral medication.
ESTROGENS - TABS	MC/DEL MC/DEL	ESTRADIOL ¹ PREMARIN TABS	MC/DEL MC/DEL MC/DEL		ESTRADIOL-NORETHINDRONE ¹ ESTRACE TABS MENEST TABS NORETHINDRON-ETHINYL	Use PA Form# 20420 For GAHT - Use PA Form 30900.pdf Must fail preferred products before non-preferred products. 1. Clinical PA required for patients <19 years of age. Use PA Form #30900	Preferred drugs must be tried for at least 90 days and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ESTROGEN COMBO'S	MC/DEL MC/DEL MC/DEL MC/DEL	ANGELIQ COMBIPATCH PTTW PREMPHASE TABS PREMPRO TABS	MC/DEL MC/DEL MC MC/DEL		FEMHRT 1/5 TABS ¹ FYAVOLV LOPREEZA TAB ORTHO-PREFEST TABS ¹ SYNTEST H.S. TABS ¹	Use PA Form# 20420 1. Must fail Premphase and Prempro products before non preferred products.	Preferred drugs must be tried for at least 90 days and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
PROGESTINS	MC/DEL MC/DEL MC MC	MEDROXYPROGESTERONE ACETA ¹ NORETHINDRONE ACETATE TABS ¹ 17-ALPH HYDROXYPROGESTERONE PWDR PROGESTERONE CAPS ²	MC/DEL MC MC MC/DEL		AYGESTIN TABS CYCRIN TABS PROGESTERONE POWD ² PROMETRIUM CAPS PROVERA TABS	Use PA Form# 20420 For GAHT - Use PA Form 30900.pdf 1. Must fail Medroxyprogesterone and Norethindrone products before non-preferred products. 2. Clinical PA required for patients <19 years old. Use PA Form #30900	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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 AGENTS	MC	FENSOLVI ^{1,2}				Use PA Form# 20420 For GAHT - Use PA Form 30900.pdf 1. For pediatric patients 2 years of age and older with central precocious puberty (CPP). 2. Clinical PA required for patients <19 years old. Use PA Form #30900	
ENDOMETRIOSIS- NASAL	MC/DEL	SYNAREL (NASAL) SPRAY				Use PA Form# 20420	Synarel is also indicated for central precocious puberty.
ENDOMETRIOSIS/ UTERINE FIBROIDS- ORAL	MC MC MC/DEL	MYFEMBREE ^{1,2} ORIAHNN ¹ ORILISSA ¹				Use PA Form# 20420 1. Prior treatment of NSAID and hormonal contraceptives required. 2. Limited to 24 months due to the risk of continued bone loss, which may not be reversible.	
ENDOMETRIOSIS- INJECTABLE	MC/DEL	DEPO-SUBQ PROVERA 104				Use PA Form# 20420	

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
CONTRACEPTIVES							
CONTRACEPTIVES - PROGESTIN ONLY	MC/DEL MC/DEL MC MC MC/DEL MC/DEL	CAMILA TABS ERRIN INCASSIA TAB HEATHER TAB NORETHINDRONE ACETATE 0.35MG TABS SLYND	MC/DEL MC/DEL MC MC MC/DEL MC/DEL		JOLIVETTE NORA-BE TABS ORTHO MICRONOR TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. If member experienced adverse reactions, consider using Oral Contraceptives from other groups. DDI: Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer.
CONTRACEPTIVES - INJECTABLE	MC/DEL	MEDROXYPROGESTERONE ACETATE 150mg IM	MC/DEL		DEPO-PROVERA 150 mg SUSP	Use PA Form# 20420	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
CONTRACEPTIVE - EMERGENCY	MC/DEL MC MC MC MC MC/DEL MC MC/DEL MC	ELLA ENCONTRA ONE STEP ECONTRA EZ NEW DAY OPCION OPTION 2 MY CHOICE MY WAY LEVONORGESTREL NEXT CHOICE ¹				Use PA Form# 20420 1. Allowed 2 tablets per 30 days without PA.	Due to the extensive list of products, any covered emergency contraceptive product preferred is and available without a PA.
CONTRACEPTIVES - PATCHES/ VAGINAL PRODUCTS	MC MC MC MC/DEL	ELURYN ¹ NUVARING RING ¹ TWIRLA XULANE ²	MC MC MC MC		ANNOVERA PHEXXI ZAFEMY	Use PA Form# 20420 1. Quantity limit allowing 1 every 28 days without PA. 2. Dose limits apply allowing 3 patches per 28 days supply.	Approved if adequate clinical reason given why patient unable to comply with other preferred agents including long acting injectable.
CONTRACEPTIVES- LONG ACTING REVERSIBLE	MC/DEL	MIRENA	MC/DEL MC MC MC/DEL MC/DEL		KYLEENA LILETTA NEXPLANON PARAGARD SKYLA	Use PA Form# 20420	
CONTRACEPTIVES - MONOPHASIC COMBINATION O/C'S	MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	APRI TABS AVIANE TABS BALZIVA CRYSSELLE-28 TABS DESOGEN TABS ESTARYLLA TAB HAILEY FE TAB ISIBLOOM TAB JUNEL FE TAB LARIN FE TAB LESSINA TAB LEVORA-28 TAB MILI TAB NORGESTIMATE-ETHINYL ESTRADIOL TAB MIBELAS 24 FE TAB MICROGESTIN FE TAB RECLIPSEN SAFYRAL TAB SPRINTEC 28 TABS YASMIN 28 TABS YAZ	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		BEYAZ BREVICON-28 TABS LESSINA-28 TABS LEVORA LOESTRIN FE 1/20TABS LOESTRIN 1.5/30-21 TABS MICROGESTIN FE TABS LOESTRIN 1/20-21 TABS LO/OVRAL 21 TABS LO/OVRAL 28 TABS NEXTSTELLIS NORDETTE-28 TABS NORTREL OCELLA OVRAL PORTIA-28 TABS SAFYRAL ZOVIA	Use PA Form# 20420 If member experienced adverse reactions, consider using Oral Contraceptives from other groups.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. If member experienced adverse reactions, consider using Oral Contraceptives from other groups. DDI: Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer.
CONTRACEPTIVES - BI-PHASIC COMBINATIONS	MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC/DEL	AZURETTE TAB CAMRESE CAMRESE LO DESOGESTREL/ ETH/ ESTRAD 0.15/30mcg KARIVA TABS LO LOESTRIN FE PIMTREA TAB NORETHINDRONE-ETH ESTRADIOL TAB 0.5-35/1-35 SIMPESS TBDSPK 3MO VIORELE TAB	MC/DEL		LOSEASONIQUE	Use PA Form# 20420 If member experienced adverse reactions, consider using Oral Contraceptives from other groups.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. If member experienced adverse reactions, consider using Oral Contraceptives from other groups. DDI: Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer.

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
CONTRACEPTIVES - TRI-PHASIC COMBINATIONS	MC/DEL MC/DEL MC/DEL MC MC MC MC/DEL MC/DEL MC	ENPRESSE NORGESTIMATE-ETHINYL ESTRADIOL TAB TRIPHASIL 28 TABS TRI-LO-MILI TAB TRI-LO-ESTARYLLA TAB TRI-ESTARYLLA TRI-SPRINTEC TAB TRI-LO-SPRINTEC TRINESSA	MC/DEL MC		NORTREL 7/7/7 ORTHO TRI-CYCLEN LO TABS	Use PA Form# 20420 If member experienced adverse reactions, consider using Oral Contraceptives from other groups.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. If member experienced adverse reactions, consider using Oral Contraceptives from other groups. DDI: Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer.
CONTRACEPTIVES - MULTI-PHASIC COMBINATIONS			MC		NATAZIA	Use PA Form# 20420	
VASOMOTOR SYMPTOMS AGENTS							
VASOMOTOR SYMPTOMS AGENTS	MC/DEL	LYNKUET	MC/DEL	8	VEOZAH	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Lynkuet: • Diagnosis of vasomotor symptoms AND, • Member must have previously tried and failed one 30-day trial of either Hormone Replacement Therapy (HRT) or other guideline supported non-hormonal therapy for VMS (e.g., gabapentin, paroxetine, venlafaxine) AND, • Baseline liver function tests. Veozah: • Approval requires at least one preferred Hormone Replacement Therapy (HRT) and two preferred non-hormonal therapies (i.e., SSRIs, SNRIs, gabapentin, pregabalin, clonidine). • Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved. DDI: Avoid concomitant use of Veozah with drugs that are weak, moderate or strong CYP1A2 inhibitors.
DIABETES SUPPLIES							
DIABETIC- SUPPLIES		CONTINUOUS GLUCOSE MONITORING ¹ DIABETIC- LANCETS DIABETIC- LANCING DEVICES DIABETIC- LANCING DEVICES DIABETIC- PEN NEEDLES DIABETIC- SYRINGES DIABETIC- TEST STRIPS DIABETIC- METERS				Use PA Form# 20420 1. Dosing limits apply. Please refer to Dose Consolidation List.	Please refer to the MaineCare Preferred Diabetic Supply List available at www.mainearepdi.org . Continuous Glucose Monitoring Criteria: Patient has a diagnosis of Diabetes Mellitus AND Practitioner feels patient has sufficient training to use CGM. • 2 years of age or older for Dexcom G6 and Dexcom G7, ≥ 14 years for Medtronic Guardian, or ≥ 4 years for Freestyle Libre 2. • At least one of the following are documented: o Hypoglycemic unawareness o Treated with insulin (at least 1X day) o Has history of problematic hypoglycemia with documentation of at least one recurrent level 2 hypoglycemic events, or 1 level 3 hypoglycemic event • Approval of non-preferred products will be limited to cases where the CGM is directly integrated with the patient's insulin pump. The make and model of pump must be documented on the prior authorization.
DIABETES THERAPIES							
DIABETIC - INSULIN	MC/DEL MC MC MC MC MC MC MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	FIASP HUMALOG KWIKPEN INJ 100/ML HUMALOG JUNIOR KWIKPEN 100/ML HUMALOG MIX 75/25 HUMALOG 50/50 VIAL HUMULIN INJ 70/30 KWIKPEN HUMULIN INJ 70/30 HUMULIN R INJ U-500 INSULIN LISPRO LANTUS SOLN LEVEMIR NOVOLOG NOVOLOG MIX NOVOLOG MIX 70/30 VIAL	MC/DEL MC/DEL MC MC MC MC MC MC MC MC MC/DEL MC/DEL MC/DEL MC		APIDRA ADMELOG AFREZZA ¹ BASAGLAR HUMALOG KWIKPEN U-200 HUMULIN INJ 50/50 HUMULIN N INJ U-100 HUMULIN R U-100 INSULIN DEGLUDEC KIRSTY LYUMJEV MERILOG NOVOLIN RELJON	Use PA Form# 20420 1. Not to be as a monotherapy. Obtain lab values of pulmonary function and recent smoking history. 2. For the treatment of patients ≥ 3 years of age.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
DIABETIC - PENFILLS	MC MC MC MC MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	HUMALOG MIX KWIK 50/50 HUMALOG MIX INJ 75/25 KWP HUMALOG KWIK INJ 100/ML HUMALOG KWIK INJ 200/ML HUMULIN R U-500 KWP INSULIN LISPRO KWIKPEN U-100 LANTUS SOLOSTAR LEVEMIR FLEXTOUCH LEVEMIR FLEXPEN NOVOLIN 70/30 PEN NOVOLOG MIX PENFILL NOVOLOG PENFILL SOLN NOVOLOG FLEXPEN NOVOLOG MIX 70/30 FLEXPEN TOUJEO MAX SOLOSTAR TOUJEO SOLOSTAR	MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8	APIDRA OPTICLIK PEN AWOLI MERILOG NOVOLIN 70/30 PEN REZVOGLAR KWIKPEN TRESIBA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required	Criteria
DIABETIC - DPP- 4 ENZYME INHIBITOR	MC/DEL MC/DEL	JANUVIA ^{1,2} TRADJENTA ²	MC MC/DEL MC/DEL MC	8 8 8 8	BRYNOVIN NESINA QTERN ZITUVIO	Use PA Form# 20420 1. Preferred if therapeutic doses of metformin are seen in members drug profile for at least 60 days within the past 18 months or if phosphate binder is currently seen in the members drug profile. 2. Dosing limits apply. Please refer to Dose Consolidation List. Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Brynovin: In addition to tried and failed Preferred Agents, Brynovin requires tried and failed Non-Preferred Agent Zituvio.
DIABETIC - DPP- 4 ENZYME INHIBITOR- COMBO	MC/DEL MC/DEL MC/DEL	JANUMET ^{1,2} JANUMET XR ^{1,2} JENTADUETO ¹	MC/DEL MC/DEL MC/DEL MC MC	8 8 8 8 8	JENTADUETO XR KAZANO OSEN ZITUVIMET ZITUVIMET XR	Use PA Form# 20420 1. Preferred if therapeutic doses of metformin are seen in members drug profile for at least 60 days within the past 18 months or if phosphate binder is currently seen in the members drug profile. 2. Dosing limits apply. Please refer to Dose consolidation list. Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Zituvim / Zituvimet XR: Approvals will require trial of preferred sitagliptin/metformin products or other preferred diabetic agents.
DIABETIC - LANCET-LANCET DEVICE						Use PA Form# 20420 Please refer to the MaineCare Preferred Diabetic Supply List available at www.mainearepdi.org
DIABETIC - SYRINGES-NEEDLES						Use PA Form# 20420 Please refer to the MaineCare Preferred Diabetic Supply List available at www.mainearepdi.org
DIABETIC - OTHER			MC		SYMLIN	Use PA Form #20420
SGLT 2 INHIBITORS	MC/DEL MC/DEL	FARXIGA JARDIANCE	MC/DEL MC/DEL		INVOKANA ¹ STEGLATRO	Use PA Form# 20420 1.Dosing limits apply please refer to Dose Consolidation List. Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
SGLT 2 INHIBITOR COMBINATIONS	MC/DEL MC/DEL MC/DEL	SYNJARDY SYNJARDY XR XIGDOU XR	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		GLYXAMBI INVOKAMET INVOKAMET XR SEGLUROMET STEGLUJAN TRIJARDY XR	Use PA Form# 20420 Preferred drugs must be tried for at least 3 months at full therapeutic doses and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Glyxambi /Xigduo XR- Verify prior trials and failures or intolerance of preferred treatments from other diabetic categories. Synjardy XR is not recommended for patients with type 1 DM or for the treatment of diabetic ketoacidosis.
DIABETIC MONITOR	MC MC MC	ACCU-CHEK GUIDE RELION TRUE METRIX BLOOD GLUCOSE MONITORING SYSTEM TRUE METRIX BLOOD GLUCOSE MONITORING SYSTEM	MC MC MC MC MC MC MC		ASCENSIA ASSURE CONTOUR BREEZE Z EXACTECH FREESTYLE INSULINX FREESTYLE LITE SYSTEM KIT PRECISION XTRA METER PRODIGY	Use PA Form# 20420 Effective October 25th 2007, approvals for all non preferred meters/ test strips will require medical necessity documenting clinically significant features that are not available on any of the preferred meters.
DIABETIC TEST STRIPS	MC/DEL MC	RELION TRUE METRIX TRUE METRIX	MC MC MC MC MC MC MC MC MC MC		ACCUCHECK ASCENSIA ASSURE CONTOUR BREEZE Z EXACTECH FREESTYLE FREESTYLE LITE FREESTYLE INSULINX PRECISION XTRA PRODIGY	Use PA Form# 20420 Effective October 25th 2007, approvals for all non preferred meters/ test strips will require medical necessity documenting clinically significant features that are not available on any of the preferred meters. Effective October 1, 2023, a maximum of 100 blood glucose test strips every 90 days will be available without Prior Authorization for members currently utilizing continuous glucose monitors (CGM).
INCRETIN MIMETIC	MC/DEL MC MC/DEL	RYBELSUS TRULICITY VICTOZA	MC/DEL MC/DEL MC/DEL MC/DEL	6 8 8 8 8	OZEMPIC ADLYXIN BYDUREON BCISE SOLIQUA XULTOPHY	Use PA Form# 20420 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Soliqua must try both insulin and a preferred incretin mimetic and have a medical necessity for use that is not based on convenience or simply due to the fact that one injection is needed instead of two.
DIABETIC - ORAL SULFONYLUREAS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	CHLORPROPAMIDE TABS GLIMEPIRIDE GLIPIZIDE TABS GLIPIZIDE ER TABS GLYBURIDE MICRONIZED TABS GLYBURIDE TABS ¹ TOLAZAMIDE TABS TOLBUTAMIDE TABS	MC/DEL		GLUCOTROL XL TBCR	Use PA Form# 20420 1. PA required for members ≥65. Glyburide has a greater risk of severe prolonged hypoglycemia in older adults. Preferred drugs must be tried for at least 3 months at full therapeutic doses and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. DDI: All sulfonylureas (except glyburide) will now be non-preferred and require prior authorization if it is currently being used with either rantidine or cimetidine. DDI: Glimepiride will now be non-preferred and require prior authorization if it is currently being used with either fluconazole (except 150mg strength) or fluvoxamine.
DIABETIC -ORAL BIGUANIDES	MC/DEL MC/DEL	METFORMIN HCL TABS METFORMIN ER	MC		METFORMIN ER OSMOTIC	Use PA Form# 20420 Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
DIABETIC - THIAZOL / BIGUANIDE COMBO			MC/DEL MC/DEL MC MC		ACTOPLUS MET ¹ ACTOPLUS MET XR AVANDARYL ¹ AVANDAMET TABS ¹	Use PA Form# 20420 1. Requires use of Actos, Metformin, or other preferred anti-diabetics. DDI: Actos, Avandia, or any combination product with Actos or Avandia will now be non-preferred and require prior authorization if it is currently being used with gemfibrozil.

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required	Criteria
DIABETIC - / THIAZOL	MC/DEL	PIOGLITAZONE HCL ¹	MC/DEL MC		ACTOS TABS ¹ AVANDIA TABS ²	Use PA Form# 20420 1. Pioglitazone HCL is non-preferred as monotherapy. Pioglitazone HCL is preferred if therapeutic doses of metformin, sulfonylurea or insulin are seen in members drug profile for at least 60 days within the past 18 months. 2. Current users of Avandia who have tried Actos will be able to continue use of Avandia . 3. Dosing limits apply. See Dose Consolidation List. Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. DDI: Actos, Avandia , or any combination product with Actos or Avandia will now be non-preferred and require prior authorization if it is currently being used with gemfibrozil.
DIABETIC - ALPHAGLUCOSIDASE			MC		PRECOSE TABS	Use PA Form# 20420 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
DIABETIC - SULFONYLUREA / BIGUANIDE	MC/DEL	GLYBURIDE / METFORMIN	MC MC MC/DEL		GLUCOVANCE TABS ¹ METAGLIP TABS ¹ DUETACT ²	Use PA Form# 20420 1. Use individual ingredients. 2. Use Actos with generic glimepiride. Approved for patients failing to achieve good diabetic control with maximal doses of individual components.
DIABETIC - MEGLITINIDES	MC	NATEGLINIDE	MC/DEL MC/DEL		PRANDIN TABS STARLIX TABS	Use PA Form# 20420 Preferred drugs from other diabetic sub-categories must be tried and failed due to lack of inadequate diabetic control or intolerable side effects before non-preferred drug will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. DDI: Prandin is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for current use with both sporanox and gemfibrozil, due to a significant drug-drug interaction.
GLUCOSE ELEVATING AGENTS						
GLUCOSE ELEVATING AGENTS	MC/DEL MC/DEL MC/DEL	BAQSIMI ¹ GVOKE ² ZEGALOGUE ³	MC	8	GLUCAGON DIAGNOSTIC KIT	Use PA Form# 20420 1. For the treatment of patients ≥ 4 yrs of age. 2. For the treatment of patients ≥ 2 yrs of age. 3. For the treatment of patients ≥ 6 yrs of age. Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
THYROID						
THYROID EYE DISEASE			MC		TEPEZZA	Use PA Form# 20420
THYROID HORMONES	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	ARMOUR THYROID TABS CYTOMEL TABS ERMEZA ¹ LEVOTHROID TABS LEVOTHYROXINE SODIUM TABS LEVOXYL TABS UNITHROID TABS	MC MC/DEL MC MC/DEL		LEVOTHYROXINE SODIUM SOLR LIOTHYRONINE SYNTHROID TABS THYQUIDITY	Use PA Form# 20420 1. Clinical PA is required to confirm diagnosis of dysphagia. Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTITHYROID THERAPIES	MC/DEL MC/DEL	METHIMAZOLE TABS PROPYLTHIOURACIL TABS	MC/DEL		TAPAZOLE TABS	Use PA Form# 20420 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
CUSHING DISEASE AGENTS						
CUSHING DISEASE AGENTS			MC MC		ISTURISA ¹ RECORLEV	Use PA Form #20420 1. For the treatment of adult patients with Cushing's disease for whom pituitary surgery is not an option or has not been curative. Recorlev is associated with dose-related QT interval prolongation. QT interval prolongation may lead to life-threatening ventricular dysrhythmias such as Torsade de pointes.
OSTEOPOROSIS / BONE AGENTS						
OSTEOPOROSIS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	ALENDRONATE ENOBY ⁶ JUBBONTI ⁶ WYOST ^{6,7} XTRENBO ⁶	MC MC MC MC MC MC MC/DEL MC MC MC MC MC MC MC MC MC MC MC MC MC MC MC MC		ACTONEL TABS AUKELSO BILDYOS BILPREVDA ⁷ BINOSTO BOMYNTRA ⁷ BOSAYA CONEXENCE DUAVEE EVENITY ² EVISTA TABS ¹ FORTEO FOSAMAX TABS AND PLUS D ³ JUBEREQ OSENVELT ⁷ OSVYRTI PROLIA SOHONOS ⁶ STOBOCLO STRENSIQ ⁵ TYMLOS XGEVA	Use PA Form# 20420 1. Approval only requires failure of Alendronate. 2. Quantity limits apply, please see Dosage Consolidation List. 3. Please use Alendronate & Vitamin D. 5. Obtain baseline ophthalmology exams and renal ultrasounds and then periodically during treatment. 6. Clinical PA for indication required. 7. Previous trial of Prolia or intolerable side effects before non-preferred biosimilar will be approved. Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Binosto use preferred generic alendronate tablets. Evenity should be limited to 12 monthly doses. Sohonos : For the reduction in volume of new heterotopic ossification in adults and pediatric patients aged 8 years and older for females and 10 years and older for males with fibrodysplasia ossificans progressive (FOP).

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
FIBROBLAST GROWTH FACTOR 23 INHIBITORS	MC	CRYSVITA ¹				Use PA Form #20420 1.Preferred for patients <21 years of age for the treatment of X- linked hypophosphatemia.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
CALCIMIMETIC AGENTS							
CALCIMIMETIC AGENTS			MC MC		PARSABIV SENSIPAR	Use PA Form# 30115	Parsabiv is for the treatment of secondary hyperparathyroidism (HPT) in adults with chronic kidney disease (CKD) on hemodialysis. Parsabiv has not been studied in adults with parathyroid carcinoma, primary hyperparathyroidism, or with chronic kidney disease who are not on hemodialysis and is not recommended for use in these populations. For Sensipar baseline PTH, Ca, and phosphorous levels are required and initial approvals will be limited to 3 months. Subsequent approvals will require additional levels being done to assess changes. Will not approve if baseline Ca is less than 8.4.
GROWTH HORMONE							
GROWTH HORMONE	MC/DEL MC/DEL MC	GENOTROPIN ¹ NORDITROPIN SOLN ¹ SKYTROFA ¹	MC MC MC/DEL MC/DEL MC/DEL		HUMATROPE SOLR NUTROPIN NGENLA OMNITROPE SOGROYA	Use PA Form# 10710 1.Clinical PA is required to establish diagnosis and medical necessity.	See Growth Hormone PA form # 10710 for criteria. Step-order will still apply unless clinical contraindication supplied. Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ACHONDROPLASIA TREATMENT			MC MC		VOXZOGO ¹ YUVIWEL ²	Use PA Form# 20420 1. Pediatric patients with achondroplasia who are 5 years of age and older with open epiphyses. 2. Clinical PA is required to establish diagnosis and medical necessity.	Voxzogo : To increase linear growth in pediatric patients with achondroplasia who are 5 years of age and older with open epiphyses. This indication is approved under accelerated approval based on an improvement in annualized growth velocity. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trial(s).
GROWTH HORMONE ANTAGONISTS / AGONISTS							
GH ANTAGONISTS / AGONISTS	MC	OCTREOTIDE INJ ¹	MC MC MC MC MC MC MC/DEL	8 8 8 8 8 8 8	LANREOTIDE MYCAPSSA ² PALSONIFY ² SANDOSTATIN ² SIGNIFOR ² SOMATULINE ² SOMAVERT	Use PA Form# 10710 1.Clinical PA is required to establish diagnosis and medical necessity. 2. Non-preferred products must be used in specified step order.	Somavert : Approved for acromegaly patients failing surgery/radiation/drug therapy including bromocriptine and sandostatatin. Criteria for all: • Diagnosis of acromegaly AND • Prescribed by or in consultation with an endocrinologist AND • One of the following: • Patient has an inadequate response to surgery OR • Patient is not a candidate for surgery
VASOPRESSIN RECEPTOR ANTAGONIST							
VASOPRESSIN RECEPTOR ANTAGONIST			MC MC/DEL		JYNARQUE ¹ SAMSCA	Use PA Form# 20420 1. Clinical PA required for appropriate diagnosis	Samsca Drug Warning - Avoid use in patients with underlying liver disease, including cirrhosis, because the ability to recover from liver injury may be impaired. Limit duration of therapy to 30 days to minimize the risk of liver injury. DDI: Jynarque - Concomitant use with strong CYP3A inhibitors is contraindicated. Avoid concomitant use of Jynarque with OATP1B1/B3 and OAT3 substrates (e.g. statins, bosentan, glyburide, nateglinide, repaglinide, methotrexate, furosemide).
URINARY INCONTINENCE							
VASOPRESSINS	MC/DEL MC/DEL	DESMOPRESSIN TABS DDAVP SOLN	MC/DEL MC/DEL MC MC MC/DEL MC	5 6 8 8 8 8	DDAVP TABS DESMOPRESSIN SPRAY ¹ DESMODA DESMOPRESSIN ACETATE SOLN ¹ NOCURNA ¹ NOCTIVA ¹	Use PA Form# 20420 1. Products must be used in specified step order. Nocturnal enuresis patients will be encouraged to periodically attempt stopping DDAVP.	Approved for central diabetes insipidus and for nocturnal enuresis. For nocturnal enuresis- must be over 6 years old, must fail an adequate trial of alarm training (higher success rate, lower relapse rate) and must periodically attempt weaning (at 6 month intervals).
ANTISPASMODICS	MC/DEL MC/DEL	OXYBUTYNIN TOLTERODINE	MC/DEL MC/DEL MC/DEL		DARIFENACIN ER TAB DITROPAN FLAVOXATE HCL TAB	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTISPASMODICS - LONG ACTING	MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	FESOTERODINE GELNIQUE GEL PACKET MYRBETRIQ OXYBUTYNIN ER TABS OXYTROL SOLIFENACIN SUCCINATE TAB TROSPIMUM	MC MC/DEL MC MC/DEL MC/DEL MC MC		DITROPAN XL TBCR ENABLEX ^{1,2} GEMTESA ² TOLTERODINE TAB TOVIAZ VESICARE ¹ VESICARE LS ³	Use PA Form# 20420 1. See Criteria Section. 2. Use a preferred long acting antispasmodic. 3. For the treatment of patients ≥ 2 years of age.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. 1. Vesicare 5mg and Enablex 7.5mg maximum doses if given with drugs known to be significant CYP3A4 inhibitors (ketoconazole, sporanox, erythromycin, fluconazole, nefazodone, neflnavir, and ritonavir). DDI: Enablex 15mg and Vesicare 10mg will now be non-preferred and require prior authorization if they are currently being used in combination with any of the following medications: clarithromycin, erythromycin, crixivan, norvir, ketoconazole, fluconazole (except 150mg strength), sporanox, or nefazodone.
CHOLINERGIC	MC/DEL	BETHANECHOL	MC/DEL			Use PA Form# 20420	
HYPERAMMONIA TREATMENTS	MC	CARBAGLU TABS	MC		CARGLUMIC ACID TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
UREA CYCLE DISORDER	MC MC	BUPHENYL TABLET PHEBURANE GRANULES	MC MC MC MC/DEL MC/DEL		BUPHENYL POWDER RAVICIT LIQUID OLPRUVA SODIUM PHENYL BUTYRATE POWDER SODIUM PHENYL BUTYRATE TAB	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Olpruva : As adjunctive therapy to standard of care, which includes dietary management, for the chronic management of adult and pediatric patients weighing 20kg or greater and with a body surface area (BSA) of 1.2m2 or greater, with urea cycle disorders (UCDs) involving deficiencies of carbamylphosphate synthetase (CPS), ornithine transcarbamylase (OTC), or argininosuccinic acid synthetase (AS).
METABOLIC MODIFIER							
HERED. TYROSINEMIA			MC MC MC	6 6 8	ORFADIN NITYR HARLIKU ¹	Use PA Form# 20420 1.Clinical PA is required to establish diagnosis and medical necessity.	Approved for Type 1 hereditary tyrosinemia patients. Must include laboratory evidence of dx at first PA. Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

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

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

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
LIPID DRUGS							
CHOLESTEROL - BILE SEQUESTRANTS	MC/DEL MC/DEL	CHOLESTYRAMINE COLESTIPOL HCI	MC/DEL MC/DEL MC MC/DEL		COLESTID PREVALITE QUESTRAN WELCHOL TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
CHOLESTEROL - FIBRIC ACID DERIVATIVES	MC/DEL MC/DEL MC/DEL	FENOFIBRATE TAB GEMFIBROZIL TABS NIACIN ER	MC MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC		ANTARA LOPID FENOFIBRATE 120mg TAB FENOFIBRATE CAP FIBRICOR LIPOFEN LOFIBRA NIASPAN ER TRICOR TRIGLIDE	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. DDI: Fenofibrate is preferred but will require a prior authorization requests if used concurrent with warfarin. DDI: Gemfibrozil will now be non-preferred and require prior authorization if it is currently being used with any of the following medications: prandin, actos, avandia, any avandia/actos combination product, any HMG-COA Reductase Inhibitors (statins), or warfarin.
CHOLESTEROL - HMG COA + ABSORB INHIBITORS MORE POTENT DRUGS/- COMBINATIONS	MC/DEL MC/DEL MC MC/DEL	ATORVASTATIN EZETIM/SIMVA TAB ROSUVASTATIN SIMVASTATIN ¹	MC MC/DEL MC/DEL MC MC/DEL MC MC/DEL MC/DEL MC		ATORVALIQ CRESTOR EZALLOR SPRINKLES ³ FLOLIPID LIPITOR LIPTRUZET ZOCOR SIMVASTATIN 80MG ^{1,2} VYTORIN	Use PA Form# 20420 1. Dosing limits apply, see Dosage Consolidation List. 2. Current users grandfathered. 3. For the treatment of patients ≥ 18 years of age.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. DDI: Lipitor (doses greater than 20mg/day) will now be non-preferred and require prior authorization if it is currently being used in combination with amiodarone or cyclosporine. DDI: All preferred statins will now be non-preferred and require prior authorization if it is currently being used in combination with gemfibrozil.
CHOLESTEROL - HMG COA + ABSORB INHIBITORS LESS POTENT DRUGS/- COMBINATIONS	MC/DEL MC/DEL MC/DEL	EZETIMIBE TABS LOVASTATIN TABS ² PRAVASTATIN ²	MC MC/DEL MC/DEL MC MC/DEL MC MC MC/DEL MC/DEL MC		ALTOPREV TB24 FLUVASTATIN TAB ER LESCOL XL TB24 LIVALO MEVACOR TABS NEXLETOL NEXLIZET PRAVACHOL TABS PRAVIGARD ZETIA TABS	Use PA Form# 20420 2. Dosing limits apply, please see Dosage Consolidation List.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Zetia will be approved for patients unable to tolerate all other therapies or unable to achieve cholesterol goal with maximally tolerated dose of most potent statins. DDI: Lescol will now be non-preferred and require prior authorization if it is currently being used in combination with diclofenac. DDI: Lovastatin (doses greater than 40mg/day) will now be non-preferred and require prior authorization if it is currently being used in combination with amiodarone. DDI: Lovastatin (doses greater than 20mg per day) will now be non-preferred and require prior authorization if it is currently being used in combination cyclosporine. DDI: All preferred statins will now be non-preferred and require prior authorization if it is currently being used in combination with gemfibrozil.
CHOLESTEROL - HMG COA + ABSORB INHIBITORS STATIN/ NIACIN COMBO	MC	SIMCOR	MC		ADVICOR TBCR	Use PA Form# 20420	
FAMILIAL HYPERCHOLESTEROLEMIA	MC MC	PRALUENT (LABLER 72733) PEN ^{1,2,3,5} REPATHA ^{1,2,3}	MC MC MC MC		EVKEEZA ^{1,4} JUXTAPID KYNAMRO ¹ LEQVIO	Use PA Form# 20420 1. Clinical PA required for appropriate diagnosis. 2. Quantity limits apply. 3. Documented adherence to lipid lowering medications and abstinence from tobacco for previous 90 days. 4. For treatment of patients ≥ 12 years of age. 5. Approval of Praluent NDC's with labeler code 00024 will be considered only if labeler code 72733 NDC's are on a long-term backorder and unavailable from the manufacturer.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Juxtapid is contraindicated with strong CYP3A4 inhibitors. Juxtapid dosage should not exceed 30mg daily when it is used concomitantly with weak CYP3A4 inhibitors. Kynamro requires an appropriate lab testing prior to starting (ALT<AST), alkaline phosphatase and total bilirubin, monthly liver-related tests for the first year, then every three months. Repatha and Praluent Criteria for approval: The patient's age is FDA approved for the given indication AND • Concurrent use with statin therapy AND • Documented adherence to prescribed lipid lowering medications for the previous 90 days AND • Recommended or prescribed by a lipidologist or cardiologist AND • Inability to reach goal LDL-C despite a trial of 2 or more maximum tolerated dose of statins (one of which must be atorvastatin or rosuvastatin) and ezetimibe 10mg daily. Additional criteria for the diagnosis of heterozygous familial hypercholesterolemia (HeFH): (both are required): Total cholesterol > 290 mg/dL OR LDL-C > 190 mg/dL AND one of the following • Presence of tendon xanthomas OR • In 1st or 2nd degree relative-documented tendon xanthomas, MI at age ≤ 60 years or TC > 290 mg/dL. Additional criteria for the diagnosis of clinical atherosclerotic cardiovascular disease: History of MI, angina, coronary or other arterial revascularization, stroke, TIA, or PVD of atherosclerotic origin. Additional criteria for the diagnosis of homozygous familial hypercholesterolemia (Repatha only): Total cholesterol levels > 290mg/dL or LDL-C > 190mg/dL (adults) OR Total cholesterol levels > 260mg/dL or LDL-C > 155mg/dL (children < 16 years) and TG within reference range OR Confirmation of diagnosis by gene testing.
FAMILIAL HYPERCHOLESTEROLEMIA AND HYPERTRIGLYCERIDEMIA			MC MC		REDEMPO ¹ TRYNGOLZA ¹	Use PA Form# 20420 1. Clinical PA required for appropriate diagnosis and clinical parameters.	Tryngolza and Redemlo require fasting triglycerides of ≥ 880 mg/dL and confirmed genetically identified familial chylomicronemia syndrome (FCS).
HYPERPHAGIA - MISC							
HYPERPHAGIA - MISC			MC		VYKAT XR		FDA approved for the treatment of hyperphagia in adults and pediatric patients 4 years of age and older with Prader-Willi syndrome (PWS).

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
PULMONARY ANTI-HYPERTENSIVES							
PULMONARY ANTI-HYPERTENSIVES	MC MC/DEL MC/DEL	EPOPROSTENOL INJ ³ SILDENAFIL TADALAFIL	MC/DEL MC MC/DEL MC MC MC MC MC MC/DEL MC MC MC MC MC/DEL MC		ADEMPAS ^{1,3} ADCIRCA ⁴ ALYQ TAB FLOLAN ³ LIQREV OPSUMIT ^{1,2} OPSYNVI ⁴ ORENITRAM REMODULIN ³ REVATIO ⁴ TADLIQ ⁴ TYVASO UPTRAVI VELVETRI ³ WINREVAIR ⁴ YUTREPIA	Use PA Form# 20420 1. Requires previous trials/failure of multiple preferred medications. 2. Dosing limits apply, see the Dose Consolidation List. 3. Require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 3 or 4. 4. Require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 2 or 3.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Sildenafil will be preferred with clinical PA for treatment of pulmonary arterial hypotension (WHO Group 1) in adults to improve exercise ability and delay clinical worsening. Avoid concomitant use of sildenafil with moderate or strong Cyp3A inhibitors. DDI: Uptravi will require a prior authorization if it is currently being used in combination with strong inhibitors of CYP2C8 (gemfibrozil). DDI: Opsumit will require a prior authorization if it is currently being used in combination with drugs known to be significant CYP3A inhibitors (ketoconazole, itraconazole, clarithromycin, indinavir, nefazodone, nelfinavir, ritonavir, atazanavir, saquinavir and telithromycin). DDI: Adempas will require a prior authorization if it is currently being used in combination with drugs known to be PDE inhibitors should be avoided (including dipyridamole, adcirca and tadalafil) with adempas. Liqrev treatment of pulmonary arterial hypertension (WHO Group 1) in adults to improve exercise ability and delay clinical worsening. Avoid concomitant use of liqrev with moderate or strong CYP3A inhibitors.
ERA / ENDOTHELIN RECEPTOR ANTAGONIST	MC MC	LETAIRIS ^{1,2} TRACLEER				Use PA Form# 20420 1. Providers must be registered with LEAP Prescribing program, a restricted distribution program. 2. Clinical PA is required to establish diagnosis and medical necessity.	Letairis approvals will require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and functional class 2 or 3 symptoms. Tracleer approvals will require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 2 thru 4. DDI: Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with tracleer.
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 MC MC/DEL MC MC/DEL	DOXYLAMINE SUCC-PYRIDOXINE DOXYLAMINE SUCC-PYRIDOXINE HCL MECLIZINE HCL TABS PROMETHAZINE SUPP PROMETHAZINE SCOPOLAMINE PATCH	MC MC MC MC MC MC MC MC		ANTIVERT TABS BARHEMSYS BONJESTA DICLEGIS NEREUS PHENERGAN SOLN PROMETHAZINE SOMG SUPP PROMETHEGAN SUPP TORECAN TABS	Use PA Form# 20420 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. DDI: Concomitant use of MAOIs and Bonjesta is contraindicated.	
ANTIEMETIC - 5-HT3 RECEPTOR ANTAGONISTS/ SUBSTANCE P NEUROKININ	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	DRONABINOLCAPS GRANISETRON TAB ONDANSETRON TAB ONDANSETRON ODT TDBP ONDANSETRON SOL	MC MC MC MC MC MC MC/DEL MC/DEL MC MC MC MC MC MC/DEL MC/DEL MC MC MC MC MC/DEL MC/DEL MC/DEL MC		AKYNZEO ¹ APREPITANT ALOXI ANZEMET TABS APONVIE ⁴ CESAMET ¹ CINVANTI ⁴ EMEND ² FOCINVEZ ^{1,2} KYTRIL MARINOL CAPS SANCUSO SUSTOL SYNDROS TRIMETHOBENZAMIDE CAP VARUBI ZOFRAN ODT TDBP ³ ZOFRAN TABS ³ ZOFRAN INJ ³ ZUPLENZ	Use PA Form# 20420 1. Approvals will require diagnosis of chemo-induced nausea/vomiting and failed trials of all preferred antiemetics, including 5-HT3 class (Ondansetron) and Marinol . 2. Clinical PA is required for members on highly emetic anti-neoplastic agents. 3. Dosing limits apply, see Dosage Consolidation List. 4. Clinical PA required for appropriate diagnosis.	Preferred drugs and step therapy must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. * Ondansetron limits still apply as listed on the Ondansetron PA form for covered indications including chemotherapy, radiotherapy, post operative nausea & vomiting and hyperemesis gravidarum. Other medical indications will be approved or denied on a case-by-case basis. Hyperemesis and other medical indications approved are still subject to failure of multiple preferred antiemesis drugs. Akynzeo - Concomitant use should be avoided in patients who are chronically using a strong CYP3A inducer such as rifampin. Aponvie is for the prevention of postoperative nausea and vomiting (PONV) in adults. Varubi – Available to the few who are unable to tolerate or who have failed on preferred medications.

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
NON-SEDATING ANTHISTAMINES / DECONGESTANTS							
ANTIHISTIMINES - NON-SEDATING	MC MC/DEL MC/DEL MC	ALAVERT TABS CETIRIZINE TABS LORATADINE TAVIST ND (OTC)	MC MC MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL	5 5 5 5 5 8 8 8 8 8 9	CLARINEX TABS ^{1,5} CLARINEX SYR ^{1,2} FEXOFENADINE ¹ ZYRTEC ¹ ZYRTEC SYR ^{1,2} ALLEGRA ³ CLARITIN ³ DES Loratadin LORATADINE ODT ⁴ LEVOCETIRIZINE ⁴ XYZAL ³	Use PA Form# 20530 1. Must fail preferred drugs, OTC loratadine and cetirizine before moving to non-preferred step order drugs. 2. Clarinex and Zyrtec syrup <6 yr w/o PA. 3. Must fail all step 5 drugs (clarinex, fexofenadine and zyrtec) before moving to next step product. 4. All OTC versions of Loratadine ODT are now non-preferred. 5. PA's for Clarinex RediTabs will only be approved if between the ages of 6-11 yrs old.	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. No combination product with decongestant will be approved since pseudoephedrine available without PA. Pseudoephedrine is available with prescription.
ANTIHISTIMINES - OTHER	MC/DEL MC/DEL MC/DEL	CLEMASTINE CHLORPHENIRAMINE DIPHENHYDRAMINE				Use PA Form# 20530	
ALLERGY / ASTHMA THERAPIES							
ANAPHYLACTIC DEVICES	MC MC/DEL MC/DEL MC/DEL	AUVI- Q EPINEPHRINE EPIPEN EPIPEN JR	MC MC		NEFFY TWINJECT	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.
ALLERGEN IMMUNOTHERAPY			MC MC MC MC MC		ODACTRA ¹ ORALAIR ¹ PALFORZIA RAGWITEK GRASTEK	Use PA Form# 20420 1. See criteria section	Prescriber must provide the testing to show that the patient is allergic to the components in the prescribed therapy and must provide a clinically valid rationale why single agent sublingual therapy is being chosen over subcutaneous therapy. Palforzia is approved for use in patients with a confirmed diagnosis of peanut allergy. Initial dose escalation may be administered to patients aged 4 through 17 years. Up-dosing and maintenance may be continued in patients 4 years of age and older. Odactra is approved for 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. Oralair 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 Ryegrass, Timothy, and Kentucky Bluegrass. Have an auto-injectable epinephrine on-hand.
ANTIASTHMATIC - ANTICHOLINERGICS - INHALER	MC MC/DEL MC/DEL	INCRUSE ELLIPTA ¹ SPIRIVA HANDIHALER ^{1,2} SPIRIVA RESPIMAT	MC MC/DEL		LONHALA MAGNAIR TUDORZA	Use PA Form# 20420 1. Quantity limit of 1 inhalation daily (1 capsule for inhalation daily). Spiriva will require PA if Combivent or Atrovent nebulizer solution is in member's current drug profile. 2. We ask physicians to write "asthma" on the prescription whenever Spiriva is primarily being used for that condition. 3. Quantity limit of 1 inhalation daily.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIASTHMATIC - DIPEPTIDYL PEPTIDASE 1 INHIBITATORS	MC	BRINSUPRI ¹				Use PA Form# 20420 1. Clinical PA is required to establish diagnosis and medical necessity.	BRINSUPRI required criteria include attestation of the following: • Imaging confirming bronchiectasis • Physician attestation of need for airway clearance • History of pulmonary exacerbations in the last 12 months based on age: – Members 18 years of age or older: ≥ 2 exacerbations requiring antibiotic therapy – Members 12 to 17 years of age: ≥ 1 exacerbation requiring antibiotic therapy • Must be prescribed by, or in consultation with, a pulmonary or infectious disease specialist • Prescriber attests that underlying causes of NCFB have been adequately addressed, if applicable
ANTIASTHMATIC - PHOSPHODIESTERASE 4 INHIBITORS	MC/DEL	ROFLUMILAST	MC/DEL MC		DALIRESP OHTUVAYRE ¹	Use PA Form# 20420 1. For the maintenance treatment of chronic obstructive pulmonary disease (COPD) in adult patients.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIASTHMATIC - ANTICHOLINERGICS - NEBULIZER	MC/DEL	IPRATROPIUM BROMIDE SOLN	MC/DEL		YUPELRI	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIASTHMATIC - ANTIINFLAMMATORY AGENTS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	CROMOLYN SODIUM NEBU DUPIXENT ^{2,4} FASENRA ⁶ FASENRA AUTO INJECT ⁶ XOLAIR ^{1,4}	MC MC MC MC MC		CINQAIR ³ EXDENSUR ⁵ NUCALA ² RHAPSIDO ⁴ TEZSPIRE ⁵	Use PA Form# 20420 1. Need max inhaled steroids and written by pulmonary or allergy specialist. Must have elevated IgE and ≥ age 6. 2. For patients with severe asthma aged 12 years or older and eosinophilia. 3. For patients ≥ 18 years of age with eosinophilia. 4. Clinical PA required to establish diagnosis and medical necessity. 5. For adult and pediatric patients aged 12 years and older with severe asthma. 6. For patients ≥ 6 years of age for eosinophilia.	All will require suboptimal response to maximal doses of inhaled steroid as evidenced by asthmatic ER/Hospital admissions and Allergy/Pulmonary specialist management. Dupixent limited to patient with asthma not controlled on high dose ICS-LABA who have eosinophil greater than or equal to 150 cells or the patient is depend on an oral corticosteroid. Fasenra, Nucala and Cinqair are not indicated for treatment of other eosinophilic conditions and are not indicated for the relief of acute bronchospasm or status asthmaticus. Rhaphido for Chronic Spontaneous Urticaria - 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.

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
ANTIASTHMATIC - NASAL STEROIDS	MC/DEL MC/DEL MC MC/DEL MC/DEL MC	BUDESONIDE SPRAY FLUTICASONE SPR ³ OLOPATADINE SPRAY OMNARIS SPR ³ TRIAMCINOLONE NS QNASL	MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC MC MC/DEL MC MC/DEL	8 8 8 8 8 8 8 8 8 8 8	DYMISTA FLONASE SUSP ^{2,3} FLUNISOLIDE SOLN ^{1,3} NASONEX SUSP RHINOCORT AERO ^{2,3} RHINOCORT AQUA SUSP ^{2,3} RYALTRIS ⁴ TRI-NASAL SOLN ^{2,3} VANCENASE POCKETHALER AERS ^{2,3} VERAMYST ^{2,3} XHANCE ² ZETONNA ³	Use PA Form# 20420 1. All preferred drugs must be tried before moving to non preferred steps. 2. All step 5 medications need to be tried before moving to step 8's. 3. Dosing limits apply to whole category, see Dosage Consolidation List. 4. Use of individual ingredients or other preferred agents.	All preferred drugs and step therapy must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Khance will be considered for the treatment of nasal polyps in patients 18 years of age or older. The patient has had a documented side effect, allergy, or treatment failure of two preferred nasal glucocorticoids, one of which must be fluticasone.
ANTIASTHMATIC - NASAL MISC.	MC/DEL MC/DEL MC	AZECLASTINE CROMOLYN NASAL 4% IPRATROPIUM NASAL SOL ¹	MC/DEL MC/DEL		ASTEPRO ² PATANASE	Use PA Form# 20420 1. Ipratropium will be approved if submitted with documentation supporting use of CPAP machine. 2. Utilize Multiple preferred, as well as step therapy Azelastine.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Approved if patient fails on non sedating antihistamines and steroid nasal sprays.
ANTIASTHMATIC - BETA - ADRENERGICS	MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC MC/DEL MC/DEL MC	ALBUTEROL 0.63mg/3ml ALBUTEROL HFA ALBUTEROL NEB LEVALBUTEROL TARTRATE METAPROTERENOL PROAIR DIGIHALER ⁴ PROAIR RESPICLICK PROVENTIL HFA SEREVENT STRIVERDI TERBUTALINE SULFATE TABS VENTOLIN HFA AERS	MC/DEL MC/DEL MC MC MC MC MC MC MC MC/DEL MC/DEL MC		AIRSUPRA ALBUTEROL HFA (labeler 66993001968) VOSPIRE ER TB12 XOPENEX HFA ³ XOPENEX NEBU ^{1,2}	Use PA Form# 20420 1. Xopenex users w/ prior asthma hospitalization due to albuterol nebulizer failure will be grandfathered. 2. Quantity Limit: 12 cc/day. 3. Dosing limits apply, see Dosage Consolidation List. 4. For the treatment of patients ≥ 4 years of age.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Airsupra has new PA criteria that include the patient is aged ≥ 18, AND the patient has had a documented side effect or allergy, AND treatment failure/intolerance or contraindication to Symbicort® and Dulera® SMART therapy, AND the patient is unable to use albuterol and budesonide separately.
ANTIASTHMATIC - ADRENERGIC COMBINATIONS	MC MC MC MC MC/DEL MC/DEL MC/DEL	ADVAIR DISKUS ¹ ADVAIR HFA ¹ AIRDUO RESPICLICK ² BREO ELLIPTA ¹ DULERA FLUTICASONE-SALMETEROL SYMBICORT	MC MC/DEL MC/DEL MC		AIRDUO DIGIHALER ² BREYNA BREZTRI AEROSPHERE TRELLEGY ELLIPTA ¹	Use PA Form# 20420 1. Dosing limits apply, see Dosage Consolidation List. 2. For patients ≥ 12 years and older.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. AirDuo® Respiclick be non-preferred and require prior authorization and be available to those who are unable to tolerate or who have failed on preferred medications. DDI: Avoid concomitant use of strong CYP3A4 inhibitors (e.g. ritonavir, atazanavir, clarithromycin, indinavir, itraconazole, nefazodone, nelfinavir, saquinavir, ketoconazole, telithromycin) with AirDuo® Respiclick is not recommended due to increased systemic corticosteroid and increased cardiovascular adverse effects.
ANTIASTHMATIC - ADRENERGIC ANTICHOLINERGIC	MC/DEL MC MC/DEL MC/DEL	ALBUTEROL/IPRATROPIUM NEB. SOLN ANORO ELLIPTA COMBIVENT RESPIMAT STIOLTO	MC/DEL MC		BEVESPI AEROSPHERE ^{2,3} DUAKLIR PRESSAIR	Use PA Form# 20420 1. Please use preferred individual ingredients Albuterol and Ipratropium. 2. Dosing limits apply, see Dosage Consolidation List. 3. The safety and efficacy of use in children under the age of 18 years have not been established.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Bevespi should be used with extreme caution in patients being treated with MAO inhibitors, TCAs, or other drugs known to prolong the QTc interval. DDI: Avoid concomitant use of Bevespi with other anticholinergic-containing drugs, due to an increased risk of anticholinergic adverse events. Bevespi should be used with extreme caution in patients being treated with MAO inhibitors, TCAs, or other drugs known to prolong the QTc interval.
ANTIASTHMATIC - XANTHINES	MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL	AMINOPHYLLINE TABS THEOCHRON TB12 THEOLAIR-SR TB12 THEOPHYLLINE CR TB12 THEOPHYLLINE ELIX THEOPHYLLINE SOLN THEOPHYLLINE ER CP12 THEOPHYLLINE ER TB12	MC MC		THEO-24 CP24	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIASTHMATIC - STEROID INHALANTS	MC MC/DEL MC/DEL MC/DEL MC	ARNUITY ELLIPTA ASMANEX TWISTHALER ^{3,4} ASMANEX HFA BUDESONIDE NEB 0.25MG & 0.5MG ¹ QVAR AERS ³	MC MC/DEL MC MC/DEL MC/DEL		AEROSPAN ALVESCO ³ ARMONAIR DIGIHALER BUDESONIDE NEB 1MG PULMICORT SUSP	Use PA Form# 20420 1. Budesonide Neb 0.25mg & 0.5mg will be preferred for members under the age of 8 years old. PA will be required for members 8 years of age and older, please consider other preferred options. 2. All preferred must be tried before moving to non preferred steps. 3. Dosing limits apply, see Dosage Consolidation List. 4. Asmanex 110mcg will be limited to member between the ages of 4-11 years old.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
ANTIASTHMATIC - 5-Lipoxygenase Inhibitors			MC		ZYFLO TABS	Use PA Form# 20420	Other Preferred asthma controller drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIASTHMATIC - LEUKOTRIENE RECEPTOR ANTAGONISTS	MC/DEL MC/DEL MC/DEL	MONTELUKAST GRANULE ¹ MONTELUKAST SODIUM TAB MONTELUKAST SODIUM CHEW TAB	MC/DEL MC/DEL MC/DEL		ACCOLATE TABS SINGULAIR ² SINGULAIR GRANULES	Use PA Form# 20420 1. Montelukast Granules will only be approved if between ages of 6 - 24 months. 2. Singulair Chewable 4mg from 2 years- 5 years and Singulair Chewable 5mgs from 6 years- 14 years old.	
ANTIASTHMATIC - ALPHA-PROTEINASE INHIBITOR			MC MC MC MC/DEL		ARALAST GLASSIA PROLASTIN SUSR ZEMAIRA	Use PA Form# 20420	Prolastin and Azemaira will be approved for members with A1AT deficiency and clinically demonstrable panacinar emphysema.
ANTIASTHMATIC - HYDRO-LYTIC ENZYMES			MC		PULMOZYME SOLN	Use PA Form# 20420	Will be approved for cystic fibrosis patients.
ANTIASTHMATIC - MUCOLYTICS	MC/DEL	ACETYL CYSTEINE ¹				Use PA Form# 20420 1. Acetylcysteine is covered with diagnosis of CF.	
ANTIASTHMATIC-CFTR POTENTIATOR AND COMBINATIONS			MC MC MC MC MC MC/DEL		ALYFTREK BRONCHITOL ¹ KALYDECO ORKAMBI SYMDEKO TRIKAFTA	Use PA Form# 20420 1. For the treatment of patients ≥18 years of age with CF.	Alftytrek will be considered for the treatment of patients 6 years and older with at least one responsive mutation, including 31 additional mutations not responsive to other CFTR modulator therapies. Bronchitol will be considered as add-on maintenance therapy to improve pulmonary function in adult patients 18 years and older with cystic fibrosis (CF). Use Bronchitol only for adults who have passed the Bronchitol Tolerance Test (BTT). (see Recommended Dosage section for further information). Kalydeco will be considered for patients with cystic fibrosis (CF) aged 1 month and older who have at least one mutation in the CFTR gene that is responsive to ivacaftor potentiation based on clinical and/or in vitro assay data. If the patient's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of a CFTR mutation followed by verification with bi-directional sequencing when recommended by the mutation test instructions for use. Orkambi will be considered for patients with cystic fibrosis (CF) aged 1 year and older who are homozygous for the F508del mutation in the CFTR gene. If the patient's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of the F508del mutation on both alleles of the CFTR gene. The efficacy and safety of Orkambi have not been established in patients with CF other than those homozygous for the F508del mutation. Symdeko will be considered for patients with cystic fibrosis (CF) aged 6 years and older who are homozygous for the F508del mutation or who have at least one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to tezacaftor/ivacaftor based on in vitro data and/or clinical evidence. If the patient's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of a CFTR mutation followed by verification with bi-directional sequencing when recommended by the mutation test instructions for use. Trikafta will be considered for the treatment of cystic fibrosis (CF) in patients aged 2 years and older who have at least one F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene or mutation in the CFTR gene that is responsive based on in vitro data. If the patient's genotype is unknown, an FDA-cleared CF mutation test should be used to confirm the presence of at least one F508del mutation or a mutation that is responsive based on in vitro data.
IDIOPATHIC PULMONARY FIBROSIS	MC/DEL MC	OFEV ¹ PIR Fenidone	MC MC/DEL		ESBRIET ¹ JASCAYD ¹	Use PA Form# 20420 1. Clinical PA is required to establish diagnosis and medical necessity.	Ofev- Avoid concomitant use with P-gp and CYP4A inducers (e.g. carbamazepine, phenytoin, and St. John's wort). Esbriet- The concomitant use with strong CYP1A2 inhibitors (e.g. fluvoxamine, enoxacin) is not recommended.
COUGH/COLD							
COUGH/COLD	MC/DEL MC/DEL MC/DEL MC/DEL MC MC	DEXTROMETHORPHAN CAPS ¹ DEXTRO-GUAIF SYRP ¹ GUAIFENESIN SYRP ¹ PSEUDOEPHEDRINE ¹ ROBITUSSIN DM SYRP ¹ ROBITUSSIN SUGAR FREE SYRP ¹				Use PA Form# 20420 1. All of cough cold preparations are not covered except these preferred products.	All non-preferred products are not covered as permitted by Federal Medicaid regulations and MaineCare Policy.
DIGESTIVE AIDS / ASSORTED GI							
GI - ANTIPERISTALTIC AGENTS	MC/DEL MC/DEL MC/DEL MC/DEL MC	DIPHENOXYLATE DIPHENOXYLATE/ATROPINE LOPERAMIDE HCL CAPS/LIQ OPIUM TINCTURE TINC PAREGORIC TINC	MC/DEL MC MC		LOFENE TABS LONOX TABS MOTOFEN TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Certain drugs require specific diagnoses for approval.
GI - ANTI-DIARRHEAL/ANTACID - MISC.	MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	ATROPINE SULFATE SOLN BISMATROL BISMUTH SUBSALICYLATE CALCIUM CARBONATE (ANTACID) CHEW DICYCLOMINE HCL GLYCOPYRROLATE TABS HYOSCYAMINE CAPS & TABS HYOSCYAMINE SULFATE KAOPECTATE MAGNESIUM OXIDE TABS MAG-OX 400 TABS PAMINE TABS PROPANTHELINE BROMIDE TABS SODIUM BICARBONATE TABS TUMS	MC/DEL MC/DEL MC/DEL MC MC MC MC MC MC MC MC MC MC MC MC		BELLADONNA ALKALOIDS & OP BENTYL TABS BENTYL SYRP CIVPOSA DARTISLA ODT ² ED-SPAZ MYTESI ¹ GLYCOPYRROLATE INJ LEVSIN TABS LEVSIN/SL SUBL NULEV TDP OSCIMIN ROBINUL INJ ROBINUL TABS	Use PA Form# 20420 1. Dosing limits apply, see Dose Consolidation List. 2. It is not indicated as monotherapy for treatment of peptic ulcer because effectiveness in peptic ulcer healing has not been established.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Certain drugs require specific diagnoses for approval. Preferred products that used to require diag codes still require diag codes unless indicated otherwise. Mytesi requires a diagnosis of non-infectious diarrhea in patients with HIV/AIDS on anti-retroviral therapy, prior trials of preferred, more cost effective anti-diarrheal.

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required	Criteria
GI- BILE ACID			MC MC		CHOLBAM ¹ CTXLI ¹	Indication of bile acid synthesis disorders due to single enzyme defects (SEDs) AND for adjunctive treatment of peroxisomal disorders (PDs). Use PA Form# 20420 1. Clinical PA is required to establish diagnosis and medical necessity.
GI- EOSINOPHILIC ESOPHAGITIS	MC	EOHILIA ¹				Use PA Form# 20420 1. Approvals will not be longer than 12 weeks of treatment in adult and pediatric patients 11 years of age and older. Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Eohilia: Dietary modification, PPIs, and topical glucocorticoids are required as initial therapy.
GI - H2-ANTAGONISTS	MC MC/DEL	ACID REDUCER TABS CIMETIDINE	MC/DEL MC		NIZATIDINE CAPS PEPCID AC	Use PA Form# 20420 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. DDI: Cimetidine will now be non-preferred and require prior authorization if it is currently being used with any sulfonylurea (except for glyburide). DDI: Cimetidine will require prior authorization if being used in combination with plavix.
GI- IBAT INHIBITORS			MC MC MC		BYLVAY ^{1,2} LIVMARLI ^{1,2} LYNAVOY ³	Use PA Form# 20420 1. For the treatment of patients ≥ 3 mos of age. 2. Clinical PA required for appropriate diagnosis. 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. LYNAVOY: FDA approved indication for the treatment of cholestatic pruritus associated with primary biliary cholangitis (PBC) in adult patients.
GI - PROTON PUMP INHIBITOR	MC/DEL MC/DEL MC/DEL	OMEPRAZOLE CAPS ² PANTOPRAZOLE ² LANSOPRAZOLE CAPS ²	MC/DEL MC/DEL MC MC/DEL MC MC MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC	6 6 7 7 8 8 8 8 8 8 8 8 8 8	NEXIUM CPDR ³ NEXIUM SUS ⁵ PRILOSEC OTC ³ ACIPHEX TBEC ³ DEXILANT (KAPIDEX) ² KONVOMEP ² OMEPRAZOLE-SODIUM BICARBONATE CAPS OMEPRAZOLE MAGNESIUM PREVACID CPDR ³ PREVACID SOLUTABS ^{1,4} PRILOSEC CPDR PROTONIX INJ PROTONIX ² VOQUEZNA TABS	Use PA Form# 20720 1. Prevacid Solutabs available without PA for child less than 9 years old. 2. Dosing limits apply, please see Dosage Consolidation List. 3. All preferred and step therapy must be tried and failed. 4. Payment for Prevacid Solutabs for patients 9 and older will be considered for those patients who cannot tolerate a preferred solid oral dosage form. 5. Nexium sus available without PA if member is <12 yrs of age and ≤1 pack per day. All preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step-order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Please refer to the PPI PA form for additional criteria on Non-Preferred PPIs. DDI: Omeprazole will require prior authorization if being used in combination with plavix. DDI: Lansoprazole will require prior authorization if being used in combination with plavix. DDI: Prevacid, Omeprazole and Pantoprazole will now be non-preferred and require prior authorization if they are currently being used in combination with any of the following medications: ampicillin, B-12, fe salts, griseofulvin, sporanox, ketoconazole, reyataz, or vantin. DDI: All non-preferred PPIs require prior authorization, but with any prior authorization request, the member's drug profile will also be monitored for current use with ampicillin, B-12, Fe salts, griseofulvin, itraconazole, ketoconazole, reyataz or vantin due to a significant drug-drug interaction.
GI - ULCER ANTI-INFECTIVE	MC MC	PYLERA TALICIA	MC MC		VOQUEZNA DUAL PAK VOQUEZNA TRIPLE PAK	Use PA Form# 20420
GI - PROSTAGLANDINS	MC	MISOPROSTOL TABS	MC/DEL		CYTOTEC TABS	Use PA Form# 20420 Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drug will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
GI - DIGESTIVE ENZYMES	MC/DEL MC	CREON ¹ ZENPEP ¹	MC/DEL MC	8 8	PERTZYE VIOKACE	Use PA Form# 20420 1. Clinical PA is required to establish CF diagnosis and medical necessity. In all cases except cystic fibrosis patients, objective evidence of pancreatic insufficiency (fat malabsorption test etc) must be supplied. Non-Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before other non-preferred drugs will be approved in step-order , unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
GI - ANTI - FLATULENTS / GI STIMULANTS	MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC/DEL	AMITIZA CALULOSE SYRP CONSTULOSE SYRP ENULOSE SYRP GASTROCROM CONC GENERLAC SYRP LACTULOSE SYRP LUBIPROSTONE METOCLOPRAMIDE HCL	MC MC/DEL MC MC/DEL MC MC/DEL MC/DEL MC MC/DEL		CEPHULAC SYRP INFANTS GAS RELIEF SUSP GIMOTI SPRAY REGLAN TABS	Use PA Form# 20420 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Certain drugs require specific diagnoses for approval.
GI - INFLAMMATORY BOWEL AGENTS	MC MC MC/DEL MC/DEL	MESALAMINE ENIMA KIT PENTASA SULFAZINE EC TBEC SULFASALAZINE TABS	MC/DEL MC/DEL MC MC/DEL MC/DEL		AZULFIDINE EN-TABS TBEC AZULFIDINE TABS DIPENTUM CAPS GIAZO LIALDA TABS ¹ ROWASA ENEM SFROWASA	Use PA Form# 20420 1. Current users grandfathered. Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Giazo is only indicated for males, as the safety efficacy for use in females has not been established. Prior trials of preferred products.
GI - IRRITABLE BOWEL SYNDROME AGENTS	MC	LOTIRONEX TABS	MC		VIBERZI	Use PA Form# 20420 Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
INTRA-VAGINALS							
VAGINAL - ANTIBACTERIALS	MC/DEL MC/DEL MC MC/DEL	CLEOCIN CREA CLEOCIN SUPP CLINDESSE CREA NUVESSA	MC MC/DEL MC	8 8 8	METROGEL VAGINAL GEL ¹ VANDAZOLE XACIATO	Use PA Form# 20420. 1. Dosing limits apply, see Dosage Consolidation List.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before less preferred drugs will be approved in step-order , unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
VAGINAL - ANTI FUNGALS	MC/DEL MC/DEL MC/DEL MC MC MC/DEL MC/DEL MC MC/DEL MC MC	CLOTRIMAZOLE CREA CLOTRIMAZOLE-3 CREA GYNE-LOTTRIMIN CREA MICONAZOLE CREA MICONAZOLE 3 KIT CREA OTC MICONAZOLE 7 CREA MICONAZOLE NITRATE CREA NYSTATIN TABS TERCONAZOLE CREAM VAGITROL V-R MICONAZOLE-7 CREA	MC MC MC MC MC/DEL MC/DEL MC MC MC/DEL MC MC		AVC CREA CLOTRIMAZOLE 3 DAY CREA GYNAZOLE-1 CREA GYNE-LOTTRIMIN 3 TABS MICONAZOLE 3 COMBO PACK KIT ¹ MICONAZOLE 3 SUPP TERAZOL 3 CREA TERAZOL 7 CREA TERCONAZOLE SUPP	Use PA Form# 20420. 1. Quantity limit: 1/script/2 weeks.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. DDI: Miconazole will require prior authorization if being used in combination with warfarin.
VAGINAL - ESTROGENS	MC/DEL MC/DEL	ESTRING RING PREMARIN CREA	MC/DEL MC/DEL		ESTRACE CREA ¹ VAGIFEM TABS ¹	Use PA Form# 20420. 1. Must fail all preferred products before non-preferred.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
VAGINAL - OTHER	MC/DEL MC MC	ACID JELLY GEL ACI-JEL GEL CERVICAL AMINO ACID CREA	MC		AMINO ACID CERVICAL CREA	Use PA Form# 20420.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
BENIGN PROSTATIC HYPERPLASIA (BPH)							
BPH	MC/DEL MC/DEL MC/DEL MC/DEL	DOXAZOSIN MESYLATE TABS FINASTERIDE ¹ 5mg TERAZOSIN HCL CAPS TAMSULOSIN HCL	MC/DEL MC/DEL MC MC/DEL MC MC MC/DEL MC/DEL MC MC/DEL	5 8 8 8 8 8 8 8 8 8 8	FLOMAX CP24 ALFUZOSIN AVODART ^{2,4} CARDURA TABS ⁴ ENTADFI ^{8,6} JALYN ^{3,4} PROSCAR TABS ⁴ RAPAFLO ⁴ TEZRULY UROXATRAL ⁴	Use PA Form# 20420. 1. There will be dosing limits of 1 tab per day without PA. 2. Prior use of preferred agent prior to any approvals. 3. Use of preferred (Tamsulosin and Finasteride) and (Tamsulosin and non-preferred Avodart). 4. Non-preferred products must be used in specified order. 5. Use of individual ingredients preferred (Finasteride and Tadalafil). 6. Entadfi is not recommended for more than 26 weeks.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Approval of a non-preferred 5-alpha reductase inhibitor requires objective clinical evidence of a very enlarged prostate rather than just the presence of obstructive urinary outflow symptoms along with adequate trial of preferred proscar.
ANXIOLYTICS							
ANXIOLYTICS - BENZODIAZEPINES	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	ALPRAZOLAM TABS CHLORDIAZEPOXIDE HCL CAPS CLORAZEPATE DIPOTASSIUM TABS DIAZEPAM OXAZEPAM CAPS	MC/DEL MC MC/DEL MC/DEL MC/DEL		ALPRAZOLAM ER LOREEV XR NIRAVAM TRANXENE XANAX TABS XANAX XR	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.
ANXIOLYTICS - MISC.	MC/DEL MC MC MC/DEL MC/DEL MC/DEL	BUSPIRONE HCL TABS HYDROXYZINE HCL SOLN HYDROXYZINE HCL SYRP HYDROXYZINE HCL TABS ¹ HYDROXYZINE PAMOATE CAPS MEPROBAMATE TABS	MC MC MC MC/DEL MC/DEL		BUSPAR TABS DROPERIDOL SOLN DROPERIDOL SOLN DROPERIDOL SOLN	Use PA Form# 20420. 1. Dosing limits apply, see Dose Consolidation List.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTI-DEPRESSANTS							
ANTIDEPRESSANTS - MAO INHIBITORS	MC/DEL	NARDIL TABS	MC/DEL		TRANLYCYPROMINE	Use PA Form# 20420.	
ANTIDEPRESSANTS - MAO INHIBITORS TOPICAL			MC/DEL		EMSAM ¹	Use PA Form# 20420. 1. Dosing limits apply, see Dose Consolidation List.	Preferred drugs (including a preferred SSRI, a non-SSRI, and venlafaxine ER) must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIDEPRESSANTS - SELECTED SSRI's AND OTHERS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	BUPROPION SR BUPROPION XL 150mg and 300mg CITALOPRAM DULOXETINE ^{2,9} ESCITALOPRAM FLUOXETINE 10mg AND 20mg CAPS FLUOXETINE 10mg AND 20mg TABS FLUOXETINE HCL LIQD FLUVOXAMINE MALEATE TABS MIRTAZAPINE NEFAZODONE	MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC/DEL	8 8 8 8 8 8 8 8 8 8 8	AUVELITY ¹¹ BUPROPION XL 450mg CELEXA CYMBALTA ² DRIZALMA SPRINKLES EFFEXOR TABS EFFEXOR XR CP24 EXXUA ¹⁰ FETZIMA ⁷ FORFIVO XL IRENKA	Use PA Form# 20420. 1. Strong caution with pediatric population. 2. Max daily dose allowed is 120mg, combination of multiple strengths require PA. 4. Dosing limits allowing 2 tabs/day and a max daily limit of 200mg / day applies. See Dose Consolidation List. 5. Dosing limits apply, see Dose Consolidation List and max daily dose applies. Max daily dose allowed is 375mg.	Preferred drugs (including failure of at least one preferred SSRI, one SNRI and one non-SSRI/SNRI) must be tried for at least 4 weeks each and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Cymbalta: Fibromyalgia diagnosis- prior use and failure of preferred generics (amitriptyline or cyclobenzaprine) and gabapentin prior to approval. Savella: Fibromyalgia diagnosis and trial of a preferred generic amitriptyline, cyclobenzaprine, duloxetine and gabapentin prior to approval. Zulresso is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS) called the Zulresso REMS. Spravato: Treatment Resistant Depression: • Must be 18 years of age or older; and medication must be administered under the direct, on site, supervision of a licensed healthcare provider with post-administration observation of a minimum of least 2-hours. The medication must be prescribed by or in consultation with a psychiatrist and prescriber must be enrolled in the REMS program.

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	PAROXETINE ¹ SERTRALINE HCL TRAZODONE HCL TABS VENLAFAXINE ER CAPS ¹³ VENLAFAXINE TABS ⁵	MC/DEL MC/DEL MC MC MC/DEL MC MC/DEL MC/DEL MC/DEL MC MC MC MC MC/DEL MC/DEL MC/DEL MC/DEL MC MC MC/DEL MC/DEL MC MC MC/DEL MC/DEL MC/DEL MC/DEL MC MC MC/DEL MC/DEL	8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 9 9	KHEDEZLA LEXAPRO TABS LUVOX TABS MAPROTILINE HCL TABS MIRTAZAPINE ODT OLEPTRO PAROXETINE CR ¹ PAXIL ¹ PAXIL CR ¹ PRISTIQ PROZAC PROZAC CAPS PROZAC WEEKLY CPDR RALDESY REMERON TABS REMERON SOLTAB TDP SARAFEM CAPS SAVELLA ⁴ SPRAVATO ⁸ TRAZODONE HCL 300MG TABS TRINTELIX VENLAFAXINE ER TABS ⁵ WELLBUTRIN TABS WELLBUTRIN SR TBCR ZOLOFT ZULRESSO ¹⁰ ZURZUVAE ¹² FLUOXETINE 90mg TABS ⁶ VIBRYD ⁶	6. Non-preferred products must be used in specified step order. 7. Requires previous trials/failure of multiple preferred medications. Dosing limits apply, see Dose Consolidation List. Max daily dose of 80mg if used concomitantly with strong CYP3A4 inhibitor. 8. Psychiatry recommended. Please see criteria section. 9. Please use multiples of the 20mg; the 40mg is still non-preferred. 10. For the treatment of patients ≥ 18 years of age. 11. Use individual ingredients separately. 12. Approval will be limited to a 14-day treatment course. 13. Dosing limits apply, see Dose Consolidation List and max daily dose applies. Max daily dose allowed is	* Approval is based upon failure of at least two antidepressants and failure of an antidepressant used adjunctively with one recognized augmentation strategy such as lithium, an atypical antipsychotic, thyroid hormone, etc. * Ongoing use of Spravato beyond 3 months is based upon a positive response as evidenced by at least a 30 % reduction from baseline as measured by a standardized rating scale including PHQ 9, Hamilton Depression Rating Scale, or QIDS). Spravato: MDD with Suicidal Ideation. Approval for this indication only if it is started in an inpatient unit, given adjunctively with an optimized antidepressant regimen, and with an 8-12 week initial approval with ongoing use dependent upon documentation of ongoing benefit. DDI: Drizalma Sprinkle avoid the concomitant use of duloxetine with potent CYP1A2 inhibitors (e.g. fluvoxamine, cimetidine, ciprofloxacin, enoxacin). DDI: Fluvoxamine will require prior authorization if being used in combination with plavix. DDI: Fluvoxamine will now be non-preferred and require prior authorization if it is currently being used with glimepiride (amaryl). DDI: Fluoxetine will require prior authorization if being used in combination with plavix. DDI: Preferred Nefazodone will now be non-preferred and require prior authorization if it is currently being used in combination with either onglyza 5mg, enablex 15mg or vesicare 10mg. DDI: Reduce the Zurzuvae dosage when used with a strong CYP3A4 inhibitor.
ANTIDEPRESSANTS - TRI-CYClics	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC MC/DEL MC/DEL	AMITRIPTYLINE HCL TABS ¹ CLOMIPRAMINE HCL CAPS ¹ DESIPRAMINE HCL TABS ¹ DOXEpin HCL ¹ (not generic Silenor) IMIPRAMINE HCL TABS ¹ NORTRIPTYLInE HCL ¹ PROTRIPTYLINE HCL TABS ¹ SURMONTIL CAPS ¹	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC MC/DEL MC/DEL		AMOXAPINE TABS ANAFRANIL CAPS DOXEpin HCL 150 MG ² DOXEpin (generic Silenor) NORPRAMIN TABS PAMELOR TOFRANIL VIVACTIL TABS	Use PA Form# 20420 Use PA Form# 10220 for Brand Name requests 1. Users over the age of 65 require a PA. 2. Use multiples of 50mg.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
SEDATIVE / HYPNOTICS							
SEDATIVE/HYPNOTICS - BARBITURATE	MC MC/DEL MC MC/DEL	BUTISOL SODIUM TABS ¹ CHLORAL HYDRATE SYRP ¹ MEBARAL TABS ¹ PHENOBARBITAL ¹	MC MC/DEL		LUMINAL SOLN SOMNOTE CAPS	Use PA Form# 20420 1. PA required for new users of preferred products if over 65 years.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
SEDATIVE/HYPNOTICS - BenzODIAZEPINES	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	DORAL TABS ¹ ESTAZOLAM TABS ¹ FLURAZEPAM HCL CAPS ¹ TEMAZEPAH CAPS 15 & 30MG ¹ TRIAZOLAM TABS ¹	MC MC MC/DEL MC/DEL		HALCION TABS ¹ MIDAZOLAM HCL SYRP RESTORIL CAPS ¹ TEMAZEPAH 7.5MG ¹	Use PA Form# 30110 1. Dosing limits apply, see Dosing Consolidation List.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Benzodiazepines do cause dependence with continued use and usage should be limited to 7-10 days at a time. Chronic intermittent use (2-3 days per week max) is the standard of care.
SEDATIVE/HYPNOTICS - Non-BenzODIAZEPINES	MC/DEL MC MC/DEL MC/DEL	MIRTAZAPINE TRAZODONE ZOLPIDEM ² ZALEPLON ²³	MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC MC/DEL		AMBIEN ¹ ESZOPICLONE ZOLPIDEM ER AMBIEN CR ¹ BELSOMRA ¹ DAYVIGO ¹ EDLUAR HETLIOZ INTERMEZZO LUNESTA ¹ SONATA CAPS ¹ ROZEREM QUVIVIQ ZOLPIMIST	Use PA Form# 30110 1. Quantity Limit of 12 per 34 days. 2. Quantity limits will be allowed up to 30/30, but intermittent therapy is recommended. 3. Only Zolpidem trial/failure will be required to obtain Zaleplon. 4. Must fail all preferred products before non-preferred.	All preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Ambien, Ambien CR, Lunesta, Sonata, Zaleplon and Zolpidem may cause dependence with continued use and as with benzodiazepines, usage should be limited to 7-10 days at a time. Chronic intermittent use (2-3 days per week max) is the standard of care. Please refer to Sedative/Hypnotic PA form. DDI: Belsomra with strong CYP3A inhibitors (e.g. ketoconazole, itraconazole, posaconazole, clarithromycin, nefazodone, ritonavir, saquinavir, nelfinavir, indinavir, boceprevir, telaprevir, telithromycin, and conivaptan) is not recommended.

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
ANTI-PSYCHOTICS							
ANTIPSYCHOTICS - ATYPICALS	MC	ABILIFY ASIMTUFI	MC/DEL	8	ABILIFY DISC TAB, INJ and SOL ¹	Use PA form# 20440 for Multiple Antipsychotic requests Use PA form# 10130 for non-preferred single therapy atypical requests If prescribing 2 or more antipsychotics, PA will be required for both drugs, except if one is Clozapine . This includes combination of Seroquel with Seroquel XR . 1. Established users of single therapy atypicals were grandfathered. 2. Prior Authorization will be required for preferred medications for members under the age of 5. 3. Dosing limits apply, refer to the Dose Consolidation List. 4. Requires step through one (1) preferred drug for all indications except AMDD. AMDD requires insufficient response from two antidepressants. 5. Will require a step through one (1) preferred drug for all indications. Prior Auth required for < 18 years of age.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Non preferred atypicals will be approved for patients with FDA-approved indications, and for specific conditions supported by at least two published peer-reviewed double-blinded, placebo-controlled randomized trials that are not contradicted by other studies of similar quality and as long as all first line preferred therapies have been tried and failed at full therapeutic doses for adequate durations (at least two weeks). Quetiapine prescriptions for are limited to a maximum daily dose of 800mg. Uzedy: Establish tolerability with oral risperidone prior to initiating Uzedy. Atypicals: Prior Authorization will be required for preferred medication to assure indication is in accordance with FDA approved or literature supported evidence-based best practices. The approved indications are: • schizophrenia • bipolar disorder • agitation related to autism • adjunct in major depressive disorder Lybalvi: Step through aripiprazole and latuda. If criteria is met then initial approval for 3 months. Subsequent approvals will be based on evidence of not gaining >= 10% baseline body weight for ongoing approval. If weight gain >= 10% of initial body weight, then criteria for ongoing use not met. Cobenfy: Patient must be 18–65 years old AND meet criteria for the diagnosis of schizophrenia, AND trial of 2 prior preferred second generation antipsychotics showing minimal response in control of symptoms of schizophrenia OR trial of SGA that have yielded side effects of weight gain which has not been responsive to lifestyle & medication augmentation AND patient must have baseline tests including heart rate, liver enzymes, kidney function tests, and bilirubin prior to starting treatment. Invega Hafyera: The patient is started and stabilized on the medication OR the patient has been adequately treated with Invega Sustenna (paliperidone palmitate 1-month) for at least four months or Invega Trinza (paliperidone palmitate 3- month) following at least one 3-month injection cycle. DDI: It is recommended to reduce the Vraylar dose if it is used concomitantly with a strong CYP3A inhibitor (such as itraconazole, ketoconazole). The concomitant use of Vraylar with a CYP3A4 inducer (such as rifampin, carbamazepine) is not recommended. DDI: The concomitant use of Nuplazid with other drugs known to prolong the QT interval (e.g. Class IA antiarrhythmics, Class 3 antiarrhythmics, antipsychotics, and antibiotics such as gatifloxacin and moxifloxacin).
	MC	ABILIFY MAINTENA	MC	8	ABILIFY TABS ²		
	MC/DEL	ARIPIPRAZOLE SOL	MC/DEL	8	ARIPIPRAZOLE ODT		
	MC/DEL	ARIPIPRAZOLE TAB ³	MC	8	BYSANTI		
	MC	ARISTADA	MC	8	COBENFY		
	MC	ARISTADA INITIO	MC	8	ERZOFR		
	MC	CAPLYTA ⁵	MC	8	FANAPT		
	MC/DEL	OLANZAPINE ^{2,3}	MC/DEL	8	GEODON		
	MC/DEL	OLANZAPINE ^{2,3} ODT	MC	8	INVEGA		
	MC/DEL	INVEGA HAFYERA	MC	8	IGALMI		
	MC	INVEGA SUSTENNA	MC	8	LATUDA		
	MC/DEL	INVEGA TRINZA INJ	MC	8	LYBALVI		
	MC/DEL	LURASIDONE TAB	MC	8	NUPLAZID		
	MC/DEL	PALIPERIDONE ER	MC	8	OPIZA		
	MC/DEL	PERSERIS	MC	8	REXULTI		
	MC	RISPERDAL CONSTA	MC	8	RISPERDAL TAB		
	MC/DEL	RISPERIDONE ODT	MC	8	RISPERDAL M TAB ¹		
	MC/DEL	RISPERIDONE TAB ^{2,3}	MC	8	RISPERDAL SOLN		
	MC/DEL	RISPERIDONE SOLN ²	MC	8	RYKINDO		
	MC/DEL	QUETIAPINE ^{2,3}	MC/DEL	8	SAPHRIS ¹		
	MC/DEL	QUETIAPINE XR	MC	8	SECUADO		
	MC	UZEDY	MC/DEL	8	SEROQUEL TABS		
	MC	VRAYLAR ⁴	MC	8	ZYPREXA TABS		
	MC/DEL	ZIPRASIDONE ^{2,3}	MC	8	ZYPREXA RELPREVV		
			MC	8	ZYPREXA ZYDIS TBDP ¹		
			MC/DEL	9	SEROQUEL XR		
ANTIPSYCHOTICS - SPECIAL ATYPICALS	MC/DEL	CLOZAPINE TABS	MC/DEL		CLOZAPINE ODT	Use PA Form# 20420	Preferred generic drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred brand will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Patients previously stabilized on brand name drug will be approved.
			MC		CLOZARIL TABS		
			MC/DEL		VERSACLOZ SUSP		
ANTIPSYCHOTICS - TYPICAL	MC/DEL	CHLORPROMAZINE HCL	MC/DEL		COMPAZINE	Use PA Form# 20420 If prescribing 2 or more antipsychotics, PA will be required for both drugs, except if one is Clozapine .	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. If prescribing 2 or more antipsychotics, PA will be required for both drugs, except if one is Clozapine .
	MC/DEL	FLUPHENAZINE DECANOATE	MC/DEL		COMPRO SUPP		
	MC/DEL	FLUPHENAZINE HCL	MC/DEL		FLUPHENAZINE HCL CONC		
	MC	HALDOL	MC		HALDOL DECANOATE		
	MC/DEL	HALOPERIDOL	MC/DEL		LOXITANE CAPS		
	MC	HALOPERIDOL DECANOATE SOLN	MC		MELLARIL		
	MC	HALOPERIDOL LACTATE SOLN	MC/DEL		NAVANE CAPS		
	MC/DEL	LOXAPINE SUCCINATE CAPS	MC		PROLIXIN		
	MC/DEL	LOXITANE-C CONC	MC		STELAZINE TABS		
	MC	MOBAN TABS					
	MC/DEL	PERPHENAZINE					
	MC/DEL	PROCHLORPERAZINE					
	MC/DEL	THIORIDAZINE HCL					
	MC/DEL	THIOTHIXENE					
MC/DEL	TRIFLUOPERAZINE HCL TABS						
LITHIUM							
LITHIUM	MC/DEL	LITHIUM CARBONATE	MC/DEL		ESKALITH CAPS	Use PA Form# 20420	
	MC/DEL	LITHIUM CITRATE SYRP	MC/DEL		ESKALITH CR TBCR		
COMBINATION - PSYCHOTHERAPEUTIC							
PSYCHOTHERPEUTIC COMBINATION			MC/DEL		CHLORDIAZEPOXIDE/AMITRIPT	Use PA Form# 20420	
			MC/DEL		PERPHENAZINE/AMITRIPTYLIN		
STIMULANTS							
STIMULANT - AMPHETAMINES -SHORT ACTING	MC/DEL	AMPHETAMINE SALT COMBO ^{1,3,4}	MC/DEL		ADDERALL TABS ^{1,2,3}	Use PA Form# 20420 1. Preferred stimulants will be available without PA if diagnosis of ADHD or Narcolepsy. 2. As per recent FDA alert, Adderall & Dexedrine should not be used in patients with underlying heart defects since they may be at increased risk for sudden death. 3. Dosing limits apply, see Dosing Consolidation List. 4. Max daily dose of 50mg.	
	MC/DEL	DEXTROAMPHET SULF TABS ^{1,2,3}	MC		EVEKEO		
	MC	PROCENTRA ^{1,3}	MC/DEL		METHAMPHETAMINE HCL		
			MC		ZENZEDI		

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required	Criteria
STIMULANT - LONG ACTING AMPHETAMINES SALT	MC MC/DEL MC/DEL MC	ADDERALL XR CP24 ^{1,3,4,7} AMPHETAMINE/DEXTROAMPHET ER ^{3,4,7} LISDEXAMFETAMINE CAP VYVANSE ^{2,3,4}	MC/DEL MC MC MC		AMPHETAMINE-DEXTROAMPHETAMINE 3-BEAD CAP ER 24HR ARYNTA MYDAYIS ⁵ VYVANSE CHEW ⁴ XELSTRYM ⁸	Use PA Form# 20420. 1. As per recent FDA alert, Adderall should not be used in patients with underlying heart defects since they may be at increased risk for sudden death. 2. FDA approval is currently for adults and children 6 or older. Will be available without PA for this age group if within dosing limits. Limit of one capsule daily. Max dose of 70MG daily. 3. Preferred stimulants will be available without PA if diagnosis of ADHD. 4. Dosing limits apply, see Dosing Consolidation List. 5. For the treatment of Attention Deficit Hyperactivity Disorder (ADHD) in patients 13 years and older. 7. FDA approval is currently for adults and children 6 or older. Will be available without PA for this age group if within dosing limits. Max dose of 50MG daily without a PA. 8. For the treatment of patients ≥6 years of age.
LONG ACTING AMPHETAMINES	MC MC/DEL MC	DEXTROAMPHET SULF CPSR ^{1,3} DEXTROAMPHETAMINE ER DYANAVAL XR SUS	MC/DEL MC MC MC MC		ADZENYS ER ³ ADZENYS XR- ODT ADZENYS XR ³ DEXEDRINE CAP SR ^{2,3} DYANAVAL XR TAB	Use PA Form# 20420. 1. Preferred stimulants will be available without PA if diagnosis of ADHD. 2. As per recent FDA alert, Adderall & Dexedrine should not be used in patients with underlying heart defects since they may be at increased risk for sudden death. 3. Dosing limits apply, see Dosing Consolidation List.
STIMULANT - METHYLPHENIDATE	MC/DEL MC/DEL MC/DEL MC/DEL	DESMETHYLPHENIDATE IR TABS METHYLPHENIDATE SOL METHYLPHENIDATE TAB METHYLIN TABS ^{1,2}	MC/DEL MC/DEL MC MC MC/DEL MC/DEL		FOCALIN IR TABS METADATE ER METHYLPHENIDATE HCL CHEW METHYLIN CHEWABLES METHYLIN SOL RITALIN	Use PA Form# 20420. 1. Preferred stimulants will be available without PA if diagnosis of ADHD. 2. Dosing limits apply, see Dosing Consolidation List. Maximum daily doses are as follows: 72mg daily for Methylphenidate and 36mg daily for Dexmethylphenidate .
STIMULANT - METHYLPHENIDATE - LONG ACTING	MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC MC/DEL	CONCERTA TBCR DESMETHYLPHENIDATE CAP ER 50/50 FOCALIN XR METHYLPHENIDATE LA CAPS METHYLPHENIDATE ER CAPS 50/50 METHYLPHENIDATE ER CAPS 40/60 METHYLPHENIDATE CD CAPS 30-70 QUILLICHEW ER ^{5,1} QUILLIVANT XR SUS ^{1,5} RITALIN LA ⁴	MC MC/DEL MC MC MC MC MC/DEL MC/DEL MC/DEL	5 8 8 8 8 8 8 8 8	METADATE CD CPR ADHANSA XR ^{2,6} APTENSIO XR ² AZSTARYS ⁶ COTEMPLA XR ² COTEMPLA XR ODT ² DAYTRANA ^{2,3} JORNAY PM ^{2,6} METHYLPHENIDATE ER CAPS ^{2,4}	Use PA Form# 20420. 1. Preferred stimulants will be available without PA if diagnosis of ADHD. 2. Non-preferred products must be used in specified step order. 3. FDA approval currently only for ages 6-16. Limit of one patch daily. Max dose of 30MG daily. 4. Dosing limits apply, see Dosing Consolidation List. 5. Quilivant XR and Quillichew ER are only indicated for use in patients ≥ 6 yrs of age. 6. For the treatment of patients ≥ 6 yrs of age.
STIMULANT - STIMULANT LIKE	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC	ATOMOXETINE HCL ARMODAFINIL CLONIDINE ER GUANFACINE ER MODAFINIL TABS QELBREE ^{5,7}	MC/DEL MC MC MC MC/DEL MC MC MC MC MC MC/DEL MC MC	7 7 8 8 8 8 8 8 8 8 9 9 9	PROVIGIL TABS ³ STRATTERA ^{1,2} ATONCY ⁶ CAFCIT SOLN ³ INTUNIV KAPVAY ONYDA XR ⁶ SUNOSI WAKIX XYREM SOL XYWAV ⁴ NUVIGIL ³ DESOXYN TABS ³ DESOXYN CR ³	Use PA Form# 20710 for Provigil, Nuvigil and Xyrem Use PA Form# 20420 for all others 1. Failure of both an amphetamine and methylphenidate is required for consideration for approval of Strattera , unless history of substance abuse without current use of abuseable medication(s). Additionally, for patients <17 years of age, a trial of Guanfacine required before approval of Strattera . 2. Strattera currently has dosing limitations allowing one tablet per day for all strengths if obtain approval. Max daily dose of Strattera is 100mg. Please see Dosing Consolidation List. 3. Non-preferred products must be used in specified step order. 4. Please use generic Guanfacine. 5. For patients 7 years of age and older with narcolepsy.

DDI: The concomitant use of **Mydayis** is contraindicated with monoamine oxidase inhibitors (MAOIs) or within 14 days after discontinuing MAOI treatment, as concomitant use can increase hypertensive crisis.

DDI: The concomitant use of **Adzenys XR** is contraindicated with monoamine oxidase inhibitors (MAOIs) or within 14 days after discontinuing MAOI treatment.

Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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.

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

Sunosoi is non-preferred and is indicated to improve wakefulness in adult patients with excessive daytime sleepiness associated with narcolepsy or obstructive sleep apnea (OSA).

Wakix is non-preferred and is indicated for the treatment of excessive daytime sleepiness (EDS) in adults with narcolepsy.

Xywav: Diagnosis of cataplexy associated with narcolepsy OR excessive daytime sleepiness associated with narcolepsy. Diagnosis must be confirmed by submission of supporting documentation to include the specialist's interpretation of the Polysomnography (PSG) and Multiple Sleep Latency Test (MSLT) results.

FDA reminded healthcare professionals and patients that the combined use of **Xyrem** (sodium oxalate) with alcohol or central nervous system (CNS) depressant drugs can markedly impair consciousness and may lead to severe breathing problems (respiratory depression).

DDI: **Sunosoi** is contraindicated with MAO inhibitors or within 14 days after discontinuing the MAO inhibitor.

DDI: Concomitant use of **Qelbree** with an MAO inhibitor or within 2 weeks after discontinuing an MAO inhibitor is contraindicated.

DDI: Concomitant use of **Qelbree** significantly increases the total exposure, but not peak exposure, of sensitive CYP1A2 substrates, which may increase the risk of adverse reactions associated with these CYP1A2 substrates. Coadministration of Qelbree with sensitive CYP1A2 substrates or CYP1A2 substrates with a narrow therapeutic range (e.g. alosetron, duloxetine, ramelteon, tasimelteon, tizanidine, theophylline), is contraindicated.

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
						6. For pediatric patients 6 years of age or older. 7. Preferred with a trial and fail either Atomoxetine OR any 2 preferred ADHD agents.	
ANTI-CATALECTIC AGENTS							
PSYCHOTHERAPEUTIC AGENTS - MISC.			MC MC		NUEDEXTA XENAZINE	Use PA Form# 20710 for Xenazine	
WEIGHT LOSS							
WEIGHT LOSS						No longer covered: Phentermine, Xenical, Dibrex, 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 MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	DONEPEZIL HYDROCHLORIDE TABS ¹ DONEPEZIL HYDROCHLORIDE ODT ¹ EXELON DIS ¹ GALANTAMINE CAPS ¹ GALANTAMINE TAB ¹ MEMANTINE ¹ RIVASTIGMINE TARTRATE CAPS ¹	MC MC MC/DEL MC MC/DEL MC/DEL MC MC MC/DEL MC/DEL MC/DEL MC MC MC	6 6 7 8 8 8 8 8 8 8 8 8 8 8 9	ARICEPT TABS ² ARICEPT ODT ² DONEPEZIL HYDROCHLORIDE TABS 23MG ADLARITY ³ EXELON CAP GALANTAMINE HYDROBROMIDE SOL KISUNLA ¹ LEQEMBI ¹ MEMANTINE HCL SOL NAMENDA NAMENDA XR CAPS NAMZARIC RAZADYNE ² ZUNVEYL COGNEX CAPS ²	Use PA Form# 20420 1. PA is required to establish dementia diagnosis and baseline mental status score. 2. Must fail all preferred products before moving to non-preferred. 3. Approvals will require trials and failure or clinical rationale why preferred patches can't be used.	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Kisunla and Leqembi. Testing to rule out reversible causes of dementia (CBC, CMP, TSH, B12, urine drug screen, RPR/VDRL, (folate if alcohol abuse is present), HIV (if risk present) and an assessment including a review of current medications as a cause of intellectual decline - Prescribed by or in consultation with a neurologist or geriatrician or geriatric psychiatrist. Diagnosis of Alzheimer's disease defined as: • Confirmed presence of amyloid pathology and mild cognitive impairment or mild dementia stage of disease, consistent with Stage 3 and Stage 4 Alzheimer's disease OR • Confirmed presence of amyloid pathology and prodromal or mild dementia stage of disease, consistent with Stage 3 & Stage 4 Alzheimer's disease Testing: • Clinical Dementia Rating (CDR) global score of 0.5 or 1.0 OR • Repeatable Battery for Assessment of Neuropsychological Status (RBANS) delayed memory index score ≤ 85 OR • Mini-Mental State Examination (MMSE) score of 20-30 OR • Montreal Cognitive Assessment (MoCA) score ≤ 22 – Member is age 50 or older – Obtain recent (within one year) brain magnetic resonance imaging (MRI) prior to initiating treatment – Provider attestation to obtain MRIs prior to the 7th infusion (first dose of 10 mg/kg) and 12th infusion (sixth dose of 10 mg/kg) – Member does NOT have history or increased risk of amyloid related imaging abnormalities-edema (ARIA-E), which includes brain edema or sulcal effusions and amyloid related imaging abnormalities hemosiderin deposition (ARIA-H), which includes microhemorrhage and superficial siderosis – Member does NOT have hypersensitivity to any components of these drugs
SMOKING CESSATION							
NICOTINE PATCHES / TABLETS	MC/DEL MC/DEL	NICOTINE DIS PT24 ¹ VARENICLINE TAB	MC/DEL		NICODERM CQ PT24 ¹	Use PA Form# 20420 1. See criteria section for exemptions	As of July 1, 2014 per MaineCare policy, smoking cessation products will be covered without a copay (including MEDEL). No annual or lifetime limits, must follow FDA approved indications and therapy guidelines. Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Note: MaineCare policy, smoking cessation product were "not covered" except for during pregnancy between 9/1/12 and 1/1/14, between 1/1/2014 and 7/1/14 smoking cessation products were covered with limitations. Patients may qualify for the medication through The Maine Tobacco Helpline if they do not have MaineCare or MEDEL. Patients are encouraged to call The Maine Tobacco helpline at 1-800-207-1230.
NICOTINE REPLACEMENT - OTHER	MC/DEL MC/DEL MC/DEL	NICOTINE POLACRILEX GUM ¹ NICOTINE LOZENGE MINI NICOTINE LOZENGE	MC/DEL MC/DEL MC	8 8 8 8	NICOTROL INHALER ^{1,2} NICOTROL NASAL SPRAY ^{1,2} NICORETTE GUM ^{1,2} NICORETTE LOZENGES	Use PA Form# 20420 1. See criteria section for exemptions. 2. Must use non-preferred products in specified step order.	As of July 1, 2014 per MaineCare policy, smoking cessation products will be covered without a copay (including MEDEL). No annual or lifetime limits, must follow FDA approved indications and therapy guidelines. Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Note: MaineCare policy, smoking cessation product were "not covered" except for during pregnancy between 9/1/12 and 1/1/14, between 1/1/2014 and 7/1/14 smoking cessation products were covered with limitations. Patients may qualify for the medication through The Maine Tobacco Helpline if they do not have MaineCare or MEDEL. Patients are encouraged to call The Maine Tobacco helpline at 1-800-207-1230.
ALCOHOL DETERRENTS							
ALCOHOL DETERRENTS	MC/DEL MC MC MC/DEL	ACAMPROSATE ANTABUSE TABS DISULFIRAM TABS NALTREXONE HCL TABS	MC/DEL		ACAMPRO ¹	Use PA Form# 20420 1. Should only be used in conjunction with formal structured outpatient detoxification program.	Preferred generic drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
MISCELLANEOUS ANALGESICS							
ANALGESICS - MISC.	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL	ACETAMINOPHEN ASPIRIN ASPRIN/ APAP/ CAFF TAB BUTAL/ASA/CAFF BUTALBITAL COMPOUND BUTALBITAL/ACET TABS BUTALBITAL/APAP CAPS BUTALBITAL/APAP/CAFFEINE TABS CHOLINE MAGNESIUM TRISALI DIFLUNISAL TABS EXCEDRIN SALSALATE TABS	MC MC/DEL MC/DEL MC MC MC/DEL MC MC MC MC MC MC		AXOCET CAPS ESGIC-PLUS FIORICET TABS FIORINAL CAPS FIORTAL CAPS FORTABS TABS JOURNAVX ¹ PHRENILIN TABS PHRENILIN FORTE CAPS TRILISATE LIQD TRILISATE TABS ZEBUTAL CAPS ZORPRIN TBCR	Use PA Form# 20420. 1. QL: No greater than 14-day supply within 90 days.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Journavx requires patient must have documented clinical reason as to why they are unable to use acetaminophen and NSAIDS (which can include Cox-II inhibitors). Journavx is FDA approved for moderate to severe ACUTE pain in adults.
LONG ACTING NARCOTICS							
NARCOTICS - LONG ACTING	MC/DEL MC/DEL MC/DEL	FENTANYL PATCH ⁴ BUTRANS ⁴ MORPHINE SULFATE ER TB12	MC MC MC MC MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC MC MC/DEL	8 8 8 8 8 8 8 8 8 8 8 8 8 8 9	ARYMO ER AVINZA BELBUCA EXALGO HYSINGLA ER KADIAN METHADONE ⁵ METHADOSE ⁵ MORPHABOND ER MORPHINE SULFATE ER CAP MORPHINE SULFATE SUPP NS CONTIN TB12 ORAMORPH SR TB12 OXYCONTIN TB12 ¹ XARTEMIS ER ZOHYDRO ER OXYCODONECONC OXYCODONE ER ¹⁵	Use PA Form# 20510 Use PA Form #10300 for PAs over the opiate limit 1. Oxycontin will be available without PA for patients treated for or dying from cancer or hospice patients. CA (cancer) or HO (hospice) diag code may be used but store must verify since all scripts will be audited and stores will be liable. 3. Oxycodone ER allowed only 2 per day for all strengths except 80 mg, where 4 are allowed to achieve max total daily dose of 320mg. 4. 25mcg, 50mcg, 75mcg, 100mcg. Dosing limits apply, see Dose Consolidation List. 5. Non-preferred products must be used in specific order. 6. Methadone will be available without PA for patients treated for or dying from cancer or hospice patients or similar conditions as supported by clinical documentation. CA (cancer) or HO (hospice) diag code may be used but store must verify since all scripts will be audited and stores will be liable.	Preferred drugs (Fentanyl Patch, Morphine Sulfate ER tab, and Butrans) must be tried for at least 2 weeks each & failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug & the preferred drug(s) exists. Adequate trials include prevention/treatment of common adverse effects associated w/ narcotics (antinausea, antipruritic, etc.) as well as adequate equianalgesic dosing when converting from one narcotic to another. Also, adequate documentation of attempts to titrate dose of preferred agents to achieve adequate pain relief & desired clinical response must be provided. Member's drug regimen for additions &/or discontinuations of medications that may affect absorption &/or metabolism of preferred agents must be monitored. Approvals will not be granted if patient had access to either non-preferred products or high doses of short acting narcotics during the trial period. Non-preferred drugs will not be approved for patients showing evidence of usage patterns consistent w/ controlled substance abuse such as: 1.Frequent or persistent early refills of controlled drugs; 2.Multiple instances of early refill overrides due to reports of misplacement, stolen, dropped in toilet or sink, distant travel, etc. 3.Breaches of narcotic contracts with any provider; 4.Failure to comply with patient responsibilities in attached opioid documentation (see PA form) including but not limited to failing to submit to and pass 5.Failing to take or pass random drug testing; 6.Failing to provide old records regarding prior use of narcotics; 7.Receiving controlled substances from other prescribers that the provider submitting the PA is unaware of; 8.Documented history of substance abuse. Substance abuse evaluations may be required for patients with medical records displaying documented substance abuse or potential signs of narcotic misuse and abuse such as chronic early refills, short dosing intervals, frequent dose increases, multiple lost/stolen etc scripts and intolerance or "allergy" to all products but Oxycontin. 9. Circumventing MaineCare prior authorization requirements for narcotics by paying cash for affected narcotics (prescribers failed to submit prior authorization prior to cash narcotic scripts being filled by member). 10. Requests for any Brand name controlled substance, considered by authorities to be highly abused and diverted (Oxycontin, Percocet, Tylox, Vicodin, Dilaudid, Ultracet...) with an available AB rated generic equivalent will be denied unless it will be provided in a setting that virtually eliminates the risk of diversion. 11. Allergic reactions to any product within a specific narcotic class will justify and preclude use of any other product in the same class due to the risk of cross-hypersensitivity. Hysingla ER: Concomitant use should be avoided with mixed agonist/antagonist analgesics, partial agonist analgesics, and MAOIs. Verify prior trials and failures or intolerance of preferred treatments. Methadone – Established users must have a trial and failure of at least 2 preferred drugs for least 2 weeks. Otherwise they will be allowed 180 days to transition to a preferred product.
NARCOTICS - SELECTED	MC/DEL MC/DEL	TRAMADOL HCL TABS 50 mg ² TRAMADOL/APAP TABS	MC MC/DEL MC MC MC MC MC MC	8 8 8 8 8 8 8 8	BUPRENEX SOLN BUTORPHANOL NALBUPHINE HCL SOLN ODOLO SOLN SEGLENTIS ¹ STADOL NS SOLN TRAMADOL ER ULTRACET TABS ¹	Use PA Form# 20420. Use PA form #10300 for PAs over the opiate limit 1. Only available if component ingredients are unavailable. 2. Dosing limits apply, please see Dosing Consolidation List.	Preferred drugs from this and other narcotic classes must be tried for at least 2 weeks each and failed due to lack of efficacy or intolerable side effects before non-preferred drugs from this class will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Approvals will not be granted if patient had access to either non-preferred products or high doses of short acting narcotics during the trial period. Substance abuse evaluations may be required for patients with medical records displaying potential signs of narcotic misuse and abuse such as chronic early refills, short dosing intervals, frequent dose increases, multiple lost/stolen etc scripts and intolerance or "allergy" to all products but desired product. Allergic reactions to any product within a specific narcotic class will justify and preclude use of any other product in the same class due to the risk of cross-hypersensitivity. Non-preferred drugs will not be approved for patients showing evidence of usage patterns consistent with controlled substance abuse such as: 1. frequent or persistent early refills of controlled drugs; 2. multiple instances of early refill overrides due to reports of misplacement, stolen, dropped in toilet or sink, distant travel; 3. breaches of narcotic contracts with any provider; 4. failure to comply with patient responsibilities in attached opioid documentation (see PA form) including but not limited to failing to submit to and pass pill counts; 5. failing to take or pass random drug testing; 6. failing to provide old records regarding prior use of narcotics; 7. receiving controlled substances from other prescribers that the provider submitting the PA is unaware of. Substance abuse evaluations may be required for patients with medical records displaying potential signs of narcotic misuse and abuse such as chronic early refills, short dosing intervals, frequent dose increases, multiple lost/stolen etc scripts and intolerance or "allergy" to all products but Oxycontin. Allergic reactions to any product within a specific narcotic class will justify and preclude use of any other product in the same class due to the risk of cross-hypersensitivity. Beginning January 2017, all current opiate users who are above the maximum combined daily dose of 100 MME must titrate their total daily dose of opioid medications below 30 MME. Also, the maximum daily supply of an opiate prescription for acute pain will be limited to 7-day supplies. The maximum daily 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.

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
EXTENDED RELEASE BUPRENORPHINE	MC MC	BRIXADI ¹ SUBLOCADE ¹				Use PA form #20200 for Buprenorphine Extended Release 1. Clinical PA required.	Brixadi and Sublocade: The prescriber can attest (and medical record should document) that: -member has a documented history of opioid use disorder (OUD), -XRB is being used for the treatment of OUD (rather than pain or any other non-FDA approved indication) and -member's total daily dose of sublingual buprenorphine is less than or equal to 24 mg daily. AND at least one of the following is true: -The member's previous use of sublingual buprenorphine has included misuse, overuse, or diversion. -The member is at high risk of overdose (e.g., individuals leaving incarceration or abstinence-based treatment programs; individuals who are unhoused; or those facing potential gaps in care due to delays in care or geographically limited treatment access). -The member has experienced significant medical complications of OUD and/or of injection drug use. Occurrence should be in the last 5 years, or it should be clearly documented that the risk indicated by this infection or complication is ongoing (Examples of medical complications of OUD include: threatened the function of organs or life or limb threatening and required medical and/or surgical therapy. Examples of medical complications of injection drug use include osteomyelitis, endocarditis, renal failure, joint infection or other serious medical complications directly related to OUD.) -The member has treatment-resistant OUD, including those with ongoing illicit substance use in the context of sublingual buprenorphine treatment as documented by positive urine drug screens or other clear objective evidence, and/or further functional decline with explicit documentation of the functional decline. -The member has a significant intolerance of, or documented allergy to, sublingual buprenorphine (either buprenorphine monotherapy or buprenorphine/naloxone combination therapy) that has resulted in the patient's inability to comply with continued treatment using the sublingual product. (A true allergy is usually accompanied by rash, respiratory symptoms, or anaphylaxis. Other complaints such as bad taste, mouth tingling, etc. do not constitute evidence of allergy or significant intolerance. Formulation preference or convenience are not, in and of themselves, indications for using XRB.) -The member is in ongoing treatment with XRB and would like to continue the medication.
OPIOID WITHDRAWAL AGENTS			MC		LUCEMYRA ¹	Use PA Form#20420 1. Clinical PA for appropriate approved use and patient has documented contraindication to Clonidine.	
NARCOTIC - ANTAGONISTS							
NARCOTIC - ANTAGONISTS	MC/DEL MC MC MC MC MC	NALTREXONE HCL TABS NALOXONE INJ NARCAN NS NALOXONE SPRAY OTC VIVITROL INJ ZIMHI	MC MC MC MC/DEL		OPVEE ² KLOXXADO REZENOPY ZURNAI ²	Use PA Form# 20420 2. For the treatment of adult and pediatric patients 12 years of age and older.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
COX 2 / NSAIDS							
COX 2 INHIBITORS - SELECTIVE / HIGHLY SELECTIVE	MC/DEL MC/DEL MC/DEL MC/DEL	CELECOXIB ^{4,5} KETOROLAC TROMETHAMINE ^{2,3,5} NABUMETONE TABS ⁵ MELOXICAM TABS ^{1,5}	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC MC		CELEBREX CAPS ^{4,5} MELOXICAM CAPS ⁵ MOBIC ⁵ MOBIC SUSP ⁵ RELAFEN TABS ⁵ QMIIZ ODT VIVLODEX VYSCOX XIFYRM ⁵ ZYBIC	Use PA Form# 20420 1. Meloxicam and Xifyrm have dosing limits allowing one tablet daily of all strengths without PA. 2. Ketorolac Tromethamine is indicated for the short term (up to 5 days) management of moderately severe acute pain that requires analgesic at the opioid level in adults. Not indicated for minor or chronic pain conditions. 3. Ketorolac has dosing limits allowing 24 tablets for a 5-day supply every 30 days. 4. Dosing limits will be set at a maximum of 400mg daily. 5. The FDA has issued a Public Health Advisory warning of the potential for increased cardiovascular risk & GI bleeding with NSAID use.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
NSAIDS	MC/DEL MC/DEL	CHILDRENS IBUPROFEN DICLOFENAC POTASSIUM TABS DICLOFENAC SODIUM TABS DICLOFENAC SODIUM 1% GEL ¹ ETODOLAC FENOPROFEN CALCIUM TABS FLURBIPROFEN TABS IBUPROFEN INDOMETHACIN KETOPROFEN MECLOFENAMATE SODIUM CAPS NAPROSYN SUSP NAPROXEN SUSP NAPROXEN TABS NAPROXEN SODIUM TABS NAPROXEN SODIUM CAPS NAPROXEN DR TBEC	MC MC MC MC MC/DEL MC MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC MC MC MC		ADVIL TABS ANAPROX TABS ANAPROX DS TABS CAMBIA CATAFLAM TABS CHILDRENS ADVIL SUSP CHILD'S IBUPROFEN SUSP CHILDRENS MOTRIN SUSP CLINORIL TABS DAYPRO TABS DICLOFENAC GEL EC-NAPROSYN TBEC ETODOLAC ER 600MG FELDENE CAPS FLECTOR PATCH INDOCIN LICART	Use PA Form# 20420 The FDA has issued a Public Health Advisory warning of the potential for increased cardiovascular risk & GI bleeding with NSAID use. 1. Dosing limits apply, see Dosage Consolidation List.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Approvals will be granted for other requests based on failure of at least one generic NSAID from at least 3 different NSAID classes as described in the COX-2 PA form. The FDA has issued a Public Health Advisory warning of the potential for increased cardiovascular risk & GI bleeding with NSAID use. DDI: Diclofenac will now be non-preferred and require prior authorization if it is currently being used in combination with lescol.

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

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
PIK3CA-Related Overgrowth Spectrum (PROS)							
PIK3CA-Related Overgrowth Spectrum (PROS)			MC	8	VJOICE ¹	Use PA Form# 20420 1. PA required to confirm FDA approved indication.	Preferred drugs must be tried and failed due to lack of efficacy (failure to reach target IOP reduction) or intolerable side effects before non-preferred drugs will be approved in step-order unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
MIGRAINE THERAPIES							
MIGRAINE - ERGOTAMINE DERIVATIVES			MC MC MC		BREKIYA D.H.E. 45 SOLN DIHYDROERGOTAMINE MESYLATE INJ TRUDHESA	Use PA Form# 10110	Preferred drugs must be tried within the Migraine therapy category and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
MIGRAINE - CARBOXYLIC ACID DERIVATIVES	MC	DIVALPROEX ER TB24	MC		DEPAKOTE ER TB24	Use PA Form# 10110	
MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)–Tabs/Nasal	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	RELPAK ¹ RIZATRIPTAN ODT RIZATRIPTAN TABS SUMATRIPTAN TABS ¹ ZOLMITRIPTAN TAB ¹ NARATRIPTAN HCl TABS ¹	MC MC MC/DEL MC MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		AMERGE TABS ^{1,2} AXERT TABS ^{1,2} FROVA TABS ^{1,2} IMITREX NASAL SPRAY ¹ IMITREX TABS ^{1,2} MAXALT ^{1,2,3} MAXALT MLT ^{1,2,3} ONZETRA XSAIL ² SUMATRIPTAN NASAL SPRAY ¹ ZOLMITRIPTAN ODT ZOLMITRIPTAN SPRAY ZOMIG TABS ^{1,2} ZOMIG NASAL SPARY ^{1,2} ZOMIG ZMT TDDP ^{1,2}	Use PA Form# 10110 1. All drugs in this category have dosing limits. Refer to Dose Consolidation Table. 2. Must fail all preferred products before non-preferred. 3. Established users will be grandfathered.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Quantity limit exceptions will require ongoing therapy with therapeutic doses of highly effective prophylactic medication as listed on the Triptan PA form.
MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)–Injectables	MC MC/DEL MC/DEL	IMITREX CARTRIDGE ¹ SUMATRIPTAN SYRINGE ¹ SUMATRIPTAN PEN INJECT ¹	MC/DEL MC MC		TOSYMRA ZEMBRACE ¹ IMITREX PEN INJECT ¹	Use PA Form# 10110 1. Dosing limits apply, see Dosage Consolidation List.	
MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)–Combinations			MC/DEL		TREXIMET ^{1,2}	Use PA Form# 10110 1. Dosing limits apply, see Dosage Consolidation List. 2. Use preferred Sumatriptan and Naproxen separately. Treximet only available if component ingredients of Sumatriptan and Naproxen are unavailable.	
MIGRAINE - SELECTIVE SEROTONIN AGONISTS–Combinations			MC		SYMBRAVO ¹	1. Dosing limits apply, see Dosage Consolidation List.	
MIGRAINE - PREVENTATIVE TREATMENT	MC MC/DEL MC/DEL MC/DEL MC/DEL	AIMOVIG ¹ AJOVY ¹ AJOVY AUTO INJECT ¹ EMGALITY SYRINGE ¹ 120mg/ml EMGALITY PEN ¹ 120mg/ml	MC MC MC		NURTEC ODT QLIPTA VYEPTI ²	Use PA Form# 10110 1. See criteria section. 2. Dosing limits apply, see Dosage Consolidation List.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Aimovig, Ajovy and Emgality: The patient is 18 years of age or older AND patient has a diagnosis of episodic migraine (4-14 headache days per month with migraine lasting 4 hours or more) or chronic migraine (≥ 15 headache days per month, of which ≥ 8 are migraine days, for at least 3 months) AND patient has failed or has a contraindication to an adequate trial (≥ 60 days) of at least 2 medications for migraine prophylaxis from at least 2 different classes.
MIGRAINE - ACUTE TREATMENT	MC MC MC	NURTEC ODT ¹ SPASTRIN TABS UBRELVY ¹	MC MC MC/DEL MC		BELCOMP-PB SUPP ELYXYB MIGRAZONE CAPS MIGERGOT SUP REYVOW	Use PA Form# 10110 1. Dosing limits apply, see Dosage Consolidation List.	Nurtec ODT will be preferred after 2 adequate trials of at least two preferred triptans. Reyvow is non-preferred and is indicated for the acute treatment of migraine with or without aura in adults. Reyvow is not indicated for the preventive treatment of migraine. Ubrelvy is preferred after 2 adequate trials of at least two preferred triptans for the acute treatment of migraine with or without aura in adults. It is not indicated for migraine prevention. Zavzpret: The patient must have a documented side effect, allergy, or treatment failure to preferred oral CGRP Inhibitor and two non-preferred oral CGRP Inhibitors.
GOUT							
GOUT	MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL	ALLOPURINOL TABS COLCHICINE TAB FEBUXOSTAT TAB MITIGARE PROBENECID TABS PROBENECID/COLCHICINE TABS	MC/DEL MC MC MC/DEL MC		COLCHICINE CAP COLCRYS GLOPERBA ULORIC ¹ ZYLOPRIM TABS	Use PA Form# 20420 1. Failure of therapeutic (300mg) dose of Allopurinol (failure define as not being able to get uric acid levels below 6mg/dl) or severe renal disease.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. DDI: The concomitant use of Gloperba and CYP3A4 inhibitors (e.g. clarithromycin, ketoconazole, grapefruit juice, erythromycin, verapamil, etc.) should be avoided due to the potential for serious and life-threatening toxicity.
MISC.							
ACID SPHINGOMYELINASE DEFICIENCY (ASMD)			MC		XENPOZYME ^{1,2}	Use PA Form# 20420 1. For treatment of non-central nervous system manifestations of acid sphingomyelinase deficiency (ASMD) in adult & pediatric patients. 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.
ANESTHETICS - MISC.	MC MC MC	BUPIVACAINE HCL SOLN LIDOCAINE HCL SOLN MARCANE SOLN	MC MC/DEL MC		SENSORCAINE-MPF SOLN SYNVISC INJ XYLOCAINE SOLN	Use PA Form# 30130	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

[illegible]

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required	Criteria
	MC/DEL	LAMOTRIGINE IR ²	MC	8	ONFI	
	MC/DEL	LAMOTRIGINE XR	MC	8	OXTELLAR XR ⁵	
	MC/DEL	LEVETIRACETAM SOLN	MC/DEL	8	PHENYTEK CAPS	
	MC/DEL	LEVETIRACETAM TABS	MC/DEL	8	POTIGA	
	MC/DEL	LEVETIRACETAM ER TABS	MC/DEL	8	PREGABALIN (ORAL) SOL	
	MC/DEL	LYRICA ³	MC	8	ROWEEPPRA TAB	
	MC/DEL	LYRICA SOL ³	MC	8	SABRIL	
	MC/DEL	NAYZILAM ¹	MC	8	SEZABY	
	MC/DEL	OXCARBAZEPINE	MC	8	SPRITAM	
	MC/DEL	OXCARBAZEPINE SUS	MC	8	SYMPAZAN	
	MC/DEL	PREGABALIN CAPS	MC/DEL	8	TEGRETOL TAB	
	MC/DEL	PHENYTOIN	MC/DEL	8	TIAGABINE	
	MC/DEL	QUDEXY XR	MC	8	TOPAMAX	
	MC/DEL	TEGRETOL SUS	MC/DEL	8	TOPIRAMATE ER CAPS	
	MC/DEL	TOPIRAMATE	MC	8	TOPAMAX SPRINKLE ER CAPS ²	
	MC/DEL	TOPIRAMATE SPRINKLE IR CAPS	MC	8	TOPAMAX SPRINKLE IR CAPS ²	
	MC/DEL	TRILEPTAL SUS	MC/DEL	8	TOPIRAMATE SPRINKLE ER CAPS ²	
	MC/DEL	VALPROIC ACID TABS	MC	8	TROKENDI ^{2,6}	
	MC/DEL	VALPROIC ACID SOL	MC	8	VIGAFYDE	
	MC	VALTOCO ²	MC/DEL	8	VIMPAT ⁴	
	MC/DEL	ZONISAMIDE	MC/DEL	8	VIMPAT SOL ⁴	
			MC	8	XCOPRI	
			MC/DEL	8	ZARONTIN SYRP	
			MC/DEL	8	ZARONTIN CAP	
			MC/DEL	8	ZARONTIN SOL	
			MC	8	ZONISADE	
			MC	8	ZTALMY	
			MC/DEL	9	KEPPRA XR	
			MC/DEL	9	NEURONTIN	
			MC	9	RELGAABI	
			MC/DEL	9	TEGRETOL-XR TB12	
					<u>BIPOLAR DISORDER: STEP ORDER</u>	SEE ANTICONVULSANT INDICATION CHART AT THE END OF THIS DOCUMENT
				M ~ A		
				4 ~ 4	LAMICTAL	M= Monotherapy
				4 ~ 4	LITHIUM	A= Adjunctive
				4 ~ 4	CARBAMAZEPINE	9= No Evidence
				4 ~ 4	VALPROATE	The step orders show the relative strength of evidence for use in bi-polar and will guide prior authorization determinations.
				4 ~ 4	ATYPICAL ANTIPSYCHOTICS EXC. CLOZAPINE	Step 4 drugs-no PA required.
				5 ~ 5	TRILEPTAL	
				9 ~ 6	TOPAMAX	
				9 ~ 7	KEPPRA TABS	
				9 ~ 8	GABITRIL TABS	
				9 ~ 9	NEURONTIN	
					<u>PEDIATRIC BIPOLAR1 DISORDER: STEP ORDER</u>	
				M ~ A	(6-18 YEARS WITH OR WITHOUT PSYCHOSIS)	Two-step 1 preferred drugs must be tried before Trileptal.
				4 ~ 4	LITHIUM	The step orders show the relative strength of evidence for use in bi-polar and will guide prior authorization determinations.
				4 ~ 4	CARBAMAZEPINE	Step 4 drugs-no PA required.
				4 ~ 4	VALPROATE	
				4 ~ 4	ATYPICAL ANTIPSYCHOTICS EXC.CLOZAPINE	
				4 ~ 4	LAMICTAL	
				5 ~ 5	TRILEPTAL	
ANTI-PARKINSON DRUGS						
PARKINSONS - ANTICHOLINERGICS	MC/DEL	BENZTROPINE MESYLATE TABS				Use PA Form# 20420
	MC	COGENTIN SOLN				
	MC/DEL	TRIHEXYPHENIDYL				

[illegible]

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required	Criteria
	MC	PRENATAL VITAMIN PLUS LOW IRON (ORAL) TABLET	MC		POLY-VI-SOL/IRON SOLN	
	MC/DEL	PRENATAL RX/BETA-CAROTENE ¹	MC		POLY-VITAMIN DROPS SOLN	
	MC/DEL	PREPLUS (ORAL) TABLET	MC		PRECARE	
	MC/DEL	RENAL CAPS	MC		PREFERA OB	
	MC/DEL	RENAPHRO CAPS	MC		PREMESIS RX TABS	
	MC	STRESS TAB NF TABS	MC		PRENATABS CBF TABS ¹	
	MC	THERAPEUTIC-M TABS	MC		PRENATAL CARE TABS ¹	
	MC	THERAVITE LIQD	MC		PRENATAL MR 90 TBCR ¹	
	MC/DEL	TRINATAL RX 1 (ORAL) TABLET	MC/DEL		PRENATAL MTR/SELENIUM TABS ¹	
	MC/DEL	TRIVEEN-DUO DHA (ORAL) COMBO. PKG	MC		PRENATAL OPTIMA ADVANCE TABS ¹	
	MC/DEL	TRI-VITAMIN/FLUORIDE SOLN	MC/DEL		PRENATAL PC 40 TABS ¹	
	MC	VITA CON FORTE CAPS	MC/DEL		PRENATAL RX TABS ¹	
	MC	VITAPLEX PLUS TABS	MC		PRENATE ¹	
			MC		PRENATE ELITE ¹	
			MC		PRIMACARE MISC	
			MC		PROTEGRA CAPS	
			MC		STUARTNATAL PLUS 3 TABS ¹	
			MC		TRI-VI-SOL SOLN	
			MC		TRI-VI-SOL/IRON SOLN	
			MC/DEL		ULTRA NATALCARE TABS	
			MC		ULTRA-NATAL TABS ¹	
			MC		VICON FORTE CAPS	
			MC		VINATAL FORTE TABS ¹	
			MC		VINATE ¹	
			MC/DEL		VINATE ADVANCED TABS ¹	
MISCELLANEOUS MINERALS						
MINERALS	MC	CALCARB	MC		ANEMAGEN	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Certain drugs require specific diagnoses for approval. DDI: Fe salts will now be non-preferred and require prior authorization if it is currently being used in combination with either prevacid, pantoprazole, prilosec, or any currently non preferred PPI.
	MC	CALCI-MIX CAPSULE CAPS	MC		CALCET TABS	
	MC	CALCIQUID SYRP	MC/DEL		CALCIUM 600-D TABS	Please refer to OTC list for covered products.
	MC	CALCITRATE/VITAMIN D TABS	MC		CALCIUM/VITAMIN D TABS	
	MC/DEL	CALCIUM	MC		CALTRATE 600 PLUS/VIT D TABS	Click here for the OTC List
	MC/DEL	CALCIUM CARBONATE	MC		CALTRATE PLUS TABS	
	MC/DEL	CALCIUM CITRATE TABS	MC		CHROMAGEN	Please refer to OTC List for covered products.
	MC/DEL	CALCIUM GLUCONATE TABS	MC		CITRACAL PLUS TABS	
	MC/DEL	CALCIUM LACTATE TABS	MC		CONTRIN CAPS	Preferred products that used to require diag codes still require diag codes unless indicated otherwise.
	MC	CALCIUM/MAGNESIUM TABS	MC		FEODEN FORTE CAPS	
	MC/DEL	CALCIUM/VITAMIN D TABS	MC		FEROCON CAPS	
	MC	CALTRATE 600 TABS	MC/DEL		FERREX 150 CAPS	
	MC/DEL	CHEWABLE CALCIUM CHEW	MC		FERRO-SEQUELS TBCR	
	MC	CITRACAL TABS	MC		FE-TINIC CAPS	
	MC	CITRACAL + D TABS	MC		FE-TINIC 150 FORTE CAPS	
	MC	CITRUS CALCIUM TABS	MC/DEL		FLUOR-A-DAY SOLN	
	MC	CITRUS CALCIUM 1500 + D TABS	MC		HEMOCYTE TABS	
	MC/DEL	EFFERVESCENT POTASSIUM TBEF	MC/DEL		K-DUR TBCR	
	MC/DEL	FEOSTAT CHEW	MC		KLOR-CON PACK	
	MC	FERATAB TABS	MC		K-LYTE	
	MC/DEL	FER-GEN-SOL SOLN	MC/DEL		K-PHOS TABS NEUTRAL	
	MC	FER-IRON SOLN	MC		K-TABS TBCR	
	MC	FERRONATE TABS	MC		K-VESCENT PACK	
	MC/DEL	FERROUS SULFATE	MC		MICRO-K 10 MEG CPCR	
	MC/DEL	FLUOR-A-DAY CHEW	MC		NU-IRON 150 CAPS	
	MC	FLUORIDE CHEW	MC/DEL		OYSTER SHELL CALCIUM/VITA TABS	
	MC	FLUORIDE SODIUM CHEW	MC/DEL		POLY-IRON 150 CAPS	
	MC	FLUORITAB CHEW	MC/DEL		POLYSACCHARIDE IRON CAPS	
	MC	HM CALCIUM TABS	MC/DEL		POTASSIUM BICARB/CHLORIDE	
	MC	K+ POTASSIUM PACK	MC/DEL		POTASSIUM CHLORIDE 10MEQ CAPS	
	MC	KAON ELIX	MC/DEL		POTASSIUM CHLORIDE 8MEQ CAPS	
	MC	KAON-CL-10 TBCR	MC		TUMS 500 CHEW	
	MC	KCL 0.075% / D5W / NACL 0.2% SOLN	MC		VIACTIV CHEW	
	MC	K-EFFERVESCENT TBEF				
	MC	KLOR-CON				
	MC	KLOTRIX TBCR				
	MC/DEL	K-PHOS TABS				
	MC/DEL	K-VESCENT TBEF				
	MC/DEL	LURIDE CHEW				
	MC/DEL	MAGNESIUM GLUCONATE TABS				

[illegible]

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
ERYTHROPOEITINS							
	MC	EPOGEN SOLN	MC	8	ARANESP SOLN ¹	Use PA Form# 10520	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs in step-order will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Please see the EPO PA form for other approval and renewal criteria.
	MC	MIRCERA SYRINGE	MC	8	PROCRT SOLN ¹	1. Clinical PA is required to establish medical necessity and that appropriate lab monitoring is being done.	
	MC	RETACRIT					
GRANULOCYTE CSF							
GRANULOCYTE CSF	MC	FULPHILA	MC	8	FILKRI	Use PA Form# 20520	See approval criteria detailed on Granulocyte Colony Stimulating Factor PA form.
	MC	NEUPOGEN SYRINGE	MC	8	FYLNETRA	1. Must be used in specified step order.	
	MC	NEUPOGEN VIAL	MC	8	GRANIX SYRINGE		
	MC/DEL	NYVEPRIA SYRINGE	MC	8	GRANIX VIAL		
			MC	8	LEUKINE		
			MC/DEL	8	NIVESTYM		
			MC	8	ROLVEDON		
			MC	8	RYZNEUTA		
			MC	8	STIMUFEND		
			MC/DEL	8	ZARXIO		
			MC/DEL	8	ZIEXTENZO		
			MC	9	NEULASTA ¹		
GAUCHER DISEASE							
GAUCHER DISEASE			MC		CERDELGA ¹	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Exceeding days supply limits for LMWH class requires PA.
		MC		YARGESA ¹	1. Clinical PA for indication required.	Yargesa: As monotherapy for the treatment of adult patients with mild to moderate type 1 Gaucher disease for whom enzyme replacement therapy is not a therapeutic option (e.g., due to allergy, hypersensitivity, or poor venous access).	
NIEMANN-PICK DISEASE AGENTS							
NIEMANN-PICK DISEASE AGENTS			MC		AQNEURSA ¹	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
		MC		MIPLYFFA ¹	1. Clinical PA required for appropriate diagnosis.		
ANTICOAGULANTS / PLATELET AGENTS							
ANTICOAGULANTS	MC	COUMADIN TABS	MC		ARIXTRA SOLN	Use PA form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Exceeding days supply limits for LMWH class requires PA. DDI: Warfarin will require prior authorization if being used in combination with fluconazole, miconazole, or voriconazole. DDI: Warfarin will require prior authorization if being used in conjunction with gemfibrozil or fenofibrate. DDI: Rifampin will require prior authorization if being used in combination with savaysa.
	MC/DEL	ENOXAPARIN ¹	MC/DEL		FONDAPARINUX	1. Enoxaparin therapy durations greater than 7 days every 30 days require PA. 2. Use other strengths available to obtain desired dose. 3. Diagnosis required. 4. For the treatment of patients aged 3 months to less than 12 years of age.	
	MC	ELIQUIS	MC/DEL		FRAGMIN INJ		
	MC	ELIQUIS STARTER PACK	MC/DEL		FRAGMIN VIAL		
	MC	HEPARIN SODIUM/NaCL 0.9% SOLN	MC/DEL		LOVENOX SOLN		
	MC	HEP-LOCK SOLN	MC/DEL		LOVENOX 300 ²		
	MC	INNOHEP	MC/DEL		LOVENOX SUBQ SYRINGE		
	MC	HEPARIN LOCK SOLN	MC/DEL		PRADAXA ORAL PELLETS ⁴		
	MC/DEL	HEPARIN LOCK FLUSH SOLN	MC		IPRIVASK		
	MC/DEL	HEPARIN SODIUM SOLN	MC/DEL		SAVAYSAS ³		
	MC/DEL	HEPARIN SODIUM LOCK FLUSH SOLN					
	MC/DEL	PRADAXA					
	MC/DEL	JANTOVEN					
	MC/DEL	WARFARIN SODIUM TABS					
	MC/DEL	XARELTO					
	MC/DEL	XARELTO STARTER PACK					
ANTIHEMOPHILIC AGENTS	MC	ALPHANATE	MC/DEL		ADYNOVATE VIAL	Use PA Form# 20420	Non-preferred will only be approved if other preferred products are unavailable. Beqvez - FDA Approved Indication: An adeno-associated virus vector-based gene therapy indicated for the treatment of adults with moderate to severe hemophilia B (congenital factor IX deficiency) who: • Currently use factor IX prophylaxis therapy, or • Have current or historical life-threatening hemorrhage, or • Have repeated, serious spontaneous bleeding episodes, and, • Do not have neutralizing antibodies to adeno-associated virus serotype Rh74var (AAVRh74var) capsid as detected by an FDA-approve test. Hemgenix is an adeno-associated viral vector-based gene therapy for IV infusion after dilution. For treatment of adults with Hemophilia B (congenital Factor IX deficiency) who: Currently use Factor IX prophylaxis therapy, or have current or historical life-threatening hemorrhage, or have repeated, serious spontaneous bleeding episodes. Altuvilio is a von Willebrand Factor (VWF) independent recombinant DNA-derived, Factor VIII concentrate indicated for use in adults and children with hemophilia A (congenital factor VIII deficiency) for: Routine prophylaxis to reduce the frequency of bleeding episodes, On-demand treatment and control of bleeding episodes, Perioperative management of bleeding. Roctavian: For the treatment of adults with severe hemophilia A (congenital factor VIII deficiency with factor VIII activity <1 IU/dL) without antibodies to adeno-associated virus serotype 5 (AAV5) detected by an FDA-approved test. Inclusion: • Severe factor VIII deficiency (less than 1% native factor VIII). Exclusion Criteria: • Antibodies to the virus AAV5 • Factor VIII inhibitors (or history of) • Known significant fibrosis of cirrhosis of the liver, or unexplained elevated LFTs
	MC	ALPHANINE SD	MC		ADVATE ^{1,2,5}	1. Only if other products unavailable. 2. Advate may be available with PA in cases of large volume dosing in patients with poor venous access. 3. Not indicated for use in children <12 years of age due to greater risk for hypersensitivity reactions and is not indicated for use in previously untreated patients. 4. Clinical PA required for appropriate diagnosis. 5. Established users will be grandfathered.	
	MC/DEL	ALPROLIX VIAL	MC		ALTUVILIO ⁴		
	MC/DEL	BEBULIN VIAL	MC/DEL		AFSTYLA		
	MC/DEL	BENEFIX SOLR	MC/DEL		BEQVEZ		
	MC/DEL	HELIXATE FS KIT	MC/DEL		ESPEROCT		
	MC	HEMOFIL - M	MC/DEL		ELOCTATE		
	MC	HUMATE-P SOLR	MC/DEL		HEMGENIX		
	MC/DEL	IXINTY VIAL	MC/DEL		IDELVION		
	MC/DEL	JIVI ³	MC/DEL		KOGENATE FS ⁵		
	MC	KOATE-DVI	MC		RECOMBINATE VIAL ⁵		
	MC	KONYNE - 80	MC		ROCTAVIAN ⁴		
	MC/DEL	KOVALTRY	MC		SEVENFACT		
	MC/DEL	REBINYN					
	MC	MONARC - M					
	MC	MONOCLATE - P					
	MC	MONONINE					
	MC/DEL	NOVOEIGHT					
	MC	NOVOSEVEN SOLR					
	MC	NUWIQ					
	MC/DEL	PROFILNINE					

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
	MC MC MC/DEL MC MC/DEL	RECOMBINATE SOLR REFACTO RIXUBIS VIAL WILATE INJ XYNTHA					- History of inadequate compliance with prophylaxis, or regular bleeds despite adequate prophylaxis - Conditions in which high-dose steroids are contraindicated. - Inability to abstain from alcohol for one year - Plan to impregnate a partner within 6 months of infusion - Hypersensitivity to mannitol - Active infections, either acute or uncontrolled chronic - HIV infection (limited information on use in this population)
NON-FACTOR REPLACEMENT THERAPY	MC	HEMLIBRA	MC/DEL MC/DEL MC MC		ALHEMO HYMPAVZI QFITLIA QFITLIA PEN	Use PA Form# 20420	Subsequent changes made to Antihemophilic Agents: Factor Therapy to move Hemlibra to Non-Factor Therapy
PLATELET AGGREGATION INHIBITORS	MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL	ASPIRIN ASPIRIN-DIPYRIDAMOLE ER CPMP 12HR BRILINTA 90mg DIPYRIDAMOLE TABS CLOPIDOGREL 75MG PRASUGREL HCL TAB	MC/DEL MC/DEL MC MC MC/DEL MC/DEL		TICLOPIDINE HCL TABS BRILINTA 60mg DURLAZA EFFIENT PERSANTINE TABS PLAVIX TABS ZONTIVITY	Use PA Form# 20715 for Plavix, Effient & Brilinta Use PA form# 20420 for other requests 1. Dosing limits apply, see Dose Consolidation List.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. A special PA may be obtained at the pharmacy for members scheduled for "stent" placement or have had placement if in the last 12months. Please indicate on prescription date of stent placement. Brilinta: Concomitant use with strong CYP3A4 inhibitors should be avoided (including ketoconazole, itraconazole, atazanavir, and telithromycin). Doses of simvastatin and lovastatin >40mg should be avoided. DDI: exists for using maintenance ASA dose >100mg, as it reduces the effectiveness of Brilinta. DDI: Plavix will require prior authorization if being used in combination with omeprazole, esomeprazole, cimetidine, fluconazole, ketoconazole, intelence, fluoxetine, ticlopidine, and flvoxamine.
PLATELET AGGR. INHIBITORS / COMBO'S - MISC.	MC/DEL MC/DEL	CILOSTAZOL PENTOXIFYLLINE ER TBCR	MC/DEL MC/DEL MC/DEL MC MC		AGRYLIN CAPS ANAGRELIDE CAPS PLETAL TABS TRENTAL TBCR YOSPRALA	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.
HEMATOLOGICALS							
MONOCLONAL ANTIBODY			MC MC MC/DEL MC MC MC/DEL MC MC MC/DEL MC MC		BKEMV EMPAVELI ENSPRYNG EPYSQLI FABHALTA GAMIFANT PIASKY SOLIRIS ULTOMIRIS UPLIZNA VOYDEYA	Use PA Form# 20420	A diagnosis of Paroxysmal nocturnal hemoglobinuria (PNH) using the HAM test or flow cytometry is required. In addition, the patient must show evidence of having received a meningitis vaccine at least 2 weeks prior to the start of therapy. Gamifant is recommended for the treatment of adult and pediatric (newborn and older) patients with primary hemophagocytic lymphohistiocytosis (HLH) with refractory, recurrent, or progressive disease or intolerance with conventional HLH therapy. Fabhalta and Ultomiris are recommended for the treatment of adults with paroxysmal nocturnal hemoglobinuria (PNH). Bkemv and Epysql 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 MC/DEL MC MC/DEL MC/DEL MC	BIVIGAM ¹ CUTAQUIG ¹ GAMMAGARD S-D ¹ HIZENTRA ¹ PANZYGA ¹ PRIVIGEN ¹	MC MC MC/DEL MC MC/DEL MC MC/DEL		ALYGLO ASCENIV ² CUVITRU GAMMAPLEX INJ HYQVIA OCTAGAM INJ ¹ QVIGY¹ XEMBIFY ¹	Use PA Form# 20420 1. Clinical PA required. 2. For the treatment of patients between 12 to 17 years of age.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Alyglo is indicated for treatment of primary humoral immunodeficiency in adults ages 17 or older. Cutaquig is indicated as replacement therapy for primary humoral immunodeficiency (PI) in adults. Xembify is indicated for treatment of primary humoral immunodeficiency (PI) in patients 2 years of age and older. Asceniv indicated for the treatment of primary humoral immunodeficiency (PI) in adults and adolescents (12 to 17 years of age). PI includes but is not limited to the humoral immune defect in congenital agammaglobulinemia, common variable immunodeficiency (CVID), X-linked agammaglobulinemia, Wiskott-Aldrich syndrome, and severe combined immunodeficiencies (SCID).
HEREDITARY ANGIOEDEMA		PROPHYLAXIS			PROPHYLAXIS		
	MC MC MC MC/DEL	CINRYZE ¹ HAEGARDA ¹ ORLADEYO ^{1,2} TAKHZYRO ¹	MC MC MC MC		ANDEMBRY DAWNZERA ² ORLADEYO SPRINKLES	Use PA Form# 20420 1. Clinical PA is required to establish diagnosis and medical necessity. 2. For the treatment of patients ≥ 12 yrs of age.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Haegarda is indicated for routine prophylaxis to prevent Hereditary Angioedema (HAE) attacks in adolescent and adult patients
		TREATMENT			TREATMENT		
	MC/DEL MC MC/DEL	BERINERT KIT ¹ FIRAZYR ¹ RUCONEST VIAL ¹	MC/DEL MC MC/DEL		KALBITOR VIAL EKTERLY ²	Use PA Form# 20420 1. Clinical PA is required to establish diagnosis and medical necessity. 2. For the treatment of patients ≥ 12 yrs of age.	
HEMATOLOGICAL AGENTS- THROMBOPOIETIN RECEPTOR AGONISTS	MC MC	PROMACTA ¹ NPLATE ¹	MC MC/DEL MC/DEL		ALVAIZ DOPTELET MULPLETA	Use PA Form# 20420 1. Clinical PA required. Must see prior trial with insufficient response to corticosteroids and immunoglobulins.	Doptelet and Mulpeita: For the treatment of thrombocytopenia in adults with chronic liver disease who are scheduled to undergo a procedure.

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
HEMATOLOGICAL AGENTS-IgAN			MC/DEL MC MC MC	8 8 8 8	FILSPARI ¹ TARPEYO ¹ VANRAFIA ¹ VOYXACT ¹	Use PA Form# 20420 1. Clinical PA is required to establish diagnosis and medical necessity.	All preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. PA required to confirm FDA-approved indication. Vanrafia is for adults with biopsy proven primary IgAN AND eGFR>=30 cc/min/1.73m3 AND urine protein >=1 g/day AND on stable dose of maximally tolerated renin-angiotensin system inhibitor. Additional criteria for all: • Diagnosis of primary immunoglobulin A nephropathy (IgAN) AND • Patients at risk for disease progression (e.g., proteinuria) of at least 0.5 g/day, or by other criteria as clinical risk scoring using the International IgAN prediction tool, AND • Patient has been on a minimum 90-day trial or maximally tolerated dose and will continue to receive: an angiotensin converting enzyme (ACE) inhibitor or angiotensin II receptor blocker (ARB), AND • Prescribed in consultation or by a nephrologist
ANEMIA - ALPHA or BETA THALASSEMIA			MC MC MC		AQVESME ¹ REBLOZYL ZYNTEGLO	Use PA Form# 20420 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. 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. Zynteglo is indicated for the treatment of adult and pediatric patients with β-thalassemia who require regular red blood cell (RBC) transfusions.
HEMATOLOGIC DISORDER TREATMENT AGENTS			MC/DEL MC MC		CABLVI WAYRILZ ¹ TAVALISSE	Use PA Form# 20420 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. Cablivi is recommended for the treatment of adult patients with acquired thrombotic thrombocytopenic purpura (aTTP), in combination with plasma exchange and immunosuppressive therapy. Wayritz : Baseline platelet count is less than 30,000/mcl. and prescribed in consultation or by a hematologist/oncologist.
COMPLEMENT RECEPTOR ANTAGONIST			MC		TAVNEOS	Use PA Form# 20420	
WHIM SYNDROME AGENTS			MC		XOLREMDI	Use PA Form# 20420	Xolremdi : In patients 12 years of age and older with WHIM syndrome (warts, hypogammaglobulinemia, infections, and myelokathexis) to increase the number of circulating mature neutrophils and lymphocytes.
HEMOSTATIC							
HEMOSTATIC	MC/DEL MC	AMICAR AMINOCAPROIC ACID	MC MC MC		FIBRYGA FESILTY ¹ RIASTAP	Use PA Form# 20420 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. 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	Use PA Form# 20420	Givlaari is indicated for the treatment of adults with acute hepatic porphyria (AHP).
PYRUVATE KINASE DEFICIENCY AGENTS							
PYRUVATE KINASE DEFICIENCY AGENTS			MC		PYRUKYND ¹	Use PA Form# 20420 1. PA required to confirm FDA approved indication.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s).
OP. - ANTIBIOTICS							
OP. - ANTIBIOTICS	MC MC MC/DEL MC MC/DEL MC MC MC/DEL MC/DEL MC/DEL	AK-SPORE OINT BACITRACIN/NEOMYCIN/POLYM BACITRACIN/POLYMYXIN B OINT CHLOROPTIC SOLN ERYTHROMYCIN OINT NEOSPORIN SOLN POLYSPORIN TRIMETHOPRIM SULFATE/POLY TOBRAMYCIN SULFATE SOLN	MC MC MC MC MC MC/DEL MC/DEL MC MC MC/DEL MC/DEL MC/DEL MC/DEL MC		AK-POLY-BAC OINT AK-SULF OINT AK-TOB SOLN AZASITE BACITRACIN OINT BLEPH-10 SOLN GATIFLOXACIN DROPS GENTAMICIN SULFATE GENTAK ILOTYCIN OINT LEVOFLOXACIN DROPS NEOMYCIN/BACIPOLYM OINT NEOMYCIN/POLYMYXIN/GRAMIC NEOSPORIN OINT OCUSULF-10 SOLN OCUTRICIN SOLN POLYTRIM DROPS SULFACETAMIDE SODIUM DROPS SULFACETAMIDE SODIUM OINT TERAK OINT	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
OP. - ANTI-PARASITIC			MC		XDEMIVY ¹	Use PA Form# 20420 1. For the treatment of Demodex blepharitis.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

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CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
OP. - PROSTAGLANDINS	MC/DEL MC MC/DEL MC/DEL	LATANOPROST SOL 0.005% LUMIGAN SOLN ROCKLATAN TRAVATAN-Z	MC/DEL MC/DEL MC MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC	7 8 8 8 8 8 8 8 8 8 8	ZIOPATAN BIMATOPROST 0.03% DROPS DURYSTA IYUZEH RESCULA ^{1,2,3} TRAVATAN SOLN TRAVOPROST VYZULTA XALATAN SOLN ¹ XELPROS ZOLYMBUS	Use PA Form# 20420 1. All preferred must be tried. 2. Dosing limits apply, see Dosing Consolidation List. 3. Clinical PA is required to establish diagnosis and medical necessity.	Preferred drugs must be tried and failed due to lack of efficacy (failure to reach target IOP reduction) or intolerable side effects before non-preferred drugs. In step-order , will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
OP. - CYCLOPLEGICS	MC MC/DEL MC/DEL MC/DEL	AK-PENTOLATE SOLN ATROPINE SULFATE CYCLOPENTOLATE HCL SOLN ISOPTO HYOSCINE SOLN	MC/DEL MC MC/DEL MC		CYCLOGYL SOLN ISOPTO ATROPINE SOLN ISOPTO HOMATROPINE SOLN MUROCOLL-2 SOLN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
OP. - MIOTICS - DIRECT ACTING	MC/DEL MC MC MC/DEL MC/DEL	ISOPTO CARBACHOL SOLN ISOPTO CARPINE SOLN PILOCAR SOLN PILOCARPINE HCL SOLN PILOPINE HS GEL				Use PA Form# 20420	
OP. - SELECTIVE ALPHA ADRENERGIC AGONISTS	MC MC MC MC/DEL MC/DEL	ALPHAGAN SOLN ALPHAGAN P 0.1% SOLN ALPHAGAN P 0.15% SOLN BRIMONIDINE DROPS 0.2 % SIMBRINZA	MC/DEL MC/DEL		BRIMONIDINE TARTRATE DROPS 0.15 % IOPIDINE SOLN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
OP. - ANTI-ALLERGICS	MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL	AZELASTINE HCL DROPS BEPREVE CROMOLYN SODIUM DROPS KETOTIFEN FUMARATE DROPS LASTACRAFT OLOPATADINE HCL 0.1% OLOPATADINE HCL 0.2% ZADITOR SOLN	MC MC/DEL MC/DEL MC MC/DEL MC MC/DEL		ALOCRIL SOLN ALOMIDE SOLN EMADINE SOLN OPTICROM SOLN PATANOL SOLN ZERVIAE EPINASTINE	Use PA Form# 20420	All preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
OP. ANTI-ALLERGICS- MASTCELL STABILIZER CLASS			MC/DEL		ALAMAST SOLN	Use PA Form# 20420	
OP. - CARBONIC ANHYDRASE INHIBITORS/COMBO	MC/DEL MC MC/DEL MC/DEL	AZOPT SUSP COMBIGAN DORZOLAMIDE DORZOLAMIDE/TIMOLOL	MC/DEL		COSOPT SOLN PF	Use PA Form# 20420	
OP. - NSAID'S	MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	ACULAR SOLN ¹ DUREZOL KETOROLAC OPTH 0.4% KETOROLAC OPTH 0.5% MAXIDEX SUSP NEVANAC PREDNISOLONE DROPS	MC MC MC/DEL MC MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC MC MC		ACULAR LS ¹ ACUVAIL ¹ BROMFENAC BROMSITE ¹ BYQLOVI DEXAMETHASONE DROPS DICLOFENAC OPTH 0.1% FLURBIPROFEN SODIUM SOLN ILEVRO LOTEMAX SM DROPS GEL 0.38% PROLENSA OCUFEN SOLN ¹ XIBROM ¹ VOLTAREN SOLN ¹	Use PA Form# 20420 1. Must fail all preferred products before non-preferred.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
OP. - OF INTEREST	MC MC MC MC	EYSUVIS ² LUCENTIS RESTASIS DROPPERETTE XIIDRA	MC MC MC/DEL MC/DEL MC MC MC MC MC MC MC MC		BYOOVIZ BEVOU BOTOX SOLR CEQUA CIMERLI CYCLOSPORINE DROPPERETTE CYSTADROPS ¹ CYSTARAN ¹ EYLEA EYLEA HD ¹ IZERVAY ¹ LUCENTIS LUXTRNA	Use PA Form# 20420 1. PA required to confirm appropriate diagnosis and clinical parameters for use. 2. For the short-term (up to two weeks) treatment of the signs and symptoms of dry eye disease.	Must fail adequate trials of multi agents from artificial tears and lubricant category. Beovu is non-preferred and indicated for the treatment of Neovascular (wet) Age-Related Macular Degeneration (AMD) Eylea is non-preferred and indicated for the treatment of: Neovascular (wet) Age-Related Macular Degeneration (AMD), Macular Edema following Retinal Vein Occlusion (RVO), Diabetic Macular Edema (DME), Diabetic Retinopathy (DR) Luxturna will be considered for the treatment of patients with confirmed biallelic RPE65 mutation-associated retinal dystrophy. Patients must have viable retinal cells as determined by the treating physician(s). Miebo is non-preferred and is indicated for the treatment of the signs and symptoms of dry eye disease (DED). Oxervate is non-preferred and is indicated for the treatment of neurotrophic keratitis. Pavblu : Clinical rationale for why eylea cannot be used Syfovre is non-preferred and is indicated for the treatment of geographic atrophy (GA) secondary to age-related macular degeneration (AMD). Vevye - Must fail adequate trials of multi agents from artificial tears and lubricant category and a preferred cyclosporine alternative.

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CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
TOPICAL - ANTIFUNGALS	MC/DEL MC/DEL MC MC MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC	BETAMETHASONE CLOTRIMAZOLE CREA BETAMETHASONE CLOTRIMAZOLE LOT CICLOPIROX 0.77 CREA CICLOPIROX 0.77 SUSP CLOTRIMAZOLE ECONAZOLE NITRATE CREA KETOCONAZOLE CREA KETOCONAZOLE SHAM LOPROX 1.0 CREA LOPROX 1.0 LOTN LOPROX GEL LOPROX TS LOTN MICONAZOLE NITRATE CREA MYCO-TRIACET II CREA NYSTATIN NYSTATIN/TRIAMCINOLONE CREA NYSTOP POWD TRI-STATIN II CREA	MC/DEL MC MC MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC MC MC/DEL MC MC/DEL		CICLOPIROX SOLN EXELDERM FUNGIZONE CREA HYDROCORT/IDOOQ CREA KERYDIN ¹ LOPROX 0.77 LOTN LOPROX 0.77 CREA LOPROX 0.77 SUSP LOPROX SHAMPOO SHAM LOTRIMIN LOTRISONE LOT LOTRISONE CREA MENTAX CREA MYCOGEN II CREA NAFTIN NIZORAL SHAM NYSTATIN/TRIAMCINOLONE OINT NYSTAT-RX POWD OXISTAT PENLAC NAIL LACQUER SOLN	Use PA Form# 10120 1. Diagnosis required.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Kerydin- Verify prior trials and failures or intolerance of preferred treatments, including both topical and oral agents DDI: Ketoconazole will now be non-preferred and require prior authorization if they are currently being used in combination with any of the following medications: prevacid, pantoprazole, onglyza or omeprazole.
TOPICAL - ANTIPRURITICS	MC	ZONALON CREA	MC MC		KORSUVA PRUDOXIN CREA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - ANTIPSORIATICS	MC/DEL	CALCIP/BETAMETHASONE SUS	MC/DEL MC MC MC MC/DEL MC MC MC		TACLONEX ¹ ENSTILAR OXSORALEN ULTRA CAPS ¹ PSORIATEC CREA ¹ SORIATANE CK KIT ¹ VECTICAL ¹ VTAMA ZORYVE	Use PA Form# 20420 1. Must fail all preferred products before non-preferred.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - ANTISEBORRHEICS	MC/DEL	SELENIUM SULFIDE SHAM	MC MC MC		CARMOL SCALP TREATMENT KIT ZNP BAR ZORYVE FOAM	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Zoryve Foam: For the treatment of seborrheic dermatitis in adult and pediatric patients 9 years of age and older.
TOPICAL - ANTIVIRALS			MC/DEL MC MC		DENAVIR CREA ^{1,3} YCANTH ZELSUVMI ⁴	Use PA Form# 20420 1. Must fail oral treatment with Valacyclovir . 2. Approvals limited to 1 tube per 180 days. 3. Dosing limits apply, see Dosing Consolidation List. 4. For the topical treatment of molluscum contagiosum in adult and pediatric patients 1 year of age and older.	
TOPICAL - ANTINEOPLASTICS	MC/DEL	FLUOROURACIL 5% CREA	MC		SOLARAZE GEL	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - BURN PRODUCTS	MC MC/DEL MC MC MC/DEL	FURACIN CREA SILVER SULFADIAZINE CREA SSD AF CREA SSD CREA THERMAZENE CREA	MC/DEL		SILVADENE CREA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - CORTICOSTEROIDS		LOW POTENCY			LOW POTENCY	Use PA Form# 20420	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 MC/DEL MC MC MC	DERMA-SMOOTH- FS BODY HYDROCORTISONE CREA HYDROCORTISONE LOTN HYDROCORTISONE LOTN TEXACORT SOLN	MC/DEL MC MC/DEL MC/DEL MC MC MC MC MC/DEL		ACLOVATE DESONATE GEL FLUOCINOLONE ACETONIDE FLUOCINOLONE HALOG HYDROCORTISONE POWD LIDA MANTLE HC CREA PROCTOCORT CREA VERDESO	1. Dosing limits apply, see Dosing Consolidation List. 2. Treatment beyond 4 weeks is not recommended. 3. For the treatment of patients ≥ 12 yrs of age. 4. For the treatment of patients ≥ 18 yrs of age.	

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

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
TOPICAL - LOCAL ANESTHETICS	MC MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL	AF CAPSICUM OLEORESIN CREA CAPSAICIN CREA CAPSAICIN PATCH DIBUCAINE OINT ELA-MAX ¹ LIDOCAINE/PRILOCAINE CREA ¹ LIDOCAINE CREAM LIDOCAINE GEL LIDOCAINE PTCH 5%	MC/DEL MC/DEL MC MC MC MC/DEL MC/DEL		EMLA PADS EMLA CREA LIDA MANTLE CREA PONTOCAINE SOLN SYNERA ZOSTRIX ZTLIDO ²	Use PA Form# 20420 1. Lidocaine/Prilocaine cream and Ela-Max products require PA for users over 18 yrs of age. 2. Dosing limits still apply, see Dose Consolidation List.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - DEPIGMENTING AGENTS			MC MC MC MC/DEL MC/DEL MC MC MC		ALUSTRA CREA EPIQUIN MICRO GLYQUIN CREA HYDROQUINONE CREA HYDROQUINONE/SUNSCREENS SOLAQUIN FORTE CREA TRI-LUMA CREA ELDOQUIN	Use PA Form# 20420	As per Medicaid Policy, cosmetic drugs are not covered. Non-cosmetic clinical applications will be considered by prior authorization on a case-by-case basis.
TOPICAL - SCABICIDES AND PEDICULICIDES	MC/DEL MC MC/DEL MC/DEL MC	ACTICIN CREA LICE KILLING SHAM LICE TREATMENT CREME RINS LIQD PERMETHRIN LOTN NATROBA ¹	MC MC MC/DEL MC MC MC/DEL		ELIMITE CREA EURAX LINDANE MALATHION OVIDE LOTN SPINOSAD SUSP	Use PA Form# 20420 1. Dosing limits apply, see Dosage Consolidation List.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - WOUND / DECUBITUS CARE			MC MC MC		FILSUIVEZ REGRANEX GEL VYJUVEK	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Regranex will be approved for diabetic patients in good control (hgb1c <8), who are not smoking, with a stage III or IV WOCN AND NPUAP lower extremity diabetic ulcer and with an adequate blood supply (Tcap 02 >30, ABI>0.7 or ASP> 70), and where the underlying cause has been corrected. The wound must be free of infection and have been previously treated with preferred standard therapies for at least 2 months. Maximum approval for 20 weeks. Accuzyme and Ethezyme products have been removed from the PDL due to FDA concerns regarding drugs containing papain. Filsuvez: The patient has a diagnosis of dystrophic or junctional epidermolysis bullosa. The patient is at least 6 months old and does not have current evidence or history of squamous cell carcinoma or active infection in the area requiring filsuvez application. The patient has used standard wound care treatments, including silicone or foam dressings without wound resolution Vyjuvek: For the treatment of wounds in patients 6 months of age and older with dystrophic epidermolysis bullosa (DEB) with mutation(s) in the collagen type VII alpha 1 chain (COL7A1) gene.
TOPICAL - ASTRINGENTS / PROTECTANTS			MC MC MC		MOISTURIN DRY SKIN CREA PROSHIELD PLUS SKIN PROTE CREA SURGILUBE GEL	Use PA Form# 20420 1. Dosing limits apply, see Dosage Consolidation List.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
HYPERHIDROSIS THERAPY - AXILLARY	MC	XERAC AC SOLN	MC		SOFDRA ^{1,2}	1. Clinical PA is required to establish diagnosis and medical necessity. 2. For adults and pediatric patients 9 yrs of age and older.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Sofdra : prescribed by a dermatologist.
TOPICAL - ANTISEPTICS / DISINFECTANTS	MC/DEL	POVIDONE-IODINE SOLN	MC MC MC MC		BETADINE OINT FORMALYDE-10 AERS IODOSORB LAZERFORMALYDE SOLUTION SOLN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
MISCELLANEOUS EYE							
OP. - EYE	MC MC MC MC MC MC/DEL	AK-DILATE SOLN EYE WASH SOLN NAPHAZOLINE HCL SOLN PHENYLEPHRINE HCL SOLN PONTOCAINE SOLN SODIUM CHLORIDE	MC MC/DEL MC		LENS PLUS REWETTING DROPS MURO 128 NEO-SYNEPHRINE SOLN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
MISCELLANEOUS EAR							
EAR	MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC MC MC	A/B OTIC SOLN ACETASOL SOLN ACETASOL HC SOLN ACETIC ACID ACETIC ACID/HYDROCORTISON ALLERGEN SOLN CARBAMIDE PEROXIDE 6.5% OTIC SOLN CIPRO HC SUSP CORTISPORIN-TC SUSP CORTOMYCIN COLY-MYCIN-S SUSP EAR DROPS SOLN	MC MC MC/DEL MC/DEL MC/DEL MC MC MC MC MC MC MC MC		ANTIBIOTIC EAR SOLN ANTIBIOTIC EAR SUSP CIPRODEX CIPROFLOXACIN HCL DEBROX SOLN DERMOTIC FLOXIN OTIPRIO OTOVEL	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.

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
	MC MC/DEL MC MC/DEL MC/DEL	EAR DROPS RX SOLN EAR WAX REMOVAL DROPS FLUOCINOLONE ACETONIDE OIL DROPS 0.01% NEOMYCIN/POLYMYXIN/HC OFLOXACIN 0.3% OTIC					
MOUTH ANTISEPTICS							
MOUTH ANTI-INFECTIVES	MC MC/DEL	NILSTAT SUSP NYSTATIN SUSP	MC MC		MYCELEX TROC ORAVIG	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.
MOUTH ANTISEPTICS	MC/DEL MC/DEL MC MC	CHLORHEXIDINE GLUCONATE LIDOCAINE VISCOUS SOLN TRIAMCINOLONE IN ORABASE PSTE TRIAMCINOLONE ORADENT PSTE	MC MC MC MC		APHTHASOL PSTE ¹ PERIOGARD SOLN ¹ TRIAMCINOLONE ACETONIDE PSTE ¹	Use PA Form# 20420 1. Must fail all preferred products before non-preferred.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
DENTAL PRODUCTS							
DENTAL PRODUCTS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC	ETHEDENT CREA GEL-KAM CONC GEL-KAM GEL 0.4% PHOS FLUR SOLN SF 5000 PLUS CREA SF GEL STANNOUS FLUORIDE ORAL RI CONC	MC/CMC MC/DEL MC/DEL MC MC MC MC		APF GEL DENTAGEL GEL PHOS-FLUR GEL THERA-FLUR-N GEL	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ARTIFICIAL SALIVA/STIMULANTS							
ARTIFICIAL SALIVA/ STIMULANTS	MC	SALIVA SUBSTITUTE SOLN	MC MC MC		EVOXAC CAPS RADIACARE SOLR SALAGEN TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
MISCELLANEOUS ANORECTAL							
ANORECTAL - MISC.	MC MC MC/DEL MC/DEL	CORTENEMA ENEM ELA-MAX 5 CREA PROCTOSOL HC CREA PROCTOZONE-HC CREA	MC/DEL MC/DEL MC/DEL MC		CORTIFOAM FOAM PROCTOFOAM HC FOAM PROCTO-KIT CREA 2.5% RECTIV OINT	Use PA Form# 20420	
T-CELL ACTIVATION INHIBITOR							
PSORIASIS BIOLOGICALS	MC MC MC MC MC MC/DEL MC MC MC/DEL MC MC MC	ADALIMUMAB-FKJP ^{5,7} ENBREL ^{1,5} ENBREL SURECLICK ¹ HUMIRA ^{1,5} OTEZLA PYZCHIVA ^{5,7} SELARSDI ^{5,7} SIMLANDI ⁵ SKYRIZI ⁶ TALTZ ² TREMIFYA ^{5,7}	MC MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL MC MC MC/DEL MC MC MC MC/DEL MC MC MC MC MC		AMJEVITA BIMZELX ³ COSENTYX ⁴ CYLTEZO HADLIMA HULIO HYRIMOZ ICOTYDE ILUMYA ³ IMULDOSA OTEZLA XR ^{3,4} OTULFI SOTYKTU SPEVIGO STARJEMZA STELARA STEOEYMA YESINTEK YUFLYMA YUSIMRY	Use PA Form# 20910 1. Dosing limits apply, see Dosage Consolidation List. 2. Clinical PA required and will be preferred for the indication of plaque psoriasis, psoriatic arthritis and ankylosing spondylitis. 3. For the treatment of adults with moderate-to-severe plaque psoriasis who are candidates for systemic therapy or phototherapy. 4. Please see Criteria section. 5. Will not require a PA if at least one systemic drug such as methotrexate, cyclosporine, methoxsalen or acitretin is in members drug profile. 6. Clinical PA required and will be preferred for the indication of plaque psoriasis, psoriatic arthritis, Crohn's disease and ulcerative colitis. 7. Clinical PA required.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Cosentyx approvals for 300mg dose(s) must use "300DOSE" package (containing 2 x 150mg pens or syringes). Taltz: It is recommended to assess for TB infection prior to starting treatment with Taltz. Stelara will require using preferred trial of Skyrizi if unable please provide clinical rational as why inappropriate.
ALTERNATIVE MEDICINES							
ALTERNATIVE MEDICINES	MC MC	DIMETHYL SULFOXIDE SOLN MELATONIN	MC/DEL		CO-ENZYME Q-10	Use PA Form# 20420	Will only be approved for specific conditions supported by at least two double-blinded, placebo-controlled randomized trials that are not contradicted by other studies of similar quality.
ULTRA-RARE DISEASE AGENTS							
ULTRA-RARE DISEASE AGENTS			MC MC MC MC MC		FORZINITY ¹ IMCIVREE ¹ KYGEVVI ¹ LOARGYS ¹ YARTEMLEA ¹	Use PA Form# 20420 1. Clinical PA required for appropriate diagnosis and clinical parameters.	IMCIVREE: 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 MC/DEL MC	8 8 8	CLOVIQUE DEPEN TITRATABS TABS EXJADE ¹	Use PA Form# 20420 1. FDA indication of treatment of chronic iron overload due to blood transfusions in members 2 years of age and older is required for approval of Exjade .	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Clovique should be used when continued treatment with penicillamine is no longer possible because of intolerable or life endangering side effects.

CATEGORY	Coverage Indicator	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
ANTILEPROTIC							
ANTILEPROTIC			MC		THALOMID CAPS ¹	Use PA Form# 20420 1. All PA requests for 150mg dosing will require use of Thalomid 100mg and 50mg capsules.	Approved for indications of leprosy, treatment-resistant multiple myeloma and AIDS.
ANTINEOPLASTIC AGENTS							
ANTINEOPLASTIC AGENTS - ANTIADNDROGENS	MC/DEL	BICALUTAMIDE	MC/DEL		CASODEX	Use PA Form# 20420	
ANTINEOPLASTIC AGENTS- LHRH ANALOGS	MC/DEL	LUPRON DEPOTSyringeKIT ¹	MC/DEL		FIRMAGON ²	Use PA Form# 20420	
	MC/DEL	LUPRON DEPOT- PED KIT(1-month) ¹	MC/DEL		SUPPRELIN LA (IMPLANT) KIT ³	For GAHT - Use PA Form 30900.pdf	
	MC/DEL	LUPRON DEPOT-PED SYRINGEKIT ³ (3-month)	MC		TRELSTAR VANTAS ²	1. Dosing limits apply, please refer to Dosage Consolidation List. 2. PA required to confirm FDA approved indication. 3. Clinical PA required for patients <19 years of age. Use PA Form #30900	
	MC/DEL	TRIPTODUR VIAL					
ANTINEOPLASTIC AGENTS - TYROSINE KINASE INHIBITORS			MC MC/DEL MC		SPRYCEL ¹ TYKERB ² GLEEVEC ¹	Use PA Form# 20420 1. Verification of diagnosis is required. 2. PA required to confirm FDA approved indication and to monitor for potential drug-drug interactions.	
ANTINEOPLASTICS-MISCELLANEOUS	MC MC/DEL MC/DEL	AMIFOSTINE MERCAPTOPURINE OXALIPLATIN	MC MC/DEL MC MC/DEL MC/DEL		DOCEFREZ ELOXATIN ETHYOL LEUPROLIDE ¹ PURINETHOL ZOLINZA	Use PA Form# 20420 For GAHT - Use PA Form 30900.pdf 1. Clinical PA required for patients <19 years of age. Use PA Form #30900	
ANTINEOPLASTICS- MONOCLONAL ANTIBODIES	MC/DEL	TRAZIMERA	MC/DEL MC/DEL MC MC/DEL MC MC MC/DEL		ENHERTU HERCEPTIN HERCESSI HERZUMA KANJINTI OGIVRI ONTRUZANT	Use PA Form# 20420	
CANCER							
CANCER	MC MC/DEL MC MC MC/DEL MC MC/DEL MC	ALIMTA ANASTROZOLE TABS ERBITUX IMATINIB MESYLATE LETROZOLE RUXIENCIE VIDAZA ZIRABEV	MC MC MC/DEL MC MC MC/DEL MC MC MC/DEL MC/DEL MC MC MC/DEL MC/DEL MC MC MC MC MC/DEL MC MC MC MC/DEL MC MC MC/DEL MC MC MC/DEL MC MC MC/DEL MC MC MC		ABECMA AKEEGA ALECENSA ALIQOPA ³ ALUNBRIG ¹ ALYMSYS ARIMIDEX AUCATZYL AUGTYRO AVMAPKI-FAKZYNUA AYVAKIT AVASTIN BALVERSA BAVENCIO ^{1,8} BEIZRAY BENDEKA ³ BESPONSA ³ BESREMI ¹ BIZENGRI BLENREP BOSULIF BRAFTOVI ¹ BREYANZI BRUKINSA CABOMETYX ³ CAMCEVI CALQUENCE ³ CAVHANZA COMETRIQ ^{3,4,5} COTELLIC COPIKTRA DANZITEN DARZALEX ³	Use PA Form# 20420 1. PA required to confirm appropriate diagnosis and testing. 2. Avoid CYP3A drug interaction. 3. Clinical PA required for appropriate diagnosis. 4. Re-approval will require documentation of response without disease progression and tolerance to treatment. 5. Dosing limits apply, see Dosage Consolidation List. 6. Max daily dose of 300mg. 7. Monitor liver enzymes periodically and stop treatment upon Grade 3 or higher elevation of liver enzymes approved indication. 8. For patients ≥ 12 years of age. 9. For the treatment of patients up to 25 years of age with B-cell acute lymphoblastic leukemia (ALL) that is refractory or in second or later relapse.	All Non-Preferred: A clinical PA is required to confirm appropriate clinical indication for the individual drug request. Specific to each drug all age, clinical testing requirements, previous step therapies, adjunctive drug therapy requirements, and response without disease progression will also be evaluated for clinical appropriateness. The standard for the appropriate indication will include the FDA label as well as current NCCN guidelines. Scemblis is for the treatment of adult patients with: Philadelphia chromosome-positive chronic myeloid leukemia (Ph+ CML) in chronic phase (CP), previously treated with two or more tyrosine kinase inhibitors (TKIs).

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

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

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

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Tabs / Caps / Patches: Quantities in Units

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

Injectibles: Quantities in ML

Multi-Dose Vial: MDV

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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

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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 ¹	255GM		255GM/90
HUMIRA	40mg/0.8ml		4/28
HYDROXYZINE TAB	All Strengths	3	270/90
IMIQUIMOD	5%		12/28
INTAL	800MCG	8 INHALATIONS	28.4/34
IRBESARTAN	All Strengths	1	90/90
ISOSORBIDE MONO	30MG	2	180/90
ISOSORBIDE MONO	60 MG	1.5	135/90
JANUMET	All Strengths	2	70/35
JANUVIA	All Strengths	1	35/35
JUVISYNC	All Strengths	1	35/35
KETOPROFEN	100MG	2	180/90
KETOPROFEN	200MG	1	90/90
KETOROLAC	10MG	4.8	24/30
LAC-HYDRIN CREAM	12%		1TUBE/30
LAMOTRIGINE	25MG	6	540/90
LAMOTRIGINE	100MG	2	180/90
LANSOPRAZOLE CAPS	All Strengths	2	180/90
LATUDA	All Strengths	1	17/34
LEFLUNOMIDE	10MG	1	90/90
LESCOL	20MG	1	35/35
LEXAPRO	5MG	0.5	15/30
LIPITOR	10MG	1	35/35
LIPITOR	20MG	1	35/35
LIPITOR	40MG	1.5	53/35
LISINOP/HCTZ	10/12.5MG	1	90/90
LINEZOLID	600mg		28/60
LINZESS	All Strengths	1	35/35
LOSARTAN	All Strengths	1	90/90
LOSARTAN - HCT	All Strengths	1	90/90
LOTENSIN - HCT	5 - 6.25	1	35/35
LOTENSIN - HCT	10 - 12.5	1	35/35
LOVASTATIN	10MG	1.5	135/90
LOVASTATIN	20MG	1.5	135/90
LOVENOX INJ	30MG/.3ML	0.6	14 injections/7
LOVENOX INJ	40MG/.4ML	0.8	14 injections/7
LOVENOX INJ	60MG/.6ML	1.2	14 injections/7
LOVENOX INJ	80MG/.8ML	1.6	14 injections/7
LOVENOX INJ	100MG/ML	2	14 injections/7
LOVENOX INJ	120MG/.8ML	1.6	14 injections/7
LOVENOX INJ	150MG/ML	2	14 injections/7
LUPRON DEPOT INJ	11.25MG	KIT	1/90
LUPRON DEPOT INJ	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

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 ¹	10,20,30,40MG	2	70/35
OXYCONTIN ¹	80MG	4	140/35
PAXIL	10MG	1.5	53/35
PAXIL	20MG	1	35/35
PLAN B			2/15 or 4/30
PLENDIL	2.5MG	1	35/35
PLENDIL	5MG	1.5	53/35
PRAVACHOL	10MG	1	35/35
PRAVACHOL	20MG	1	35/35
PRAVACHOL	40MG	1	35/35
PRAVACHOL	80MG	1	35/35
PREVPAC MIS	500MG-30MG		14/30
PRILOSEC OTC	20MG	2	168/84
PRINIVIL	2.5MG	1	35/35
PRINIVIL	5MG	1	35/35
PRINIVIL	10MG	1.5	53/35
PRINIVIL	20MG	1.5	53/35

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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 ²	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

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.

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

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

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. Click on "General Pharmacy Info."

Updated July 1, 2025