CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
PDL Effective July 1, 2025								
*PLEASE NOTE: For a search box hit Ctrl F								
** PLEASE NOTE: All cost effective generics applicable to DEL are considered PREFERRED Drugs. "BASIC" Covered Drugs are bolded with the Coverage Indicator of "MC / DEL".*								
General Criteria for all PDL categories- For more information or help using the PDL, providers may call 1-888-445-0497; members should call 1-866-796-2463. To access PDL and PA materials via the internet: www.mainecarepdl.org								
A: Preferred Drugs- Unless otherwise specified, preferred drugs are available without prior authorization. Step order may apply for preferred drugs in some drug categories as indicated on the PDL. (See item "D" below for explanation of step order.)								
B: Requests for Non-preferred Drugs- Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.								
C: Adequate Drug Trials- 1. The minimum trial period for each preferred and step order drug is two weeks, unless otherwise stated within specific PDL drug categories; trials with less than a two week duration will be reviewed on a case-by-case basis; 2. A trial will not be considered valid if preferred or non-preferred products were readily available (by override, individual purchase, samples, etc.); 3. Certain drug trials, such as with controlled substances, may require evidence that the preferred drugs were actually tried (example: with random pill counts and with random urine drug tests, using the methods of GC/MS with no lower threshold); 4. Adequate trials require documentation of attempts to titrate dose of preferred agents toward desired clinical response. 5. Adequate trials include prevention/treatment of common adverse effects associated with preferred agents (example: antinausea, antipruritic, etc.)								
D: Step Order- When numbers appear in the "step order" column, it means drugs in this category must be used in the order specified, with the lower numbers having preference over the higher numbers. Chart notes should be provided to confirm drug trials that do not appear in the member's MaineCare drug profile.								
E. The Department will institute strategies to ensure cost effectiveness through the use of an enhanced Drug Benefit Preferred brand drugs will no longer be preferred in any PDL drug category where preferred generic drugs are also available. It is expected that preferred generics will be used prior to any preferred brands. This will be operated as a form of step care. Preferred brands in these categories will require prior authorization for these high utilization / high cost members.								
F: Brand Name Medication Requests- (Must be submitted on the Brand Name PA request form)- According to MaineCare Benefits Manual Chapter II (80.07-5), when medically necessary covered brand-name drugs have an A-rated generic equivalent available, the most cost effective medically necessary version will be approved and reimbursed, since the brand-name and A-rated generic drugs have been determined by the FDA to be chemically and therapeutically equivalent. The Bureau does not make determinations as to whether or not a generic drug is clinically inferior or inequivalent to its brand version. This is the proper role of the FDA. Physicians should submit their reports of generic inequivalence directly to the FDA via the MEDWATCH.								
G: PA requests for non- FDA Approved Indications- Decisions will be made on a case-by-case basis until the DUR committee is able to review the evidence and make a recommendation. Interim approvals and DUR recommendations for approval of a drug for a non- FDA approved indication will require a minimum of two published, peer reviewed, non contradicted, double- blind, placebo-controlled randomized clinical studies establishing both safety and efficacy.								
H: Dose Consolidation Requirements- Some drugs may also be affected by dose consolidation requirements. Please see Dose Consolidation List and/or Splitting Tables provided in the PDL.								
I. Trials from Multiple Drug Classes - Trial/failure/intolerance to preferred agents from multiple classes within the same category or other categories of drugs may be required prior to the approval of non-preferred agents (e.g., Cymbalta, Zofran, Elidel and others).								
J. Drug-specific PA Forms- Drug-specific PA forms contain medical necessity documentation requirements and/or criteria that may not be repeated in the PDL. Drug-specific PA forms may be obtained on the web at *www.mainecarepdl.org* .								
K. PA Exemptions for Prescribers- According to MaineCare Benefits Manual Chapter II (80.07-4), providers may receive a three (3) month exemption from prior authorization requirement for certain categories of drugs when they demonstrate high compliance with the Department's PDL. The Department will notify providers in writing which drug categories are included and what dates apply to the exemption. If a provider loses his/ her exemption, members who previously were not required to obtain a PA while the prescriber was exempt will be required to do so, and criteria for approval of that medication will need to be met.								
L: Drug-Drug Interactions (DDI)- The DUR Committee has implemented new drug-drug interaction edits requiring prior authorization. Several drug-drug combinations and PDL drug categories are affected by new PA requirements. These will be indicated in the PDL with DDI notation. Please see the DDI document provided in the PDL.								
AROMATIC L-AMINO ACID DECARBOXYLASE DEFICIENCY (AADC)								
AADC DEFICIENCY AGENTS						KEBILIDI (INJECTION) VIAL 280000000000 VG/0.5ML ELDOCAGENE EXUPARVOVEC-TNEQ	Use PA Form# 20420	
ASSORTED ANTIBIOTICS								
BETA-LACTAMS / CLAVULANATE COMBO'S	MC/DEL		AMOXICILLIN	MC/DEL		AUGMENTIN[3]	Use PA Form# 20420 3. Chewable 125mg & 250mg and Solution 125mg/5ml and 250mg/5ml available without PA. 4. Use preferred generic amoxicillin/clavulanate potassium alternatives.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Ampicillin will now be non-preferred and require prior authorization if it is currently being used in combination with either Prevacid, pantoprazole, Prilosec, or any currently non preferred PPI.
	MC/DEL		AMOXICILLIN/POTASSIUM CLA CHEW	MC/DEL		AUGMENTIN XR TB12[4]		
	MC/DEL		AMOXICILLIN/POTASSIUM CLA SUSR					
	MC/DEL		AMOXICILLIN/POTASSIUM CLA TABS					
	MC/DEL		AMPICILLIN					
	MC		BICILLIN L-A SUSP					
	MC/DEL		DICLOXACILLIN SODIUM CAPS					
	MC		OXACILLIN SODIUM SOLR					
	MC/DEL		PENICILLIN V POTASSIUM					
	MC		UNASYN SOLR					
CEPHALOSPORINS	MC/DEL		CEFADROXIL HEMIHYDRATE	MC		CEDAX	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	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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.
	MC/DEL		CEFAZOLIN SODIUM SOLR	MC/DEL		CEFACLOR[1]		
	MC/DEL		CEFDINIR	MC/DEL		CEFADROXIL MONOHYDRATE TABS		
	MC/DEL		CEFEPIME	MC/DEL		**CEFIXIME SUS**		
	MC/DEL		CEFPODOXIME	MC/DEL		CEPHALEXIN TABS		
	MC/DEL		**CEFPODOXIME PROXETIL SUS**	MC		CEPHALEXIN 750MG CAPS		
	MC/DEL		**CEFPODOXIME PROXETIL TAB**	MC/DEL		CEFTIN		
	MC/DEL		CEFIXIME 400MG[2] CAP	MC		DAXBIA		
	MC/DEL		CEFPROZIL	MC		FETROJA[3]		
	MC/DEL		CEPHALEXIN 250MG & 500MG CAPS	MC/DEL		FORTAZ		

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	MC		CEFTAZIDIME 6MG	MC/DEL		FORTAZ SOLN	treatment of complicated urinary tract infections (cUTIs)	
	MC/DEL		CEFTIN SUSP	MC		KEFLEX CAPS		
	MC/DEL		CEFTRIAXONE	MC		OMNICEF		
	MC/DEL		CEFUROXIME AXETIL TABS	MC/DEL		ROCEPHIN		
	MC/DEL		CEPHALEXIN MONOHYDRATE	MC/DEL		SUPRAX[2]		
	MC		FORTAZ SOLR	MC		TAZICEF SOLR		
	MC/DEL		SUPRAX CHEWABLE	MC/DEL		TEFLARO		
	MC		TAZICEF 6GM					
MACROLIDES / ERYTHROMYCIN'S	MC/DEL		AZITHROMYCIN TABS	MC/DEL		AZITHROMYCIN POW	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.
	MC/DEL		AZITHROMYCIN SUSP	MC/DEL		CLARITHROMYCIN SUSP		
	MC		E.E.S.	MC/DEL		CLARITHROMYCIN TABS		
	MC		ERYPED 200 SUSR	MC		DIFICID		
	MC		ERYPED 400 SUSR	MC		PCE TBEC		
	MC		ERY-TAB TBEC	MC/DEL		ZITHROMAX TABS		
	MC		ERYTHROCIN STEARATE TABS	MC/DEL		ZITHROMAX 1GM PAK		
	MC/DEL		ERYTHROMYCIN	MC/DEL		ZITHROMAX TRI-PAK		
				MC/DEL		ZITHROMAX SUSP		
				MC/DEL		ZMAX		
				MC/DEL		ZINPLAVA		
TETRACYCLINES	MC/DEL		DOXYCYCLINE MONOHYDRATE 100mg & 50mg CAPS	MC		DECLOMYCIN TABS	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.
	MC/DEL		MINOCYCLINE HCL CAPS	MC/DEL		DORYX CPEP		
	MC/DEL		TETRACYCLINE HCL CAPS	MC/DEL		DOXYCYCLINE HYCLATE		
				MC/DEL		DOXYCYCLINE MONOHYDRATE 150mg & 75mg CAPS		
				MC/DEL		DYNACIN CAPS		
				MC/DEL		MINOLIRA ER		
				MC/DEL		NUZYRA[1]		
				MC/DEL		ORACEA		
				MC/DEL		PERIOSTAT		
				MC		SEYSARA[2]		
				MC/DEL		SOLODYN ER		
				MC		XIMINO		
FLUOROQUINOLONES	MC/DEL		CIPROFLOXACIN	MC		AVELOX SOLN	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. **DDI:** Factive is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for concurrent use with amiodarone.
	MC/DEL		LEVOFLOXACIN	MC		AVELOX ABC PACK TABS		
	MC/DEL		OFLOXACIN	MC		BAXDELA		
				MC		CIPRO		
				MC		FACTIVE		
				MC		LEVAQUIN TABS SOLN/INJ		
				MC		LEVAQUIN TABS[1]		
				MC		NOROXIN TABS		
				MC		PROQUIN XR		
AMINO GLYCOSIDES	MC		GENTAMICIN	MC/DEL		ARIKAYCE[1,2]	Use PA Form# 20420 1. Clinical PA to verify appropriate diag 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 Current users of Tobi Nebu and Tobramycin Soln will be allowed a grace period until 10/1/15 to transition to preferred Kitabis. 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.
	MC		KITABIS PAK	MC		BETHKIS[1]		
	MC/DEL		NEOMYCIN SULFATE TABS	MC/DEL		TOBI PODHALER[1]		
	MC/DEL		**TOBRAMYCIN AMPUL-NEB**	MC		TOBI NEBU[2]		
				MC/DEL		TOBRAMYCIN SULFATE SOLN[2]		
				MC/DEL		ZEMDRI[2]		

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ANTI-MYCOBACTERIALS / ANTI-TUBERCULOSIS	MC/DEL MC/DEL MC/DEL MC/DEL		ETHAMBUTOL HCL TABS MYAMBUTOL TABS **RIFABUTIN CAPS** RIFAMPIN	MC/DEL MC/DEL MC		MYCOBUTIN CAPS **PRETOMANID** RIFADIN CAPS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Pretomanid is indicated as part of a combination regimen with bedaquiline and linezolid for the treatment of adults with pulmonary extensively drug resistant (XDR) or treatment-intolerant or non-responsive multidrug-resistant (MDR) tuberculosis (TB). Approval of this indication is based in limited clinical safety and efficacy data. This drug is indicated for use in a limited and specific population of patients. **DDI:** Preferred rifampin will be non-preferred and require prior authorization if it is currently being used in combination with either Pradaxa or Latuda.
ANTIMALARIAL AGENTS	MC/DEL MC MC/DEL MC/DEL		**DARAPRIM TABS** **KRINTAFEL**[2] **MEFLOQUINE HCL TABS** **QUININE SULFATE**	MC MC/DEL MC/DEL MC MC MC/DEL		ARALEN TABS **CHLOROQUINE PHOSPHATE TABS**[3] **HYDROXYCHLOROQUINE TABS**[3] ISONARIF[1] MALARONE TABS **PLAQUENIL TABS**	Use PA Form# 20420 1. Ingredients available as preferred without PA. 2. Krintafel is preferred for ≥ 16 years of age. 3. Established users will be grandfathered	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Avoid coadministration of Krintafel® with Organic Cation Transporter 2 (OCT2) and Multidrug and Toxin Extrusion (MATE) substrates (e.g. dofetilide, metformin).
ANTHELMINTICS	MC/DEL MC/DEL MC/DEL		**ALBENDAZOLE** **PRAZIQUANTEL TAB** STROMECTOL TABS	MC MC MC/DEL		ALBENZA TABS EMVERM BILTRICIDE TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIBIOTICS - MISC.	MC MC MC MC/DEL MC MC/DEL MC MC/DEL MC MC MC/DEL MC/DEL MC/DEL MC MC		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 XIFAXAN 200mg	MC MC MC MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC MC/DEL MC/DEL MC MC		AEMCOLO COLISTIMETHATE SODIUM SOLR CAYSTON[3] FLAGYL CAPS FLAGYL TABS FLAGYL ER TBCR KETEK LIKMEZ METRONIDAZOLE 375MG CAPS[1] METRONIDAZOLE 750MG TABS[1] NEBUPENT SOLR REBYOTA[5] TINDAMAX VANCOMYCIN 10GM INJ.[2] XENLETA XIFAXAN VOWST[5]	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 trail and failure of preferred Tobi before approval will be granted. 4. Quantity limit of one per 150ml bottle. 5. For the treatment of patients 18 years of age and older.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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. For macrolide resistant infections when quinolones inappropriate **DDI:** Ketek is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for concurrent use with either Enablex 15mg or Vesicare 10mg or carbamazepine. 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. Xenleta will be considered for the treatment of adults with community-acquired bacterial pneumonia (CABP) caused by the following susceptible microorganisms: Streptococcus pneumoniae, Staphylococcus aureus (methicillin-susceptible isolates), Hemophilus influenzae, Legionella pneumophila, Mycoplasma pneumoniae, and Chlamydophila pneumoniae. 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). 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.
CARBAPENEMS				MC MC MC/DEL MC/DEL		INVANZ SOLR MERREM SOLR PRIMAXIN RECARBRIO	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

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LINCOSAMIDES / OXAZOLIDINONES / LEPROSTATICS	MC/DEL		CLEOCIN SOLN	MC/DEL	8	CLEOCIN CAPS	Use PA Form# 30820 for Zyvox & Vibativ Use PA Form# 20420 for all others 1. Use multiple 150's for Clindamycin instead of 300's. 2. Quantity limit of 14 days supply within a 60day period.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. For Zyvox or Vibativ, please see the criteria listed in the Antibacterial Antibiotics PA form.
	MC/DEL		CLEOCIN SUSR	MC/DEL	8	CLINDAMYCIN HCL 300CAPS[1]		
	MC/DEL		CLINDAMYCIN HCL 150CAPS	MC	8	SIVEXTRO		
	MC		DAPSONE TABS	MC/DEL	8	VIBATIV		
	MC/DEL		**LINEZOLID 600mg TABS[2]**	MC/DEL	9	ZYVOX SUSR		
				MC/DEL	9	ZYVOX TABS		
ANTI INFECTIVE COMBO'S - MISC.	MC/DEL		ERYTHROMYCIN/SULF SUSR	MC		BACTRIM DS TABS	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.
	MC/DEL		SEPTRA/DS TABS	MC		VABOMERE[1]		
	MC/DEL		SULFAMETHOXAZOLE/TRIMETH					
	MC/DEL		TRIMETHOPRIM/SULFAMETHOXA					
ANTIPROTOZOALS	MC/DEL		**BENZNIDAZOLE[2]**	MC		ALINIA[1]	Use PA Form# 20420 1. Alina is preferred for children less than 12 years of age. 2. Clinical PA required for appropriate diagnosis.	Benznidazole is indicated for pediatric patients 2 to 12 years of age for the treatment of Chagas disease (American trypanosomiasis) caused by Trypanosoma cruzi.
	MC/DEL		LAMPIT[2]					
ANTI - FUNGALS								
ANTIFUNGALS - ASSORTED	MC		ANCOBON CAPS	MC/DEL	6	LAMISIL TABS[4]	Use PA Form# 20420 See quantity limit table. Non-preferred products must be used in specified step order. Continue to use Anti-Fungal PA form for non-preferred products. 1. QL--1/every 7-day period (150mg only). 2. Sporanox QL 300cc/month with PA. See quantity limit table. 3. Sporanox QL 30/month with PA. 4. Quantity limit of one tablet daily. Please see dosage consolidation list. 5. Approved if immuno suppressed/ HIV or if the member has failed a 7 day trial of a preferred antifungal therapy. 6. Eraxis will be approved if submitting with documentation that it was initiated during a hospitalization and this request is to finish the hospital course. 7. Quantity limits allowing 30 day supply without PA. PA will be required if using > 30 days.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. The other criteria are listed on the Antifungal PA form including the required proof of a non-cosmetic fungal infection. **DDI:** Any Griseofulvin will now be non-preferred and require prior authorization if it is currently being used in combination with either Prevacid, pantoprazole, Prilosec, or any currently non preferred PPI. **DDI:** Sporanox is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for current use with Enablex 15mg, Vesicare 10mg, Prandin, Prevacid, pantoprazole, Prilosec, or any currently non preferred PPI, due to a significant drug-drug interaction. **DDI:** Vfend is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for concurrent use with Warfarin. **DDI:** Fluconazole (except 150mg strength) will now be non-preferred and require prior authorization if it is currently being used with glimepiride (Amaryl), Enablex 15mg, or Vesicare 10mg. Diflucan is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for concurrent use with either glimepiride (Amaryl), Enablex 15mg, or Vesicare 10mg. **DDI:** Fluconazole will require prior authorization if being used in combination with Plavix or Warfarin. **DDI:** Ketoconazole will now be non-preferred and require prior authorization if they are currently being used in combination with any of the following medications: Prevacid, Pantoprazole, Plavix, Onglyza, Enablex 15mg, Vesicare 10mg, Latuda, Cometriq, Tafinlar or Omeprazole. Rezzayo: In patients 18 years of age or older who have limited or no alternative options for the treatment of candidemia and invasive candidiasis.
	MC/DEL		FLUCONAZOLE[1]	MC/DEL	6	ITRACONAZOLE		
	MC/DEL		KETOCONAZOLE TABS[7]	MC	8	BREXAFEMME		
	MC/DEL		NYSTATIN	MC/DEL	8	CRESEMBA[9]		
	MC/DEL		TERBINAFINE TABS[4]	MC/DEL	8	GRIFULVIN V TABS		
	MC/DEL		**VORICONAZOLE TABS**	MC	8	GRISEOFULVIN SUSP		
				MC	8	GRISEOFULVIN ULTRAMICROSI TABS		
				MC	8	GRIS-PEG TABS		
				MC	8	REZZAYO[9]		
				MC/DEL	8	SPORANOX SOLN[2]		
				MC/DEL	8	SPORANOX PULSEPAK CAPS[3]		
				MC/DEL	8	SPORANOX CAPS[3]		
				MC/DEL	8	DIFLUCAN		
				MC/DEL	8	ERAXIS INJ[6]		
				MC	8	GRIFULVIN SUSP		
				MC/DEL	8	ONMEL		
				MC/DEL	8	NOXAFIL[5]		
				MC/DEL	8	TOLSURA		
				MC/DEL	8	VFEND TABS		
				MC	8	VIVJOA		

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							8. For children < 18, quantity limits allows 8 weeks supply without PA. PA will be required if using > than 8 weeks. If 18 and older PA will be required for any quantity. Not approving for Onychomycosis indication. 9. For patients ≥ 18years of age	
ANTI - VIRALS								
ANTIRETROVIRALS	MC/DEL		**ABACAVIR TABS**	MC/DEL	8	**ABACAVIR SOL**	Use PA Form# 20420 1. Quantity limit of one per day 2. Only preferred if Norvir script is in member's profile within the past 30 days of filling Prezista 3.Isentress Chewable will only be approved if between the age of 2-12 years old 4. Clinical PA required. 5. Only preferred for post-exposure prophylaxis.	Fuzeon: Prescriber is either an HIV specialist provider or has consulted with one. Documentation of genotype testing is supplied and shows that there is no other potent, appropriate two or three drug oral regimen available, AND patient has a positive HIV viral load within past 6 months while on his/her current antiretroviral regimen AND the drug will be prescribed with at least two other drugs that are likely to be active based on the genotype testing. **DDI:** Reyataz requires prior authorization if it is currently being used in combination with either Prevacid, pantoprazole, Prilosec, or any currently non preferred PPI . **DDI:** Norvir requires prior authorization if it is currently being used in combination with either Enablex 15mg or Vesicare 10mg. **DDI:** Preferred Crixivan caps requires prior authorization if it is currently being used in combination with either Enablex 15mg or Vesicare 10mg. DDI: 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. DDI: Administration with the following drugs: the anticonvulsants carbamazepine, oxcarbazepine, phenobarbital, and phenytoin; the antimycobacterials rifampin and rifapentine; proton pump inhibitors such as dexlansoprazole, esomeprazole, lansoprazole, omeprazole, pantoprazole, rabeprazole; systemic dexamethasone (more than a single dose); and St. John's wort with **Odefsey** is contraindicated. Stribild: PA required; must provider rationale as to why the member's medical need cannot be met with preferred agents, particularly Genvoya or combinations of preferred and agents AND must be antiretroviral treatment-naïve or virologically controlled on current therapy (HIV-1RNA < copies/ml) AND be HBV negative AND not be combined with other anti-retroviral agents. DDI: Tivicay will require prior authorization is used with nevirapine, oxcarbazepine, phenytoin, phenobarbital, carbamazepine, and St. John's wort. DDI:Aatazanavir or darunavir and the following drugs are contraindicated (due to potential for serious and/or life-threatening events or loss of therapeutic effect): alfuzosin, dronedarone, rifampin, irinotecan, dihydroergotamine, ergotamine, methylergonovine, cisapride, St. John's wort, lovastatin, simvastatin, pimozide, nevirapine, sildenafil (when given as Revatio® for treatment of PAH), indinavir, triazolam, or PO midazolam will be non-preferred and require prior authorization if it is currently being used in combination with Tybost. DDI: Combined P-gp, UGT1A1 and strong CYP3A inhibitors may significantly increase plasma concentrations of Sunlenca®. Concomitant administration of Sunlenca® with these inhibitors is not recommended. Sunlenca: In combination with other antiretroviral(s) for the treatment of HIV-1 infection in heavily treatment-experienced adults with multidrug resistant HIV-1 infection failing their current antiretroviral regimen due to resistance, intolerance, or safety considerations.
	MC/DEL		**ATAZANAVIR**	MC	8	ATRIPLA[1]		
	MC		BIKTARVY	MC/DEL	8	CIMDUO		
	MC		CABENUVA	MC/DEL	8	COMBIVIR TABS		
	MC		COMPLERA[1]	MC/DEL	8	EDURANT		
	MC/DEL		DELSTRIGO	MC/DEL	8	EPZICOM[1]		
	MC		DESCOVY[1]	MC/DEL	8	FUZEON		
	MC		DIDANOSINE	MC/DEL	8	INTELENCE		
	MC/DEL		DOVATO	MC/DEL	8	ISENTRESS[3]		
	MC		EFAVIRENZ TAB	MC/DEL	8	ISENTRESS HD		
	MC/DEL		**EFAVIRENZ CAP**	MC	8	JULUCA		
	MC		EFAVIRENZ-EMTRICITABINE-TENOFOVIR DF TAB	MC	8	KALETRA		
	MC		EMTRICITABINE-TENOFOVIR	MC/DEL	8	**LAMIVUDINE SOLN**		
	MC		EMTRIVA[1]	MC/DEL	8	LEXIVA		
	MC		EPIVIR SOL	MC/DEL	8	NEVIRAPINE		
	MC/DEL		EVOTAZ[1]	MC	8	NORVIR		
	MC		GENVOYA[1,4]	MC/DEL	8	PIFELTRO		
	MC/DEL		ISENTRESS 400MG[5]	MC	8	RETROVIR		
	MC/DEL		ISENTRESS CHEW[3]	MC	8	REYATAZ		
	MC/DEL		ISENTRESS POWDER	MC/DEL	8	SELZENTRY		
	MC/DEL		**LAMIVUDINE TABS**	MC	8	STAVUDINE		
	MC/DEL		**LAMIVUDINE/ZIDOVUDINE**	MC	8	STRIBILD[1]		
	MC/DEL		**LOPINAVIR-RITONAVIR SOL**	MC/DEL	8	SYMFI[4]		
	MC		LOPINAVIR-RITONAVIR TAB	MC/DEL	8	SYMFI LO[4]		
	MC		ODEFSEY[1]	MC/DEL	8	SYMTUZA		
	MC/DEL		PREZCOBIX	MC/DEL	8	TRIZIVIR TABS		
	MC		PREZISTA[2]	MC	8	TRUVADA[1]		
	MC/DEL		**RITONAVIR TAB 100MG**	MC/DEL	8	VIRACEPT TABS		
	MC		RUKOBIA[4]	MC	8	VITEKTA		
	MC		SUNLENCA[4]	MC	8	ZERIT		
	MC		SUSTIVA[1]	MC	8	VIDEX EC		
	MC		TIVICAY	MC	8	VIREAD TABS[1]		
	MC		TIVICAY PD	MC/DEL	8	ZIAGEN TABS		
	MC		TRIUMEQ[1]	MC/DEL	8	ZIAGEN SOL		
	MC		TROGARZO[4]	MC/DEL	9	VIRAMUNE XR		
	MC		TYBOST					
	MC		VIREAD POW					
	MC/DEL		**ZIDOVUDINE**					

CATEGORY	Coverage Indicator	Step Order	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/DEL MC/DEL MC/DEL		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 Livtencity will be approved.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Prevymis: Documentation that member is high-risk for CMV reactivation as defined by transplant guidelines or that there has been significant myelosuppression by one of the preferred agents. DDI: Livtencity is a substrate of CYP3A4. Coadministration of Livtencity® with strong inducers of CYP3A4 is not recommended, except for selected anticonvulsants.
HERPES AGENTS	MC/DEL MC/DEL		ACYCLOVIR VALACYCLOVIR HCL	MC/DEL MC MC/DEL MC MC/DEL	8 8 8 8 9	FAMCICLOVIR[1] SITAVIG ZOVIRAX[1] VALTREX TABS[1] FAMVIR TABS[1]	Use PA Form# 20420 1. Must fail Acyclovir and 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 MC/DEL MC/DEL MC/DEL MC/DEL		AMANTADINE TABS FLUMADINE TABS FLUMIST RIMANTADINE HCL TABS TAMIFLU[1] TAMIFLU SUS XOFLUZA	Use PA Form# 20420 for all others 1. Tamiflu and Oseltamivir 10 caps or 60cc's per month. Will be audited for presence of positive influenza tests in patient or family member.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
IMMUNE SERUMS								
IMMUNE SERUMS	MC		HYPERRHO INJ					
HEPATITIS AGENTS								
HEPATITIS C AGENTS	MC MC MC/DEL MC/DEL MC/DEL MC MC/DEL		SOFOSBUVIR/VELPATASVIR[2] (Authorized generic labeler 72626 Asegua Therapeutics) MAVYRET[2] PEGASYS KIT[1] PEGASYS SOLN PEG-INTRON KIT[1] RIBAVIRIN **RIBASPHERE**	MC/DEL MC/DEL MC MC MC/DEL MC MC MC MC MC MC/DEL		COPEGUS TABS DAKLINZA EPCLUSA[2] HARVONI[2] REBETOL CAPS RIBAPAK SOVALDI[2] VIEKIRA PAK[2] VIEKIRA XR[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	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		ACTIMMUNE	Use PA Form# 20420	Approved for chronic granulomatous disease, osteopetrosis and idiopathic pulmonary fibrosis.
HEPATITIS B ONLY	MC/DEL MC		**ENTECAVIR** TENOFOVIR	MC MC MC MC		BARACLUDE HEPSERA TABS TYZEKA 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.

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
RSV PROPHYLAXIS								
RSV PROPHYLAXIS				MC		SYNAGIS[1]	Use PA Form# 30120 1. MaineCare will approve Synagis PA's for start date of November 29, 2021 for infants who meet the guidelines. PA will be approved for max of 5 doses. Maximum 1 dose/30 days. MaineCare will start accepting PAs November 1, 2021."	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 MC/DEL		PLEGRIDY[1] EXTAVIA	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 MC/DEL MC MC MC MC MC	8 8 8 8 8 8 8 8 8 8 8 8 8	AMPYRA AUBAGIO BAFIERTAM BRIUMVI GILENYA **GLATOPA** **MAVENCLAD[3]** **MAYZENT** OCREVUS[2] OCREVUS ZUNOVO[2] **PONVORY[2]** TASCENSO ODT[2,4] TECFIDERA VUMERITY ZEPOSIA	Use PA Form# 20430 1. Providers must be enrolled in the TOUCH Prescribing program, a restricted distribution program. Clinical PA is required to establish diagnosis and medical necessity. 2. Clinical PA is required to establish diagnosis and medical necessity. 3. Due to safety profile, use of Mavenclad® is generally recommended for patients who have had an inadequate response to, or are unable to tolerate, an alternate drug indicated for the treatment of MS 4. For the treatment of patients 10 years of age and older. 5. Approved after single step through preferred drugs.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Mavenclad** will require multiple trials of preferred agents including Mayzent for secondary progressive disease. **DDI:** Due to significant increases in exposure to siponimod, concomitant use of Mayzent® and drugs that cause moderate CYP2C9 and moderate or strong CYP3A4 inhibition is not recommended. Ponvory: Before initiation of Ponvory® treatment, assess the following: •Complete Blood Count (CBC)- Obtain a recent (i.e. within the last 6 months) CBC, including lymphocyte count. •Cardiac Evaluation- oObtain 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. oDetermine 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 immune-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®. •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

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
ASSORTED NEUROLOGICS								
NEUROLOGICS - MISC.	MC MC		BOTOX[2,4] DYSPORT[4]	MC MC/DEL MC MC/DEL MC MC/DEL		DAXXIFY FIRDAPSE MYOBLOC[1] RUZURGI[3] 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 3. For the treatment of patients between ages 6-16 years of age. 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. Ruzurgi is recommended for the treatment of Lambert-Eaton myasthenic syndrome (LEMS) in patients 6 years to less than 17 years of age.
NEUROLOGICS- hATTR AGENTS				MC MC/DEL MC/DEL MC/DEL MC/DEL		AMVUTTRA[1] ATTRUBY ONPATTRO[1] TEGSEDI[1] **VYNDAMAX**[1] **VYNDAQEL**[1] WAINUA[1]	Use PA Form# 20420 1. PA required for appropriate diagnosis.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Certain drugs require specific diagnoses for approval. **Tegsedi®** should be non-preferred and approved for patients for whom other treatments, including Onpattro®, have been ineffective. Vyndamax will be considered for the treatment of the cardiomyopathy of wild type or hereditary transthyretin-mediated amyloidosis (ATTR-CM) in adults to reduce cardiovascular mortality and cardiovascular-related hospitalization
NEUROLOGICS- SMA	MC MC MC		GENE ZOLGENSMA[1] NON-GENE EVRYSDI[1,2] SPINRAZA[1]			GENE NON-GENE	Use PA Form# 20420 1. Clinical PA is required to establish diagnosis and medical necessity 2. For patients 2 months of age and older.	**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 treating 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 Treating provider agrees to do platelet count and coagulation test before each dose 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.

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
NEUROLOGICS- RETT SUNDROME				MC		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 MC MC		EXSERVAN QALSODY RILUTEK TABS RADICAVA[1] RELYVRIO[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/DEL		XENAZINE	Use PA Form# 20420 Use PA Form# 20710 for Xenazine 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 Ingrezza® 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		AGAMREE[4] AMONDYS 45[1] DEFLAZACORT ELEVIDYS[3] DUVYZAT EXONDYS 51[1] VILTEPSO[3] VYONDYS 53	Use PA Form# 20420 1. Clinical prior authorization 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. Amondy 45, Exondys 51 and Vyondys 53: • The prescriber is, or has consulted with, a neuromuscular disorder specialist AND • The dose does not exceed 30mg/kg once weekly AND • The patient is currently on a stable corticosteroid dose for at least 6 months (at least 3 months for Elevidy). Amondy 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 Viltepso: The prescriber is, or has consulted with, a neuromuscular disorder specialist AND • The dose does not exceed dosing AND • The patient is currently on a stable corticosteroid dose for at least 3 months. Viltepso: For Duchenne muscular dystrophy (DMD) in patients who have a confirmed mutation of the DMD gene that is amenable to exon 53 skipping. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial.
MYASTHENIA GRAVIS	MC		PYRIDOSTIGMINE	MC MC MC MC		MESTINON 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.

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
STEROIDS								
GLUCOCORTICOIDS/ MINERALOCORTICOIDS	MC/DEL		BUDESONIDE EC 3mg DR CAPS	MC		ALKINDI SPRINKLE	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:** All preferred steroids will require clinical PA for patients over 60 that are currently on fluoroquinolone therapy.
	MC		CELESTONE SUSP	MC		CORTEF 10 and 20 TABS		
	MC/DEL		CORTEF 5	MC/DEL		FLORINEF TABS		
	MC/DEL		CORTISONE ACETATE TABS	MC		HEMADY		
	MC/DEL		DELTASONE TABS	MC/DEL		**MEDROL TABS**		
	MC/DEL		DEPO-MEDROL SUSP	MC		MEDROL DOSEPAK TABS		
	MC/DEL		DEXAMETHASONE	MC		MILLIPRED		
	MC		DEXPAK	MC		ORTIKOS		
	MC/DEL		FLUDROCORTISONE ACETATE TABS	MC		ORAPRED SOLN		
	MC/DEL		HYDROCORTISONE	MC		PEDIAPRED LIQD		
	MC		KENALOG	MC		PREDNISONE INTENSOL CONC		
	MC/DEL		METHYLPREDNISOLONE TABS	MC		STERAPRED TABS		
	MC/DEL		PREDNISOLONE	MC		ZILRETTA		
	MC/DEL		**PREDNISONE**					
	MC/DEL		SOLU-CORTEF SOLR					
	MC/DEL		SOLU-MEDROL SOLR					
HORMONE REPLACEMENT THERAPIES								
ANDROGENS / ANABOLICS	MC/DEL		ANDRODERM PT24	MC		ANADROL-50	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Additionally, laboratory evidence of a testosterone deficiency must be supplied. One of each dosage form should be tried (tablet, injection, and topical) Oxandrolone: Weight gain (adjunctive therapy): Adjunctive therapy to promote weight gain after weight loss following extensive surgery, chronic infections, or severe trauma, and in some patients who, without definite pathophysiologic reasons, fail to gain or to maintain normal weight. Other indications included in manufacturer labeling: Adjunctive therapy to offset protein catabolism with prolonged corticosteroid administration. Requirement for documentation of weight loss over two readings- Patient has involuntary weight loss of more than 10% of total body weight in less than four months) and, BMI < 18.5 (Normal BMI = 18.5 to 24.9)
	MC/DEL		ANDROGEL 1%	MC		ANDRO LA 200 OIL		
	MC/DEL		ANDROGEL PUMP 1.62%	MC/DEL		ANDROGEL PACKETS 1.62%		
	MC/DEL		DANAZOL CAPS	MC		ANDROID CAPS		
	MC/DEL		TESTOSTERONE CYP	MC		AXIRON		
				MC		AZMIRO		
				MC		DELATESTRYL OIL		
				MC/DEL		DEPO-TESTOSTERONE OIL		
				MC		FORTESTA		
				MC		HALOTESTIN TABS		
				MC/DEL		JATENZO		
				MC/DEL		METHITEST TAB		
				MC/DEL		**METHYLTESTOSTERONE CAP**		
				MC/DEL		**OXANDROLONE**		
				MC/DEL		STRIANT MUC ER		
				MC		TESTIM		
				MC/DEL		**TESTOSTERONE GEL PACKETS**		
				MC/DEL		**TESTOSTERONE SOL**		
				MC		TESTRED CAPS		
				MC		TLANDO		
				MC/DEL		VOGELXO		
				MC/DEL		XYOSTED		
ESTROGENS - PATCHES / TOPICAL	MC		EVAMIST	MC/DEL	5	**ESTRADIOL PTWK**	Use PA Form# 20420 1. Step order drugs must be used in specified step order.	Approved for failures on multiple oral estrogen agents after 90 day trials or if unable to swallow any oral medication.
	MC/DEL		MINIVELLE PATCH	MC/DEL	8	**DIVIGEL**[1]		
	MC/DEL		VIVELLE-DOT PTTW	MC/DEL	8	**CLIMARA PTWK**		
				MC/DEL	8	**ELESTRIN**[1]		
				MC/DEL	**8**	**MENOSTAR PATCH**		
ESTROGENS - TABS	MC/DEL		ESTRADIOL	MC/DEL		ENJUVIA	Use PA Form# 20420 Must fail preferred products before non-preferred products.	Preferred drugs must be tried for at least 90 days and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		PREMARIN TABS	MC/DEL		**ESTRADIOL-NORETHINDRONE**		
				MC/DEL		**ESTRACE TABS**		
				MC		ESTRATAB TABS		
				MC/DEL		**MENEST TABS**		
				MC/DEL		**NORETHINDRON-ETHINYL**		
				MC		ORTHO-EST TABS		

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

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
CONTRACEPTIVES - PATCHES/ VAGINAL PRODUCTS	MC		ELURYNG[1]	MC		ANNOVERA	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.
	MC		NUVARING RING[1]	MC		PHEXXI		
	MC		TWIRLA	MC		ZAFEMY		
	MC/DEL		**XULANE**[2]					
CONTRACEPTIVES- LONG ACTING REVERSIBLE	MC/DEL		MIRENA	MC/DEL		KYLEENA	Use PA Form# 20420	
				MC		LILETTA		
				MC		NEXPLANON		
				MC/DEL		PARAGARD		
				MC/DEL		SKYLA		
CONTRACEPTIVES - MONOPHASIC COMBINATION O/C'S	MC/DEL		APRI TABS	MC/DEL		BEYAZ	Use PA Form# 20420 If member experienced adverse reactions, consider using Oral Contraceptives from other groups.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. If member experienced adverse reactions, consider using Oral Contraceptives from other groups. **DDI:** Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer.
	MC/DEL		AVIANE TABS	MC/DEL		BREVICON-28 TABS		
	MC/DEL		BALZIVA	MC/DEL		LESSINA-28 TABS		
	MC/DEL		CRYSELLE-28 TABS	MC/DEL		LEVORA		
	MC		DESOGEN TABS	MC/DEL		LOESTRIN FE 1/20 TABS		
	MC/DEL		ESTARYLLA TAB	MC/DEL		LOESTRIN 1.5/30-21 TABS		
	MC		HAILEY FE TAB	MC/DEL		MICROGESTIN FE TABS		
	MC/DEL		ISIBLOOM TAB	MC/DEL		LOESTRIN 1/20-21 TABS		
	MC/DEL		**JUNEL FE TAB**	MC		LO/OVRAL 21 TABS		
	MC		LARIN FE TAB	MC/DEL		LO/OVRAL 28 TABS		
	MC/DEL		**LESSINA TAB**	MC		NEXTSTELLIS		
	MC		LEVORA-28 TAB	MC/DEL		NORDETTE-28 TABS		
	MC		MILI TAB	MC/DEL		NORTREL		
	MC/DEL		NORGESTIMATE-ETHINYL ESTRADIOL TAB	MC/DEL		OCELLA		
	MC/DEL		**MIBELAS 24 FE TAB**	MC/DEL		OVRAL		
	MC/DEL		MICROGESTIN FE TAB	MC/DEL		PORTIA-28 TABS		
	MC/DEL		RECLIPSEN	MC/DEL		SAFYRAL		
	MC/DEL		SAFYRAL TAB	MC/DEL		ZOVIA		
	MC/DEL		SPRINTEC 28 TABS					
	MC/DEL		YASMIN 28 TABS					
	MC/DEL		YAZ					
CONTRACEPTIVES - BI-PHASIC COMBINATIONS	MC/DEL		AZURETTE TAB	MC/DEL		LOSEASONIQUE	Use PA Form# 20420 If member experienced adverse reactions, consider using Oral Contraceptives from other groups.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. If member experienced adverse reactions, consider using Oral Contraceptives from other groups. **DDI:** Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer.
	MC/DEL		**CAMRESE**					
	MC/DEL		**CAMRESE LO**					
	MC		DESOGESTREL/ ETH/ ESTRAD 0.15/30mcg					
	MC/DEL		KARIVA TABS					
	MC/DEL		LO LOESTRIN FE					
	MC/DEL		PIMTREA TAB					
	MC		NORETHINDRONE-ETH ESTRADIOL TAB 0.5-35/1-35					
	MC		SIMPESSE TBDSPK 3MO					
	MC/DEL		VIORELE TAB					
CONTRACEPTIVES - TRI-PHASIC COMBINATIONS	MC/DEL		ENPRESSE	MC/DEL		NORTREL 7/7/7	Use PA Form# 20420 If member experienced adverse reactions, consider using Oral Contraceptives from other groups.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. If member experienced adverse reactions, consider using Oral Contraceptives from other groups. **DDI:** Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer.
	MC/DEL		**NORGESTIMATE-ETHINYL ESTRADIOL TAB**	MC		ORTHO TRI-CYCLEN LO TABS		
	MC/DEL		TRIPHASIL 28 TABS					
	MC		TRI-LO-MILI TAB					
	MC		TRI-LO-ESTARYLLA TAB					
	MC		TRI-ESTARYLLA					
	MC/DEL		TRI-SPRINTEC TAB					
	MC/DEL		**TRI-LO-SPRINTEC**					
	MC		TRINESSA					

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
CONTRACEPTIVES - MULTI-PHASIC COMBINATIONS				MC		NATAZIA	Use PA Form# 20420	
VASOMOTOR SYMPTOMS AGENTS								
VASOMOTOR SYMPTOMS AGENTS				MC/DEL		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. **Veozah**: Approval requires at least one preferred Hormone Replacement Therapy (HRT) and two preferred non-hormonal therapies (i.e., SSRIs, SNRIs, gabapentin, pregabalin, clonidine). 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.mainecarepdl.org **Continuous Glucose Monitoring Criteria**: Patient has a diagnosis of Diabetes Mellitus AND Practitioner feels patient has sufficient training to use CGM • 2 years of age or older for Dexcom G6 and Dexcom G7, ≥ 14 years for Medtronic Guardian, or ≥ 4 years for Freestyle Libre 2. • At least one of the following are documented: o Hypoglycemic unawareness o Treated with insulin (at least 1X day) o Has history of problematic hypoglycemia with documentation of at least one recurrent level 2 hypoglycemic events, or 1 level 3 hypoglycemic event • Approval of non-preferred products will be limited to cases where the CGM is directly integrated with the patient's insulin pump. The make and model of pump must be documented on the prior authorization.
DIABETES THERAPIES								
DIABETIC - INSULIN	MC/DEL MC MC MC MC MC MC MC MC/DEL MC/DEL		**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 ASPART PROT MIX 70-30 INSULIN ASPART INSULIN LISPRO LANTUS SOLN LEVEMIR	MC/DEL MC/DEL MC/DEL MC MC MC MC MC MC MC/DEL 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 LYUMJEV **NOVOLIN** **NOVOLOG** **NOVOLOG MIX** NOVOLOG MIX 70/30 FLEXPEN RELION	Use PA Form# 20420 1. Not to be as a monotherapy. Obtain lab values of pulmonary function and recent smoking history 2. For the treatment of patients ≥3 years of age	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
DIABETIC - PENFILLS	MC MC MC MC MC/DEL MC MC MC 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 ASPART PROT MIX 70-30 PEN INSULIN ASPART PEN INSULIN LISPRO KWIKPEN U-100 LANTUS SOLOSTAR LEVEMIR FLEXTOUCH LEVEMIR FLEXPEN **TOUJEO MAX SOLOSTAR** **TOUJEO SOLOSTAR**	MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL		APIDRA OPTICLIK PEN **NOVOLIN 70/30 PEN** NOVOLOG MIX PENFILL **NOVOLOG PENFILL SOLN** NOVOLOG FLEXPEN NOVOLOG MIX 70/30 VIAL REZVOGLAR KWIKPEN **TRESIBA**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
DIABETIC - DPP- 4 ENZYME INHIBITOR	MC/DEL MC/DEL		JANUVIA[1,2] TRADJENTA[2]	MC/DEL MC/DEL MC/DEL MC		**NESINA** **ONGLYZA[2]** 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 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. **DDI:** Onglyza 5mg 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).
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 MC/DEL MC MC		**JENTADUETO XR** **KAZANO** **KOMBIGLYZE XR** **OSENI** **ZITUVIMET** **ZITUVIMET XR**	Use PA Form# 20420 1. Preferred if therapeutic doses of metformin are seen in members drug profile for at least 60 days within the past 18 months or if phosphate binder is currently seen in the members drug 2. Dosing limits apply. Please refer to Dose consolidation list.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Zituvimet/ Zituvimet XR:** Approvals will require trial of preferred sitagliptin/metformin products or other preferred diabetic agents.
DIABETIC - LANCET-LANCET DEVICE							Use PA Form# 20420	Please refer to the MaineCare Preferred Diabetic Supply List available at www.mainecarepdl.org
DIABETIC - SYRINGES-NEEDLES							Use PA Form# 20420	Please refer to the MaineCare Preferred Diabetic Supply List available at www.mainecarepdl.org
DIABETIC - OTHER				MC/DEL MC		CYCLOSET SYMLIN	Use PA Form #20420 for all others	
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.

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
SGLT 2 INHIBITOR COMBINATIONS	MC/DEL MC/DEL MC/DEL		SYNJARDY SYNJARDY XR XIGDOU XR	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		GLYXAMBI INVOKAMET INVOKAMET XR SEGLUROMET STEGLUJAN TRIJARDY XR	Use PA Form# 20420	Preferred drugs must be tried for at least 3 months at full therapeutic doses and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Glyxambi /Xigduo XR-** Verify prior trials and failures or intolerance of preferred treatments from other diabetic categories **Synjardy® XR** is not recommended for patients with type 1 DM or for the treatment of diabetic ketoacidosis.
DIABETIC MONITOR	MC		RELION TRUEMETRIX AIR BLOOD GLUCOSE MONITORING SYSTEM TRUEMETRIX AIR BLOOD GLUCOSE MONITORING SYSTEM TRUEMETRIX BLOOD GLUCOSE MONITORING SYSTEM	MC MC MC MC MC MC MC MC		ACCUCHECK ASCENSIA ASSURE CONTOUR BREEZE Z EXACTECH FREESTYLE INSULINX FREESTYLE LITE SYSTEM KIT PRECISION XTRA METER PRODIGY	Use PA Form# 20420	Effective October 25th 2007, approvals for all non preferred meters/ test strips will require medical necessity documenting clinically significant features that are not available on any of the preferred meters.
DIABETIC TEST STRIPS	MC		RELION TRUEMETRIX TRUEMETRIX	MC MC MC MC MC MC MC MC MC MC		ACCUCHECK ASCENSIA ASSURE CONTOUR BREEZE Z EXACTECH FREESTYLE FREESTYLE LITE FREESTYLE INSULINX PRECISION XTRA PRODIGY	Use PA Form# 20420	Effective October 25th 2007, approvals for all non preferred meters/ test strips will require medical necessity documenting clinically significant features that are not available on any of the preferred meters. Effective October 1, 2023, a maximum of 100 blood glucose test strips every 90 days will be available without Prior Authorization for members currently utilizing continuous glucose monitors (CGM).
INCRETIN MIMETIC	MC/DEL MC MC/DEL		RYBELSUS TRULICITY VICTOZA	MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL	5 8 8 8 8 8	OZEMPIC ADLYXIN BYDUREON BCISE MOUNJARO SOLIQUA XULTOPHY	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Soliqua** must try both insulin and a preferred incretin mimetic and have a medical necessity for use that is not based on convenience or simply due to the fact that one injection is needed instead of two.
DIABETIC - ORAL SULFONYLUREAS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		CHLORPROPAMIDE TABS GLIMEPIRIDE GLIPIZIDE TABS GLIPIZIDE ER TABS GLYBURIDE MICRONIZED TABS GLYBURIDE TABS[1] TOLAZAMIDE TABS TOLBUTAMIDE TABS	MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL		AMARYL TABS DIABETA TABS GLUCOTROL TABS GLUCOTROL XL TBCR GLYNASE TABS MICRONASE TABS	Use PA Form# 20420 1. PA required for members ≥65. Glyburide has a greater risk of severe prolonged hypoglycemia in older adults.	Preferred drugs must be tried for at least 3 months at full therapeutic doses and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** All sulfonylureas (except glyburide) will now be non-preferred and require prior authorization if it is currently being used with either ranitidine or cimetidine. **DDI:** Glimepiride will now be non-preferred and require prior authorization if it is currently being used with either fluconazole (except 150mg strength) or fluvoxamine. Amaryl is non-preferred but with any prior authorization requests, the member's drug profile will also be monitored for concurrent use with either fluconazole or fluvoxamine.

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
DIABETIC -ORAL BIGUANIDES	MC/DEL MC/DEL		**METFORMIN HCL TABS** METFORMIN ER	MC MC MC MC/DEL		GLUCOPHAGE TABS GLUCOPHAGE XR TB24 FORTAMET METFORMIN ER OSMOTIC	Use PA Form# 20420	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
DIABETIC - THIAZOL / BIGUANIDE COMBO				MC/DEL MC/DEL MC MC		ACTOPLUS MET[1] ACTOPLUS MET XR AVANDARYL[1] **AVANDAMET TABS**[1]	Use PA Form# 20420 1. Requires use of Actos, Metformin, or other preferred anti-diabetics.	**DDI:** Actos, Avandia, or any combination product with Actos or Avandia will now be non-preferred and require prior authorization if it is currently being used with gemfibrozil.
DIABETIC - / THIAZOL	MC/DEL		**PIOGLITAZONE HCL**[1]	MC/DEL MC		**ACTOS TABS**[3] **AVANDIA TABS**[2]	Use PA Form# 20420 1. Pioglitazone HCL is non-preferred as monotherapy. Pioglitazone HCL is preferred if therapeutic doses of metformin, sulfonylurea or insulin are seen in members drug profile for at least 60 days within the past 18 months. 2. Current users of Avandia who have tried Actos will be able to continue use of Avandia. 3. Dosing limits apply 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. 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/DEL			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		BAQSIMI[1] **GVOKE**[2]	MC MC MC		GLUCAGON DIAGNOSTIC KIT ZEGALOGUE[3]	Use PA Form# 20420 1. For the treatment of patients ≥ 4 years of age. 2. For the treatment of patients ≥ 2 years of age. 3. For the treatment of patients ≥ 6 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.
THYROID								
THYROID EYE DISEASE				MC		**TEPEZZA**	Use PA Form# 20420	

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
THYROID HORMONES	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		**ARMOUR THYROID TABS** **CYTOMEL TABS** **ERMEZA**[1] **LEVOTHROID TABS** **LEVOTHYROXINE SODIUM TABS** **LEVOXYL TABS** **UNITHROID TABS**	MC MC/DEL MC MC/DEL		LEVOTHYROXINE SODIUM SOLR LIOTHYRONINE SYNTHROID TABS THYQUIDITY	Use PA Form# 20420 1.Clinical PA is required to confirm diagnosis of dysphagia.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTITHYROID THERAPIES	MC/DEL MC/DEL		**METHIMAZOLE TABS** **PROPYLTHIOURACIL TABS**	MC/DEL		**TAPAZOLE TABS**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
CUSHING DISEASE AGENTS								
CUSHING DISEASE AGENTS				MC MC		ISTURISA[1] RECORLEV	Use PA Form #20420 1. For the treatment of adult patients with Cushing's disease for whom pituitary surgery is not an option or has not been curative.	**Recorlev®** is associated with dose-related QT interval prolongation. QT interval prolongation may lead to life-threatening ventricular dysrhythmias such as Torsade de pointes.
OSTEOPOROSIS / BONE AGENTS								
OSTEOPOROSIS	MC/DEL		ALENDRONATE	MC/DEL MC MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC/DEL MC/DEL MC MC MC MC MC/DEL		**ACTONEL TABS** AREDIA SOLR BINOSTO BONIVA INJECTION KIT BONIVA TABS[2,4] CALCITONIN NS **DUAVEE** **DIDRONEL TABS** EVISTA TABS[1] **EVENITY**[2] FORTEO FORTICAL **FOSAMAX TABS AND PLUS D**[3] PROLIA SOHONOS[6] STRENSIQ[5] TYMLOS XGEVA ZOMETA	Use PA Form# 20420 1. Approval only requires failure of Alendronate. 2. Quantity limits apply, please see dosage consolidation list. 3. Please use Alendronate and Vitamin D. 4. Please use other preferred agents. 5. Obtain baseline ophthalmology exams and renal ultrasounds and then periodically during treatment 6. Clinical PA for indication re	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Binosto** use preferred generic alendronate tablets **Evenity®** should be limited to 12 monthly doses **Sohonos**: For the reduction in volume of new heterotopic ossification in adults and pediatric patients aged 8 years and older for females and 10 years and older for males with fibrodysplasia ossificans progressive (FOP).
FIBROBLAST GROWTH FACTOR 23 INHIBITORS	MC		CRYSVITA[1]				Use PA Form #20420 1.Preferred for patients <21 years 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.

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
GROWTH HORMONE								
GROWTH HORMONE	MC/DEL MC/DEL MC		GENOTROPIN[1] NORDITROPIN SOLN[1] SKYTROFA[1,2]	MC MC MC/DEL MC/DEL MC MC MC/DEL MC/DEL	8 8 8 8 8 8 8 8	HUMATROPE SOLR INCRELEX NUTROPIN NGENLA OMNITROPE SAIZEN SOLR SOGROYA TEV-TROPIN	Use PA Form# 10710 1.Clinical PA is required to establish diagnosis and medical necessity. 2. Preferred after single step therapy of short acting growth hormone.	See **Growth Hormone PA** form 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		VOXZOGO[1]	Use PA Form# 20420 1. Pediatric patients with achondroplasia who are 5 years of age and older with open epiphyses.	**Voxzogo**: To increase linear growth in pediatric patients with achondroplasia who are 5 years of age and older with open epiphyses. This indication is approved under accelerated approval based on an improvement in annualized growth velocity. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trial(s).
SOMATOSTATIC AGENTS				MC/DEL MC MC MC/DEL MC	7 8 8 8 8	OCTREOTIDE INJ[1] BYNFEZIA[1] MYCAPSSA[1] SANDOSTATIN[1] SOMATULINE[1]	Use PA Form# 10710 1. Non-preferred products must be used in specified step order.	
GROWTH HORMONE ANTAGONISTS								
GH ANTAGONISTS				MC		SOMAVERT	Use PA Form# 10710	Approved for acromegaly patients failing surgery/radiation/drug therapy including bromocriptine and sandostatin.
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/DEL MC	5 6 8 8 8	DDAVP TABS **DESMOPRESSIN SPRAY[1]** DESMOPRESSIN ACETATE SOLN[1] NOCDURNA[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	**8** 8 **8**	**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 TROSPIUM	MC MC/DEL MC MC/DEL MC/DEL MC MC	8 8 8 8 8 8 8	**DITROPAN XL TBCR** ENABLEX[1,2] GEMTESA[2] **TOLTERODINE TAB** TOVIAZ VESICARE[1] VESICARE[3] LS	Use PA Form# 20420 1. See Criteria Section. 2. Use a preferred long acting antispasmodic. 3. For the treatment of patients ≥ 2 years of age.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. 1. **Vesicare 5mg and Enablex 7.5mg** maximum doses if given with drugs known to be significant CYP3A4 inhibitors.(Ketoconazole, Sporanox, Erythromycin, Fluconazole, Nefazodone, Nelfinavir, and Ritonavir) **DDI:** Enablex 15mg and Vesicare 10mg will now be non-preferred and require prior authorization if they are currently being used in combination with any of the following medications: clarithromycin, erythromycin, Ketek, Crixivan, Norvir, ketoconazole, fluconazole (except 150mg strength), Sporanox. nefazodone, or diltiazem.
CHOLINERGIC	MC/DEL		**BETHANECHOL**	MC/DEL		**URECHOLINE**	Use PA Form# 20420	

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
HYPERAMMONIA TREATMENTS	MC		CARGLUMIC ACID TABS	MC		CARBAGLU 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 RAVICTI LIQUID OLPRUVA **SODIUM PHENYLBUTYRATE POWDER** **SODIUM PHENYLBUTYRATE TAB**		Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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		ORFADIN	Use PA Form# 20420	Approved for Type 1 hereditary tyrosinemia patients. Must include laboratory evidence of dx at first PA.
FABRY DISEASE AGENTS				MC MC MC/DEL		ELFABRIO[1] FABRAZYME[2] GALAFOLD[1]	Use PA Form# 20420 1.Clinical PA to verify appropriate diagnosis. 2.For the treatment of patients 2 years of age and older.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Elfabrio and Galfold**: For the treatment of adults with confirmed Fabry disease.
ANTIHYPERTENSIVES / CARDIAC								
CARDIAC GLYCOSIDES	MC/DEL MC/DEL MC/DEL		**DIGITEK TABS** **DIGOXIN** **LANOXIN**				Use PA Form# 20420	
CARDIAC MYOSIN INHIBITORS				MC		CAMZYOS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Camzyos**: For the treatment of adults with symptomatic New York Heart Association (NYHA) class II-III obstructive hypertrophic cardiomyopathy (HCM) to improve functional capacity and symptoms. **DDI:** Concomitant use of Camzyos® with a moderate to strong CYP2C19 inhibitor or a strong CYP3A4 inhibitor is contraindicated.
CARDIAC - SINUS NODE INHIBITORS				MC		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		TRYVIO	Use PA Form#20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Tryvio**: In combination with other antihypertensive drugs, is indicated for the treatment of resistant hypertension, to lower blood pressure (BP) in adult patients who are not adequately controlled on other drugs. Resistant HTN is defined as a patient who takes at least 3 different class antihypertensive medications with complementary mechanisms including thiazide, ACE inhibitor, ARB, long-acting calcium channel blocker, with a trial of spironolactone, unless contra-indicated
CARDIAC- SOLUBLE GUANYLATE CYCLASE STIMULATORS				MC/DEL		**VERQUVO**	Use PA Form# 20420	
CARDIAC RISK REDUCTION- SGLT2/GLP-1				MC MC MC/DEL		INPEFA[1] LODOCO WEGOVY	Use PA Form #23976 1. To reduce the risk of cardiovascular death, hospitalization for heart failure, and urgent heart failure visit in adults with: Heart failure or Type 2 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. **Lodoco**: Patient must have tried and failed generic colchicine due to lack of efficacy or intolerable side effects **Wegovy: Patient does not have diagnosis of diabetes, end stage renal disease/dialysis, or HFrEF (EF < 45%)** Patient has BMI > 27 kg/m2, and is not being used for weight loss only Patient has history of at least one of the following: o Stroke o Myocardial Infarction o Symptomatic peripheral arterial disease

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
ANTIANGINALS--Isosorbide Di-nitrate/ Mono-Nitrates	MC/DEL MC/DEL		ISOSORBIDE MONONITRATE TABS ISOSORBIDE MONONITRATE ER	MC MC MC MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		DILATRATE SR CPCR ISORDIL TABS ISORDIL TITRADOSE TABS ISOSORBIDE DINITRATE SUBL **ISOSORBIDE DINITRATE TABS** ISOSORBIDE DINITRATE CR TBCR **ISOSORBIDE DINITRATE ER TBCR** ISOSORBIDE DINITRATE TD TBCR **IMDUR TB24** ISMO TABS MONOKET 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.
NITRO - OINTMENT/CAP/CR	MC/DEL MC/DEL MC MC		NITROBID OINT NITROGLYCERIN CPCR NITROL OINT NITRO-TIME CPCR				Use PA Form# 20420	
NITRO - PATCHES	MC/DEL MC/DEL	1 1	NITROGLYCERIN PT24[1] NITRO-DUR PT 24 0.8MG[1]	MC MC/DEL		NITRODISC PT24 **NITRO-DUR PT24**	Use PA Form# 20420 1. At least 2 step 1's and step 3 of the preferred products must be used in specified order or PA will be required.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
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 TIMOLOL MALEATE TABS	MC MC/DEL MC MC MC MC/DEL MC/DEL MC/DEL MC MC MC MC		ASPRUZYO **BETAPACE TABS** **BETAPACE AF TABS** **COREG CR**[3] **COREG TABS** **CORGARD TABS** **INDERAL TABS** **HEMANGEOL SOL** INDERAL XL CAP INDERAL LA CPCR 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.
BETA BLOCKERS - CARDIO SELECTIVE	MC/DEL 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	

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
CALCIUM CHANNEL BLOCKERS--Amlodipine, Bepridil, Diltiazem, Felodipines, Isradipines, Nifedipines, Nisoldipine, and Verapamil	MC/DEL		AMLODIPINE[1]	MC/DEL		**KATERZIA**	Use PA Form# 20420 1. Dosing limits apply, please see dose consolidation list.	
				MC		NORLIQVA		
				MC/DEL		**NORVASC TABS[1]**		
	MC		DILTIA XT CP24	MC/DEL	5	**DILACOR XR CP24[1]**	Use PA Form# 20420 1. Products must be used in specified order or PA will be required. Just write "Diltiazem 24-hour"and the pharmacy will use a preferred long acting diltiazem that does not require PA.	Preferred drugs must be tried and failed (in step-order) due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** All preferred diltiazem will now be non-preferred and require prior authorization if they are currently being used in combination with either Enablex 15mg or Vesicare 10mg. All non-preferred diltiazem require prior authorization, but with any prior authorization request, the member's drug profile will also be monitored for current use with Enablex 15mg or Vesicare 10mg.
	MC/DEL		**DILTIAZEM HCL ER CP24**	MC/DEL	6	**TAZTIA[1]**		
	MC/DEL		**DILTIAZEM HCL XR CP24**	MC	8	CARDIZEM TABS[1]		
	MC/DEL		**DILTIAZEM CD 300MG CP24**	MC	8	CARDIZEM CD CP24[1]		
	MC/DEL		**DILTIAZEM CD 360MG CP24**	MC	8	CARDIZEM LA TB24[1]		
	MC		CARTIA XT CP24[1]	MC	8	CARDIZEM SR CP12[1]		
	MC/DEL		**DILTIAZEM CD CP24[1]**	MC/DEL	8	**DILTIAZEM HCL TABS[1]**		
	MC/DEL		**DILTIAZEM HCL ER CP24[1]**	MC/DEL	8	**DILTIAZEM HCL ER CP12[1]**		
	MC/DEL		**DILTIAZEM XR CP24[1]**	MC/DEL	8	**DILTIAZEM HCL ER CP12[1]**		
	MC/DEL		**TIAZAC CP24[1]**					
				MC/DEL		**PLENDIL TB24**	Use PA Form# 20420	Other Preferred calcium channel blockers must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC/DEL		**FELODIPINE**		
				MC		DYNACIRC CAPS	Use PA Form# 20420 1. 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.
				MC		DYNACIRC CR TBCR[1]		
				MC		CARDENE SR CPCR	Use PA Form# 20420	Other Preferred calcium channel blockers must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC		NICARDIPINE HCL CAPS		
	MC/DEL		**AFEDITAB CR**	MC/DEL		**ADALAT CC TBCR[1]**	Use PA Form# 20420 1. Established users of Adalat CC are grandfathered.	Preferred drug must be tried and failed in step order due to lack of efficacy or intolerable side effects before non-preferred drugs in step order will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**NIFEDIAC CC**	MC/DEL		**NIFEDIPINE CAPS**		
	MC/DEL		**NIFEDICAL XL TBCR**	MC/DEL		**PROCARDIA CAPS**		
	MC/DEL		**NIFEDIPINE TBCR**	MC/DEL		**PROCARDIA XL TBCR**		
	MC/DEL		**NIFEDIPINE ER TBCR**					
				MC		SULAR TB24	Use PA Form# 20420 1. Established users of 10MG and 20MG strengths are grandfathered.	
				MC		SULAR CR[1]		
	MC/DEL	1	**VERAPAMIL HCL CR TBCR**	MC/DEL		**CALAN TABS**	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 (in step-order) due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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	1	**VERAPAMIL HCL ER TBCR**	MC/DEL		**CALAN SR TBCR**		
	MC/DEL	1	**VERAPAMIL HCL SR TBCR**	MC/DEL		**COVERA-HS TBCR**		
				MC		ISOPTIN-SR		
				MC/DEL		VERAPAMIL HCL ER CP24		
				MC/DEL		**VERAPAMIL HCL SR CP24**		
				MC/DEL		**VERAPAMIL HCL TABS**		
				MC/DEL		**VERELAN CP24**		
				MC/DEL		**VERELAN PM CP24**		
ANTIARRHYTHMICS	MC/DEL		**AMIODARONE HCL**	MC/DEL		**CORDARONE**	Use PA Form# 20420 1. Prescription must be written by Cardiologist.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Amiodarone will now be non-preferred and require prior authorization if it is currently being used in combination with either Lovastatin (doses greater than 40mg/day) or Lipitor (doses greater than 20mg/day) or Levofloxacin or Gemifloxacin, or Moxifloxacin, or Ofloxacin. **DDI:** Multaq will be preferred unless the following medications are seen in the member's drug profile within the last 35 days for brand name medications or 90 days for generic medications: Erythromycin, Amiodarone and other antiarrhythmics, TCA's, Phenothiazine, Ketoconazole, Itraconazole, Voriconazole, Cyclosporine, Telithromycin, Clarithromycin, Nefazodone, Ritonavir.
	MC/DEL		**DISOPYRAMIDE**	MC/DEL		**DISOPYRAMIDE**		
	MC/DEL		**FLECAINIDE**	MC/DEL		MULTAQ		
	MC/DEL		**MEXILETINE HCL**	MC/DEL		**NORPACE**		
	MC/DEL		**PROCAINAMIDE**	MC/DEL		**PACERONE**		
	MC/DEL		**PROPAFENONE**	MC		QUINIDEX		
	MC		QUINAGLUTE	MC/DEL		TAMBOCOR		
	MC/DEL		**QUINIDINE GLUCONATE**	MC/DEL		TIKOSYN[1]		
	MC/DEL		**QUINIDINE SULFATE**	MC		**RYTHMOL SR**		
				MC/DEL		**RYTHMOL**		

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
ACE INHIBITORS	MC/DEL		BENAZEPRIL HCL	MC	5	MAVIK TABS	Use PA Form# 20420 1. Non-preferred products must be used in specified order.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Non-preferred products are subject to step-order requirements unless clinical circumstances warrant exception.
	MC/DEL		CAPTOPRIL TABS	MC/DEL	5	**ACCUPRIL TABS**		
	MC/DEL		ENALAPRIL MALEATE TABS	MC/DEL	8	**ACEON TABS**[1]		
	MC/DEL		FOSINOPRIL SODIUM	MC/DEL	8	**ALTACE CAPS**[1]		
	MC/DEL		LISINOPRIL TABS	MC	8	EPANED		
	MC/DEL		RAMIPRIL	MC/DEL	8	**LOTENSIN TABS**[1]		
	MC/DEL		QUINAPRIL HCL	MC/DEL	8	**MOEXIPRIL HCL**[1]		
				MC	8	**MONOPRIL HCT TABS**[1]		
				MC/DEL	8	**PRINIVIL TABS**[1]		
				MC	8	QBRELIS		
				MC/DEL	8	**UNIVASC**[1]		
				MC	8	VASOTEC TABS[1]		
				MC/DEL	8	**ZESTRIL TABS**[1]		
ANGIOTENSIN RECEPTOR BLOCKER	MC/DEL		AMLODIPINE-OLMESARTAN TAB[3]	MC/DEL	8	**ATACAND TABS**	Use PA Form# 20420 1. Dosing limits apply, please see dose consolidation list. 2. Use preferred active ingredients which are available without PA. 3. Preferred without a PA only if patient on a diabetic therapy or prior ACE therapy.	Per best practices patient should have trialed prior therapy of ACE inhibitor or currently on a diabetic therapy
	MC/DEL		IRBESARTAN[1]	MC/DEL	8	**AVAPRO**		
	MC/DEL		LOSARTAN[1]	MC/DEL	8	**BENICAR TABS**		
	MC/DEL		MICARDIS TABS[3]	MC/DEL	8	**COZAAR**		
	MC/DEL		OLMESARTAN[1]	MC/DEL	8	**DIOVAN**		
	MC/DEL		TELMISARTAN[1]	MC/DEL	8	EDARBI		
				MC	8	TEVETEN TABS		
DIRECT RENIN INHIBITOR				MC/DEL		AMTURNIDE	Use PA Form# 20420 1. Must show failure of single and combination therapy from all preferred antihypertensive categories.	
				MC/DEL		TEKTURNA[1]		
				MC/DEL		TEKAMLO		
ANTIHYPERTENSIVES - CENTRAL	MC/DEL		CLONIDINE HCL TABS	MC/DEL		**CLONIDINE PATCH**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		GUANFACINE HCL TABS	MC/DEL		CLONIDINE TTS		
	MC/DEL		HYDRALAZINE HCL TABS	MC		GUANABENZ ACETATE TABS		
	MC		HYLOREL TABS	MC		ISMELIN TABS		
	MC/DEL		METHYLDOPA TABS	MC/DEL		**MINIPRESS CAPS**		
	MC/DEL		MINOXIDIL TABS	MC		**NEXICLON**		
	MC/DEL		PRAZOSIN HCL CAPS	MC/DEL		**TENEX TABS**		
	MC/DEL		RESERPINE TABS					
ACE INHIBITORS AND CA CHANNEL BLOCKERS				MC/DEL	8	**AMLODIPINE/BENAZEPRIL**	Use PA Form# 20420 1. Prestalia will only be approved for patients ≥ 18 years of age. Use individual preferred generic medications.	
				MC	8	PRESTALIA[1]		
				MC	8	TARKA TBCR		
				MC/DEL	9	**LOTREL CAPS**		
ACE AND THIAZIDE COMBO'S	MC/DEL		BENAZEPRIL HCL/HYDROCHLOR	MC/DEL		**ACCURETIC TABS**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		CAPTOPRIL/HYDROCHLOROTHIA	MC		MONOPRIL HCT TABS		
	MC/DEL		ENALAPRIL MALEATE/HCTZ TABS	MC/DEL		**PRINZIDE TABS**		
	MC/DEL		LISINOPRIL-HCTZ TABS	MC/DEL		**UNIRETIC TABS**		
	MC/DEL		LOTENSIN HCT TABS	MC		VASERETIC TABS		
				MC/DEL		**ZESTORETIC TABS**		

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
BETA BLOCKERS AND DIURETIC COMBO'S	MC/DEL MC/DEL MC/DEL		ATENOLOL/CHLORTHALIDONE BISOPROLOL FUMARATE/HCTZ PROPRANOLOL/HCTZ	MC/DEL MC/DEL MC MC MC/DEL		CORZIDE TABS LOPRESSOR HCT TABS TENORETIC TIMOLIDE 10/25 TABS ZIAC 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.
ARB'S AND CA CHANNEL BLOCKERS	MC/DEL MC/DEL MC/DEL		AMLODIPINE/VALSARTAN AMLODIPINE/VALSARTAN HCT TRIBENZOR	MC/DEL MC MC/DEL MC/DEL		AZOR BYVALSON EXFORGE EXFORGE HCT	Use PA Form# 20420	DDI: Byvalson will be non-preferred and require a prior authorization if it is currently being used in combination with drugs known to be significant CYP2D6 inhibitors (e.g. quinidine, propafenone, fluoxetine, paroxetine). Per best practices patient should have trialed prior therapy of ACE inhibitor or currently on a diabetic therapy
ARB'S AND DIURETICS	MC/DEL MC/DEL MC/DEL MC/DEL		BENICAR HCT[1] LOSARTAN HCT[1] MICARDIS HCT TABS[1] VALSARTAN-HCT[1]	MC/DEL MC/DEL MC MC/DEL MC/DEL MC	7 8 8 8 8 8	IRBESARTAN HYDROCHLOROTHIAZIDE ATACAND HCT TABS AVALIDE TABS[1] DIOVAN HCT TABS[1] HYZAAR TABS TEVETEN HCT TABS	Use PA Form# 20420 1. Dosing limits apply, please see dose consolidation list.	Per best practices patient should have trialed prior therapy of ACE inhibitor or currently on a diabetic therapy
ANGIOTENSIN MODULATORS-ARB COMBINATION	MC		ENTRESTO	MC/DEL MC		EDARBYCLOR ENTRESTO SPRINKLES	Use PA Form# 20420	
ARB'S AND DIRECT RENIN INHIBITOR COMBINATION				MC/DEL		VALTURNA	Use PA Form# 20420	
DIURETICS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC		ACETAZOLAMIDE TABS AMILORIDE HCL BUMETANIDE CHLOROTHIAZIDE TABS CHLORTHALIDONE TABS EDECRIN TABS EDECRIN TABS HYDROCHLOROTHIAZIDE INDAPAMIDE TABS METHAZOLAMIDE TABS METHYCLOTHIAZIDE TABS SPIRONOLACTONE SPIRONOLACTONE/HYDRO TORSEMIDE TABS TRIAMTERENE/HCTZ ZAROXOLYN TABS	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC MC MC MC MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC		ALDACTAZIDE TABS ALDACTONE TABS BUMEX TABS DEMADEX TABS DIAMOX DIURIL DYAZIDE CAPS CAROSPIR ENDURON TABS FUROSCIX INSPRA INZIRQO KERENDIA KEVEYIS LASIX TABS MAXZIDE MICROZIDE CAPS MIDAMOR TABS NAQUA TABS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Furoscix**: The indication for use is the treatment of congestion due to fluid overload in adults with NYHA Class II or Class III chronic heart failure AND the medication is being prescribed by or in consultation with a cardiologist AND the patient is experiencing symptoms despite compliance with oral loop diuretic therapy AND oral loop diuretic therapy will be resumed as soon as practical AND medical reasoning beyond convenience is provided for not pursuing therapy in an outpatient infusion setting. PA approval will be authorized for 1 month. **Kerendia**: Patient must be on max tolerated preferred ACE-I/ARB and SGLT-2 DDI: The concomitant use of Keveyis® with high dose aspirin is contraindicated.
CCB / LIPID				MC/DEL		CADUET	Use PA Form# 20420	
NEUROGENIC ORTHOSTATIC HYPOTENSION								
NEUROGENIC ORTHOSTATIC HYPOTENSION				MC		NORTHERA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
LIPID DRUGS								
CHOLESTEROL - BILE SEQUESTRANTS	MC/DEL MC/DEL		CHOLESTYRAMINE COLESTIPOL HCl	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.

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
CHOLESTEROL - FIBRIC ACID DERIVATIVES	MC/DEL MC/DEL MC/DEL		FENOFIBRATE TAB **GEMFIBROZIL TABS** **NIACIN ER**	MC MC/DEL 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, please 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 they are currently being used in combination cyclosporine. **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. **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	8 8 8 8 8 8 8 8 8 8	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.

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
FAMILIAL HYPERCHOLESTEROLEMIA AND HYPERTRIGLYCERIDEMIA						TRYNGOLZA	Use PA Form# 20420	Tryngolza requires fasting triglycerides of ≥ 880 mg/dL and confirmed genetically identified familial chylomicronemia syndrome (FCS)
PULMONARY ANTI-HYPERTENSIVES								
PULMONARY ANTI-HYPERTENSIVES	MC MC/DEL MC/DEL MC		EPOPROSTENOL INJ[3,6] SILDENAFIL TADALAFIL VENTAVIS[3]	MC/DEL MC MC/DEL MC MC MC MC MC MC MC/DEL MC MC MC MC MC/DEL		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]**	Use PA Form# 20420 1. Requires previous trials/failure of multiple preferred medications. 2. Dosing limits apply, please 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 (WHO) functional class 2 or 3.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Sildenafil** will be preferred with clinical PA for treatment of pulmonary arterial hypotension (WHO Group 1) in adults to improve exercise ability and delay clinical worsening. Avoid concomitant use of Sildenafil with moderate or strong Cyp3A inhibitors **DDI:** Uptravi will require a prior authorization if it is currently being used in combination with strong inhibitors of CYP2C8 (gemfibrozil) **DDI:** Opsumit will require a prior authorization if it is currently being used in combination with drugs known to be significant CYP3A inhibitors (ketoconazole, itraconazole, clarithromycin, indinavir, nefazodone, nelfinavir, ritonavir, atazanavir, saquinavir and telithromycin). **DDI:** Adempas will require a prior authorization if it is currently being used in combination with drugs known to be PDE inhibitors should be avoided (including dipyridamole, adcira and tadalafil) with adempas **Liqrev**: treatment of pulmonary arterial hypertension (WHO Group 1) in adults to improve exercise ability and delay clinical worsening. Avoid concomitant use of Liqrev with moderate or strong CYP3A inhibitors.
ERA / ENDOTHELIN RECEPTOR ANTAGONIST	MC MC		LETAIRIS[1,2] TRACLEER				Use PA Form# 20420 1. Providers must be registered with LEAP Prescribing program, a restricted distribution program. 2. Clinical PA is required to establish diagnosis and medical necessity.	**Letairis** approvals will require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and functional class 2 or 3 symptoms. **Tracleer** approvals will require WHO Group 1 diagnosis of primary PAH (Primary Pulmonary Hypertension) and NYHA functional class 2 thru 4. **DDI:** Preferred Oral Contraceptives will now be non-preferred and require prior authorization if it is currently being used in combination with Tracleer.
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/DEL MC MC/DEL MC		DOXYLAMINE SUCC-PYRIDOXINE HCL MECLIZINE HCL TABS PROMETHAZINE SUPP PROMETHAZINE TRANSDERM-SCOP PT72	MC MC MC MC MC MC MC MC		ANTIVERT TABS BARHEMSYS BONJESTA DICLEGIS PHENERGAN SOLN PROMETHAZINE 50MG 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		**DRONABINOL CAPS** GRANISETRON TAB **ONDANSETRON TAB** **ONDANSETRON ODT TBDP** **ONDANSETRON SOL**	MC MC MC MC MC MC MC MC MC	8 8 8 8 8 8 8 8 8	AKYNZEO[1] APREPITANT ALOXI ANZEMET TABS APONVIE[4] CESAMET[1] CINVANTI[4] EMEND[2]	Use PA Form# 20420 1. Approvals will require diagnosis of chemo-induced nausea/vomiting and failed trials of all preferred anti-emetics, including 5-HT3 class (Ondansetron) and Marinol.	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	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
				MC	8	FOCINVEZ[1,2]	2. Clinical PA is required for members on highly emetic anti-neoplastic agents.	
				MC/DEL	8	KYTRIL		
				MC/DEL	8	MARINOL CAPS		
				MC	8	SANCUSO		
				MC	8	SUSTOL	3. Dosing limits apply, please see Dosage Consolidation List	
				MC	8	SYNDROS		
				MC	8	TRIMETHOBENZAMIDE CAP		
				MC	8	VARUBI	4. Clinical PA required for appropriate diagnosis	
				MC/DEL	8	ZOFRAN ODT TBDP[3]		
				MC/DEL	8	ZOFRAN TABS[3]		
				MC/DEL	8	ZOFRAN INJ[3]		
				MC	8	ZUPLENZ		
NON-SEDATING ANTIHISTAMINES / DECONGESTANTS								
ANTIHISTIMINES - NON-SEDATING	MC		ALAVERT TABS	MC	5	CLARINEX TABS[1,5]	Use PA Form# 20530 1. Must fail preferred drugs, OTC loratadine and cetirizine before moving to non-preferred step order drugs. 2. Clarinex and Zyrtec syrup <6 yr w/o PA. 3. Must fail all step 5 drugs (Clarinex, Fexofenadine and Zyrtec) before moving to next step product. 4. All OTC versions of loratadine ODT are now non-preferred. 5. PA's for Clarinex RediTabs will only be approved if between the ages of 6-11 years old.	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. No combination product with decongestant will be approved since pseudoephedrine available without PA. **Pseudoephedrine** is available with prescription.
	MC/DEL		CETIRIZINE TABS	MC	5	CLARINEX SYR[1,2]		
	MC/DEL		LORATADINE	MC/DEL	5	FEXOFENADINE[1]		
	MC		TAVIST ND (OTC)	MC/DEL	5	ZYRTEC[1]		
				MC/DEL	5	ZYRTEC SYR[1,2]		
				MC/DEL	8	ALLEGRA[3]		
				MC	8	CLARITIN[3]		
				MC/DEL	8	DESLORATADIN		
				MC/DEL	8	LORATADINE ODT[4]		
				MC/DEL	8	LEVOCETIRIZINE[4]		
				MC/DEL	9	XYZAL[3]		
ANTIHISTIMINES - OTHER	MC/DEL		CLEMASTINE				Use PA Form# 20530	
	MC/DEL		CHLORPHENIRAMINE					
	MC/DEL		DIPHENHYDRAMINE					
ALLERGY / ASTHMA THERAPIES								
ANAPHYLACTIC DEVICES	MC/DEL		**EPINEPHRINE**	MC		AUVI- Q	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**EPIPEN**	MC		NEFFY		
	MC/DEL		**EPIPEN JR**	MC		TWINJECT		
ALLERGEN IMMUNOTHERAPY				MC		ODACTRA	Use PA Form# 20420 1. See criteria section	Prescriber must provide the testing to show that the patient is allergic to the components in the prescribed therapy and must provide a clinically valid rationale why single agent sublingual therapy is being chosen over subcutaneous therapy **Palforzia**® is approved for use in patients with a confirmed diagnosis of peanut allergy. Initial dose escalation may be administered to patients aged 4 through 17 years. Up-dosing and maintenance may be continued in patients 4 years of age and older. **Odactra**® is approved for use in persons 12 through 65 years of age. Note that Odactra® is not indicated for the immediate relief of allergic symptoms. Treatment must start 12 weeks before expected onset of pollen season and only after confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for any of the 5 grass species contained in Oralair **Oralair:** Patient age ≥10 years and ≤65 years Have an auto-injectable epinephrine on-hand
				MC		ORALAIR[1]		
				MC		PALFORZIA		
				MC		RAGWITEK		
				MC		GRASTEK		

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
ANTIASTHMATIC - ANTICHOLINERGICS - INHALER	MC MC/DEL MC/DEL		**INCRUSE ELLIPTA**[3] SPIRIVA HANDIHALER[1,2] **SPIRIVA RESPIMAT**	MC MC/DEL		LONHALA MAGNAIR **TUDORZA**	Use PA Form# 20420 1. Quantity limit of 1 inhalation daily (1 capsule for inhalation daily) Spiriva will require PA if Combivent or Atrovent nebulizer solution is in member's current drug profile. 2. We ask physicians to write "asthma" on the prescription whenever Spiriva is primarily being used for that condition. 3. Quantity limit of 1 inhalation daily	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIASTHMATIC - 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 MC/DEL		ATROVENT SOLN **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 MC/DEL		CROMOLYN SODIUM NEBU DUPIXENT[2,4] **FASENRA**[2] **FASENRA**[2] **AUTO INJCT** XOLAIR[1]	MC MC MC MC		CINQAIR[3] **NUCALA**[2] TEZSPIRE[5]	Use PA Form# 20420 1. Need max inhaled steroids and written by pulmonary or allergy specialist. Must have elevated IgE and ≥ to 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. 5. For adult and pediatric patients aged 12 years and older with severe asthma.	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.
ANTIASTHMATIC - NASAL STEROIDS	MC/DEL MC/DEL MC MC/DEL MC/DEL MC		BUDESONIDE SPRAY FLUTICASONE SPR[3] OLOPATADINE SPRAY OMNARIS SPR[3] TRIAMCINOLONE NS QNASL	MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC MC MC MC/DEL MC MC/DEL	8 8 8 8 8 8 8 8 8 8 8 8	DYMISTA FLONASE SUSP[2,3] FLUNISOLIDE SOLN[1,3] NASONEX SUSP RHINOCORT AERO[2,3] RHINOCORT AQUA SUSP[2,3] RYALTRIS[4] TRI-NASAL SOLN[2,3] VANCENASE POCKETHALER AERS[2,3] VERAMYST[2,3] XHANCE[2] ZETONNA[2]	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.	Preferred drugs and step therapy must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Xhance** will be considered for the treatment of nasal polyps in patients 18 years of age or older. The patient has had a documented side effect, allergy, or treatment failure of two preferred nasal glucocorticoids, one of which must be fluticasone.

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
ANTIASTHMATIC - NASAL MISC.	MC/DEL MC/DEL MC		AZELASTINE CROMOLYN NASAL 4% IPRATROPIUM NASAL SOL[1]	MC/DEL MC/DEL	8 8	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.	Approved if patient fails on nonsedating antihistamines and steroid nasal sprays.
ANTIASTHMATIC - BETA - ADRENERGICS	MC/DEL MC/DEL MC MC/DEL MC MC/DEL MC MC/DEL MC/DEL MC/DEL MC MC/DEL		**ALBUTEROL NEB** **ALBUTEROL HFA (Teva labeler 00093 AND Sandoz 00781)** LEVALBUTEROL TARTRATE **METAPROTERENOL** PROAIR RESPICLICK **PROVENTIL HFA** **SEREVENT** **STRIVERDI** **TERBUTALINE SULFATE TABS** **ALBUTEROL 0.63mg/3ml** **VENTOLIN HFA AERS** **PROAIR DIGIHALER[4]**	MC/DEL MC/DEL MC/DEL MC MC MC MC		**ACCUNEB NEBU** **ALBUTEROL HFA** **BRETHINE** VOLMAX TBCR 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, please 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.
ANTIASTHMATIC - ADRENERGIC COMBINATIONS	MC MC MC MC MC/DEL MC 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] **AIRSUPRA** **BREZTRI AEROSPHERE** **TRELEGY ELLIPTA[1]**	Use PA Form# 20420 1. Dosing limits apply, please 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/DEL MC/DEL		**BEVESPI AEROSPHERE[2,3]** **DUAKLIR PRESSAIR** DUONEB SOLN[1]	Use PA Form# 20420 1. Please use preferred individual ingredients Albuterol and Ipratropium. 2. Dosing limits apply, please see dosing consolidation list. 3. The safety and efficacy of use in children under the age of 18 years have not been established.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. DuoNeb components are available separately without PA. **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/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/DEL MC MC/DEL		**THEO-24 CP24** THEOLAIR TABS **UNIPHYL 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.

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
ANTIASTHMATIC - STEROID INHALANTS	MC MC/DEL MC/DEL MC/DEL MC/DEL MC		**ARNUITY ELLIPTA** **ASMANEX TWISTHALER** [4] ASMANEX HFA[5] **BUDESONIDE NEB 0.25MG & 0.5MG**[1] **PULMICORT FLEXHALER** [3] QVAR AERS[3]	MC MC/DEL MC MC/DEL MC/DEL	8 8 8 8 8	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, please see dosage consolidation list. 4. Asmanex 110mcg will be limited to member between the ages of 4-11years old. 5. Asmanex HFA will be preferred for members under the age of 6 years old. PA will be required for members 6 years of age and older, please consider other preferred options.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIASTHMATIC - 5-Lipoxygenase Inhibitors				MC		**ZYFLO CR 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	8 8 8	**ACCOLATE TABS** **SINGULAIR**[2] **SINGULAIR GRANULES**	Use PA Form# 20420 1.Montelukast Granules will only be approved if between ages of 6months-24 months. 2.Singulair Chewable 4mg from 2years-5years and Singulair Chewable 5mgs from 6years-14years old.	
ANTIASTHMATIC - ALPHA-PROTEINASE INHIBITOR				MC MC/DEL MC MC	8 8 8 8	ARALAST **ZEMAIRA** GLASSIA PROLASTIN SUSR	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/DEL		PULMOZYME SOLN	Use PA Form# 20420	Will be approved for cystic fibrosis patients.
ANTIASTHMATIC - MUCOLYTICS	MC/DEL		ACETYLCYSTEINE[1]	MC		MUCOMYST	Use PA Form# 20420 1. Acetylcysteine is covered with diagnosis of CF.	

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
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.	**Alfytrek** will be considered for the treatment of patients 6 years and older with at least one responsive mutation, including 31 additional mutations not responsive to other CFTR modulator therapies **Bronchitol** will be considered as add-on maintenance therapy to improve pulmonary function in adult patients 18 years and older with cystic fibrosis (CF). Use Bronchitol® only for adults who have passed the Bronchitol® Tolerance Test (BTT). (see Recommended Dosage section for further information **Kalydeco** will be considered for patients with cystic fibrosis (CF) aged 1 month and older who have at least one mutation in the CFTR gene that is responsive to ivacaftor potentiation based on clinical and/or in vitro assay data. If the patient's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of a CFTR mutation followed by verification with bi-directional sequencing when recommended by the mutation test instructions for use. **Orkambi** will be considered for patients with cystic fibrosis (CF) aged 1 year and older who are homozygous for the F508del mutation in the CFTR gene. If the patient's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of the F508del mutation on both alleles of the CFTR gene. The efficacy and safety of Orkambi have not been established in patients with CF other than those homozygous for the F508del mutation. **Symdeko** will be considered for patients with cystic fibrosis (CF) aged 6 years and older who are homozygous for the F508del mutation or who have at least one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to tezacaftor/ivacaftor based on in vitro data and/or clinical evidence. If the patient's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of a CFTR mutation followed by verification with bi-directional sequencing when recommended by the mutation test instructions for use. **Trikafta** will be considered for the treatment of cystic fibrosis (CF) in patients aged 2 years and older who have at least one F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene or mutation in the CFTE gene that is responsive based on in vitro data. If the patient's genotype is unknown, an FDA-cleared CF mutation test should be used to confirm the presence of at least one F508del mutation or a mutation that is responsive based on in vitro data.
IDIOPATHIC PULMONARY FIBROSIS	MC/DEL		**OFEV**[1]	MC MC		ESBRIET[1] PIRFENIDONE	Use PA Form# 20420 1. Diagnosis required	**Ofev**- Avoid concomitant use with P-gp and CYPA4 inducers (e.g. carbamazepine, phenytoin, and St. John's wort **Esbriet**- The concomitant use with strong CYP1A2 inhibitors (e.g. fluvoxamine, enoxacin) is not recommended
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		**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/DEL MC MC MC MC MC MC		**BELLADONNA ALKALOIDS & OP** BENTYL TABS BENTYL SYRP CUVPOSA DARTISLA ODT[2] ED-SPAZ MYTESI[1] GLYCOPYRROLATE INJ LEVSIN TABS LEVSIN/SL SUBL NULEV TBDP OSCIMIN ROBINUL INJ ROBINUL TABS	Use PA Form# 20420 1.Dosing limits apply please refer to 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.
GI- BILE ACID				MC		CHOLBAM	Use PA Form# 20420	Indication of bile acid synthesis disorders due to single enzyme defects (SEDs) AND for adjunctive treatment of peroxisomal disorders (PDs)

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
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 MC/DEL		ACID REDUCER TABS CIMETIDINE FAMOTIDINE	MC MC MC/DEL MC/DEL MC		AXID CAPS AXID AR TABS NIZATIDINE CAPS PEPCID 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		BYLVAY[1,2] LIVMARLI[1,2]	Use PA Form# 20420 1. For the treatment of patients ≥ 3months of age 2. Clinical PA required for appropriate diagnosis	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Certain drugs require specific diagnoses for approval.
GI - PROTON PUMP INHIBITOR	MC/DEL MC/DEL MC/DEL		OMEPRAZOLE CAPS[2] PANTOPRAZOLE[2] LANSOPRAZOLE CAPS [2]	MC/DEL MC/DEL MC MC MC/DEL MC MC MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	6 6 7 7 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 (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 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			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/DEL MC/DEL		PERTZYE ULTRESA 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 in step-order due to lack of efficacy or intolerable side effects before other non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
GI - ANTI - FLATULENTS / GI STIMULANTS	MC/DEL MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL		AMITIZA CALULOSE SYRP CONSTULOSE SYRP ENULOSE SYRP GASTROCROM CONC GENERLAC SYRP LACTULOSE SYRP METOCLOPRAMIDE HCL	MC 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/DEL MC MC MC/DEL MC/DEL		APRISO BALSALAZIDE MESALAMINE ENMA KIT PENTASA **SULFAZINE EC TBEC** **SULFASALAZINE TABS**	MC/DEL MC/DEL MC MC MC/DEL MC MC MC/DEL MC/DEL MC/DEL MC MC MC		ASACOL 800MG HD AZULFIDINE EN-TABS TBEC AZULFIDINE TABS COLAZAL CAPS DELZICOL DIPENTUM CAPS GIAZO LIALDA TABS[1] **MESALAMINE TAB** ROWASA ENEM SFROWASA UCERIS RECTAL FOAM[2] UCERIS TABS[2]	Use PA Form# 20420 1. Current users grandfathered. 2. 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. **Giazo** is only indicated for males, as the safety.efficacy for use in females has not been established. Prior trials of preferred products. **Uceris Rectal Foam or Tab**- Concomitant use with CYP3A inhibitors (e.g. ketoconazole, itraconazole, ritonavir, indinavir, saquinavir, erythromycin, cyclosporine, and grapefruit juice) should be avoided. Verify prior trials and failures or intolerance of preferred treatments
GI - IRRITABLE BOWEL SYNDROME AGENTS	MC/DEL		LOTRONEX TABS	MC		VIBERZI	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
GI- SHORT BOWL SYNDROME				MC		GATTEX	Use PA Form# 20420	**Gattex** requires a diagnosis of adult SBS who are dependent on parenteral support. Appropriate colonoscopy and lab assessments 6months prior to starting
GI- NASH				MC		REZDIFFRA	Use PA Form# 20420	Rezdiffra: The patient must have a diagnosis of NASH 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
MISCELLANEOUS GI								
GI - MISC.	MC/DEL MC/DEL MC MC MC/DEL MC/DEL MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC MC MC		BISAC-EVAC SUPP BISACODYL BISCOLAX SUPP CINOBAC CAPS CITRATE OF MAGNESIA SOLN CITRUCEL CLENPIQ SOL COLYTE DIOCTO SYRP DOCUSATE CALCIUM CAPS DOCUSATE SODIUM FIBER LAXATIVE TABS FLEET GENFIBER POWD GLYCERIN HIPREX TABS KRISTALOSE PACK LINZESS MAALOX MILK OF MAGNESIA SUSP MINERAL OIL MIRALAX BULK POWD (BRAND)	MC/DEL MC MC/DEL MC/DEL MC/DEL MC MC MC MC/DEL MC/DEL MC/DEL MC MC MC/DEL MC/DEL MC MC MC MC/DEL MC MC MC		ACTIGALL CAPS BENEFIBER CARAFATE CLEARLAX POW COLACE CAPS DIOCTO-C SYRP DOC SOD /CAS CAP DOC-Q-LAX CAPS DOCUSATE SODIUM/CAS CAPS DOK PLUS DULCOLAX SUPP ENEMEEZ FIBER CON TABS FIBER-LAX TABS GAVILYTE-H GOLYTELY SOLR IBSRELA IQIRVO LINZESS 72mcg[4] LIVDELZI MALTSUPEX MIRALAX PACKETS	Use PA Form# 20420 1. PA required to confirm FDA approved indication. 2. For the treatment of carcinoid syndrome diarrhea in combination with somatostatin analog (SSA) therapy in adults inadequately controlled by SSA therapy 3. For the treatment of Opioid Induced Constipation(OIC) 4. 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. Certain drugs require specific diagnoses for approval. **Linzess** is preferred for adults as treatment of IBS-Constipation AND treatment of chronic idiopathic constipation in adults. Trulance should be avoided in pediatric patients less than 18 years of age. **Iqirvo:** For the treatment of primary biliary cholangitis (PBC) in combination with ursodeoxycholic acid (UDCA) in adults who have had an inadequate response to UDCA, or as monotherapy in patients unable to tolerate UDCA. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trial(s). **Livdelzi:** Clinical PA is required for the treatment of primary biliary cholangitis (PBC) in combination with ursodeoxycholic acid (UDCA) in adults who have had an inadequate response to UDCA, or as monotherapy in patients unable to tolerate UDCA. Patients who do not have a diagnosis of decompensated cirrhosis.

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
	MC/DEL		MOVANTIK	MC/DEL		MOTEGRITY		
	MC/DEL		MOVIPREP POWD PACK	MC		OCALIVA[1]		
	MC		PEG 3350- ELECTROLYTE SOL	MC		PEG-ELECTROLYTES SOLR		
	MC		PEG 3350 POWDER	MC		PEG 3350 PACKETS		
	MC/DEL		SENNA	MC		PREPOPIK PAK		
	MC/DEL		SENOKOT GRAN	MC		RELISTOR TABS		
	MC/DEL		SENOKOT SYRP	MC/DEL		SENEXON TABS		
	MC/DEL		SENOKOT CHILDRENS SYRP	MC/DEL		SENOKOT TABS		
	MC		SENOKOT XTRA TABS	MC		SENOKOT S TABS		
	MC/DEL		STOOL SOFTENER CAPS	MC/DEL		SORBITOL		
	MC/DEL		SUCRALFATE TABS	MC		STOOL SOFTENER PLUS CAPS		
	MC/DEL		SUPREP SOL	MC		SUFLAVE		
	MC		TRULANCE[2]	MC		SUTAB		
	MC		UNI-EASE CAPS	MC/DEL		SYMPROIC[3]		
	MC		URSO FORTE	MC/DEL		UNI-CENNA TABS		
	MC/DEL		URSODIOL	MC		UNI-EASE PLUS CAPS		
				MC		V-R NATURAL SENNA LAXATIV TABS		
				MC		URSO 250		
				MC		XERMELO[2]		
MISC. UROLOGICAL								
UROLOGICAL - MISC.	MC		ACETIC ACID 0.25% SOLN	MC		CITRIC ACID/SODIUM CITRAT SOLN	Use PA Form# 20420 1. Elmiron requires adequate proof of Dx with supportive testing.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		CYTRA-K SOLN	MC/DEL		CYTRA-2 SOLN		
	MC		FOSFOMYCIN (NDC 82036427401 ONLY)	MC/DEL		ELMIRON CAPS[1]		
	MC		K-PHOS MF TABS	MC		FURADANTIN SUSP		
	MC/DEL		METHENAMINE MANDELATE TABS	MC/DEL		MACROBID CAPS		
	MC/DEL		NEOSPORIN GU IRRIGANT SOLN	MC/DEL		MACRODANTIN CAPS		
	MC/DEL		NITROFURANTOIN MONO CAPS	MC/DEL		NITROFURANTOIN MACR SUSP		
	MC/DEL		PHENAZOPYRIDINE HCL TABS	MC		POTASSIUM CITRATE/CITRIC SOLN		
	MC/DEL		PHENAZOPYRIDINE PLUS	MC/DEL		PYRIDIUM PLUS TABS		
	MC		POT CITRATE TAB	MC		PYRIDIUM TABS		
	MC/DEL		PROSED/DS TABS	MC/DEL		RENACIDIN SOLN		
	MC		TRICITRATES SYRP	MC		UROCIT-K		
	MC/DEL		URELIEF PLUS					
	MC		UREX TABS					
	MC/DEL		URISED TABS					
	MC/DEL		UROQID #2 TABS					
PHOSPHATE BINDERS								
PHOSPHATE BINDERS	MC/DEL		CALCIUM ACETATE CAP[1]	MC		AURYXIA[1]	Use PA Form# 20420 1. Diag required.	Preferred drugs must be tried and failed in step-order due to lack of efficacy or intolerable side effects before less preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Xphozah** to reduce serum phosphorus in adults with chronic kidney disease (CKD) on dialysis as add-on therapy in patients who have an inadequate response to phosphate binders or who are intolerant of any dose of phosphate binder therapy.
	MC/DEL		FOSRENOL CHEW[1]	MC/DEL		CALCIUM ACETATE TAB[1]		
	MC/DEL		MAGNEBIND - 400[1]	MC/DEL		ELIPHOS[1]		
	MC		PHOSLYRA[1]	MC/DEL		FOSRENOL PWDR[1]		
	MC/DEL		RENVELA[1]	MC		VELPHORO[1]		
				MC		XPHOZAH		
INTRA-VAGINALS								
VAGINAL - ANTIBACTERIALS	MC/DEL		CLEOCIN CREA	MC/DEL		METROGEL VAGINAL GEL[1]	Use PA Form# 20420 1. Dosing limits apply, please see Dosage Consolidation List.	Preferred drugs must be tried and failed in step-order due to lack of efficacy or intolerable side effects before less preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		CLEOCIN SUPP	MC/DEL		VANDAZOLE		
	MC		CLINDESSE CREA	MC		XACIATO		
	MC/DEL		METRONIDAZOLE VAGINAL GEL[1]					
	MC/DEL		NUVESSA					

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
VAGINAL - ANTI FUNGALS	MC/DEL		CLOTRIMAZOLE CREA	MC		AVC CREA	Use PA Form# 20420 1. Quantity limit: 1/script/2 weeks	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **DDI:** Miconazole will require prior authorization if being used in combination with Warfarin.
	MC/DEL		CLOTRIMAZOLE-3 CREA	MC		CLOTRIMAZOLE 3 DAY CREA		
	MC/DEL		GYNE-LOTRIMIN CREA	MC		GYNAZOLE-1 CREA		
	MC		MICONAZOLE CREA	MC		GYNE-LOTRIMIN 3 TABS		
	MC		MICONAZOLE 3 KIT CREA OTC	MC/DEL		MICONAZOLE 3 COMBO PACK KIT[1]		
	MC/DEL		MICONAZOLE 7 CREA	MC/DEL		MICONAZOLE 3 SUPP		
	MC/DEL		MICONAZOLE NITRATE CREA	MC		TERAZOL 3 CREA		
	MC		NYSTATIN TABS	MC		TERAZOL 7 CREA		
	MC/DEL		TERCONAZOLE CREAM	MC/DEL		TERCONAZOLE SUPP		
	MC		VAGITROL					
	MC		V-R MICONAZOLE-7 CREA					
VAGINAL - CONTRACEPTIVES							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.
VAGINAL - ESTROGENS	MC/DEL		**ESTRING RING**	MC/DEL		ESTRACE CREA[1]	Use PA Form# 20420 1. Must fail all preferred products before non-preferred.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**PREMARIN CREA**	MC/DEL		VAGIFEM TABS[1]		
VAGINAL - OTHER	MC/DEL		ACID JELLY GEL	MC		AMINO ACID CERVICAL CREA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		ACI-JEL GEL					
	MC		CERVICAL AMINO ACID CREA					
BENIGN PROSTATIC HYPERPLASIA (BPH)								
BPH	MC/DEL		**DOXAZOSIN MESYLATE TABS**	MC/DEL	5	**FLOMAX CP24**	Use PA Form# 20420 1. There will be dosing limits of 1 tab per day with out PA. 2. Prior use of preferred agent prior to any approvals. 3. Use of preferred (tamsulosin and finasteride) and (tamsulosin and non-preferred Avodart). 4. Non-preferred products must be used in specified order. 5. Use of individual ingredients preferred (Finasteride and tadalafil). 6. Entadfi® is not recommended for more than 26 weeks	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Approval of a non-preferred 5-alpha reductase inhibitor requires objective clinical evidence of a very enlarged prostate rather than just the presence of obstructive urinary outflow symptoms along with adequate trial of preferred Proscar.
	MC/DEL		FINASTERIDE[1] 5mg	MC/DEL	8	ALFUZOSIN		
	MC/DEL		TERAZOSIN HCL CAPS	MC	8	AVODART[2,4]		
	MC/DEL		**TAMSULOSIN HCL**	MC/DEL	8	**CARDURA TABS**[4]		
	MC/DEL			MC	8	ENTADFI[5,6]		
				MC	8	JALYN[3,4]		
				MC/DEL	8	PROSCAR TABS[4]		
				MC/DEL	8	RAPAFLO[4]		
						TEZRULY		
				MC/DEL	8	UROXATRAL[4]		
ANXIOLYTICS								
ANXIOLYTICS - BENZODIAZEPINES	MC/DEL		ALPRAZOLAM TABS	MC/DEL	8	ALPRAZOLAM ER	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		CHLORDIAZEPOXIDE HCL CAPS	MC/DEL	8	ATIVAN		
	MC/DEL		CLORAZEPATE DIPOTASSIUM TABS	MC	8	LOREEV XR		
	MC/DEL		DIAZEPAM	MC/DEL	8	NIRAVAM		
	MC/DEL		LORAZEPAM	MC/DEL	8	SERAX		
	MC/DEL		OXAZEPAM CAPS	MC/DEL	8	TRANXENE		
				MC/DEL	8	XANAX TABS		
				MC/DEL	9	XANAX XR		

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
ANXIOLYTICS - MISC.	MC/DEL		BUSPIRONE HCL TABS	MC		BUSPAR TABS	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.
	MC		HYDROXYZINE HCL SOLN	MC		DROPERIDOL SOLN		
	MC		HYDROXYZINE HCL SYRP	MC/DEL		DROPERIDOL SOLN		
	MC/DEL		HYDROXYZINE HCL TABS[1]	MC/DEL		DROPERIDOL SOLN		
	MC/DEL		HYDROXYZINE PAMOATE CAPS					
	MC/DEL		MEPROBAMATE TABS					
ANTI-DEPRESSANTS								
ANTIDEPRESSANTS - MAO INHIBITORS	MC/DEL		NARDIL TABS	MC/DEL		**TRANYLCYPROMIINE**	Use PA Form# 20420	
ANTIDEPRESSANTS - MAO INHIBITORS TOPICAL				MC/DEL		EMSAM[1]	Use PA Form# 20420 1. Dosing limits apply, please refer to Dose consolidation list.	Preferred drugs (including a preferred SSRI, a non-SSRI, and Venlafaxine ER) must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTIDEPRESSANTS - SELECTED SSRI's AND OTHERS	MC/DEL		BUPROPION HCL TABS	MC/DEL	8	APLENZIN[4]	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. Please see dose consolidation list. 5. Dosing limits apply, please refer to Dose consolidation list and max daily dose applies. Max daily dose allowed is 375mg. 6. Non-preferred products must be used in specified step order. 7. Requires previous trials/failure of multiple preferred medications. Dosing limits apply, please see the 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.	Preferred drugs (including failure of at least one preferred SSRI, one SNRI and one non-SSRI/SNRI) must be tried for at least 4 weeks each and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **CYMBALTA:** Fibromyalgia diagnosis- prior use and failure of preferred generics (amitriptyline or cyclobenzaprine) and gabapentin prior to approval. **SAVELLA:** Fibromyalgia diagnosis and trial of a preferred generic amitriptyline, cyclobenzaprine, duloxetine and gabapentin prior to approval. **Zulresso®** is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS) called the Zulresso® REMS. **Spravato:** Treatment Resistant Depression • Must be 18 years of age or older; and medication must be administered under the direct, on site, supervision of a licensed healthcare provider with post-administration observation of a minimum of least 2-hours. The medication must be prescribed by or in consultation with a psychiatrist and prescriber must be enrolled in the REMS program. • Approval is based upon failure of at least two antidepressants and failure of an antidepressant used adjunctively with one recognized augmentation strategy such as lithium, an atypical antipsychotic, thyroid hormone, etc. • Ongoing use of Spravato beyond 3 months is based upon a positive response as evidenced by at least a 30 % reduction from baseline as measured by a standardized rating scale including PHQ 9, Hamilton Depression Rating Scale, or QIDS). **Spravato:** MDD with Suicidal Ideation Approval for this indication only if it is started in an inpatient unit, given adjunctively with an optimized antidepressant regimen, and with an 8-12 week initial approval with ongoing use dependent upon documentation of ongoing benefit. **DDI: Fluvoxamine** will now be non-preferred and require prior authorization if it is currently being used with glimepiride (Amaryl). **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: Fluoxetine** will require prior authorization if being used in combination with Plavix. **DDI: Fluvoxamine** will require prior authorization if being used in combination with Plavix. DDI: **Drizalma Sprinkle** avoid the concomitant use of duloxetine with potent CYP1A2 inhibitors (e.g. fluvoxamine, cimetidine, ciprofloxacin, enoxacin). DDI: Reduce the **Zurzuvae®** dosage when used with a strong CYP3A4 inhibitor.
	MC/DEL		BUPROPION SR	MC	8	AUVELITY[11]		
	MC/DEL		BUPROPION XL 150mg and 300mg	MC/DEL	8	BUPROPION XL 450mg		
	MC/DEL		CITALOPRAM	MC/DEL	8	CELEXA		
	MC/DEL		DULOXETINE[2,9]	MC	8	CYMBALTA[2]		
	MC/DEL		ESCITALOPRAM	MC/DEL	8	DRIZALMA SPRINKLES		
	MC/DEL		FLUOXETINE 10mg AND 20mg CAPS	MC/DEL	8	EFFEXOR TABS		
	MC/DEL		FLUOXETINE 10mg AND 20mg TABS	MC/DEL	8	EFFEXOR XR CP24		
	MC/DEL		FLUOXETINE HCL LIQD	MC/DEL	8	FETZIMA[7]		
	MC/DEL		FLUVOXAMINE MALEATE TABS	MC	8	FORFIVO XL		
	MC/DEL		MIRTAZAPINE	MC/DEL	8	IRENKA		
	MC/DEL		NEFAZODONE	MC/DEL	8	KHEDEZLA		
	MC/DEL		PAROXETINE[1]	MC/DEL	8	LEXAPRO TABS		
	MC/DEL		SERTRALINE HCL	MC	8	LUVOX TABS		
	MC/DEL		TRAZODONE HCL TABS	MC	8	MAPROTILINE HCL TABS		
	MC/DEL		VENLAFAXINE ER CAPS[5]	MC/DEL	8	MIRTAZAPINE ODT		
	MC/DEL		VENLAFAXINE TABS[5]	MC	8	OLEPTRO		
				MC/DEL	8	PAROXETINE CR[1]		
				MC/DEL	8	PAXIL[1]		
				MC/DEL	8	PAXIL CR[1]		
				MC/DEL	8	PRISTIQ		
				MC	8	PROZAC		
				MC	8	PROZAC CAPS		
				MC	8	PROZAC WEEKLY CPDR		
						RALDESY		
				MC/DEL	8	REMERON TABS		
				MC/DEL	8	SARAFEM CAPS		
				MC/DEL	8	SPRAVATO[8]		
				MC/DEL	8	TRAZODONE HCL 300MG TABS		
				MC/DEL	8	TRINTELLIX		
				MC	8	WELLBUTRIN TABS		
				MC	8	WELLBUTRIN SR TBCR		
				MC	8	WELLBUTRIN XL		
				MC/DEL	8	REMERON SOLTAB TBDP		
				MC/DEL	8	SAVELLA[4]		
				MC/DEL	8	ZOLOFT		
				MC/DEL	8	ZULRESSO[10]		
				MC	8	ZURZUVAE[12]		
				MC/DEL	8	VENLAFAXINE ER TABS[5]		
				MC/DEL	9	VIIBRYD[6]		
				MC/DEL	9	FLUOXETINE 90mg TABS[6]		

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
ANTIDEPRESSANTS - TRI-CYCLICS	MC/DEL		AMITRIPTYLINE HCL TABS[1]	MC/DEL		AMOXAPINE TABS	Use PA Form# 20420 Use PA Form# 10220 for Brand Name requests 1. Users over the age of 65 require a pa. 2. Use multiples of 50mg.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		CLOMIPRAMINE HCL CAPS[1]	MC/DEL		ANAFRANIL CAPS		
	MC/DEL		DESIPRAMINE HCL TABS[1]	MC/DEL		DOXEPIN HCL 150 MG[2]		
	MC/DEL		DOXEPIN HCL[1] (not generic Silenor)	MC/DEL		DOXEPIN (generic Silenor)		
	MC/DEL		IMIPRAMINE HCL TABS[1]	MC/DEL		NORPRAMIN TABS		
	MC/DEL		NORTRIPTYLINE HCL[1]	MC/DEL		PAMELOR		
	MC		PROTRIPTYLINE HCL TABS[1]	MC		TOFRANIL		
	MC		SURMONTIL CAPS[1]	MC		VIVACTIL TABS		
SEDATIVE / HYPNOTICS								
SEDATIVE/HYPNOTICS - BARBITURATE	MC		BUTISOL SODIUM TABS[1]	MC		LUMINAL SOLN	Use PA Form# 20420 1. PA required for new users of preferred products if over 65 years.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		CHLORAL HYDRATE SYRP[1]	MC/DEL		SOMNOTE CAPS		
	MC		MEBARAL TABS[1]					
	MC/DEL		PHENOBARBITAL[1]					
SEDATIVE/HYPNOTICS - BENZODIAZEPINES	MC/DEL		DORAL TABS[1]	MC		HALCION TABS[1]	Use PA Form# 30110 1. Dosing limits apply, please see dosing consolidation list.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Benzodiazepines do cause dependence with continued use and usage should be limited to 7-10 days at a time. Chronic intermittent use (2-3 Days per week max) is the standard of care
	MC/DEL		ESTAZOLAM TABS[1]	MC		MIDAZOLAM HCL SYRP		
	MC/DEL		FLURAZEPAM HCL CAPS[1]	MC/DEL		RESTORIL CAPS[1]		
	MC/DEL		TEMAZEPAM CAPS 15 & 30MG[1]	MC/DEL		TEMAZEPAM 7.5MG[1]		
	MC/DEL		TRIAZOLAM TABS[1]					
SEDATIVE/HYPNOTICS - Non-Benzodiazepines	MC/DEL	1	MIRTAZAPINE	MC/DEL	7	AMBIEN[1]	Use PA Form# 30110 1. Quantity Limit of 12 per 34 days. 2. Quantity limits will be allowed up to 30/30, but intermittent therapy is recommended. 3. Only zolpidem trial/failure will be required to obtain Zaleplon. 4. Must fail all preferred products before non-preferred	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Ambien, Ambien CR, Lunesta, Sonata, Zaleplon and Zolpidem may cause dependence with continued use and as with benzodiazepines, usage should be limited to 7-10 days at a time. Chronic intermittent use (2-3 days per week max) is the standard of care. Please refer to Sedative/Hypnotic PA form. DDI: Belsomra® with strong CYP3A inhibitors (e.g. ketoconazole, itraconazole, posaconazole, clarithromycin, nefazodone, ritonavir, saquinavir, nelfinavir, indinavir, boceprevir, telaprevir, telithromycin, and conivaptan) is not recommended
	MC	1	TRAZODONE	MC/DEL	7	**ESZOPICLONE**		
	MC/DEL	1	ZOLPIDEM [2]	MC/DEL	7	**ZOLPIDEM ER**		
	MC/DEL	2	ZALEPLON[2,3]	MC/DEL	8	AMBIEN CR[1]		
				MC/DEL	8	BELSOMRA[1]		
				MC	8	DAYVIGO[1]		
				MCDEL	8	EDLUAR		
				MC	8	HETLIOZ		
				MC/DEL	8	INTERMEZZO		
				MC/DEL	8	LUNESTA[1]		
				MC/DEL	8	SONATA CAPS[1]		
				MC/DEL	8	ROZEREM		
				MC	8	QUVIVIQ		
				MC/DEL	8	ZOLPIMIST		
ANTI-PSYCHOTICS								
ANTIPSYCHOTICS - ATYPICALS	MC		ABILIFY ASIMTUFII	MC/DEL	8	ABILIFY DISC TAB, INJ and SOL[1]	Use PA form# 20440 for Multiple Antipsychotic requests Use PA form# 10130 for non preferred single therapy atypical requests If prescribing 2 or more antipsychotics, PA will be required for both drugs, except if one is Clozapine. This also 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.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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.
	MC		ABILIFY MAINTENA	MC	8	ABILIFY TABS[2]		
	MC/DEL		ARIPIPRAZOLE TAB[3]	MC/DEL	8	**ARIPIPRAZOLE SOL**		
	MC		ARISTADA	MC/DEL	8	ARIPIPRAZOLE ODT		
	MC		ARISTADA INITIO	MC	8	CAPLYTA		
	MC/DEL		**OLANZAPINE[2,3]**	MC	8	COBENFY		
	MC/DEL		**OLANZAPINE[2,3] ODT**	MC	8	ERZOFRI		
	MC/DEL		INVEGA HAFYERA	MC	8	FANAPT		
	MC		INVEGA SUSTENNA	MC/DEL	8	GEODON		
	MC/DEL		INVEGA TRINZA INJ	MC	8	INVEGA		
	MC/DEL		**LURASIDONE TAB**	MC	8	IGALMI		
	MC/DEL		**PALIPERIDONE ER**	MC	8	LATUDA		
	MC/DEL		PERSERIS	MC	8	LYBALVI		
	MC		RISPERDAL CONSTA	MC	8	NUPLAZID		
	MC/DEL		RISPERIDONE ODT	MC	8	OPIPZA		
	MC/DEL		RISPERIDONE TAB[2,3]	MC	8	REXULTI		
	MC/DEL		RISPERIDONE SOLN[2]	MC	8	RISPERDAL TAB		
	MC		RYKINDO	MC	8	RISPERDAL M TAB[1]		
	MC/DEL		QUETIAPINE[2,3]	MC	8	RISPERDAL SOLN		
	MC/DEL		QUETIAPINE XR	MC/DEL	8	SAPHRIS[1]		

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
	MC		VRAYLAR[4]	MC	8	SECUADO	3. Dosing limits apply please refer to the dose consolidation list. 4.Requires step through 1 preferred drug for all indications except AMDD. AMDD requires insufficient response from two antidepressants	DDI: It is recommended to reduce the Vraylar® dose if it is used concomitantly with a strong CYP3A inhibitor (such as itraconazole, ketoconazole). The concomitant use of Vraylar® with a CYP3A4 inducer (such as rifampin, carbamazepine) is not recommended. DDI: The concomitant use of Nuplazid with other drugs known to prolong the QT interval (e.g. Class IA antiarrhythmics, Class 3 antiarrhythmics, antipsychotics, and antibiotics such as gatifloxacin and moxifloxacin).
	MC/DEL		**ZIPRASIDONE[2,3]**	MC/DEL	8	SEROQUEL TABS		
				MC	8	UZEDY		
				MC	8	ZYPREXA TABS		
				MC		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/DEL		CLOZARIL TABS	MC/DEL		CLOZARIL TABS		
	MC/DEL		VERSACLOZ SUSP	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		SERENTIL					
	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[1,4]	MC/DEL		ADDERALL TABS	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, please see dosing consolidation list. 4. Max daily dose of 50mg.	
	MC/DEL		DEXTROAMPHET SULF TABS	MC		EVEKEO		
	MC		PROCENTRA	MC/DEL		METHAMPHETAMINE HCL		
				MC		ZENZEDI		

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
STIMULANT - LONG ACTING AMPHETAMINES SALT	MC/DEL MC MC		AMPHETAMINE/DEXTROAMPHET ER[2,4,7] ADDERALL XR CP24[1,3,4,7] VYVANSE[2,3,4]	MC MC MC		MYDAYIS[5] VYVANSE CHEW[4,6] 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, please see dosing consolidation list. 5. For the treatment of Attention Deficit Hyperactivity Disorder (ADHD) in patients 13 years and older 6. Vyvanse chew grace period for current user through June 2022. 7. FDA approval is currently for adults and children 6 or older. Will be available without PA for this age group if within dosing limits. Max dose of 50MG daily without a PA. 8. For the treatment of patients 6 years of age and older.	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.
LONG ACTING AMPHETAMINES	MC MC/DEL MC		DEXTROAMPHET SULF CPSR[1,3] **DEXTROAMPHETAMINE ER** DYANAVEL XR SUS	MC/DEL MC MC MC MC		ADZENYS ER[3] ADZENYS XR- ODT ADZENYS XR[3] DEXEDRINE CAP SR[2,3] DYANAVEL XR TAB	Use PA Form# 20420 1. Preferred stimulants will be available without PA if diagnosis of ADHD. 2. As per recent FDA alert, Adderall & Dexedrine should not be used in patients with underlying heart defects since they may be at increased risk for sudden death. 3. Dosing limits apply, please see dosing consolidation list.	DDI: : The concomitant use of Adzenys® XR is contraindicated with monoamine oxidase inhibitors (MAOIs) or within 14 days after discontinuing MAOI treatment.

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
STIMULANT - METHYLPHENIDATE	MC/DEL		DEXMETHYLPHENIDATE IR TABS	MC/DEL		FOCALIN IR TABS	Use PA Form# 20420 1. Preferred stimulants will be available without PA if diagnosis of ADHD. 2. Dosing limits apply, please see dosing consolidation list. Maximum daily doses are as follows: 72mg daily for methylphenidate and 36mg daily for dexmethylphenidate.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Please refer to General Criteria category E.
	MC/DEL		METHYLPHENIDATE SOL	MC/DEL		METADATE ER		
	MC/DEL		**METHYLPHENIDATE TAB**	MC		METHYLPHENIDATE HCL CHEW		
	MC/DEL		METHYLIN TABS[1,2]	MC		METHYLIN CHEWABLES		
				MC/DEL		METHYLIN SOL		
				MC/DEL		RITALIN		
STIMULANT - METHYLPHENIDATE - LONG ACTING	MC		CONCERTA TBCR	MC	5	METADATE CD CPCR	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, please see dosing consolidation list. 5. Quillivant XR and Quillichew ER are only indicated for use in patients 6 years of age and older. 6. For the treatment of patients ≥ 6 years of age.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**DEXMETHYLPHENIDATE CAP ER 50/50**	MC/DEL	8	ADHANSIA XR[2,6]		
	MC/DEL		FOCALIN XR	MC	8	APTENSIO XR[2]		
	MC/DEL		METHYLPHENIDATE LA CAPS	MC	8	AZSTARYS[6]		
	MC/DEL		METHYLPHENIDATE ER CAPS 50/50	MC	8	COTEMPLA XR[2]		
	MC/DEL		METHYLPHENIDATE ER CAPS 40/60	MC	8	COTEMPLA XR ODT[2]		
	MC/DEL		METHYLPHENIDATE CD CAPS 30-70	MC/DEL	8	DAYTRANA[2,3]		
	MC		QUILLICHEW ER[5,1]	MC/DEL	8	JORNAY PM[2,6]		
	MC		QUILLIVANT XR SUS[1,5]	MC/DEL	8	METHYLPHENIDATE ER CAPS[2,4]		
	MC/DEL		RITALIN LA[4]					
STIMULANT - STIMULANT LIKE	MC/DEL		**ATOMOXETINE HCL**	MC/DEL	7	PROVIGIL TABS[3]	Use PA Form# 20710 for Provigil, Nuvigil and Xyrem Use PA Form# 20420 for all others 1. Failure of both an amphetamine and methylphenidate is required for consideration for approval of Strattera, unless history of substance abuse without current use of abusable medication(s). Additionally, for patients <17 years of age, a trial of guanfacine in 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.	**Provigil** requests require diagnosis of Narcolepsy, ADHD, or Obstructive Sleep Apnea. Previous failures of methylphenidate and amphetamine is required for Narcolepsy and ADHD diagnosis, with additional Strattera trial needed with ADHD diagnosis. Please refer to detailed criteria on Provigil PA form **Sunsosi** is non-preferred and is indicated for to improve wakefulness in adult patients with excessive daytime sleepiness associated with narcolepsy or obstructive sleep apnea (OSA). **Wakix** is non-preferred and is indicated for the treatment of excessive daytime sleepiness (EDS) in adults with narcolepsy Xywav: Diagnosis of cataplexy associated with narcolepsy OR excessive daytime sleepiness associated with narcolepsy. Diagnosis must be confirmed by submission of supporting documentation to include the specialist's interpretation of the Polysomnography (PSG) and Multiple Sleep Latency Test (MSLT) results FDA reminded healthcare professionals and patients that the combined use of **Xyrem** (sodium oxalate) with alcohol or central nervous system (CNS) depressant drugs can markedly impair consciousness and may lead to severe breathing problems (respiratory depression DDI: **Sunosi®** is contraindicated with MAO inhibitors or within 14 days after discontinuing the MAO inhibitor. DDI: Concomitant use of **Qelbree®** with an MAO inhibitor or within 2 weeks after discontinuing an MAO inhibitor is contraindicated DDI: Concomitant use of **Qelbree®** significantly increases the total exposure, but not peak exposure, of sensitive CYP1A2 substates, which may increase the risk of adverse reactions associated with these CYP1A2 substrates. Coadministration of Qelbree® with sensitive CYP1A2 substrates or CYP1A2 substrates with a narrow therapeutic range (e.g. alosetron, duloxetine, ramelteon, tasimelteon, tizanidine, theophylline), is contraindicated.
	MC/DEL		ARMODAFINIL	MC	7	STRATTERA[1, 2]		
	MC/DEL		CLONIDINE ER	MC	8	CAFCIT SOLN[3]		
	MC/DEL		**GUANFACINE ER**	MC/DEL	8	INTUNIV		
	MC/DEL		MODAFINIL TABS	MC	8	KAPVAY		
	MC		QELBREE[6,7]	MC	8	ONYDA XR[6]		
				MC/DEL	8	SUNOSI		
				MC	8	WAKIX		
				MC	8	XYREM SOL		
				MC	8	XYWAV[5]		
				MC/DEL	9	NUVIGIL[3]		
				MC	9	DESOXYN TABS[3]		
				MC	9	DESOXYN CR[3]		

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
							3. Non-preferred products must be used in specified step order. 4. Please use generic Guanfacine. 5. For patients 7 years of age and older with narcolepsy. 6. For pediatric patients 6 years of age or older 7. Preferred with a trial and fail either Atomoxetine OR any 2 preferred ADHD agents.	
ANTI-CATAPLECTIC AGENTS								
PSYCHOTHERAPEUTIC AGENTS - MISC.				MC MC		NUEDEXTA XENAZINE	Use PA Form# 20710 for Xenazine	
WEIGHT LOSS								
WEIGHT LOSS							No longer covered: PHENTERMINE, XENICAL,DIDREX, and MERIDIA	Weight loss drugs are not covered as permitted by Federal Medicaid regulations and Maine Medicaid (MaineCare) Policy.
ALZHEIMER DISEASE								
ALZHEIMER - Cholinomimetics/Others	MC/DEL 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/DEL MC MC	6 6 7 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 LEQEMBI[1,2] MEMANTINE HCL SOL NAMENDA NAMENDA XR CAPS NAMZARIC RAZADYNE[2] COGNEX CAPS[2] ZUNVEYL	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 cant 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 and 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 - Failure of or inability to tolerate at least two other preferred Alzheimer therapies for at least four months each, one of which should include a combination of a cholinesterase inhibitor with memantine •If the initial drug utilized is the combination of a cholinesterase inhibitor and memantine, then only that single trial of two drugs is required
SMOKING CESSATION								
NICOTINE PATCHES / TABLETS	MC/DEL MC/DEL MC/DEL MC/DEL		CHANTIX TAB[1] CHANTIX STARTER PACK 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.

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
NICOTINE REPLACEMENT - OTHER	MC/DEL		NICOTINE POLACRILEX GUM[1]	MC/DEL	8	NICOTROL INHALER[1,2]	Use PA Form# 20420 1. See criteria section for exemptions 2. Must use non-preferred products in specified step order.	As of July 1, 2014 per MaineCare policy, smoking cessation products will be covered without a copay(including MEDEL). No annual or lifetime limits, must follow FDA approved indications and therapy guidelines. Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (in step-order) will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Note:** MaineCare policy, smoking cessation product were "not covered" except for during pregnancy between 9/1/12 and 1/1/14, between 1/1/2014 and 7/1/14 smoking cessation products were covered with limitations Patients may qualify for the medication through The Maine Tobacco Helpline if they do not have MaineCare or MEDEL. Patients are encouraged to call The Maine Tobacco helpline at 1 800-207-1230.
	MC/DEL		NICOTINE LOZENGE MINI	MC/DEL	8	NICOTROL NASAL SPRAY[1,2]		
	MC/DEL		NICOTINE LOZENGE	MC/DEL	8	NICORETTE GUM[1,2]		
				MC	8	NICORETTE LOZENGES		
ALCOHOL DETERRENTS								
ALCOHOL DETERRENTS	MC/DEL		**ACAMPROSATE**	MC/DEL		**ACAMPRO[1]**	Use PA Form# 20420 1. Should only be used in conjunction with formal structured outpatient detoxification program.	Preferred generic drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		ANTABUSE TABS					
	MC		DISULFIRAM TABS					
	MC/DEL		NALTREXONE HCL TABS					
MISCELLANEOUS ANALGESICS								
ANALGESICS - MISC.	MC/DEL		ACETAMINOPHEN	MC		AXOCET CAPS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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)
	MC/DEL		**ASPIRIN**	MC/DEL		ESGIC-PLUS		
	MC/DEL		ASPRIN/ APAP/ CAFF TAB	MC/DEL		FIORICET TABS		
	MC/DEL		BUTAL/ASA/CAFF	MC		FIORINAL CAPS		
	MC/DEL		BUTALBITAL COMPOUND	MC		FIORTAL CAPS		
	MC/DEL		BUTALBITAL/ACET TABS	MC/DEL		FORTABS TABS		
	MC/DEL		BUTALBITAL/APAP CAPS			JOURNAVX		
	MC/DEL		BUTALBITAL/APAP/CAFFEINE TABS	MC		PHRENILIN TABS		
	MC/DEL		**CHOLINE MAGNESIUM TRISALI**	MC		PHRENILIN FORTE CAPS		
	MC/DEL		**DIFLUNISAL TABS**	MC		TRILISATE LIQD		
	MC		EXCEDRIN	MC		TRILISATE TABS		
	MC/DEL		**SALSALATE TABS**	MC		ZEBUTAL CAPS		
				MC		ZORPRIN TBCR		
LONG ACTING NARCOTICS								
NARCOTICS - LONG ACTING	MC/DEL		FENTANYL PATCH[4]	MC	8	ARYMO ER	Use PA Form# 20510 Use PA form #10300 for PAs over the opiate limit 1. Oxycontin will be available without PA for patients treated for or dying from cancer or hospice patients. CA (cancer) or HO (hospice) diag code may be used but store must verify since all scripts will be audited and stores will be liable. 2. Established users are grandfathered. 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.	Preferred drugs (Fentanyl Patch, Morphine Sulfate ER tab, Butrans and Embeda) 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 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 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 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
	MC/DEL		BUTRANS[4]	MC	8	AVINZA		
	MC/DEL		MORPHINE SULFATE ER TB12	MC	8	BELBUCA		
				MC	8	EXALGO		
				MC/DEL	8	HYSINGLA ER		
				MC	8	KADIAN		
				MC/DEL	8	METHADONE		
				MC/DEL	8	METHADOSE		
				MC/DEL	8	MORPHABOND ER		
				MC/DEL	8	MORPHINE SULFATE ER CAP		
				MC/DEL	8	MORPHINE SULFATE SUPP		
				MC/DEL	8	MS CONTIN TB12		
				MC	8	OPANA ER		
				MC/DEL	8	ORAMORPH SR TB12		
				MC/DEL	8	OXYCONTIN TB12[1]		
				MC	8	XARTEMIS ER		
				MC	8	ZOHYDRO ER		
				MC	8	OXYCODONECONC		
				MC/DEL	9	OXYCODONE ER[3,5]		

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
							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.	Methadone – Established users must have a trial and failure of at least 2preferred drugs for least 2 weeks. Otherwise they will be allowed 180 days to transition to a preferred product.
NARCOTICS - SELECTED	MC/DEL		TRAMADOL HCL TABS	MC/DEL	7	RYZOLT	Use PA Form# 20420 Use PA form #10300 for PAs over the opiate limit 1. Only available if component ingredients are unavailable.	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. in Substance abuse evaluations may be required for patients with medical records displaying potential signs of narcotic misuse and abuse such as chronic early refills, short dosing intervals, frequent dose increases, multiple lost/stolen etc scripts and intolerance or "allergy" to all products but Oxycontin. Allergic reactions to any product within a specific narcotic class will justify and preclude use of any other product in the same class due to the risk of cross-hypersensitivity. Beginning January 2017, all current opiate users who are above the maximum combined daily dose of 100 MME must titrate their total daily dose of opioid medications below 30 MME. Also, the maximum daily supply of an opiate prescription for acute pain will be limited to 7-day supplies. The maximum day supply of an opiate prescription for chronic pain will be limited to 30-day supplies. As of July 1, 2017 all users of opioid medications must comply with the maximum combined daily dose of 100 MME. However, for MaineCare members, effective January 1, 2017, opioid prescription(s) for more than a 7-day supply and/or more than 30 MME/ day will require a prior authorization. Please note that MaineCare implemented a 30 MME limit January 1, 2013 that is still effective. Post-surgical members may receive prior authorizations for opiates up to a 60 days in length if medical necessity is provided by the surgical provider. An MME conversion chart is available at www.mainecarepdl.org. Click on “General Pharmacy Info.” **Please see the Pain Management Policy tab for the complete criteria**
	MC/DEL		TRAMADOL/APAP TABS	MC	8	BUPRENEX SOLN		
				MC/DEL	8	BUTORPHANOL		
				MC	8	NALBUPHINE HCL SOLN		
				MC	8	QDOLO SOLN		
				MC	8	SEGLENTIS[1]		
				MC	8	STADOL NS SOLN		
				MC	8	TRAMADOL ER		
				MC	8	ULTRACET TABS[1]		
				MC	9	ULTRAM ER		
MISCELLANEOUS NARCOTICS								
NARCOTICS - MISC.	MC/DEL		ACETAMINOPHEN/CODEINE	MC/DEL	8	ABSTRAL	Use PA Form# 20420 Use PA form #10300 for PAs over the opiate limit 1. Fentanyl OT loz (Barr) and Capital and codeine suspension products require PA for users over 18 years of age. PA is not required if under 18 years of age.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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. 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.
	MC/DEL		ASPIRIN/CODEINE TABS	MC/DEL	8	APADAZ		
	MC/DEL		BUTAL/ASA/CAFF/COD CAPS	MC/DEL	8	ASCOMP/CODEINE CAPS		
	MC		BUTALBITAL/ASPIRIN/CAFFEI CAPS	MC/DEL	8	BUTALBITAL/APAP/CAFFEINE/ CAPS		
	MC		CAPITAL AND CODEINE SUSP[1]	MC/DEL	8	BUTALBITAL COMPOUND- CODEINE CAP		
	MC		CAPITAL/CODEINE SUSP[1]	MC	8	DEMEROL		
	MC/DEL		CODEINE PHOSPHATE SOLN	MC/DEL	8	DILAUDID		
	MC/DEL		CODEINE SULFATE TABS	MC	8	DILAUDID-HP SOLN		
	MC/DEL		ENDOCET TABS[3]	MC	8	FENTANYL CITRATE SOLN		

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
	MC/DEL		ENDODAN TABS	MC/DEL	8	FENTORA	2. Oxycodone/acet 10/650 is 8 times more expensive. Use twice as many of oxycod/acet 5/325 instead. You can mix and match preferred strengths of oxycodone and oxycodone/acet to minimize acet. dose similar to certain non-preferred drugs. 3. Only preferred manufacturer's products will be available without prior authorization.	Post-surgical members may receive prior authorizations for opiates up to a 60 days in length if medical necessity is provided by the surgical provider. An MME conversion chart is available at www.mainecarepdl.org. Click on "General Pharmacy Info." **Please see the Pain Management Policy for the complete criteria**
	MC/DEL		FENTANYL OT LOZ[1]	MC/DEL	8	FIORICET/CODEINE CAPS		
	MC/DEL		FENTANYL OT LOZ1	MC	8	FIORINAL/CODEINE #3 CAPS		
	MC/DEL		HYDROCODONE/ACETAMINOPHEN	MC	8	FIORTAL/CODEINE CAPS		
	MC/DEL		HYDROMORPHONE HCL[3]	MC/DEL	8	HYDROCODONE/IBUPROFEN		
	MC		LORTAB ELX	MC/DEL	8	HYDROMORPHONE ER		
	MC/DEL		MEPERIDINE SOL	MC/DEL	8	HYDROMORPHONE RECTAL SUPP		
	MC/DEL		OXYCODONE TAB	MC	8	IBUDONE		
	MC/DEL		OXYCODONE/ACETAMINOPHEN[2,3]	MC/DEL	8	**LEVORPHANOL TARTRATE TAB**		
	MC/DEL		ROXICET	MC/DEL	8	LORCET		
	MC		ROXIPRIN TABS	MC	8	LORTAB		
				MC	8	MAXIDONE TABS		
				MC/DEL	8	MEPERIDINE TABS		
				MC/DEL	8	NORCO TABS		
				MC/DEL	8	ONSOLIS		
				MC/DEL	8	OXECTA		
				MC/DEL	8	OXYCODONE CAP		
				MC/DEL	8	OXYCODONE/APAP 10/650		
				MC/DEL	8	OXYCODONE/APAP 7.5/500		
				MC/DEL	8	PENTAZOCINE/ACET TABS		
				MC/DEL	8	PENTAZOCINE/NALOXONE TABS		
				MC	8	PERCOCET TABS		
				MC	8	PERCOCET TABS		
				MC	8	PHRENILIN W/CAFFEINE/CODE CAPS		
				MC/DEL	8	ROXICET 5/500 TABS		
				MC	8	ROXICODONE TABS		
				MC/DEL	8	ROXYBOND		
				MC	8	SYNALGOS-DC CAPS		
				MC	8	TALACEN TABS		
				MC	8	TREZIX		
				MC	8	TYLENOL/CODEINE #3 TABS		
				MC	8	TYLOX CAPS		
				MC	8	XOLOX		
				MC	8	VICODIN		
				MC	8	VICOPROFEN TABS		
				MC	8	ZYDONE TABS		
				MC	9	ACTIQ LPOP		
				MC	9	CONZIP		
				MC	9	OPANA		
OPIOID DEPENDENCE TREATMENTS	MC		SUBOXONE FILM[2]	MC/DEL		BUPRENORPHINE[1]	Use PA Form #20100 1. Buprenorphine will only be approved for use during pregnancy. 2. See Criteria Section	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Members will continue to be required to follow the criteria listed below: 1-Induction period for 30 days 2-Max dose of 32 mg for induction 3-Max dose of 24 mg for maintenance 4-There is not more than one opioid fill in member's drug profile between current fill of buprenorphine and a prior buprenorphine fill within the past 90 days 5- Should provide evidence of monthly monitoring including random pill counts, urine drug tests and use of Maine Prescription Monitoring Program reports. 6- Buprenorphine monotherapy is preferred if member is pregnant and dose not > 24 mg day and pregnancy diagnosis is noted on the prescription.
	MC/DEL		BUPRENORPHINE/NALOXONE TABS[2]	MC		ZUBSOLV		

CATEGORY	Coverage Indicator	Step Order	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 Extended Release Buprenorphine 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		EVZIO OPVEE[2] KLOXXADO REVIA TABS[1]	Use PA Form# 20420 1. Will only be approved for side effects experienced with generic that are not described in the literature as occurring with the brand version. 2. For the treatment of adult and pediatric patients 12 years of age and older.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
COX 2 / NSAIDS								
COX 2 INHIBITORS - SELECTIVE / HIGHLY SELECTIVE	MC/DEL MC/DEL MC/DEL MC/DEL		**CELECOXIB[4,5]** KETOROLAC TROMETHAMINE [2,3,5] NABUMETONE TABS[5] MELOXICAM TABS[1,5]	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		CELEBREX CAPS[4,5] MELOXICAM CAPS[5] **MOBIC[5]** MOBIC SUSP[5] **RELAFEN TABS[5]** **QMIIZ ODT** **VIVLODEX**	Use PA Form# 20420 1. Meloxicam has 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 of chronic pain conditions. 3. Ketorolac has dosing limits allowing 24 tablets for a 5 day supply every 30 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.

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
							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.	
NSAIDS	MC/DEL		**CHILDRENS IBUPROFEN**	MC		ADVIL TABS	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, 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. Approvals will be granted for other requests based on failure of at least one generic NSAID from at least 3 different NSAID classes as described in the COX-II PA form. The FDA has issued a Public Health Advisory warning of the potential for increased cardiovascular risk & GI bleeding with NSAID use. **DDI:** Diclofenac will now be non-preferred and require prior authorization if it is currently being used in combination with lescol.
	MC/DEL		**DICLOFENAC POTASSIUM TABS**	MC		ANAPROX TABS		
	MC/DEL		**DICLOFENAC SODIUM TABS**	MC		ANAPROX DS TABS		
	MC/DEL		**DICLOFENAC SODIUM 1% GEL**[1]	MC		CAMBIA		
	MC/DEL		**ETODOLAC**	MC/DEL		**CATAFLAM TABS**		
	MC/DEL		**FENOPROFEN CALCIUM TABS**	MC		CHILDRENS ADVIL SUSP		
	MC/DEL		**FLURBIPROFEN TABS**	MC		CHILD'S IBUPROFEN SUSP		
	MC/DEL		**IBUPROFEN**	MC/DEL		CHILDREN'S MOTRIN SUSP		
	MC/DEL		**INDOMETHACIN**	MC/DEL		**CLINORIL TABS**		
	MC/DEL		**KETOPROFEN**	MC/DEL		**DAYPRO TABS**		
	MC/DEL		**MECLOFENAMATE SODIUM CAPS**	MC/DEL		**DICLFENAC GEL**		
	MC/DEL		NAPROSYN SUSP	MC/DEL		**EC-NAPROSYN TBEC**		
	MC/DEL		NAPROXEN SUSP	MC/DEL		**ETODOLAC ER 600MG**		
	MC/DEL		**NAPROXEN TABS**	MC		FELDENE CAPS		
	MC/DEL		**NAPROXEN SODIUM TABS**	MC/DEL		FLECTOR PATCH		
	MC/DEL		**NAPROXEN SODIUM CAPS**	MC/DEL		IBU-200		
	MC/DEL		**NAPROXEN DR TBEC**	MC		INDOCIN		
	MC/DEL		**OXAPROZIN TABS**	MC		LICART		
	MC/DEL		**SULINDAC TABS**	MC/DEL		**LODINE**		
	MC/DEL		**TOLMETIN SODIUM**	MC		LOFENA		
	MC/DEL		VOLTAREN GEL	MC/DEL		**MOTRIN**		
				MC		NALFON CAPS		
				MC/DEL		NAPRELAN TBCR		
				MC/DEL		NAPROSYN TABS		
				MC/DEL		**NAPROXEN SODIUM TBCR**		
				MC		PENNSAID		
				MC/DEL		**PIROXICAM CAPS**		
				MC		PONSTEL CAPS		
				MC		RELAFEN DS		
				MC		SB IBUPROFEN TABS		
				MC		SPRIX		
				MC		TIVORBEX		
				MC		TOLECTIN		
				MC		V-R IBUPROFEN TABS		
				MC		ZORVOLEX		
NSAID - PPI				MC		PREVACID NAPRA-PAC	Use PA Form# 20420 1. Use a preferred NSAID and PPI separately.	
				MC/DEL		VIMOVO[1]		
RHEUMATOID ARTHRITIS								
RHEUMATOID ARTHRITIS	MC/DEL		ACTEMRA VIALS			ADALIMUMAB-AACF	Use PA Form# 20900 1. Dosing limits apply. Please see dose consolidation list. 2. Established users will be grandfathered.	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.
	MC/DEL		ACTEMRA SYRINGES	MC		AMJEVITA		
	MC/DEL		**ADALIMUMAB-FKJP**[3]	MC/DEL		**ARAVA**		
	MC		AVSOLA	MC/DEL		CIMZIA		
	MC/DEL		**AZATHIOPRINE**	MC/DEL		**CYLTEZO**		
	MC		**ENBREL**[2]	MC/DEL		ENTYVIO		
	MC		ENBREL SURECLICK[2]	MC		HADLIMA		

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
	MC		**KINERET SOLN**	MC/DEL		**HULIO**	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	**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
	MC/DEL		LEFLUNOMIDE	MC/DEL		**HYDROXYCHLOROQUINE**[2]		
	MC/DEL		METHOTREXATE	MC/DEL		**HYRIMOZ**		
	MC		ORENCIA	MC		IDACIO		
	MC/DEL		**SULFASALAZINE TABS**	MC/DEL		**ILARIS**[1,3,4]		
	MC		SIMLANDI[3]	MC/DEL		INFLECTRA		
	MC		SIMPONI PEN	MC		INFLIXIMAB VIAL		
	MC		SIMPONI AUTOINJECTOR	MC		JYLAMVO		
	MC/DEL		**RINVOQ**[3]	MC/DEL		**KEVZARA**		
	MC		**HUMIRA**[1,2]	MC		OLUMIANT		
	MC/DEL		**XELJANZ**[3,6]	MC		OMVOH		
	MC/DEL		**XELJANZ XR**	MC		OTREXUP		
	MC/DEL		**XELJANZ XR SOL**	MC		RASUVO[7]		
				MC		REDITREX		
				MC		**REMICADE**		
				MC/DEL		**RENFLEXIS**		
				MC		SIMLANDI		
				MC		TOFIDENCE		
				MC		VELSIPITY		
				MC		YUFLYMA		
				MC		YUSIMRY		
				MC		XATMEP[5]		
				MC		ZYMFENTRA		
ALOPECIA AREATA AGENTS								
ALOPECIA AREATA AGENTS				MC	7	OLUMIANT	Use PA Form# 20420	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC/DEL	8	LITFULO		
MISCELLANEOUS ARTHRITIS								
ARTHRITIS - MISC.	MC		RIDAURA CAPS	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.
	MC		MYOCHRYSINE SOLN					
LUPUS-SLE								
LUPUS-SLE				MC		BENLYSTA[1]	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)
				MC		LUPKYNIS		
				MC		SAPHNELO		
PIK3CA-Related Overgrowth Spectrum (PROS)								
PIK3CA-Related Overgrowth Spectrum (PROS)				MC		VIJOICE[1]	Use PA Form# 20420 1. PA required to confirm FDA approved indication.	Preferred drugs must be tried and failed, in step-order, due to lack of efficacy (failure to reach target IOP reduction) or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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/DEL		D.H.E. 45 SOLN	Use PA Form# 10110	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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		TRUDHESA		
MIGRAINE - CARBOXYLIC ACID DERIVATIVES	MC		DIVALPROEX ER TB24	MC		DEPAKOTE ER TB24	Use PA Form# 10110	

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)--Tabs/Nasal	MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL	1 1 1 1 1 **1** 2	MIGRANAL NASAL SPRAY RELPAX[1] **RIZATRIPTAN ODT** **RIZATRIPTAN TABS** SUMATRIPTAN TABS[1] **ZOLMITRIPTAN TAB[1]** NARATRIPTAN HCI TABS[1]	MC MC MC/DEL MC MC MC/DEL MC/DEL MC MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL MC/DEL		AMERGE TABS[1,2] AXERT TABS[1,2] FROVA TABS[1,2] IMITREX NASAL SPRAY[1] IMITREX TABS[1,2] MAXALT[1,2,3] MAXALT MLT[1,2,3] ONZETRA XSAIL[2] SUMATRIPTAN NASAL SPRAY[1] **ZOLMITRIPTAN ODT** **ZOLMITRIPTAN SPRAY** ZOMIG TABS[1,2] ZOMIG NASAL SPARY[1,2] ZOMIG ZMT TBDP[1,2]	Use PA Form# 10110 1. All drugs in this category have dosing limits. Please refer to dose consolidation table. 2. Must fail all preferred products before non-preferred. 3.Established users will be grandfathered	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Quantity limit exceptions will require ongoing therapy with therapeutic doses of highly effective prophylactic medication as listed on the Triptan PA form.
MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)--Injectables	MC MC/DEL MC/DEL		IMITREX CARTRIDGE[1] SUMATRIPTAN SYRINGE[1] SUMATRIPTAN PEN INJCTR[1]	MC/DEL MC MC		TOSYMRA ZEMBRACE[1] IMITREX PEN INJCTR[1]	Use PA Form# 10110 1. Dosing limits apply. Please refer to the dose consolidation table.	
MIGRAINE - SELECTIVE SEROTONIN AGONISTS (5HT)--Combinations				MC/DEL		TREXIMET[1,2]	Use PA Form# 10110 1. Dosing limits apply. Please see dose consolidation list. 2. Use preferred Sumatriptan and Naproxen separately. Treximet only available if component ingredients of sumatriptan and naproxen are unavailable.	
MIGRAINE - PREVENTATIVE TREATMENT	MC MC/DEL MC/DEL MC/DEL MC/DEL		AIMOVIG[1] AJOVY[1] AJOVY AUTO INJCT[1] EMGALITY SYRINGE[1] 200mg/ml EMGALITY PEN[1]	MC MC MC		NURTEC ODT[2] QULIPTA VYEPTI[2]	Use PA Form# 10110 1. See criteria section 2. Dosing limits apply, please see the dose consolidation list.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **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. **Ubrelvy** is non-preferred and is indicated for the acute treatment of migraine with or without aura in adults. This is not indicated for the preventive treatment of migraine. **Nurtec** ODT will be preferred after 2 adequate trials of at least two preferred triptans
MIGRAINE - ACUTE TREATMENT	MC MC/DEL		NURTEC ODT[1] SPASTRIN TABS	MC MC MC/DEL MC/DEL MC MC MC/DEL		BELCOMP-PB SUPP ELYXYB MIGRAZONE CAPS MIGERGOT SUP REYVOW UBRELVY ZAVZPRET	Use PA Form# 10110 1. Dosing limits apply, please see the dose 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 non-preferred and is indicated for the acute treatment of migraine with or without aura in adults. This is not indicated for the preventive treatment of migraine. **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.

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
MISC.								
ACID SPHINGOMYELINASE DEFICIENCY (ASMD)				MC		XENPOZYME[1,2]	1.For treatment of non-central nervous system manifestations of acid sphingomyelinase deficiency (ASMD) in adult and 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 MARCAINE SOLN	MC MC/DEL MC		SENSORCAINE-MPF SOLN SYNVISC INJ XYLOCAINE SOLN	Use PA Form# 30130	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
COLD AGGLUTININ DISEASE (CAD)				MC		ENJAYMO[1]	1.Indicated to decrease the need for red blood cell transfusion due to hemolysis in adults with cold agglutinin disease (CAD).	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
CONGENITAL ADRENAL HYPERPLASIA				MC		CRENESSITY	Use PA Form# 30130	Crenessity - As adjunctive treatment to glucocorticoid replacement to control androgens in adults and pediatric patients 4 years of age and older with classic congenital adrenal hyperplasia (CAH)
PRIMARY HYPEROXALURIA TYPE 1 (PH1)						OXLUMO[1] RIVFLOZA	Use PA Form# 20420 1. PA is required to establish diagnosis and medical necessity.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Rivfloza: The patient has a diagnosis of Primary Hyperoxaluria Type I (PH1) confirmed via genetic testing (identification of alanine: glyoxylate aminotransferase gene (AGXT) mutation) AND urinary oxalate excretion > 0.5mmol/1.73 m2 or urinary oxalate: creatinine ratio is above the upper limit of normal for age AND is at least 9 years of age AND medication is being prescribed by, or in consultation, with a nephrologist or urologist
SICKLE CELL DISEASE	MC MC MC/DEL MC		DROXIA CASGEVY[2,3] **HYDROXYUREA** LYFGENIA[2,3]	MC MC MC/DEL		ADAKVEO ENDARI[1] SIKLOS XROMI	Use PA Form# 20420 1.Evidence of other preferred L-glutamine products utilization and reason for failure. 2. For the treatment of patients ≥ 12 years of age. 3. PA required to confirm FDA approved indication.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
HUTCHINSON- GILFORD PROGERIA SYNDROME (HGPS)				MC		ZOKINVY[1,2]	Use PA Form# 20420 1.In patients 12 months of age and older with a body surface area (BSA) of 0.39m2 and above 2. PA required to confirm FDA approved indication.	**ZOKINVY**: To reduce the risk of mortality in Hutchinson-Gilford Progeria Syndrome (HGPS). For the treatment of processing-deficient Progeroid Laminopathies with either: Heterozygous LMNA mutation with progerin-like protein accumulation OR Homozygous or compound heterozygous ZMPSTE24 mutations
OBSTRUCTIVE SLEEP APNEA				MC		ZEPBOUND	Use PA Form# 20420	**Zepbound** for adults with a BMI ≥ 30 mg/kg2 and diagnosis of moderate to severe OSA, confirmed by sleep study within the last 3 years documenting AHI ≥ 15, AND in which CPAP is ineffective (AHI > 5 during therapeutic section of sleep study) or patient is unable to tolerate CPAP for at least 90 days AND for whom lifestyle modifications have been attempted for at least 3 months with failure to achieve weight loss. Note: Not for patients with T1DM, T2DM
VACCINES	MC/DEL MC MC/DEL MC/DEL		ABRYSVO AREXVY GARDASIL 9 SHINGRIX				Use PA Form# 20420	**Gardasil** 9 will be preferred by MaineCare for ages 19-45 for FDA approved indications. Under the Maine Immunization Program Gardasil 9 is covered under the Vaccine for Children Program for ages 9-18. Please contact 1-800-867-4775 or 207-287-3746 for assistance. **Abrysvo** will be a preferred vaccine indicated for active immunization for the prevention of lower respiratory tract disease (LRTD) caused by respiratory syncytial virus (RSV) in individuals 60 years of age and older. Active immunization of pregnant individuals at 32 through 36 weeks gestational age for the prevention of LRTD and severe LRTD caused by RSV in infants from birth through 6 months of age. **Arexvy** will be preferred for active immunization for the prevention of LRTD caused by respiratory syncytial virus (RSV) in individuals 60 years of age and older. **SHINGRIX** (>= 50yo) is preferred as of 11-20-20 with respective age edit.

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
APDS				MC		JOENJA[1,2,3]	Use PA Form# 20420 1.Clinical PA required for appropriate diagnosis 2. For the treatment of patients 2 years of age and older. 3. Avoid CYP3A drug interaction.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ALPHA- MANNOSIDOSIS				MC		LAMZEDE	Use PA Form# 20420 1.Clinical PA required for appropriate diagnosis	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
ANTI-CONVULSANTS								
ANTICONVULSANTS	MC/DEL		BRIVIACT	MC	8	APTIOM	Use PA Form# 20420 All non-preferred meds must be used in specified order 1. Quantity limit: 5/month 2. Dosing limits apply, please see dose consolidation list. 3. Dosing limits apply per strength as well as a maximum daily dose of 600mg. Please see dose consolidation list. 4. Adjunctive therapy 17 and older. 5. Max dose 2400mg 6. Clinical PA required for appropriate diagnosis 7. Epidiolex is for the treatment of seizures associated with Lennox-Gastaut syndrome (LGS), Dravet syndrome (DS) or TS (Tuberous Sclerosis Complex) in patients 1 years of age and older. 8. For seizures associated with Dravet syndrome in patients 2 years of age and older 9. Adjunctive therapy 12 and older. 10. Initial monotherapy for the treatment of partial-onset or primary generalized tonic-clonic seizures in patients 2 years of age and older. Adjunctive therapy for the treatment of partial-onset seizures, primary generalized tonic-clonic seizures, and seizures associated with Lennox Gastaut syndrome in patients 2 years of age and older. The preventive	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Approvals will be for patients with a variety of drug-specific FDA-approved indications and for specific conditions supported by at least two published peer-reviewed double-blinded, placebo-controlled randomized trials that are not contradicted by other studies of similar quality after recommendation by the DUR Committee and as long as all first line therapies have been tried and failed at full therapeutic doses for adequate durations (at least two weeks). **Topamax and Neurontin** - Second line therapy for migraine prophylaxis after trial of at least three preferred preventive medications from Group 1 listed on page 2 of the Acute Migraine PA form. All non-preferred meds must be used in specified order. **Diacomit** is for the treatment of seizures associated with Dravet syndrome (DS) in patients 6 months of age and older and weighing 7kg or more There are no clinical data to support the use of Diacomit® as monotherapy in DS. **Xcopri** criteria: History of trials with at least 4 AEDs (2 generic, 2 branded or Uncontrolled seizures on three AEDs; or Uncontrolled on 2 AEDs given along with VNS. Uncontrolled defined as 3 or more TC seizures per year (increases risk of SUDEP); > 6 disabling seizures per year . Any patient who has gone to the ED 2 or more times in the prior 12 months (who has also tried and failed at least 3 other drugs). Ongoing use requires 50 percent reduction in seizure frequency after three months. **Motpoly XR:** pediatric patient weight must be > 50kg and requires multiple preferred medication trials including generic lacosamide **Libervant:** For the acute treatment of intermittent, stereotypic episodes of frequent seizure activity (i.e., seizure clusters, acute repetitive seizures) that are distinct from a patient's usual seizure pattern in patients with epilepsy 2 to 5 years of age as long as all preferred therapies have been tried and failed at full therapeutic doses. **Vigafyde:** Indicated as monotherapy for the treatment of infantile spasms in pediatric patients 1 month to 2 years of age for whom the potential benefits outweigh the potential risk of vision loss. **Epidiolex** Criteria for Lennox-Gastaut syndrome (LGS) and Dravet: a trial of two drugs (clobazam, levetiracetam, valproate derivatives, lamotrigine, topiramate, rufinamide, or felbamate). Please use Drug-Drug Interaction PA form #10400 for this combination. ***** SEE CHART AT END OF DOCUMENT ***** DDI: Concomitant use of Diacomit® with other CNS depressants, including alcohol, may increase the risk of sedation and somnolence. Concomitant use of strong inducers (CYP1A2, CYP3A4, or CYP2C19 inducers, such as rifampin, phenytoin, phenobarbital, and carbamazepine) should be avoided, or dosage adjustments should be made. DDI: Avoid concomitant use of Nayzilam® with moderate or strong CYP3A inhibitors.
	MC/DEL		CARBAMAZEPINE	MC	8	BANZEL		
	MC		CARBAMAZEPINE ER CAP	MC	8	CARBAMAZEPINE SUS		
	MC/DEL		CARBATROL CP12	MC	8	DEPAKOTE		
	MC/DEL		CELONTIN CAPS	MC	8	DEPAKOTE ER		
	MC/DEL		**CLOBAZAM**	MC	8	DIACOMIT		
	MC/DEL		CLONAZEPAM TABS	MC/DEL	8	DIVALPROEX SODIUM SPRINKLE CAPS		
	MC		DEPAKOTE SPRINKLES CPSP	MC	8	ELEPSIA XR[9]		
	MC/DEL		DIAZEPAM GEL[1]	MC	8	EPRONTIA SOLN[10]		
	MC/DEL		DILANTIN	MC/DEL	8	FELBATOL		
	MC/DEL		DIVALPROEX SODIUM	MC/DEL	8	FELBATOL SUS		
	MC		DIVALPROEX SPRINKLE CAP	MC/DEL	8	FELBAMATE SUS		
	MC/DEL		EPIDIOLEX[7]	MC	8	FINTEPLA[8]		
	MC/DEL		EPITOL TABS	MC	8	FYCOMPA[2]		
	MC/DEL		ETHOSUXIMIDE SYRP	MC/DEL	8	HORIZANT		
	MC/DEL		EQUETRO	MC	8	GRALISE		
	MC/DEL		GABAPENTIN[2] CAP	MC/DEL	8	KEPPRA TABS		
	MC/DEL		GABAPENTIN[2] TAB	MC/DEL	8	KEPPRA SOLN		
	MC/DEL		GABAPENTIN SOL	MC/DEL	8	KLONOPIN TABS		
	MC/DEL		GABITRIL TABS	MC	8	LAMICTAL IR		
	MC/DEL		**LACOSAMIDE SOL**	MC	8	LAMICTAL ODT		
	MC/DEL		**LACOSAMIDE TAB**	MC	8	LAMICTAL XR		
	MC		LAMICTAL CHEW	MC/DEL	8	**LEVETIRACETAM INJ**		
	MC/DEL		LAMOTRIGINE ER ODT	MC	8	LIBERVANT		
	MC/DEL		LAMOTRIGINE IR[2]	MC/DEL	8	LYRICA CR		
	MC/DEL		LAMOTRIGINE XR	MC/DEL	8	LYRICA SOL[3]		
	MC/DEL		LEVETIRACETAM SOLN	MC	8	MOTPOLY XR		
	MC/DEL		LEVETIRACETAM TABS	MC/DEL	8	MYSOLINE TABS		
	MC/DEL		**LEVETIRACETAM ER TABS**	MC	8	ONFI		
	MC/DEL		LYRICA[3]	MC/DEL	8	OXCARBAZEPINE SUS		
	MC/DEL		NAYZILAM[1]	MC	8	OXTELLAR XR[5]		
	MC/DEL		OXCARBAZEPINE	MC/DEL	8	PHENYTEK CAPS		
	MC/DEL		PREGABALIN CAPS	MC/DEL	8	POTIGA		
	MC/DEL		PHENYTOIN	MC/DEL	8	PREGABALIN (ORAL) SOL		
	MC/DEL		PRIMIDONE TABS	MC	8	ROWEEPRA TAB		
	MC/DEL		QUDEXY XR	MC	8	SABRIL		
	MC/DEL		TEGRETOL SUS	MC	8	SEZABY		
	MC/DEL		TOPIRAMATE	MC	8	SPRITAM		
	MC/DEL		TOPIRAMATE SPRINKLE IR CAPS	MC	8	SYMPAZAN		
	MC/DEL		TRILEPTAL SUS	MC/DEL	8	TEGRETOL TAB		
	MC/DEL		VALPROIC ACID TABS	MC/DEL	8	TIAGABINE		
	MC/DEL		VALPROIC ACID SOL	MC	8	TOPAMAX		

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
	MC		VALTOCO[2]	MC/DEL	8	TOPIRAMATE ER CAPS	[illegible] treatment of migraine in patients 12 years and older. Will require a step though topiramate.	
	MC/DEL		ZONISAMIDE	MC	8	TOPAMAX SPRINKLE ER CAPS[2]		
				MC	8	TOPAMAX SPRINKLE IR CAPS[2]		
				MC/DEL	8	TOPIRAMATE SPRINKLE ER CAPS[2]		
				MC	8	TROKENDI[2,6]		
				MC	8	VIGAFYDE		
				MC/DEL	8	VIMPAT[4]		
				MC/DEL	8	VIMPAT SOL[4]		
				MC	8	XCOPRI		
				MC/DEL	8	ZARONTIN SYRP		
				MC/DEL	8	ZARONTIN CAP		
				MC/DEL	8	ZARONTIN SOL		
				MC	8	ZONISADE		
				MC	8	ZTALMY		
				MC/DEL	9	KEPPRA XR		
				MC/DEL	9	NEURONTIN		
				MC/DEL	9	TEGRETOL-XR TB12		
						BIPOLAR DISORDER: STEP ORDER	SEE ANTICONVULSANT INDICATION CHART AT THE END OF THIS DOCUMENT M= Monotherapy A= Adjunctive 9= No Evidence The step orders show the relative strength of evidence for use in bi-polar and will guide prior authorization determinations. Step 4 drugs-no PA required.	
					M ~ A			
					4 ~ 4	LAMICTAL		
					4 ~ 4	LITHIUM		
					4 ~ 4	CARBAMAZEPINE		
					4 ~ 4	VALPROATE		
					4 ~ 4	ATYPICAL ANTIPSYCHOTICS EXC. CLOZAPINE		
					5 ~ 5	TRILEPTAL		
					9 ~ 6	TOPAMAX		
					9 ~ 7	KEPPRA TABS		
					9 ~ 8	GABITRIL TABS		
					9 ~ 9	NEURONTIN		
						PEDIATRIC BIPOLAR1 DISORDER: STEP ORDER	Two-step 1 preferred drugs must be tried before Trileptal. The step orders show the relative strength of evidence for use in bi-polar and will guide prior authorization determinations. Step 4 drugs-no PA required.	
					M ~ A	(6-18 YEARS WITH OR WITHOUT PSYCHOSIS)		
					4 ~ 4	LITHIUM		
					4 ~ 4	CARBAMAZEPINE		
					4 ~ 4	VALPROATE		
					4 ~ 4	ATYPICAL ANTIPSYCHOTICS EXC.CLOZAPINE		
					4 ~ 4	LAMICTAL		
					5 ~ 5	TRILEPTA		
ANTI-PARKINSON DRUGS								
PARKINSONS - ANTICHOLINERGICS	MC/DEL		BENZTROPINE MESYLATE TABS				Use PA Form# 20420	
	MC		COGENTIN SOLN					
	MC/DEL		**TRIHEXYPHENIDYL**					
PARKINSONS - ADENOSINE RECEPTOR ANTAGONIST				MC/DEL		**NOURIANZ**	Use PA Form# 20420	Preferred drug must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. DDI: Avoid use of Nourianz® with strong CYP3A4 inducers (e.g. carbamazepine, rifampin, phenytoin, St. John's wort).
PARKINSONS - COMT INHIBITORS				MC/DEL		**COMTAN TABS**	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.
				MC		ONGENTYS		
				MC/DEL		**TASMAR TABS**		

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
PARKINSONS - SELECTED DOPAMIN AGONISTS	MC/DEL		PRAMIPEXOLE	MC/DEL	5	MIRAPEX TABS[1]	Use PA Form# 20420 1. As of 12/08 users of Mirapex will be grandfathered if diagnosis is Parkinson's.	Preferred drug must be tried and failed in step-order due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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		ROPINIROLE	MC	8	REQUIP TABS		
			NEUPRO PATCH	MC/DEL	8	MIRAPEX ER		
				MC/DEL	8			
PARKINSONS- MAOIS				MC		XADAGO	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
PARKINSONS - DOPAMINERGICS/CARBII/ LEVO	MC/DEL		AMANTADINE HCLCAPS	MC/DEL		APOKYN	Use PA Form# 20420 1. Approvals will require concurrent therapy with Levodopa and failed trials of Selegiline, Comtan, and Stalevo. 2. Approvals will require trials of Carbidopa/-Levodopa, Selegiline, Comtan, and Stalevo. 3. Only preferred manufacturer's products will be available without prior authorization. 4. Approvals will require trials of preferred medications including extended-release levodopa/carbidopa tablets	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Inbrija is recommended for the intermittent treatment of OFF episodes in patients with Parkinson's disease treated with carbidopa/levodopa.
	MC/DEL		AMANTADINE HCL TABS	MC		AZILECT[2]		
	MC/DEL		BROMOCRIPTINE MESYLATE TABS	MC/DEL		CARBIDOPA/LEVODOPA RAPDIS		
	MC/DEL		BROMOCRIPTINE MESYLATE CAPS	MC		CREXONT[4]		
	MC/DEL		CARBIDOPA/LEVODOPA TABS[3]	MC		ELDEPRYL CAPS		
	MC/DEL		CARBIDOPA/LEVODOPA ER	MC		GOCOVRI		
	MC/DEL		CARBIDOPA/LEVO/ENTACAPONE TAB	MC/DEL		INBRIJA		
	MC		LARODOPA TABS	MC		KYNMOBI		
	MC/DEL		SELEGILINE CAPS HCL	MC		LODOSYN TABS		
	MC/DEL		SELEGILINE TABS HCL			ONAPGO		
				MC		OSMOLEX ER		
				MC/DEL		PARLODEL CAPS		
				MC/DEL		PARLODEL TABS		
				MC		RYTARY		
				MC		SINEMET TABS		
				MC		SINEMET TBCR		
						VYALEV		
				MC		ZELAPAR[1]		
PARKINSONS - COMBO.				MC/DEL		STALEVO[1]	Use PA Form# 20420 1.Clinical PA is required to establish diagnosis and medical necessity.	
				MC		CARBIDOPA/LEVODOPA/ENTACA[1]		
MUSCLE RELAXANTS								
MUSCLE RELAXANTS	MC/DEL		BACLOFEN TABS	MC/DEL	7	ORPHENADRINE CITRATE	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. At least 4 preferred drugs (including tizanidine) must be tried for at least 2 weeks and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Elderly patients, over 65, will require written notice of the increased sedative risks and impaired driving. Prior Authorization will not be given for:1. frequent or persistent early refills of controlled drugs; 2. multiple instances of early refill overrides due to reports of misplacement, stolen, dropped in toilet or sink, distant travel, etc. Non-preferred products must be used in specified step order. Non-preferred drugs will not be approved if members circumventing MaineCare prior authorization requirements by paying (prescribers failed to submit prior authorization prior to cash narcotic scripts being filled by member). **Lorzone** is non preferred and requires at least 4 preferred drugs (including tizanidine) and step care therapy (orphenadrine), as well as reasons for why chlorzoxazone is not acceptable.
	MC/DEL		CHLORZOXAZONE TABS	MC/DEL	8	CARISOPRODOL 350MG TABS		
	MC/DEL		CYCLOBENZAPRINE HCL 5mg & 10mg TABS	MC/DEL	8	AMRIX		
	MC		LIORESAL INTRATHECAL KIT	MC/DEL	8	DANTRIUM CAPS		
	MC/DEL		METHOCARBAMOL TABS	MC	8	FLEQSUVY		
	MC/DEL		TIZANIDINE HCL TABS	MC	8	LIORESAL TABS		
				MC	8	LORZONE		
				MC	8	LYVISPAH		
				MC/DEL	8	METAXALONE		
				MC	8	NORFLEX TBCR		
				MC	8	OZOBAX		
				MC	8	ROBAXIN-750 TABS		
				MC	8	VECUROMIUM INJ		
				MC/DEL	8	ZANAFLEX TABS		
				MC/DEL	9	CARISOPRODOL 250MG TABS		
				MC/DEL	9	CHLORZOXAZONE 250mg TABS		
				MC/DEL	9	SKELAXIN TAB		
				MC/DEL	9	SOMA TABS		
				MC	9	TANLOR		

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
MUSCLE RELAXANT - COMBO.				MC/DEL		CARISOPRODOL/ASPIRIN TABS	Use PA Form# 20420	Individual components are available with PA described in the section above.1. frequent or persistent early refills of non-controlled drugs; 2. multiple instances of early refill overrides due to reports of misplacement stolen, dropped in toilet or sink, distant travel, etc.
				MC/DEL		CARISOPRODOL/ASPIRIN/CODE		
				MC		NORGESIC TABS		
				MC/DEL		ORPHENADRINE COMPOUND		
				MC/DEL		ORPHENADRINE/ASA/CAFF		
				MC		ORPHENGESIC		
PARATHYROID HORMONE								
PARATHYOID HORMONE				MC		NATPARA[1]	Use PA Form# 20420 1. Recommended only for those who cannot be well-controlled on calcium supplements and active forms of vitamin D alone.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC		YORVIPATH[1]		
VITAMINS								
VITAMINS	MC		CYANOCOBALAMIN SOLN	MC		AQUASOL E SOLN	Use PA Form# 20420 **Please refer to OTC list for covered products.** Click here for the OTC List	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Certain drugs require specific diagnoses for approval. **Please refer to OTC list for covered products.** Preferred products that used to require diag codes still require diag codes unless indicated otherwise. **DDI:** B-12 will now be non-preferred and require prior authorization if it is currently being used in combination with either Prevacid, pantoprazole, Prilosec, or any currently non preferred PPI.
	MC		FERIVA CAP	MC		AQUAVIT-E SOLN		
	MC		FERIVAFA CAP	MC		DHT SOLN		
	MC/DEL		FOLIC ACID TABS	MC		FUSION PLUS CAP		
	MC/DEL		MEPHYTON TABS	MC		HEMOCYTE PLU CAP		
	MC/DEL		NIACIN	MC		INTEGRA CAP		
	MC		NIACOR TABS	MC		INTEGRA F CAP		
	MC/DEL		NICOTINIC ACID SR CPCR	MC		INTEGRA PLUS CAP		
	MC		PYRIDOXINE HCL TABS	MC		NASCOBAL GEL		
	MC		TANDEM CAP	MC		TANDEM PLUS CAP		
	MC/DEL		THIAMINE HCL SOLN					
	MC/DEL		VITAMIN B-1 TABS					
	MC/DEL		VITAMIN B-12					
	MC		VITAMIN B-6 TABS					
	MC/DEL		VITAMIN C					
	MC/DEL		VITAMIN E CAPS					
	MC/DEL		VITAMIN E/D-ALPHA CAPS					
	MC		VITAMIN K1 SOLN					
	MC		V-R VITAMIN E CAPS					
VITAMIN D's	MC/DEL		**CALCITRIOL CAPS[1]**	MC		CALCIJEX	Use PA Form# 20420 1. Diagnosis of dialysis (renal failure) required. 2. Only specific NDCs available	Preferred products require dialysis/renal failure diagnosis. Rayaldee requires clinical PA to verify stage 3 or 4 CKD.
	MC/DEL		**ROCALTROL**	MC/DEL		**DOXERCALCIF CAP**		
	MC/DEL		**VITAMIN D2[2]**	MC/DEL		**DOXERCALCIF INJ**		
	MC/DEL		**VITAMIN D3[2]**	MC/DEL		**PARICALCITROL CAP**		
	MC/DEL		**VITAMIN DROPS**	MC/DEL		**PARICALCITROL INJ**		
	MC		PARICALCITOL CAPS	MC/DEL		HECTOROL (ORAL)		
				MC/DEL		HECTOROL (PARENTERAL)		
				MC		RAYALDEE		
				MC		ZEMPLAR INJ		
				MC		ZEMPLAR CAPS		
EMZYMES								
POMPE DISEASE AGENTS				MC		NEXVIAZYME[1]	Use PA Form# 20420 1. For patients 1 year of age and older with late-onset Pompe disease (lysosomal acid alpha-glucosidase [GAA] deficiency).	All preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs (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. **Pombiliti and Opfolda** are for the treatment of adult patients with late-onset Pompe disease (lysosomal acid alpha-glucosidase [GAA] deficiency) weighing ≥40kg and who are not improving on their current enzyme replacement therapy (ERT).
				MC		LUMIZYME		
				MC		OPFOLDA		
				MC		POMBILITI		

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
MISC MULTI-VITAMINS								
VITAMINS - MISC.	MC		CENTRUM TABS	MC		ADEKS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Certain drugs require specific diagnoses for approval.
	MC		CENTRUM JR/IRON CHEW	MC/DEL		ADVANCED NATALCARE TABS	1. Diag codes are no longer required on prenatal vitamins.	
	MC		CENTRUM-LUTEIN TABS	MC		AQUADEKS		
	MC		CEROVITE ADVANCED FO TABS	MC		CENTRUM JR/EXTRA C CHEW		
	MC/DEL		CHEWABLE MULTIVIT/FL CHEW	MC		CENTRUM PERFORMANCE TABS		
	MC		COD LIVER OIL CAPS	MC		CENTRUM SILVER TABS	**Please refer to OTC list.**	**Please refer to OTC list.**
	MC/DEL		COMPLETE NATAL DHA (ORAL) COMBO PKG	MC		DALYVITE LIQD		
	MC		COMPLETE SENIOR TABS	MC		EMBREX 600 MISC	Click here for the OTC List	Preferred products that used to require diag codes still require diag codes unless indicated otherwise.
	MC		DAILY MULTI VIT/IRON	MC		FERRALET 90		
	MC/DEL		DIALYVITE 1MG	MC		IBERET		
	MC/DEL		DIALYVITE 800MG	MC		MATERNA TABS		
	MC/DEL		FULL SPECTRUM B	MC		MAXARON		
	MC		M.V.I.-12 INJ	MC		MULTIRET FOLIC -500 TBCR		
	MC		MULTI-VIT/FLUORIDE	MC/DEL		NATAFORT TABS		
	MC/DEL		NATALCARE RX TABS	MC/DEL		NATALCARE CFE 60 TABS[1]		
	MC/DEL		NEPHRONEX	MC/DEL		NATALCARE GLOSS TABS[1]		
	MC/DEL		NIVA-PLUS (ORAL) TABLET	MC		NATALCARE PIC TABS[1]		
	MC/DEL		ONE DAILY TABS	MC		NATALCARE PIC FORTE TABS[1]		
	MC/DEL		ONE-DAILY MULTIVITAMINS	MC/DEL		NATALCARE PLUS TABS[1]		
	MC/DEL		ONE-TABLET-DAILY	MC		NATALCARE THREE TABS[1]		
	MC/DEL		POLY-VIT/IRON/FLUORID SOLN	MC/DEL		NATACHEW CHEW		
	MC/DEL		POLY-VITAMIN/FLUORIDE SOLN	MC		NATALFIRST TABS		
	MC/DEL		POLY-VITAMINS/IRON SOLN	MC		NATATAB RX TABS		
	MC		PRENATA (ORAL) TAB CHEW	MC/DEL		NEPHPLEX RX TABS		
	MC/DEL		PRENATAL TABS[1]	MC/DEL		NEPHROCAPS CAPS		
	MC/DEL		PRENATAL FORMULA 3 TABS[1]	MC/DEL		NEPHRO-VITE TABS		
	MC/DEL		PRENATAL PLUS TABS[1]	MC		NESTABS RX TABS		
	MC/DEL		PRENATAL PLUS NF TABS[1]	MC/DEL		NIFEREX		
	MC		PRENATAL PLUS/27MG IRON[1]	MC/DEL		OCUVITE TABS		
	MC		PRENATAL PLUS/IRON TABS[1]	MC		POLY-VI-FLOR SOLN		
	MC		PRENATAL VITAMIN PLUS LOW IRON (ORAL) TAB	MC		POLY-VI-SOL SOLN		
	MC/DEL		PRENATAL RX/BETA-CAROTENE[1]	MC		POLY-VI-SOL/IRON SOLN		
	MC/DEL		PREPLUS (ORAL) TABLET	MC		POLY-VITAMIN DROPS SOLN		
	MC/DEL		RENAL CAPS	MC		PRECARE		
	MC/DEL		RENAPHRO CAPS	MC		PREFERA OB		
	MC		STRESS TAB NF TABS	MC		PREMESIS RX TABS		
	MC		THERAPEUTIC-M TABS	MC		PRENATABS CBF TABS[1]		
	MC		THERAVITE LIQD	MC		PRENATAL CARE TABS[1]		
	MC/DEL		TRINATAL RX 1 (ORAL) TABLET	MC		PRENATAL MR 90 TBCR[1]		
	MC/DEL		TRIVEEN-DUO DHA (ORAL) COMBO. PKG	MC/DEL		PRENATAL MTR/SELENIUM TABS[1]		
	MC/DEL		TRI-VITAMIN/FLUORIDE SOLN	MC		PRENATAL OPTIMA ADVANCE TABS[1]		
	MC		VITA CON FORTE CAPS	MC		PRENATAL PC 40 TABS[1]		
	MC		VITAPLEX PLUS TABS	MC/DEL		PRENATAL RX TABS[1]		
				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]		

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
				MC		VINATE[1]		
				MC/DEL		VINATE ADVANCED TABS[1]		
MISCELLANEOUS MINERALS								
MINERALS	MC		CALCARB	MC		ANEMAGEN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Certain drugs require specific diagnoses for approval.
	MC		CALCI-MIX CAPSULE CAPS	MC		CALCET TABS		
	MC		CALCIQUID SYRP	MC/DEL		**CALCIUM 600-D TABS**		**DDI:** Fe salts will now be non-preferred and require prior authorization if it is currently being used in combination with either Prevacid, pantoprazole, Prilosec, or any currently non preferred PPI.
	MC		CALCITRATE/VITAMIN D TABS	MC		CALCIUM/VITAMIN D TABS		
	MC/DEL		CALCIUM	MC		CALTRATE 600 PLUS/VIT D TABS		
	MC/DEL		CALCIUM CARBONATE	MC		CALTRATE PLUS TABS		
	MC/DEL		CALCIUM CITRATE TABS	MC		CHROMAGEN		
	MC/DEL		CALCIUM GLUCONATE TABS	MC		CITRACAL PLUS TABS	**Please refer to OTC list.**	**Please refer to OTC list.**
	MC/DEL		CALCIUM LACTATE TABS	MC		CONTRIN CAPS		
	MC		CALCIUM/MAGNESIUM TABS	MC		FEOGEN FORTE CAPS	Click here for the OTC List	Preferred products that used to require diag codes still require diag codes unless indicated otherwise.
	MC/DEL		**CALCIUM/VITAMIN D TABS**	MC		FEROCON CAPS		
	MC		CALTRATE 600 TABS	MC/DEL		FERREX 150 CAPS		
	MC/DEL		CHEWABLE CALCIUM CHEW	MC		FERRO-SEQUELS TBCR		
	MC		CITRACAL TABS	MC		FE-TINIC CAPS		
	MC		CITRACAL + D TABS	MC		FE-TINIC 150 FORTE CAPS		
	MC		CITRUS CALCIUM TABS	MC/DEL		FLUOR-A-DAY SOLN		
	MC		CITRUS CALCIUM 1500 + D TABS	MC		HEMOCYTE TABS		
	MC		EFFERVESCENT POTASSIUM TBEF	MC/DEL		K-DUR TBCR		
	MC/DEL		FEOSTAT CHEW	MC		KLOR-CON PACK		
	MC		FERATAB TABS	MC		K-LYTE		
	MC/DEL		FER-GEN-SOL SOLN	MC/DEL		K-PHOS TABS NEUTRAL		
	MC		FER-IRON SOLN	MC		K-TABS TBCR		
	MC		FERRONATE TABS	MC		K-VESCENT PACK		
	MC/DEL		FERROUS SULFATE	MC		MICRO-K 10 MEG CPCR		
	MC/DEL		FLUOR-A-DAY CHEW	MC		NU-IRON 150 CAPS		
	MC		FLUORIDE CHEW	MC/DEL		**OYSTER SHELL CALCIUM/VITA TABS**		
	MC		FLUORIDE SODIUM CHEW	MC/DEL		POLY-IRON 150 CAPS		
	MC		FLUORITAB CHEW	MC/DEL		POLYSACCHARIDE IRON CAPS		
	MC		HM CALCIUM TABS	MC/DEL		POTASSIUM BICARB/CHLORIDE		
	MC		K+ POTASSIUM PACK	MC/DEL		POTASSIUM CHLORIDE 10MEQ CAPS		
	MC		KAON ELIX	MC/DEL		POTASSIUM CHLORIDE 8MEQ CAPS		
	MC		KAON-CL-10 TBCR	MC		TUMS 500 CHEW		
	MC		KCL 0.075%/D5W/NACL 0.2% SOLN	MC		VIACTIV CHEW		
	MC		K-EFFERVESCENT TBEF					
	MC		KLOR-CON					
	MC		KLOTRIX TBCR					
	MC/DEL		K-PHOS TABS					
	MC/DEL		K-VESCENT TBEF					
	MC/DEL		LURIDE CHEW					
	MC/DEL		MAGNESIUM GLUCONATE TABS					
	MC/DEL		MAGNESIUM SULFATE SOLN					
	MC		MAGTABS					
	MC		MICRO-K 8 MEG					
	MC/DEL		OS-CAL TABS					
	MC/DEL		**OS-CAL 500 + D TABS**					
	MC/DEL		**OYSCO**					
	MC/DEL		OYST-CAL TABS					
	MC/DEL		**OYST-CAL D TABS**					
	MC/DEL		**OYST-CAL/VITAMIN D TABS**					
	MC/DEL		OYSTER CALCIUM TABS					
	MC/DEL		OYSTER SHELL					
	MC		PHARMA FLUR					

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
	MC/DEL		PHOSPHA 250 NEUTRAL TABS					
	MC		POTASSIUM BICARBONATE TBEF					
	MC/DEL		POTASSIUM CHLORIDE 8MEQ					
	MC		POTASSIUM EFFERVESCENT					
	MC/DEL		SELENIUM TABS					
	MC		SLOW-MAG TBCR					
	MC/DEL		SODIUM FLUORIDE					
	MC		V-R CALCIUM					
	MC		V-R OYSTER SHELL CALCIUM					
	MC		ZINC SULFATE CAPS					
PHENYLKETONURIA (PKU) TREATMENT AGENTS								
PHENYLKETONURIA (PKU) TREATMENT AGENTS- INJECTABLES				MC		PALYNZIQ[1]	Use PA Form# 20420 1. For the treatment of patients ≥ 18 years of age.	Palynziq is not to be used in combination with Kuvan
PHENYLKETONURIA (PKU) TREATMENT AGENTS- ORAL				MC		KUVAN JAVYGTOR (ORAL) TABLET SOL 100 MG JAVYGTOR (ORAL) POWD PACK 100 MG JAVYGTOR (ORAL) POWD PACK 500 MG SAPROPTERIN DIHYDROCHLORIDE (ORAL) TABLET SOL 100 MG SAPROPTERIN DIHYDROCHLORIDE (ORAL) POWD PACK 100 MG SAPROPTERIN DIHYDROCHLORIDE (ORAL) POWD PACK 500 MG CYSTADANE (ORAL) POWDER 1G/SCOOP	Use PA Form# 20420	
MISC. ELECTROLYTES/NUTRITIONALS								
ELECTROLYTES/ NUTRITIONALS	MC		INTRALIPID EMUL[1]	MC		BOOST[1]	Use PA Form# 20420 & SGA Form 1. This list of nutritionals is incomplete. All nutritionals still require a PA except for the miscellaneous products listed as preferred. SGA form required for nutritionals unless member has a G/I . . 2. Formerly known as Omacor.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Certain drugs require specific diagnoses for approval. Medical foods are not to be authorized solely for the purpose of enhancing nutrient intake or managing body weight if the participant is able to eat conventional foods adequately. Medical foods may be approved if the member has a medical condition which precludes or restricts the use of conventional foods and necessitates the use of a formula. Concurrent Stimulant therapy is not an acceptable medical reason/condition for use of medical foods for enhancing nutrient intake or managing body weight. For children under the age of 5, MaineCare will not provide milk- or soy-based standard infant formulas. Regular formulas may be sought through your nearest WIC office. MaineCare will continue to cover medical food for all participants in MaineCare when medical necessity is met. **Vascepa** requires adjunct therapy for specific indication to reduce TG in those with severe hypertriglyceridemia (500mg per deciliter or more). Proper indication per lab values is required before approval
	MC		P.T.E. -5 SOLN[1]	MC		CASEC POWD[1]		
	MC		SEA-OMEGA CAPS[1]	MC		CHOICE DM LIQD[1]		
				MC		DELIVER 2.0 LIQD[1]		
				MC		DOJOLVI		
				MC		ENFAMIL[1]		
				MC		ENSURE[1]		
				MC		GLUCERNA[1]		
				MC		ISOCAL LIQD[1]		
				MC		KINDERCAL TF LIQD[1]		
				MC		KINDERCAL TF/FIBER LIQD[1]		
				MC		L-CARNITINE CAPS[1]		
				MC		LIPISORB LIQD[1]		
				MC		LOVAZA[1,2]		
				MC		MODULEN IBD POWD[1]		
				MC		NUTRAMIGEN POWD[1]		
				MC		NUTREN[1]		
				MC		NUTRITIONAL SUPPLEMENT LIQD[1]		
				MC		NUTRIVENT 1.5 LIQD[1]		
				MC		PEPTAMEN[1]		
				MC		PHENYLADE[1]		
				MC		PHENYL-FREE[1]		
				MC		PKU 3 POWD[1]		
				MC		PREGESTIMIL POWD[1]		
				MC		PROBALANCE LIQD[1]		
				MC		PROSOBEE[1]		
				MC		SCANDISHAKE PACK[1]		
				MC		VASCEPA		

CATEGORY	Coverage Indicator	Step Order	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 1. Clinical PA is required to establish medical necessity and that appropriate lab monitoring is being done.	Non-Preferred drugs must be tried and failed in step-order, due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Please see the EPO PA form for other approval and renewal criteria.
	MC		MIRCERA SYRINGE	MC	8	PROCRIT SOLN[1]		
	MC		RETACRIT					
GRANULOCYTE CSF								
GRANULOCYTE CSF	MC		FULPHILA	MC	8	FYLNETRA	Use PA Form# 20520 1. Must be used in specified step order.	See approval criteria detailed on Granulocyte Colony Stimulating Factor PA form.
	MC		NEUPOGEN SYRINGE	MC	8	GRANIX SYRINGE		
	MC		NEUPOGEN VIAL	MC	8	GRANIX VIAL		
	MC/DEL		**NYVEPRIA SYRINGE**	MC	8	LEUKINE		
				MC/DEL	8	NIVESTYM		
				MC	8	ROLVEDON		
				MC	8	STIMUFEND		
				MC/DEL	8	ZARXIO		
				MC/DEL		ZIEXTENZO		
				MC	9	NEULASTA[1]		
GAUCHER DISEASE								
GAUCHER DISEASE				MC		CERDELGA[1]	Use PA Form# 20420 1. Clinical PA for indication required.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Exceeding days supply limits for LMWH class requires PA. **Yargesa**: As monotherapy for the treatment of adult patients with mild to moderate type 1 Gaucher disease for whom enzyme replacement therapy is not a therapeutic option (e.g., due to allergy, hypersensitivity, or poor venous access).
				MC		YARGESA[1]		
NIEMANN-PICK DISEASE AGENTS								
NIEMANN-PICK DISEASE AGENTS				MC		AQNEURSA[1]	Use PA Form# 20420 1. Clinical PA required for appropriate diagnosis.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC		MIPLYFFA[1]		
ANTICOAGULANTS / PLATELET AGENTS								
ANTICOAGULANTS	MC		COUMADIN TABS	MC		ARIXTRA SOLN	Use PA form# 20420 1. Enoxaparin therapy durations greater than 7 days every 30 days require PA. 2. Use other strengths available to obtain desired dose. 3. Diagnosis required 4. For the treatment of patients aged 3 months to less than 12 years of age.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Exceeding days supply limits for LMWH class requires PA. **DDI:** Warfarin will require prior authorization if being used in combination with fluconazole, miconazole, or voriconazole. **DDI:** Warfarin will require prior authorization if being used in conjunction with Gemfibrozil or Fenofibrate. **DDI:** Rifampin will require prior authorization if being used in combination with Savaysa
	MC/DEL		ENOXAPARIN[1]	MC/DEL		FONDAPARINUX		
	MC		ELIQUIS	MC/DEL		FRAGMIN INJ		
	MC		ELIQUIS STARTER PACK	MC/DEL		FRAGMIN VIAL		
	MC		HEPARIN SODIUM/NACL 0.9% SOLN	MC/DEL		**LOVENOX SOLN**		
	MC		HEP-LOCK SOLN	MC/DEL		LOVENOX 300[2]		
	MC		**INNOHEP**	MC/DEL		LOVENOX SUBQ SYRINGE		
	MC		HEPARIN LOCK SOLN	MC/DEL		PRADAXA ORAL PELLETS[4]		
	MC/DEL		HEPARIN LOCK FLUSH SOLN	MC		IPRIVASK		
	MC/DEL		HEPARIN SODIUM SOLN	MC/DEL		SAVAYSAS[3]		
	MC/DEL		HEPARIN SODIUM LOCK FLUSH SOLN					
	MC/DEL		PRADAXA					
	MC/DEL		JANTOVEN					
	MC/DEL		**WARFARIN SODIUM TABS**					
	MC/DEL		XARELTO					
	MC/DEL		XARELTO STARTER PACK					
ANTIHEMOPHILIC AGENTS	MC		ALPHANATE	MC/DEL		ADYNOVATE VIAL	Use PA Form# 20420 1. Only if other products unavailable. 2. Advate may be available with PA in cases of large volume dosing in patients with poor venous access.	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- approved test.
	MC		ALPHANINE SD	MC		ADVATE[1,2,5]		
	MC/DEL		ALPROLIX VIAL	MC		ALTUVIIIO[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		

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
	MC		HUMATE-P SOLR	MC/DEL		HEMGENIX	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	**Hemgenix®** is an adeno-associated viral vector-based gene therapy for IV infusion after dilution. For treatment of adults with Hemophilia B (congenital Factor IX deficiency) who: Currently use Factor IX prophylaxis therapy, or have current or historical life-threatening hemorrhage, or Have repeated, serious spontaneous bleeding episodes. **Altuviiio** is a von Willebrand Factor (VWF) independent recombinant DNA-derived, Factor VIII concentrate indicated for use in adults and children with hemophilia A (congenital factor VIII deficiency) for: Routine prophylaxis to reduce the frequency of bleeding episodes, On-demand treatment and control of bleeding episodes, Perioperative management of bleeding. **Roctavian**: For the treatment of adults with severe hemophilia A (congenital factor VIII deficiency with factor VIII activity <1 IU/dL) without antibodies to adeno-associated virus serotype 5 (AAV5) detected by an FDA-approved test. Inclusion: Severe factor VIII deficiency (less than 1% native factor VIII). Exclusion Criteria: Antibodies to the virus AAV5 Factor VIII inhibitors (or history of) Known significant fibrosis of cirrhosis of the liver, or unexplained elevated LFTs History of inadequate compliance with prophylaxis, or regular bleeds despite adequate prophylaxis Conditions in which high-dose steroids are contraindicated. -Inability to abstain from alcohol for one year Plan to impregnate a partner within 6 months of infusion -Hypersensitivity to mannitol -Active infections, either acute or uncontrolled chronic -HIV infection (limited information on use in this population)
	MC/DEL		IXINITY VIAL	MC/DEL		IDELVION		
	MC/DEL		JIVI[3]	MC/DEL		KOGENATE FS[5]		
	MC		KOATE-DVI	MC		RECOMBINATE VIAL[5]		
	MC		KONYNE - 80	MC		ROCTAVIAN[4]		
	MC/DEL		KOVALTRY	MC		SEVENFACT		
	MC/DEL		REBINYN					
	MC		MONARC - M					
	MC		MONOCLATE - P					
	MC		MONONINE					
	MC/DEL		NOVOEIGHT					
	MC		NOVOSEVEN SOLR					
	MC		NUWIQ					
	MC/DEL		PROFILNINE					
	MC		RECOMBINATE SOLR					
	MC		REFACTO					
	MC/DEL		RIXUBIS VIAL					
	MC		WILATE INJ					
	MC/DEL		XYNTHA					
NON-FACTOR REPLACEMENT THERAPY	MC		HEMLIBRA	MC/DEL		ALHEMO	Use PA Form# 20420	Subsequent changes made to Antihemophilic Agents: Factor Therapy to move Hemlibra to Non-Factor Therapy
				MC/DEL		HYMPAVZI		
						QFITLIA		
						QFITLIA PEN		
PLATELET AGGREGATION INHIBITORS	MC/DEL		ASPIRIN	MC/DEL	7	TICLOPIDINE HCL TABS	Use PA Form# 20715 for Plavix, Effient & Brilinta Use PA form# 20420 for other requests 1. Dosing limits 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. A special PA may be obtained at the pharmacy for members scheduled for "stent" placement or have had placement if in the last 12months. Please indicate on prescription date of stent placement. **Brilinta**- Concomitant use with strong CYP3A4 inhibitors should be avoided (including ketoconazole, itraconazole, atazanavir, and telithromycin). Doses of simvastatin and lovastatin >40mg should be avoided. **DDI:** exists for using maintenance ASA dose >100mg, as it reduces the effectiveness of Brilinta **DDI:** Plavix will require prior authorization if being used in combination with omeprazole, esomeprazole, cimetidine, fluconazole, ketoconazole, intelence, fluoxetine, ticlopidine, and fluvoxamine.
	MC		ASPIRIN-DIPYRIDAMOLE ER CPMP 12HR	MC/DEL	8	BRILINTA 60mg		
	MC/DEL		BRILINTA 90mg	MC	8	DURLAZA		
	MC/DEL		**DIPYRIDAMOLE TABS**	MC	8	EFFIENT		
	MC/DEL		**CLOPIDOGREL 75MG**	MC/DEL	8	PERSANTINE TABS		
	MC/DEL		**PRASUGREL HCL TAB**	MC/DEL	8	PLAVIX TABS		
				MC/DEL	8	**ZONTIVITY**		
PLATELET AGGR. INHIBITORS / COMBO'S - MISC.	MC/DEL		**CILOSTAZOL**	MC/DEL		**AGRYLIN CAPS**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		PENTOXIFYLLINE ER TBCR	MC/DEL		**ANAGRELIDE CAPS**		
				MC/DEL		**PLETAL TABS**		
				MC		TRENTAL TBCR		
				MC		YOSPRALA		
HEMATOLOGICALS								
MONOCLONAL ANTIBODY						BKEMV	Use PA Form# 20420	A diagnosis of Paroxysmal nocturnal hemoglobinuria (PNH) using the HAM test or flow cytometry is required. In addition, the patient must show evidence of having received a meningitis vaccine at least 2 weeks prior to the start of therapy. **Gamifant** is recommended for the treatment of adult and pediatric (newborn and older) patients with primary hemophagocytic lymphohistiocytosis (HLH) with refractory, recurrent, or progressive disease or intolerance with conventional HLH therapy. **Fabhalta** and **Ultomiris** are recommended for the treatment of adults with paroxysmal nocturnal hemoglobinuria (PNH). **Bkemv** and **Epysqli** have updated criteria for a diagnosis of generalized myasthenia gravis (gMG): must have confirmation that patients are anti-acetylcholine receptor (AChR) antibody positive.
				MC		EMPAVELI		
				MC/DEL		ENSPRYNG		
						EPYSQLI		
				MC		FABHALTA		
				MC/DEL		GAMIFANT		
				MC		PIASKY		
				MC		SOLIRIS		
				MC/DEL		ULTOMIRIS		
				MC		UPLIZNA		
				MC		VOYDEYA		

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
IMMUNE GLOBULIN	MC MC/DEL MC MC MC/DEL MC/DEL MC		BIVIGAM[1] CUTAQUIG[1] GAMUNEX-C 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] XEMBIFY	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**			**PROPHYHLAXIS**		
	MC MC MC MC/DEL		CINRYZE[1] HAEGARDA[1] ORLADEYO[1,2] TAKHZYRO[1]				Use PA Form# 20420 **1. Clinical PA is required to establish diagnosis and medical necessity.** 2. For the treatment of patients ≥ 12 years of age.	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		KALBITOR VIAL	Use PA Form# 20420	
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 Mulpelta: For the treatment of thrombocytopenia in adults with chronic liver disease who are scheduled to undergo a procedure.
HEMATOLOGICAL AGENTS-IgAN				MC/DEL MC		FILSPARI[1] TARPEYO VANRAFIA	Use PA Form# 20420 1. PA required to confirm FDA approved indication.	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
ANEMIA- BETA THALASSEMIA				MC MC		REBLOZYL ZYNTEGLO	Use PA Form# 20420	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. 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		**CABLIVI** TAVALISSE	Use PA Form# 20420	**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.
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.

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
HEMOSTATIC								
HEMOSTATIC	MC/DEL MC		AMICAR AMINOCAPROIC ACID	MC MC		FIBRYGA RIASTAP	Use PA Form# 20420	**Fibryga** and **Riastap** are indicated for the treatment of acute bleeding episodes in adults and adolescents with congenital fibrinogen deficiency, including afibrinogenemia and hypofibrinogenemia. Fibryga® is not indicated for dysfibrinogenemia.
ACUTE HEPATIC PORPHYRIA (AHP)								
ACUTE HEPATIC PORPHYRIA (AHP)				MC		GIVLAARI	Use PA Form# 20420	**Givlaari** is indicated for the treatment of adults with acute hepatic porphyria (AHP).
PYRUVATE KINASE DEFICIENCY AGENTS								
PYRUVATE KINASE DEFICIENCY AGENTS				MC		PYRUKYND[1]	Use PA Form# 20420 1.PA required to confirm FDA approved indication.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s)
OP. - ANTIBIOTICS	MC MC MC/DEL MC MC/DEL MC MC 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 MC/DEL MC/DEL MC MC MC/DEL MC/DEL MC/DEL MC 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/BACI/POLYM 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		XDEMVY[1]	Use PA Form# 20420 1. For the treatment of Demodex blepharitis.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
OP. - RHO KINASE INHIBITORS	MC		RHOPRESSA				Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s)
OP. - QUINOLONES	MC/DEL MC/DEL MC/DEL MC/DEL		CILOXAN OINT CIPROFLOXACIN SOL 0.3% OFLOXACIN QUIXIN SOLN	MC/DEL MC/DEL MC		BESIVANCE CILOXAN SOLN OCUFLOX 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. -QUINOLONES-4TH GENERATION	MC/DEL		**MOXIFLOXACIN 0.5% SOLN (Generic Vigamox)**	MC		ZYMAXID	Use PA Form# 20420	

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
OP. - ARTIFICIAL TEARS AND LUBRICANTS	MC/DEL		ARTIFICIAL TEARS OINT	MC/DEL		ARTIFICIAL TEARS SOLN OP	Use PA Form# 20420 1. Dosing limits 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.
	MC/DEL		ARTIFICIAL TEARS SOLN	MC		BION TEARS SOLN		
	MC		CELLUVISC SOLN	MC		DRY EYES OINT		
	MC		EYE LUBRICANT OINT	MC		DURATEARS OINT		
	MC/DEL		GENTEAL	MC/DEL		HYPO TEARS		
	MC		LIQUITEARS SOLN	MC/DEL		ISOPTO TEARS SOLN		
	MC		MAJOR TEARS SOLN	MC		LACRI-LUBE		
	MC		PURALUBE OINT	MC		LUBRIFRESH P.M. OINT		
	MC		PURALUBE TEARS SOLN	MC		MURINE SOLN		
	MC		REFRESH SOLN OP	MC/DEL		MUROCEL SOLN		
	MC		REFRESH PLUS SOLN[1]	MC/DEL		NATURE'S TEARS SOLN		
	MC		REFRESH PM OINT	MC		REFRESH SOLN		
				MC		REFRESH TEARS SOLN[1]		
				MC		TEARGEN SOLN		
				MC		TEARISOL SOLN		
				MC/DEL		TEARS NATURALE		
				MC/DEL		TEARS PURE SOLN		
				MC		TEARS RENEWED OINT		
				MC/DEL		THERATEARS SOLN		
				MC		V-R ARTIFICIAL TEARS SOLN		
OP. - BETA - BLOCKERS	MC/DEL		**BETOPTIC-S SUSP**	MC		BETAGAN SOLN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**CARTEOLOL HCL SOLN**	MC/DEL		**BETAXOLOL HCL SOLN**		
	MC/DEL		**LEVOBUNOLOL HCL SOLN**	MC		ISTALOL		
	MC/DEL		METIPRANOLOL SOLN	MC/DEL		**OCUPRESS SOLN**		
				MC		OPTIPRANOLOL SOLN		
				MC/DEL		**TIMOPTIC SOLN**		
				MC		TIMOLOL DROP		
				MC/DEL		**TIMOLOL SOL-GEL**		
				MC/DEL		**TIMOPTIC-XE SOLG**		
OP. - ANTI-INFLAMMATORY / STEROIDS OPHTH.	MC		AK-SPORE HC OINT	MC		AK-TROL SUSP	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		ALREX SUSP	MC		BAC/POLY/NEOMY/HC OINT		
	MC/DEL		DEXAMETH SOD PHOS SOLN	MC		BLEPHAMIDE S.O.P. OINT		
	MC/DEL		FLUOROMETHOLONE SUSP	MC		BLEPHAMIDE SUSP		
	MC		FML DROPS SUSP 1%	MC		BROMDAY		
	MC		FML FORTE SUSP	MC		EFLONE SUSP		
	MC		FML S.O.P. OINT	MC/DEL		FLAREX SUSP		
	MC/DEL		**LOTEMAX OINT**	MC		FLUOR-OP SUSP		
	MC/DEL		**LOTEMAX GEL**	MC/DEL		**ILUVIEN IMPLANT**		
	MC/DEL		LOTEMAX SUSP	MC/DEL		**INVELTYS**		
	MC/DEL		NEO/POLY/DEXAMETH OINT	MC/DEL		**LOTEMAX SM DROPS GEL 0.38%**		
	MC		NEO/POLY/DEXAMETH SUSP	MC		MAXITROL OPTH OINT 0.1%		
	MC		PRED-G SUSP	MC		NEO/POLY/BAC/HC OINT		
	MC		PRED FORTE SUSP 1%	MC/DEL		NEOM/POLY/DEX OPTH OINT 0.1%		
	MC		PRED MILD SUSP	MC/DEL		**OMNIPRED DROPS SUSP**		
	MC/DEL		PREDNISOLONE	MC/DEL		OZURDEX		
	MC/DEL		TOBRADEX OINT	MC		PRED-G S.O.P. OINT		
	MC/DEL		TOBREX OINT	MC/DEL		PREDNISOLONE SODIUM PHOSHATE SOL		
	MC		SULFACETAMIDE/PREDNISOLONE	MC/DEL		**RETISERT IMPLANT**		
	MC/DEL		ZYLET SUSP	MC/DEL		SULFACET SOD/PRED SOLN		
				MC/DEL		**TRIESENCE VIAL**		
				MC/DEL		TOBRADEX ST		
				MC/DEL		TOBRAMYCIN SUSP DEXAMETHASONE		
				MC		VASOCIDIN SOLN		
				MC/DEL		VEXOL SUSP		
				MC		XIPERE		

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
OP. - PROSTAGLANDINS	MC/DEL		**LATANOPROST SOL 0.005%**	MC/DEL	7	**ZIOPTAN**	Use PA Form# 20420 1. All preferred must be tried. 2. Dosing limits apply, please see dosing consolidation list. 3. Clinical PA is required to establish diagnosis and medical necessity.	Preferred drugs must be tried and failed, in step-order, due to lack of efficacy (failure to reach target IOP reduction) or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		LUMIGAN SOLN	MC/DEL	8	**BIMATOPROST 0.03% DROPS**		
	MC/DEL		ROCKLATAN	MC	8	DURYSTA		
	MC/DEL		**TRAVATAN-Z**	MC	8	IYUZEH		
				MC	8	RESCULA[1,2,3]		
				MC/DEL	8	**TRAVATAN SOLN**		
				MC/DEL	8	**TRAVOPROST**		
				MC/DEL	8	**VYZULTA**		
				MC/DEL	8	XALATAN SOLN[1]		
				MC/DEL	8	**XELPROS**		
OP. - CYCLOPLEGICS	MC		AK-PENTOLATE SOLN	MC/DEL		CYCLOGYL SOLN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		ATROPINE SULFATE	MC		ISOPTO ATROPINE SOLN		
	MC/DEL		CYCLOPENTOLATE HCL SOLN	MC/DEL		ISOPTO HOMATROPINE SOLN		
	MC/DEL		ISOPTO HYOSCINE SOLN	MC		MUROCOLL-2 SOLN		
OP. - MIOTICS - DIRECT ACTING	MC/DEL		**ISOPTO CARBACHOL SOLN**				Use PA Form# 20420	
	MC		ISOPTO CARPINE SOLN					
	MC		PILOCAR SOLN					
	MC/DEL		**PILOCARPINE HCL SOLN**					
	MC/DEL		**PILOPINE HS GEL**					
OP. - SELECTIVE ALPHA ADRENERGIC AGONISTS	MC		ALPHAGAN SOLN	MC/DEL		**BRIMONIDINE TARTRATE DROPS 0.15 %**	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		ALPHAGAN P 0.1% SOLN	MC/DEL		**IOPIDINE SOLN**		
	MC		ALPHAGAN P 0.15% SOLN					
	MC/DEL		BRIMONIDINE DROPS 0.2 %					
	MC/DEL		SIMBRINZA					
OP. - ANTI-ALLERGICS	MC/DEL		AZELASTINE HCL DROPS	MC	8	ALOCRIL SOLN	Use PA Form# 20420	All preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		BEPREVE	MC/DEL	8	ALOMIDE SOLN		
	MC/DEL		CROMOLYN SODIUM DROPS	MC/DEL	8	EMADINE SOLN		
	MC/DEL		**KETOTIFEN FUMARATE DROPS**	MC	8	OPTICROM SOLN		
	MC		LASTACAFT	MC/DEL	8	PATANOL SOLN		
	MC/DEL		**OLOPATADINE HCL 0.1%**	MC	8	ZERVIATE		
	MC/DEL		**OLOPATADINE HCL 0.2%**	MC/DEL	9	EPINASTINE		
	MC/DEL		ZADITOR SOLN					
OP. ANTI-ALLERGICS- MASTCELL STABILIZER CLASS				MC/DEL		ALAMAST SOLN	Use PA Form# 20420	
OP. - CARBONIC ANHYDRASE INHIBITORS/COMBO	MC/DEL		**AZOPT SUSP**	MC/DEL		**COSOPT SOLN PF**	Use PA Form# 20420	
	MC		COMBIGAN					
	MC/DEL		DORZOLAMIDE					
	MC/DEL		DORZOLAMIDE/TIMOLOL					
OP. - NSAID'S	MC		ACULAR SOLN[1]	MC	8	ACULAR LS[1]	Use PA Form# 20420 1. Must fail all preferred products before non-preferred.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		**DUREZOL**	MC	8	BROMSITE[1]		
	MC/DEL		KETOROLAC OPTH 0.4%	MC/DEL	8	DEXAMETHASONE DROPS		
	MC/DEL		KETOROLAC OPTH 0.5%	MC/DEL	8	DICLOFENAC OPTH 0.1%		
	MC/DEL		**MAXIDEX SUSP**	MC	8	FLURBIPROFEN SODIUM SOLN		
	MC/DEL		NEVANAC	MC/DEL	8	ILEVRO		
	MC/DEL		PREDNISOLONE DROPS	MC/DEL	8	**LOTEMAX SM DROPS GEL 0.38%**		
				MC/DEL	8	PROLENSA		
				MC	8	OCUFEN SOLN[1]		
				MC	8	XIBROM[1]		
				MC	8	VOLTAREN SOLN[1]		
				MC	8	ACUVAIL[1]		
				MC/DEL	9	BROMFENAC		

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
OP. - OF INTEREST	MC/DEL		CYCLOSPORINE OPTH 0.05%	MC		BYOOVIZ	Use PA Form# 20420 1. PA required to confirm appropriate diagnosis and clinical parameters for use. 2. For the short-term (up to two weeks) treatment of the signs and symptoms of dry eye disease.	Must fail adequate trials of multi agents from artificial tears and lubricant category. **Beovu** is non-preferred and indicated for the treatment of Neovascular (wet) Age-Related Macular Degeneration (AMD) **Eylea** is non-preferred and indicated for the treatment of: Neovascular (wet) Age-Related Macular Degeneration (AMD), Macular Edema following Retinal Vein Occlusion (RVO), Diabetic Macular Edema (DME), Diabetic Retinopathy (DR) **Luxturna** will be considered for the treatment of patients with confirmed biallelic RPE65 mutation-associated retinal dystrophy. Patients must have viable retinal cells as determined by the treating physician(s). **Miebo** is non-preferred and is indicated for the treatment of the signs and symptoms of dry eye disease (DED). **Oxervate** is non-preferred and is indicated for the treatment of neurotrophic keratitis. **Pavblu**: Clinical rationale for why Eylea cannot be used **Syfovre** is non-preferred and is indicated for the treatment of geographic atrophy (GA) secondary to age-related macular degeneration (AMD). **Vevye** - Must fail adequate trials of multi agents from artificial tears and lubricant category and a preferred cyclosporine alternative.
	MC		EYSUVIS[2]	MC		BEOVU		
	MC		LUCENTIS	MC		BOTOX SOLR		
	MC		RESTASIS DROPPERETTE	MC/DEL		CEQUA		
	MC		XIIDRA	MC		CIMERLI		
				MC		CYCLOSPORINE DROPERETTE		
				MC		CYSTADROPS[1]		
				MC		CYSTARAN[1]		
				MC		EYLEA		
				MC		EYLEA HD[1]		
				MC		IZERVAY[1]		
				MC		LUCENTIS		
				MC		LUXTURNA		
				MC/DEL		MIEBO		
				MC/DEL		OXERVATE		
				MC		PAVBLU		
				MC/DEL		RESTASIS MULTIDOSE DROPS		
				MC		SUSVIMO		
				MC		SYFOVRE		
				MC		TYRVAYA		
				MC		VABYSMO		
				MC		VERKAZIA		
				MC		VEVYE		
DERMATOLOGICAL								
ISOTRETINION, ACNE	MC		AMNESTEEM[1]	MC		ABSORICA	Use PA Form# 20420 1. Users 24 or under, PA will not be required.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		CLARAVIS[1]	MC		ABSORICA LD		
	MC		MYORISAN[1]					
	MC		ZENATANE[1]					
TOPICAL - ACNE PREPARATIONS	MC		ERYDERM SOLN	MC/DEL		ADAPALENE 0.3% GEL	Use PA Form# 10220 for Brand Name requests Use PA Form# 20420 for all other requests 1. Users 24 or under, PA will not be required. 2. Dosing limits allowing one package per month. Please refer to Dose Consolidation List. 3. Only available if component ingredients are unavailable. 4. Dosing limits apply, please see dosing consolidation list. 5. Not approved for use in children <12 years of age 6. For the treatment of patients ≥ 9 years of age.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		ERYTHROMYCIN GEL	MC/DEL		AKLIEF[6]		
	MC/DEL		ERYTHROMYCIN SOLN	MC		ALTINAC CREA		
	MC/DEL		EVOCLIN	MC/DEL		ALTRENO		
	MC		ISOTRETINOIN	MC		AMZEEQ[6]		
	MC		METRONIDAZOLE CREA[2]	MC		ARAZLO LOTION[6]		
	MC		METRONIDAZOLE GEL[2]	MC		AVITA CREA		
	MC		METRONIDAZOLE LOTN[2]	MC		BENZAC		
	MC/DEL		TRETINOIN .025%, .05%, .01% GEL[1]	MC/DEL		BENZACLIN GEL[3]		
	MC		TRETINOIN CREA[1,2]	MC/DEL		BENZAGEL-10 GEL		
				MC/DEL		BENZAMYCIN GEL		
				MC/DEL		BENZAMYCINPAK PACK		
				MC		BENZEFOAM		
				MC		BENZOYL PEROXIDE		
				MC		BREVOXYL		
				MC		CABTREO GEL[5]		
				MC/DEL		CLEOCIN-T[2]		
				MC		CLINAC BPO GEL		
				MC		CLINDAGEL GEL		
				MC/DEL		CLINDAMYCIN PHOSPHATE CREAM[2]		
				MC		CLINDETS SWAB		
				MC		DESQUAM-E GEL		
				MC		DESQUAM-X		
				MC		DIFFERIN 0.3% GEL		
				MC		DIFFERIN		
				MC		EMGEL GEL		

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
				MC		EPIDUO		
				MC		EPSOLAY		
				MC		ERYCETTE PADS		
				MC		FINEVIN CREA		
				MC/DEL		KLARON LOTN		
				MC		METROCREAM CREA[2]		
				MC		METROGEL GEL[2]		
				MC		METROLOTION LOTN[2]		
				MC		NEOBENZ MICRO		
				MC/DEL		NORITATE CREA		
				MC		ONEXTON[5]		
				MC/DEL		PLIXDA		
				MC		RETIN-A GEL[2]		
				MC		RETIN-A CREA[2]		
				MC		RETIN-A MICRO GEL		
				MC		RHOFADE		
				MC/DEL		SODIUM SULFACET/SULF LOTN		
				MC		SOOLANTRA[4]		
				MC/DEL		TRIAZ		
				MC		TWYNEO		
				MC		VELTIN		
				MC		WINLEVI[5]		
				MC		ZENCIA WASH		
				MC		ZETACET		
				MC/DEL		ZIANA		
				MC		ZILXI		
TOPICAL- ATOPIC DERMATITIS	MC/DEL	1	ELIDEL CREA	MC/DEL		CIBINQO	Use PA Form# 20420 1. Avoid live vaccines if treated with Dupixent 2. Clinical PA required. 3. For the treatment of patients ≥ 12 years of age. 4. Preferred after a trial and failure of TCI.	Preferred drugs also indicated for this condition, including topical steroids, cyclosporin AND calcineurin inhibitors must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Note: If unable to use TCIs then a trial of Eucrisa could be recommended before Dupixent.
	MC/DEL	1	PIMECROLIMUS CRE (AUTH GENERIC LABELER 68682 Oceanside Pharmaceuticals)	MC		EBGLYSS[2,3]		
				MC		NEMLUVIO		
	MC/DEL	1	PROTOPIC OINT					
	MC/DEL	1	TACROLIMUS OINT					
	MC	2	ADBRY[2,4]					
	MC/DEL	2	DUPIXENT[1,2,4]					
	MC	2	EUCRISA[2,4]					
	MC	2	OPZELURA[2,3,4]					
TOPICAL - ANTIBIOTIC	MC		BACIT/NEOMYCIN/POLYM OINT	MC/DEL		CENTANY OINT 2%[1]	Use PA Form# 20420 1. Dosing limits apply, please see dosing consolidation list.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		BACITRACIN OINT	MC/DEL		MUPIROCIN CREA[1]		
	MC/DEL		GENTAMICIN SULFATE	MC/DEL		TRIPLE ANTIBIOTIC OINT		
	MC/DEL		MUPIROCIN OINT[1]	MC		XEPI		
TOPICAL - ANTIFUNGALS	MC/DEL		BETAMETHASONE CLOTRIMAZOLE CREA	MC/DEL	8	CICLOPIROX SOLN	Use PA Form# 10120 1. Diagnosis required	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Kerydin**- Verify prior trials and failures or intolerance of preferred treatments, including both topical and oral agents **DDI:** Ketoconazole will now be non-preferred and require prior authorization if they are currently being used in combination with any of the following medications: Prevacid, pantoprazole, Onglyza or Omeprazole.
	MC/DEL		BETAMETHASONE CLOTRIMAZOLE LOT	MC	8	EXELDERM		
	MC		CICLOPIROX 0.77 CREA	MC	8	FUNGIZONE CREA		
	MC		CICLOPIROX 0.77 SUSP	MC/DEL	8	HYDROCORT/IODOQ CREA		
	MC/DEL		CLOTRIMAZOLE	MC	8	JUBLIA		
	MC		ECONAZOLE NITRATE CREA	MC	8	KERYDIN[1]		
	MC/DEL		KETOCONAZOLE CREA	MC/DEL	8	LOPROX 0.77 LOTN		
	MC/DEL		KETOCONAZOLE SHAM	MC/DEL	8	LOPROX 0.77 CREA		
	MC/DEL		LOPROX 1.0 CREA	MC/DEL	8	LOPROX 0.77 SUSP		
	MC/DEL		LOPROX 1.O LOTN	MC/DEL	8	LOPROX SHAMPOO SHAM		
	MC/DEL		LOPROX GEL	MC	8	LOTRIMIN		
	MC/DEL		LOPROX TS LOTN	MC/DEL	8	LOTRISONE LOT		
	MC/DEL		MICONAZOLE NITRATE CREA	MC/DEL	8	LOTRISONE CREA		

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
	MC		MYCO-TRIACET II CREA	MC	8	LUZU		
	MC/DEL		NYSTATIN	MC/DEL	8	MENTAX CREA		
	MC/DEL		NYSTATIN/TRIAMCINOLONE CREA	MC	8	MYCOGEN II CREA		
	MC/DEL		NYSTOP POWD	MC	8	NAFTIN		
	MC		TRI-STATIN II CREA	MC	8	NIZORAL SHAM		
				MC/DEL	8	NYSTATIN/TRIAMCINOLONE OINT		
				MC	8	NYSTAT-RX POWD		
				MC/DEL	8	OXISTAT		
				MC/DEL	9	PENLAC NAIL LACQUER SOLN		
TOPICAL - ANTIPRURITICS	MC		ZONALON CREA	MC		KORSUVA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC		PRUDOXIN CREA		
TOPICAL - ANTIPSORIATICS	MC/DEL		CALCIP/BETAMETHASONE SUS	MC/DEL	7	TACLONEX[1]	Use PA Form# 20420 1. Must fail all preferred products before non-preferred.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC/DEL	8	DUOBRII		
				MC	8	ENSTILAR		
				MC	8	OXSORALEN ULTRA CAPS[1]		
				MC	8	PSORIATEC CREA[1]		
				MC/DEL	8	SORIATANE CK KIT[1]		
				MC	8	VECTICAL[1]		
				MC	8	VTAMA		
				MC	8	ZORYVE		
TOPICAL - ANTISEBORRHEICS	MC/DEL		SELENIUM SULFIDE SHAM	MC		CARMOL SCALP TREATMENT KIT	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Zoryve Foam**: For the treatment of seborrheic dermatitis in adult and pediatric patients 9 years of age and older.
				MC		ZNP BAR		
				MC		ZORYVE FOAM		
TOPICAL - ANTIVIRALS				MC/DEL		**ACYCLOVIR OINT**	Use PA Form# 20420 1. Must fail oral treatment with Acyclovir or Valacyclovir. 2. Approvals limited to 1 tube per 180 days. 3. Dosing limits apply, please see dosing consolidation list. 4. For the topical treatment of molluscum contagiosum in adult and pediatric patients 2 years of age and older.	
				MC/DEL		DENAVIR CREA[1,3]		
				MC		YCANTH		
				MC		ZOVIRAX OINT[1,2]		
TOPICAL - ANTINEOPLASTICS	MC		EFUDEX	MC/DEL		CARAC CREA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC/DEL		FLUOROURACIL		
				MC		SOLARAZE GEL		
				MC/DEL		ZYCLARA		
TOPICAL - BURN PRODUCTS	MC		FURACIN CREA	MC/DEL		SILVADENE CREA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		SILVER SULFADIAZINE CREA					
	MC		SSD AF CREA					
	MC		SSD CREA					
	MC/DEL		THERMAZENE CREA					
TOPICAL - CORTICOSTEROIDS			**LOW POTENCY**			**LOW POTENCY**	Use PA Form# 20420 1. Dosing limits apply, please see dosing consolidation list.	At least 1 drug from each potency of preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		DERMA-SMOOTHE- FS BODY	MC/DEL		ACLOVATE		
	MC/DEL		HYDROCORTISONE CREA	MC		ANUSOL HC-1 OINT		
	MC		HYDROCORTISONE LOTN	MC		DESONATE GEL		

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
	MC		HYDROCORTISONE LOTN	MC/DEL		**FLUOCINOLONE ACETONIDE**	2. Treatment beyond 4 weeks is not recommended.	
	MC		TEXACORT SOLN	MC/DEL		**FLUOCINOLONE**		
				MC		HALOG	3. For the treatment of patients ≥ 12 years of age.	
				MC		HYDROCORTISONE POWD		
			MEDIUM POTENCY	MC		LIDA MANTLE HC CREA	4. For the treatment of patients ≥ 18 years of age.	
	MC/DEL		DESOXIMETASONE 0.05% CREA/GEL	MC		PROCTOCORT CREA		
	MC		FLUTICASONE PROPIONATE CREA/OINT	MC/DEL		VERDESO		
	MC		HYDROCORTISONE BUTYRATE					
	MC		HYDROCORTISONE OINT			**MEDIUM POTENCY**		
	MC		HYDROCORTISONE VALERATE					
	MC		MOMETASONE FUROATE OINT	MC/DEL		**BESER LOTION**[3]		
	MC		TRIAMCINOLONE ACETONIDE .025-.1%	MC		CLODERM CREA		
				MC/DEL		CORDRAN		
				MC/DEL		CUTIVATE CREA / OINT		
			HIGH POTENCY	MC/DEL		CUTIVATE LOTN		
	MC/DEL		DESONIDE[1]	MC/DEL		DERMATOP		
	MC		TRIAMCINOLONE ACETONIDE .5%	MC		ELOCON OINT		
				MC		KENALOG AERS		
				MC/DEL		LOCOID		
			VERY HIGH POTENCY	MC/DEL		LUXIQ FOAM		
	MC/DEL		AUGMENTED BETA DIP	MC		PANDEL CREA		
	MC/DEL		BETAMETHASONE VALERATE	MC		TOPICORT		
	MC		DIFLORASONE DIACETATE	MC		TOPICORT LP CREA		
	MC		HALOBETASOL	MC/DEL		TOVET FOAM[3]		
				MC		WESTCORT		
			MISCELLANEOUS					
	MC		PROCTO-KIT CREA 1%			**HIGH POTENCY**		
				MC		AMCINONIDE CREA		
				MC		BETAMETHASONE DIPROPIONATE		
				MC/DEL		**DESOXIMETASONE 0.25% CREA/OINT**		
						VERY HIGH POTENCY		
				MC/DEL		BRYHALI LOTN		
				MC/DEL		**CLOBETASOL PROPINATE LOTN**		
				MC/DEL		CLOBETASOL PROPINATE SHAMPOO 0.05%		
				MC/DEL		CORMAX		
				MC/DEL		DIPROLENE		
				MC/DEL		IMPEKLO[4]		
				MC/DEL		LEXETTE		
				MC/DEL		OLUX FOAM		
				MC/DEL		PSORCON		
				MC/DEL		PSORCON E		
				MC		SERNIVO SPRAY[2]		
				MC/DEL		TEMOVATE		
				MC		ULTRAVATE		
TOPICAL - STEROID LOCAL ANESTHETICS				MC		EPIFOAM FOAM	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
TOPICAL - STEROID COMBINATIONS	MC		DERMA-SMOOTHE-FS SCALP	MC		CARMOL-HC CREA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
TOPICAL - EMOLLIENTS	MC/DEL		AMMONIUM LACTATE CREA[1]	MC		LAC-HYDRIN CREA[1]	Use PA Form# 20420 1. 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.
	MC		AMMONIUM LACTATE LOTN 12%[1]	MC		LAC-HYDRIN LOTN 12%		
	MC		VITAMIN A & D MEDICATED OINT	MC		MEDERMA GEL		
				MC		MIMYX		
				MC		RENOVA CREA		
TOPICAL - ENZYMES / KERATOLYTICS / UREA				MC		CARMOL 40 CREA	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Ziox, Panafil and Papain** products have been removed from the PDL due to FDA safety concerns regarding drugs containing Papain.
				MC		SALEX CREA		
				MC		SALEX LOTN		
TOPICAL - GENITAL WARTS	MC/DEL		IMIQUIMOD 5%[2]	MC/DEL	5	PODOFILOX SOLN	Use PA Form# 20420 1. Non-preferred products must be used in specified order. 2. Dosing limits still apply. Please see dose consolidation list.	
				MC/DEL	8	CONDYLOX[1]		
				MC/DEL	8	ALDARA[1]		
				MC	8	PICATO		
				MC	8	VEREGEN[1]		
				MC	8	ZYCLARA[1]		
TOPICAL - LOCAL ANESTHETICS	MC		AF CAPSICUM OLEORESIN CREA	MC/DEL		EMLA PADS	Use PA Form# 20420 1. Lidocaine/Prilocaine cream and Ela-Max products require PA for users over 18 years of age. 2. 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.
	MC/DEL		CAPSAICIN CREA	MC/DEL		EMLA CREA		
	MC/DEL		CAPSAICIN PATCH	MC		LIDA MANTLE CREA		
	MC/DEL		**DIBUCAINE OINT**	MC		PONTOCAINE SOLN		
	MC		ELA-MAX[1]	MC		SYNERA		
	MC/DEL		LIDOCAINE/PRILOCAINE CREA[1]	MC		ZOSTRIX		
	MC/DEL		LIDOCAINE CREAM	MC/DEL		ZTLIDO[2]		
	MC/DEL		LIDOCAINE GEL					
	MC/DEL		**LIDOCAINE PTCH 5%**					
TOPICAL - DEPIGMENTING AGENTS				MC	8	ALUSTRA CREA	Use PA Form# 20420	As per Medicaid Policy, cosmetic drugs are not covered. Non-cosmetic clinical applications will be considered by prior authorization on a case by case basis.
				MC	8	EPIQUIN MICRO		
				MC	8	GLYQUIN CREA		
				MC/DEL	8	HYDROQUINONE CREA		
				MC/DEL	8	HYDROQUINONE/SUNSCREENS		
				MC	8	SOLAQUIN FORTE CREA		
				MC	8	TRI-LUMA CREA		
				MC	9	ELDOQUIN		
TOPICAL - SCABICIDES AND PEDICULICIDES	MC/DEL		ACTICIN CREA	MC		ELIMITE CREA	Use PA Form# 20420 1. Dosing limits apply, please refer to dosage consolidation list.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		LICE KILLING SHAM	MC		EURAX		
	MC/DEL		LICE TREATMENT CREME RINS LIQD	MC/DEL		LINDANE		
	MC/DEL		PERMETHRIN LOTN	MC		MALATHION		
	MC		NATROBA[1]	MC		OVIDE LOTN		
				MC/DEL		**SPINOSAD SUSP**		
TOPICAL - WOUND / DECUBITUS CARE				MC		FILSUVEZ	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. Regranex will be approved for diabetic patients in good control (hgba1c <8), who are not smoking, with a stage III or IV WOCN AND NPUAP lower extremity diabetic ulcer and with an adequate blood supply (Tcp 02 >30, ABI>0.7 or ASP> 70), and where the underlying cause has been corrected. The wound must be free of infection and have been previously treated with preferred standard therapies for at least 2 months. Maximum approval for 20 weeks. **Accuzyme and Ethezyme** products have been removed from the PDL due to FDA concerns regarding drugs containing Papain. **Filsuvez**: The patient has a diagnosis of dystrophic or junctional epidermolysis bullosa. The patient is at least 6 months old and does not have current evidence or history of squamous cell carcinoma or active infection in the area requiring Filsuvez application. The patient has used standard wound care treatments, including silicone or foam dressings without wound resolution **Vyjuvek**: For the treatment of wounds in patients 6 months of age and older with dystrophic epidermolysis bullosa (DEB) with mutation(s) in the collagen type VII alpha 1 chain (COL7A1) gene.
				MC		REGRANEX GEL		
				MC		VYJUVEK		

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
TOPICAL - ASTRINGENTS / PROTECTANTS	MC		XERAC AC SOLN	MC		LOWILA BAR	Use PA Form# 20420 1. Dosing limits apply, please refer to dosage consolidation list.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC		MOISTURIN DRY SKIN CREA		
				MC		PROSHIELD PLUS SKIN PROTE CREA		
				MC		SURGILUBE GEL		
TOPICAL - ANTISEPTICS / DISINFECTANTS	MC/DEL		POVIDONE-IODINE SOLN	MC		BETADINE OINT	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC		FORMALYDE-10 AERS		
				MC		IODOSORB		
				MC		LAZERFORMALYDE SOLUTION SOLN		
MISCELLANEOUS EYE								
OP. - EYE	MC		AK-DILATE SOLN	MC		LENS PLUS REWETTING DROPS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		EYE WASH SOLN	MC/DEL		MURO 128		
	MC		NAPHAZOLINE HCL SOLN	MC		NEO-SYNEPHRINE SOLN		
	MC		PHENYLEPHRINE HCL SOLN					
	MC		PONTOCAINE SOLN					
	MC/DEL		SODIUM CHLORIDE					
MISCELLANEOUS EAR								
EAR	MC/DEL		A/B OTIC SOLN	MC		ANTIBIOTIC EAR SOLN	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC		ACETASOL SOLN	MC		ANTIBIOTIC EAR SUSP		
	MC/DEL		ACETASOL HC SOLN	MC/DEL		CIPRODEX		
	MC/DEL		ACETIC ACID	MC/DEL		**CIPROFLOXACIN HCL**		
	MC/DEL		ACETIC ACID/HYDROCORTISON	MC/DEL		DEBROX SOLN		
	MC/DEL		ALLERGEN SOLN	MC		DERMOTIC		
	MC		CARBAMIDE PEROXIDE 6.5% OTIC SOLN.	MC		FLOXIN		
	MC/DEL		CIPRO HC SUSP	MC		OTIPRIO		
	MC/DEL		CORTISPORIN-TC SUSP	MC		OTOVEL		
	MC/DEL		CORTOMYCIN					
	MC		COLY-MYCIN-S SUSP					
	MC		EAR DROPS SOLN					
	MC		EAR DROPS RX SOLN					
	MC/DEL		EAR WAX REMOVAL DROPS					
	MC		FLUOCINOLONE ACETONIDE OIL DROPS 0.01%					
	MC/DEL		NEOMYCIN/POLYMYXIN/HC					
	MC/DEL		OFLOXACIN 0.3% OTIC					
MOUTH ANTISEPTICS								
MOUTH ANTI-INFECTIVES	MC		NILSTAT SUSP	MC		MYCELEX TROC	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		NYSTATIN SUSP	MC		ORAVIG		
MOUTH ANTISEPTICS	MC/DEL		CHLORHEXIDINE GLUCONATE	MC		APHTHASOL PSTE[1]	Use PA Form# 20420 1. Must fail all preferred products before non-preferred.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		LIDOCAINE VISCOUS SOLN	MC		PERIOGARD SOLN[1]		
	MC		TRIAMCINOLONE IN ORABASE PSTE	MC		TRIAMCINOLONE ACETONIDE PSTE[1]		
	MC		TRIAMCINOLONE ORADENT PSTE					
DENTAL PRODUCTS								
DENTAL PRODUCTS	MC/DEL		ETHEDENT CREA	MC0MC		APF GEL	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
	MC/DEL		GEL-KAM CONC	MC/DEL		DENTAGEL GEL		
	MC/DEL		GEL-KAM GEL 0.4%	MC/DEL		PHOS-FLUR GEL		
	MC/DEL		PHOS FLUR SOLN	MC		THERA-FLUR-N GEL		
	MC/DEL		SF 5000 PLUS CREA					
	MC/DEL		SF GEL					
	MC		STANNOUS FLUORIDE ORAL RI CONC					
ARTIFICIAL SALIVA/STIMULANTS								
ARTIFICIAL SALIVA/STIMULANTS	MC		SALIVA SUBSTITUTE SOLN	MC		EVOXAC CAPS	Use PA Form# 20420	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists.
				MC		RADIACARE SOLR		
				MC		SALAGEN TABS		

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
MISCELLANEOUS ANORECTAL								
ANORECTAL - MISC.	MC		CORTENEMA ENEM	MC/DEL		ANUSOL-HC CREA	Use PA Form# 20420	
	MC		ELA-MAX 5 CREA	MC/DEL		CORTIFOAM FOAM		
	MC/DEL		HYDROCORTISONE ENEM	MC/DEL		PROCTOFOAM HC FOAM		
	MC/DEL		PROCTOSOL HC CREA	MC/DEL		PROCTO-KIT CREA 2.5%		
	MC/DEL		PROCTOZONE-HC CREA	MC		RECTIV OINT		
T-CELL ACTIVATION INHIBITOR								
PSORIASIS BIOLOGICALS			ADALIMUMAB-FKJP	MC		AMJEVITA	Use PA Form# 20910 1. Dosing limits apply, please refer to 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.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved, unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of 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). It is recommended to assess for TB infection prior to starting treatment with **Taltz®**. **Stelara** will require using preferred trial of **Skyrizi** if unable please provide clinical rational as why inappropriate.
	MC		ENBREL[1,5]	MC/DEL		BIMZELX[3]		
	MC		ENBREL SURECLICK[1]	MC		**COSENTYX[4]**		
	MC		HUMIRA[1,5]	MC/DEL		CYLTEZO		
	MC		OTEZLA	MC		HADLIMA		
			SIMLANDI	MC/DEL		HULIO		
	MC/DEL		SKYRIZI[6]	MC/DEL		HYRIMOZ		
	MC		TALTZ[2]	MC		IDACIO		
				MC/DEL		ILUMYA[3]		
						OTULFI		
						PYZCHIVA		
						SELARSDI		
				MC		SILIQ		
				MC		SOTYKTU		
				MC/DEL		SPEVIGO		
				MC		STELARA		
						STEQEYMA		
				MC		TREMFYA		
						YESINTEK		
				MC		YUFLYMA		
				MC		YUSIMRY		
ALTERNATIVE MEDICINES								
ALTERNATIVE MEDICINES	MC		DIMETHYL SULFOXIDE SOLN	MC/DEL		CO-ENZYME Q-10	Use PA Form# 20420	Will only be approved for specific conditions supported by at least two double-blinded, placebo-controlled randomized trials that are not contradicted by other studies of similar quality.
	MC		MELATONIN					
CHELATING AGENTS								
CHELATING AGENTS	MC/DEL		**CUPRIMINE CAPS**	MC		CLOVIQUE	Use PA Form# 20420 1. FDA indication of treatment of chronic iron overload due to blood transfusions in members 2 years of age and older is required for approval of Exjade.	Preferred drugs must be tried and failed due to lack of efficacy or intolerable side effects before non-preferred drugs will be approved (in step order), unless an acceptable clinical exception is offered on the Prior Authorization form, such as the presence of a condition that prevents usage of the preferred drug or a significant potential drug interaction between another drug and the preferred drug(s) exists. **Clovique®** should be used when continued treatment with penicillamine is no longer possible because of intolerable or life endangering side effects.
				MC		DEPEN TITRATABS TABS		
				MC/DEL		EXJADE[1]		
				MC		SYPRINE		
				MC/DEL		**TRIENTINE CAPS**		
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 1. Dosing limits apply, please refer to dosage consolidation list. 2. PA required to confirm FDA approved indication.	
	MC/DEL		LUPRON DEPOT- PED KIT[1](1-month)	MC/DEL		SUPPRELIN LA (IMPLANT) KIT		
	MC/DEL		LUPRON DEPOT-PED SYRINGEKIT (3-month)	MC/DEL		TRELSTAR		
	MC/DEL		TRIPTODUR VIAL	MC		VANTAS[2]		

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
ANTINEOPLASTIC AGENTS - TYROSINE KINASE INHIBITORS				MC MC/DEL MC		SPRYCEL[1] TYKERB[2] GLEEVEC[1]	Use PA Form# 20420 1. Verification of diagnosis is required. 2. PA required to confirm FDA approved indication and to monitor for potential drug-drug interactions.	
ANTINEOPLASTICS-MISCELLANEOUS	MC MC/DEL MC/DEL		AMIFOSTINE MERCAPTOPURINE **OXALIPLATIN**	MC MC/DEL MC/DEL MC MC/DEL MC/DEL		DOCEFREZ ELOXATIN ETHYOL LEUPROLIDE PURINETHOL ZOLINZA	Use PA Form# 20420	
ANTINEOPLASTICS- MONOCLONAL ANTIBODIES	MC/DEL		TRAZIMERA	MC/DEL MC/DEL MC MC.DEL MC MC MC/DEL		ENHERTU HERCEPTIN HERCESSI HERZUMA KANJINTI OGIVRI ONTRUZANT	Use PA Form# 20420	
CANCER								
CANCER	MC MC/DEL MC MC MC/DEL MC MC/DEL MC		ALIMTA ANASTROZOLE TABS ERBITUX **IMATINIB MESYLATE** LETROZOLE RUXIENCE VIDAZA ZIRABEV	MC MC MC MC/DEL MC MC MC/DEL MC MC MC/DEL MC MC MC MC MC MC MC/DEL MC MC MC MC MC/DEL MC/DEL MC MC MC MC MC/DEL MC MC MC MC/DEL MC/DEL		ABECMA AKEEGA ALECENSA ALIQOPA[3] ALUNBRIG[1] ALYMSYS ARIMIDEX AUCATZYL AUGTYRO AYVAKIT AVASTIN BALVERSA BAVENCIO[1,8] BENDEKA[3] BESPONSA[3] BESREMI[1] BIZENGRI BLENREP BOSULIF BRAFTOVI[1] BREYANZI BRUKINSA CABOMETYX[3] CAMCEVI CALQUENCE[3] COMETRIQ[3,4,5] COTELLIC COPIKTRA DANZITEN DARZALEX[3] DATROWAY DAURISMO ELREXFIO	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, please see dosage consolidation list. 6. Max daily dose of 300mg. 7. Monitor liver enzymes periodically and stop treatment upon Grade 3 or higher elevation of liver enzymes approved indication 8. For patients ≥ 12 years of age 9. For the treatment of patients up to 25 years of age with B-cell acute lymphoblastic leukemia (ALL) that is refractory or in second or later relapse.	All non-preferred: A clinical PA is required to confirm appropriate clinical indication for the individual drug request. Specific to each drug all age, clinical testing requirements, previous step therapies, adjunctive drug therapy requirements, and response without disease progression will be also be evaluated for clinical appropriateness. The standard for the appropriate indication will include the FDA label as well as current NCCN guidelines Scemblix is for the treatment of adult patients with: Philadelphia chromosome-positive chronic myeloid leukemia (Ph+ CML) in chronic phase (CP), previously treated with two or more tyrosine kinase inhibitors (TKIs).

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
				MC/DEL		EMPLICITI(IV)[8]		
				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]		
						GOMEKLI		
						GRAFAPEX		
				MC/DEL		IBRANCE		
				MC		ICLUSIG[3]		
				MC/DEL		IDHIFA[3]		
				MC		IMBRUVICA		
				MC		IMDELLTRA		
				MC/DEL		IMFINZI		
				MC/DEL		IMJUDO		
				MC		IMKELDI		
				MC		IMLYGIC		
				MC/DEL		INLYTA		
				MC/DEL		INREBIC		
				MC		INQOVI		
				MC		ITOVEBI		
				MC		IWILFIN		
				MC		JAKAFI		
				MC		JAYPIRCA[1,2]		
				MC		JEMPERLI		
				MC/DEL		KEYTRUDA[1]		
				MC		KIMMTRAK		
				MC		KISQALI[1]		
				MC/DEL		KOSELUGO		
				MC		KRAZATI[3]		
				MC		KYMRIAH[3,9]		
				MC		KYPROLIS[1]		
				MC		LARTRUVO[1]		
				MC		LAZCLUZE		
				MC		LENVIMA		
				MC/DEL		LIBTAYO[1]		
				MC		LONSURF		
				MC/DEL		LORBRENA		
				MC		LOQTORZI		
				MC		LUMAKRAS		
				MC/DEL		LUMOXITI[1]		
				MC		LUNSUMIO[1]		
				MC		LYNPARZA[1]		
				MC		LYTGOBI		
				MC		NEXAVAR[1]		
				MC		NERLYNX[3]		
				MC		NINLARO(PO)		
				MC/DEL		NUBEQA		
				MC		MARGENZA		

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
				MC/DEL		MEKINIST[3,4]		
				MC/DEL		MEKTOVI[1]		
				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/DEL		PIQRAY		
				MC		POLIVY		
				MC		POMALYST		
				MC		PORTRAZZA[3]		
				MC		QINLOCK		
				MC		RETEVMO		
						REVUFORJ		
						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]		

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

CATEGORY	Coverage Indicator	Step Order	PREFERRED DRUGS	Coverage Indicator	Step Order	NON-PREFERRED DRUGS PA Required		Criteria
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.

Last update 07/2025

PDL DOSAGE CONSOLIDATION LIST

Tabs/Caps/Patches: Quantities in units

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

Injectibles: Quantities in ML

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

Drug Name	Strength	Limit/Day	Limit/Days
ABILIFY SOLUTION	1MG/ML	30ML	1020/34
ACCUPRIL	5MG	1	35/35
ACCUPRIL	10MG	1	35/35
ACCUPRIL	20MG	1	35/35
ACEON	2MG	1	35/35
ACEON	4MG	1	35/35
ACTONEL	5MG	1	35/35
ACTONEL	35MG	1/WK	5/35
ACTOS	All Strengths	1	35/35
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
ADVAIR HFA	All Strengths	4	120/30
ADZENYS XR	All Strengths	1	30/30
AEROBID	250MCG	8 INHALATIONS	21/35
AEROBID-M	250MCG	8 INHALATIONS	21/35
ALAVERT-NON DROW	TAB	1	96/96
ALENDRONATE	All Strengths	1/WK	35/35
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
AMARYL	1MG	1	35/35
AMARYL	2MG	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
AMLODIPINE	2.5MG	1.5	53/35 DAYS
AMLODIPINE	5MG	1.5	53/35 DAYS
AMMONIUM LACTATE CREA	12%		1 TUBE/10
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
ARAVA	10MG	1	35/35
ARCAPTA	75MCG	1 INHALATION	35/35
ARICEPT	5MG	1	35/35
ARICEPT	10MG	1	35/35
ARIPIPRAZOLE	2MG	2	180/90
ARIPIPRAZOLE	5MG	2	180/90
ARIPIPRAZOLE	10MG	2	180/90
ARIPIPRAZOLE	15MG	2	180/90
ARIPIPRAZOLE	20MG	1.5	135/90
ARIPIPRAZOLE	30MG	1	90/90
ARIXTRA INJECTION	2.5MG/0.5ML		7/30
ARIXTRA INJECTION	5MG/0.4ML		7/30
ARIXTRA INJECTION	7.5MG/0.6ML		7/30
ARIXTRA INJECTION	10MG/0.8ML		7/30
ARMONAIR	All Strengths	I INHALATION	60U/30
ASMANEX 30 UNITS	220MCG	1 INHALATION	30U/30
ASMANEX 60 UNITS	220MCG	2 INHALATIONS	60U/30
ASMANEX 120 UNITS	220MCG	4 INHALATIONS	120U/30
ATACAND	4MG	1.5	53/35
ATACAND	8MG	1.5	53/35
ATROVENT HFA	17MCG	12 INHALATIONS	25.8/34
ATROVENT 30ML	0.03%	12 SPRAYS	30/30
ATROVENT 15ML	0.06%	16 SPRAYS	45/30
AVANDIA	2MG	1.5	53/35
AVANDIA	4MG	1	35/35
AVAPRO	75MG	1.5	53/35
AVAPRO	150MG	1	35/35
AXERT (Step 8)	6.25MG		12/30
AXERT (Step 8)	12.5MG		12/30
AZELEX	20%		1 TUBE/18
AZILECT	All Strengths	1	35/35
BACTROBAN CREAM			1 TUBE/30
BECONASE AQ	42MCG	8 INHALATIONS	50/30
BENICAR-HCT	All Strengths	1	30/30
BENAZEPRIL	5MG	1	35/35
BENAZEPRIL	10MG	1.5	53/35
BENAZEPRIL	20MG	1	35/35
BENAZEP/HCTZ	5-6.25	1	35/35
BENAZEP/HCTZ	10/12.5	1	35/35
BEVESPI AERO		4 INHALATIONS	120/30
BONIVA	2.5MG	1	35/35
BOTOX (ADULTS)	100U/ML	1 session/90 days	600U/90
BOTOX (CHILDREN>12)	100U/ML	1 session/90 days	400U/90
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
CALAN SR	120MG	1	35/35
CALAN SR	180MG	2	70/35
CALAN SR	240MG	2	70/35
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
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
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
CITALOPRAM	10MG	2	180/90
CITALOPRAM	20MG	2	180/90
CITALOPRAM	40MG	1	90/90
CLARINEX	REDI TAB	1	35/35
CLEOCIN-T		1 PACKAGE	1/30
CLINDAMYCIN PHOSPHATE		1 PACKAGE	1/30
COMBIVENT	103-18MCG	12 INHALATIONS	30/35
Drug Name	Strength	Limit/Day	Limit/Days
EFFEXOR XR	37.5MG	1	35/35
EFFEXOR XR	75MG	1	35/35
EMSAM	All Strengths	1	34/34
ENALAPRIL	2.5	1	90/90

ATACAND	16MG	1	35/35
ATRIPLA	600MG	1	35/35
ATOMOXETINE	All Strengths	1	90/90
COMETRIQ	80MG	1	35/35
COMETRIQ	20MG	3	105/35
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
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
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
DDAVP	5ML		15/34
DENAVIR CREAM			2gm/30
DEPO-PROVERA	150MG/ML		1/90
DEPO-PROVERA	400MG/ML		2.5/90
DEPO-TESTOSTERONE	200MG/ML		20/90
DESMOPRESSIN	0.1MG	12	420/35
DESMOPRESSIN	0.2MG	6	210/35
DESONIDE	0.05%		2 TUBES/30
DESOWEN	0.05%		2 TUBES/30
DETROL LA	2MG	1	35/35
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
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
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
DILTIAZEM CAP	360MG/24	1	90/90
DIOVAN	80MG	1	35/35
DIOVAN - HCT	80 - 12.5	1	35/35
DITROPAN XL	5MG	1	35/35
DITROPAN XL	10MG	2	70/35
DORAL	7.5MG		10/30
DOXAZOSIN	1MG	1	90/90
DOXAZOSIN	2MG	1.5	135/90
DOXAZOSIN	4MG	1.5	135/90
DRYSOL SOL	20%		1 BOTTLE/30DAYS
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
DULOXETINE	20MG	3	270/90
DULOXETINE	30MG	3	270/90
DULOXETINE	60MG	2	180/90
EDEX	All Strengths		1/30
Drug Name	Strength	Limit/Day	Limit/Days
ILARIS			2/28

ENALAPRIL	5MG	1.5	135/90
ENALAPRIL	10MG	1.5	135/90
ENALAPR/HCTZ	5-12.5	1	90/90
ENBREL	25MG/ML		8/28
ENBREL SURECLICK			8/28
ESTAZOLAM	1MG		10/30
ESTAZOLAM	2MG		10/30
ESTRING MIS	2MG		1/90
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
FENTANYL	25MCG/HR		11/33
FENTANYL	50MCG/HR		11/33
FENTANYL	75MCG/HR		11/33
FENTANYL	100MCG/HR		22/33
FETZIMA	All Strengths	1	35/35
FINASTERIDE	5MG	1	90/90
FLONASE	50MCG	4 SPRAYS	32/34
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
FLOVENT DISKUS	50MCG, 100MCG	4 INHALATIONS	60/30
FLOVENT DISKUS	250MCG	3 INHALATIONS	120/30
FLUCONAZOLE	150MG		1/7
FLUNISOLIDE SOLN	0.025%	16 SPRAYS	75/30
FLUOXETINE CAP	40MG	2	180/90
FLUOXETINE CAP	20MG	4	360/90
FLUOXETINE CAP	10MG	3	270/90
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
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
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
FROVA TAB (Step 8)	2.5MG		12/30
FULYZAQ	125MG	2	70/35
FUZEON	KIT	1	1/30
FYCOMPA	All Strengths	1	35/35
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
GEODON	40MG	2	70/35
GEODON	60MG	2	70/35
GEODON	80MG	2	70/35
GEODON	INJ	2	70/35
GILOTRIF	All Strengths	1	35/35
GLIMEPIRIDE	1MG	1	90/90
GLIMEPIRIDE	2MG	1	90/90
GLUCOSE TES STRP		12	420/35
GLUCAGEN INJ. HYPOKIT			2/30
GLYCOLAX*	255GM		255GM/90

*** Available for once daily dosing to members under the age of 18 years**

Drug Name	Strength	Limit/Day	Limit/Days
LUNESTA	2MG		12/34
LUNESTA	3MG		12/34
LUPRON DEPOT INJ	11.25MG	KIT	1/90
LUPRON DEPOT INJ	22.5	KIT	1/90
LUPRON DEPOT INJ	30MG		1/90

HALCION	0.125MG		10/35
HALCION	0.25		10/35
HUMIRA	40mg/0.8ml		4/28
HYDROXYZINE TAB	All Strengths	3	270/90
HYTRIN	1MG	1	35/35
HYTRIN	5MG	1	35/35
HYZAAR	50-12.5	1	35/35
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
IMIQUIMOD	5%		12/30
IMIQUIMOD	5%		12/30
INTAL	800MCG	8 INHALATIONS	28.4/34
INVOKANA	All Strengths	1	35/35
IPRATROPIUM 30ML	0.03%	12 SPRAYS	90/90
IPRATROPIUM 15ML	0.06%	16 SPRAYS	135/90
ISOPTIN SR	180MG	2	70/35
IRBESARTAN	All Strengths	1	90/90
ISOPTIN SR	240MG	2	70/35
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
KHEDEZLA	All Strengths	1	35/35
LAC-HYDRIN CREAM	12%		1TUBE/30
LAMICTAL	25MG	6	210/35
LAMICTAL	25MG CHW	6	210/35
LAMICTAL	100MG	2	70/35
LAMISIL	250MG	1	35/35
LAMOTRIGINE	25MG	6	540/90
LAMOTRIGINE	100MG	2	180/90
LANSOPRAZOLE CAPS	All Strengths	2	180/90
LATUDA	All Strengths	1	17/34
LESCOL	20MG	1	35/35
LEVAQUIN	250MG	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
LOSARTAN	All Strengths	1	90/90
LOSARTAN- HCT	All Strengths	1	90/90
LOTENSIN	5MG	1	35/35
LOTENSIN	10MG	1.5	35/35
LOTENSIN	20MG	1	53/35
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
LUNESTA	1MG		12/34
Drug Name	Strength	Limit/Day	Limit/Days
NIFEDIPINE ER	90MG	1	90/90
NIFEDIPINE ER,CR	30MG	1	90/90
NORVASC	2.5MG	1.5	53/35 DAYS
NORVASC	5MG	1.5	53/35 DAYS
NURTEC ODT	All Strengths		8/30
NUVARING		1/MO	1/28

LUPRON DEPOT INJ	30MG	KIT	1/90
LYRICA	25,50,75MG	3	102/35
LYRICA	100,150,200MG	3	102/35
LYRICA	225,300MG	2	70/35
MAVIK	1MG	1	35/35
MAVIK	2MG	1	35/35
MAXAIR AUTO	200MCG	12 INHALATIONS	14/30
MAXALT (step 8)	5MG		12/30
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
MELOXICAM TABS	All Strengths	1	90/90
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
METROCREAM		1 PACKAGE	1/30
METROGEL		1 PACKAGE	1/30
METROLOTION		1 PACKAGE	1/30
METRONIDAZOLE CREAM		1 PACKAGE	1/30
METRONIDAZOLE GEL		1 PACKAGE	1/30
METRONIDAZOLE LOTION		1 PACKAGE	1/30
MEVACOR	10MG	1.5	53/35
MEVACOR	20MG	1.5	53/35
MIACALCIN		3.75ml	1 bottle/34
MICARDIS	All Strengths	1	30/30
MICARDIS-HCT	All Strengths	1	30/30
MIGRANAL NASAL SPRAY	All Strengths		12/30
MIRALAX	255G	8.5G	1 bottle/30
MIRALAX	17G/PACKET	0.5 packet	15 packets/30
MIRTAZAPINE	15mg	3	270/90
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
MUPIROCIN			1 TUBE/30
NABUMETONE	500MG	2	180/90
NABUMETONE	750MG	2	180/90
NARATRIPTAN			12/30
NASACORT AERS	55 MCG	4 SPRAYS	9.3/25
NASONEX	50MCG	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
NIFEDIPINE CR	90MG	1	90/90
NIFEDIPINE ER	60MG	1	90/90
NIFEDIPINE ER	30MG	1	90/90
NIFEDIPINE ER	60MG	1	90/90
Drug Name	Strength	Limit/Day	Limit/Days
RELPAX	All Strengths		12/30
REMODULIN	All Strengths		1 MDV/30
RESTORIL	7.5MG		10/30
RESTORIL	15MG		10/30
RESTORIL	30MG		10/30
RETIN-A		1 TUBE	1 TUBE/30
REVLIMID	All Strengths	1	35/35
REYVOW	All Strengths		4/30
RHINOCORT AQ	32MCG	8 SPRAYS	18/30
REFRESH PLUS		15 ML	1 bottle/30
REFRESH PLUS		30 ML	2 bottles/30
REFRESH TEARS		15 ML	1 bottle/30
REFRESH TEARS		30 ML	2 bottles/30
RESCULA			2 bottles/35

ODOMZO	200mg	1	30/30
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
ONGLYZA	All Strengths	1	35/35
OPSUMIT	All Strengths	1	35/35
ORUVAIL	100MG	2	70/35
ORUVAIL	200MG	1	35/35
OXAPROZIN	600MG	2	180/90
OXYCODONE ER	10,20,40MG	2	70/35
OXYCODONE ER	80MG	4	140/35
OXYCONTIN**	10,20,30,40MG	2	70/35
OXYCONTIN**	80MG	4	140/35
PANTOPRAZOLE	All Strengths	2	180/90
PAROXETINE	10MG	2	180/90
PAROXETINE	20MG	2	180/90
PAXIL	10MG	1.5	53/35
PAXIL	20MG	1	35/35
PEGASYS KIT		KIT	1/28
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
PRAVASTATIN	10MG	1	35/35
PRAVASTATIN	20MG	1	35/35
PRAVASTATIN	40MG	2	180/90
PRAVASTATIN	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
PRINZIDE	10-12.5	1	35/35
PROAIR HFA	90mcg	12 INHALATIONS	17/34
PROTONIX	20MG	2	70/35
PROTONIX	40MG	2	70/35
PROZAC	10MG	1.5	53/35
PULMICORT	200MCG	8 INHALATIONS	1/25
PULMICORT FLEX	All Strengths	8 Inhalations	2/30
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***	15MG/ML	20ML	700ML/35
RELAFEN	500MG	2	70/35
RELAFEN	750MG	2	70/35
REMERON	15MG	1.5	53/35

Drug Name	Strength	Limit/Day	Limit/Days
SULAR	10MG	1.5	53/35
SULAR	20MG	1	35/35
SUMATRIPTAN PEN INJ	All Strengths		12/30
SUMATRIPTAN NASAL SPRAY	All Strengths		12/30
SUMATRIPTAN SYRINGE	All Strengths		12/30
SUMATRIPTAN TAB	All Strengths		12/30
SYNVISC INJ	8MG/ML		2/30
SYRINGES		10	1000/100
TAFINLAR	50MG	6	210/35
TAFINLAR	75MG	4	140/35

REYATAZ	All Strengths	1	35/35
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
RISPERIDONE	0.5MG	3	270/90
RISPERIDONE	0.25MG	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
SAVELLA	All Strengths	2	70/35
SEREVENT DISKUS	50MCG	2 INHALATIONS	60/30
SEROQUEL	100MG		45/30
SEROQUEL XR	150MG	1	35/35
SEROQUEL XR	200MG	1	35/35
SEROQUEL XR	300MG	2	70/35
SEROQUEL XR	400MG	2	70/35
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
SIMVASTATIN	80MG	1	35/35
SINGULAIR	4MG	1	35/35
SINGULAIR	5MG	1	35/35
SINGULAIR	10MG	1	35/35
SONATA	5MG		12/34
SONATA	10MG		12/34
SPIRIVA	HANDIHLR	1 INHALTION	30/30
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
SUPRAX	400MG	1	1/7

Drug Name	Strength	Limit/Day	Limit/Days
XOPENEX HFA		12 INHALATIONS	2 INHALERS/34
XOPENEX NEB		12CC	408/34
ZALEPLON	All Strengths		30/30
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
ZIPRASIDONE	20MG	3	270/90
ZIPRASIDONE	40MG	3	270/90
ZOCOR	5MG	1	35/35
ZOCOR	10MG	1.5	53/35
ZOCOR	20MG	1.5	53/35
ZOCOR	40MG	1.5	53/35
ZOFRAN*	4MG	3	90/30
ZOFRAN*	8MG	1.5	45/30
ZOFRAN*	24MG	0.5	15/30
ZOFRAN*	4MG/5ML	15ML	450/30
ZOLMITRIPTAN TAB	All Strengths		12/30

TAMIFLU CAPS	75MG		10/30
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
TELMISARTAN	All Strengths	1	90/90
TEMAZEPAM	7.5MG		10/30
TEMAZEPAM	15MG		10/30
TEMAZEPAM	30MG		10/30
TEQUIN	200MG	1	35/35
TERAZOSIN	1MG	1	90/90
TERAZOSIN	5MG	1	90/90
TERBINAFINE	250MG	1	35/35
TEST STRIPS	Blood Glucose	12	420/35
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
TILADE	1.75MG	8 INHALATIONS	48.6/35
TOPAMAX SPRINKLES	All Strengths	1	35/35
TOPROL XL	25MG	1.5	53/35
TOPROL XL	50MG	1.5	53/35
TRADJENTA	All Strengths	1	35/35
TRAMADOL	50MG	8	720/90
TRAMADOL/ APAP	37.5/325MG	8	720/90
TRETINOIN		1 TUBE	1 TUBE/30
TRELEGY ELLIPTA	All Strengths	1INHALATION	30U/30
TREXIMET	85/500	2.5	12/30
TRIAZOLAM	0.125MG		10/30
TRIAZOLAM	0.25MG		10/30
TROKENDI XR	25MG	1	35/35
TROKENDI XR	50MG	1	35/35
TROKENDI XR	100MG	1	35/35
TROKENDI XR	200MG	2	70/35
UBRELVY	All Strengths		10/30
ULTRAM	50MG	8	280/35
UNIVASC	7.5MG	1.5	53/35 DAYS
UTIBRON	7.5mcg/15.6mc	2 INHALATIONS	60/30
VALTOCO	All Strengths		10/30
VALSARTAN-HCT	All Strengths	1	90/90
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
VENLAFAXINE TABS	25	3	270/90
VENLAFAXINE TABS	37.5	3	270/90
VENLAFAXINE TABS	100	3	270/90
VENLAFAXINE ER CAPS	37.5	3	270/90
VENLAFAXINE ER CAPS	75	3	270/90
VENLAFAXINE ER	150	2	180/90
VENTOLIN HFA	90MCG	12 INHALATIONS	36/34
VERAPAMIL ER, SR	120MG	1	90/90
VERAPAMIL ER, CR, SR	180MG	2	90/90
VERAPAMIL ER, CR, SR	240MG	2	90/90
VERELAN	180MG	1	35/35
VERELAN SR	120MG	1	35/35
VERELAN SR	180MG	1	35/35
VERELAN SR	240MG	2	70/35
VERAMYST	27.5MCG	4 sprays	10/30
VYEPTI	All Strengths		4/30
VYVANSE	All Strengths	1	35/35
VYVANSE CHEW	All Strengths	1	35/35

ZOLOFT	25MG	0.5	18/35
ZOLOFT	50MG	0.5	18/35
ZOLOFT	100MG	3	105/35
ZOLPIDEM (step 1)	5MG		30/30
ZOLPIDEM (step 1)	10MG		30/30
ZOMIG (Step 8)	5MG		12/30
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
ZYPREXA ZYDIS	5MG	1	35/35
ZYPREXA ZYDIS	10MG	1	35/35
ZYPREXA ZYDIS	15MG	1	35/35
ZYPREXA ZYDIS	20MG	1	35/35

*Cancer diagnosis with non-daily chemotherapy required

**Available without pa with CA and HO diag.

*** Ranitidine syrup available without PA to users less than 6 years old.

MDV=Multidose Vial