Preferred Drug List (PDL)

Including:

Prior Authorization Criteria

Therapeutic Duplication

Electronic Step Care and Concurrent Medications

First Fill

Underutilization

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Please use the NDC Drug Lookup to find Prior Authorization (PA) Forms

Guiding Rules of the Preferred Drug List (PDL):

THIS LIST REFERS TO MEDICATIONS PROCESSED BY PHARMACY POINT OF SALE SYSTEMS.

For Clinic Administered Drugs - Prior authorization criteria for medication claims processed by physician/clinic billing using 837P codes can be found at the end of this document or by using this link:
Clinic Administered Drugs - Prior Authorization Criteria.
For medications not on this list, FDA or compendia supported indications are required.

- Prior authorization criteria apply in addition to the general Drug Utilization Review policy that is in effect for the entire pharmacy program
    - Other documents explaining coverage rules can be found at www.hidesigns.com/ndmedicaid:
        - Preferred Diabetic Supply List (PDSL)
        - Coverage Rules on Medications

- Please use the NDC Drug Lookup tool to access PA form, view coverage status, quantity limits, copay, and prior authorization information for all medications.

- Length of prior authorizations is a year unless otherwise specified.

- The use of pharmaceutical samples will not be considered when evaluating the member's medical condition or prior prescription history for drugs that require prior authorization.

- Prior authorization for a non-preferred agent in any category will be given only if all other criteria is met, including clinical criteria and step therapy specific to that category. Requests for non-preferred brand name agents with a generic formulation available must meet the Dispense as Written (DAW1) criteria for approval in addition to as any other applicable coverage criteria/rule (unless otherwise noted).

- A trial will be considered a failure if a product was not effective at maximum tolerated dose with good compliance, as evidenced by paid claims or pharmacy print outs or patient has a documented contraindication, intolerance, or adverse reaction to an ingredient

- Unless otherwise specified, the listing of a brand or generic name includes all legend forms of that drug. OTC drugs are not covered unless specified.

*** - Indicates that additional PA criteria applies as indicated in the Product PA Criteria

Contents

Please use the NDC Drug Lookup to find Prior Authorization (PA) Forms

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General

Combination agents

General Prior Authorization Form

Group Criteria:

- Clinical justification must be provided for combination products that are comprised of components available and more cost effective when prescribed separately (subject to clinical review).

Dispense as Written (DAW1)

Prior Authorization Form - Dispense As Written (DAW1)
MedWatch Form

Criteria for ALL DAW requests (must meet one of the following (A or B):

A. Primary insurance requires a ND Medicaid non-preferred branded product
   - *Approval: until the end of the calendar year*

B. All of the following are met (1-3):
   1. The requested brand-name product must not have an authorized generic available
   2. The patient must have failed a 30-day trial of each pharmaceutically equivalent generic product from each available manufacturer, as evidenced by paid claims or pharmacy print outs
      a. A failure is defined as product was not effective at maximum tolerated dose or caused adverse reaction where the branded product is expected to have a different result and other alternatives (e.g. medications in same class) are not an option for the patient

b. The patient or prescriber preference is NOT criteria considered for approval

3. A MedWatch form for each trial of each product from the available manufacturer(s) must be filled out and attached to request

Medications that cost over $3000/month

General Prior Authorization Form

Group Criteria:

- **Initial Criteria:** *Approval Duration = 6 months*
  - The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- **Renewal Criteria**: *Approval Duration = 12 months*
  - The provider must have experienced and maintained clinical benefit since starting treatment with the requested medication, as evidenced by medical documentation (e.g. chart notes) attached to the request (subject to clinical review).

PA REQUIRED
CYSTADROPS (cysteamine)
CYSTARAN (cysteamine)
ENSPRYNG (satralizumab-mwge)
EVRYSDI (risdiplam)
GATTEX (teduglutide)
IMCIVREE (setmelanotide)
INCRELEX (mecasermin)
MYCAPSSA (octreotide)
OXERVATE (cenegermin-bkbj)
OXLUMO (lumasiran)
SYPRINE (trientine)
ZOKINVY (lonafamib)

Non-solid dosage preparations

General Prior Authorization Form

Electronic Age Verification

A. Non-solid dosage preparations of preferred products are automatically covered for all patients younger than 9 years old. For coverage of these products in patients 9 years of age or older, one of the following criteria must be met (A or B): The patient is unable to swallow solid dosage medications due to one of the following:
   - Swallow study documentation – *Approval 1 year*
   - Feeding tube placement and the medication is not available in a dosage form that can be crushed or poured into the tube – *Approval 1 year*
   - Permanent disability of swallowing solid dosage forms - A*pproval 2 years*
   - Short-term restriction (e.g. mouth surgery) - *Approval 1 month*

B. Clinical justification has been provided as to why a solid dosage medication cannot be used (subject to clinical review)

Preferred Dosage Forms List:

Prior Authorization Form - Non-Preferred Dosage Form

Please use the NDC Drug Lookup to find Prior Authorization (PA) Forms

See Preferred Dosage Forms List

Cardiology

Therapeutic Duplication

Overrides Available

- One Strength of one medication is allowed at a time
  - Exceptions:
    - Carvedilol IR 25mg allowed with all other strengths
    - Warfarin strengths are allowed together
    - Prazosin strengths are allowed together
- Medication classes not payable together:
  - Entresto, ACE Inhibitors, ARBs, and Renin Inhibitors are not allowed with each other
  - Sildenafil, Tadalafil, Adempas, nitrates are not allowed with each other
  - Carvedilol and Labetalol are not allowed with other alpha blockers (Alfuzosin ER, doxazosin, dutasteride-tamsulosin, prazosin, terazosin, and tamsulosin)
    - Carvedilol and Labetalol are nonselective beta blockers with alpha 1 blocking activity
  - Tizanidine is not allowed with other alpha 2 agonists (clonidine, clonidine/chlorthalidone, guanfacine, methyldopa)
    - Tizanidine is also an alpha 2 agonist
  - Clopidogrel is not covered with esomeprazole or omeprazole. Other PPIs such as pantoprazole are covered with clopidogrel.
    - Clopidogrel is a substrate for 2C19 and esomeprazole and omeprazole are strong 2C19 inhibitors and can decrease effectiveness of Clopidogrel.
  - Clopidogrel, Prasugrel, Ticagrelor, and Ticlopidine are not covered with morphine. Other opioid analgesics are covered with Clopidogrel, Prasugrel, Ticagrelor, and Ticlopidine.
    - Morphine may diminish the antiplatelet effect and serum concentrations of P2Y12 Inhibitor antiplatelet agents (clopidogrel, prasugrel, ticagrelor, and ticlopidine).

Blood Modifying Agents

Anticoagulants - Oral:

Underutilization

- Eliquis, Pradaxa, Xarelto, and Savaysa must be used compliantly and will reject on point of sale for late fill

Prior Authorization

General Prior Authorization Form

Product Specific Criteria:

*****Xarelto 2.5mg** - Patient must have an FDA approved indication

Non-Preferred Agents Criteria:

- The patient must have a diagnosis of an FDA-approved indication.
- The patient must have had a 30-day trial of each preferred agent, as evidenced by paid claims or pharmacy printouts.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
ELIQUIS (Apixaban)	SAVAYSA (edoxaban)

Please use the NDC Drug Lookup to find Prior Authorization (PA) Forms

PRADAXA (dabigatran)	
XARELTO (rivaroxaban) 10mg, 15mg, 20mg	
XARELTO (rivaroxaban) 2.5mg[PA***]	

Anticoagulants - Injectable

General Prior Authorization Form

Electronic Diagnosis Verification

- Fondaparinux is covered for a diagnosis of heparin-induced thrombocytopenia (HIT)

Non-Preferred Agents Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The patient must have had a 30-day trial of enoxaparin, as evidenced by paid claims or pharmacy printouts.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
enoxaparin	ARIXTRA (fondaparinux)
fondaparinux	FRAGMIN (dalteparin)
	LOVENOX (enoxaparin)

Antifibrinolytic Agents

Prior Authorization Form - Antihemophilic Factors

Group Criteria:

- **Non-Preferred Agents Criteria:** *Approval Duration = 12 months*
  - The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age)
  - The patient must have had a 30-day trial of each preferred agent, as evidenced by paid claims or pharmacy printouts.
  - Clinical justification must be provided explaining why the patient is unable to use all other products (subject to clinical review)

Product Specific Criteria:

- **Non-Solid Dosage Formulations:** The patient must be unable to ingest solid dosage form as evidenced by swallow study documentation

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
AMICAR (aminocaproic acid) tablet – *Brand Preferred*	aminocaproic acid oral solution
AMICAR (aminocaproic acid) oral solution– *Brand Preferred*	aminocaproic acid tablet
tranexamic acid tablet	LYSTEDA (tranexamic acid)

Antihemophilic Factor Products

Prior Authorization Form - Antihemophilic Factors

Group Criteria:

- The provider must attest that the patient visits an accredited Hemophilia Treatment Center once per year
- The date of the patient's last appointment with treatment center must be provided
- Contact information for treatment center must be provided

Non-Preferred Agents Criteria:

- Clinical justification must be provided explaining why the patient is unable to use the PREFERRED AGENTS (subject to clinical review).
- The patient may qualify for non-preferred product if they are stable on current therapy (have had a paid claim for requested therapy in the past 45 days)

FACTOR VIIa

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
NOVOSEVEN RT (coagulation Factor VIIa recombinant)	
SEVENFACT (coagulation Factor VIIa recombinant)	
FACTOR VIII – HEMOPHILIA A	
PREFERRED AGENTS (CLINICAL PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
ADVATE (factor VIII recombinant)	ADYNOVATE (factor VIII recombinant, PEGylated)
AFSTYLA (factor VIII recombinant, single chain)	ELOCTATE (factor VIII recombinant, Fc fusion protein)
HEMOFIL M (factor VIII plasma derived; mAb-purified)	ESPEROCT (factor VIII recombinant, glycopegylated – exei)
KOATE (factor VIII plasma derived, chromatography purified)	JIVI (factor VIII recombinant, pegylated-aucl)
KOGENATE FS (factor VIII recombinant)	KOVALTRY (factor VIII recombinant)
NOVOEIGHT (factor VIII recombinant)	OBIZUR (recombinant, B domain-deleted porcine factor VIII)
NUWIQ (factor VIII recombinant)	
RECOMBINATE (factor VIII recombinant)	
XYNTHA (factor VIII recombinant)	
XYNTHA SOLOFUSE (factor VIII recombinant)	
FACTOR VIII:C – HEMOPHILIA A	
PREFERRED AGENTS (CLINICAL PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
MONOCLATE-P (Antihemophilic Factor VIII:C (human))	
FACTOR VIII – HEMOPHILIA A/vWF	
PREFERRED AGENTS (CLINICAL PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
ALPHANATE (Antihemophilic Factor/Von Willebrand Factor Complex (Human))	
HUMATE-P (Factor VIII/von Willebrand Factor (human))	
WILATE (Factor VIII/von Willebrand Factor (human))	
FACTOR VIII – VON WILLEBRAND FACTOR - RECOMBINANT	
PREFERRED AGENTS (CLINICAL PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
	VONVENDI (Recombinant human vWF)
FACTOR IX – HEMOPHILIA B	
PREFERRED AGENTS (CLINICAL PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
ALPHANINE SD (factor IX, plasma-derived)	ALPROLIX (factor IX recombinant, Fc fusion)
BENEFIX (factor IX recombinant)	IDELVION (factor IX recombinant, albumin fusion)
IXINITY (factor IX recombinant)	REBINYN (factor IX recombinant, glycol-PEGylated)
MONONINE (factor IX, plasma-derived mAb purified)	
PROFILNINE (factor IX complex)	
RIXUBIS (factor IX recombinant)	
FACTOR IXa/IX	
PREFERRED AGENTS (CLINICAL PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
HEMLIBRA (Emicizumab-kxwh)	
FACTOR X	
PREFERRED AGENTS (CLINICAL PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
COAGADEX (Coagulation Factor X (Human))	
FACTOR X	
PREFERRED AGENTS (CLINICAL PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
CORIFACT (Factor XIII Concentrate (Human))	
FACTOR XIII A – SUBUNIT, RECOMBINANT	
PREFERRED AGENTS (CLINICAL PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
TRETTEN (Factor XIII A-Subunit, recombinant)	
ANTI-INHIBITOR COAGULANT COMPLEX	
PREFERRED AGENTS (CLINICAL PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
FEIBA NF (Anti-Inhibitor Coagulant Complex)	

Please use the NDC Drug Lookup to find Prior Authorization (PA) Forms

Hematopoietic, Colony Stimulating Factors

General Prior Authorization Form

Group Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).

Non-Preferred Agents Criteria:

- Clinical justification must be provided explaining why the patient is unable to use the preferred product (subject to clinical review).

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
FULPHILA (Pegfilgrastrim-JMDB)	GRANIX (TBO-Filgrastim)
LEUKINE (Sargramostim)	NEULASTA (Pegfilgrastim)
NEUPOGEN (Filgrastim)	NIVESTYM (Figrastim-AAFI)
UDENYCA (Pegfligrastim-CBQV)	ZARXIO (Filgrastim-SNDZ)
ZIEXTENZO (Pegfligrastim-BMEZ)	

Platelet Aggregation Inhibitors

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The patient must have had 30-day trials of at least 2 preferred platelet aggregation inhibitor agents, as evidenced by paid claims or pharmacy printouts.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
aspirin	clopidogrel 300mg
aspirin/dipyridamole ER	EFFIENT (prasugrel)
BRILINTA (ticagrelor)	PLAVIX (clopidogrel)
clopidogrel 75 mg	ZONTIVITY (vorapaxar)
dipyridamole	
prasugrel	

Thrombocytopenia

General Prior Authorization Form

Group Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- Documentation of the patient's current platelet count must be attached to the request

Non-Preferred Agents Criteria:

- The patient must have had trials with each preferred agent (at the recommended dose and duration) with each preferred agent, as evidenced by paid claims or pharmacy Printouts.

Diagnosis Specific Criteria: Chronic immune thrombocytopenia (ITP):

- Criteria for coverage of **Promacta, Doptelet, Nplate, Tavalisse**:
    - **Initial Criteria:**
        - The provider must attest that the patient's degree of thrombocytopenia and clinical condition increase the risk for bleeding
            - The patient must have experienced an inadequate response after one of the following (A or B):
                A. The patient must have failed a trial of appropriate duration of a corticosteroid or immunoglobulins as evidenced by paid claims or pharmacy print outs
                B. The patient must have undergone a splenectomy

- **Renewal Criteria:**
  - The patient must be experiencing a significant increase in platelet count and bleeding reduction risk on therapy (supported by documentation)
  - If on maximum dose: The patient's platelet count must have increased to a level sufficient to avoid clinically important bleeding after the recommended duration for the product*
    *Promacta, Nplate, Doptelet: 4 weeks
    *Tavalisse: 12 weeks

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
PROMACTA (eltrombopag)	DOPTELET (avatrombopag)
TAVALISSE (fostamatinib)	NPLATE (romiplostim)

Diagnosis Specific Criteria: Chronic liver disease-associated thrombocytopenia

- Criteria for coverage of **Doptelet** and **Mulpleta**
  - The patient must have a diagnosis of chronic liver disease
  - The patient must be scheduled to undergo a procedure that puts the patient at risk of bleeding
    - The prescriber must include documentation of the name and scheduled date of the procedure
  - The provider must indicate the date therapy will be initiated and discontinued*
    *Doptelet: given from 10-13 to 5-8 days prior to procedure
    *Mulpleta: given from 8-14 to 2-8 days prior to procedure

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
DOPTELET (Avatrombopag)	MULPLETA (Lusutrombopag)

Diagnosis Specific Criteria: Chronic hepatitis C infection-associated thrombocytopenia

- Criteria for coverage of **Promacta**
  - The patient must have a diagnosis of hepatitis C and be currently receiving or planning to initiate interferon-based treatment
    - Prescriber must attest that the patient's degree of thrombocytopenia prevents continuation or initiation of interferon

Diagnosis Specific Criteria: Aplastic Anemia

- Criteria for coverage of **Promacta**
  - One of the following must be met (A or B):
    A. The patient must be receiving Promacta as first-line treatment in combination with standard immunosuppressive therapy (e.e. corticosteroid, Atgam, cyclosporin)
    B. The patient must have had an insufficient response to treatment with prior immunosuppressive therapy

Hypertension

Calcium Channel Blockers

General Prior Authorization Form

Group Criteria:

- **Non-Preferred Agents Criteria:** *Approval Duration = 12 months*
  - The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
  - The patient must have had a 30-day trial of each preferred calcium channel blocker of a unique active ingredient, as evidenced by paid claims or pharmacy printouts.
  - Clinical justification must be provided explaining why the patient is unable to use all other products to treat hypertension (subject to clinical review).

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Amlodipine	CONJUPRI (levamlodipine)
Felodipine	

Isradipine	
Nicardipine	
Nifedipine	
Nisoldipine	

Vecamyl

General Prior Authorization Form

Group Criteria:

- The patient must have documented history of failure to achieve blood pressure goals (using maximum tolerated doses) of all first- and second-line agents as defined by the most recent JNC report.

Heart Failure

Edecrin

General Prior Authorization Form

Product Specific Criteria:

- **Ethacrynic acid**: One of the following must be met (A or B)
  - The patient must have a documented sulfa allergy
  - The patient must have failed a 30-day trial of each preferred agent, as evidenced by paid claims or pharmacy print outs.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
furosemide	ethacrynic acid
bumetanide	
torsemide	

Heart Failure

Electronic Diagnosis Verification

Product Specific Criteria:

- **Entresto:** The patient must have an FDA-approved indication for use

AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
ENTRESTO (sacubitril/valsartan)	
FARXIGA (dapagliflozin)	

Lipid-Lowering Agents

General Prior Authorization Form

Group Criteria:

- **Initial Criteria:** *Approval Duration = 3 months*
  - The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age)
  - The patient must have LDL levels of >130 mg/dL after a 90-day trial of each of the following, as evidenced by paid claims or pharmacy printouts:
    - A lipid lowering agent other than a statin combined with either Crestor (rosuvastatin) ≥20 mg or Lipitor (atorvastatin) ≥ 40 mg
    - A PCSK9 Inhibitor combined with either Crestor (rosuvastatin) ≥20 mg or Lipitor (atorvastatin) ≥ 40 mg

- The patient must currently be receiving a maximally tolerated statin (HMG-CoA reductase inhibitor) agent, as evidenced by paid claims or pharmacy printouts
- Clinical justification must be provided explaining why the patient is unable to use all other products to lower their cholesterol (subject to clinical review)

- **Renewal Criteria:** *Approval Duration = 12 months*
  - The patient must currently be receiving a maximally tolerated statin (HMG-CoA reductase inhibitor) agent, as evidenced by paid claims or pharmacy printouts
  - The patient must have experienced and maintained clinical benefit since starting treatment with the requested medication, as evidenced by medical documentation (e.g. chart notes) attached to the request (subject to clinical review)

ACL (ATP Citrate Lyase) INHIBITORS	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
	NEXLETOL (bempedioc acid)
	NEXLIZET (bempedoic acid and ezetimibe)
MTP (Microsomal Triglyceride Transfer Protein) INHIBITOR	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
	JUXTAPID (lomitapide)
EICOSAPENTAENOIC ACID (ESA) ETHYL ESTER	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
VASCEPA (icosapent ethyl) – *Brand Preferred*	icosapent ethyl
PCSK9 (Proprotien Convertase Subtilisin/Kexin Type 9) INHIBITORS	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
PRALUENT PEN (Alirocumab) – Labeler 72733	PRALUENT PEN (Alirocumab) – Labeler 00024
	REPATHA PUSHTRONEX (Evolocumab)
	REPATHA SURECLICK (Evolocumab)
	REPATHA SYRINGE (Evolocumab)
STATINS (HMG-CoA (3-hydroxy-3-methylglutaryl-CoA Reductase Inhibitors)	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
Amlodipine/Atorvastatin	ALTROPREV (lovastatin)
Atorvastatin	CADUET (Amlodipine/Atorvastatin)
Ezetimibe/Simvastatin	CRESTOR (rosuvastatin)
Fluvastatin	EZALLOR SPRINKLE (rosuvastatin)
JUVISYNC (sitaglipitin/simvastatin)	Fluvastatin ER
LIVALO (pitavastatin)	LESCOL XL (Fluvastatin)
Lovastatin	LIPITOR (atorvastatin)
Pravastatin	PRAVACHOL (pravastatin)
Rosuvastatin	VYTORIN (ezetimibe/simvastatin)
Simvastatin	ZOCOR (simvastatin)
	ZYPITAMAG (pitavastatin)

Pulmonary Hypertension

General Prior Authorization Form

PDE-5 Inhibitors

Electronic Age Verification

- Sildenafil/Tadalafil: Prior authorization is not required for ages less than 12 years old
- Revatio Suspension: Prior authorization is not required for ages less than 9 years old

Prior Authorization Criteria

Group Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age), with medical documentation (e.g. clinical notes) of their diagnosis attached to the request.
    - o

PREFERRED AGENTS (CLINCAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
ALYQ (Tadalafil)	ADCIRCA (Tadalafil) TABLET
REVATIO (Sildenafil) SUSPENSION*** - *Brand Preferred*	REVATIO (Sildenafil) TABLET
Sildenafil tablet	Sildenafil Suspension
Tadalafil tablet	

Soluble Guanylate Cyclase Stimulators

Electronic Diagnosis Verification

- The patient must have an FDA-approved diagnosis for use

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
ADEMPAS (riociguat)	

Endothelin Receptor Antagonists

Electronic Diagnosis Verification

- The patient must have an FDA-approved diagnosis for use

Prior Authorization Criteria

Group Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The patient must have had a 30-day trial of each preferred agent, as evidenced by paid claims or pharmacy printouts.
    - o

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Ambrisentan	Bosentan
TRACLEER (bosentan) SUSPENSION***	LETAIRIS (ambrisentan)
TRACLEER (bosentan) TABLETS - *Brand Preferred*	OPSUMIT (macitentan)

Prostacyclins

Electronic Diagnosis Verification

- The patient must have an FDA-approved diagnosis for use

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
ORENITRAM ER (Treprostinil) TABLET	REMODULIN (Treprostinil) INJECTION
UPTRAVI (Selexipag) TABLET	
Treprostinil injection	
TYVASO (Treprostinil) INHALATION	
VENTAVIS (Iloprost) INHALATION	

Dermatology

Acne

Therapeutic Duplication

- One strength of one retinoid medication is allowed at a time

- One strength of one benzoyl peroxide containing medication is allowed at a time

Electronic Age Verification

- The patient must be between 12 and 35 years of age

Prior Authorization Criteria

General Prior Authorization Form

Non-Preferred Agents Criteria:

- Clinical justification must be provided explaining why the patient is unable to use the preferred agents (subject to clinical review)

CLINDAMYCIN-BENZOYL PEROXIDE	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
ACANYA (Clindamycin-benzoyl peroxide) 1.2%-2.5% - *Brand Preferred*	BENZACLIN (Clindamycin/benzoyl peroxide without pump) 1%-5%
Clindamycin-benzoyl peroxide 1%-5% with pump	BENZACLIN (Clindamycin/benzoyl peroxide with pump) 1%-5%
Clindamycin-benzyl peroxide 1.2%-5%	Clindamycin-benzoyl peroxide 1.2%-2.5%
Clindamycin/benzoyl peroxide 1%-5% without pump	NEUAC (Clindamycin/benzoyl peroxide) 1.2%-5%
ONEXTON (Clindamycin/benzoyl peroxide) 1.2%-3.75%	
CLINDAMYCIN	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
Clindamycin capsule	CLEOCIN T (Clindamycin) GEL
Clindamycin gel	CLEOCIN T (Clindamycin) LOTION
Clindamycin lotion	CLEOCIN T (Clindamycin) MED SWAB
Clindamycin solution	CLINDACIN P (Clindamycin) MED SWAB
Clindamycin med. swab	CLINDACIN ETZ (Clindamycin) MED SWAB
EVOCLIN (Clindamycin) FOAM – *Brand Preferred*	CLINDAGEL (Clindamycin) GEL DAILY
ZIANA (Clindamycin-tretinoin 1.2%-0.025%) - *Brand Preferred*	Clindamycin Gel Daily
	Clindamycin foam
	Clindamycin-tretinoin 1.2%-0.025%
RETINOID	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
ALTRENO (tretinoin) LOTION	ATRALIN (Tretinoin) 0.05% GEL
RETIN-A (Tretinoin) GEL 0.01%, 0.025% - *Brand Preferred*	ARAZLO (Tazarotene) 0.045% LOTION
RETIN-A (Tretinoin) CREAM - *Brand Preferred*	Clindamycin-tretinoin 1.2%-0.025%
RETIN-A MICRO (Tretinoin Microsphere) GEL WITHOUT PUMP 0.4%, 0.1% - *Brand Preferred* (45 gram size)	FABIOR (Tazarotene) 0.1% FOAM
RETIN-A MICRO PUMP (Tretinoin Microsphere) 0.4%, 0.1% - *Brand Preferred* (45 gram size)	RETIN-A (Tretinoin) GEL 0.05%
RETIN-A MICRO PUMP (Tretinoin Microsphere) 0.08%	RETIN-A MICRO PUMP (Tretinoin Microsphere) 0.06%
Tretinoin gel (Generic co-preferred)	tretinoin microsphere with pump
Tretinoin cream (Generic co-preferred)	tretinoin microsphere without pump
ZIANA (Clindamycin-tretinoin 1.2%-0.025%) - *Brand Preferred*	
ADAPALENE	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
Adapalene gel	Adapalene 0.1% cream
Adapalene/Benzoyl Peroxide 0.1%-2.5%	Adapalene 0.3% gel with pump
DIFFERIN (adapalene) CREAM - *Brand Preferred*	DIFFERIN (adapalene) GEL

DIFFERIN (adapalene) GEL W/ PUMP - *Brand Preferred*	EPIDUO (adapalene/benzoyl peroxide) 0.1%-2.5%
DIFFERIN (adapalene) LOTION	
EPIDUO FORTE (adapalene/benzoyl peroxide) 0.3%-2.5%	
OTHER	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
ACZONE (Dapsone) GEL WITHOUT PUMP 5% - *Brand Preferred*	ACZONE (Dapsone) GEL WITH PUMP 7.5%
Cleansing Wash (Sulfacetamide sodium/Sulfur/Urea) 10%-4%-10%	AKLIEF (Trifarotene) CREAM 0.005%
SSS 10-5 (Sulfacetamide) FOAM	BP 10-1 (Sulfacetamide sodium/Sulfur) CLEANSER
Sulfacetamide 10% suspension	Dapsone gel without pump 5%
Sodium Sulfacetamide/Sulfur Cleanser 10%-5% (W/W)	Dapsone gel pump 7.5%
Sodium Sulfacetamide/Sulfur Cleanser 9%-4%	SSS 10-5 (Sulfacetamide) CLEANSER
Sodium Sulfacetamide/Sulfur Cleanser 9%-4.5%	Sodium sulfacetamide/sulfur pads 10%-4%
Sodium Sulfacetamide/Sulfur Cleanser 10%-2%	Sodium Sulfacetamide/Sulfur Cream 10%-2%
Sodium Sulfacetamide/Sulfur Suspension 8%-4%	SUMADAN (Sodium Sulfacetamide/Sulfur) CLEANSER 9%-4.5%
Sodium Sulfacetamide/Sulfur Cleanser 9.8% -4.8%	SUMAXIN (Sodium sulfacetamide/sulfur pads) PADS 10%-4%
SUMAXIN (Sodium Sulfacetamide/Sulfur) CLEANSER 9%-4%	SUMAXIN TS (Sodium Sulfacetamide/Sulfur) SUSPENSION 8%-4%
WINLEVI (clascoterone) 1% topical cream	
TETRACYCLINES	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
Doxycycline hyclate capsule	AMZEEQ (Minocycline) Foam
Doxycycline hyclate tablet 20mg, 100mg	Demeclocycline
Doxycycline monohydrate 25 mg/5mL suspension	DORYX (Doxycycline hyclate) TABLET DR
Doxycycline monohydrate tablet 50 mg, 75mg, 100mg	DORYX MPC (Doxycycline hyclate) TABLET DR
Doxycycline monohydrate capsule 50 mg, 100mg	Doxycycline monohydrate capsule 75mg, 150mg
Minocycline capsule	Doxycycline hyclate tablet 75mg, 150 mg
VIBRAMYCIN (Doxycycline calcium) 50 mg/5mL SYRUP	Doxycycline monohydrate tablet 75mg, 150 mg
	Doxycycline hyclate tablet DR
	MINOCIN (Minocycline) CAPSULE
	Minocycline tablet
	Minocycline Tablet ER
	MINOLIRA ER (Minocycline) TABLET
	MORGIDOX (Doxycycline hyclate) CAPSULE
	SEYSARA (Sarecycline)
	SOLODYN ER (Minocycline) TABLET
	Tetracycline
	VIBRAMYCIN (Doxycycline monohydrate) 25mg/5mL SUSPENSION
	XIMINO (Minocycline) CAPSULE ER

Actinic Keratosis

General Prior Authorization Form

Product Specific Criteria:

- Diclofenac 3% sodium gel requires electronic diagnosis verification of FDA indication

Non-Preferred Agents Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The patient must have had a 6-month trial of each preferred agent of a unique active ingredient, as evidenced by paid claims or pharmacy printouts.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
CARAC (Fluorouracil) 0.5% CREAM – *Brand Preferred*	ALDARA (Imiquimod) 0.5% CREAM
Diclofenac 3% sodium gel	EFUDEX (Fluorouracil) 5% CREAM
Imiquimod 5% cream packet	Fluorouracil 0.5% cream
Fluorouracil 5% cream	Fluorouracil 2% solution
ZYCLARA (imiquimod) 3.75% CREAM PUMP – *Brand Preferred*	Fluorouracil 5% solution
	Imiquimod 3.75% cream pump
	PICATO (ingenol mebutate)
	TOLAK (Fluorouracil) 4% CREAM
	ZYCLARA (imiquimod) 3.75% CREAM PACKET
	ZYCLARA (imiquimod) 2.5% CREAM PUMP

Antifungals – Topical

General Prior Authorization Form

Diagnosis Specific Criteria:

- **Onychomycosis:** *Approval Duration = 12 months*
  - The patient must have a diagnosis of an FDA approved indication for use
    - Diagnosis must be confirmed by potassium hydroxide (KOH) preparation
  - The patient must have had a trial of one oral agent (terbinafine, fluconazole, or itraconazole), for the length of recommended treatment time for patient's particular infection, as evidenced by paid claims or pharmacy printouts
  - Adequate time must have passed since treatment cessation to accurately assess healthy toenail outgrow (at least 6 months)
  - One of the following must be met (A or B):
    A. Clinical justification must be provided explaining why the patient is unable to use the preferred agents (subject to clinical review)
    B. The active ingredient of the requested product is not available in a preferred formulation
- **Other diagnoses:** *Approval Duration = 12 months*
  - The patient must have had a trial of 3 preferred agents, for the length of recommended treatment time for patient's particular infection, as evidenced by paid claims or pharmacy printouts
  - One of the following must be met (A or B):
    A. Clinical justification must be provided explaining why the patient is unable to use the preferred agents (subject to clinical review)
    B. The active ingredient of the requested product is not available in a preferred formulation

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Ciclopirox cream	CICLODAN (Ciclopirox) CREAM

Ciclopirox gel	CICLODAN (Ciclopirox) SOLUTION
Ciclopirox shampoo	EXTINA (Ketoconazole) FOAM
Ciclopirox solution	JUBLIA (efinaconazole) SOLUTION
Ciclopirox suspension	KERYDIN (tavaborole) SOLUTION
Clotrimazole cream	Ketoconazole foam
Clotrimazole solution	LOPROX (Ciclopirox) CREAM
Econazole cream	LOPROX (Ciclopirox) SHAMPOO
ERTACZO (sertraconazole) CREAM	LOPROX (Ciclopirox) SUSPENSION
EXELDERM CREAM (sulconazole) – *Brand Preferred*	LUZU (Luliconazole) Cream
EXELDERM SOLUTION (sulconazole) – *Brand Preferred*	Miconazole/zinc oxide/white petrolatum ointment
Ketoconazole cream	Natfifine Cream
Ketoconazole shampoo	Natfifine Gel
Luliconazole cream	NAFTIN (Naftifine) CREAM
MENTAX (butenafine) CREAM	NAFTIN (Naftifine) GEL
Miconazole cream	Oxiconazole cream
Nystatin cream	OXISTAT (Oxiconazole) CREAM
Nystatin ointment	OXISTAT (Oxiconazole) LOTION
Nystatin powder	Tavaborole solution
NYAMYC (Nystatin) POWDER	VUSION (Miconazole/Zinc/White Petrolatum) OINTMENT
Nystatin – triamcinolone cream	
Nystatin – triamcinolone ointment	
NYSTOP (Nystatin) POWDER	

Antipsoriatics – Topical

General Prior Authorization Form

Non-Preferred Agents Criteria:

- **For Foams and Sprays:**
  - Patient must have failed 30-day trials of the preferred solution and shampoo formulations, as evidenced by paid claims or pharmacy print outs
- **For Lotions:**
  - Patient must have failed a 30-day trial of a preferred agent, as evidenced by paid claims or pharmacy print outs
- **For Ointments:**
  - Patient must have failed 30-day trials of the preferred ointment formulations, as evidenced by paid claims or pharmacy print outs

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
calcipotriene ointment	calcipotriene/betamethasone ointment
calcipotriene solution	calcipotriene/betamethasone suspension
calcipotriene cream	Calcipotriene foam
TACLONEX (calcipotriene/betamethasone) SUSPENSION – *Brand Preferred*	calcitriol ointment
TACLONEX (calcipotriene/betamethasone) OINTMENT – *Brand Preferred*	DOVONEX (Calcipotriene) CREAM
TAZORAC (Tazarotene) CREAM 0.1% - *Brand Preferred*	DUOBRII (halobetasol/tazarotene) LOTION
TAZORAC (Tazarotene) GEL	ENSTILAR (calcipotriene/betamethasone) FOAM
VECTICAL (Calcitriol) OINTMENT – *Brand Preferred*	SORILUX (calcipotriene) FOAM
	Tazarotene 0.1% cream

Eczema / Atopic Dermatitis

Electronic Age Verification

Product Specific: Protopic (tacrolimus) ointment 0.1%

- The patient must be 16 years of age or older

Prior Authorization Criteria

Prior Authorization Form - Eczema

Topical Corticosteroids: Please see the Preferred Drug List of Topical Corticosteroids at the end of this document

Category PA Criteria:

- Patient must meet FDA label recommendations for indication and age

Product Specific Criteria (Initial): *Approval Duration = 3 months*

- **Dupixent and Eucrisa**
    - Patient must have had a 6-week trial of at least one of the following, as evidenced by paid claims or pharmacy printouts:
        - Tacrolimus OR Pimecrolimus
    - One of the following must be met (A or B):
        - A. Patient must have had two 2-week trials of topical corticosteroids of medium or higher potency, as evidenced by paid claims or pharmacy printouts.
        - B. Patient must meet both of the following (1 AND 2):
            1. Affected area is on face, groin, axilla, or under occlusion
            2. Patient must have had two 2-week trials of topical corticosteroids of low or higher potency, as evidenced by paid claims or pharmacy printouts.

Product Specific Criteria (Renewal): *Approval Duration = 12 months*

- **Eucrisa and Dupixent:**
    - The prescriber must submit documentation showing that the patient has achieved a significant reduction in severity of atopic dermatitis since treatment initiation

PREFERRED AGENTS (NO PA REQUIRED)	PREFERRED AGENTS (CLINCAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
ELIDEL (pimecrolimus) CREAM – *Brand Preferred*	DUPIXENT (dupilumab)***	Pimecrolimus
PROTOPIC (tacrolimus) OINTMENT 0.03% – *Brand Preferred*	EUCRISA (crisaborole) OINTMENT***	Tacrolimus 0.03%
PROTOPIC (tacrolimus) OINTMENT 0.1% – *Brand Preferred*		Tacrolimus 0.1%
Topical Corticosteroids		

Infantile Hemangioma

Electronic Age Verification

- The patient must be less than 1 years of age

Electronic Diagnosis Verification

- The patient must have an FDA approved diagnosis

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
HEMANGEOL (propranolol) ORAL SOLUTION	

Lice

General Prior Authorization Form

Please use the NDC Drug Lookup to find Prior Authorization (PA) Forms

Category Criteria:

- The patient must have had a 28-day/2-application trial of each preferred agent, as evidenced by paid claims or pharmacy printouts (not required *in the presence of a documented community breakout of a resistant strain that is only susceptible to a non-preferred agent).*

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
EURAX (crotamiton) CREAM	CROTAN (Crotamiton)
LICE KILLING SHAMPOO (Piperonyl butoxide/pyrethrins)	ELIMITE (permethrin) CREAM
NIX 1% (Permethrin) CRÈME RINSE LIQUID	EURAX (crotamiton) LOTION
Permethrin 5% cream	Lindane shampoo
SM LICE TREATMENT (Permethrin) 1% CRÈME RINSE LIQUID	Malathion
Spinosad	NATROBA (spinosad)
VANALICE (Piperonyl butoxide/Pyrethrins)	OVIDE (malathion)

Steroids - Topical

See Topical Corticosteroids Preferred Medication List

Endocrinology

Androgens

General Prior Authorization Form

Group Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The patient must have had a 30-day trial of each preferred agent, as evidenced by paid claims or pharmacy printouts.
- Clinical justification must be provided explaining why the patient is unable to use the preferred products (subject to clinical review).

Injectable/Implantable

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS:
Testosterone Cypionate injection	AVEED (Testosterone Undecanoate)
Testosterone Enanthate injection	DEPO-TESTOSTERONE (Testosterone Cypionate)
	TESTOPEL (Testosterone)
	XYOSTED (Testosterone Enanthate)

Oral

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS:
JATENZO (Testosterone Undecanoate)	ANDROID (Methyltestosterone)
	Methyltestosterone
	METHITEST (Methyltestosterone)
	TESTRED (Methyltestosterone)

Topical

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
ANDRODERM (testosterone) PATCH	ANDROGEL (testosterone)
Testosterone 1% (50mg/5g) gel packet	FORTESTA (testosterone) 2% (10mg/0.5g) Gel MD PMP
Testosterone 1% (25mg/2.5g) gel packet	TESTIM (testosterone) GEL TUBE
Testosterone 1% (25mg/2.5g) gel tube	Testosterone 2% (10mg/0.5g) Gel MD PMP Bottle

Please use the NDC Drug Lookup to find Prior Authorization (PA) Forms

Testosterone 1% (50mg/5g) gel tube	Testosterone 1.62% (20.25mg/1.25g) Gel Packet
Testosterone 1% (12.5mg/1.25g) Gel MD PMP Bottle	Testosterone 1.62% (40.5mg/2.5g) Gel Packet
Testosterone 1.62% (20.25mg/1.25g) Gel MD PMP Bottle	VOGELXO (Testosterone)

Diabetes

References:

1. American Diabetes Association Diabetes Care 2020 Jan; 43(Supplement 1): S98-S110. https://doi.org/10.2337/dc20-S009

Therapeutic Duplication

- One Strength of one medication is allowed at a time
- Medication classes not payable together:
  - DPP4-Inhibitors and GLP-1 Agonists
    - GLP-1 and DPP4-Inhibitors should not be used concurrently due to similar mechanisms of action
  - DPP4-Inhibitors and Insulins
    - GLP-1 should be considered in most patients prior to insulin
    - When initiating injectable therapy, sulfonylureas and DPP-4 inhibitors are typically discontinued
  - Sulfonylureas and Insulins
    - When initiating injectable therapy, sulfonylureas and DPP-4 inhibitors are typically discontinued
  - Thiazolidinediones with Insulins or Sulfonylureas
    - Thiazolidinediones increases the adverse effects of hypoglycemia, fluid retention, and heart failure when used concomitantly with sulfonylureas and insulin.
- **COVERED options in combination WITH INSULIN** therapy: GLP-1 Agonists, SGLT-2 inhibitors, and metformin.
  - GLP-1 Agonist and SGLT-2 inhibitors are recommended first line treatments for every pathway indicated in the guidelines (ASCVD, HF, CKD, Hypoglycemia risk, and to minimize weight gain)
  - Metformin is recommended throughout treatment escalation
- Humulin R U-500 is not allowed with any other insulin (basal or prandial)
  - Humulin R U-500 is indicated for monotherapy. It acts differently than regular insulin (U-100). It provides both basal and prandial coverage. Injections can be increased to 3 times per day for prandial coverage.

Underutilization

- Toujeo, Tresiba, and Metformin 1000mg must be used compliantly and will reject on point of sale for late fill

DPP4-Inhibitors

Electronic Age Verification

- The patient must be 18 years or older for Januvia, Janumet, or Janumet XR

Electronic Step Care and Concurrent Medications

- DPP4-Inhibitors require concurrent metformin
  - A total of 84 day supply of metformin must be paid within 100 days prior to the DPP4-Inhibitors date of service.
    - Metformin is recommended to be continued with escalation of therapy with DPP4-Inhibitors. If metformin is not tolerated, SGLT2 inhibitor and GLP-1 Agonists are recommended as part of the glucose-lowering regimen independent of A1C and are first line alternatives.
    - Patients with GI intolerances to high dose IR metformin should trial at minimum a dose of 500mg ER.

Prior Authorization Criteria

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The patient must have had a 30-day trial with EACH of the following agents, as evidenced by paid claims or pharmacy printouts:
  - A preferred sitagliptin product (Janumet, Janumet XR, or Januvia)
  - A preferred linagliptin preferred product (Jentadueto or Tradjenta)
  - Victoza
- One of the following must be met (A OR B):
  A. The requested agent is a combination product containing metformin
  B. The patient is currently stable on a metformin-containing agent, with good compliance in the past 3 months, as evidenced by paid claims or pharmacy printouts (patients with GI intolerances to high dose IR metformin should trial at minimum a dose of 500mg ER).

++Clinically Non-Preferred: Alogliptin and Saxagliptan have a potentially higher risk for heart failure

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
JANUMET (sitagliptin/metformin)	++alogliptan/pioglitazone
JANUMET XR (sitagliptin/metformin)	++alogliptin
JANUVIA (sitagliptin)	++alogliptin/metformin
JENTADUETO (linagliptin/metformin)	++KAZANO (alogliptin/metformin)
JENTADUETO XR (linagliptin/metformin)	++KOMBIGLYZE XR (saxagliptin/metformin)
TRADJENTA (linagliptin)	++NESINA (alogliptin)
	++ ONGLYZA (saxagliptin)
	++OSENI (alogliptin/pioglitazone)

DPP4-Inhibitors/SGLT2 Inhibitors Combination

General Prior Authorization Form

Group Criteria:

- The prescriber must provide medical justification explaining why the patient cannot use individual preferred products separately

++Clinically Non-Preferred: Saxagliptan has a potentially higher risk for heart failure

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
	GLYXAMBI (Empagliflozin/linagliptin)
	STEGLUJAN (Ertugliflozin/Sitagliptin)
	TRIJARDY XR (Empagliflozin/Linagliptan/Metformin)
	++QTERN (Dapagliflozin/Saxagliptin)

GLP-1 Agonists

General Prior Authorization Form

Non-Preferred Step 1 Agents Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The patient must have had 90-day trials of each of the following, as evidenced by paid claims or pharmacy printouts:
  - Victoza
  - An SGLT-2 Inhibitor: Jardiance, Farxiga, or Invokana

Non-Preferred Step 2 Agents Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The patient must have had 90-day trials of each of the following, as evidenced by paid claims or pharmacy printouts:
    - Victoza
    - An SGLT-2 Inhibitor: Jardiance, Farxiga, or Invokana
    - Ozempic titrated to max dose

Product Specific Criteria:

- ***Adlyxin and Rybelsus:
    - The patient must have had 90-day trials of each of the following, as evidenced by paid claims or pharmacy printouts:
        - Bydureon BCISE
        - Trulicity

++Clinically Non-Preferred: Byetta is less effective than other available agents

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (STEP 1 – PA REQUIRED)	NON-PREFERRED AGENTS (STEP 2 – PA REQUIRED)
VICTOZA (liraglutide)	OZEMPIC (semaglutide)	ADLYXIN (lixisenatide)***
BYDUREON (exenatide microspheres)		BYDUREON BCISE (exenatide microspheres)
		++BYETTA (exenatide)
		RYBELSUS (semaglutide)***
		TRULICITY (dulaglutide)

Gastroparesis

General Prior Authorization Form

Non-Preferred Agents Criteria:

- **Initial Criteria:** *Approval Duration = 3 months*
    - The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age)
    - Clinical justification must be provided explaining why the patient is unable to use the solid dosage formulation, with relevant medical documentation (e.g. swallow study) attached to the request (subject to clinical review)
    - The patient must not have any of the following contraindications to treatment with metoclopramide:
        - Diagnosis of epilepsy
        - Gastrointestinal hemorrhage, mechanical obstruction, or perforation
        - Tardive dyskinesia
- **Renewal Criteria:** *Approval Duration = 3 months*
    - The patient must have experienced and maintained clinical benefit since starting treatment with the requested medication, as evidenced by medical documentation (e.g. chart notes) attached to the request (subject to clinical review)

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Metoclopramide tablet	GIMOTI (metoclopramide nasal spray)

Glucose Rescue Medications

Electronic Duration Verification

Override Available

- 2 doses (initial and replacement doses) are covered every 180 days without prior authorization

Prior Authorization

General Prior Authorization Form

Non-Preferred Criteria

- The prescriber must provide medical justification explaining why the patient cannot use the preferred products (subject to clinical review).

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
BAQSIMI (Glucagon)	GVOKE (Glucagon)
Glucagon Kit	GLUCOGEN (Glucagon) HYPOKIT

Insulin/GLP-1 Agonist Combination

General Prior Authorization Form

Group Criteria:

- The prescriber must provide medical justification explaining why the patient cannot use the individual preferred products separately (subject to clinical review)

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS:
	SOLIQUA (Insulin glargine/lixisenatide)
	XULTOPHY (insulin degludec/liraglutide)

Insulin

Electronic Duration Verification

Override Available

- Products containing NPH insulin are limited to 210 days of coverage for every 365 days to allow for use in pregnancy and breastfeeding.
    - Lantus and Levemir have been demonstrated to reduce the risk of symptomatic and nocturnal hypoglycemia compared with NPH insulin.

Quantity Limit

- **Toujeo Max Solostar 300 unit/mL and Tresiba 200 unit/mL:**
  Doses between 100 unit/day to 200 unit/day are covered automatically (do not require prior authorization approval for coverage). Please request an override if day supply is less than 30 days and dose is between 100 units/day and 200 units/day by calling 1-800-755-2604.
    - **For dose <100 unit/day**, the same criteria as Toujeo Solostar 100 unit/mL or Tresiba 100 unit/mL must be met as outlined below.
    - **For dose >200 units of insulin per day**, clinical justification must be provided explaining why the patient is not a candidate for U-500R (Toujeo and Tresiba are not intended as replacements for U500 insulin).

Prior Authorization

Insulin Prior Authorization Form

Group Criteria:

- **Non-preferred insulins:**
    - Clinical justification must be provided explaining why the patient is unable to use the preferred products (subject to clinical review).
- **Insulin syringe/pens:**
    - Clinical justification must be provided explaining why the patient is unable to use the preferred insulin vial/pen products (subject to clinical review).

Product Specific Criteria:

- ***Fiasp:** The patient must have had a 3-month trial of one of the following agents, as evidenced by paid claims or pharmacy printouts:
    - Novolog, Humalog, or Apidra
- ***Toujeo Solostar 100 unit/mL and 300 unit/mL and Tresiba 100 unit/mL:**
    - **Initial Criteria:** *Approval 6 months*
        - The requested agent must be prescribed by or in consultation with an endocrinologist or diabetes specialist.
        - One of the following must be met, as evidenced by provided clinical notes or labs:

- The patient experiences recurrent episodes of hypoglycemia on Insulin glargine U100 and insulin detemir U100 despite adjustments to current regimen (prandial insulin, interacting drugs, meal and exercise timing).
- The patient must be experiencing inconsistent blood sugars after a 90-day trial with good compliance, as evidenced by paid claims or pharmacy printouts of each of the following:
  - Lantus
  - Levemir

- Basal insulin requirement is less than 100 units per day
- **Toujeo Solostar 300 unit/mL:** Clinical justification must be provided explaining why the patient needs for a smaller volume of insulin (max is 80 units/injection for both Insulin glargine 300 units/mL and 100 units/mL. Patients using Insulin glargine 300 unit/mL may require more basal insulin than those receiving 100 units/mL).

- **Toujeo Solostar 100 unit/mL and 300 unit/mL and Tresiba 100 unit/mL Renewal Criteria:** *Approval 12 months*
  - The patient must have experienced at least one of the following, as evidenced by provided clinical notes or labs:
    - Reduction in frequency and/or severity of hypoglycemia
    - Improved glycemic control (A1C)

Rapid Acting Insulin	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
APIDRA (insulin glulisine) VIAL	ADMELOG (insulin lispro) VIAL
APIDRA SOLOSTAR (insulin glulisine) INSULIN PEN	ADMELOG SOLOSTAR (insulin lispro) INSULIN PEN
HUMULIN R (insulin regular, human) VIAL	AFREZZA (insulin regular, human)
Insulin aspart flexpen	FIASP (insulin aspart) CARTRIDGE***
Insulin aspart cartridge	FIASP (insulin aspart) SYRINGE***
Insulin aspart syringe	FIASP (insulin aspart) VIAL***
Insulin aspart vial	HUMALOG U-100 (insulin lispro) KWIKPEN
Insulin lispro junior	HUMALOG (insulin lispro) VIAL
Insulin lispro vial	HUMALOG (insulin lispro) CARTRIDGE
Insulin lispro insulin pen	HUMALOG U-200 (insulin lispro) KWIKPEN
NOVOLIN R (insulin regular, human) VIAL	HUMALOG JUNIOR KWIKPEN (insulin lispro)
	LYUMJEV (Insulin lispro-aabc) KWIKPEN
	LYUMJEV (Insulin lispro-aabc) VIAL
	NOVOLOG (insulin aspart) CARTRIDGE
	NOVOLOG (insulin aspart) FLEXPEN
	NOVOLOG (insulin aspart) VIAL
Intermediate Acting Insulin	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
NOVOLIN N (insulin NPH human isophane) FLEXPEN	HUMULIN N (insulin NPH human isophane) VIAL
HUMULIN R (Insulin regular, human) U-500 KWIKPEN	HUMULIN N (insulin NPH human isophane) KWIKPEN
HUMULIN R U-500 (insulin regular, human) VIAL	NOVOLIN N (insulin NPH human isophane) VIAL
Long Acting Insulin	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
LANTUS (insulin glargine) SOLOSTAR	BASAGLAR KWIKPEN U-100 (insulin glargine)
LANTUS (insulin glargine) VIAL – *Brand Required*	SEMGLEE (insulin glargine)
LEVEMIR (insulin detemir) VIAL	TOUJEO SOLOSTAR (insulin glargine)***

Please use the NDC Drug Lookup to find Prior Authorization (PA) Forms

LEVEMIR (insulin detemir) FLEXTOUCH	TRESIBA (insulin degludec) FLEXTOUCH U-100***
TOUJEO MAX SOLOSTAR (insulin glargine)	TRESIBA (insulin degludec) VIAL***
TRESIBA (insulin degludec) FLEXTOUCH U-200	
Mixed Insulin	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
HUMALOG MIX 50/50 (insulin NPL/insulin lispro) KWIKPEN	Insulin lispro mix 75/25 kwikpen
HUMALOG MIX 75/25 (insulin NPL/insulin lispro) KWIKPEN – *Brand Preferred*	NOVOLIN 70-30 (insulin NPH human/regular insulin human) VIAL
HUMALOG MIX 50/50 (insulin NPL/insulin lispro) VIAL	NOVOLIN 70-30 (insulin NPH human/regular insulin human) FLEXPEN
HUMALOG MIX 75/25 (insulin NPL/insulin lispro) VIAL	NOVOLOG MIX 70/30 (insulin aspart protamine/insulin aspart) FLEXPEN
HUMULIN 70/30 (insulin NPH human/regular insulin human) VIAL	NOVOLOG MIX 70/30 (insulin aspart protamine/insulin aspart) VIAL
HUMULIN 70/30 (insulin NPH human/regular insulin human) KWIKPEN	
Insulin aspart protamine/insulin aspart insulin pen	
Insulin aspart protamine/insulin aspart vial	

Rosiglitazone

General Prior Authorization Form

Product Specific Criteria:

- The patient must have failed a 30-day trial of pioglitazone, as evidenced by paid claims or pharmacy printouts
- Clinical justification must be provided explaining why the patient is unable to use the preferred agents and other classes of medication (subject to clinical review)

++ Clinically Non-preferred: Pioglitazone has a potential benefit over rosiglitazone for ASCVD.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Pioglitazone	++Rosiglitazone

SGLT2 Inhibitors

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The patient must have had a 30-day trial of each preferred SGLT2 inhibitor of a unique active ingredient, as evidenced by paid claims or pharmacy printouts.
- The patient is currently stable on a metformin-containing agent, with good compliance in the past 3 months, as evidenced by paid claims or pharmacy printouts (patients with GI intolerances to high dose IR metformin should trial at minimum a dose of 500mg ER).

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
FARXIGA (dapagliflozin)	STEGLATRO (ertugliflozin
INVOKANA (canagliflozin)	STEGLATROMET (ertugliflozin/metformin)
INVOKAMET (canagliflozin)	
INVOKAMET XR (canagliflozin/metformin)	
JARDIANCE (empagliflozin)	
SYNJARDY (empagliflozin/metformin)	
SYNJARDY XR (empagliflozin/metformin)	
XIGDUO XR (dapagliflozin/metformin)	

Sulfonylureas

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have failed a 30-day trial of glipizide, as evidenced by paid claims or pharmacy printouts.
- Clinical justification must be provided explaining why the patient is unable to use the preferred agents and other classes of medication (subject to clinical review).

++Clinically Non-preferred: Glyburide is not recommended due to hypoglycemia

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Glimepiride	++glyburide
Glipizide	++glyburide/metformin
Glipizide/Metformin	++glyburide, micronized
Glipizide ER	++GLYNASE (glyburide, micronized)

Dojolvi

General Prior Authorization Form

Criteria for initial requests: *Approval Duration = 12 months*

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age)
- The provider must attach documentation of DNA testing confirming the patient's diagnosis of a long-chain fatty acid oxidation disorder

Growth Hormone

Prior Authorization Form - Growth Hormone

Group Criteria:

- Patients new to GH therapy must meet the criteria below and be started on a preferred growth hormone.
    - Patients continuing GH therapy and having met the criteria listed below must be switched to a preferred growth hormone.
- **For Initial or Renewal Requests:**
    - Patient must have a diagnosis of a **covered indication** (listed below):
        - Multiple pituitary hormone deficiencies caused by a known hypothalamic-pituitary disease or its treatment (brain surgery and/or radiation)
        - Turner's syndrome
        - SHOX syndrome
        - Noonan syndrome
        - Chronic renal insufficiency
        - Prader–Willi syndrome
        - Endogenous growth hormone deficiency
    - For all covered indications:
        - Patient must not have active malignancy
        - Prescriber must be an endocrinologist or nephrologist, or prescriber must have at least one annual consultation about the patient with the pediatric specialty.
        - Patient must not have epiphyseal closure and must still be growing, unless one of the below exceptions is present:
            - Exceptions:
                - Patient has a diagnosis of Prader-Willi syndrome
                - Patient has a diagnosis of endogenous growth hormone deficiency - and is experiencing hypoglycemic episodes without growth hormone and growth hormone is needed to maintain proper blood glucose.

- Diagnosis of chronic renal insufficiency (additional criteria):
  - Patient must not have received a renal transplant.
  - Patient must consult with a dietitian to maintain a nutritious diet.
- Diagnosis of Prader–Willi syndrome (additional criteria):
  - Sleep apnea must be ruled out by sleep study in obese patients.
  - Patient must consult with a dietitian to maintain a nutritious diet.

- **Additional Criteria for Initial Authorization Requests:**
  - Diagnosis of endogenous growth hormone deficiency:
    - Must meet ONE of below criteria (A OR B)
      A. Patients with multiple pituitary hormone deficiencies caused by a known hypothalamic-pituitary disease or its treatment (brain surgery and/or radiation) must have an IGF-1 or IGFBP-3 level of less than SDS 1.3.
      B. Patient must have had two GH stimulation tests by insulin, levodopa, L-arginine, propranolol, clonidine, or glucagon with a maximum peak of < 10ng/mL after stimulation no more than 6 months apart

- **Additional Criteria for Subsequent Authorization**
  - For all covered indications:
    - Patient must have been compliant with growth hormone (last 6 fills must have been on time).
  - Diagnosis of Prader–Willi syndrome (additional criteria):
    - If patient is obese, BMI must have decreased. If patient is not obese, BMI must have maintained or decreased.

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
GENOTROPIN (somatropin)	NUTROPIN AQ (somatropin)
GENOTROPIN MINIQUICK (somatropin)	OMNITROPE (somatropin)
NORDITROPIN FLEXPRO (somatropin)	SAIZEN (somatropin)
	ZOMACTON (somatropin)

Serostim

Prior Authorization Form - Growth Hormone

Product Specific Criteria (Initial):

- Patient must have a diagnosis of treatment of HIV with wasting cachexia
- Patient must not have an active malignancy
- Prescriber must be experienced in the diagnosis and management of HIV infection
- Patient must be on concomitant antiretroviral therapy
- Patient must have failed a 3-month trial with Megace, as evidenced by paid claims or pharmacy Printouts

Product Specific Criteria (Renewal):

- Lean body mass and body weight must have increased in the past 12 weeks
- Physical endurance must have increased in past 12 weeks
- Patient must not have completed 48 weeks of continuous treatments

Zorbtive

Prior Authorization Form - Growth Hormone

Product Specific Criteria:

- Patient must not have active malignancy

- Patient must have diagnosis of short bowel syndrome
- Patient must be receiving specialized nutritional support
- Treatment duration must not be longer than 4 weeks

Osteoporosis

Electronic Diagnosis Verification

- Risedronate 30mg requires FDA indication of Paget's Disease of the bone and is not indicated for osteoporosis

Prior Authorization Form - Osteoporosis

Non-Preferred Agents Criteria (Initial): *Approval Duration = 2 years*

- The patient must have a diagnosis of an FDA-approved indication for use
- The patient must have a current BMD T-score ≤ -2.5 OR new fracture after a 6-month trial of each of the following, as evidenced by paid claims or pharmacy printouts:
  - Alendronate or Risedronate
  - Denosumab
- Patient must be at high risk of fracture, confirmed by at least one of the following:
  - The patient with a history of hip or vertebral fracture
  - The patient with a T-score of −2.5 or lower at the femoral neck or spine
  - The patient who have a T-score of between −1.0 and −2.5 at the femoral neck or spine and a ten-year hip fracture risk of ≥3% as assessed with the FRAX
  - 10-year risk of a major osteoporosis-related fracture of ≥20% as assessed with the FRAX

Product Specific Criteria:

- ***** Alendronate oral solution:**
  - The patient must be unable to ingest solid dosage form as evidenced by swallow study documentation
- *****Tymlos and Miacalcin:**
  - The patient must have a current BMD T-score ≤ -2.5 OR new fracture after a 6-month trial of Forteo (Teriparatide), as evidenced by paid claims or pharmacy printouts
- ***** Teriparatide:**
  - Clinical justification must be provided explaining why Forteo is unable to be used (subject to clinical review).

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Alendronate	ACTONEL (risedronate)
Alendronate oral solution PA***	EVISTA (Raloxifene)
Calcitonin, Salmon Nasal Spray	FORTEO (Teriparatide)
Ibandronate	MIACALCIN (Calcitonin, Salmon)***
PROLIA (Denosumab)	Teriparatide***
Raloxifene	TYMLOS (Abaloparatide)***
Risedronate	

Pituitary Suppressants

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
ELIGARD (leuprolide)	
LUPRON DEPOT (leuprolide)	
SUPPRELIN LA (histrelin)	

SYNAREL (nafarelin)	
TRESTAR (triptorelin)	
TRIPTODUR (triptorelin)	
VANTAS (histrelin)	
ZOLADEX (goserelin)	

Gastrology

Constipation – Irritable Bowel Syndrome/Opioid Induced

Therapeutic Duplication

- One medication is allowed at a time

Idiopathic Constipation

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must be 18 years of age or older.
- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The patient must have had 30-day trials of each of the following, as evidenced by paid claims or pharmacy printouts:
    - Amitiza and Linzess

Product Specific Criteria

- ***Motegrity: The patient must have had a 30-day trial with Trulance, as evidenced by paid claims or pharmacy printouts

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
AMITIZA (lubiprostone) - *Brand Preferred*	LINZESS (linaclotide) 72 mcg
LINZESS (linaclotide) 145 mcg, 290 mcg	lubiprostone
	MOTEGRITY (prucalopride)
	TRULANCE (plecanatide)

Opioid-Induced Constipation:

Electronic Step Care and Concurrent Medications

- Medications indicated for opioid-induced constipation should be discontinued when opioids are stopped.
    - A total of 28 days of opioid analgesics must be paid within 40 days prior to requested Movantik, Symproic, or Relistor's date of service

Prior Authorization Criteria

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must be 18 years of age or older.
- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The patient must be currently receiving an opioid agent, as evidenced by paid claims or pharmacy printouts.
- The patient must have had 30-day trials of each of the following, as evidenced by paid claims or pharmacy printouts:
    - Amitiza and Movantik

Non-Oral Dose Formulations Criteria:

- The patient must be unable to ingest solid dosage form as evidenced by swallow study documentation

Solid Oral Dose Formulations	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
AMITIZA (lubiprostone) - *Brand Preferred*	lubiprostone
MOVANTIK (naloxegol)	RELISTOR (methylnaltrexone) TABLET
	SYMPROIC (naldemedine)
Non-Oral Dose Formulations	
PREFERRED AGENTS (CLINICAL PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
RELISTOR (methylnaltrexone) SYRINGE	
RELISTOR (methylnaltrexone) VIAL	

Diarrhea

Electronic Step Care and Concurrent Medications

- Xifaxan: Xifaxan 550mg does not require prior authorization for hepatic encephalopathy if used concurrently with lactulose
    - A total of 30 days of Lactulose must be paid within 65 days prior to Xifaxan's date of service

Prior Authorization Criteria

General Prior Authorization Form

Non-Preferred Agents Criteria:

- Initial Criteria: *Approval Duration = 3 months*
    - The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis, age, and duration of treatment).
    - The provider must submit medication documentation confirming that infectious and medication-induced etiologies of diarrhea have been ruled out
    - The patient must have had a 30-day trial of each preferred agent, as evidenced by paid claims or pharmacy printouts.
- Renewal Criteria: *Approval Duration = 12 months*
    - The patient must have experienced and maintained clinical benefit since starting treatment with requested product, as evidenced by medical documentation (e.g. chart notes) attached to the request (subject to clinical review)

Irritable Bowel Syndrome

Product Specific Criteria:

- ***alosetron**:
    - The patient must be a female.
- ***** dicyclomine Oral Syrup:** The patient must be unable to ingest solid dosage form as evidenced by swallow study documentation

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED):
dicyclomine Capsule	alosetron***
dicyclomine Tablet	dicyclomine oral syrup***
diphenoxylate/atropine	LOMOTIL (diphenoxylate/atropine)
loperamide	VIBERZI (eluxadoline)
LOTRONEX (alosetron)*** - *Brand Preferred*	XIFAXAN (rifaximin) 550 mg tablet

HIV/AIDs

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Diphenoxylate/Atropine	LOMOTIL (Diphenoxylate/Atropine)
Loperamide	MYTESI (Crofelemer)

Digestive Enzymes

General Prior Authorization Form

Non-Preferred Agents Criteria:

- A 30-day trial of all PREFERRED AGENTS will be required before a non-preferred agent will be authorized unless patient stable on a pancreatic enzyme written by a gastroenterologist or pancreas disease specialist

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
CREON (lipase/protease/amylase)	PANCREAZE (lipase/protease/amylase)
ZENPEP (lipase/protease/amylase)	PERTZYE (lipase/protease/amylase)
	VIOKACE (lipase/protease/amylase)

Nausea/Vomiting

Chemo Induced

Prior Authorization Form - Nausea/Vomiting

Non-Preferred Agents Criteria: *Approval Duration = 6 months or until last day of chemotherapy*

- The patient must have diagnosis of nausea and/or vomiting
- Prescriber must be an oncologist
- The patient must be receiving a moderately or highly emetogenic chemotherapy
- The final date of chemotherapy treatment must be provided with the request
- Patient must have failed a 3-day trial of each preferred product(s) in the same class within the last 6 months as evidenced by paid claims or pharmacy print outs
- Patient must not have failed preferred chemical entity with same active ingredient as requested product due to side effects

NK1 RECEPTOR ANTAGONISTS	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
AKYNZEO (Netupitant/Palonosetron)	Aprepitant Capsule
VARUBI (Rolapitant) TABLET	EMEND (Aprepitant) CAPSULE
	EMEND (Aprepitant) SUSPENSION
5-HT3 RECEPTOR ANTAGONISTS	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
AKYNZEO (Netupitant/Palonosetron)	SANCUSO (Granisetron) PATCH
Granisetron tablet	ZOFRAN (Ondansetron) TABLET
Ondansetron ODT	SUSTOL (granisetron) SYRINGE
Ondansetron solution	
Ondansetron tablet	
CANNABINOIDS	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
Dronabinol Capsule	MARINOL (Dronabinol) CAPSULE

Pregnancy

Prior Authorization Form - Nausea/Vomiting

Non-Preferred Agents Criteria: *Approval Duration = 3 months or until due date*

- Patient must have diagnosis of nausea and vomiting of pregnancy
- Patient's due date must be provided

- The prescriber must submit medical justification explaining why the patient cannot use a preferred product (subject to clinical review)

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
BONJESTA (doxylamine/vitamin B6)	Doxylamine/Vitamin B6
DICLEGIS (doxylamine/vitamin B6) – *Brand Preferred*	
meclizine	
metoclopramide	
ondansetron	

Proton Pump Inhibitor

References

1. Katz PO, Gerson LB, Vela MF. Guidelines for the diagnosis and management of gastroesophageal reflux disease. Am J Gastroenterol 2013;108:308-28.
2. Fackler WK, Ours TM, Vaezi MF, Richter JE. Long-term effect of H2RA therapy on nocturnal gastric breakthrough. Gastroenterology. 2002;122:625-632.

Therapeutic Duplication

- One strength of one medication is allowed at a time
- Proton Pump Inhibitors is not allowed with:
  - H2 Blockers: Overrides Available
  - Esomeprazole or omeprazole are not covered with Clopidogrel. Other PPIs such as pantoprazole are covered with clopidogrel.
    - Clopidogrel is a substrate for 2C19 and esomeprazole and omeprazole are strong 2C19 inhibitors and can decrease effectiveness of Clopidogrel.
  - Dextroamphetamine/Amphetamine ER
    - Proton Pump Inhibitors increase blood levels and potentiate the action of amphetamine. Co-administration of Adderall XR and gastrointestinal or urinary alkalizing agents should be avoided

Electronic Age Verification

- Nexium 2.5mg and 5mg Packet: The patient must be less than 1 years old (or less than 7.5kg)

Electronic Step Care and Concurrent Medications

- Non-Preferred Step 1 Agents: Use least expensive proton pump inhibitors must be trialed first
  - A total of 28 days of 2 preferred agents at max dose must be paid within 90 days prior to step 1 agents date of service.

Prior Authorization Criteria

General Prior Authorization Form

Group Criteria: *Approval Duration = 6 months*

Non-Preferred Agents Criteria: Step 2 Agents:

- Clinical justification must be provided explaining why the patient is unable to use the other agents (subject to clinical review).
- Non-Solid Dosage Forms: The patient must have feeding tube in place

Solid Dosage Forms

SOLID DOSAGE FORMS		
PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED STEP 1 AGENTS (ELECTRONIC STEP)	NON-PREFERRED STEP 2 AGENTS (PA REQUIRED)
DEXILANT (dexlansoprazole)	esomeprazole magnesium	NEXIUM (esomeprazole)
lansoprazole	rabeprazole	omeprazole-sodium bicarbonate
omeprazole		PREVACID (lansoprazole)
pantoprazole		PRILOSEC (omeprazole)
		PROTONIX (pantoprazole)

Please use the NDC Drug Lookup to find Prior Authorization (PA) Forms

Non-Solid Dosage Forms

NON-SOLID DOSAGE FORMS		
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED STEP 1 AGENTS (ELECTRONIC STEP)**	**NON-PREFERRED STEP 2 AGENTS (PA REQUIRED)**
NEXIUM (esomeprazole) PACKET *– Brand Preferred*	PRILOSEC PACKET (omeprazole)	ACIPHEX SPRINKLE (rabeprazole)
omeprazole ODT		esomeprazole solution packet
PREVACID (lansoprazole) SOLUTAB *– Brand Preferred*		lansoprazole ODT
PROTONIX (pantoprazole) PACKET *– Brand Preferred*		omeprazole-sodium bicarbonate packet
		pantoprazole packet
		rabeprazole sprinkle

Vancomycin - Oral

General Prior Authorization Form

Non-Preferred Agents Criteria: *Approval Duration = 5 days*

- The patient must have diagnosis of *Clostridium difficile*-associated diarrhea (CDAD)
- The patient must be 18 years of age or older
- The patient must have failed a 10-day trial with a preferred agent, as evidenced by paid claims or pharmacy printouts

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
FIRVANQ (vancomycin) SOLUTION 25mg/mL	DIFICID (fidaxomicin) TABLET
Vancomycin capsule	FIRVANQ (vancomycin) SOLUTION 50mg/mL
Vancomycin solution 50mg/mL	VANCOCIN (vancomycin) CAPSULE

Genetic and Rare Disease

Cystic Fibrosis

Cystic Fibrosis - Inhaled Antibiotics

General Prior Authorization Form

Product Specific Criteria:

- ***Tobi Podhaler:**
  - The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
  - The patient must have had a 28-day trial of a preferred nebulized product, as evidenced by paid claims or pharmacy printouts.
- ***Cayston:**
  - The patient must be colonized with *Pseudomonas aeruginosa.*
  - The patient must have had a 28-day trial of TOBI Podhaler, as evidenced by paid claims or pharmacy printouts.
- ***Arikayce:**
  - The patient must be colonized with *Mycobacterium avium* complex (MAC).
  - The patient must have not achieved negative sputum cultures after a minimum duration of 6 consecutive months of background treatment with a macrolide, a rifamycin, and ethambutol.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
BETHKIS (tobramycin)	ARIKAYCE (amikacin/nebulizer) ***
KITABIS PAK (tobramycin/nebulizer) - *Brand Preferred*	CAYSTON (aztreonam)***
TOBI PODHALER (tobramycin) PA***	tobramycin
TOBI (tobramycin) – *Brand Preferred*	tobramycin/nebulizer

Cystic Fibrosis – CFTR Modulators

General Prior Authorization Form

Group Criteria: *Approval Duration = 12 months*

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The patient must have a CFTR mutation that the requested medication is FDA-approved to treat, as evidenced by medical documentation (e.g. chart notes, genetic testing) that is attached to the request

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
KALYDECO (ivacaftor)	
ORKAMBI (lumacaftor/ivacaftor)	
SYMDEKO (tezacaftor/ivacaftor)	
TRIKAFTA (elexacaftor/tezacaftor/ivacaftor)	

Hereditary Angioedema

General Prior Authorization Form

Category Criteria:

- The patient must have diagnosis of hereditary angioedema, confirmed by a specialist.

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
BERINERT (C1 Esterase Inhibitor)	FIRAZYR (icatibant)
CINRYZE (C1 Esterase Inhibitor)	
HAEGARDA (C1 Esterase Inhibitor)	
icatibant	
KALBITOR (ecallantide)	
ORLADEYO (berotrlastat)	
RUCONEST (C1 Esterase Inhibitor)	
TAKHZYRO (lanadelumab-FLYO)	

Idiopathic Pulmonary Fibrosis / Interstitial Lung Disease

Prior Authorization Form - Idiopathic Pulmonary Fibrosis

Category Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The prescriber must be, or in consult with, a pulmonologist or rheumatologist.
- The patient must have forced vital capacity (FVC) ≥ 40% of predicted within prior 60 days
- The patient must have carbon monoxide diffusing capacity (DLCO, corrected for hemoglobin) of 30% to 79% of predicted.

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
ESBRIET (Pirfenidone)	
OFEV (Nintedanib)	

Phenylketonuria

Kuvan:

Underutilization

- Kuvan must be used compliantly and will reject on point of sale for late fill

Prior Authorization Criteria

Prior Authorization Form - Phenylketonuria

Criteria for initial requests: *Approval Duration = 2 months*

- The patient must have a diagnosis of hyperphenylalaninemia
- The patient must be following a PHE restricted diet
- The patient's weight must be provided
- The patient must be 4 years of age or older
- The patient must not have been known to have two null mutations in TRANS
- Baseline PHE levels must be attached
    - For females of child bearing potential: PHE levels must be above 360 micromoles/liter
    - For males or females unable to bear children: PHE levels must be above 600 micromoles/liter
- Requested initial dose must be 10 mg/kg or less

Criteria for renewal requests: *Approval Duration = 12 months*

- The patient's weight must be provided
- If dose is the same or less than previous trial:
    - PHE level must be between 60 and 360 micromoles per liter
- For a dose increase from previous trial:
    - PHE levels must be attached that were taken after 1 month of previous trial
    - The patient's PHE level must be greater than 360 micromoles per liter
    - For increase > 10 mg/kg - patient must have failed a trial of 1 month of 10 mg/kg

Palynziq:

Prior Authorization Form - Phenylketonuria

Criteria for initial requests: *Approval Duration = 6 months*

- The patient must have a diagnosis of hyperphenylalaninemia
- The patient must be following a PHE restricted diet
- The patient must be 18 years of age or older
- PHE levels must be above 600 micromoles/liter
- The patient must have been compliant with diet and medication management for past 6 months.

Criteria for renewal requests: *Approval Duration = 12 months*

- **If dose is the same or less than previous trial:**
    - PHE level must be between 60 and 360 micromoles per liter
- **For a dose increase to 40 mg:**
    - PHE levels must be attached that were taken after 24 weeks of 20 mg
    - The patient's PHE level must be greater than 360 micromoles per liter

Immunology

Biosimilar Agents

General Prior Authorization Form

Group Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- Clinical justification must be provided explaining why the patient is unable to use the preferred agents (subject to clinical review)

Cytokine Modulators

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have had a 3-month trial of 2 preferred cytokine modulator agents, as evidenced by paid claims or pharmacy printouts.

Product Specific Criteria:

- **Skyrizi:**
  - The patient must have had a 3-month trial of 1 non-preferred agent, as evidenced by paid claims or pharmacy printouts.

ANKYLOSING SPONDYLITIS	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
ENBREL (etanercept)	CIMZIA (certolizumab)
HUMIRA (adalimumab)	COSENTYX (secukinumab)
TALTZ (ixekizumab)	SIMPONI (golimumab)
BEHCET'S SYNDROME	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
HUMIRA (adalimumab)	
OTEZLA (apremilast)	
CHRONIC INFANTILE NEUROLOGICAL, CUTANEOUS AND ARTICULAR SYNDROME	
PREFERRED AGENTS (PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
KINERET (anakinra)	
CROHN'S DISEASE	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
HUMIRA (adalimumab)	CIMZIA (certolizumab)
	STELARA (ustekinumab)
CYTOKINE RELEASE SYNDROME	
PREFERRED AGENTS (PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
ACTEMRA (tocilizumab)	
DEFICIENCY OF IL-A RECEPTOR ANTAGONIST (DIRA)	
PREFERRED AGENTS (PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
ARCALYST (ritonacept)	
KINERET (anakinra)	
GIANT CELL ARTERITIS	
PREFERRED AGENTS (PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
ACTEMRA (tocilizumab)	
HIDRADENITIS SUPPURATIVA	

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
HUMIRA (adalimumab)	
JUVENILE IDIOPAHIC ARTHRITIS	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
ENBREL (etanercept)	
HUMIRA (adalimumab)	
NON-RADIOGRAPHIC AXIAL SPONDYLARTHRITIS	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
HUMIRA (adalimumab)	CIMZIA (certolizumab)
TALTZ (ixekizumab)	COSENTYX (secukinumab)
PLAQUE PSORIASIS	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
ENBREL (etanercept)	CIMZIA (certolizumab)
HUMIRA (adalimumab)	COSENTYX (secukinumab)
TALTZ (ixekizumab)	OTEZLA (apremilast)
	SILIQ (brodalumab)***
	SKYRIZI (risankizumab-rzaa)***
	STELARA (ustekinumab)
	TREMFYA (guselkumab)
POLYARTICULAR COURSE JUVENILE IDIOPATHIC ARTHRITIS	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
XELJANZ (tofacitinib)	ACTEMRA (tocilizumab)
XELJANZ XR (tofacitinib)	ORENCIA (abatacept)
PSORIATIC ARTHRITIS	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
ENBREL (etanercept)	CIMZIA (certolizumab)
HUMIRA (adalimumab)	COSENTYX (secukinumab)
TALTZ (ixekizumab)	ORENCIA (abatacept)
	OTEZLA (apremilast)
	SIMPONI (golimumab)
	STELARA (ustekinumab)
	TREMFYA (guselkumab)
	XELJANZ (tofacitinib)
	XELJANZ XR (tofacitinib)
RHEUMATOID ARTHRITIS	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
ENBREL (etanercept)	ACTEMRA (tocilizumab)
HUMIRA (adalimumab)	CIMZIA (certolizumab)
XELJANZ (tofacitinib)	COSENTYX (secukinumab)
	KEVZARA (sarilumab)
	KINERET (anakinra)
	OLUMIANT (baricitinib)
	ORENCIA (abatacept)
	RINVOQ (upadacitinib)
	SIMPONI (golimumab)
	XELJANZ XR (tofacitinib)
SCHNITZLER SYNDROME	
PREFERRED AGENTS (PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
KINERET (anakinra)	

Please use the NDC Drug Lookup to find Prior Authorization (PA) Forms

ULCERATIVE COLITIS	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
HUMIRA (adalimumab)	SIMPONI (golimumab)
XELJANZ (tofacitinib)	STELARA (ustekinumab)
XELJANZ XR (tofacitinib)	
STERILE MULTIFOCAL OSTEOMYELITIS WITH PERIOSTITIS AND PUSTULOSIS	
PREFERRED AGENTS (PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
KINERET (anakinra)	
SYSTEMIC ONSET JUVENILE CHRONIC ARTHRITIS	
PREFERRED AGENTS (PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
ACTEMRA (tocilizumab)	
TEMPORAL ARTERITIS	
PREFERRED AGENTS (PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
ACTEMRA (tocilizumab)	
UVEITIS	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
HUMIRA (adalimumab)	

Dupixent

Prior Authorization Form - Dupixent

Asthma

Click to Jump to Criteria

Eczema

Click to Jump to Criteria

Chronic Rhinosinusitis

General Prior Authorization Form

Initial Criteria: *Approval Duration = 3 months*

- The patient must meet label recommendations for indication and age.
- Diagnosis has been confirmed by anterior rhinoscopy, nasal endoscopy, or computed tomography (CT)
- The patient must still be experiencing inflammation of paranasal sinuses after 12 weeks of treatment with intranasal or oral corticosteroids and nasal saline irrigations, as evidenced by paid claims or pharmacy printouts.

Renewal Criteria: *Approval Duration = 9 months*

- The prescriber must provide documentation showing that the patient has achieved a significant reduction in systemic or intranasal corticosteroids and reduction in inflammation.

Eosinophilic Asthma

Prior Authorization Form – Eosinophilic Asthma

Category Criteria (Initial): *Approval Duration = 3 months (Fasenra = 10 weeks)*

- The patient must meet label recommendations for indication and age.
- Must be prescribed by, or in consult with, a pulmonologist or allergist/immunologist

- The patient must have had 2 or more asthma exacerbations requiring use of oral corticosteroids in previous year despite continued compliant use of a moderate to high dose inhaled steroid in combination with a long-acting beta agonist (LABA) and long-acting muscarinic antagonist (LAMA) as evidenced by paid claims or pharmacy printouts

Non-Preferred Agents Criteria:

- The patient must have had a 3-month trial of 1 preferred Eosinophilic Asthma agent, as evidenced by paid claims or pharmacy printouts.

Category Criteria (Renewal): *Approval Duration = 12 months*

- The prescriber must provide documentation showing that the patient has achieved a significant reduction in asthma exacerbations and utilization of rescue medications since treatment initiation

Self-Injectable Products

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
FASENRA (benralizumab)	DUPIXENT (dupilumab)
	NUCALA (mepolizumab)

Health Professional Administration Only Products

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
CINQUAIR (reslizumab)	
XOLAIR (omalizumab)	

Epinephrine

General Prior Authorization Form

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
epinephrine – labeler 49502	epinephrine – labeler 00935
SYMJEPI (epinephrine)	epinephrine – labeler 11516
	EPIPEN (epinephrine)
	EPIPEN (epinephrine) JUNIOR

Gout

General Prior Authorization Form

Category Criteria:

- **Branded non-preferred agents:** The patient must have had a 30-day trial of each pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.
- **Generic non-preferred agents:** The patient must have had a 30-day trial of a pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.

Product Specific Criteria:

- **Uloric:**
  - The patient must have had a 30-day trial of allopurinol, as evidenced by paid claims or pharmacy printouts
- **Gloperba:**
  - The patient must be unable to ingest solid dosage form as evidenced by swallow study documentation

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Allopurinol Tablet	Colchicine Capsules
COLCRYS (Colchicine) TABLETS – *Brand Preferred*	Colchicine Tablets
MITIGARE (Colchicine) CAPSULE – *Brand Preferred*	Febuxostat
Probenecid-Colchicine Tablets	GLOPERBA (Colchicine) ORAL SOLUTION
Probenecid Tablets	ULORIC (Febuxostat) TABLET
	ZYLOPRIM (Allopurinol) TABLET

Immune Globulins

Prior Authorization Form - Immune Globulins

Category Criteria:

- If the patient's BMI > 30, adjusted body weight must be provided along with the calculated dose
- The patient must have a diagnosis of an FDA-approved indication for use
- The patient may qualify for non-preferred product if they are stable on current therapy (have had a paid claim for requested therapy in the past 45 days)

Product Specific Criteria:

- **Gammagard S/D:**
  - The patient must be intolerant to IgA (i.e., treatment of an autoimmune process in a patient with undetectable levels of IgA)
- **Cutaquig, Cuvitru, Hizentra, Hyqvia or Xembify:**
  - The patient must be unable to tolerate SQ administration with preferred products that can be given subcutaneously.
  - The patient must have failed a trial of at least two of the following, as evidenced by paid claims or pharmacy printouts:
    - Gamunex-C
    - Gammaked
    - Gammagard
- **Other Products:**
  - The patient must have failed a trial of at least two of the following, as evidenced by paid claims or pharmacy printouts:
    - Gammagard
    - Gamunex-C
    - Privigen

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
BIVIGAM (human immunoglobulin gamma)	ASCENIV (human immune globulin G slra)
FLEBOGAMMA DIF (human immunoglobulin gamma)	CUTAQUIG (human immune globulin G solution)
GAMASTAN (human immunoglobulin)	CUVITRU (human immunoglobulin gamma)
GAMASTAN S-D (human immunoglobulin)	GAMMAGARD S-D (human immunoglobulin gamma)
GAMMAGARD LIQUID (human immunoglobulin gamma)	HIZENTRA (human immunoglobulin gamma)
GAMMAKED (human immunoglobulin gamma)	HYQVIA (human immune globulin G and hyaluronidase)
GAMMAPLEX (human immunoglobulin gamma)	PANZYGA (Immune Globulin- IFAS)
GAMUNEX-C (human immunoglobulin gamma)	XEMBIFY (human immune globulin-klhw)
OCTAGAM (human immunoglobulin gamma)	
PRIVIGEN (human immunoglobulin gamma)	

Nucala

General Prior Authorization Form

Eosinophilic Asthma

Click to Jump to Criteria

Eosinophilic granulomatosis with polyangiitis (EGPA)

General Prior Authorization Form

Please use the NDC Drug Lookup to find Prior Authorization (PA) Forms

Group Criteria:

- **Initial Criteria:** *Approval Duration = 6 months*
  - The patient must be 18 years of age or older
  - The prescription must be written by, or in consultation with, a hematologist, pulmonolgist, or allergy/immunology specialist
  - The patient must have a diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA) characterized by
    - Patient has asthma poorly controlled on moderate doses of inhaled glucocorticoids
    - Patient has a greater than blood eosinophilia > 1000 cells/mcL or 10% eosinophils on the differential leukocyte count, as evidenced by laboratory documentation attached to the request
    - Two of more of the following:
      - Mononeuropathy (including multiplex) or polyneuropathy
      - Pulmonary infiltrates
      - Paranasal sinus abnormality
      - Eosinophilic vasculitis, perivascular eosinophilic infiltration, or eosinophil-rich granulomatous inflammation
      - Glomerulonephritis
      - Alveolar hemorrhage
      - Palpable purpura
      - Myocardial infarction due to coronaritis
      - Anti-neutrophil cytoplasmic antibody (ANCA) positivity
  - The patient must have had relapsing or recurring disease requiring systemic corticosteroids in previous year despite a 3 month trial with good compliance of one of the following medication, as evidenced by paid claims or pharmacy printouts:
    - Cyclophosphamide
    - Azathioprine
    - Methotrexate
    - Leflunomide
- **Renewal Criteria:** *Approval Duration = 12 months*
  - The patient must have experienced and maintained clinical benefit since starting treatment with the requested medication, as evidenced by medical documentation (e.g. chart notes) attached to the request (subject to clinical review)

Hypereosinophilic Syndrome

General Prior Authorization Form

Group Criteria:

- **Initial Criteria:** *Approval Duration = 6 months*
  - The patient must be 12 years of age or older
  - The prescription must be written by, or in consultation with, a hematologist, or allergy/immunology specialist
  - The patient must have a diagnosis of hypereosinophilic syndrome (HES) characterized by the following:
    - The patient must have experienced hypereosinophilic syndrome for ≥6 months
    - The provider must attest that there is no identifiable nonhematologic secondary cause
  - The patient must have experienced at least 2 HES flares within the past 12 months despite continued compliant use of oral corticosteroids and/or steroid sparing therapy (e.g. hydroxyurea)
  - The patient must have a blood eosinophil count of 1,000 cells/mcL or higher, as evidenced by laboratory documentation attached to the request
- **Renewal Criteria:** *Approval Duration = 12 months*
  - The patient must have experienced and maintained clinical benefit since starting treatment with the requested medication, as evidenced by medical documentation (e.g. chart notes) attached to the request (subject to clinical review)

Palforzia

Palforzia Prior Authorization Form

Group Criteria:

- **Initial Criteria:** *Approval Duration = 6 months*
  - The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age)
  - The patient does not have any contraindications to treatment
  - The prescriber must be or be in consultation with an allergy and/or immunology specialist
  - The provider must attest that the patient has access to injectable epinephrine, and that the patient/caregiver has been instructed and trained on its appropriate use
  - The patient must not have any of the following:
    - Uncontrolled asthma
    - A history of eosinophilic esophagitis or another eosinophilic GI disease
    - Severe or life-threatening anaphylaxis in the 60 days prior to the request
  - The patient must have a clinical history of allergy to peanuts or peanut-containing foods AND one of the following:
    - The patient has had a serum immunoglobulin E (IgE) to peanut ≥0.35 kUA/L
    - Skin prick test (SPT) to peanut ≥ 3mm compared to control
    - Allergic reaction produced during a provider observed intake of peanuts
- **Renewal Criteria:** *Approval Duration = 6 months for continued up-titration or 12 months for maintenance the 300mg dose*
  - The patient must have been compliant with Palforzia, as evidenced by pharmacy records or pharmacy claims history showing on-time fills during the last 6 months
  - The patient must not have any of the following:
    - Uncontrolled asthma
    - Severe or persistent GI symptoms
    - Eosinophilic esophagitis
  - The patient must have experienced and maintained clinical benefit since starting treatment with Palforzia, as evidenced by the following:
    - The patient continues to have a peanut allergy and has been/is being monitored for resolution of their allergy
    - The patient has been able to tolerate the maintenance dose of Palforzia (300 mg daily)
      OR
    - The prescriber has submitted a plan to continue up-titration to a final dose of 300 mg daily and have not already requested a renewal PA for the up-titration period

PA REQUIRED
PALFORZIA (peanut allergen powder)

Steroids - Nasal

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have failed a 30-day trial (within the past 2 years) of 1 preferred agent, as evidenced by paid claims or pharmacy printouts

Product Specific Criteria:

- ***Xhance (fluticasone):**
  - Clinical justification must be provided explaining why the patient is unable to use another product with the same active ingredient (subject to clinical review)

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)

BECONASE AQ (beclomethasone)	flunisolide
Fluticasone	mometasone
OMNARIS (ciclesonide)	XHANCE (fluticasone)***
QNASL (beclomethasone)	
QNASL CHILDREN'S (beclomethasone)	
ZETONNA (ciclesonide)	

Ulcerative Colitis Agents

General Prior Authorization Form

Category PA Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The patient must have had a 30-day trial of each preferred agent, as evidenced by paid claims or pharmacy printouts.

Cytokine Modulators

See Cytokine Modulators Criteria

Oral

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
APRISO (mesalamine) CAPSULE – *Brand Preferred*	AZULFIDINE (sulfasalazine)
ASACOL HD (mesalamine) – *Brand Preferred*	AZULFIDINE DR (sulfasalazine)
Balsalazide capsule	COLAZAL (balsalazide)
DELZICOL (mesalamine) CAPSULE– *Brand Preferred*	Mesalamine DR
DIPENTUM (olsalazine)	Mesalamine ER
LIALDA (mesalamine) TABLET– *Brand Preferred*	Mesalamine HD
PENTASA (mesalamine)	
Sulfasalazine DR tablet	
Sulfasalazine tablet	

Rectal

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Mesalamine enema	Mesalamine enema kit
Mesalamine rectal suppository	ROWASA (mesalamine) ENEMA KIT
	SF ROWASA (mesalamine) ENEMA
	UCERIS (budesonide) RECTAL FOAM

Infectious Disease

Antibiotics - Resistance Prevention

Prior Authorization Form – Antibiotics – Resistance Prevention

Non-Preferred Agents Criteria:

- **Initial Criteria:** *Approval Duration = 5 days*
  - Patient must have an FDA-approved indication for use (meets label recommendations for diagnosis & age)
    - Diagnosis must be proven to be caused by a susceptible microorganism by culture and susceptibility testing

- Medication must be prescribed by an infection disease specialist, an antibiotic stewardship program, or protocol.
- One of the following criteria must be met (A or B)
    A. Prescriber must provide evidence-based medical justification for use, explaining why a preferred antibiotic is not an option due to susceptibility, previous failed trials, or other contraindications (subject to clinical review)
    B. The patient is continuing treatment upon discharge from an acute care facility

- **Renewal Criteria:** *Approval Duration = 5 days*
    - Prescriber must attest that the patient's condition is improving and that it is medically necessary to continue treatment course after re-evaluation of the patient's condition.
    - The total requested duration of use must not be greater than manufacturer labeling or treatment guideline recommendations (whichever is greater).

Community-Acquired Pneumonia

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Amoxicillin	BAXDELA (Delafloxacin)
Amoxicillin-Clavulanate	FACTIVE (Gemifloxacin)
Azithromycin	XENLETA (Lefamulin)
Cefpodoxime	
Cefuroxime	
Clarithromycin	
Doxycycline	
Levofloxacin	
Linezolid	
Moxifloxacin	

Methicillin-Resistant *Staphylococcus aureus* (MRSA):

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Clindamycin	BAXDELA (Delafloxacin)
Doxycycline	NUZYRA (Omadacycline)
Linezolid	SIVEXTRO (Tedizolid)
Minocycline	
Trimethoprim-Sulfamethoxazole	

Helicobacter pylori

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
lansoprazole/amoxicillin/clarithromycin	HELIDAC (bismuth ssal/metronidazole/tetracycline)
OMECLAMOX-PAK (omeprazole/clarithromycin/amoxicillin)	PREVPAC (lansoprazole/amoxicillin/clarithromycin)
PYLERA (bismuth subcitrate potassium/metronidazole/tetracycline)	TALICIA (omeprazole/amoxicillin/rifabutin)

Tuberculosis

Product specific criteria:

***isoniazid:

- ND Health Department provides for no cost. Please contact 701-328-2378 to obtain supply.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
ethambutol	cycloserine

isoniazid[PA]	MYCOBUTIN (rifabutin)
PRIFTIN (rifapentine)	RIFADIN (rifampin)
pyrazinamide	SIRTURO (bedaquiline)
RIFAMATE (rifampin/isoniazid)	
RIFATER (rifampin/isoniazid/pyrazinamide)	
rifabutin	
rifampin	

Antifungals - Aspergillus and Candidiasis Infections

General Prior Authorization Form

Non-Preferred Agents Criteria: *Approval Duration = Per label recommendations*

- The request must be for use as prophylaxis of invasive Aspergillus and Candida infections or Oropharyngeal Candidiasis
- The patient must meet one of the following (A or B):
    - The patient must have documented history of failure to all preferred agents as evidenced by paid claims or pharmacy printouts
    - Prescriber must provide evidence-based medical justification for use, explaining why preferred antifungals are not an option due to susceptibility, previous failed trials, or other contraindications (subject to clinical review)

Solid formulations

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Clotrimazole	CRESEMBA (Isavuconazonium)
Fluconazole	DIFLUCAN (Fluconazole)
Itraconazole	Posaconazole
NOXAFIL (Posaconazole) – *Brand Preferred*	SPORANOX (Itraconazole)
Nystatin	TOLSURA (itraconazole) CAPSULE
ORAVIG (miconazole)	VFEND (Voriconazole)
Terbinafine	
Voriconazole	

Non-solid oral formulations

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
clotrimazole troche	DIFLUCAN (fluconazole) SUSPENSION
fluconazole suspension	SPORANOX (itraconazole) SOLUTION
NOXAFIL (posaconazole) SUSPENSION	VFEND (voriconazole) SUSPENSION
itraconazole solution	
voriconazole suspension	

Antimalarial Agents

Electronic Step Care and Concurrent Medications

- A total of 30 days of same active ingredient must be paid within 99 days prior to current claim for hydroxychloroquine and chloroquine. Prior authorization is required for new starts to verify hydroxychloroquine is not being used experimentally for outpatient COVID-19 infections.

Prior Authorization Criteria

General Prior Authorization Form

Please use the NDC Drug Lookup to find Prior Authorization (PA) Forms

Group Criteria:

- The request must be for TREATMENT of malaria (*NOT covered for prophylaxis)*

Non-Preferred Agents Criteria:

o The patient must have had a trial of a generic quinine in the last 30 days, as evidenced by paid claims or pharmacy print outs

Product specific criteria:

***atovaquone/proguanil 62.5-25 MG

- The patient must be less than 18 years old

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
daraprim	ARAKODA (tafenoquine)
hydroxychloroquine	atovaquone/proguanil
quinine	chloroquine
	COARTEM (artemether/lumefantrine)
	KRINTAFEL (tafenoquine)
	MALARONE (atovaquone/proguanil)
	mefloquine
	primaquine
	QUALAQUIN (quinine)

Human Immunodeficiency Virus (HIV)

Antiretrovirals

References

Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV. Department of Health and Human Services. Available at https://clinicalinfo.hiv.gov/sites/default/files/inline-files/AdultandAdolescentGL.pdf. Accessed (October 9, 2020)

Category Criteria:

- **Branded non-preferred agents:** The patient must have had a 30-day trial of each pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.
- **Generic non-preferred agents:** The patient must have had a 30-day trial of a pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.

Integrase Strand Transfer Inhibitors

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
BIKTARVY (bictegravir/emtricitabine/tenofovir)	
DOVATO (dolutegravir/Lamivudine)	
GENVOYA (elvitegravir/cobicistat/emtricitabine/tenofovir)	
ISENTRESS (raltegravir)	
JULUCA (dolutegravir/rilpivirine)	
STRIBILD (elvitegravir/cobicistat/emtricitabine/tenofovir)	
TIVICAY (dolutegravir)	
TRIUMEQ (abacavir/dolutegravir/lamivudine)	

Non-Nucleoside Reverse Transcriptase Inhibitors

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
ATRIPLA (efavirenz/emtricitabine/tenofovir) – *Brand Preferred*	efavirenz/emtricitabine/tenofovir
COMPLERA (emtricitabine/rilpivirine/tenofovir)	efavirenz/lamivudine/tenofovir
EDURANT (rilpivirine)	SUSTIVA (efavirenz)
efavirenz	
JULUCA (dolutegravir/rilpivirine)	

ODEFSEY (emtricitabine/rilpivirine/tenofovir)	
PIFELTRO (doravirine)	
rilpivirine	
SYMFI (efavirenz/lamivudine/tenofovir) – *Brand Preferred*	
SYMFI LO (efavirenz/lamivudine/tenofovir) – *Brand Preferred*	
NOT RECOMMENDED FOR FIRST LINE USE	
Etravirine: Guidelines do not recommend for treatment-naïve patients due to insufficient data. FDA indication is for treatment experienced patients and so should be reserved for salvage therapy, pretreated patients with NNRTI resistance and PI exposure or who have ongoing adverse effects with first line therapies. **Nevirapine:** Guidelines no longer recommend nevirapine for initial treatment of HIV infection in treatment-naïve patients. In resource limited settings, it can be considered as a third agent. Nevirapine demonstrated inferiority relative to efavirenz and is associated with serious and fatal hepatic and rash events.	
etravirine	
INTELENCE (etravirine)	
nevirapine	
nevirapine ER	

Nucleoside Reverse Transcriptase Inhibitors

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
abacavir	efavirenz/emtricitabine/tenofovir
abacavir/lamivudine	efavirenz/lamivudine/tenofovir
ATRIPLA (efavirenz/emtricitabine/tenofovir) – *Brand Preferred*	emtricitabine/tenofovir
BIKTARVY (bictegravir/Emtricitabine/Tenofovir)	Emtricitabine capsule
CIMDUO (lamivudine/tenofovir)	EPIVIR (lamivudine)
COMPLERA (emtricitabine/rilpivirine/tenofovir)	EPZICOM (abacavir)
DELSTRIGO (doravirine/lamivudine/tenofovir)	TRIZIVIR (abacavir/lamivudine)
DESCOVY (emtricitabine/tenofovir)	VIREAD (tenofovir)
EMTRIVA (emtricitabine) CAPSULE – *Brand Preferred*	ZERIT (stavudine) CAPSULE
Emtricitabine solution	ZIAGEN (abacavir)
GENVOYA (elvitegravir/cobicistat/emtricitabine/tenofovir)	
lamivudine	
ODEFSEY (emtricitabine/rilpivirine/tenofovir)	
SYMFI (efavirenz/lamivudine/tenofovir) – *Brand Preferred*	
SYMFI LO (efavirenz/lamivudine/tenofovir) – *Brand Preferred*	
STRIBILD (elvitegravir/cobicistat/emtricitabine/tenofovir)	
SYMTUZA (darumavir/cobicistat/emtricitabine/tenofovir)	
tenofovir	
TEMIXYS (Lamivudine/Tenofovir)	
TRIUMEQ (abacavir/dolutegravir/lamivudine)	
TRUVADA (emtricitabine/tenofovir) – *Brand Preferred*	
NOT RECOMMENDED FOR FIRST LINE USE	
Abacavir/lamivudine/zidovudine – Guidelines do not recommend ABC/3TC/ZDU (as either a triple-NRTI combination regimen or in combination with tenofovir (TDF) as a quadruple-NRTI combination regimen) due to inferior virologic efficacy. **Lamivudine/zidovudine –** Guidelines do not recommend ZDV/3TC due to greater toxicities than recommended NRTIs (including bone marrow suppression, GI toxicities, skeletal muscle myopathy, cardiomyopathy, and mitochondrial toxicities such as lipoatrophy, lactic acidosis and hepatic steatosis). **Didanosine –** Guidelines do not recommend ddl/3TC or ddl/FTC regimens due to inferior virologic efficacy, limited trial experience in ART-naïve patients, and ddl toxicities (including pancreatitis and peripheral neuropathy). ddl/TDF regimens are not recommended due to high rate of early virologic failure, rapid selection of resistance mutations, potential for immunologic nonresponse/CD4 cell decline, and increased ddl drug exposure and toxicities. **Stavudine –** Guidelines do not recommend d4T/3TC due to significant toxicities (including lipoatrophy, peripheral neuropathy) and hyperlactatemia (including symptomatic and life-threatening lactic acidosis, hepatic steatosis, and pancreatitis)	
abacavir/lamivudine/zidovudine	COMBIVIR (lamivudine/zidovudine)
didanosine	RETROVIR (zidovudine)
lamivudine/zidovudine	VIDEX EC (didanosine)
stavudine	ZERIT (stavudine) CAPSULE
VIDEX (didanosine)	
zidovudine	

Post-Attachment Inhibitor

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
TROGARZO (Ibalizumab-uiyk)	

Please use the NDC Drug Lookup to find Prior Authorization (PA) Forms

Protease Inhibitor

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Atazanavir	NORVIR (ritonavir)
EVOTAZ (atazanavir/cobicistat)	REYATAZ (atazanavir) CAPSULE
PREZCOBIX (darunavir/cobicistat)	
PREZISTA (darunavir)	
REYATAZ (atazanavir) POWDER PACK	
Ritonavir	
SYMTUZA (darumavir/cobicistat/emtricitabine/tenofovir)	
NOT RECOMMENDED FOR FIRST LINE USE	
Fosamprenavir – Guidelines do not recommend use of unboosted FPV or FPV/r due to virologic failure with unboosted FPV-based regimens that may result in selection of mutations that confer resistance to FPV and DRV. There is also less clinical trial data for FPV/r than other RTV-boosted PIs. **Lopinavir/ritonavir** – Guidelines do not recommend LPV/r due to GI intolerance, higher pill burden and higher RTV dose than other PI-based regimens **Nelfinavir –** Guidelines do not recommend use of NFV due to inferior virologic efficacy and diarrhea. **Saqinavir** – Guidelines do not recommend use of unboosted SQV due to inadequate bioavailability and inferior virologic efficacy or SQV/r due to high bill burden and QT and PR prolongation. **Tipranavir** – Guidelines do not recommend TPV/r due to inferior virologic efficacy, higher dose of RTV and higher rate of adverse events than other RTV-boosted PIs.	
APTIVUS (tipranavir)	KALETRA (lopinavir/ritonavir) SOLUTION
fosamprenavir	LEXIVA (fosamprenavir)
INVIRASE (saquinavir)	
KALETRA (lopinavir/ritonavir) TABLET	
lopinavir/ritonavir solution	
VIRACEPT (nelfinavir)	

Entry Inhibitor

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
NOT RECOMMENDED FOR FIRST LINE USE	
Enfuvirtide (Fusion Inhibitor)– Guidelines do not recommend T20 for initial therapy due to twice daily injections, high rate of injection site reactions, and it has only been studied in patients with virologic failure **Maraviroc** (CCR5 Antagonist) – Guidelines do not recommend MVC for initial therapy due to twice daily dosing, no virologic benefit compared to recommended regimens, and required CCR5 tropism testing.	
	FUZEON (enfuvirtide)
	SELZENTRY (maraviroc)

Diarrhea

Product Specific Criteria:

*** **Mytesi:** Jump to Criteria

Loss of Appetite

Product Specific Criteria:

*** **Dronabinol:** Jump to Criteria

Wasting Cachexia

Product Specific Criteria:

*** **Serostim:** Jump to Criteria

Hepatitis C Treatments

Electronic Step Care and Concurrent Medications

- A total of 28 days of ribavirin must be billed within the previous 14 days of an Epclusa claim if patient has decompensated cirrhosis (Child Pugh B or C).

- Epclusa requires prior authorization and after prior authorization is approved, Epclusa will continue to reject for prior authorization unless ribavirin is billed first when it is recommended to be used concurrently.

Prior Authorization Criteria

Prior Authorization Form – Hepatitis C

Antivirals

Category Criteria: *Approval duration – based on label recommendations*

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- Chronic Hepatitis C must be documented by one of the following:
  - **Liver fibrosis F1 and below**: 2 positive HCV RNA levels at least 6 months apart.
  - **Liver fibrosis F2 and above**: 1 positive HCV RNA test within the last 12 months.
- The patient must be drug (drugs of abuse by injection) and alcohol free as documented by 2 drug and alcohol tests, dated at least 3 months apart, with the most current test completed within 30 days of the request date, in addition to meeting criteria below as applicable:
- **If the patient has a history of alcohol use disorder**, one of the following must be met (A or B)
  A. The patient must submit an additional alcohol test dated 12 months (+/- 3 months) prior to request date
  B. All of the following must be met:
    - The patient must be receiving treatment from an enrolled addiction medicine/chemical dependency treatment provider, and the provider/facility name must be provided with the request
    - Chart notes must be attached regarding assessment of patient's readiness for treatment including readiness for abstinence from alcohol use during and after treatment
- **If the patient has a history of using drugs of abuse by injection**, one of the following must be met (A or B)
  A. The patient must submit an additional drug test dated 12 months (+/- 3 months) prior to request date
  B. All of the following must be met:
    - The patient must be receiving treatment from an enrolled addiction medicine/chemical dependency treatment (or buprenorphine waived) provider, and the provider/facility name must be provided with the request
    - Chart notes must be attached regarding assessment of readiness for treatment of the patient including readiness for abstinence from illicit drug use by injection during and after treatment
- The patient must not be receiving a known recreationally used high risk combination of drugs (e.g. "the holy trinity") for the past 6 months.
- Prescriber must be a hepatology, gastroenterology, or infectious disease specialist if the patient has any of the following:
  - Decompensated cirrhosis (Child's Pugh B or C)
  - Status post solid organ transplantation
  - Known or suspected hepatocellular carcinoma
  - Evidence/suspicion of acute liver injury while on HCV treatment
  - Prior hepatitis C treatment with a Direct Acting Antiviral Regimen
  - HIV or HBsAg positive
  - Current pregnancy or breastfeeding
- Prescriber must be, or in consult with, a hepatology, gastroenterology, or infectious disease specialist (including via Project ECHO) if the patient has any of the following:
  - Compensated cirrhosis (Child's Pugh A)
  - Prior hepatitis C treatment with a Direct Acting Antiviral Regimen
- Females using ribavirin must have a negative pregnancy test in the last 30 days and receive monthly pregnancy tests during treatment.
- Patient must have established compliant behavior including attending scheduled provider visits (defined as 1 or less no-shows) and filling all maintenance medications on time for the past 90 days, as evidenced by pharmacy claims history.

- Patient must be tested for hepatitis B, and if the test is positive, hepatitis B must either be treated or closely monitored if patient does not need treatment.
- Patient must not have life expectancy of less than 12 months due to non-liver related comorbid conditions.
- Patient and Prescriber attestation forms must be attached to request

Non-Preferred Agents Criteria:

- The patient must have had a trial of each preferred treatment options indicated for the patient's genotype, as evidenced by paid claims or pharmacy printouts.

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
EPCLUSA (sofosbuvir/velpatasvir) *Brand Preferred****	HARVONI (ledipasvir/sofosbuvir) 90mg/400mg tablet
HARVONI (ledipasvir/sofosbuvir) 45 mg/200mg tablet	HARVONI (ledipasvir/sofosbuvir) ORAL PALLET
MAVYRET (glecaprevir/pibrentasvir)***	ledipasvir/sofosbuvir 90mg/400mg tablet
SOVALDI (sofosbuvir) 200 MG TABLET	sofosbuvir/velpatasvir
	SOVALDI (sofosbuvir) 400MG TABLET
	SOVALDI (sofosbuvir) ORAL PALLET
	VIEKIRA PAK (dasabuvir/ombitasvir/paritaprevir/ritonavir)
	VOSEVI (sofosbuvir/velpatasvir/voxilaprevir)***
	ZEPATIER (elbasvir/grazoprevir)

Ribavirin

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
ribavirin capsule	
ribavirin tablet	

Influenza

Electronic Age Verification

- Xofluza: The patient must be 12 years of age or older

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS:
Oseltamivir	TAMIFLU (oseltamivir)
XOFLUZA (baloxavir marboxil)	

Nephrology/Urology

Benign Prostatic Hyperplasia

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have diagnosis of benign prostatic hyperplasia (BPH)
- The patient must have had a 30-day trial of each preferred agent, as evidenced by paid claims or pharmacy printouts

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
alfuzosin ER	AVODART (dutasteride)
CARDURA XL (doxazosin)	CARDURA (doxazosin)
doxazosin	FLOMAX (tamsulosin)
dutasteride	MINIPRESS (prazosin)
finasteride	PROSCAR (finasteride)
prazosin	RAPAFLO (silodosin)
silodosin	sildenafil

tamsulosin	tadalafil
terazosin	

Hematopoietic, Erythropoiesis Stimulating Agents

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The patient must have had a 4-week trial of each preferred agent, as evidenced by paid claims or pharmacy printouts.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
ARANESP (darbepoetin alfa)	EPOGEN (epoetin alfa)
PROCRIT (epoetin alfa)	MIRCERA (methoxy polyethylene glycol-epoetin beta)
	RETACRIT (epoetin alfa - epbx)

Hyperkalemia (Chronic)

Prior Authorization Form - Hyperkalemia

Group Criteria:

- **Initial criteria**: *Approval Duration = 3 months*
  - The patient must be 18 years of age or older.
  - Medication must be prescribed by, or in consultation with, a nephrologist
  - The patient's current serum potassium level must be exceeding the upper limit of normal, as evidenced by documentation from at least two separate lab values, submitted with the request
  - The patient must not have gastrointestinal motility disorders (e.g. severe constipation, bowel obstruction or impaction, abnormal postoperative bowel motility disorders)
  - One of the following criteria must be met:
    - The patient must have failed 30-day trials with at least two of the following products
      - Bumetanide, Chlorothiazide, Fludrocortisone, Furosemide, Hydrochlorothiazide, Indapamide, Metolazone, Torsemide
  - The patient must not be receiving the medications known to cause hyperkalemia listed below, OR medical justification must be provided explaining why discontinuation of these agents would be clinically inappropriate in this patient:
    - angiotensin-converting enzyme inhibitor
    - angiotensin II receptor blocker
    - aldosterone antagonist
    - nonsteroidal anti-inflammatory drugs (NSAIDs)
- **Renewal Criteria**: *Approval Duration = 6 months*
  - The patient's current serum potassium level is within normal limits or has been significantly reduced from baseline, as evidenced by lab documentation submitted with the request

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
LOKELMA (Sodium Zirconium Cyclosilicate)	VELTASSA (Patiromer)

Phosphate Binders

General Prior Authorization Form

Category Criteria:

- The patient must have had 30-day trials of at least 3 preferred agents of a unique active ingredient, as evidenced by paid claims or pharmacy printouts.
- The patient must have a diagnosis of end-stage renal disease or chronic kidney disease.

Solid dosage form

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Calcium acetate	AURYXIA (ferric citrate) TABLET
FOSRENOL (lanthanum) CHEWABLE TABLET – *brand preferred*	Lanthanum chew tab
Sevelamer Carbonate Tablet	RENAGEL (Sevelamer HCl) TABLET
	RENVELA (sevelamer carbonate) TABLET
	Sevelamer HCl 400mg Tablet
	Sevelamer HCl 800mg Tablet
	VELPHORO (Sucroferric oxyhydroxide)

Non-solid dosage form

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
PHOSLYRA (calcium acetate) ORAL solution	FOSRENOL (lanthanum) POWDER PACK
RENVELA (sevelamer) POWDER PACK – *Brand Preferred*	Sevelamer Powder Pack

Urinary Antispasmodics

Step Care and Concurrent Medications

- Non-Preferred Step 1 Agents: Use least expensive urinary antispasmodics must be trialed first
  - A total of 30 days of a preferred agent at max dose must be paid within 90 days prior to step 1 agents date of service.

Therapeutic Duplication

- One strength of one of the following medications is allowed at a time: dutasteride, Jalyn, or finasteride
- Alpha 1 blockers (Alfuzosin ER, Doxazosin, Dutasteride-Tamsulosin, Prazosin, Terazosin, Tamsulosin) are not allowed with carvedilol or labetalol
  - Carvedilol and Labetalol are nonselective beta blockers with alpha 1 blocking activity
- Anticholinergic medications (tolterodine, oxybutynin, trospium, solifenacin) are not covered with Acetylcholinesterase Inhibitors. Click here for a full listing of medications included.
  - The effects of an anticholinergic (blocks the effect of acetylcholine) and acetylcholinesterase inhibitors (prevents breakdown of acetylcholine) oppose each other and the therapeutic effect of both products is diminished

Prior Authorization Criteria

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The patient must have had a 30-day trial of 2 preferred agents, as evidenced by paid claims or pharmacy printouts.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED STEP 1 AGENTS (ELECTRONIC STEP)	NON-PREFERRED AGENTS (PA REQUIRED)
flavoxate	tolterodine	darifenacin ER
GELNIQUE (oxybutynin)	tolterodine ER	DETROL (tolterodine)
oxybutynin ER		DITROPAN XL (oxybutynin)
oxybutynin syrup		dutasteride/tamsulosin
oxybutynin tablet		FLOMAX (tamsulosin)
OXYTROL (oxybutynin) PATCH		JALYN (dutasteride/tamsulosin)
solifenacin		MYRBETRIQ (mirabegron)

tamsulosin		trospium ER
TOVIAZ (fesoterodine)		VESICARE (solifenacin)
trospium		

Neurology

Alzheimer's Disease

Therapeutic Duplication

- One memantine medication is allowed at a time
- Anticholinergic medications are not covered with Acetylcholinesterase Inhibitors **(**Aricept, Exelon, Razadyne, Pyridostigmine). Click here for a full listing of medications included.
  - The effects of an anticholinergic (blocks the effect of acetylcholine) and acetylcholinesterase inhibitors (prevents breakdown of acetylcholine) oppose each other and the therapeutic effect of both products is diminished

Electronic Age Verification

- Patients must be greater than 30 years old or documentation of diagnosis must be provided.

Prior Authorization Criteria

General Prior Authorization Form

Non-Preferred Product Criteria:

- The patient must have a diagnosis of an FDA-approved indication for use
- The patient must have had a 30-day trial of a pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.
- The patient must not reside in facility with skilled nursing care.

Product Specific Criteria:

- Donepezil 23mg:
  - Clinical justification must be provided explaining why the patient is unable to use the preferred products (subject to clinical review).

Cholinesterase Inhibitors	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
donepezil 5mg, 10mg Tablet	ARICEPT (donepezil)
EXELON (rivastigmine) PATCH – *Brand Preferred*	donepezil ODT
galantamine Tablet	donepezil 23mg tablet
galantamine ER	galantamine oral solution
rivastigmine capsule	RAZADYNE (galantamine)
	RAZADYNE ER (galantamine)
	rivastigmine patch
NMDA Receptor Antagonists	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
memantine	memantine oral solution
	memantine ER
	NAMENDA (memantine)
	NAMENDA XR (memantine)
Cholinesterase Inhibitors / NMDA Receptor Antagonist Combinations	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
NAMZARIC (memantine/donepezil)	

Anticonvulsants

Therapeutic Duplication

- One Vimpat strength is allowed at a time
- Lyrica and Gabapentin are not allowed together
- Lyrica and Gabapentin oral solutions are not allowed with benzodiazepines, muscle relaxant, or narcotic tablets or capsules Overrides available
    - If a patient can swallow, they should be transitioned to a tablet or capsule formulation

Electronic Diagnosis Verification

- **Diacomit, Epidiolex, Fentepla:** The patient must have a FDA approved diagnosis

Electronic Step Care and Concurrent Medications

- Diacomit is FDA approved to be used in combination with clobazam.
    - A total of 28 days of clobazam must be paid within 45 days prior to Diacomit (stiripentol)

Prior Authorization Criteria

Group Criteria:

- **Branded non-preferred agents:** The patient must have had a 30-day trial of 2 pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.
- **Generic non-preferred agents:** The patient must have had a 30-day trial of a pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.

Anticonvulsant Prevention

Carbamazepine Derivatives	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED):**
carbamazepine chewable tablet	carbamazepine XR tablet
carbamazepine ER capsule	CARBATROL (carbamazepine)
carbamazepine oral suspension	EPITOL (carbamazepine)
carbamazepine tablet	EQUETRO (carbamazepine)
oxcarbazepine tablet	oxcarbazepine oral solution
OXTELLAR XR (oxcarbazepine)	TEGRETROL (carbamazepine oral suspension)
TEGRETOL (carbamazepine)	TRILEPTAL (oxcarbazepine)
TRILEPTAL (oxcarbazepine) ORAL SUSPENSION – *Brand Preferred*	
TEGRETOL XR (carbamazepine) – *Brand Preferred*	
First Generation	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED):**
CELONTIN (methsuximide)	DEPAKENE (valproic acid) CAPSULE
clobazam	DEPAKENE (valproic acid) ORAL SOLUTION
clobazam oral solution	DEPAKOTE (divalproex sodium) TABLET
divalproex ER	DEPAKOTE ER (divalproex sodium)
divalproex sprinkle	DEPAKOTE SPRINKLE (divalproex sodium)
divalproex tablet	DILANTIN (phenytoin) CHEWABLE TABLET
ethosuximide capsule	DILANTIN (phenytoin) ORAL SUSPENSION
ethosuximide oral solution	DILANTIN ER (phenytoin)
FELBATOL (felbamate) TABLET– *Brand Preferred*	felbamate oral suspension
FELBATOL (felbamate) ORAL SUSPENSION - *Brand Preferred*	felbamate tablet
PEGANONE (ethotoin)	MYSOLINE (primidone)
phenobarbital elixir	ONFI (clobazam)
phenobarbital tablet	ONFI (clobazam) ORAL SOLUTION
phenytoin chewable tablet	PHENYTEK (phenytoin)

Please use the NDC Drug Lookup to find Prior Authorization (PA) Forms

phenytoin ER capsule	SYMPAZAN (clobazam)
phenytoin suspension	ZARONTIN (ethosuximide)
primidone	ZARONTIN (ethosuximide) ORAL SOLUTION
valproic acid capsule	
valproic acid oral solution	
Second Generation	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED):**
BANZEL (rufinamide) ORAL SUSPENSION – *Brand Preferred*	KEPPRA (levetiracetam)
BANZEL (rufinamide) TABLET	KEPPRA (levetiracetam) ORAL SOLUTION
BRIVIACT (brivaracetam)	KEPPRA XR (levetiracetam)
DIACOMIT (stiripentol)	LAMICTAL (lamotrigine)
EPIDIOLEX (cannabidiol)	LAMICTAL (lamotrigine) DOSE PACK
FINTEPLA (fenfluramine) ORAL SOLUTION	LAMICTAL ODT (lamotrigine)
FYCOMPA (perampanel)	lamotrigine chewable tablet
FYCOMPA (perampanel) ORAL SUSPENSION	lamotrigine ER
gabapentin capsule	LYRICA (pregabalin)
gabapentin oral solution	LYRICA (pregabalin) ORAL SOLUTION
gabapentin tablet	NEURONTIN (gabapentin) CAPSULE
GABITRIL (tiagabine) - *Brand Preferred*	NEURONTIN (gabapentin) ORAL SOLUTION
LAMICTAL ODT (lamotrigine) DOSE PACK	NEURONTIN (gabapentin) TABLET
LAMICTAL ER (lamotrigine) DOSE PACK	QUDEXY XR (topiramate)
LAMICTAL XR (lamotrigine) - *Brand Preferred*	rufinamide
LAMICTAL (lamotrigine) CHEWABLE TABLET- *Brand Preferred*	SPRITAM (levetiracetam)
lamotrigine dose pack	SUBVENITE (lamotrigine)
lamotrigine ODT	tiagabine
lamotrigine tablet	TOPAMAX (topiramate)
levetiracetam ER	TOPAMAX (topiramate) SPRINKLE CAPSULE
levetiracetam oral solution	VIGADRONE (vigabatrin)
levetiracetam tablet	vigabatrin
pregabalin	vigabatrin powder pack
pregabalin oral solution	ZONEGRAN (zonisamide)
SABRIL (vigabatrin) - *Brand Preferred*	
SABRIL (vigabatrin) POWDER PACK - *Brand Preferred*	
topiramate ER	
topiramate sprinkle capsule	
topiramate tablet	
TROKENDI XR (topiramate)	
XCOPRI (cenobamate)	
zonisamide	
Third Generation	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED):**
APTIOM (Eslicarbazepine)	
VIMPAT (lacosamide)	
VIMPAT (lacosamide) ORAL SOLUTION	

Anticonvulsant treatment

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED):
DIASTAT PEDIATRIC (diazepam) RECTAL GEL – *Brand Preferred*	Diazepam pediatric rectal gel
DIASTAT ACUDIAL (diazepam) RECTAL GEL – *Brand Preferred*	Diazepam rectal gel
NAYZILAM (midazolam) SPRAY	
VALTOCO (diazepam) SPRAY	

Emflaza

Prior Authorization Form - Emflaza

Please use the NDC Drug Lookup to find Prior Authorization (PA) Forms

Initial Criteria: *Approval Duration = 6 months*

- The patient must be 2 years of age or older
- The patient must have diagnosis of Duchenne muscular dystrophy (DMD) confirmed by the documented presence of abnormal dystrophin or a confirmed mutation of the dystrophin gene
- Onset of weakness must have occurred before 2 years of age
- The medication must be prescribed by or in consultation with a physician who specializes in the treatment of Duchenne Muscular Dystrophy (DMD) and/or neuromuscular disorders
- The patient must have serum creatinine kinase activity of at least 10 times the upper limit of normal (ULN) prior to initiating treatment
- The patient must have failed a 6-month trial of prednisone due to inadequate treatment response, intolerance, or contraindication, as evidenced by paid claims or pharmacy printouts
- The provider must submit baseline motor milestone score results from at least ONE the following assessments:
    i. 6-minute walk test (6MWT)
    ii. North Star Ambulatory Assessment (NSAA)
    iii. Motor Function Measure (MFM)
    iv. Hammersmith Functional Motor Scale (HFMS)
- The patient must have ONE of the following significant intolerable adverse effects supported by documentation:
    i. Cushingoid appearance
    ii. Central (truncal) obesity
    iii. Undesirable weight gain (>10% of body weight gain increase over 6-month period)
    iv. Diabetes and/or hypertension that is difficult to manage
    v. Severe behavioral adverse effect

Renewal Criteria: *Approval Duration = 12 months*

- The patient must have ONE of the following (A or B)
    - Improvement in motor milestone score from baseline from ONE the following assessments:
        i. 6MWT – improvement of 20 meters from baseline
        ii. NSAA – improvement of 2 points from baseline
        iii. MFM – improvement of 2 points from baseline
        iv. HFMS – improvement of 2 points from baseline
    - The patient must have had improvement of adverse effects experienced on prednisone supported by documentation:
        i. Cushingoid appearance
        ii. Central (truncal) obesity
        iii. Undesirable weight gain (>10% of body weight gain increase over 6-month period)
        iv. Diabetes and/or hypertension that is difficult to manage
        v. Severe behavioral adverse effect

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Prednisone	EMFLAZA (deflazacort)

Headache/Migraine

Prophylaxis of Migraine – CGRP Inhibitors

Prior Authorization Form –Migraine/Cluster Headache Prophylaxis

Group Criteria:

- **Initial (approval duration: 3 months):**
    - Patient must experience 3 or more migraine days per month.
    - The patient must have had 2-month trials of at least two of the following agents from different therapeutic classes, as evidenced by paid claims or pharmacy printouts:
        - amitriptyline, atenolol, divalproex sodium, metoprolol, nadolol, propranolol, timolol, topiramate, venlafaxine

- Prescriber must submit documentation, including clinical notes regarding failure of prior treatments to reduce migraine frequency after 2-month trial.

- **Renewal:**
  - The patient must have experienced at least a 50% reduction in migraines from baseline, since starting treatment with a CGRP inhibitor.

Non-Preferred Agents Criteria:

- The patient must have had a 3-month trial of each preferred agent, as evidenced by paid claims or pharmacy printouts.

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
AJOVY (fremanezumab-vfrm)	AIMOVIG (erenumab-aooe)
EMGALITY (galcanazumab-gnlm)	

Treatment of Migraine

Therapeutic Duplication

- One strength of one medication is allowed at a time

Prior Authorization Criteria

General Prior Authorization Form

Group Criteria:

- Within the past 2 years, the patient must have had 30-day trials of two triptans (5HT-1 agonists), as evidenced by paid claims or pharmacy printouts.

Non-Preferred Agents:

- Within the past 2 years, the patient must have had a 30-day trial of the preferred agent, as evidenced by paid claims or pharmacy printouts.

Non-Triptan Agents

PREFERRED AGENTS (CLINCAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
NURTEC ODT (rimegepant)	CAMBIA (diclofenac potassium) POWDER PACK
	D.H.E.45 (dihydroergotamine) INJECTION
	dihydroergotamine injection
	dihydroergotamine nasal spray
	ERGOMAR (ergotamine) SL TABLET
	MIGERGOT (ergotamine/caffeine) RECTAL SUPPOSITORY
	MIGRANAL (dihydroergotamine) SPRAY
	REYVOW (Lasmiditan)
	UBRELVY (Ubrogepant)

Triptans (5HT-1 agonists)

Approval Duration = 6 months

All (Preferred and Non-Preferred) Non-Oral Dosage Form Agents:

- Patients must not able to take oral medications (as evidenced by swallow study documentation):

Non-Preferred Step 1 Agents Criteria:

- Patients 18 years old or older: The patient must have had a 30-day trial of each preferred agent, as evidenced by paid claims or pharmacy printouts.
- Patients 6 to 17 years of age: The patient must have had a 30-day trial of rizatriptan, as evidenced by paid claims or pharmacy printouts.

Non-preferred step 2 agents:

- The patient must have had a 30-day trial of each available preferred triptan agent, as evidenced by paid claims or pharmacy printouts.
- Clinical justification must be provided explaining why the patient is unable to use all other products (subject to clinical review).

Solid Oral Dosage Forms		
PREFERRED AGENTS (NO PA REQUIRED)	**PREFERRED STEP 1 AGENTS (PA REQUIRED)**	**NON-PREFERRED STEP 2 AGENTS (PA REQUIRED)**
RELPAX (eletriptan) TABLET – *Brand Preferred*	Naratriptan Tablet	Almotriptan Tablet
Rizatriptan tablet	Zolmitriptan Tablet	AMERGE (naratriptan) TABLET
Sumatriptan tablet		Eletriptan Tablet
		FROVA (frovatriptan) TABLET
		Frovatriptan Tablet
		IMITREX (sumatriptan) TABLET
		MAXALT (rizatriptan) TABLET
		Sumatriptan/Naproxen Tablet
		TREXIMET (Sumatriptan/Naproxen) TABLET
		ZOMIG (zolmitriptan) TABLET
Non-Solid Oral Dosage Form		
PREFERRED AGENTS (NO PA REQUIRED)	**PREFERRED STEP 1 AGENTS (PA REQUIRED)**	**NON-PREFERRED STEP 2 AGENTS (PA REQUIRED)**
Rizatriptan ODT	Zolmitriptan ODT	MAXALT MLT (rizatriptan)
		ZOMIG ODT (zolmitriptan)
Non-Oral Dosage Forms		
PREFERRED AGENTS (CLINICAL PA REQUIRED)	**PREFERRED STEP 1 AGENTS (PA REQUIRED)**	**NON-PREFERRED STEP 2 AGENTS (PA REQUIRED)**
ONZETRA XSAIL (sumatriptan) NASAL SPRAY	ZOMIG (zolmitriptan) NASAL SPRAY	IMITREX (sumatriptan) CARTRIDGE
		IMITREX (sumatriptan) PEN INJCTR
		IMITREX (sumatriptan) SPRAY
		Sumatriptan Cartridge
		Sumatriptan Pen Injctr
		Sumatriptan Spray
		Sumatriptan Syringe
		Sumatriptan Vial
		TOSYMRA (Sumatriptan) NASAL SPRAY
		ZEMBRACE SYMTOUCH (Sumatriptan)

Cluster Headache

Initial PA Criteria: *Approval Duration: 3 months*

- Patient must meet ICHD-3 criteria for diagnosis of cluster headache:
  - Severe or very severe unilateral orbital, supraorbital and/or temporal pain lasting 15-180 minutes (during active time course)
  - Either or both of the following:
    - At least one of the following symptoms or signs, ipsilateral to the headache:
      - Conjunctival injection and/or lacrimation
      - Nasal congestion and/or rhinorrhea
      - Eyelid edema
      - Forehead and facial swelling
      - Miosis and/or ptosis

- A sense of restlessness or agitation
  - Occurring with a frequency between one every other day and 8 per day (during active time course)

Cluster Headache Prevention

Non-preferred agents:

- Patient must use medication as preventative treatment during episodic cluster headache episodes (cluster periods usually last between 2 weeks and 3 months with pain-free periods lasting at least 3 months), as medication is not indicated for chronic use
- Patient must have had a 2-month trial with verapamil

Renewal PA Criteria: *Approval Duration: 9 months*

- Prescriber must submit documentation indicating that the members' cluster headaches have been reduced in frequency and/or severity as a result of therapy per patient headache journal

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Topiramate	EMGALITY (Galcanazumab-gnlm)
Verapamil	

Cluster Headache Treatment

Non-preferred agents:

- The patient must have had a 30-day trial of two unique pharmaceutical preferred agents within the past 24 months, as evidenced by paid claims or pharmacy printouts.

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
ONZETRA XSAIL (sumatriptan) NASAL SPRAY	D.H.E.45 (dihydroergotamine) INJECTION
ZOMIG (Zolmitriptan) NASAL SPRAY	Dihydroergotamine (DHE) intranasal
Zolmitriptan oral	Dihydroergotamine Injection
Zolmitriptan ODT	Dihydroergotamine Nasal Spray
	ERGOMAR (ergotamine) SL TABLET
	IMITREX (sumatriptan) CARTRIDGE
	IMITREX (sumatriptan) PEN INJCTR
	IMITREX (sumatriptan) SPRAY
	IMITREX (sumatriptan) VIAL
	MIGRANAL (dihydroergotamine) SPRAY
	Sumatriptan Cartridge
	Sumatriptan intranasal
	Sumatriptan Pen Injctr
	Sumatriptan Spray
	Sumatriptan subcutaneous
	Sumatriptan Syringe
	Sumatriptan Vial
	TOSYMRA (Sumatriptan) NASAL SPRAY
	ZEMBRANCE SYMTOUCH (Sumatriptan)

Multiple Sclerosis

Interferons

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The patient must have had a 3-month trial of at least 1 preferred agent, as evidenced by paid claims or pharmacy printouts.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
AVONEX (interferon beta-1A) PEN	EXTAVIA (interferon beta-1B)
AVONEX (interferon beta-1A) SYRINGE	PLEGRIDY (peginterferon beta-1A) PEN
AVONEX (interferon beta-1A) VIAL	PLEGRIDY (peginterferon beta-1A) SYRINGE
BETASERON (interferon beta-1B)	REBIF (interferon beta-1A)
	REBIF REBIDOSE (interferon beta-1A)

Injectable Non-Interferons

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The patient must have had a 90-day trial of each of the following:
  - Gilenya
  - Copaxone 20mg/mL

Product Specific Criteria:

- Copaxone (glatiramer) 40mg/mL, glatiramer 20mg/mL, glatiramer 40mg/mL:
  - Clinical justification must be provided explaining why the patient is unable to use the preferred products (subject to clinical review).

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
COPAXONE (glatiramer) 20 MG/ML – *Brand Preferred*	COPAXONE (glatiramer) 40 MG/ML
	glatiramer 20mg/ml
	glatiramer 40mg/ml
	GLATOPA (glatiramer)
	KESIMPTA (ofatumumab)

Oral Non-Interferons

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The patient must have had a 3-month trial of each preferred agent, as evidenced by paid claims or pharmacy printouts.
- One of the following must be met (A OR B):
  - The patient must have had a 3-month trial of Copaxone, as evidenced by paid claims or pharmacy printouts.
  - If patient has a documented intolerance, hypersensitivity, or labeled contraindication to Copaxone, the patient must have had a 3-month trial interferon beta-1, as evidenced by paid claims or pharmacy printouts.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
AUBAGIO (teriflunomide)	BAFIERTAM (monomethyl fumarate)
GILENYA (fingolimod)	dimethyl fumarate
TECFIDERA (dimethyl fumarate) – *Brand Preferred*	MAVENCLAD (cladribine)
	MAYZENT (siponimod)
	VUMERITY (diroximel fumarate)
	ZEPOSIA (ozanimod)

Narcolepsy

Therapeutic Duplication

- Sunosi and Wakix are not allowed together
- Provigil and Nuvigil are not allowed together

Please use the NDC Drug Lookup to find Prior Authorization (PA) Forms

- Xyrem, Xywav is not allowed with sleeping medication or benzodiazepines

Electronic Step Care and Concurrent Medications

- Sunosi requires a 30 day trial of Nuvigil to be paid within 60 days of submitted claim
- Wakix requires titration to 17.8 mg dose with 4.45 mg tablets.

Underutilization

- Wakix and Sunosi must be used compliantly and will reject on point of sale for late fill

Prior Authorization Criteria

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age)

Diagnosis Specific Criteria:

- **Narcolepsy:**
  - The patient must have failed 30-day trials of each preferred agent and at least 1 additional CNS stimulant indicated for treatment of narcolepsy, as evidenced by paid claims or pharmacy printouts
  - Provider must submit documentation of prior treatment failure, as evidenced by documentation of one of the following, while on prior treatments:
    - Multiple Sleep Latency Test (MSLT) <8 minutes
    - EPWORTH sleepiness scale score ≥10

Renewal Criteria:

- Provider must submit documentation of symptom improvement, as evidenced by documentation of one of the following, while on prior treatments:
  - Multiple Sleep Latency Test (MSLT) <8 minutes
  - EPWORTH sleepiness scale score ≥10

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Modafinil	Armodafinil
NUVIGIL (Armodafinil) – *Brand Preferred*	PROVIGIL (Modafinil)
SUNOSI (Solriamfetol)	WAKIX (Pitolisant)
	XYREM (Sodium Oxybate)
	XYWAV (Sodium, calcium, magnesium, potassium oxybate)

Nuedexta

Prior Authorization Form - Nuedexta

Group Criteria (Initial): *Approval Duration = 3 months*

- The patient must be 18 years of age or older
- The patient must not have a diagnosis of any of the following: prolonged QT interval, heart failure, or complete atrioventricular (AV) block
- The prescriber must provide the following information:
  - Baseline Center for Neurological Studies lability (CNS-LS) score
  - Baseline weekly PBA episode count
- The patient must have diagnosis of pseudobulbar affect (PBA) due to one of the following neurologic conditions and meet additional criteria for diagnosis:
  - Amytrophic Lateral Sclerosis (ALS)

- Multiple Sclerosis (MS)
- Alzheimer's Disease
- Stroke

o **Additional initial criteria for a diagnosis of PBA due to Alzheimer's disease or stroke:**
  - Neurologic condition must have been stable for at least 3 months
  - Patient must have failed** a 3-month trial of at least one medication from each of the classes listed below (A and B), as evidenced by paid claims or pharmacy print outs:
    A. **SSRIs**: sertraline, fluoxetine, citalopram and paroxetine
    B. **Tricyclic Antidepressants**: nortriptyline and amitriptyline
  - o A PBA episode count and CNS-LS score must be provided for before and after each trial

***A failure is defined as one of the following:*
- *PBA count decreased less than 75 percent, stayed the same, or increased from baseline in each trial*
- *CHS-LS score decreased less than 7 points, stayed the same, or increased from baseline in each trial*

Group Criteria (Renewal): *Approval Duration = 6 months*
- o Benefit of continued therapy must be assessed
- o Baseline and current PBA episode count must be included with request
- o Current PBA episode must be reduced by at least 75% from baseline
- o **Additional initial criteria for a diagnosis of PBA due to Alzheimer's disease or stroke:**
  - Baseline and current Center for Neurological Studies lability (CNS-LS) must be included with request
  - Current CNS-LS score must be reduced by at least 30% from baseline

Parkinson's disease

Electronic Step Care and Concurrent Medications
- Xadago and Nourianz is FDA approved for adjunctive treatment to levodopa/carbidopa.
  - o A total of 28 days of levodopa/carbidopa treatment must be paid within 40 days prior to Xadago or Nourianz's date of service

Prior Authorization Criteria

General Prior Authorization Form

Non-Preferred Agents Criteria (Renewal):

Documentation of disease stabilization or improvement in disease since initiation of treatment must be provided

Parkinson's Agents – Adenosine Receptor Agonist

- **Non-Preferred Agents Criteria:**
  - o The patient must have a diagnosis of an FDA-approved indication for use
  - o Medication must be prescribed by, or in consultation with, a neurologist
  - o The patient must be currently experiencing intermittent hypomobility or "off" episodes
  - o The patient must be currently taking an extended release formulation of carbidopa – levodopa, as evidenced by paid claims or pharmacy printouts, and will continue taking carbidopa – levodopa concurrently with requested agent
  - o The patient must be exhibiting deterioration in quality of response to during levodopa/carbidopa therapy for intermittent hypomobility, or "off" episodes
  - o The patient must have had inadequate response to rasagiline and selegiline, as evidenced by paid claims or pharmacy printouts

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)

NOURIANZ (Istradefylline)	

Parkinson's Agents –Dopaminergic Agents for Intermittent Treatment of Off Episode

- **Group Criteria**
  - The patient must have a diagnosis of an FDA-approved indication for use
  - Medication must be prescribed by, or in consultation with, a neurologist
  - The patient must be currently taking carbidopa – levodopa, as evidenced by paid claims or pharmacy printouts, and will continue taking carbidopa – levodopa concurrently with requested agent
  - Documentation of intermittent hypomobility or off episodes (number and frequency) must be provided
  - At least one of the following criteria must be met (A and/or B):
    A. Patient is experiencing unpredictable off periods, morning off, delayed on, no on or failure of on response
    B. Patient is experiencing wearing off episodes or other levodopa dose cycle related dystonias or akathisias, and a treatment adjustment plan is attached (e.g. levodopa dose and interval adjustments, bedtime dose of CR or ER levodopa/ carbidopa, addition of adjunctive therapy)

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Subcutaneous	
APOKYN (apomorphine)	
Enteral Suspension	
DUOPA (levodopa/carbidopa)	
Oral Inhalation	
INBRIJA (levodopa)	
KYNMOBI (apomorphine)	

Parkinson's Agents –Non-ergot Dopamine Receptor Agonists Maintenance

- **Non-Preferred Agents Criteria**
  - The patient must have a diagnosis of an FDA-approved indication for use
  - The patient is must not currently be residing in a facility with skilled nursing care
  - Clinical justification must be provided explaining why the patient is unable to use the preferred agents (subject to clinical review).

Maintenance - Oral	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
Pramipexole IR	MIRAPEX (pramipexole)
Ropinirole IR	MIRAPEX ER (pramipexole)
Ropinirole ER	Pramipexole ER
	REQUIP (ropinirole)
Maintenance - Topical	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
NEUPRO (Rotigotine) PATCH	

Parkinson's Agents –Dopamine Precursor

- **Non-Preferred Agents Criteria:**
  - The patient must have a diagnosis of an FDA-approved indication for use
  - The patient is must not currently be residing in a facility with skilled nursing care
  - Clinical justification must be provided explaining why the patient is unable to use the preferred agents (subject to clinical review).

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)

carbidopa-levodopa-entacapone	carbidopa-levodopa ODT
carbidopa-Levodopa capsules	RYTARY (levodopa/carbidopa)
carbidopa-Levodopa ER	

Parkinson's Agents –MAO-B Inhibitors

- **Non-Preferred Agents Criteria**
  - The patient must have failed a 30-day trial of selegiline, as evidenced by paid claims or pharmacy printouts

Product Specific Criteria:

- ***Xadago:**
  - The patient must have a diagnosis of an FDA-approved indication for use
  - Medication must be prescribed by, or in consultation with, a psychiatrist or neurologist
  - The patient must be currently experiencing intermittent hypomobility or "off" episodes
  - The patient must be currently taking an extended release formulation of carbidopa – levodopa, as evidenced by paid claims or pharmacy printouts, and will continue taking carbidopa – levodopa concurrently with requested agent
  - The patient must be exhibiting deterioration in quality of response to during levodopa/carbidopa therapy for intermittent hypomobility, or "off" episodes
  - The patient must have had inadequate response to rasagiline and selegiline, as evidenced by paid claims or pharmacy printouts

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
AZILECT (Rasagiline) – *Brand Preferred*	EMSAM (Selegiline) PATCH
Selegiline	Rasagiline
ZALAPAR ODT (selegiline)	XADAGO (Safinamide)***

Parkinson's Agents – COMT inhibitor

- **Non-Preferred Agents Criteria**
  - The patient must have failed a 30-day trial of entacapone, as evidenced by paid claims or pharmacy printouts

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
entacapone	COMTAN (entacapone)
	ONGENTYS (opicapone)
	TASMAR (tolcapone)
	Tolcapone

Parkinson's Agents – Other

- **Non-Preferred Agents Criteria**
  - The patient must have a diagnosis of an FDA-approved indication for use
  - The patient is must not currently be residing in a facility with skilled nursing care
  - Clinical justification must be provided explaining why the patient is unable to use the preferred agents (subject to clinical review).

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
amantadine IR capsule	amantadine IR tablet
	GOCOVRI (amantadine ER)
	OSMOLEX ER (amantadine ER)

Parkinson's Agents –Ergot Dopamine Receptor Agonists

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)

Bromocriptine	PARLODEL (bromocriptine)
Cabergoline	

Parkinson's Agents – Anticholinergics

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Benztropine	COGENTIN (benztropine)
Trihexyphenidyl	

Tardive Dyskinesia

Electronic Step Care and Concurrent Medications

- Start Ingrezza with Initiation Pack before continuing therapy with 80mg capsules
    - The 30-count 40 mg bottle is not packaged for titration to 80 mg. If therapy is expected to be continued at 40 mg at time of drug initiation, please call for override.

Prior Authorization

Prior Authorization Form – Tardive Dyskinesia

Category Criteria

- The patient must be 18 years of age or older.
- The prescription must be written by/in consultation with a specialist (neurologist or psychiatrist).
- The patient must have a diagnosis of tardive dyskinesia, including the following:
    - Involuntary athetoid or choreiform movements
    - History of treatment with dopamine receptor blocking agent (DRBA)
    - Symptom duration lasting longer than 4-8 weeks
- The patient must not be taking monoamine oxidase inhibitor (MAOI)
- The patient is not pregnant or breastfeeding

Product Specific Criteria:

- ***** Austedo/tetrabenazine:**
    - The patient must have a diagnosis of Huntington's disease or Tardive Dyskinesia.
    - The patient must not have hepatic impairment

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
AUSTEDO (deutetrabenazine)***	
INGREZZA (valbenazine)	
tetrabenazine***	

Ophthalmic

Antihistamines

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have had 30-day trials of at least 3 preferred agents, as evidenced by paid claims or pharmacy printouts.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
ALOCRIL (nedocromil)	Epinastine
ALOMIDE (lodoxamide)	Olopatadine 0.2%
Azelastine	ZERVIATE (cetirizine)
BEPREVE (bepotastine)	

Cromolyn	
LASTACAFT (alcaftadine)	
Olopatadine 0.1%	
PAZEO (olopatadine)	

Anti-infectives

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have had 3-day trials of at least 3 preferred agents, as evidenced by paid claims or pharmacy printouts.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Bacitracin/polymyxin B ointment	AZASITE (azithromycin)
BESIVANCE (besifloxacin) DROPS	Bacitracin ointment
CILOXAN (ciprofloxacin) OINTMENT	BLEPH-10 (sulfacetamide) DROPS
Ciprofloxacin drops	CILOXAN (ciprofloxacin) DROPS
Erythromycin ointment	Gatifloxacin drops
GENTAK (gentamicin sulfate) OINTMENT	Levofloxacin drops
Gentamicin sulfate drops	MOXEZA (moxifloxacin) DROPS
Gentamicin sulfate ointment	NEO-POLYCIN (neomycin SU/bacitracin/polymyxin B) OINTMENT
Moxifloxacin drops	NEOSPORIN (neomycin SU/polymyxin B/gramicidin) DROPS
Neomycin SU/bacitracin/polymyxin B ointment	OCUFLOX (ofloxacin) DROPS
Neomycin SU/polymyxin B/gramicidin drops	POLYCIN (bacitracin/polymyxin) OINTMENT
Ofloxacin drop	POLYTRIM (polymyxin B/trimethoprim) DROPS
Polymyxin B/trimethoprim drops	Sulfacetamide ointment
Sulfacetamide drops	TOBREX (tobramycin) DROPS
Tobramycin drops	VIGAMOX (moxifloxacin) DROPS
TOBREX (tobramycin) OINTMENT	ZYMAXID (gatifloxacin) DROPS

Anti-infectives/Anti-inflammatories

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have had 7-day trials of at least 2 preferred agents, as evidenced by paid claims or pharmacy printouts.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
BLEPHAMIDE (sulfacetamide/prednisolone) DROPS	BLEPHAMIDE S.O.P. (sulfacetamide/prednisolone) ointment
Neomycin/polymyxin b/dexamethasone drops	MAXITROL (neomycin/polymyxin b/dexamethasone) DROPS
Neomycin/polymyxin b/dexamethasone ointment	MAXITROL (neomycin/polymyxin b/dexamethasone) OINTMENT
PRED-G (gentamicin/prednisol ac) DROPS	Neomycin/bacitracin/polymyxin b/hydrocortisone ointment
PRED-G (gentamicin/prednisol ac) OINTMENT	Neomycin/polymyxin b/hydrocortisone drops
Sulfacetamide/prednisolone drops	NEO-POLYCIN HC (neomycin SU/bacitracin/polymyxin B/hydrocortisone) OINTMENT
TOBRADEX (tobramycin/dexamethasone) DROPS	TOBRADEX ST (tobramycin/dexamethasone) DROPS
TOBRADEX (tobramycin/dexamethasone) OINTMENT	Tobramycin/dexamethasone
ZYLET (tobramycin/lotepred etab) DROPS	

Anti-inflammatories

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have had 5-day trials of at least 2 preferred agents, as evidenced by paid claims or pharmacy printouts.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
ACUVAIL (ketorolac)	ACULAR (ketorolac)
ALREX (loteprednol)	ACULAR LS (ketorolac)
Diclofenac sodium	Bromfenac sodium
DUREZOL (Difluprednate)	BROMSITE (bromfenac sodium)
FLAREX (fluorometholone)	Dexamethasone sodium phosphate
Fluorometholone	EYSUVIS (loteprednol)
Flurbiprofen sodium	INVELTYS (loteprednol)
FML FORTE (fluorometholone)	FML (fluorometholone)
FML S.O.P. (fluorometholone)	LOTEMAX SM (loteprednol)
ILEVRO (nepafenac)	Loteprednol eye drops
ketorolac tromethamine 0.4%	OMNIPRED 1% (prednisolone acetate)
ketorolac tromethamine 0.5%	PRED FORTE 1% (prednisolone acetate)
LOTEMAX (loteprednol) DROPS – *Brand Preferred*	PROLENSA (bromfenac)
LOTEMAX (loteprednol) GEL DROPS	
LOTEMAX (loteprednol) OINTMENT	
MAXIDEX (dexamethasone)	
NEVANAC (nepafenac)	
PRED MILD 0.12% (prednisolone acetate)	
Prednisolone acetate 1%	
Prednisolone sodium phosphate 1%	

Dry Eye Syndrome

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have had a 14-day trial of the preferred agent, as evidenced by paid claims or pharmacy printouts.

Product Specific Criteria:

- **Cequa, Restasis Multidose**
  - The patient must have had a 30-day trials of Xiidra, as evidenced by paid claims or pharmacy printouts.
  - Clinical justification must be provided explaining why the patient is unable to use all other products (subject to clinical review).

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
RESTASIS (cyclosporine)	CEQUA (cyclosporine)***
	RESTASIS MULTIDOSE (cyclosporine)***
	XIIDRA (lifitegrast)

Glaucoma

Alpha Adrenergic

General Prior Authorization Form

Non-Preferred Agents Criteria:

- **Branded non-preferred agents:** The patient must have had a 30-day trial of each pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.

- **Generic non-preferred agents:** The patient must have had a 30-day trial of a pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
ALPHAGAN P 0.1% (brimonidine)	brimonidine 0.15%
ALPHAGAN P 0.15% (brimonidine) – *Brand Preferred*	
apraclonidine 0.5%	
IOPIDINE (apraclonidine) 1%	
brimonidine 0.2%	
COMBIGAN (brimonidine/timolol)	
SIMBRINZA (brinzolamide/brimonidine)	

Beta Blockers

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have had a 30-day trial of at least 2 preferred ophthalmic beta blocker products of a unique active ingredient, as evidenced by paid claims or pharmacy printouts.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
BETOPTIC S (betaxolol) 0.25%	betaxolol 0.5%
carteolol	ISTALOL (timolol maleate) Daily
COMBIGAN (brimonidine/timolol)	timolol daily
dorzolamide/timolol	timolol gel forming solution
levobunolol	TIMOPTIC (timolol maleate)
timolol maleate	TIMOPTIC OCUDOSE 0.25% (timolol)
Timolol maleate/PF 0.25%	TIMOPTIC-XE (timolol gel forming solution)
TIMOPTIC OCUDOSE 0.5% (timolol)	

Prostaglandins

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have had a 30-day trial of at least 2 preferred ophthalmic prostaglandin products of a unique active ingredient, as evidenced by paid claims or pharmacy printouts.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Latanoprost	Bimatoprost 0.03%
LUMIGAN (Bimatoprost) 0.01%	Travoprost
ROCKLATAN (Netarsudil/Latanoprost)	VYZULTA (latanoprostene)
TRAVATAN Z (Travoprost) - *Brand Preferred*	XALATAN (Latanoprost)
ZIOPTAN (Tafluprost)	XELPROS (Latanoprost)

Other

Non-Preferred Agents Criteria:

- **Branded non-preferred agents:** The patient must have had a 30-day trial of each pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.
- **Generic non-preferred agents:** The patient must have had a 30-day trial of a pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
AZOPT (Brinzolamide)	ISOPTO CARPINE (Pilocarbine)
Dorzolamide	TRUSOPT (Dorzolamide)
PHOSPHOLINE (Echothiophate Iodide)	
Pilocarpine	

RHOPRESSA (Netarsudil)	
ROCKLATAN (Netarsudil/Latanoprost)	

Otic

Anti-infectives/Anti-inflammatories – Fluoroquinolones

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have had a 7-day trial of one preferred product in the past 3 months, as evidenced by paid claims or pharmacy printouts.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
CIPRO HC (ciprofloxacin/hydrocortisone)	Ciprofloxacin/dexamethasone otic drops
CIPRODEX (ciprofloxacin/dexamethasone) – *Brand Preferred*	Ciprofloxacin/Fluocinolone
	OTOVEL (ciprofloxacin/fluocinolone)

Pain

Lidocaine topical cream

Prior Authorization Form - Anesthetics - Topical

Group Criteria:

- The request must be for patient home use of cream, prior to injection pain from a medically necessary procedure

Lidocaine patch

General Prior Authorization Form

- **Generic non-preferred agents:** The patient must have had a 30-day trial of a pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
LIDODERM (lidocaine) 5% PATCH – *Brand Preferred*	Lidocaine 5% patch
ZTLIDO (Lidocaine) 1.8% PATCH	

NSAIDS

Therapeutic Duplication

Overrides Available

- One strength of one medication is allowed at a time (topical and oral formulations are not allowed together)

Electronic Diagnosis Verification

- **Mefenamic acid and Meclofenamate:** The patient must have diagnosis of dysmenorrhea or endometriosis

Solid Oral Dosage Forms

Prior Authorization Form - NSAIDs

Non-Preferred Agents Criteria:

- The patient must have failed a 30-day trial of 3 different oral generic NSAIDs including a COX-2 inhibitor with GI intolerances, as evidenced by paid claims or pharmacy print outs

Product Specific Criteria:

- **Branded NSAIDs and non-preferred strengths**:
  - Clinical justification must be provided explaining why the patient is unable to use other NSAID agents (subject to clinical review)

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
celecoxib 50mg, 100mg, 200mg	ARTHROTEC (diclofenac/misoprostol)
diclofenac potassium	celecoxib 400mg
diclofenac sodium 50mg, 75mg	CELEBREX (celecoxib)
etodolac	CONSENSI (amlodipine/celecoxib)
fenoprofen 600mg	DAYPRO (oxaprozin)
flurbiprofen	diclofenac sodium ER 100mg
ibuprofen	diclofenac sodium 35mg capsule
indomethacin	diclofenac/misoprostol
indomethacin ER	DUEXIS (famotidine/ibuprofen)
ketoprofen 50mg, 75mg	etodolac ER
ketorolac	FELDENE (piroxicam)
meclofenamate	fenoprofen 400mg
mefenamic acid	INDOCIN (indomethacin)
meloxicam	ketoprofen 25mg
nabumetone	ketoprofen ER 200mg
naproxen 220mg, 250mg, 500mg	meloxicam, submicronized
piroxicam	MOBIC (meloxicam)
Sulindac	NALFON (fenoprofen)
tolmetin 200mg, 400mg	NAPRELAN (naproxen)
VIMOVO (naproxen/esomeprazole) – *Brand preferred*	naproxen ER 375 mg
	naproxen 275mg, 550mg
	naproxen/esomeprazole
	oxaprozin
	RELAFEN DS (nabumetone)
	tolmetin 600mg
	VIVLODEX (meloxicam, submicronized)
	ZIPSOR (diclofenac)
	ZORVOLEX (diclofenac, submicronized)

Non-Solid Oral Dosage Forms

Prior Authorization Form - NSAIDs

Non-Preferred Agents Criteria:

- The patient must have had 30-day trials of each preferred agent, as evidenced by paid claims or pharmacy printouts.
- Clinical justification must be provided explaining why the patient is unable to use the preferred products (subject to clinical review).

PREFERRED AGENTS	NON-PREFERRED AGENTS
Ibuprofen	INDOCIN (Indomethacin) SOLUTION
Naproxen	

Nasal

Prior Authorization Form - NSAIDs

Non-Preferred Agents Criteria:

- The patient must have had 30-day trials of 2 oral and 1 topical preferred agents, as evidenced by paid claims or pharmacy printouts.
- Clinical justification must be provided explaining why the patient is unable to use another dosage form (subject to clinical review).

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
	Ketorolac Nasal Spray
	SPRIX (Ketorolac) NASAL SPRAY

Topical:

Prior Authorization Form - NSAIDs

Non-Preferred Agents Criteria:

- The patient must have had 30-day trials of each preferred agent, as evidenced by paid claims or pharmacy printouts.
- Clinical justification must be provided explaining why the patient is unable to use the preferred products (subject to clinical review).

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Diclofenac 1% Gel	Diclofenac Patch
Diclofenac 1.5% Topical Solution	LICART (Diclofenac) PATCH 1.3%
FLECTOR (diclofenac) PATCH *(Brand Preferred)*	PENNSAID (Diclofenac) 2% PACKET
	PENNSAID (Diclofenac) 2% PUMP

Opioid Analgesics – Long Acting

Therapeutic Duplication

- One extended release product/strength is allowed at a time
- One immediate release product is allowed (single ingredient or combination)
- Nucynta and Nucynta ER are not allowed with other narcotic medications
- Opioid-acetaminophen combination products are not allowed with acetaminophen
- Tramadol immediate release with tramadol extended release
- Methadone is not allowed
- 3A4 Substrates (Fentanyl, methadone, and oxycodone) are not allowed with strong 3A4 inhibitors. Click here for a full listing of medications included.
- Methadone: Not allowed with opioids, benzodiazepines, or opioid use disorder medications
- Opioids are not allowed with:
  - Quetiapine IR: Due to guidance in The SUPPORT for Patients and Communities Act (H.R. 6) on CNS depression risk between antipsychotics and opioids. Override Criteria Available
  - Benzodiazepines: Override Criteria Available
  - Carisoprodol: The "Holy Trinity" consists of an opioid, a benzodiazepine, and carisoprodol and is a highly abused dangerous combination that can lead to additive CNS depression, overdose, and death. It is not covered.
  - Opioid use disorder medications Override Criteria Available
- Morphine is not covered with Clopidogrel, Prasugrel, Ticagrelor, and Ticlopidine. Other opioid analgesics are covered with Clopidogrel, Prasugrel, Ticagrelor, and Ticlopidine.
  - Morphine may diminish the antiplatelet effect and serum concentrations of P2Y12 Inhibitor antiplatelet agents (clopidogrel, prasugrel, ticagrelor, and ticlopidine).

Underutilization

- Long acting opioid analgesics must be used compliantly and will reject on point of sale for late fill

Morphine Milligram Equivalents (MME)

Prior Authorization Form – Opioid Analgesics

- A cumulative maximum of 90 MME will be allowed without authorization
- Patient must meet Prior Authorization Criteria

Prior Authorization Criteria

Prior Authorization Form – Opioid Analgesics

Category Criteria (initial):

- The prescriber must attest that they have reviewed the past 3 months of the patient's North Dakota PDMP reports.
- The patient must have not achieved therapeutic goal with non-narcotic medication (NSAIDs, TCAs, SNRIs, Corticosteroids, etc.) and non-medication alternatives (Weight Loss, Physical Therapy, Cognitive Behavioral Therapy, etc.).
- The patient must have established opioid tolerability by using short acting opioids daily for at least 90 days prior to request for long acting opioid, as evidenced by paid claims or pharmacy printouts
- The patient must have access to Narcan and be counseled on overdose risk
- The prescription must be written by or in consultation with an oncologist or pain management specialist with a pain management contract (with treatment plan including goals for pain and function, and urine and/or blood screens) if one of the following:
  - Cumulative daily dose of opioids exceeds 90 MED/day

Non-Preferred Agents Criteria:

- Clinical justification must be provided explaining why the patient is unable to use other opioid and non-opioid analgesic agents (subject to clinical review).

Category Criteria (renewal):

- Documentation noting progress toward therapeutic goal must be included with request (including pain level and function).

Partial Agonist/Antagonist Opioids

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
BELBUCA (Buprenorphine)	buprenorphine patches
Butorphanol	
BUTRANS (buprenorphine) PATCHES – *Brand Preferred*	

Abuse Deterrent Formulations/Unique Mechanisms from Full Agonist Opioids

Prior Authorization Form – Opioid Analgesics

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
NUCYNTA ER (tapentadol)	ARYMO ER (morphine)
OXYCONTIN (oxycodone) – *Brand Preferred*	CONZIP (tramadol ER) CAPSULES
Tramadol ER Tablets	HYSINGLA ER (hydrocodone)
	Levorphanol
	Methadone
	MORPHABOND ER (morphine)
	Tramadol ER Capsules
	XTAMPZA ER (oxycodone)

Full Agonist Opioids Without Abuse Deterrent Formulations

Prior Authorization Form – Opioid Analgesics

Product Specific Criteria:

- **Fentanyl Patch:**

- Patient must meet one of the following criteria:
  - The patient has an indication of cancer pain or palliative care pain
  - The patient requires a long acting narcotic and cannot tolerate an oral dosage form
- Patient must have a BMI ≥17
- **Fentanyl Patch 12 mcg/hr**:
  - Patient must meet one of the following (A or B):

A. The patient must be receiving a total daily opioid dose less than or equal to 60 Morphine Equivalent Dose (MED), as evidenced by paid claims or pharmacy printouts

B. The patient must be continuously tapering off opioids from a higher strength Fentanyl patch

Full Agonist Opioids Without Abuse Deterrent Formulations	
PREFERRED AGENTS (CLINICAL PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
Fentanyl 12 mcg/hr	EXALGO (hydromorphone)
Fentanyl 25 mcg/hr, 50 mcg/hr, 75 mcg/hr, 100 mcg/hr	Fentanyl patch 37.5 mcg/hr, 62.5 mcg/hr, 87.5 mcg/hr
Morphine ER tablets	Hydrocodone ER Tablets
	Hydromorphone ER tablets
	KADIAN (morphine)
	Morphine ER capsules
	MS CONTIN (morphine)
	Oxycodone ER
	Oxymorphone ER tablets
	ZOHYDRO ER (hydrocodone)

Opioid Analgesic – Short Acting

First Fill

- Short acting opioid analgesics must be filled with a 7-day supply if no previous fill within past 34 days
  - If patient is filling prescription less than every 34 days due to decreased utilization, please get a new prescription for a lower quantity that reflects actual utilization within a 34-day window.

Prior Authorization Criteria

Prior Authorization Form – Opioid Analgesics

Product Specific Criteria:

- **Subsys, Fentanyl Citrate Buccal Tablet, Lazanda, Actiq, and Abstral:**
  - The patient's age must be within label recommendations
  - The patient must have a diagnosis of cancer pain
  - The patient must currently be on around the clock opioid therapy for at least a week, as evidenced by paid claims or pharmacy printouts
    - The around the clock opioid therapy must be equivalent to 60 mg oral morphine daily, 25 mcg transdermal fentanyl/hour, 30mg oxycodone daily, 8 mg of oral hydromorphone daily, or equianalgesic dose of another opioid daily
- **ALL Other Non-Preferred Short-Acting Opioid Analgesics (Initial):**
  - The patient must have required around-the-clock pain relief for the past 90 days, as evidenced by paid claims or pharmacy printouts
  - The prescriber must attest that they have reviewed the past 3 months of the patient's North Dakota PDMP reports
  - The patient must have not achieved therapeutic goal with non-narcotic medication (NSAIDs, TCAs, SNRIs, Corticosteroids, etc.) and non-medication alternatives (Weight Loss, Physical Therapy, Cognitive Behavioral Therapy, etc.)

- The prescription must be written by or in consultation with an oncologist or pain management specialist with a pain management contract (with treatment plan including goals for pain and function, and urine and/or blood screens)

o **Oxycodone IR**
- The above Initial Criteria must be met
- The patient must currently be on a long-acting opioid analgesic that provides a daily Morphine Equivalent Dose (MED) which meets requirements below (based on requested strength), as evidenced by paid claims or pharmacy printouts (Please use an Opioid Dose Calculator to find the MED for specific products):
  - **Oxycodone 15 mg tablet:** long-acting opioid must provide ≥150 mg MED per day
  - **Oxycodone 20 mg tablet:** long-acting opioid must provide ≥200 mg MED per day
  - **Oxycodone 30 mg tablet:** long-acting opioid must provide ≥300 mg MED per day
- **Solution:** The patient must be unable to ingest solid dosage form as evidenced by swallow study documentation

o **Meperidine, butalbital-codeine products:**
- The above Initial Criteria must be met
- Clinical justification must be provided explaining why the patient is unable to use other opioid and non-opioid analgesic products (subject to clinical review).

o **ALL Other Non-Preferred Short-Acting Opioid Analgesics (Renewal):**
- Documentation noting progress toward therapeutic goal must be included with request (including pain level and function).

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
acetaminophen-codeine solution	ABSTRAL (fentanyl) SUBLINGUAL TABLET
acetaminophen-codeine tablets	ACTIQ (fentanyl) LOZENGE
benzhydrocodone-acetaminophen	butalbital-codeine
codeine tablets	CONZIP (tramadol) CAPSULE
hydrocodone-acetaminophen 7.5-325/15ml Solution	DEMEROL (meperidine)
hydrocodone-acetaminophen 5-325 MG	DILAUDID (hydromorphone)
hydrocodone-acetaminophen 7.5-325 MG	ENDOCET (oxycodone-acetaminophen)
hydrocodone-acetaminophen 10-325 MG	FENTORA (fentanyl) EFFERVESCENT TABLET
hydrocodone-ibuprofen 7.5mg-200mg	fentanyl citrate buccal tablet
hydromorphone liquid	fentanyl lozenge
hydromorphone tablet	hydrocodone-acetaminophen 5-163mg/7.5mL solution
meperidine	hydrocodone-acetaminophen 2.5-325 MG
morphine tablets	hydrocodone-acetaminophen 10MG-300MG
morphine solution	hydrocodone-acetaminophen 5 MG-300MG
NUCYNTA (tapentadol) TABLETS	hydrocodone-acetaminophen 7.5-300 MG
oxycodone 5mg, 10mg tablets	hydrocodone-ibuprofen 5mg-200mg and 10mg-200mg
oxycodone solution	LAZANDA (fentanyl) SPRAY
oxycodone-acetaminophen 5-325 MG	LORCET (hydrocodone-acetaminophen)
oxycodone-acetaminophen 10 -325 MG	LORTAB (hydrocodone-acetaminophen) SOLUTION
oxymorphone tablets	NALOCET (oxycodone-acetaminophen)
tramadol tablets	NORCO (hydrocodone-acetaminophen)
tramadol-acetaminophen tablets	OPANA (oxymorphone)
	OXAYDO (oxycodone)
	oxycodone 15mg, 20mg, 30mg
	oxycodone-acetaminophen 2.5-325 MG
	oxycodone-acetaminophen 7.5-325 MG
	PERCOCET (oxycodone/acetaminophen)
	PRIMLEV (oxycodone/acetaminophen)
	QDOLO (tramadol) ORAL SOLUTION

Please use the NDC Drug Lookup to find Prior Authorization (PA) Forms

	ROXICODONE (oxycodone)
	ROXYBOND (oxycodone)
	SUBSYS (fentanyl) SPRAY
	ULTRACET (tramadol/acetaminophen)
	ULTRAM (tramadol)
	VICODIN (hydrocodone/acetaminophen)

Skeletal Muscle Relaxants

Therapeutic Duplication

Overrides Available

- One strength of one medication is allowed at a time
- Carisoprodol is not allowed with opioids, benzodiazepines, or opioid use disorder medications
  - The "Holy Trinity" consists of an opioid, a benzodiazepine, and carisoprodol and is a highly abused dangerous combination that can lead to additive CNS depression, overdose, and death. It is not covered.
- Tizanidine is not allowed with:
  - Antipsychotics: visual hallucinations being reported in 3% of patients receiving tizanidine, psychosis has also been reported.
  - Other alpha 2 agonists (clonidine, clonidine/chlorthalidone, guanfacine, methyldopa) as tizanidine is also an alpha 2 agonist

Prior Authorization Criteria

General Prior Authorization Form

Non-Preferred Agents Criteria: *Approval Duration = 3 months*

- The patient must have failed two 30-day trials of other skeletal muscle relaxants, as evidenced by paid claims or pharmacy printouts.

Product Specific Criteria

- **Metaxalone:** *Approval Duration = 3 months*
  - One of the required 30-day trials must be methocarbamol, as evidenced by paid claims or pharmacy printouts.
- **Carisoprodol:** *Approval Duration = 1 week*
  - Clinical justification must be provided explaining why the patient is unable to use the preferred agents (subject to clinical review)

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Baclofen	AMRIX (Cyclobenzaprine) TAB 24HR
Chlorzoxazone 500mg	Chlorzoxazone 375mg and 750mg
Cyclobenzaprine 5mg and 10mg	Cyclobenzaprine 7.5mg
Dantrolene	Cyclobenzaprine ER
Methocarbamol	Carisoprodol
Orphenadrine ER	Carisoprodol-aspirin
Tizanidine tablets	Carisoprodol-aspirin-codeine
	DANTRIUM (Dantrolene)
	FEXMID (Cyclobenzaprine)
	LORZONE (Chlorzoxazone)
	METAXALL (Metaxalone)
	Metaxalone
	NORGESIC FORTE (orphenadrine/aspirin/caffeine)

	OZOBAX (Baclofen) SOLUTION
	ROBAXIN (Methocarbamol)
	SKELAXIN (Metaxalone)
	SOMA (Carisoprodol)
	Tizanidine capsules
	ZANAFLEX (Tizanidine)

Psychiatry

ADHD Agents

Therapeutic Duplication

- **For all stimulants:**
  - The following are not payable:
    - Multiple strengths of a single medication
    - Amphetamine Agent + Methylphenidate Agent
    - Multiple Long Acting Agents
    - Multiple Short Acting Agents
    - Non-Solid dosage + Solid dosage forms

- These long acting products are not allowed with short acting products is not allowed with the following products:
  - Aptensio XR (Methylphenidate)
  - Adhansia XR (Methylphenidate)
  - Cotempla XR-ODT (Methylphenidate)
  - Daytrana (Methylphenidate)
  - Adderall XR (Mixed Salts of a Single-Entity Amphetamine Product)
  - Adzenys XR ODT (Amphetamine Suspension, Extended Release)
  - Adzenys ER (Amphetamine Suspension, Extended Release)
  - Dyanavel XR (amphetamine suspension, Extended Release)
  - Mydayis (Mixed Salts of a Single-Entity Amphetamine Product)
  - Vyvanse (Lisexamfetamine)
  - Vyvanse Chewable (Lisexamfetamine)

- Amphetamines: One product will be allowed at a time. The following are not payable regimens:
  - Dextroamphetamine/Amphetamine ER with Proton Pump Inhibitors
    - Proton Pump Inhibitors increase blood levels and potentiate the action of amphetamine. Co-administration of Adderall XR and gastrointestinal or urinary alkalizing agents should be avoided
  - Concurrent use of Mydayis with benzodiazepines or sedatives
    - Insomnia has been reported in 25-56% of patients receiving Mydayis. Patients reporting insomnia should use a shorter acting product that does not reach steady state.

- Methylphenidates: The following are not payable regimens
  - Concurrent use of dexmethylphenidate and methylphenidate

- **For all non-stimulants:**
  - One strength of one medication is allowed at a time except for Guanfacine 4mg IR and ER which may be combined Guanfacine IR and ER, respectively, to form dosages up to 7mg per day
  - Clonidine, guanfacine are not allowed with each other or other alpha 2 agonists (clonidine/chlorthalidone, methyldopa, or tizanidine)
    - Methyldopa and tizanidine are also alpha 2 agonists

First Fill

- Long Acting ADHD medications (stimulants and guanfacine ER) must be filled with a 14-day supply (or less) if no previous fill within past 99 days

Prior Authorization Criteria

General Prior Authorization Form

Non-Preferred Agents Criteria:

- **Branded non-preferred agents:** The patient must have had a 10-day trial of each pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.
- **Generic non-preferred agents:** The patient must have had a 10-day trial of a pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.

Product Specific Criteria:

- *** **Clonidine ER**: Patient must have had a 30-day trial of immediate release clonidine, as evidenced by pharmacy claims or pharmacy printouts.

Non-Stimulants

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
clonidine	atomoxetine
guanfacine	clonidine ER***
guanfacine ER	INTUNIV (guanfacine ER)
STRATTERA (atomoxetine) – *Brand Preferred*	

Stimulants

Stimulants - Methylphenidates	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
ADHANSIA XR (methylphenidate)	Dexmethylphenidate ER
APTENSIO XR (methylphenidate) – *Brand Preferred*	FOCALIN (dexmethylphenidate)
CONCERTA (methylphenidate) – *Brand Preferred*	METADATE ER (methylphenidate)
COTEMPLA XR - ODT (methylphenidate)	METHYLIN (methylphenidate) chew tablets
DAYTRANA (methylphenidate)	Methylphenidate ER 72 mg
Dexmethylphenidate	Methylphenidate ER capsule
FOCALIN XR (dexmethylphenidate) – *Brand Preferred*	Methylphenidate ER tablet
JORNAY PM (methylphenidate)	Methylphenidate LA capsules - 50-50
Methylphenidate solution	METHYLIN (methylphenidate) solution
Methylphenidate CD 30-70	RITALIN (methylphenidate)
Methylphenidate chew tablet	
Methylphenidate ER capsules 50-50	
Methylphenidate tablet	
QUILLICHEW ER (methylphenidate)	
QUILLIVANT XR (methylphenidate)	
RITALIN LA (methylphenidate LA capsules - 50-50)– *Brand Preferred*	

Stimulants - Amphetamines	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
ADDERALL XR (dextroamphetamine/amphetamine) – *Brand Preferred*	ADZENYS ER (amphetamine) SOLUTION
ADZENYS XR - ODT (amphetamine)	ADDERALL (dextroamphetamine/amphetamine)
amphetamine	DEXEDRINE (dextroamphetamine)
amphetamine ER solution	dextroamphetamine 5 mg/5 ml
DESOXYN (Methamphetamine) – *Brand Preferred*	EVEKEO (amphetamine)
dextroamphetamine	methamphetamine
dextroamphetamine ER	ZENZEDI (dextroamphetamine)
dextroamphetamine/amphetamine	dextroamphetamine/amphetamine ER
DYANAVEL XR (amphetamine)	
EVEKEO ODT (amphetamine)	
MYDAYIS (dextroamphetamine/amphetamine)	
PROCENTRA (dextroamphetamine) – *Brand Preferred*	
VYVANSE (lisdexamfetamine)	
VYVANSE (lisdexamfetamine) CHEW TABLET	

Atypical Antipsychotics

Therapeutic Duplication

Overrides Available

- Long acting injections are not allowed with oral tablets of the same active ingredient or prodrug
    - In some cases (e.g. missed/delayed dose or during initiation), time-limited concomitant therapy with oral formulation may be indicated.
- First generation antipsychotics: Chloropromazine, Fluphenazine, Perphenazine, Thioridazine, Trifluoperazine, Haloperidol
    - One strength allowed at a time
    - No other antipsychotic medication is allowed concurrently
- Second generation antipsychotics:
    - Aripiprazole: one strength is allowed at a time
    - Risperidone: not allowed with paliperidone concurrently
    - Caplyta, Fanapt, Latuda, Paliperidone, Rexulti, Saphris, Secuado, Vraylar, Ziprasidone: one strength is allowed at a time and no other antipsychotic medication is allowed concurrently
    - Quetiapine:
        - Immediate release: 200mg, 300mg, and 400mg are not allowed together
        - Extended release: 200mg, 300mg, and 400mg are not allowed together or with immediate release. 150mg is not allowed with 50mg.
        - Opioids are not allowed with quetiapine IR due to risk of CNS depression. Override Criteria Available
    - Olanzapine:
        - Olanzapine 2.5mg is not allowed with olanzapine 5mg or 7.5mg
        - Olanzapine 5mg not allowed with 10mg or 15mg
        - All other olanzapine tablet strengths are allowed together
        - ODT and tablets are not allowed concurrently
        - Olanzapine/Fluoxetine is not allowed with any other product containing olanzapine.

Additional information:

- Quantity limit is 1 tablet per day due to the 30 hour half-life of the medication
- Pharmacokinetic studies show that olanzapine tablets and olanzapine ODT are bioequivalent

- Tizanidine is not allowed with antipsychotics due to visual hallucinations being reported in 3% of patients receiving tizanidine, psychosis has also been reported.

Oral

Electronic Step Care and Concurrent Medication

- Start Vraylar with Initiation pack or 7 days of 1.5 mg tablets prior to continuing therapy with doses of 3 mg or more
  - Vraylar requires titration from 1.5 mg dose at initiation.

Underutilization

- Caplyta, Fanapt, Latuda, Paliperidone ER, Rexulti, Saphris, Sacuado, and Vraylar must be used compliantly and will reject on point of sale for late fill

First Fill

- Caplyta, Fanapt, Latuda, Paliperidone ER, Rexulti, Saphris, Sacuado, and Vraylar must be filled with a 10 day supply if no previous fill within past 99 days

Prior Authorization Criteria

Non-Preferred Agents Criteria:

- **Branded non-preferred agents:** The patient must have had a 30-day trial of each pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.
- **Generic non-preferred agents:** The patient must have had a 30-day trial of a pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.

Product Specific Criteria:

- ***Olanzapine/fluoxetine**: Clinical justification must be provided explaining why the patient is unable to use the preferred, individual products separately (subject to clinical review).

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Aripiprazole solution	ABILIFY (aripiprazole)
Aripiprazole	ABILIFY DISCMELT (aripiprazole)
Aripiprazole ODT	Asenapine
CAPLYTA (Lumateperone)	CLOZARIL (clozapine)
Clozapine	GEODON (ziprasidone)
Clozapine ODT	Olanzapine/Fluoxetine***
FANAPT (Iloperidone)	Paliperidone ER
INVEGA ER (paliperidone) – *Brand Preferred*	RISPERDAL (risperidone)
LATUDA (Lurasidone)	RISPERDAL (risperidone) ORAL SOLUTION
Olanzapine	RISPERDAL M-TAB (risperidone)
Olanzapine ODT	SEROQUEL (quetiapine)
Quetiapine	SEROQUEL XR (quetiapine)
Quetiapine ER	ZYPREXA (olanzapine)
REXULTI (Brexpiprazole)	ZYPREXA ZYDIS (olanzapine)
Risperidone	
Risperidone ODT	
Risperidone oral solution	
SAPHRIS (Asenapine) – *Brand Preferred*	
SECUADO (Asenapine)	
VRAYLAR (Cariprazine)	
Ziprasidone	

Please use the NDC Drug Lookup to find Prior Authorization (PA) Forms

Long Acting Injectable

Electronic Step Care and Concurrent Medication

- Oral formulations must be used prior to injectable formulations to establish tolerability and achieve steady state.
    - Please call for exception if there is a history of tolerability to active ingredient and no requirement for oral overlap for missed dose / initiation of long-acting injectable antipsychotic.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
ABILIFY MAINTENA (aripiprazole)	
ARISTADA (aripiprazole lauroxil)	
ARISTADA INITIO (aripiprazole lauroxil)	
INVEGA SUSTENNA (paliperidone)	
INVEGA TRINZA (paliperidone)	
PERSERIS (risperidone)	
RISPERDAL CONSTA (risperidone)	
ZYPREXA RELPREVV (olanzapine)	

Sedatives/Hypnotics

Therapeutic Duplication

- One strength of one medication is allowed at a time
    - Benzodiazepines indicated only for insomnia are not covered with other non-barbiturate insomnia medications or other benzodiazepines
- Sedative/hypnotics are not covered with:
    - Xyrem
    - Mydayis
        - Insomnia has been reported in 25-56% of patients receiving Mydayis. Patients reporting insomnia should use a shorter acting product that does not reach steady state.
    - Long Acting Benzodiazepines due to CNS depression
        - Belsomra and Dayvigo are not covered with short or long acting benzodiazepines
- Ramelteon is a 1A2 Substrate and is not covered with Fluvoxamine, a strong 1A2 inhibitor
- Mirtazapine is not allowed with other alpha 2 agonists (clonidine, clonidine/chlorthalidone, guanfacine, methyldopa)
    - Mirtazapine is also an alpha 2 agonist
- Benzodiazepines are not covered with Opioids: Override Criteria Available

Electronic Step Care and Concurrent Medications

- Zolpidem: Initiation with trial of 5 mg must be used for 7 days within 90 days prior to 10 mg tablets
    - Zolpidem is recommended to be used at lowest dose possible.

Prior Authorization Criteria

Prior Authorization Form - Sedative/Hypnotics

Product Specific Criteria (Initial): *Approval Duration = 1 month*

- **Belsomra, Dayvigo:**
    - The patient's insomnia must be characterized by difficulty with sleep onset and maintenance
    - The patient must have had the following 25-day trials with the most recent failure within the last 30 days, as evidenced by paid claims or pharmacy printouts
        - Silenor (doxepin)
        - Eszopiclone

        - Zolpidem ER
- **Temazepam, zolpidem SL:**
    - The patient's insomnia must be characterized by difficulty with sleep onset and maintenance
    - The patient must have had the following 25-day trials with the most recent failure within the last 30 days, as evidenced by paid claims or pharmacy printouts
        - Zolpidem ER
        - Eszopiclone
        - Silenor (doxepin)
        - Belsomra
- **Edluar (Zolpidem):**
    - The patient's insomnia must be characterized by difficulty with sleep onset
    - The patient must have had the following 25-day trials with the most recent failure within the last 30 days, as evidenced by paid claims or pharmacy printouts
        - Zolpidem IR
        - Zaleplon
        - Eszopiclone
- **Triazolam, fluazepam, estazolam, Seconal sodium, Zolpimist:**
    - Clinical justification must be provided explaining why the patient is unable to use the preferred agents (subject to clinical review)

Product Specific Criteria (Renewal): *Approval Duration = 6 months (2 weeks for b*enzodiazepines)

- **ALL Agents:**
    - The prescriber has provided confirmation that other conditions causing sleep issues have been ruled out
- **Benzodiazepines (temazepam, triazolam, flurazepam, estazolam):**
    - The patient must be undergoing dose tapering

NON - DEA SCHEDULED (NON-ADDICTIVE) MEDICATION:	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
Mirtazapine	Doxepin
ROZEREM (ramelteon)	Ramelteon
SILENOR (doxepin) – *Brand Preferred*	
Trazodone	
DEA SCHEDULED MEDICATIONS	
PREFERRED AGENTS (NO PA REQUIRED)	**NON-PREFERRED AGENTS (PA REQUIRED)**
Eszopiclone	AMBIEN (Zolpidem)
Zaleplon	AMBIEN CR (Zolpidem)
Zolpidem	BELSOMRA (Suvorexant)
Zolpidem ER	DAYVIGO (Lemborexant)
	EDLUAR (Zolpidem)
	Estazolam
	Flurazepam
	INTERMEZZO (Zolpidem) SL TABLET
	LUNESTA (Eszopiclone)
	SECONAL SODIUM (Secobarbital)
	Temazepam
	Triazolam
	ZOLPIMIST (Zolpidem)
	Zolpidem SL tab

Respiratory

References:

2. Albuterol Overuse: A Marker of Psychological Distress? Joe K. Gerald, Tara F. Carr, Christine Y. Wei, Janet T. Holbrook, Lynn B. Gerald. J Allergy Clin Immunol Pract. 2015 Nov-Dec; 3(6): 957–962. Published online 2015 Sep 1. doi: 10.1016/j.jaip.2015.06.021. PMCID: PMC4641773
3. Global Initiative for Asthma. Global strategy for asthma management and prevention. 2019 GINA Main Report. Available from: www.ginasthma.org. (Accessed February 5, 2020)
4. National Asthma Education and Prevention Program, Third Expert Panel on the Diagnosis and Management of Asthma. Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma. Bethesda (MD): National Healrth, Lung, and Blood Institute (US); 2007 Aug. Available from: https://www.ncbi.nlm.nih.gov/books/NBK7232
5. High-Dose Albuterol by Metered-Dose Inhaler Plus a Spacer Device Versus Nebulization in Preschool Children With Recurrent Wheezing: A Double-Blind, Randomized Equivalence Trial Dominique Ploin, François R. Chapuis, Didier Stamm, Jacques Robert, Louis David, Pierre G. Chatelain, Guy Dutau and Daniel Floret Pediatrics August 2000, 106 (2) 311-317; DOI: https://doi.org/10.1542/peds.106.2.311

Therapeutic Duplication

Overrides Available

- One medication from each class is allowed at time (nebulizers and inhalers are not payable together)
  - One inhaled steroid
  - Long acting anticholinergic
  - Leukotriene pathway inhibitor
  - One long acting beta agonist
  - One short acting beta agonist
    - Inhalers and Nebulizers work equally well whether used at home, in school, or otherwise outside of the home. If patient receives multiple forms of rescue medication, the risk of unidentified uncontrolled asthma and rescue inhaler dependence is increased.

- Anticholinergic medications are not covered with Acetylcholinesterase Inhibitors (Aricept, Exelon, Razadyne, Pyridostigmine). Click here for a full listing of medications included.
  - The effects of an anticholinergic (blocks the effect of acetylcholine) and acetylcholinesterase inhibitors (prevents breakdown of acetylcholine) oppose each other and the therapeutic effect of both products is diminished

Concurrent Medication and Step Care

- Daliresp
  - A total of 25 days of an inhaled short or long acting anticholinergic must be paid within 45 days prior to daliresp's date of service.
    - According to the Global Initiative for Chronic Obstructive Lung Disease (GOLD) guidelines, Daliresp is a recommended add-on therapy to patients experiencing exacerbations while on antimuscarinic therapy.

Albuterol/Levalbuterol Rescue Inhalers

Concurrent Medication and Step Care

- Ventolin HFA
  - A total of 30 days of steroid inhaler must be paid within 40 days prior to Ventolin HFA or ProAir Respiclick's date of service. The quantity limit for ProAir HFA is set to 2 canisters per 6 months (2

puffs per day). If more is needed, patient must switch to Ventolin HFA and be on a steroid inhaler to control asthma.

- According to the GINA guidelines:
  - A low dose ICS should be taken whenever SABA taken for step 1 control of asthma.
  - Dispensing ≥ 3 canisters per year is associated with higher risk of emergency department presentations
  - Dispensing ≥ 12 canisters per year is associated with higher risk of death

- Exception:
  - If primary insurance will only pay for Ventolin HFA or ProAir Respiclick and patient is well-controlled without steroid inhaler (i.e. uses less than 2 canisters per 6 months).

Prior Authorization

General Prior Authorization Form
MedWatch Form

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Albuterol HFA – Labeler 66993, 50090	Albuterol HFA – Labeler 00933, 00254, 45802, 69097, 71205
PROAIR (albuterol) HFA – *Brand Preferred*	ProAir Digihaler
PROAIR RESPICLICK (albuterol)	PROVENTIL (albuterol) HFA
XOPENEX (levalbuterol) HFA - *Brand Preferred*	VENTOLIN (albuterol) HFA

Anticholinergics/Beta Agonists Combinations

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The patient must have had a 30-day trial of 2 preferred, combination anticholinergic/long-acting beta agonist products, as evidenced by paid claims or pharmacy printouts.

Product Specific Criteria:

- ***Duaklir Pressair:**
  - The patient must have had a 30-day trial of Stiolto Respimat, as evidenced by paid claims or pharmacy printouts.
  - Clinical justification must be provided explaining why the patient is unable to use the preferred products (subject to clinical review).

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Albuterol/ipratropium	DUAKLIR PRESSAIR (Aclidinium/Formoterol)***
ANORO ELLIPTA (umeclidinium/vilanterol)	DUONEB (albuterol/ipratropium)
BEVESPI AEROSPHERE (glycopyrrolate/formoterol)	STIOLTO RESPIMAT (tiotropium/olodaterol)
COMBIVENT RESPIMAT (albuterol/ipratropium)	

Corticosteroids – Inhaled

Electronic Duration Verification:

Overrides Available

- Budesonide Suspension 1mg/2mL is payable for 30 days every 75 days. Guidelines recommend that once control is achieved, dose should be titrated down to minimum dose required to maintain control. For doses 1.5mg per day or lower, please use 0.5mg/2mL strength.
- For diluted nasal rinses, please use 0.5mg/2mL instead of 1mg/2mL for doses 1mg per day or higher.

Prior Authorization

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have had a 30-day trial of each preferred inhaler of a unique active ingredient, as evidenced by paid claims or pharmacy printouts.

Product Specific Criteria:

- *** **Asmanex Twisthaler, Alvesco**: Patient must have had a 30-day trial of Asmanex HFA, as evidenced by pharmacy claims or pharmacy printouts.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Budesonide Suspension	ALVESCO (ciclesonide)***
FLOVENT DISKUS (fluticasone)	ARMONAIR DIGIHALER (fluticasone)
FLOVENT HFA (fluticasone)	ARNUITY ELLIPTA (fluticasone)
PULMICORT FLEXHALER (budesonide)	ASMANEX HFA (mometasone)
	ASMANEX (mometasone) TWISTHALER***
	PULMICORT RESPULES (budesonide)
	QVAR REDIHALER (beclomethasone)

Long Acting Anticholinergics

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have had a 30-day trial of at least 2 preferred long-acting anticholinergic agents, as evidenced by paid claims or pharmacy printouts.
    - Either single ingredient or combination products will count toward trials.
- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).

Product Specific Criteria:

- ***Lonhala Magnair**:
    - The patient must have had a 30-day trial of Yupelri, as evidenced by paid claims or pharmacy printouts.
    - Clinical justification must be provided explaining why the patient is unable to use the preferred products (subject to clinical review).

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
INCRUSE ELLIPTA (umeclidinium)	LONHALA MAGNAIR (glycopyrrolate)***
SPIRIVA HANDIHALER (tiotropium)	YUPELRI (revefenacin)
SPIRIVA RESPIMAT 2.5 MCG (tiotropium)	
TUDORZA PRESSAIR (aclidinium)	

Spiriva Respimat 1.25 mcg

General Prior Authorization Form

Criteria for coverage:

- The patient must have a diagnosis of asthma
- The patient must have failed a 30-day trial of a steroid inhaler and a long acting beta agonist

Long Acting Beta Agonists

General Prior Authorization Form

Group Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).

Product Specific Criteria:

- ***Brovana**: The patient must have had a 30-day trial of Perforomist, as evidenced by paid claims or pharmacy printouts.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)

PERFOROMIST (formoterol)	BROVANA (arformoterol)***
SEREVENT DISKUS (salmeterol)	
STRIVERDI RESPIMAT (olodaterol)	

Steroid/Long Acting Beta Agonist (LABA) Combination Inhalers

General Prior Authorization Form

Criteria for coverage:

- The patient must have had 30-day trials of each preferred agent, as evidenced by paid claims or pharmacy printouts
- The patient must have a diagnosis of an FDA-approved indication for use and meet the criteria for that diagnosis
    - **For COPD diagnosis: one of the following must be met (A or B):**
        - A. The patient must have failed 30-day trials of at least 1 agent from each of the below lists (I and II)
            - I. Tudorza Pressair, Spiriva Handihaler, Spiriva Respimat, or Incruse Ellipta
            - II. Brovana, Striverdi Respimat, Perforomist, or Serevent.
        - B. The patient must have failed 30-day trials of at least 1 of the following agents below:
            - Anoro Ellipta, Stiolto Respimat, Bevespi Aerosphere, or Trelegy Ellipta
    - **For asthma diagnosis:**
        - The patient must have been reviewed for step down therapy for all renewal requests.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
ADVAIR DISKUS (fluticasone/salmeterol) – *Brand Preferred*	AIRDUO DIGIHALER(fluticasone/salmeterol)
ADVAIR HFA (fluticasone/salmeterol)	BREO ELLIPTA (fluticasone/vilanterol)
DULERA (mometasone/formoterol)	budesonide/formoterol
SYMBICORT (budesonide/formoterol)	fluticasone/salmeterol
	WIXELA INHUB (fluticasone/salmeterol)

Steroid/Anticholinergics/Long Acting Beta Agonists Combinations

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- **For COPD diagnosis:** the patient must have had a 30-day trial of the following combinations (both 1 AND 2), as evidenced by paid claims or pharmacy printouts:
    1. Steroid/Long Acting Beta Agonist (LABA) Combination Inhalers + Long Acting Anticholinergics
    2. Combination Anticholinergics/Long Acting Beta Agonist + Inhaled Steroid
- **For asthma diagnosis:** the patient must have had at least two 30-day trials of a steroid/LABA combination inhaler (unique ingredients for each trial) + Spiriva Respimat 1.25 mg inhaler, as evidenced by paid claims or pharmacy printouts

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
	BREZTRI AEROSPHERE (budesonide/glycopyrrolate/formoterol)
	TRELEGY ELLIPTA (fluticasone/umeclidinium/vilanterol)

Substance Use

Nicotine / Tobacco Dependence Treatment

Concurrent Medication and Step Care

- A total of 14 days of Nicotine patch, Chantix, or Zyban must be paid within 40 days prior to Nicotrol Nasal Spray, Nicotine Lozenge, NIcotrol Inhaler, or Nicotine Gum's date of service.
    - Better outcomes are associated with concurrent use of short acting and long acting tobacco cessation products.

- A total of 14 days of Nicotine patch must be paid within 40 days prior to Zyban's date of service.
    - Better outcomes are associated with concurrent use of short acting and long acting tobacco cessation products. Nicotine products can help bridge treatment until Zyban becomes effective.

Electronic Duration Verification

Override Available

- A total of 12 consecutive weeks will be covered for all other products, every 6 months

Therapeutic Duplication

- Nicotine Gum, Lozenge, Inhaler, and Spray will not be paid concurrently
- Zyban will not be paid with other forms of bupropion

Underutilization

- Nicotine Patch, Chantix, and Bupropion must be used compliantly and will reject on point of sale for late fill

Prior Authorization Criteria

General Prior Authorization Form

Non-Preferred Agents Criteria:

- **Branded non-preferred agents:** The patient must have had a 30-day trial of each pharmaceutically equivalent preferred agent, as evidenced by paid claims or pharmacy printouts.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Bupropion SR	NICODERM CQ (Nicotine) PATCH
CHANTIX (Varenicline)	NICORETTE (Nicotine Polacrilex) GUM
Nicotine Lozenge	ZYBAN (Bupropion SR)
Nicotine Patch	
Nicotine Polarcrilex Gum	
NICOTROL (Nicotine Polacrilex) INHALER	
NICOTROL (Nicotine Polacrilex) SPRAY	

Opioid Dependence Treatment

Lucemyra

General Prior Authorization Form

Group Criteria:

- The patient must have a diagnosis of an FDA-approved indication for use
- The patient must have had a 30-day trial of each preferred agent, as evidenced by paid claims or pharmacy printouts.
- Clinical justification must be provided explaining why the patient is unable to use the preferred agents (subject to clinical review)

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Clonidine	LUCEMYRA (Lofexidine)
Guanfacine	

Opioid Antagonist

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
VIVITROL (Naltrexone Microspheres)	

Opioid Partial Agonist

Therapeutic Duplication

- One strength of one medication is allowed at a time
- Opioid Partial Agonists are not allowed with:
    - Methadone
    - Carisoprodol
    - Opioid Analgesics Override Criteria Available

Underutilization

- Buprenorphine and buprenorphine/naloxone must be used compliantly and will reject on point of sale for late fill

Prior Authorization Criteria

General Prior Authorization Form

Product Specific Criteria:

- *** **Buprenorphine tablets**: The patient must be pregnant or breastfeeding, and estimated delivery date/duration of need for breastfeeding must be provided.

Non-Preferred Agents Criteria:

- The patient must have had a 30-day trial of each preferred agent, as evidenced by paid claims or pharmacy printouts.
- Clinical justification must be provided explaining why the patient is unable to use the preferred products (subject to clinical review).
- A MedWatch form for each trial of each product from the available manufacturer(s) must be filled out and attached to request
- DAW (Dispense As Written) Criteria must be met in addition to Opioid Partial Agonist Group PA Criteria.
- For all non-preferred agents OTHER than Zubsolv (buprenorphine/naloxone):
    - The patient must have failed a 30-day trial of Zubsolv (buprenorphine/naloxone)
    - Clinical justification must be provided explaining why the patient is unable to use Zubsolv (subject to clinical review).
    - A MedWatch form for each trial of each product from the available manufacturer(s) must be filled out and attached to request
    - DAW (Dispense As Written) Criteria must be met in addition to Opioid Partial Agonist Group PA Criteria.

ORAL AGENTS	
PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
buprenorphine-naloxone tablets	BUNAVAIL FILM (buprenorphine/naloxone)
buprenorphine tablets***	buprenorphine/naloxone film
	SUBOXONE FILM (buprenorphine/naloxone)
	ZUBSOLV (buprenorphine/naloxone)
NON-ORAL AGENTS	
PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
SUBLOCADE (buprenorphine)	

Obstetrics/Gynecology

Estrogens

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have failed 30-day trials of at least two preferred products, as evidenced by paid claims or pharmacy printouts.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
CLIMARA PRO (estradiol-levonorgestrel) PATCH	ACTIVELLA (Estradiol/Norethindrone) TABLET
COMBIPATCH (Estradiol- Norethindrone)	ALORA (Estradiol) PATCH TWICE WEEKLY
ELESTRIN (estradiol) GEL	AMABELZ (Estradiol/Norethindrone) TABLET
Estradiol Tablet	BIJUVA (Estradiol/Progesterone)
ESTRING (estradiol)	CLIMARA (Estradiol) PATCH WEEKLY

EVAMIST (estradiol) SPRAY	DELESTROGEN (Estradiol Valerate) INJECTION
MENOSTAR (estradiol) PATCH	DEPO-ESTRADIOL (Estradiol Cypionate) INJECTION
Norethindrone-Ethinyl Estradiol tablet	DIVIGEL (estradiol) GEL
PREMARIN (estrogens, conjugated) INJECTION	DOTTI (Estradiol) PATCH TWICE WEEKLY
PREMARIN (estrogens, conjugated) TABLET	ESTRACE (Estradiol) TABLET
PREMARIN (estrogens, conjugated) VAGINAL CREAM	Estradiol Valerate Injection
PREMPHASE (estrogen, conj.,m-progest) TABLET	Estradiol- Norethindrone Tablet
PREMPRO (estrogen, conj.,m-progest) TABLET	Estradiol Patch Twice Weekly
VAGIFEM (estradiol) VAGINAL TABLET	Estradiol Patch Weekly
	Estradiol Vaginal Cream
	Estradiol Vaginal Tablet
	FEMRING (estradiol)
	FYAVOLV (Norethindrone-Ethinyl Estradiol) TABLET
	JINTELI (Norethindrone-Ethinyl Estradiol) TABLET
	LOPREEZA (Estradiol/Norgestimate) TABLET
	MENEST (estrogens, esterified) TABLET
	MIMVEY (Estradiol/Norgestimate) TABLET
	MINIVELLE (Estradiol) PATCH TWICE WEEKLY
	PREFEST (Estradiol/Norgestimate) TABLET
	VIVELLE-DOT (Estradiol) PATCH TWICE WEEKLY
	YUVAFEM (estradiol) VAGINAL TABLET

Mifepristone

Prior Authorization Form - Mifeprex

Criteria for coverage: *Approval Duration = 1 month*

- Gestational age must be less than or equal to 70 days
- One of the following criteria must be met (A or B):
  - A. **Pregnancy must have resulted from an act of rape or incest, and one of the following (I or II)**
    - I. The provider has provided a signed written statement indicating that the rape or act of incest has been reported to the appropriate law enforcement agency, or in the case of a minor who is a victim of incest, to an agency authorized to receive child abuse and neglect reports. The statement must indicate to whom the report was made.
    - II. The provider has provided written statement signed by the recipient and the provider that the recipient's pregnancy resulted from rape or incest and by professional judgement, the provider agrees with the woman's statement.
  - B. **Both of the following must be met (I and II)**
    - I. The woman must suffer from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would as certified by a provider, place the woman in danger of death unless an abortion is performed
    - II. The provider must provide a signed written statement indicating why, in the provider's professional judgement, the life of a woman would be endangered if the fetus were carried to term

Oriahnn

Diagnosis

- The patient must have an FDA approved indication

Age

- The patient must be 18 years of age or older

Prior Authorization Form

General Prior Authorization Form

Group Criteria:

- **Initial Criteria:** *Approval Duration = 12 months*
  - The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age)
  - The patient must not be pregnant
  - The provider must attest that the patient does not have any contraindications to treatment with Oriahnn
- The patient must have failed the following trials (A and B), as evidenced by paid claims or pharmacy printouts:
  - A. A 3-cycle trial of mefenamic acid or meclofenamate, celecoxib, ibuprofen 1800mg/day or equivalent high dose NSAID
  - B. A 3-cycle trial of an oral estrogen-progestin or progestin contraceptives
- **Renewal Criteria:** *Approval Duration = 12 months*
  - The patient must not have received ≥24 months of Oriahnn, as evidenced by paid claims or pharmacy printouts
  - The provider must attest that the patient does not have any contraindications to treatment with Oriahnn
  - The patient must have experienced and maintained clinical benefit since starting treatment with Oriahnn, as evidenced by medical documentation (e.g. chart notes) attached to the request (subject to clinical review)

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
ORIAHNN (Elagolix, Estradiol, and Norethindrone acetate)	

Orilissa

Prior Authorization Form - Orilissa

Initial Criteria: *Approval Duration = 6 months*

- The patient must be 18 years of age or older
- The patient must have a diagnosis of moderate to severe pain associated with endometriosis
- The patient must not have osteoporosis or severe liver disease (Child-Pugh Class C).
- The patient must have failed the following trials (A and B), as evidenced by paid claims or pharmacy printouts:
  - A. A 3-cycle trial of mefenamic acid or meclofenamate, celecoxib, ibuprofen 1800mg/day or equivalent high dose NSAID
  - B. A 3-cycle trial of an oral estrogen-progestin or progestin contraceptives

Renewal Criteria: *Approval Duration = 18 months*

- Prescriber must submit documentation of improvement in pain score from baseline
- Request must be for maintenance dosing (150 mg strength).

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
ORILISSA (Elagolix)	

Progesterone

Prior Authorization Form - Makena

Non-Preferred Agents Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).

- The patient must have had a 30-day trial of each preferred agent, as evidenced by paid claims or pharmacy printouts.
- Clinical justification must be provided explaining why medication is medically necessary

PREFERRED AGENTS (CLINICAL PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
MAKENA (hydroxyprogesterone caproate) – *Brand Preferred*	hydroxyprogesterone caproate

Vaginal Anti-Infectives

General Prior Authorization Form

Non-Preferred Agents Criteria:

- The patient must have an FDA-approved indication for use (meets label recommendations for diagnosis and age).
- The patient must have had 30-day trials of 3 preferred vaginal anti-infective agents, as evidenced by paid claims or pharmacy printouts.

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
AVC (sulfanilamide)	Clindamycin cream
CLEOCIN (clindamycin) SUPPOSITORY	CLEOCIN (Clindamycin) CREAM
CLINDESSE (Clindamycin) CREAM	METROGEL-VAGINAL (Metronidazole)
GYNAZOLE 1 (butoconazole) CREAM	MICONAZOLE 3 (miconazole) suppository
Metronidazole gel	SOLOSEC (secnidazole)
NUVESSA (Metronidazole) GEL	terconazole suppository
terconazole cream	VANDAZOLE (Metronidazole) GEL
tinidazole	

Preferred Dosage Forms List:

Prior Authorization Form - Non-Preferred Dosage Form

Criteria for coverage:

- Clinical justification must be provided explaining why the patient is unable to use the preferred agents (subject to clinical review).
- The patient must have a diagnosis of an FDA-approved indication for use
- The patient must not have any contraindication to the requested product
- The patient must have failed* a therapeutic course** of each preferred agent (listed in boxes below) within the past 2 years, as evidenced by paid claims or pharmacy printouts.

**: A failure is defined as product was not effective at maximum tolerated dose or patient has a documented intolerance or adverse reaction to inactive ingredients where the non-preferred product is expected to have a different result and other alternatives (e.g. medications in same class) are not an option for the patient*

***: Trials must have been at least 30 days in duration unless otherwise indicated*

Amoxicillin ER

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Amoxicillin IR	Amoxicillin ER

Antihistamines

Therapeutic Duplication

- One strength of one medication is allowed at a time

Please use the NDC Drug Lookup to find Prior Authorization (PA) Forms

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Cetirizine Chew Tablet	Desloratadine ODT
Cetirizine Solution	Levocetirizine solution
Cetirizine Tablet	
Desloratadine Tablet	
Levocetirizine Tablet	
Loratadine Solution	
Loratadine Tablet	

Bactroban

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Bactroban ointment	Bactroban cream

Belladonna Alkaloids/Phenobarbital

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Belladonna Alkaloids/Phenobarbital Tablets	Belladonna Alkaloids/Phenobarbital Elixir

Bowel Prep Agents

Required trial duration: 1 complete dose

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
GAVILYTE-G	CLENPIQ
GOLYTELY 227.1-21.5	COLYTE
MOVIPREP	GOLYTELY 236-22.74G
OSMOPREP	GAVILYTE-C
PEG-3350 AND ELECTROLYTES 236-22.74G	GAVILYTE-N
	NULYTELY
	PEG 3350-ELECTROLYTE 240-22.72G
	PEG 3350-ELECTROLYTE 420 G
	PEG 3350/SOD SUL/NACL/KCL/ASB/C
	PLENVU
	SUPREP
	SUTAB
	TRILYTE

Brisdelle (Paroxetine)

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Paroxetine tablets	Paroxetine Mesylate 7.5mg capsules

Butalbital-Acetaminophen-Caffeine

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Butalbital-Acetaminophen-Caffeine Tablets	Butalbital-Acetaminophen-Caffeine Capsules
	ESGIC (Butalbital-Acetaminophen-Caffeine) CAPSULES
	VANATOL LQ (Butalbital-Acetaminophen-Caffeine) SOLUTION
	VANATOL S (Butalbital-Acetaminophen-Caffeine) SOLUTION
	ZEBUTAL (Butalbital-Acetaminophen-Caffeine) CAPSULES

Daxbia (Cephalexin)

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Cephalexin	Daxbia (Cephalexin)

Fenofibrate

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Fenofibrate capsules	Fenofibrate tablets 40mg, 120mg
Fenofibrate tablets 48mg, 54mg, 145mg, 160mg	FENOGLIDE (Fenofibrate)
	LIPOFEN (Fenofibrate)
	TRICOR (Fenofibrate)
	TRIGLIDE (Fenofibrate)

Gabapentin

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Gabapentin	GRALISE (gabapentin)
Gabapentin	HORIZANT (gabapentin)
Pramipexole	
Ropinirole	

Jadenu (Deferasirox)

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Deferasirox tablet for suspension	EXJADE (Deferasirox tablet for suspension)
	Deferasirox tablets
	JADENU (Deferasirox) SPRINKLE
	JADENU (Deferasirox) TABLETS

Kits

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
FDA approved products prescribed separately	CAMPHOTREX 4%-10% ROLL-ON G (menthol/camphor)
	CICLOPIROX (ciclopirox/urea/camphor/methol)
	CICLODAN (ciclopirox/urea/camphor/methol)
	CICLODAN (ciclopirox/skin cleanser 28)
	CLINDACIN ETZ (clindamycin phos/skin clnsr 19)
	CLINDACIN PAC (clindamycin phos/skin clnsr 19)
	DERMACINRX ARM PAK (lidocaine/dimethacone)
	DERMACINRX LEXITRAL PHARMAP (diclofenac/capsicum oleoresin)
	DERMACINRX PHN PAK (lidocaine/emollient cmb No. 102)
	DERMACINRX SILAPAK (triamcinolone/dimeth/silicone)
	DERMACINRX SILAZONE (triamcinolone/silicones)
	DERMACINRX SURGICAL PHARMAP (mupirocin/chlorhexidine/dimeth)
	DERMACINRX THERAZOLE PAK (clotrimazole/betameth dip/zinc)
	DERMACINRX ZRM PAK (lidocaine/dimethicone)
	ELLZIA PAK (triamcinolone/dimethicone)
	ESOMEP-EZS KIT (esomeprazole mag/glycerin)
	ECONASIL (econazole/gauze/silicone)

Please use the NDC Drug Lookup to find Prior Authorization (PA) Forms

	FLUOPAR (fluocinonide/dimethacone)
	FLUOVIX PLUS (fluocinonide/silicone,adhesive)
	GABACAINE KIT (gabapentin/lidocaine)
	INFAMMACIN (diclofenac/capsicum)
	KETODAN (ketoconazole/skin cleanser 28)
	LIDOPURE PATCH 5% COMBO PAC (lidocaine/kinesiology tape)
	LIDOTIN (gabapentin/lidocaine/silicone)
	LIPRITIN (gabapentin/lidocaine/prilocaine/dressing)
	LOPROX (ciclopirox/skin cleanser No. 40)
	MIGRANOW KIT(sumatriptan/menthol/camphor)
	MORGIDOX (Doxycycline/skin cleanser No. 19)
	NOPIOID-TC KIT (cyclobenzaprine/lidocaine/menthaine)
	NUVAKAAN KIT (lidocaine/prilocaine/silicone)
	PRILO PATCH KIT (lidocaine/prilocaine)
	PRIZOTRAL II (lidocaine/prilocaine/lidocaine)
	PRO DNA MEDICATED COLLECTION (lidocaine/glycerin)
	QUTENZA (capsaicin/skin cleanser)
	SALEX (salicylic acid/ceramide comb 1) CREAM KIT
	SALEX (salicylic acid/ceramide comb 1) LOTION KIT
	SILAZONE-II KIT (triamcinolone aceton/silicones)
	SOLARAVIX (Diclofenac/silicone, adhesive)
	SUMADAN KIT (sulfacetamide/sulfur/cleansr23)
	SUMAXIN CP KIT (sulfacetamide/sulfur/cleansr23)
	TICANASE KIT (fluticasone/sodium chloride/sodium bicarbonate)
	TRIXYLITRAL (diclofenac/lidocaine/tape)
	XRYLIX 1.5% KIT (diclofenac/kinesiology tape)
	ZILACAINE PATCH 5% COMBO PA (lidocaine/silicone, adhesive)

Metformin

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Metformin ER	FORTAMET (Metformin)
	GLUMETZA (Metformin)
	RIOMET (Metformin) ORAL SOLUTION
	RIOMET ER (Metformin) ORAL SOLUTION

Methotrexate

Required trial duration: 6 weeks

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
methotrexate	OTREXUP (methotrexate)
	RASUVO (methotrexate)
	TREXALL (methotrexate)

Mupirocin

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Mupirocin Ointment	Mupirocin Calcium Cream

Please use the NDC Drug Lookup to find Prior Authorization (PA) Forms

Nascobal (Cyanocobalamin) Nasal Spray

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Cyanocobalamin Injection	NASCOBAL (Cyanocobalamin) NASAL SPRAY

Nitroglycerin Spray

Required trial duration: 1 dose while on preventative medication

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Nitroglycerin sublingual tablets	GONITRO (Nitroglycerin) SUBLINGUAL PACKET
	Nitroglycerin Spray
	NITROLINGUAL (Nitroglycerin) SPRAY

Nocdurna (desmopressin)

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Desmopressin	Nocdurna (desmopressin)

Onmel (itraconazole)

Required trial duration: 12 weeks with 6 months outgrow following treatment for onychomycosis

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Itraconazole capsule	ONMEL (itraconazole) TABLET
Terbinafine	

Penicillamine

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
DEPEN (Penicillamine) TITRATAB – *Brand Preferred*	CUPRIMINE (Penicillamine) CAPSULE
	Penicillamine Capsule
	Penicillamine Tablet

Potassium

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Potassium tablets	Potassium Solution
	Potassium Powder for Solution

Procysbi (cysteamine)

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
CYSTAGON (cysteamine)	PROCYSBI (cysteamine)
	PROCYSBI GRANULES (cysteamine)

Siklos (Hydroxyurea)

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
DROXIA (Hydroxyurea capsule)	SIKLOS (Hydroxyurea tablet)
Hydroxyurea capsule	

Steroids - Oral

Additional Criteria for coverage of Emflaza: See Emflaza Criteria on this document

Rayos required trial duration: 12 weeks with 2AM dosing of prednisone

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Budesonide 3mg EC Capsules	ALKINDI (hydrocortisone) SPRINKLE CAPSULE

Cortisone	Budesonide 9 mg ER Tablet
Dexamethasone	DEXPAK (dexamethasone)
Hydrocortisone	DXEVO (dexamethasone)
Methylprednisone	EMFLAZA (deflazacort)
Prednisolone sodium phosphate 5mg/5ml, 15mg/5ml, 25mg/5ml	MILLIPRED (Prednisolone)
Prednisone Solution	ORTIKOS (budesonide)
Prednisone Tablets	Prednisone Intensol
	Prednisolone sodium phosphate ODT
	Prednisolone sodium phosphate 10mg/5ml, 20mg/5ml solution
	RAYOS (prednisone)
	TAPERDEX (dexamethasone)
	UCERIS (budesonide)

Tacrolimus

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Tacrolimus	ASTAGRAF XL (Tacrolimus)
	ENVARSUS ER (Tacrolimus)

Tiglutik (riluzole)

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
riluzole	RILUTEK (Riluzole)
	TIGLUTIK (Riluzole) ORAL SUSPENSION

Tirosint (levothyroxine)

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Levothyroxine tablet	Levothyroxine capsules
TIROSINT (levothyroxine) 13 mcg, 25 mcg, 50 mcg, 75 mcg, 88 mcg 100 mcg 112 mcg, 125 mcg, 137 mcg, and 150 mcg capsule – *Brand Preferred*	SYNTHROID (levothyroxine) TABLET
	TIROSINT (levothyroxine) 175 mcg and 200 mcg capsule
	TIROSINT (levothyroxine) solution

Tussicaps

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
Hydrocodone/chlorpheniramine ER suspension	TUSSICAPS (hydrocodone/chlorpheniramine)
Promethazine/codeine	
ZODRYL AC (chlorpheniramine/codeine)	

Topical Corticosteroids Preferred Medication List

Electronic Duration Verification

Override Available

Class 1 topical steroids are covered for 30 days every 90 days. Joint AAD-NFP guidelines for management and treatment of psoriasis recommend limiting the use of Class 1 topical steroids to no more than twice daily up to 4 weeks.

Please use the NDC Drug Lookup to find Prior Authorization (PA) Forms

- Transitions to lower potent agents, intermittent therapy, and combination treatment with non-steroids are recommended to minimize side effects. Class 1 steroids are covered with class 2 steroids to facilitate an alternating schedule.

Prior Authorization

General Prior Authorization Form

Non-Preferred Agents Criteria:

- **Non-preferred Step 1 agents (not labeled as "STEP 2"):**
    - The patient must have failed a 2-week trial of all preferred drug entities within the same potency category and dosage form group within the last 3 months, as evidenced by paid claims or pharmacy printouts
- **Non-preferred agents labeled as "STEP 2":**
    - The patient must have failed a 2-week trial of all preferred and non-preferred drug entities within the same potency category and dosage form group within the last 3 months.

Potency	Dosage Form	Preferred		Non-Preferred	
Class 1 - Very High Potency	**Class 1 - Very High Potency**				
	Cream	clobetasol Propionate	0.05%	clobetasol emollient	0.05%
				betamethasone, augmented gel	0.05%
				betamethasone, augmented lotion	0.05%
	Ointment	betamethasone, augmented	0.05%	clobetasol emulsion foam	0.05%
		clobetasol propionate	0.05%	clobetasol propionate foam	0.05%
	Foam, Gel, Lotion, Shampoo, Solution, Spray, Tape	clobetasol propionate solution	0.05%	desoximetasone spray	0.25%
		clobetasol propionate lotion	0.05%	halobetasol propionate	0.05%
		Clobex shampoo – *Brand Preferred*	0.05%	halobetasol propionate	0.05%
		Clobex spray – *Brand Preferred*	0.05%	Impeklo (clobetasol) lotion	0.05%
		clobetasol propionate gel	0.05%	Lexette (halobetasol) foam	0.05%
				STEP 2* Ultravate (halobetasol) lotion	0.05%
				STEP2* Cordran (flurandrenolide) Tape	4MCG/SQ CM
				STEP2* fluocinonide	0.10%
Class 2 - High Potency	**Class 2 - High Potency**				
	Cream	Betamethasone, augmented	0.05%	Apexicon E	0.05%
		Desoximetasone	0.25%	Fluocinonide-E	0.05%
		Diflorasone Diacetate	0.05%	STEP2* Amcinonide	0.10%
		Fluocinonide	0.05%		
		Halog– *Brand Preferred*	0.10%		
		Triamcinolone Acetonide	0.50%		
	Ointment	Betamethasone Dipropionate	0.05%	Diflorasone Diacetate	0.05%

Please use the NDC Drug Lookup to find Prior Authorization (PA) Forms

		Betamethasone Valerate	0.10%		
		Desoximetasone	0.25%		
		Fluocinonide	0.05%		
		Fluticasone Propionate	0.01%		
		Halog (halcinonide)	0.10%		
		Mometasone Furoate	0.10%		
		Triamcinolone Acetonide	0.50%		
	Gel, Lotion Solution	Fluocinonide gel	0.05%	STEP2* Amcinonide Lotion	0.10%
		Fluocinonide solution	0.05%	Bryhali (halobetasol)	0.01%
				Desoximetasone gel	0.05%
				Halog (halcinonide) Solution	0.1%
Class 3 - Medium Potency	**Class 3 - Medium Potency**				
	Cream	Betamethasone Valerate	0.10%	Betamethasone Dipropionate	0.05%
		Fluticasone Propionate	0.05%	Clocortolone Pivalate	0.10%
		Mometasone Furoate	0.10%	Fluocinolone Acetonide	0.025%
		Synalar	0.025%	Pandel	0.10%
		Triamcinolone Acetonide	0.10%	Prednicarbate	0.10%
				STEP2* Desoximetasone	0.05%
				STEP2* Flurandrenolide	0.05%
				STEP2* Hydrocortisone Butyrate	0.10%
				STEP2* Hydrocortisone Butyrate Emollient	0.10%
				STEP2* Hydrocortisone Valerate	0.20%
	Ointment	Fluocinolone Acetonide	0.025%	Desoximetasone	0.05%
		Desonide	0.05%	Hydrocortisone Valerate	0.20%
		Hydrocortisone Butyrate	0.10%	Triamcinolone	0.05%
		Prednicarbate	0.10%	STEP2* Flurandrenolide	0.05%
		Triamcinolone Acetonide	0.10%		
		Triamcinolone Acetonide	0.025%		
	Aerosol, Foam, Lotion, Solution, Spray	Mometasone Furoate Solution	0.10%	Betamethasone Valerate Foam	0.12%
		Betamethasone Dipropionate Lotion	0.05%	Triamcinolone Acetonide Aerosol	0.147MG/G
		Hydrocortisone Butyrate Solution	0.10%	STEP2* Flurandrenolide Lotion	0.05%
		Triamcinolone Acetonide Lotion	0.10%	STEP2* Fluticasone Propionate Lotion	0.05%
				STEP2* Sernivo spray (Betamethasone)	0.05%
Class 4 - Low Potency	**Class 4 - Low Potency**				
	Cream	Alclometasone Dipropionate	0.05%		
		Desonide	0.05%		
		Fluocinolone Acetonide	0.01%		
		Hydrocortisone	2.50%		
		Hydrocortisone	1.00%		

Please use the NDC Drug Lookup to find Prior Authorization (PA) Forms

		Triamcinolone Acetonide	0.025%		
	Ointment	Alclometasone Dipropionate	0.05%		
		Hydrocortisone	1.00%		
		Hydrocortisone	2.50%		
	Oil, Lotion, Gel Shampoo, Solution	Betamethasone Valerate Lotion	0.10%	Desonide Gel	0.05%
		Capex Shampoo	0.01%		
		Desonide Lotion	0.05%		
		Fluocinolone Acetonide Oil	0.01%		
		Fluocinolone Acetonide Solution	0.01%		
		Hydrocortisone Lotion	2.50%		
		Texacort Solution	2.50%		
		Triamcinolone Acetonide Lotion	0.025%		

Clinic Administered Drugs

Brineura

Prior Authorization Form - Brineura

Initial Criteria: *Approval Duration = 6 months*

- Patient must be between 3 and 8 years of age.
- The patient must have diagnosis of late infantile neuronal ceroid lipofuscinosis type 2 (CLN2), also known as tripeptidyl peptidase 1 (TPP1) deficiency confirmed by the following:
    - A genetic test confirming CLN2 disease
    - An enzyme assay confirming deficiency of tripeptidyl peptidase 1 (TPP1)
- Brineura must be prescribed by or in consultation with a metabolic specialist, geneticist, or pediatric neurologist.
- Patient must not have ventriculoperitoneal shunts
- Baseline results of motor and language domains of the Hamburg CLN2 Clinical Rating Scale must be submitted and meet the following parameters
    - Results must show a combined score of less than 6 in the motor and language domains
    - Results must show a score of at least 1 in each of these domains

Renewal Criteria: *Approval Duration = 12 months*

- The patient must not have acute, unresolved localized infection on or around the device insertion site or suspected or confirmed CNS infection
- Patient maintains at a score of at least 1 in the motor domain on the Hamburg CLN2 Clinical Rating Scale
- The patient has responded to therapy compared to pretreatment baseline with stability/lack of decline* in motor function/milestones

**: Decline is defined as having an unreversed (sustained) 2-category decline or an unreversed score of 0 in the Motor domain of the CLN2 Clinical Rating Scale*

Duchenne Muscular Dystrophy (DMD)

Exondys / Vyondys

Category Criteria (Initial): *Approval Duration: 8 weeks*

- The patient must be a male between ages of 4 and 19 years old

- The prescriber must be, or in consult with, a neurologist specializing in treatment of DMD (submit documentation of formal consultation with specialist)
- The patient must have an FDA-approved diagnosis confirmed by genetic test as recommended by manufacturer
- The prescriber must submit medical records confirming the patient has
  - A baseline 6-Minute Walk Time (6MWT) ≥ 300 meters while walking independently (e.g. without side-by-side assist, cane, walker, wheelchair, etc.)
  - Stable respiratory function – FVC predicted > 50%, not requiring ventilatory assistance
  - Stable cardiac function – LVEF > 40 % by ECHO
  - Inadequate treatment response with standard corticosteroid therapy for a minimum of 6 months with adherence, as evidenced by paid claims or pharmacy printouts
- The patient must be currently taking corticosteroids, as evidenced by paid claims or pharmacy printouts, and will continue taking with requested agent
- Weight and calculated dose must be provided consistent with approved FDA dose of 30 mg/kg infused once weekly
- The patient must not be taking any other RNA antisense agent or any other gene therapy

Category Criteria (Renewal): *Approval Duration: 6 months*
- The prescriber must be, or in consult with, a neurologist specializing in treatment of DMD (submit documentation of formal consultation with specialist)
- The prescriber must submit medical records confirming the patient has maintained
  - A 6MWT ≥ 300 meters while walking independently (e.g. without side-by-side assist, cane, walker, wheelchair, etc.)
  - Stable respiratory function – FVC predicted > 50%, not requiring ventilatory assistance
  - Stable cardiac function – LVEF > 40 % by ECHO

Eosinophilic Asthma

Please see Clinical Criteria if being dispensed by a pharmacy

If billed by medical/physician billing, does not require prior authorization if being used for an FDA approved indication.

Self-Injectable Products

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
FASENRA (benralizumab)	DUPIXENT (dupilumab)
	NUCALA (mepolizumab)

Health Professional Administration Only Products

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
CINQUAIR (reslizumab)	
XOLAIR (omalizumab)	

Gamifant

Category Criteria (Initial): *Approval Duration: 3 months or up to the hematopoietic stem cell transplantation (HSCT) date*
- The prescriber must be, or in consultation with, a hematologist, oncologist, immunologist, or transplant specialist
- The patient must have diagnosis of primary hemophagocytic lymphohistiocytosis (HLH)
- The patient has refractory, recurrent or progressive disease or intolerance with conventional HLH therapy (i.e., etoposide + dexamethasone, cyclosporine A, or Anti-thymocyte globulin)
- The patient must be a candidate for stem cell transplant
- The patient must have one of the following:
  - Confirmation of a gene mutation known to cause primary HLH (e.g. PRF1, UNC13D, STX11 RAB27A, or STXBP2)
  - Confirmation of 5 of the following clinical characteristics:
    - Fever ≥ 101.3F for over 7 days

- Splenomegaly
- Two of the following cytopenias in the peripheral blood:
  - Hemoglobin < 9 g/dL (or < 10 g/dL in infants less than 4 weeks of age)
  - Platelet count < 100,000/microL
  - ANC <1000/microL
- One of the following:
  - Hypertriglyceridemia defined as fasting triglycerides ≥ 265 mg/dL (2 mmol/L)
  - Hypofibrinogenemia defined as fibrinogen ≤ 1.5 g/L
- Hemophagocytosis in bone marrow or spleen or lymph nodes with no evidence of malignancy
- Low or absent natural killer cell activity
- Ferritin ≥ 500 mg/L
- Soluble CD25 (i.e., soluble IL-2 receptor) ≥ 2,400 U/mL

- The requested medication must be administered with dexamethasone as part of the induction or maintenance phase of stem cell transplant, which is to be discontinued at the initiation of conditioning for stem cell transplant

Category Criteria (Renewal): *Approval Duration: 3 months or up to the HSCT date*
- At least 3 HLH abnormalities must be improved by at least 50% from baseline.

Spinal Muscular Atrophy (SMA)

Spinraza

Prior Authorization Form - Spinraza

Criteria: *Approval Duration = 12 months*

- For a diagnosis of Spinal Muscular Atrophy (SMA) Type 1, 2, or 3:
  - The patient must not have respiratory insufficiency (need for invasive or noninvasive ventilation for more than 6 hours per 24-hour period)
  - The patient must not require gastric feeding tubes for the majority of feeds
  - The patient must not have severe contractures or severe scoliosis
  - The patient must not have wasting or cachexia
- For a diagnosis of Spinal Muscular Atrophy (SMA) Type 3:
  - The patient must be less than 2 years of age
  - The patient must be experiencing issues with ambulating (falls, trouble climbing stairs, unable to walk independently)

Zolgensma

Criteria: *Approval Duration = 1 month (Approval is limited to a single intravenous infusion per lifetime)*

- Patient is less than 2 years of age
- The diagnosis is spinal muscular atrophy (SMA) with genetic testing confirming bi-allelic deletions or mutations in the *SMN1 gene*
- Medication is prescriber per the dosing guidelines in the package insert (recommended dose is 1.1×10^{14} vector genomes per kilogram)
- Baseline Documentation has been submitted confirming anti-adeno-associated virus serotype 9 (anti-AAV9) antibody titer is ≤ 1:50 measured by Enzyme-linked Immunosorbent Assay (ELISA) binding immunoassay
- Patient must not have advanced SMA evidenced by one of the following
  - Complete paralysis of limbs
  - Permanent ventilator dependence (defined as requiring invasive ventilation (tracheostomy) or respiratory assistance for 16 of more hours per day (including noninvasive ventilatory support) continuously for 14 or more days in the absence of an acute reversible illness, excluding perioperative ventilation.

Synagis

Prior Authorization Form - Synagis

Criteria: *Approval Duration = 5 months (allows for 5 monthly doses between October 19th through April 21st)*

- Patient must have one of the following diagnoses (A, B, or C) and the additional criteria outlined for diagnosis:
  - **Prematurity:**
    - < 29 weeks, 0 days gestational age
    - ≤12 months of age at start of RSV season
  - **Chronic Lung Disease of Prematurity (CLD)**
    - ≤12 months of age at start of RSV season
      - < 32 weeks, 0 days gestational age
      - Requires supplemental oxygen > 21% for at least the first 28 days after birth
    - 13-24 months of age at start of RSV season
      - < 32 weeks, 0 days gestational age
      - Requires supplemental oxygen > 21% for at least the first 28 days after birth
      - Continues to receive medical support within six months before the start of RSV season with supplemental oxygen, diuretic, or chronic corticosteroid therapy
  - **Congenital Heart Disease**
    - ≤12 months of age at start of RSV season
      - Hemodynamically significant cyanotic or acyanotic congenital heart disease with medical therapy required

Duration Overrides Available

Glucose Rescue Medications

Please call for an override by calling provider relations at 1-800-755-2604:

The following information will need to be submitted as a follow up for the override by either emailing medicaidpharmacy@nd.gov or documenting on General Prior Authorization Form:

- The provider must attest if it is known that the previous dose was taken by the patient (and not diverted or given to another person)
- One of the following criteria must be met (A, B, or C)
  - The previous dose has expired
  - The dose was used by patient for a hypoglycemic episode
  - The patient is currently taking insulins or sulfonylureas and meets one of the following criteria:
    - The diabetes treatment has been adjusted to prevent future instances of hypoglycemia
    - The provider has provided medical justification why the diabetes treatment has not been adjusted at this time to prevent future instances of hypoglycemia.

Insulin

For NPH: Please submit clinical justification explaining why the patient is unable to use Lantus or Levemir (subject to clinical review) and attach to Insulin Prior Authorization Form

- Lantus and Levemir have been demonstrated to reduce the risk of symptomatic and nocturnal hypoglycemia compared with NPH insulin.

Naloxone Rescue Medications

Please call for an override by calling provider relations at 1-800-755-2604:

The following information will need to be submitted as a follow up for the override by either emailing medicaidpharmacy@nd.gov or documenting on General Prior Authorization Form:

- The provider must attest that it is known that the previous dose was taken by the patient (and not diverted or given to another patient)
- One of the following criteria must be met (A, B, or C)
  A. The previous dose has expired
  B. The dose was used by patient for illicit drug use
  C. The patient is currently taking opioids and meets one of the following criteria:
    - The opioid dose must have been decreased
    - The provider has provided medical justification why the opioid dose as not been decreased

Nicotine / Tobacco Dependence Treatment

Chantix: Please call for an override if the following conditions apply by calling provider relations at 1-800-755-2604:

- Patent is abstinent from tobacco
- Treatment duration is requested to be extended to 24 consecutive weeks

Topical Corticosteroids

Please call for an override if the following conditions apply by calling provider relations at 1-800-755-2604:

- Location of application: palms and soles
- Indication: psoriasis
- Close monitoring for side effects

Therapeutic Duplication Overrides Available

Therapeutic duplication descriptions for medications on the PDL are embedded within those categories. This is a listing of therapeutic duplication categories overrides available for selected therapeutic duplication categories.

Albuterol Inhalers and Nebulizers

Please call for an override if any of the following circumstances apply by calling provider relations at 1-800-755-2604:

- Maximally treated patients (compliance with inhaled steroid, long acting beta agonist, long acting muscarinic antagonist, and daliresp) with end-stage COPD will be allowed an ongoing override
- Acutely ill children will be allowed a one-time override
- Patients with cystic fibrosis will be allowed an ongoing override

Antipsychotics

Please provide the following information when requesting an override by emailing medicaidpharmacy@nd.gov:

1. When are the breakthrough symptoms are occurring (timeframe from injection)? Any other contributing factors (non-pharmacological) and how addressed if so?
2. At what point, would the first medication would be considered a failure / other treatment would be considered?
3. What is the anticipated benefit of another medication (vs. increasing dose or switching medication)?
4. For injections:
    a. What would be the tapering goal for oral antipsychotic if symptoms abate as long-term supplemental use of oral with injectable safety/efficacy data lacking?
    b. What is the site of administration?

Beta Blockers

Please have the following information when requesting an override by calling provider relations at 1-800-755-2604. Overrides may be available for beta blockers with slightly different mechanisms of action for use within the cardiac or nephrology specialty: non-selective or selective beta blocking activity; with or without alpha-1 blocker activity.

1. Are prescribers of each medication aware of the other?
2. Is a cardiologist and/or nephrologist involved in therapy who agrees to duplication?

Gabapentin Liquid

Please call for an override if all the following circumstances apply by calling provider relations at 1-800-755-2604:

- All of patient's other medications dispensed in solid formulations are being crushed or opened to administer because patient is unable to swallow

NSAIDS

Please call for an override if all the following circumstances apply by calling provider relations at 1-800-755-2604:

- Patient is prescribed ketorolac and will stop regular NSAID therapy during course of ketorolac

Opioids and Benzodiazepines/Quetiapine IR (CNS Depression)

Opioid and Benzodiazepines/Quetiapine IR Concurrent Use Form

Due to guidance in The SUPPORT for Patients and Communities Act (H.R. 6) on CNS depression, this includes:

- Long acting opioids over 90 MME/day or immediate release opioids over 15 MME/dose in combination with benzodiazepines
- Chronic opioid therapy in combination with quetiapine IR

Criteria:

- The prescriber must attest that they have reviewed the past 3 months of the patient's North Dakota PDMP reports.
- The patient has access to Narcan and has been counseled on overdose risk
- One of the following criteria must be met:
  - Prescriber must be or be in consult with an oncologist, palliative care specialist, or pain management specialist including a pain management contract (with treatment plan including goals for pain and function, and urine and/or blood screens)
  - Patient must have taper plan of one or both agents
  - The following criteria is met:
    - Prescriber(s) of both agents have provided reasons why opioid analgesics and benzodiazepines/quetiapine IR cannot be avoided, or lower doses be used (subject to clinical review)
    - Prescriber(s) from both the opioid and benzodiazepine (not applicable to quetiapine IR) attest to the following:
      - The patient must have not achieved therapeutic goal with non-narcotic medication (NSAIDs, TCAs, SNRIs, Corticosteroids, etc.) and non-medication alternatives (Weight Loss, Physical Therapy, Cognitive Behavioral Therapy, etc.
    - Opioid dose does not exceed 90 MME/day

Opioids and Quetiapine IR - Acute

Please call for an override if the following circumstances apply by calling provider relations at 1-800-755-2604:

- Patient is being chronically treated for a psychiatric condition with the quetiapine and the following apply:
  - Patient has been counseled on CNS depression risks with concurrent use
  - The patient has access to Narcan and has been counseled on overdose risk
  - The patient has an acute condition that cannot be reasonably treated with non-opioid therapy (e.g. surgery)

Opioids and Opioid Use Disorder Medication

Please call for an override if the following circumstances apply by calling provider relations at 1-800-755-2604:

- Patient is chronically being treated with opioid use disorder medication and all the following apply:
  - The patient has an acute condition that cannot be reasonably treated with non-opioid therapy (e.g. surgery)
  - Prescribers of both opioid and opioid use disorder are aware of each other and agree to opioid therapy

- Opioid duration is of a one-time occurrence or taper plan is provided

Proton Pump Inhibitors

Please call for an override if any of the following circumstances apply by calling provider relations at 1-800-755-2604:

- Patient is experiencing nocturnal symptoms after compliance with nighttime dose of proton pump inhibitor. A two-month override may be approved for concurrent H2 blocker use.
- H2 blocker is being used concurrently with a H1 blocker for severe allergy prophylaxis, unrelated to PPI use for GI symptoms

Skeletal Muscle Relaxants

Please call for an override if all the following circumstances apply by calling provider relations at 1-800-755-2604:

- Patient has cerebral palsy or another chronic spastic disorder
- Prescriber is a physiatrist
- Requested combination is baclofen and tizanidine

Therapeutic Duplication

Therapeutic duplication descriptions for medications on the PDL are embedded within those categories. This is a listing of therapeutic duplication categories on medications that are not managed by the PDL for selected therapeutic duplication categories.

Anticholinergics and Acetylcholinesterase Inhibitors

Anticholinergics	Acetylcholinesterase Inhibitors
Anoro Ellipta (Umeclidinium Bromide/Vilanterol)	Aricept (donepezil)
Atrovent HFA (Ipratropium Bromide)	Exelon (Rivastigmine)
Benztropine	Razadyne (Galantamine)
Bevespi Aerosphere (glycopyrrolate/formoterol)	Pyridostigmine
Breztri aerosphere (budesonide/glycopyrrolate/formoterol)	
Combivent Respimat (Ipratropium/Albuterol)	
Cuvposa (Glycopyrrolate)	
Detrol (tolterodine)	
Dicyclomine	
Enablex (Darifenacin)	
Glycopyrrolate	
Incruse Ellipta (Umeclidinium Bromide)	
Lonhala Magnair (glycopyrrolate)	
Oxybutynin	
Propantheline	
Spiriva (Tiotropium Bromide)	
Spiriva Respimat (Tiotropium Bromide)	
Stiolto Respimat (Tiotropium/Olodaterol)	
Toviaz (Fesoterodine)	
Trelegy Ellipta (Fluticasone/Umeclidinium/Vilanterol)	
Trihexyphenidyl	
Trospium	

Tudorza Pressair (Aclidinium Bromide)	
Vesicare (Solifenacin)	
Yupelri (Revefenacin)	

Antidepressant Medications

- One strength of one medication per therapeutic class is allowed at a time
  - Therapeutic classes:
    - SSRIs
    - SNRIs
    - Tricyclic Antidepressants
    - Bupropion
    - Mirtazapine
    - Selegiline
- Mirtazapine is not allowed with other alpha 2 agonists (clonidine, clonidine/chlorthalidone, guanfacine, methyldopa)
  - Mirtazapine is also an alpha 2 agonist
- Fetzima, Viibryd, or Brintellix are not allowed with other antidepressant medications
  - Exceptions: trazodone and mirtazapine
- Fluvoxamine, a strong 1A2 inhibitor, is not covered with Ramelteon, a 1A2 Substrate.

Benzodiazepines

- One short acting medication is allowed at a time: alprazolam, lorazepam, oxazepam
- One long acting medication is allowed at a time: chlordiazepoxide, clonazepam, diazepam, alprazolam ER
- Benzodiazepines are not covered with
  - Opioids: Override Criteria Available
  - Xyrem, Xywav
  - Mydayis
    - Insomnia has been reported in 25-56% of patients receiving Mydayis. Patients reporting insomnia should use a shorter acting product that does not reach steady state.
- Benzodiazepines indicated only for insomnia are not allowed with other non-barbiturate insomnia medications or other benzodiazepines
- Long Acting Benzodiazepines are not covered with sleeping medication due to CNS depression
  - Belsomra and Dayvigo are not covered with short or long acting benzodiazepines
- 3A4 Substrates (alprazolam, clonazepam, midazolam,) are not allowed with strong 3A4 inhibitors. Click here for a full listing of medications included.

CYP450 3A4 Interactions

Strong 3A4 Inhibitors	3A4 Substrates
Atazanavir	Alprazolam
Clarithromycin	Clonazepam
Cobicistat	Corlanor
Darunavir	Fentanyl
Dasabuvir	Midazolam
Idelaisib	Methadone
Indinavir	Oxycodone
Itraconazole	

Ketoconazole	
Lopinavir	
Mifepristone	
Nefazodone	
Nelfinavir	
Ombitasvir	
Paritaprevir	
Posaconazole	
Ritonavir	
Saquinavir	
Telithromycin	
Voriconazole	

Long Acting Contraception

- One strength of one medication is allowed at a time

Electronic Step Care and Concurrent Medications

Electronic Step Care and Concurrent Medications for medications on the PDL are embedded within those categories. This is a listing of Electronic Step Care and Concurrent Medications on medications that are not managed by the PDL.

Antidepressants

- Trintellix: Initiation with 10 mg must be used for 10 days prior to continuing therapy with 20 mg
  - Trintellix recommended starting dose is 10 mg once daily.
- Desvenlafaxine ER: 30 days of 50 mg must be paid within 40 days of 25 mg date of service
  - 25 mg is intended only for gradual titration before discontinuation. It is not a therapeutic dose.

Hepatic Encephalopathy

- Xifaxan: Xifaxan 550mg does not require prior authorization for hepatic encephalopathy if used concurrently with lactulose
  - A total of 30 days of Lactulose must be paid within 65 days prior to Xifaxan's date of service.

Test strips, Lancets, Meters

- A total of a 25 day supply of Insulin and/or Sulfonylurea therapy must be paid within 150 days prior to diabetic test strip's date of service.
  - The ADA guidelines point out the lack of clinical utility and cost-effectiveness of routine Self-Monitoring of Blood Glucose (SMBG) in non-insulin treated patients. Both the Society of General Internal Medicine and the Endocrine Society recommend against routine SMBG for type 2 diabetes patients not on insulin or agents that cause hypoglycemia.
- Gestational Diabetes is a covered indication for diabetic testing supplies. Patients with gestational diabetes must have prenatal vitamins or folic acid preparations in their prescription claim history for testing supplies to pay.

Potassium Supplements

- A total of a 30-day supply of diuretic must be paid within 100 days prior to potassium supplement's date of service.

- Potassium labs should be regularly monitored when receiving continuous potassium supplementation to prevent hyperkalemia, especially in the absence of a potassium wasting diuretic.
- A yearlong override will be granted after confirmation of continued need and monitoring

First Fill

First Fill for medications on the PDL are embedded within those categories. This is a listing of First Fill on medications that are not managed by the PDL.

Antidepressants

- Viibryd and Trintellix must be filled with a 10 day supply if no previous fill within past 99 days