Ohio Medicaid

Pharmacy Benefit Management Program

Unified Preferred Drug List

Medicaid Fee-for-Service and Managed Care Plans

Effective January 1, 2024

AR = Age Restriction **QL** = Quantity Limit **ST** = Step Therapy Required **PA** = Clinical Prior Authorization Required **BvG** = Brand Preferred Over Generic

Helpful Links

Prior Authorization (PA)

Prior Authorization (PA) Information | pharmacy.medicaid.ohio.gov

- **General Prior Authorization Requirements**
- **PA and Step Therapy Frequently Asked Questions (FAQ)**

Drug Coverage

Drug Coverage Information | pharmacy.medicaid.ohio.gov

- **Drug Lookup Tool**
- **UPDL Criteria**
- **Quantity Limits**
- **Preferred Diabetic Supply List**

General Information

- The Statewide UPDL is not an all-inclusive list of drugs covered by Ohio Department of Medicaid.
- Medications that are new to market will be non-preferred, PA required until reviewed by the Ohio Department of Medicaid Pharmacy and Therapeutics (P&T) Committee.
- The document is listed in sections defined by therapeutic class. Drugs are listed by generic name if a generic is available unless the brand name of the drug is preferred. In most cases, when a generic for a brand-name drug is available, the generic drug will be preferred, and the brand name will be non-preferred. Some drugs may also require a specific manufacturer or the brand to be dispensed.
- Ohio Department of Medicaid will only cover drugs that are part of the Medicaid Drug Rebate Program, with limited exceptions. This document may not reflect the most current rebate status of a drug (i.e., a drug may be listed on the document but is non-rebateable and therefore non-payable).
- Some therapeutic categories are grandfathered. These categories will be denoted with an "*" next to their title on the table on contents and their place within the criteria document.
- Some therapeutic categories may have quantity limits on specific drugs detailed in the criteria document, however this is not an all-inclusive list. For a list of the quantity limits on specific drugs, please reference the Quantity Limit Document found here: Quantity Limits Document | pharmacy.medicaid.ohio.gov

Terminology/Abbreviations:

AR (Age Restriction) – An edit allowing claims for members within a defined age range to be covered without PA
BvG (Brand Preferred Over the Generic) – The brand name drug is preferred over the generic equivalent
PA (Clinical Prior Authorization) – A prior authorization (PA) is required before the drug will be covered
QL (Quantity Limit) – A limit on the quantity that will be covered within a given time frame
ST (Step Therapy) – Drug requires a trial with one or more preferred drugs before being covered

New UPDL Criteria Format

- Beginning January 2023 and with a few minor exceptions, all therapeutic categories have the same standardized outline format. The design of this new format is intended to have a cumulative approach bottom-to-top.

Example Category

LENGTH OF AUTHORIZATIONS: X days or Initial: X days; Subsequent: X days (if different)

GRANDFATHERING*:
Patients who have a claim for a non-preferred drug in the previous 120 days will be automatically approved to continue the drug. Patients who have taken the drug previously, but do not have claims history (e.g. new to Medicaid), will need to submit a prior authorization in order to continue coverage.

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

CLINICAL PA CRITERIA *(if applicable):*

"DRUG" CRITERIA *(if applicable)*:

STEP THERAPY CRITERIA:

- Must have had an inadequate clinical response of at least X days with at least X preferred drugs

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least X days with X preferred drugs
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

ADDITIONAL "DRUG" CRITERIA *(if applicable)*:

ADDITIONAL INFORMATION *(if applicable)*:

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's response to treatment from baseline and/or attestation of clinical stabilization

QL – Drug: X doses per X days
AR – a PA is required for patients X years and older OR younger than X years

Interpretation of New UPDL Criteria Format

- Beginning January 2023 and with a few minor exceptions, all therapeutic categories have the same standardized outline format. The design of this new format is intended to have a cumulative approach bottom-to-top. The following scenarios will aid in illustrating this point:

Scenario 1: Clinical PA drug
- All Authorizations
- Clinical PA Criteria

Scenario 2: Clinical PA drug with drug-specific criteria
- All Authorizations
- Drug-Specific Criteria

Scenario 3: Step-Therapy drug
- All Authorizations
- Clinical PA Criteria (if applicable)
- Step Therapy Criteria

Scenario 4: Non-Preferred drug
- All Authorizations
- Clinical PA Criteria (if applicable)
- Step Therapy Criteria (if applicable)
- Non-Preferred Criteria

Scenario 5: Non-Preferred drug with drug-specific criteria
- All Authorizations
- Clinical PA Criteria (if applicable)
- Step Therapy Criteria (if applicable)
- Non-Preferred Criteria
- Additional Drug-Specific Criteria

Table of Contents

Analgesic Agents: Gout	
PREFERRED	**NON-PREFERRED**
Allopurinol 100, 300mg QL	Allopurinol 200mg
Colchicine Tab PA QL	Febuxostat
Colcrys Tab PA QL	Gloperba Susp QL
Probenecid QL	Mitigare BvG QL
	Probenecid/Colchicine QL

Link to Criteria: Analgesic Agents: Gout

Analgesic Agents: NSAIDS	
PREFERRED	**NON-PREFERRED**
Celecoxib QL	Diclofenac/Misoprostol
Diclofenac Sodium IR, DR, ER, Gel 1%	Diclofenac Gel 3%, Patch 1.3%, Soln 1.5%, 2%
Etodolac	Diclofenac Potassium
Fenoprofen 600mg	Diclotrex
Flurbiprofen	Elyxyb
Ibuprofen	Fenoprofen 400mg
Indocin	Ibuprofen/Famotidine
Indomethacin	Ketorolac Tromethamine Nasal Spray
Ketoprofen ER	Ketoprofen
Ketorolac	Licart Patch
Meclofenamate	Meloxicam Cap
Mefenamic Acid	Naproxen CR, DR, ER, EC
Meloxicam Tab	Naproxen/Esomeprazole
Nabumetone	Pennsaid BvG
Naproxen IR	Qmiiz ODT
Naproxen Susp AR	Relafen DS
Oxaprozin	Zorvolex
Piroxicam	
Sulindac	

Link to Criteria: Analgesic Agents: NSAIDS

Analgesic Agents: Opioids	
PREFERRED	**NON-PREFERRED**
Acetaminophen/Codeine QL	Acetaminophen/Caffeine/Dihydrocodeine QL
Butalbital/Acetaminophen/Caffeine/Codeine QL	Belbuca QL
Butalbital/Aspirin/Caffeine/Codeine QL	Benzhydrocodone/Acetaminophen QL
Butorphanol QL	Buprenorphine TD Patch Weekly QL
Butrans BvG PA QL	Butalbital/Acetaminophen/Caffeine/Codeine 50/300/40/30mg QL
Codeine QL	Dsuvia QL
Hydrocodone/Acetaminophen QL	Fentanyl QL
Hydromorphone IR QL	Hydrocodone Bitartrate ER 12HR Cap QL
Morphine IR Tab, Sol QL	Hydrocodone Bitartrate ER 24HR Tab QL
Morphine ER Tab PA QL	Hydrocodone/Acetaminophen 5-300, 7.5-300, 10-300mg QL
Nucynta IR QL	Hydrocodone/Ibuprofen QL
Nucynta ER PA QL	Hydromorphone ER QL
Oxycodone Cap, Sol, Tab QL	Levorphanol QL
Oxycodone/Acetaminophen QL	
Tramadol QL	

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Analgesic Agents: Opioids	
PREFERRED	**NON-PREFERRED**
Tramadol/Acetaminophen QL	Meperidine QL Methadone QL Morphine ER 24HR Cap QL Oxycodone ER QL Oxycodone/Ibuprofen QL Oxymorphone IR, ER QL

Link to Criteria: Analgesic Agents: Opioids

Blood Formation, Coagulation, and Thrombosis Agents: Colony Stimulating Factors	
PREFERRED	**NON-PREFERRED**
Neupogen PA Nivestym PA Nyvepria PA Ziextenzo PA	Fulphila Fylnetra Granix Leukine Neulasta Releuko Rolvedon Stimufend Udenyca Zarxio

Link to Criteria: Blood Formation, Coagulation, and Thrombosis Agents: Colony Stimulating Factors

Blood Formation, Coagulation, and Thrombosis Agents: Hematopoietic Agents	
PREFERRED	**NON-PREFERRED**
Epogen PA Mircera PA Retacrit PA	Aranesp Procrit

Link to Criteria: Blood Agents: Blood Formation, Coagulation, And Thrombosis Agents: Hematopoietic Agents

Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia Factor*	
PREFERRED	**NON-PREFERRED**
Advate PA Adynovate PA Afstyla PA Alphanate PA Alphanine SD PA Alprolix PA Benefix PA Corifact PA Eloctate PA Esperoct PA Feiba PA Hemlibra PA Hemofil M PA Humate-P PA Idelvion PA Ixinity PA	Altuviiio Jivi Nuwiq Obizur Rebinyn Sevenfact Vonvendi

Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia Factor*	
PREFERRED	**NON-PREFERRED**
Koate [PA]	
Kogenate FS [PA]	
Kovaltry [PA]	
Mononine [PA]	
Novoeight [PA]	
Novoseven RT [PA]	
Profilnine [PA]	
Recombinate [PA]	
Rixubis [PA]	
Wilate [PA]	
Xyntha [PA]	

Link to Criteria: Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia Factors

Blood Formation, Coagulation, and Thrombosis Agents: Heparin-Related Preparations	
PREFERRED	**NON-PREFERRED**
Enoxaparin	Fondaparinux
	Fragmin

Link to Criteria: Blood Formation, Coagulation, and Thrombosis Agents: Heparin-Related Preparations

Blood Formation, Coagulation, and Thrombosis Agents: Oral Anticoagulants	
PREFERRED	**NON-PREFERRED**
Eliquis	Dabigatran Cap
Pradaxa Cap [BvG] Pellet Pak [AR]	Savaysa
Warfarin	
Xarelto Susp [AR] Tab [QL]	

Link to Criteria: Blood Formation, Coagulation, and Thrombosis Agents: Oral Anticoagulants

Blood Formation, Coagulation, and Thrombosis Agents: Oral Antiplatelet	
PREFERRED	**NON-PREFERRED**
Aspirin	Yosprala
Aspirin/Dipyridamole ER	Zontivity
Brilinta	
Clopidogrel	
Prasugrel [QL]	

Link to Criteria: Blood Formation, Coagulation, and Thrombosis Agents: Oral Antiplatelet

Cardiovascular Agents: Angina, Hypertension and Heart Failure	
PREFERRED	**NON-PREFERRED**
Acebutolol [QL]	Aliskiren
Amlodipine [QL]	Aspruzyo Sprinkle
Amlodipine/Benazepril	Camzyos
Amlodipine/Olmesartan [QL]	Candesartan
Amlodipine/Valsartan	Candesartan/HCTZ
Amlodipine/Valsartan/HCTZ	Carospir
Atenolol [QL]	Carvedilol ER
Atenolol/Chlorthalidone	Clonidine ER (generic of Nexiclon XR)
Benazepril	Corlanor
Benazepril/HCTZ	Diltiazem 24HR ER Tabs [QL]

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Cardiovascular Agents: Angina, Hypertension and Heart Failure	
PREFERRED	**NON-PREFERRED**
Betaxolol QL	Edarbi
Bisoprolol QL	Edarbyclor
Bisoprolol/HCTZ	Hydralazine/HCTZ
Bystolic BvG	Innopran XL
Captopril	Inpefa
Captopril/HCTZ	Isradipine
Cartia XT	Kapspargo
Carvedilol QL	Katerzia
Clonidine IR, Patch	Kerendia
Diltiazem QL	Levamlodipine
Diltiazem 12HR ER Cap QL	Nebivolol
Diltiazem 24HR ER Cap QL	Nimodipine
Doxazosin	Nisoldipine
Dutoprol	Norliqva
Enalapril Tab	Nymalize
Enalapril/HCTZ	Qbrelis
Enalapril Sol	Sotylize AR
Entresto PA	Tekturna/HCTZ
Eplerenone	Telmisartan
Felodipine ER QL	Telmisartan/HCTZ
Fosinopril	Verapamil 200, 300mg ER 24HR QL
Fosinopril/HCTZ	Verquvo
Guanfacine	
Hemangeol PA	
Hydralazine	
Irbesartan QL	
Irbesartan/HCTZ QL	
Labetalol QL	
Lisinopril	
Lisinopril/HCTZ	
Losartan QL	
Losartan/HCTZ	
Methyldopa	
Methyldopa/HCTZ	
Metoprolol Succinate QL	
Metoprolol Tartrate QL	
Metoprolol/HCTZ QL	
Minoxidil	
Moexipril	
Nadolol QL	
Nadolol/Bendroflumethiazide	
Nicardipine QL	
Nifedipine QL	
Olmesartan	
Olmesartan/Amlodipine/HCTZ	
Olmesartan/HCTZ	

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Cardiovascular Agents: Angina, Hypertension and Heart Failure	
PREFERRED	**NON-PREFERRED**
Propranolol	
Propranolol/HCTZ	
Quinapril	
Quinapril/HCTZ	
Ramipril	
Ranolazine	
Sotalol QL	
Spironolactone	
Spironolactone/HCTZ	
Telmisartan/Amlodipine	
Terazosin	
Timolol QL	
Trandolapril	
Trandolapril/Verapamil	
Valsartan QL	
Valsartan/HCTZ QL	
Verapamil IR, SR QL	

Link to Criteria: Cardiovascular Agents: Angina, Hypertension & Heart Failure

Cardiovascular Agents: Antiarrhythmics	
PREFERRED	**NON-PREFERRED**
Amiodarone 200mg QL	Amiodarone 100, 400mg QL
Disopyramide QL	Multaq
Dofetilide	
Flecainide QL	
Mexiletine QL	
Norpace CR QL	
Propafenone IR, ER QL	
Quinidine IR, ER QL	

Link to Criteria: Cardiovascular Agents: Antiarrhythmics

Cardiovascular Agents: Lipotropics	
PREFERRED	**NON-PREFERRED**
Atorvastatin QL	Altoprev
Cholestyramine Regular, Light	Amlodipine/Atorvastatin
Colestipol Tab	Atorvaliq
Ezetimibe	Colesevelam
Fenofibrate 48, 145mg Tab QL	Colestipol Granules
Gemfibrozil QL	Ezallor
Lovastatin QL	Ezetimibe/Simvastatin
Niacin IR, ER OTC QL	Fenofibrate Cap QL
Omega-3-Acid Ethyl Esters	Fenofibrate 40, 54, 120, 160mg Tab QL
Praluent PA	Fenofibric Acid QL
Pravastatin	Fluvastatin
Prevalite	Juxtapid
Repatha PA	Livalo
Rosuvastatin QL	Nexletol

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Cardiovascular Agents: Lipotropics	
PREFERRED	**NON-PREFERRED**
Simvastatin QL	Nexlizet Niacin ER Tab QL Vascepa BvG Zypitamag

Link to Criteria: Cardiovascular Agents: Lipotropics

Cardiovascular Agents: Pulmonary Arterial Hypertension*	
PREFERRED	**NON-PREFERRED**
Ambrisentan PA Sildenafil PA Sildenafil Susp AR PA Tadalafil PA Tadliq AR PA Tracleer Tab BvG PA	Adempas Bosentan Epoprostenol Liqrev Opsumit Orenitram Tracleer Susp Treprostinil Tyvaso Uptravi Ventavis

Link to Criteria: Cardiovascular Agents: Pulmonary Arterial Hypertension

Central Nervous System (CNS) Agents: Alzheimer's Agents*	
PREFERRED	**NON-PREFERRED**
Donepezil 5, 10mg, ODT, Tab AR QL ~~Donepezil ODT AR QL~~ Galantamine IR Tab, ER Cap AR QL Memantine Tab AR Rivastigmine Cap AR QL Rivastigmine Patch AR	Adlarity AR Donepezil 23mg Tab AR QL Galantamine Sol AR QL Memantine ER, Sol AR Namzaric AR

Link to Criteria: Central Nervous System (CNS) Agents: Alzheimer's Agents

Central Nervous System (CNS) Agents: Anti-Migraine Agents, Acute	
PREFERRED	**NON-PREFERRED**
Imitrex Nasal Spray BvG QL Naratriptan QL Nurtec ODT QL ST Rizatriptan QL Sumatriptan Inj, Tab QL Tosymra BvG QL	Almotriptan Dihydroergotamine Eletriptan Ergomar Frovatriptan Migergot Onzetra Xsail QL Reyvow Sumatriptan/Naproxen Sumatriptan Nasal Spray QL Trudhesa Ubrelvy Zavzpret Zolmitriptan

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Link to Criteria: Central Nervous System (CNS) Agents: Anti-Migraine Agents, Acute

Central Nervous System (CNS) Agents: Anti-Migraine Agents, Cluster Headache	
PREFERRED	**NON-PREFERRED**
Verapamil QL	Emgality QL

Link to Criteria: Central Nervous System (CNS) Agents: Anti-Migraine Agents, Cluster Headache

Central Nervous System (CNS) Agents: Anti-Migraine Agents, Prophylaxis	
PREFERRED	**NON-PREFERRED**
Aimovig QL ST	Emgality QL
Ajovy QL ST	Nurtec ODT QL
Cardiovascular Agents: Beta-Blockers	Qulipta QL
CNS Agents: Anticonvulsants	
CNS Agents: Serotonin-Norepinephrine Reuptake Inhibitors	
CNS Agents: Tricyclic Antidepressants	

Link to Criteria: Central Nervous System (CNS) Agents: Anti-Migraine Agents, Prophylaxis

Central Nervous System (CNS) Agents: Anticonvulsants*	
PREFERRED	**NON-PREFERRED**
Banzel Tab BvG	Aptiom
Briviact	~~Briviact~~
Carbamazepine	Celontin BvG
Clobazam	Clonazepam ODT
Clonazepam	Elepsia XR
Diacomit PA QL	Felbamate
Divalproex IR, ER	Fintepla
Epidiolex ST QL	Lamotrigine ER
Eprontia AR	Levetiracetam ER Tab
Ethosuximide	Oxcarbazepine Susp
Fycompa ST	Oxtellar XR
Gabapentin QL	Peganone
Lacosamide ST	Qudexy XR BvG
Lamotrigine IR, ODT	Rufinamide Tab, Soln
Levetiracetam IR Tab, Sol	Spritam
Oxcarbazepine Tab	Sympazan
Phenobarbital	Tiagabine
Phenytoin	Topiramate Sprinkle Cap
Pregabalin QL	Trokendi XR BvG
Primidone	Vigabatrin
Topiramate	Vigabatrin Powder AR
Trileptal Susp BvG	Xcopri
Valproic Acid	Zonisade Susp
Zonisamide Cap	Ztalmy

Link to Criteria: Central Nervous System (CNS) Agents: Anticonvulsants

Central Nervous System (CNS) Agents: Anticonvulsants Rescue	
PREFERRED	**NON-PREFERRED**
Diastat	
Diazepam Gel	

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Central Nervous System (CNS) Agents: Anticonvulsants Rescue	
PREFERRED	**NON-PREFERRED**
Nayzilam AR	
Valtoco AR	

Link to Criteria: Central Nervous System (CNS) Agents: Anticonvulsants Rescue

Central Nervous System (CNS) Agents: Antidepressants*	
PREFERRED	**NON-PREFERRED**
Bupropion QL	Aplenzin
Bupropion SR (generic of Wellbutrin SR) QL	Auvelity
Bupropion XL (generic of Wellbutrin XL) QL	Brisdelle
Citalopram Tab, Soln QL	Bupropion XL (generic of Forfivo XL) QL
Duloxetine 20, 30, 60mg QL	Citalopram Cap
Escitalopram QL	Clomipramine
Fluoxetine 10, 20, 40mg QL	Desvenlafaxine
Fluoxetine Sol QL	Drizalma Sprinkle
Fluvoxamine QL	Duloxetine 40mg QL
Mirtazapine QL	Emsam
Nefazodone QL	Fetzima
Paroxetine IR Tab, Sol QL	Fluoxetine 60mg, DR QL
Sertraline Tab	Fluvoxamine ER QL
Tranylcypromine	Marplan
Trazodone 50, 100, 150mg QL	Paroxetine Cap, ER Tab
Venlafaxine IR Tab, ER Cap QL	Pexeva
	Phenelzine
	Sertraline Cap
	Trazodone 300mg QL
	Trintellix
	Venlafaxine ER Tab
	Viibryd BvG

Link to Criteria: Central Nervous System (CNS) Agents: Antidepressants

Central Nervous System (CNS) Agents: Attention Deficit Hyperactivity Disorder Agents	
PREFERRED	**NON-PREFERRED**
Amphetamine/Dextroamphetamine IR, ER AR QL	Adhansia XR AR
Atomoxetine Cap AR QL	Adzenys ER, XR ODT
Clonidine ER	Amphetamine Tab
Concerta AR QL	Azstarys AR
Dexmethylphenidate Tab AR QL	Cotempla XR ODT AR
Dexmethylphenidate ER (generic of Focalin XR) AR QL	Daytrana AR BvG
Dextroamphetamine IR Tab, ER Cap AR QL	Evekeo ODT
Dextroamphetamine Sol AR	Jornay PM AR
Dyanavel XR AR	Methamphetamine
Guanfacine ER QL	Methylphenidate Chewable Tab AR QL
Methylphenidate ER Cap AR QL (generic of Metadate CD, Ritalin LA)	Methylphenidate ER AR QL (generic of Aptensio XR, Relexxii)
	Mydayis QL
	Vyvanse Chewable Tab
Methylphenidate ER Tab AR QL (generic of Concerta, Methylin ER, Ritalin SR)	Xelstrym AR
	Zenzedi AR QL

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Central Nervous System (CNS) Agents: Attention Deficit Hyperactivity Disorder Agents	
PREFERRED	**NON-PREFERRED**
Methylphenidate Sol AR QL	
Methylphenidate Tab AR QL	
Procentra AR	
Qelbree ST	
Quillichew ER AR	
Quillivant XR AR	
Ritalin LA AR QL	
Vyvanse Cap QL	

Link to Criteria: Central Nervous System (CNS) Agents: Attention Deficit Hyperactivity Disorder Agents

Central Nervous System (CNS) Agents: Atypical Antipsychotics*	
PREFERRED	**NON-PREFERRED**
Abilify Maintena QL	Abilify Asimtufii
Aripiprazole QL	Abilify Mycite
Aristada QL	Aripiprazole Sol
Aristada Initio	Asenapine
Clozapine	Caplyta
Fanapt ST	Clozapine ODT Rapdis
Geodon QL	Fluoxetine/Olanzapine
Invega Hafyera ER PA	Lybalvi
Invega Sustenna QL	Nuplazid
Invega Trinza QL	Olanzapine ODT
Lurasidone QL	Rexulti
Olanzapine QL	Secuado
Paliperidone Tab	Uzedy
Perseris	Versacloz
Quetiapine IR, ER QL	~~Vraylar~~
Risperdal Consta QL	Zyprexa Relprevv QL
Risperidone QL	
Saphris BvG ST	
Vraylar ST	
Ziprasidone QL	

Link to Criteria: Central Nervous System (CNS) Agents: Atypical Antipsychotics

Central Nervous System (CNS) Agents: Fibromyalgia Agents	
PREFERRED	**NON-PREFERRED**
Pregabalin QL	Savella

Link to Criteria: Central Nervous System (CNS) Agents: Fibromyalgia Agents

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Central Nervous System (CNS) Agents: Medication Assisted Treatment of Opioid Addiction	
PREFERRED	**NON-PREFERRED**
Buprenorphine/Naloxone	Buprenorphine
Clonidine	Lucemyra QL
Sublocade QL	
Suboxone	
Vivitrol	
Zubsolv	

Link to Criteria: Central Nervous System (CNS) Agents: Medication Assisted Treatment of Opioid Addiction

Central Nervous System (CNS) Agents: Movement Disorders	
PREFERRED	**NON-PREFERRED**
Austedo PA ST	
Ingrezza PA	
Tetrabenazine PA	

Link to Criteria: Central Nervous System (CNS) Agents: Movement Disorders

Central Nervous System (CNS) Agents: Multiple Sclerosis*	
PREFERRED	**NON-PREFERRED**
~~Aubagio~~ ~~BvG~~	Bafiertam
Avonex	Extavia
Betaseron	Glatiramer
Copaxone BvG	Glatopa
Dalfampridine	~~Kesimpta~~
Dimethyl Fumarate	Mavenclad
Fingolimod	Mayzent
Gilenya	Plegridy
Kesimpta	Ponvory
Rebif	Tascenso ODT
Teriflunomide	~~Teriflunomide~~
	Vumerity
	Zeposia

Link to Criteria: Central Nervous System (CNS) Agents: Multiple Sclerosis

Central Nervous System (CNS) Agents: Narcolepsy	
PREFERRED	**NON-PREFERRED**
Amphetamine/Dextroamphetamine IR/ER AR	Sunosi
Armodafinil	Wakix
Dextroamphetamine ER AR	Xyrem BvG
Methylphenidate ER AR	Xywav
Methylphenidate Tab AR	
Modafinil	

Link to Criteria: Central Nervous System (CNS) Agents: Narcolepsy

Central Nervous System (CNS) Agents: Neuropathic Pain	
PREFERRED	**NON-PREFERRED**
Amitriptyline	Gralise
Carbamazepine	Horizant
Desipramine	Pregabalin ER

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Central Nervous System (CNS) Agents: Neuropathic Pain	
PREFERRED	**NON-PREFERRED**
Doxepin 10, 25, 50, 75, 100, 150mg	~~Ztlido~~
Doxepin Sol	
Duloxetine QL	
Gabapentin QL	
Imipramine	
Lidocaine Patch	
Nortriptyline	
Oxcarbazepine	
Pregabalin QL	
Ztlido ST	

Link to Criteria: Central Nervous System (CNS) Agents: Neuropathic Pain

Central Nervous System (CNS) Agents: Parkinson's Agents	
PREFERRED	**NON-PREFERRED**
Amantadine	Apokyn
Carbidopa	Carbidopa/Levodopa Dispersible Tab
Carbidopa/Levodopa	Carbidopa/Levodopa/Entacapone
Entacapone	Gocovri
Pramipexole	Inbrija
Ropinirole	Kynmobi
Selegiline	Neupro
	Nourianz
	Ongentys
	Osmolex ER
	Pramipexole ER
	Rasagiline
	Ropinirole ER
	Rytary
	Tolcapone
	Xadago
	Zelapar

Link to Criteria: Central Nervous System (CNS) Agents: Parkinson's Agents

Central Nervous System (CNS) Agents: Restless Legs Syndrome	
PREFERRED	**NON-PREFERRED**
Pramipexole	Horizant
Ropinirole	Neupro

Link to Criteria: Central Nervous System (CNS) Agents: Restless Legs Syndrome

Central Nervous System (CNS) Agents: Sedative-Hypnotics, Non-Barbiturate	
PREFERRED	**NON-PREFERRED**
Estazolam QL	Belsomra
Temazepam 15, 30mg QL	Dayvigo
Zaleplon QL	Doxepin 3, 6mg
Zolpidem QL	Eszopiclone QL
	Intermezzo
	Quviviq

Central Nervous System (CNS) Agents: Sedative-Hypnotics, Non-Barbiturate	
PREFERRED	**NON-PREFERRED**
	Ramelteon Temazepam 7.5, 22mg QL Zolpidem ER, SL

Link to Criteria: Central Nervous System (CNS) Agents: Sedative-Hypnotics, Non-Barbiturate

Central Nervous System (CNS) Agents: Skeletal Muscle Relaxants, Non-Benzodiazepine	
PREFERRED	**NON-PREFERRED**
Baclofen Tab Chlorzoxazone 250, 500mg QL Cyclobenzaprine 5, 10mg QL Dantrolene Methocarbamol QL Tizanidine Tab QL	Baclofen Solution Carisoprodol Chlorzoxazone 375, 750mg QL Cyclobenzaprine 7.5mg QL Cyclobenzaprine ER QL ~~Fleqsuvy~~ BvG Lyvispah Metaxalone Orphenadrine Tizanidine Cap

Link to Criteria: Central Nervous System (CNS) Agents: Skeletal Muscle Relaxants, Non-Benzodiazepine

Central Nervous System (CNS) Agents: Smoking Deterrents	
PREFERRED	**NON-PREFERRED**
Bupropion QL Chantix QL Nicotine QL Varenicline QL	

Link to Criteria: Central Nervous System (CNS) Agents: Smoking Deterrents

Dermatologic Agents: Oral Acne Products	
PREFERRED	**NON-PREFERRED**
Accutane PA Amnesteem PA Claravis PA Isotretinoin PA Myorisan PA Zenatane PA	Absorica Absorica LD

Link to Criteria: Dermatologic Agents: Oral Acne Products

Dermatologic Agents: Topical Acne Products	
PREFERRED	**NON-PREFERRED**
Adapalene Gel 0.1% AR Benzoyl Peroxide Clindamycin Gel, Lot, Sol Clindamycin/Benzoyl Peroxide Erythromycin Erythromycin/Benzoyl Peroxide Neuac Sodium Sulfacetamide	Adapalene Cream, Sol 0.1% AR Adapalene Gel 0.3% AR Adapalene/Benzoyl Peroxide AR Aklief AR Altreno AR Amzeeq Arazlo AR Azelaic Acid Gel

AR = Age Restriction **QL** = Quantity Limit **ST** = Step Therapy Required **PA** = Clinical Prior Authorization Required **BvG** = Brand Preferred Over Generic

Dermatologic Agents: Topical Acne Products	
PREFERRED	**NON-PREFERRED**
Sodium Sulfacetamide/Sulfur Cream	Benzoyl Peroxide Foam
Sodium Sulfacetamide/Sulfur Wash Susp	Clindacin Kit
Tretinoin AR	Clindamycin Foam, Swabs
	Clindamycin/Tretinoin AR
	Dapsone Gel
	Epsolay
	Finacea Foam
	Onexton Gel
	Ovace Plus
	Plixda AR
	Sodium Sulfacetamide/Sulfur Gel
	Sodium Sulfacetamide Pads
	Tazarotene Cream, Foam, Gel 0.1% AR
	Twyneo AR
	Winlevi

Link to Criteria: Dermatologic Agents: Topical Acne Products

Endocrine Agents: Androgens	
PREFERRED	**NON-PREFERRED**
Androderm AR PA	Jatenzo AR
Testosterone Gel 1% AR PA	Methyltestosterone AR
Testosterone Gel 1% Pump AR PA	Natesto AR
	Testopel AR
	Testosterone Cypionate AR
	Testosterone Gel 1.62%, 2% AR
	Testosterone Sol 30mg/ACT AR
	Tlando AR
	Xyosted AR

Link to Criteria: Endocrine Agents: Androgens

Endocrine Agents: Diabetes – Hypoglycemia Treatments	
PREFERRED	**NON-PREFERRED**
Baqsimi QL	Glucagon Emerg Kit [Labeler 00548 & 63323] QL
Glucagen Hypokit QL	
Glucagon Emerg Kit [Labeler 00002] QL	
Gvoke QL	
Zegalogue QL	

Link to Criteria: Endocrine Agents: Diabetes – Hypoglycemia Treatments

Endocrine Agents: Diabetes – Insulin	
PREFERRED	**NON-PREFERRED**
Apidra	Admelog QL
Humalog 50-50	Afrezza
Humalog 75-25	Basaglar QL
Humalog U-100 Kwikpen, Vial QL	Fiasp QL
Humulin 70-30	Humalog U-100 Tempo Pen
Humulin R U-500 QL	Humalog U-200 QL

Endocrine Agents: Diabetes – Insulin	
PREFERRED	**NON-PREFERRED**
Insulin Aspart QL	Humulin N U-100
Insulin Aspart Protamine/Insulin Aspart	Humulin R U-100
Insulin Lispro QL	Lyumjev
Lantus BvG QL	Novolin 70-30
Levemir	Novolin N U-100
Novolog 70-30	Novolin R U-100
Novolog U-100 QL	Rezvoglar
Toujeo	Semglee BvG QL
Tresiba BvG ST	

Link to Criteria: Endocrine Agents: Diabetes – Insulin

Endocrine Agents: Diabetes – Non-Insulin	
PREFERRED	**NON-PREFERRED**
Acarbose QL	Adlyxin
Actoplus Met XR	Alogliptin
Byetta	Alogliptin/Metformin
	Alogliptin/Pioglitazone
Farxiga	Bydureon Bcise
Glimepiride QL	Glimepiride/Pioglitazone
Glipizide QL	Glucophage
Glipizide/Metformin QL	Glyxambi
Glyburide QL	Invokamet XR
Glyburide/Metformin QL	Jentadueto XR
Invokamet	Kombiglyze XR BvG
Invokana	Metformin ER QL (Generic of Fortamet, Glumetza)
Janumet	Metformin Sol
Janumet XR	Mounjaro
Januvia	Onglyza BvG
Jardiance	Ozempic
Jentadueto	Qtern
Metformin IR, ER QL (Generic of Glucophage XR)	Rybelsus
Miglitol	Segluromet
Nateglinide QL	Soliqua
Pioglitazone QL	Steglatro
Pioglitazone/Metformin QL	Steglujan
Repaglinide	Symlinpen
Repaglinide/Metformin	Synjardy XR
Synjardy	Trijardy XR
Tradjenta	~~Xigduo XR~~
Trulicity QL	Xultophy
Victoza QL	
Xigduo XR	

Link to Criteria: Endocrine Agents: Diabetes – Non-Insulin

Endocrine Agents: Endometriosis	
PREFERRED	**NON-PREFERRED**
Danazol ST	Synarel

Endocrine Agents: Endometriosis	
PREFERRED	**NON-PREFERRED**
Depo-Subq Provera 104 ST	
Lupaneta Pack ST	
Lupron Depot QL ST 3.75, 11.25mg	
Myfembree QL ST	
Orilissa ST	
Zoladex ST	

Link to Criteria: Endocrine Agents: Endometriosis

Endocrine Agents: Estrogenic Agents	
PREFERRED	**NON-PREFERRED**
Climara Pro QL	Angeliq
Combipatch QL	Climara QL
Dotti QL	Divigel BvG
Estradiol Cream, Tab	Duavee
Estradiol Patch QL	Elestrin BvG
Estring QL	Estradiol 10mcg Vag Tab
Ethinyl Estradiol/Norethindrone Acetate	Estradiol/Norethindrone Acetate
Lyllana QL	Estrogel BvG
Menest	Evamist
Premarin	Femring
Premphase	Menostar QL
Prempro	Minivelle QL
	Prefest
	Vivelle-Dot QL

Link to Criteria: Endocrine Agents: Estrogenic Agents

Endocrine Agents: Growth Hormone	
PREFERRED	**NON-PREFERRED**
Genotropin PA	Humatrope
Norditropin PA	Nutropin
Zomacton	Omnitrope
	Saizen
	Serostim
	Skytrofa
	Sogroya
	~~Zomacton~~

Link to Criteria: Endocrine Agents: Growth Hormone

Endocrine Agents: Osteoporosis – Bone Ossification Enhancers	
PREFERRED	**NON-PREFERRED**
Alendronate Tab	Alendronate Susp
Calcitonin-Salmon	Fosamax Plus D
Forteo PA QL	Risedronate
Hydroxyprogesterone Caproate QL	Tymlos QL
Ibandronate	

Link to Criteria: Endocrine Agents: Osteoporosis – Bone Ossification Enhancers

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Endocrine Agents: Progestin Agents	
PREFERRED	**NON-PREFERRED**
Makena QL	
Medroxyprogesterone Acetate Tab	
Megestrol	
Norethindrone Acetate	
Progesterone	
Progesterone In Oil	

Link to Criteria: Endocrine Agents: Progestin Agents

Endocrine Agents: Uterine Fibroids	
PREFERRED	**NON-PREFERRED**
Lupron Depot PA 3.75, 11.25mg	
Myfembree PA QL	
Oriahnn PA QL	

Link to Criteria: Endocrine Agents: Uterine Fibroids

Gastrointestinal Agents: Anti-Emetics	
PREFERRED	**NON-PREFERRED**
Aprepitant 40, 125mg	Aprepitant 80 mg
Diclegis BvG	Aprepitant TriPac
Dimenhydrinate	Bonjesta
Diphenhydramine	Doxylamine/Pyridoxine
Emend 125mg Susp	Metoclopramide ODT
Emend 80mg BvG	Sancuso
Emend TriPac BvG	Zuplenz
Meclizine	
Metoclopramide	
Ondansetron	
Phosphorated Carbohydrate	
Prochlorperazine	
Promethazine	
Scopolamine	
Trimethobenzamide	

Link to Criteria: Gastrointestinal Agents: Anti-Emetics

Gastrointestinal Agents: Bowel Preparations	
PREFERRED	**NON-PREFERRED**
Clenpiq	Moviprep
Gavilyte-C	PEG3350-SOD SUL-NACL-KCL-ASB-C 7.5-2.691G
Gavilyte-G	Plenvu
Golytely	SOD SULF-POTASS SULF-MAG SULF Soln
PEG-3350 and Electrolytes 236-22.7G, 420G	Suflave
Suprep BvG	Sutab

Link to Criteria: Gastrointestinal Agents: Bowel Preparations

Gastrointestinal Agents: Crohn's Disease	
PREFERRED	**NON-PREFERRED**
Azathioprine	Ortikos ER

Gastrointestinal Agents: Crohn's Disease	
PREFERRED	**NON-PREFERRED**
Budesonide ER Cap	
Mercaptopurine	
Methotrexate	
Sulfasalazine	

Link to Criteria: Gastrointestinal Agents: Crohn's Disease

Gastrointestinal Agents: Hepatic Encephalopathy	
PREFERRED	**NON-PREFERRED**
Lactulose	
Xifaxan ST	

Link to Criteria: Gastrointestinal Agents: Hepatic Encephalopathy

Gastrointestinal Agents: Irritable Bowel Syndrome (IBS) with Diarrhea	
PREFERRED	**NON-PREFERRED**
Diphenoxylate/Atropine	Alosetron
Loperamide QL	Viberzi
Xifaxan ST	

Link to Criteria: Gastrointestinal Agents: Irritable Bowel Syndrome (IBS) with Diarrhea

Gastrointestinal Agents: Pancreatic Enzymes	
PREFERRED	**NON-PREFERRED**
Creon	Pancreaze
Zenpep	Pertzye
	Viokace

Link to Criteria: Gastrointestinal Agents: Pancreatic Enzymes

Gastrointestinal Agents: Proton Pump Inhibitors	
PREFERRED	**NON-PREFERRED**
Lansoprazole Cap	Aciphex
Nexium Granules BvG	Dexilant BvG
Omeprazole Cap AR	Esomeprazole
Pantoprazole Tab AR	Esomeprazole Granules
Protonix Pak AR BvG	Konvomep
	Lansoprazole ODT
	Omeprazole Tab AR
	Omeprazole/Sodium Bicarbonate
	Pantoprazole Packet
	Prilosec Susp
	Rabeprazole

Link to Criteria: Gastrointestinal Agents: Proton Pump Inhibitors

Gastrointestinal Agents: Ulcerative Colitis	
PREFERRED	**NON-PREFERRED**
Balsalazide Disodium	Dipentum
Budesonide ER Tab QL	Mesalamine DR Tab 800mg
Mesalamine DR Cap, Tab 1.2gm	Mesalamine Supp
Mesalamine Enema	Uceris Foam BvG QL
Mesalamine ER Cap 0.375mg	Zeposia

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Gastrointestinal Agents: Ulcerative Colitis	
PREFERRED	**NON-PREFERRED**
Pentasa [BvG]	
Sulfasalazine	

Link to Criteria: Gastrointestinal Agents: Ulcerative Colitis

Gastrointestinal Agents: Unspecified GI	
PREFERRED	**NON-PREFERRED**
Amitiza [ST]	Aemcolo
Bisacodyl	Gattex
Casanthranol/Docusate Sodium	Ibsrela
Dicyclomine	Linzess 72mcg
Diphenoxylate/Atropine	Motegrity
Lactulose	Mytesi
Linzess [ST] 145, 290mcg	Relistor
Loperamide	Symproic
Lubiprostone [ST]	Zorbtive
Movantik [ST]	
Polyethylene Glycol	
Psyllium Fiber	
Senna	
Trulance [ST]	
Xifaxan [ST]	

Link to Criteria: Gastrointestinal Agents: Unspecified GI

Genitourinary Agents: Benign Prostatic Hyperplasia	
PREFERRED	**NON-PREFERRED**
Alfuzosin	Cardura XL
Doxazosin	Dutasteride/Tamsulosin
Dutasteride	Entadfi
Finasteride	Silodosin
Prazosin	
Tadalafil [PA] 2.5, 5mg	
Tamsulosin	
Terazosin	

Link to Criteria: Genitourinary Agents: Benign Prostatic Hyperplasia

Genitourinary Agents: Electrolyte Depleter Agents	
PREFERRED	**NON-PREFERRED**
Calcium Acetate, Carbonate	Auryxia
Phoslyra	Lanthanum Carbonate
Sevelamer	Velphoro

Link to Criteria: Genitourinary Agents: Electrolyte Depleter Agents

Genitourinary Agents: Urinary Antispasmodics	
PREFERRED	**NON-PREFERRED**
Gelnique	Darifenacin [QL]
Myrbetriq Tab	Fesoterodine
Oxybutynin [QL]	Gemtesa

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Genitourinary Agents: Urinary Antispasmodics	
PREFERRED	**NON-PREFERRED**
Oxytrol	Myrbetriq Granules AR
Solifenacin QL	Tolterodine
Toviaz BvG	Trospium QL
	Vesicare LS AR

Link to Criteria: Genitourinary Agents: Urinary Antispasmodics

Immunomodulator Agents: Systemic Inflammatory Disease	
PREFERRED	**NON-PREFERRED**
Adbry PA	Actemra
Dupixent PA	Adalimumab-adaz (Generic of Hyrimoz)
Enbrel PA	Adalimumab-fkjp (Generic of Hulio)
Humira PA	Amjevita
Kineret PA	Cibinqo
Otezla PA	Cimzia
Taltz PA ST	Cosentyx
Xeljanz IR PA	Cyltezo
	Hadlima
	Idacio
	Ilumya
	Kevzara
	Litfulo
	Olumiant
	Orencia
	Rinvoq
	Siliq
	Simponi
	Skyrizi
	Sotyktu
	Stelara
	Tremfya
	Xeljanz Sol, XR
	Yuflyma
	Yusimry

Link to Criteria: Immunomodulator Agents for Systemic Inflammatory Disease

Infectious Disease Agents: Antibiotics – Cephalosporins	
PREFERRED	**NON-PREFERRED**
Cefaclor IR, ER	Cefixime Cap
Cefaclor Susp AR	Cefixime Susp AR
Cefadroxil	Cefpodoxime
Cefdinir	Cephalexin 750mg
Cefprozil	Suprax Chewable Tab AR
Cefprozil Susp AR	
Cefuroxime	
Cephalexin 250, 500mg	

Link to Criteria: Infectious Disease Agents: Antibiotics – Cephalosporins

AR = Age Restriction **QL** = Quantity Limit **ST** = Step Therapy Required **PA** = Clinical Prior Authorization Required **BvG** = Brand Preferred Over Generic

Infectious Disease Agents: Antibiotics – Inhaled	
PREFERRED	**NON-PREFERRED**
Tobramycin [PA QL]	Arikayce
	Bethkis [QL]
	Cayston
	Kitabis Pak [QL]
	Tobi Podhaler [QL]

Link to Criteria: Infectious Disease Agents: Antibiotics – Inhaled

Infectious Disease Agents: Antibiotics – Macrolides	
PREFERRED	**NON-PREFERRED**
Azithromycin	Eryped
Clarithromycin	Erythrocin Stearate
	Erythromycin

Link to Criteria: Infectious Disease Agents: Antibiotics – Macrolides

Infectious Disease Agents: Antibiotics – Quinolones	
PREFERRED	**NON-PREFERRED**
Ciprofloxacin	Baxdela
Ciprofloxacin Susp [AR]	Ciprofloxacin ER
Levofloxacin	Moxifloxacin
	Ofloxacin

Link to Criteria: Infectious Disease Agents: Antibiotics – Quinolones

Infectious Disease Agents: Antibiotics – Tetracyclines	
PREFERRED	**NON-PREFERRED**
Doxycycline 50, 100mg	Demeclocycline
Doxycycline Syr [AR]	Doxycycline 20, 40, 75, 150mg
Minocycline Cap	Doxycycline DR
Tetracycline	Minocycline IR, ER Tab
Vibramycin Susp [AR]	Nuzyra

Link to Criteria: Infectious Disease Agents: Antibiotics – Tetracyclines

Infectious Disease Agents: Antifungals	
PREFERRED	**NON-PREFERRED**
Fluconazole	Brexafemme
Flucytosine	Cresemba
Griseofulvin	Itraconazole
Ketoconazole	Noxafil Susp
Terbinafine	Oravig
	Posaconazole
	Tolsura
	Vivjoa
	Voriconazole

Link to Criteria: Infectious Disease Agents: Antifungals

Infectious Disease Agents: Antivirals – Hepatitis C Agents	
PREFERRED	**NON-PREFERRED**
Mavyret [PA]	Harvoni

Infectious Disease Agents: Antivirals – Hepatitis C Agents	
PREFERRED	**NON-PREFERRED**
Pegasys PA	Ledipasvir/Sofosbuvir
Ribavirin PA	Sovaldi
Sofosbuvir/Velpatasvir PA	Vosevi
	Zepatier

Link to Criteria: Infectious Disease Agents: Antivirals – Hepatitis C Agents

Infectious Disease Agents: Antivirals – Herpes	
PREFERRED	**NON-PREFERRED**
Acyclovir	Famciclovir
Valacyclovir	Sitavig

Link to Criteria: Infectious Disease Agents: Antivirals – Herpes

Infectious Disease Agents: Antivirals – HIV*	
PREFERRED	**NON-PREFERRED**
Abacavir Sulfate	Abacavir Susp
Abacavir/Lamivudine	Abacavir/Lamivudine/Zidovudine
Apretude	Aptivus
Atazanavir Sulfate	Cimduo
Biktarvy	Darunavir
~~Cimduo~~	Didanosine
Complera	Edurant
Delstrigo	Efavirenz/Lamivudine/Tenofovir Disoproxil Fumarate
Descovy	Emtricitabine
Dovato	Fosamprenavir
Efavirenz	Fuzeon
Efavirenz/Emtricitabine/Tenofovir	Intelence BvG
Emtricitabine/Tenofovir Disoproxil Fumarate	Lamivudine Tab
Emtriva BvG	Lamivudine Sol AR
Evotaz	Lamivudine/Zidovudine
Genvoya	Nevirapine IR, ER Tab
Isentress	Nevirapine Sol AR
Isentress Chew Tab AR	Norvir Powder, Sol
Juluca	Selzentry BvG
Lopinavir/Ritonavir	Stavudine
Odefsey	Stribild
Pifeltro	Symfi BvG
Prezcobix	Symfi Lo BvG
Prezista BvG	Tybost
Ritonavir Tab	Viracept
Rukobia ER PA	
~~Symfi BvG~~	
~~Symfi Lo BvG~~	
Symtuza	
Temixys	
Tenofovir Disoproxil Fumarate 300mg	
Tivicay	
Tivicay PD	

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Infectious Disease Agents: Antivirals – HIV*	
PREFERRED	**NON-PREFERRED**
Triumeq	
Triumeq PD [PA]	
Viread Tab, Powder	
Zidovudine	

Link to Criteria: Infectious Disease Agents: Antivirals – HIV

Ophthalmic Agents: Antibiotic and Antibiotic-Steroid Combination Drops and Ointments	
PREFERRED	**NON-PREFERRED**
Bacitracin-Polymyxin	Azasite
Ciloxan	Bacitracin
Ciprofloxacin	Besivance
Erythromycin	Blephamide
Gentamicin	Gatifloxacin
Moxifloxacin	Levofloxacin
Neomycin/Polymyxin/Bacitracin	Moxifloxacin (Generic of Moxeza)
Neomycin/Polymyxin/Bacitracin/Hydrocortisone	Neomycin/Polymyxin/Hydrocortisone
Neomycin/Polymyxin/Dexamethasone	Pred-G
Neomycin/Polymyxin/Gramicidin	Sulfacetamide Sodium Ophth Oint 10%
Ofloxacin	Tobradex ST [BvG]
Polymyxin/Trimethoprim	Zylet
Sulfacetamide Sodium Ophth Sol 10%	
Sulfacetamide/Prednisolone	
Tobramycin	
Tobramycin/Dexamethasone 0.3/0.1%	

Link to Criteria: Ophthalmic Agents: Antibiotic and Antibiotic-Steroid Combination Drops and Ointments

Ophthalmic Agents: Antihistamines & Mast Cell Stabilizers	
PREFERRED	**NON-PREFERRED**
Azelastine	Alocril
Bepreve [BvG]	Alomide
Cromolyn	Epinastine
Ketotifen	Zerviate
Olopatadine	

Link to Criteria: Ophthalmic Agents: Antihistamines & Mast Cell Stabilizers

Ophthalmic Agents: Dry Eye Treatments	
PREFERRED	**NON-PREFERRED**
Restasis Trays [BvG ST]	Cequa
Xiidra	Eysuvis
	Miebo
	Restasis Multi-Dose
	Tyrvaya
	~~Xiidra~~

Link to Criteria: Ophthalmic Agents: Dry Eye Treatments

Ophthalmic Agents: Glaucoma Agents	
PREFERRED	**NON-PREFERRED**
Alphagan P 0.1%	Apraclonidine
Alphagan P 0.15% BvG	Betoptic S
Azopt BvG ST	Bimatoprost
Betaxolol	Brimonidine 0.15%
Brimonidine 0.2%	Brinzolamide
Carteolol	Iopidine
Combigan BvG ST	Istalol
Dorzolamide	Lumigan
Dorzolamide/Timolol	Timolol Maleate Droperette
Latanoprost	Travoprost
Levobunolol	Vyzulta
Metipranolol	Xelpros
Rhopressa	Zioptan BvG
Rocklatan	
Simbrinza	
Timolol 0.5% Gel, Soln	
Travatan Z BvG ST	

Link to Criteria: Ophthalmic Agents: Glaucoma Agents

Ophthalmic Agents: NSAIDs	
PREFERRED	**NON-PREFERRED**
Diclofenac	Acuvail
Flurbiprofen	Bromfenac
Ketorolac	Bromsite
	Ilevro
	Nevanac
	Prolensa

Link to Criteria: Ophthalmic Agents: NSAIDs

Ophthalmic Agents: Ophthalmic Steroids	
PREFERRED	**NON-PREFERRED**
Alrex BvG	Inveltys
Dexamethasone Sodium Phosphate	Lotemax SM
Difluprednate	Loteprednol
Durezol	
Flarex	
Fluorometholone	
Fml Forte	
Fml S.O.P.	
Lotemax BvG	
Maxidex	
Pred Forte	
Pred Mild	
Prednisolone Acetate	
Prednisolone Sodium Phosphate	

Link to Criteria: Ophthalmic Agents: Ophthalmic Steroids

Otic Agents: Antibacterial and Antibacterial/Steroid Combinations	
PREFERRED	**NON-PREFERRED**
Cipro HC	Ciprofloxacin
Ciprodex BvG	Ciprofloxacin/Dexamethasone
Cortisporin-TC	Ciprofloxacin/Fluocinolone
Neomycin/Polymyxin B/Hydrocortisone	
Ofloxacin	

Link to Criteria: Otic Agents: Antibacterial and Antibacterial/Steroid Combinations

Respiratory Agents: Antihistamines – Second Generation	
PREFERRED	**NON-PREFERRED**
Cetirizine Syr, Tab QL	Cetirizine Chewable AR
Cetirizine/Pseudoephedrine	Clarinex-D
Loratadine Rapid Dissolve QL	Desloratadine
Loratadine Syr, Tab QL	Fexofenadine
Loratadine/Pseudoephedrine	Levocetirizine

Link to Criteria: Respiratory Agents: Antihistamines – Second Generation

Respiratory Agents: Cystic Fibrosis	
PREFERRED	**NON-PREFERRED**
Kalydeco PA QL	Bronchitol
Orkambi PA QL	
Symdeko PA QL	
Trikafta Pak AR, Tab PA	

Link to Criteria: Respiratory Agents: Cystic Fibrosis

Respiratory Agents: Epinephrine Auto-Injectors	
PREFERRED	**NON-PREFERRED**
Epinephrine (labeler 49502)	Epipen
Symjepi	Epipen JR

Link to Criteria: Respiratory Agents: Epinephrine Auto-Injectors

Respiratory Agents: Hereditary Angioedema	
PREFERRED	**NON-PREFERRED**
Haegarda PA	Berinert
Ruconest PA	Cinryze
Takhzyro PA	Icatibant Acetate
	Kalbitor

Link to Criteria: Respiratory Agents: Hereditary Angioedema

Respiratory Agents: Inhaled Agents	
PREFERRED	**NON-PREFERRED**
Advair Diskus BvG	Aerospan HFA
Advair HFA BvG	Airduo Digihaler, Respiclick
Albuterol HFA	Alvesco
Albuterol Nebulizer Sol 0.021% (0.63mg/3mL), 0.042% (1.25mg/3mL) AR	Arformoterol Nebulizer Sol
	Armonair Digihaler, Respiclick
Albuterol Nebulizer Sol 0.083% (2.5mg/3mL), 0.5% (5mg/mL) Conc	Arnuity Ellipta
	Asmanex HFA
Albuterol Nebulizer Sol 0.083% (2.5mg/3mL), 0.5%	Bevespi Aerosphere

Respiratory Agents: Inhaled Agents	
PREFERRED	**NON-PREFERRED**
Anoro Ellipta	Breo Ellipta BvG
Asmanex Twisthaler	Breztri Aerosphere
Atrovent HFA QL	Budesonide/Formoterol QL
Budesonide Nebulizer Sol AR QL	Duaklir Pressair
Combivent Respimat	Fluticasone/Salmeterol
Cromolyn Neb Sol	Formoterol Fumarate Nebulizer Sol
Dulera	Levalbuterol Nebulizer Sol
Flovent BvG QL	Lonhala Magnair
Incruse Ellipta	Proair Digihaler, Respiclick
Ipratropium	Qvar QL
Ipratropium/Albuterol Nebulizer Sol QL	Tiotropium Inhaled Caps
Proair HFA	Trelegy Ellipta
Proventil HFA	Tudorza
Pulmicort Flexhaler QL	Wixela Inhub
Serevent Diskus	Xopenex HFA
Spiriva BvG QL	Yupelri
Stiolto	
Striverdi Respimat	
Symbicort BvG QL	
Ventolin HFA	

Link to Criteria: Respiratory Agents: Inhaled Agents

Respiratory Agents: Leukotriene Receptor Modifiers & Inhibitors	
PREFERRED	**NON-PREFERRED**
Montelukast QL	Zileuton
Zafirlukast ST	Zyflo

Link to Criteria: Respiratory Agents: Leukotriene Receptor Modifiers & Inhibitors

Respiratory Agents: Monoclonal Antibodies-Anti-IL/Anti-IgE	
PREFERRED	**NON-PREFERRED**
Dupixent PA	Nucala
Fasenra PA	Tezspire
Xolair PA	

Link to Criteria: Respiratory Agents: Monoclonal Antibodies-Anti-IL/Anti-IgE

Respiratory Agents: Nasal Preparations	
PREFERRED	**NON-PREFERRED**
Azelastine	Azelastine/Fluticasone Spray
Flunisolide	Beconase AQ
Fluticasone (Generic of Flonase)	Budesonide
Ipratropium QL	Mometasone
Olopatadine	Omnaris
	Qnasl
	Ryaltris
	Xhance
	Zetonna

Link to Criteria: Respiratory Agents: Nasal Preparations

AR = Age Restriction **QL** = Quantity Limit **ST** = Step Therapy Required **PA** = Clinical Prior Authorization Required **BvG** = Brand Preferred Over Generic

Respiratory Agents: Other Agents	
PREFERRED	**NON-PREFERRED**
	Roflumilast

Link to Criteria: Respiratory Agents: Other Agents

Topical Agents: Antifungals	
PREFERRED	**NON-PREFERRED**
Alevazol	Butenafine
Ciclopirox	Ciclopirox Kit
Clotrimazole	Ertaczo
Clotrimazole/Betamethasone	Jublia
Econazole	Ketoconazole Foam
Ketoconazole	Luliconazole
Miconazole	Miconazole/Zinc Oxide/White Petrolatum Oint
Nystatin	Naftifine
Nystatin/Triamcinolone	Oxiconazole
Terbinafine	Tavaborole
Tolnaftate	

Link to Criteria: Topical Agents: Antifungals

Topical Agents: Antiparasitics	
PREFERRED	**NON-PREFERRED**
Natroba BvG	Eurax
Permethrin	Ivermectin Lot
Piperonyl Butoxide/Pyrethrins	Malathion
Vanalice	Spinosad

Link to Criteria: Topical Agents: Antiparasitics

Topical Agents: Corticosteroids	
PREFERRED	**NON-PREFERRED**
Amcinonide	Alclometasone
Betamethasone Dip/Calcipotriene Oint	Apexicon E
Betamethasone Valerate	Betamethasone Dipropionate
Clobetasol Propionate	Betamethasone Dipropionate/Calcipotriene Susp
Derma-Smoothe/FS BvG	Betamethasone Valerate Aerosol Foam
Desonide Cream, Oint	Bryhali
Diflorasone Diacetate	Clocortolone Pivalate
Fluocinolone Acetonide 0.01% Cream, Sol, 0.05%	Cordran Tape
Flurandrenolide	Desonate Gel
Fluticasone Propionate Cream, Oint	Desonide Lotion
Hydrocortisone	Desoximetasone
Mometasone Furoate	Fluocinolone Acetonide 0.01% Oil
Prednicarbate	Fluocinolone Acetonide 0.025%, 0.1%
Triamcinolone Cream, Lotion, Oint	Fluticasone Propionate Lotion
	Halcinonide Cream
	Halobetasol Propionate
	Halog
	Hydrocortisone Butyrate, Valerate

Topical Agents: Corticosteroids	
PREFERRED	**NON-PREFERRED**
	Impeklo Pandel Triamcinolone Spray

Link to Criteria: Topical Agents: Corticosteroids

Topical Agents: Immunomodulators	
PREFERRD	**NON-PREFERRED**
Elidel [AR BvG ST] Tacrolimus [AR ST]	Eucrisa Hyftor Opzelura Pimecrolimus [AR] Vtama Zoryve

Link to Criteria: Topical Agents: Immunomodulators

Ohio Medicaid

Pharmacy Benefit Management Program

Unified Preferred Drug List

Medicaid Fee-for-Service and Managed Care Plans

Effective January 1, 2024

AR = Age Restriction **QL** = Quantity Limit **ST** = Step Therapy Required **PA** = Clinical Prior Authorization Required **BvG** = Brand Preferred Over Generic

Helpful Links

Prior Authorization (PA)

Prior Authorization (PA) Information | pharmacy.medicaid.ohio.gov

- **General Prior Authorization Requirements**
- **PA and Step Therapy Frequently Asked Questions (FAQ)**

Unified Preferred Drug List (UPDL)

Ohio Unified Preferred Drug List | pharmacy.medicaid.ohio.gov

- **Unified Preferred Drug List (UPDL)**

General Information

- The Statewide UPDL is not an all-inclusive list of drugs covered by Ohio Department of Medicaid.
- Medications that are new to market will be non-preferred, PA required until reviewed by the Ohio Department of Medicaid Pharmacy and Therapeutics (P&T) Committee.
- The document is listed in sections defined by therapeutic class. Drugs are listed by generic name if a generic is available unless the brand name of the drug is preferred. In most cases, when a generic for a brand-name drug is available, the generic drug will be preferred, and the brand name will be non-preferred. Some drugs may also require a specific manufacturer or the brand to be dispensed.
- Ohio Department of Medicaid will only cover drugs that are part of the Medicaid Drug Rebate Program, with limited exceptions. This document may not reflect the most current rebate status of a drug (i.e., a drug may be listed on the document but is non-rebateable and therefore non-payable).
- Some therapeutic categories are grandfathered. These categories will be denoted with an "*" next to their title on the table on contents and their place within the criteria document.
- Some therapeutic categories may have quantity limits on specific drugs detailed in the criteria document, however this is not an all-inclusive list. For a list of the quantity limits on specific drugs, please reference the Quantity Limit Document found here: Quantity Limits Document | pharmacy.medicaid.ohio.gov

Terminology/Abbreviations:

AR (Age Restriction) – An edit allowing claims for members within a defined age range to be covered without PA
BvG (Brand Preferred Over the Generic) – The brand name drug is preferred over the generic equivalent
PA (Clinical Prior Authorization) – A prior authorization (PA) is required before the drug will be covered
QL (Quantity Limit) – A limit on the quantity that will be covered within a given time frame

ST (Step Therapy) – Drug requires a trial with one or more preferred drugs before being covered

New UPDL Criteria Format

- With a few minor exceptions, all therapeutic categories have the same standardized outline format. The design of this new format is intended to have a cumulative approach bottom-to-top.

Example Category

LENGTH OF AUTHORIZATIONS: X days or Initial: X days; Subsequent: X days (if different)

GRANDFATHERING*:
Patients who have a claim for a non-preferred drug in the previous 120 days will be automatically approved to continue the drug. Patients who have taken the drug previously, but do not have claims history (e.g. new to Medicaid), will need to submit a prior authorization in order to continue coverage.

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

CLINICAL PA CRITERIA *(if applicable):*

"DRUG" CRITERIA *(if applicable)*:

STEP THERAPY CRITERIA:
- Must have had an inadequate clinical response of at least X days with at least X preferred drugs

NON-PREFERRED CRITERIA:
- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least X days with X preferred drugs
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

ADDITIONAL "DRUG" CRITERIA *(if applicable)*:

ADDITIONAL INFORMATION *(if applicable)*:

SUBSEQUENT AUTHORIZATION CRITERIA:
- Must provide documentation of patient's response to treatment from baseline and/or attestation of clinical stabilization

QL – Drug: X doses per X days
AR – a PA is required for patients X years and older OR younger than X years

Interpretation of New UPDL Criteria Format

- Beginning January 2023 and with a few minor exceptions, all therapeutic categories have the same standardized outline format. The design of this new format is intended to have a cumulative approach bottom-to-top. The following scenarios will aid in illustrating this point:

Scenario 1: Clinical PA drug
- All Authorizations
- Clinical PA Criteria

Scenario 2: Clinical PA drug with drug-specific criteria
- All Authorizations
- Drug-Specific Criteria

Scenario 3: Step-Therapy drug
- All Authorizations
- Clinical PA Criteria (if applicable)
- Step Therapy Criteria

Scenario 4: Non-Preferred drug
- All Authorizations
- Clinical PA Criteria (if applicable)
- Step Therapy Criteria (if applicable)
- Non-Preferred Criteria

Scenario 5: Non-Preferred drug with drug-specific criteria
- All Authorizations
- Clinical PA Criteria (if applicable)
- Step Therapy Criteria (if applicable)
- Non-Preferred Criteria
- Additional Drug-Specific Criteria

Table of Contents

Analgesic Agents: Gout

LENGTH OF AUTHORIZATIONS: 365 days except 180 days for Familial Mediterranean Fever

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

CLINICAL PA CRITERIA:

- Must have had an inadequate clinical response with an NSAID and oral corticosteroid within the last 30 days for acute gout diagnosis **OR**
- Must have had an inadequate clinical response of at least 30 days with the maximally tolerated xanthine oxidase inhibitor dose for chronic gout diagnosis

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days with at least one preferred drug
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

ADDITIONAL COLCHICINE CAPSULE (MITIGARE) CRITERIA:

- Must have had an inadequate clinical response of 30 days with colchicine tablets

ADDITIONAL COLCHICINE SOLUTION (GLOPERBA) CRITERIA:

- Must be unable to swallow tablets or capsules for authorization of colchicine solution

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

QL – All colchicine products: 6 doses per claim for acute gout; 2 doses per day for 30 days for chronic gout; 4 doses per day per 30 days for Familial Mediterranean Fever

Analgesic Agents: NSAIDs

LENGTH OF AUTHORIZATIONS: Dependent upon the table below

	Authorization Length
H. Pylori Treatment	30 days
Transdermal/Topical	90 days
All Other Treatments	365 days

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

AR – Naproxen Suspension: a PA is required for patients 12 years old and older

Analgesic Agents: Opioids

Ohio law requires prescribers to request and review an OARRS report before initially prescribing or personally furnishing any controlled substance, such as an opioid analgesic or a benzodiazepine, and gabapentin

LENGTH OF AUTHORIZATIONS: For the course of therapy, up to 180 days. Initial short-acting and long-acting requests may only be authorized for up to 90 days

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

BUPRENORPHINE TOPICAL (BUTRANS) CRITERIA:

- For doses greater than 5 mcg/hour must provide documentation of an inadequate clinical response with at least one opioid formulation taken for at least 60 of the last 90 days

MORPHINE SULFATE ER (KADIAN, MS CONTIN) & TAPENTADOL ER (NUCYNTA) CRITERIA:

- Unless receiving for cancer pain, palliative care, or end-of-life/hospice care, must provide documentation of an inadequate clinical response with at least one opioid formulation taken for at least 60 of the last 90 days
- Must also meet LONG-ACTING OPIOID CRITERIA

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 7 days of at least two unrelated preferred drugs of the same duration of action (SHORT-ACTING or LONG-ACTING)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)
- Must also meet applicable SHORT-ACTING or LONG-ACTING OPIOID CRITERIA

ADDITIONAL SHORT-ACTING OPIOIDS CRITERIA:

- The system defines an "initial request" as having no opioid claims in the previous 90 days
- **Initial short-acting requests** can be authorized up to 90 days
    - Length of authorization is dependent on indication, previous patient utilization, and requested length of therapy (could be more restrictive)
    - To exceed acute opioid limits, documentation of the following must be provided:
        - Diagnosis code which must be for somatic type pain
        - Prescriber attestation that the benefits and risks of opioid therapy have been

discussed with patient

- Exemptions to the additional criteria:
  - Patients receiving short-acting opioids for active cancer treatment, palliative care, and end-of-life/hospice care, sickle cell, severe burn, traumatic crushing of tissue, amputation, major orthopedic surgery
  - Prescriber attestation that patient is opioid tolerant (i.e., new to Medicaid or was on higher dose in hospital)

- **Subsequent short-acting requests** can be authorized up to 180 days
  - Documentation of the following must be provided:
    - Current treatment plan
    - Demonstrated adherence to treatment plan through progress notes, including pain and function scores, random urine screenings results reviewed, concerns addressed, and no serious adverse outcomes observed
- **Dose escalation requests** can be authorized up to 180 days
  - Documentation of the following must be provided:
    - Prescriber attestation that dose escalation is likely to result in improved function or pain control
    - Requests for a cumulative daily dose > 80 MED must be prescribed by or in consultation with a pain specialist, specialist in the area of the body affected by pain, or anesthesiologist

Patients with initial prescriptions for opioid therapy, defined as no rx claims for opioids in the last 90 days, will be limited to 30 MED per day and a maximum of 7 days per prescription. Prior authorization will be required to exceed these limits.

ADDITIONAL LONG-ACTING OPIOIDS CRITERIA:

- The system defines an "initial long-acting request" as having no opioid claims in the previous 90 days
- **Initial long-acting requests** can be authorized up to 90 days
  - Documentation of the following must be provided:
    - Request is a daily dose equivalent of ≤ 80 MED
    - Inadequate clinical response to both non-opioid pharmacologic and non-pharmacologic treatments
    - Current use of opioids for ≥ 60 of the last 90 days
    - Treatment plan including risk assessment, substance abuse history, concurrent therapies, and requirements for random urine screenings (baseline urine drug tests must be submitted)
    - Pain and function scores at each visit
    - Opioid contract required to be in place and submitted with PA form
  - Exemptions to the additional criteria:
    - Patients receiving long-acting opioids for cancer pain, palliative care, or end-of-life/hospice care

- **Subsequent long-acting requests** can be authorized up to 180 days
    - Documentation of the following must be provided:
        - Current treatment plan
        - Demonstrated adherence to treatment plan through progress notes, including pain and function scores, random urine screenings results reviewed, concerns addressed, and no serious adverse outcomes observed
- **Dose escalation requests** can be authorized up to 180 days
    - Documentation of the following must be provided:
        - Prescriber attestation that dose escalation is likely to result in improved function or pain control
        - Requests for a cumulative daily dose > 80 MED must be prescribed by or in consultation with a pain specialist, specialist in the area of the body affected by pain, or anesthesiologist

ADDITIONAL TRANSMUCOSAL FENTANYL CRITERIA:

- Must be prescribed by an oncologist, pain specialist, or hospice/palliative prescriber
- Must be concurrently taking a long-acting opioid at a therapeutic dose of any of the following for at least 7 days without adequate pain relief:

≥ 60 mg oral morphine/day	≥ 8 mg oral hydromorphone/day
≥ 25 mcg/hr transdermal fentanyl	≥ 25 mg oral oxymorphone/day
≥ 30 mg oral oxycodone/day	Equianalgesic dose of another opioid

BUPRENORPHINE BUCCAL FILM (BELBUCA) CRITERIA:

- Must meet ADDITIONAL LONG-ACTING OPIOID Criteria

QL – Transmucosal Fentanyl: 4 doses per day

Blood Formation, Coagulation, and Thrombosis Agents: Colony Stimulating Factors

LENGTH OF AUTHORIZATIONS: Dependent upon diagnosis below

Diagnosis	Authorization Length
Acute Myeloid Leukemia (AML)	14 days or duration of chemotherapy regimen
Malignancy at risk for febrile neutropenia or undergoing myeloablative chemotherapy prior to allogeneic or autologous bone marrow transplantation	14 days or duration of chemotherapy regimen
Myeloid Engraftment for bone marrow transplant (BMT)	30 days
Severe, chronic neutropenia with absolute neutrophil count (ANC) of less than 500/mm^3 and have symptoms associated with neutropenia (e.g., fever, infections, oropharyngeal ulcers).	30 days
Hematopoietic radiation injury syndrome	30 days

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

CLINICAL PA CRITERIA:

- Must provide documentation of diagnosis, patient's weight, and duration of treatment

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 14 days with at least one preferred drug
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

Blood Formation, Coagulation, and Thrombosis Agents: Hematopoietic Agents

LENGTH OF AUTHORIZATIONS: Dependent upon diagnosis below

Authorization of epoetin alfa or darbepoetin:

Diagnosis	Hemoglobin Level	Authorization Length
Anemia due to chronic renal failure, patient on dialysis	≤11	365 days
Anemia due to chronic renal failure, patient not on dialysis	≤10	365 days
Chemotherapy-induced anemia	≤10	90 days
Anemia in myelodysplastic syndrome	≤11	180 days

Authorization of epoetin alfa ONLY:

Diagnosis	Hemoglobin Level	Authorization Length
Autologous blood donation, patient will require blood transfusions	>10 to ≤13	30 days
Anemia of prematurity, age ≤6 months	N/A	42 days
Anemia associated with chronic inflammatory disorders (e.g., rheumatoid arthritis)	≤11	180 days
Anemia associated with ribavirin combination therapy in hepatitis C-infected patient	≤11	180 days
Anemia in zidovudine-treated HIV-infected patients	≤11	180 days

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 14 days with at least one preferred drug
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia Factors*

LENGTH OF AUTHORIZATIONS: 365 Days

GRANDFATHERING*:
Patients who have a claim for a non-preferred drug in the previous 120 days will be automatically authorized to continue the drug. Patients who have taken the drug previously, but do not have claims history (e.g., new to Medicaid), will need to submit a prior authorization in order to continue coverage.

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

CLINICAL PA CRITERIA:
- Must provide documentation of patient's body weight

NON-PREFERRED CRITERIA:
- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 14 days with at least one preferred drug
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

ADDITIONAL EXTENDED HALF-LIFE FACTOR CRITERIA
- Must provide attestation that the patient is not a suitable candidate for treatment with a shorter-acting half-life drug

SUBSEQUENT AUTHORIZATION CRITERIA:
- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

Blood Formation, Coagulation, and Thrombosis Agents: Heparin-Related Preparations

LENGTH OF AUTHORIZATIONS: Dependent upon criteria below

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

NON-PREFERRED CRITERIA:b

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 14 days with at least one preferred drug
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

ADDITIONAL INFORMATION:

- For most indications: Guidelines from the American College of Chest Physicians limit duration of therapy in the outpatient setting for most indications to less than 35 days and patients should be transitioned to oral anticoagulant as soon as possible
- For requests over 35 days and/or the patient cannot be transitioned to an oral anticoagulant, prescriber must submit additional documentation for reasoning:
    - For patients with cancer – authorized up to 180 days
    - For pregnant women – authorized up to 280 days
    - For patients unable to take an oral anticoagulant – authorized up to 180 days

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

Blood Formation, Coagulation, and Thrombosis Agents: Oral Anticoagulants

LENGTH OF AUTHORIZATION: 365 days

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

AR – All drugs: a PA is required for patients older than 12 years old

Blood Formation, Coagulation, and Thrombosis Agents: Oral Antiplatelet

LENGTH OF AUTHORIZATION: 365 days

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

Cardiovascular Agents: Angina, Hypertension & Heart Failure

LENGTH OF AUTHORIZATIONS: 365 days except nimodipine: 21 days

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

PROPRANOLOL ORAL SOLUTION (HEMANGEOL) CRITERIA:

- Must provide documentation of the patient's weight

SACUBITRIL/VALSARTAN (ENTRESTO) CRITERIA:

- Must provide documentation of chronic heart failure classified as either NYHA Class II-IV or ACC/AHA Stage B-D

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days of at least two preferred drugs within the same class, if indicated for diagnosis
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

ADDITIONAL FINERENONE (KERENDIA) CRITERIA:

- Must be on a maximally tolerated dose of an angiotensin-converting enzyme inhibitor or angiotensin receptor blocker
- Must provide documentation of an inadequate clinical response to a SGLT2 Inhibitor **OR** provide documentation of medical necessity beyond convenience for why the patient cannot try a SGLT2 inhibitor (i.e., chronic kidney disease diagnosis)

ADDITIONAL MAVACAMTEN (CAMZYOS) CRITERIA:

- Must be prescribed by or in consultation with a cardiologist
- Must provide documentation of NYHA Class II-III symptoms and left ventricular ejection fraction ≥55%

ADDITIONAL SOTAGLIFLOZIN (INPEFA) CRITERIA:

- Must provide documentation of an inadequate clinical response to at least two SGLT2 Inhibitors

ADDITIONAL VERICIGUAT (VERQUVO) CRITERIA:

- Must provide documentation of ejection fraction
- Must have been hospitalized for the treatment of heart failure in the previous 180 days or needs treatment with an outpatient intravenous diuretic in the previous 90 days
- Must be treated with an agent from **ALL** the following unless contraindicated:
    - Angiotensin-converting enzyme inhibitor, angiotensin II receptor blocker, **OR** an angiotensin receptor neprilysin inhibitor
    - Beta-blocker
    - Aldosterone antagonist and/or SGLT2 inhibitor as appropriate for renal function

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

AR – Sotylize Solution: a PA is required for patients 6 years and older

Cardiovascular Agents: Antiarrhythmics

LENGTH OF AUTHORIZATIONS: 365 Days

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days with at least one preferred drug
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

Cardiovascular Agents: Lipotropics

LENGTH OF AUTHORIZATIONS: See below

Juxtapid (Initial)	180 days
Vascepa, Lovaza, ACL inhibitors (Initial)	84 days
All others (Initial and Subsequent)	365 days

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

CLINICAL PA CRITERIA:

- Must provide documentation of baseline labs **AND** have documented adherence to 90 days of prescribed lipid lowering medications
- Must have had an inadequate clinical response of at least 90 days **AND** unable to reach goal LDL-C (see below) despite treatment with maximally tolerated dose of high-potency statin and ezetimibe (or a clinical reason that these drugs cannot be utilized)

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days (or 90 days for fibrates) with at least one preferred drug in the same drug class
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

ADDITIONAL LOVASTATIN ER (ALTOPREV), PITAVASTATIN (LIVALO), FLUVASTATIN (LESCOL) CRITERIA

- Must have had an inadequate clinical response of at least 30 days with two preferred drugs in the same drug class

ADDITIONAL COLESEVELAM (WELCHOL) CRITERIA:

- Must provide documentation of a Type 2 Diabetes diagnosis

ADDITIONAL ICOSAPENT ETHYL (VASCEPA) CRITERIA:

- Must provide documentation of baseline labs indicating triglyceride levels ≥500mg/dL after an inadequate clinical response to fibrates, niacin, and diet/exercise
- Must provide documentation of discontinuation of drugs known to increase triglyceride levels (i.e., beta blockers, thiazides, and estrogens), if clinically appropriate

ADDITIONAL LOMITAPIDE (JUXTAPID) & ATP CITRATE LYASE (ACL) INHIBITOR CRITERIA:

- Must provide documentation of baseline labs **AND** have documented adherence to 90 days of prescribed lipid lowering medications
- Must have had inadequate clinical response of at least 90 days **AND** unable to reach goal LDL-C with high-potency statin, ezetimibe and PCSK9 inhibitor (or a clinical reason that these drugs cannot be utilized)

ADDITIONAL INFORMATION:

- High potency statins: atorvastatin (Lipitor) 40-80mg & rosuvastatin (Crestor) 20-40mg
- LDL goals for Familial Hypercholesterolemia (includes Heterozygous & Homozygous FH): LDL ≤ 100mg/dL for adults or LDL ≤ 110mg/dL for those < 18 years of age
- LDL goals for Clinical Atherosclerotic Cardiovascular Disease (ASCVD): LDL ≤ 70mg/dL

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

Cardiovascular Agents: Pulmonary Arterial Hypertension*

LENGTH OF AUTHORIZATIONS: 365 Days

GRANDFATHERING*:
Patients who have a claim for a non-preferred drug in the previous 120 days will be automatically approved to continue the drug. Patients who have taken the drug previously, but do not have claims history (e.g., new to Medicaid), will need to submit a prior authorization in order to continue coverage.

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

CLINICAL PA CRITERIA:
- Must provide documentation of NYHA Functional Class for Pulmonary Hypertension and symptoms experienced by patient

NON-PREFERRED CRITERIA:
- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs, one of which must be a phosphodiesterase-5 inhibitor
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

ADDITIONAL INFORMATION:
- Patients who have class III or IV symptoms defined by the NYHA Functional Class for Pulmonary Hypertension may be authorized for inhalation or intravenous agents

SUBSEQUENT AUTHORIZATION CRITERIA:
- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

AR - Sildenafil Susp: a PA is required for patients 18 years and older
AR - Tadliq: a PA is required for patients younger than 18 years

Central Nervous System (CNS) Agents: Alzheimer's Agents*

LENGTH OF AUTHORIZATIONS: 365 Days

GRANDFATHERING*:
Patients who have a claim for a non-preferred drug in the previous 120 days will be automatically approved to continue the drug. Patients who have taken the drug previously, but do not have claims history (e.g., new to Medicaid), will need to submit a prior authorization in order to continue coverage.

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

AR – All drugs: a PA is required for patients younger than 40 years

Central Nervous System (CNS) Agents: Anti-Migraine Agents, Acute

LENGTH OF AUTHORIZATIONS: 180 Days

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

STEP THERAPY CRITERIA:

- Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

ADDITIONAL UBROGEPANT (UBRELVY) CRITERIA

- Must have had an inadequate clinical response of at least 14 days with at least one preferred oral CGRP antagonist

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

QL - Nurtec ODT: 8 doses per 30 days for acute treatment

Central Nervous System (CNS) Agents: Anti-Migraine Agents, Cluster Headache

LENGTH OF AUTHORIZATIONS: 180 days

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 60 days to at least one preferred drug
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

ADDITIONAL INFORMATION:

- An inadequate clinical response to verapamil is defined as a titration to at least 480mg daily

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

QL – Emgality: 3 doses per 30 days

Central Nervous System (CNS) Agents: Anti-Migraine Agents, Prophylaxis

LENGTH OF AUTHORIZATIONS: Initial: 180 days; Subsequent: 365 days

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

STEP THERAPY CRITERIA:

- Must have had an inadequate clinical response of at least 30 days with at least three preferred controller migraine drugs
- Must include objective documentation of severity, frequency, type of migraine, and number of headache days per month (preferably a headache diary)

ERENUMAB (AIMOVIG) CRITERIA:

- Must have had an inadequate clinical response of at least 60 days with the 70mg dose to request a dose increase

FREMANEZUMAB (AJOVY) CRITERIA:

- Must have demonstrated efficacy for at least 90 days before quarterly administration will be authorized

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days with at least three preferred controller migraine drugs **AND** one step therapy drug
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

ADDITIONAL INFORMATION:

- Controller migraine drug classes include beta-blockers, anticonvulsants, tricyclic antidepressants, or serotonin-norepinephrine reuptake inhibitors

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment (preferably a headache diary or other objective documentation of severity, frequency, and number of headache days per month).

QL – Nurtec ODT: 18 doses per 30 days for prophylactic treatment
QL – Aimovig, Ajovy: 1 dose per 30 days
QL – Emgality: 2 doses per 30 days (for initial loading dose only), then 1 dose per 30 days thereafter

Central Nervous System (CNS) Agents: Anticonvulsants*

LENGTH OF AUTHORIZATIONS: 365 days except Epidiolex and Diacomit – Initial: 180 days

GRANDFATHERING* (except Diacomit):
Patients who have a claim for a non-preferred drug in the previous 120 days will be automatically approved to continue the drug. Patients who have taken the drug previously, but do not have claims history (e.g., new to Medicaid), will need to submit a prior authorization in order to continue coverage.

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

STEP THERAPY CRITERIA:

- Must have had an inadequate clinical response of at least 30 days with at least one preferred drug

CANNABIDIOL (EPIDIOLEX) CRITERIA

- Must have had an inadequate clinical response of at least 30 days with any two of the following anticonvulsants: clobazam, levetiracetam, valproic acid, lamotrigine, topiramate, rufinamide, or felbamate within the past 365 days (members who meet this criteria will not require a PA)

STIRIPENTOL (DIACOMIT) CRITERIA

- Must be prescribed by or in consultation with a neurologist
- Must be concomitantly taking clobazam (Onfi)
- Must provide documentation of addressed comorbidities and baseline hematologic testing (CBC)
    - Patients with phenylketonuria (PKU) must provide evidence of total daily amount of phenylalanine
    - Prescribers must include management plans for patients with neutrophil counts <1,500 cells/mm^3 or platelet count <150,000/µL
- Must provide documentation of patient's weight
    - Maximum daily dose does not exceed: 50 mg/kg/day or 3,000mg/day
- Must provide baseline average number of seizure days per month (measured monthly or quarterly)

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation

- Must have had an inadequate clinical response of at least 30 days with at least two preferred

drugs
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)
- Prescriptions submitted from a prescriber who is credentialed as a neurology specialty with Ohio Medicaid AND for drugs that are used only for seizures, there must have been an inadequate clinical response of at least 30 days with one preferred drug. This provision applies only to the standard tablet/capsule dosage form.

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring (i.e., documented reduction in average number of seizure days per month [measured monthly or quarterly])

AR – Vigabatrin Powder: a PA is required for patients 3 years and older
AR – Eprontia Solution: a PA is required for patients 12 years and older

Central Nervous System (CNS) Agents: Anticonvulsants Rescue

LENGTH OF AUTHORIZATIONS: 365 Days

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response with at least one preferred drug
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

AR – Valtoco: a PA is required for patients younger than 6 years old
AR – Nayzilam: a PA is required for patients younger than 12 years old

Central Nervous System (CNS) Agents: Antidepressants*

LENGTH OF AUTHORIZATIONS: 365 Days

GRANDFATHERING*:
Patients who have a claim for a non-preferred drug in the previous 120 days will be automatically approved to continue the drug. Patients who have taken the drug previously, but do not have claims history (e.g., new to Medicaid), will need to submit a prior authorization in order to continue coverage.

PSYCHIATRIST EXEMPTION:
Prescribers (as identified below) are exempt from prior authorization of any non-preferred antidepressant, or step therapy of any preferred drug, in the standard tablet/capsule dosage forms. Other dosage forms may still require prior authorization. The exemption will be processed by the claims system when the pharmacy has submitted the prescriber on the claim using the individual national provider identifier (NPI) for the prescriber.

Prescribers are defined as:
Physicians with a specialty in psychiatry, nurse practitioners certified in psychiatric mental health, or clinical nurse specialists certified in psychiatric mental health, who are credentialed with the Ohio Department of Medicaid.

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

NON-PREFERRED CRITERIA:
- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

ADDITIONAL DEXTROMETHORPHAN/BUPROPION (AUVELITY) CRITERIA
- Must have an inadequate clinical response of at least 30 days with **ALL** of the following:
  - ONE dopamine/norepinephrine reuptake inhibitor (DNRI)
  - ONE selective norepinephrine reuptake inhibitor (SNRI)
  - TWO selective serotonin reuptake inhibitors (SSRIs) (ONE of which must be either vilazodone (Viibryd) OR vortioxetine (Trintellix))

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

Central Nervous System (CNS) Agents: Attention Deficit Hyperactivity Disorder Agents

LENGTH OF AUTHORIZATIONS: 365 days

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

STEP THERAPY CRITERIA:

- Must have had an inadequate clinical response of at least 30 days with atomoxetine **OR** at least two preferred ~~stimulants~~ ADHD agents.

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days with at least three preferred drugs
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

ADDITIONAL INFORMATION

- Requests for non-preferred immediate-release formulations must have all required trials with preferred immediate-release drugs, and requests for non-preferred extended-release formulations must have all required trials with preferred extended-release drugs
- For patients established on drugs that change from preferred to non-preferred on January 1, a prior authorization is **NOT** required until **after** June 30th of that year.

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

AR – Adderall, Dexedrine, & Zenzedi IR: a PA is required for patients younger than 3 years
AR – Adderall XR, Atomoxetine, Cotempla XR-ODT, Daytrana, Dexedrine ER, Dexmethylphenidate, Methylphenidate IR & ER, & Xelstrym: a PA is required for patients younger than 6 years
AR – Dextroamphetamine Solution & Dyanavel XR: a PA is required for patients 12 years and older
AR – Methylphenidate solution/suspension: a PA is required for patients younger than 6 years and 12 years and older

Central Nervous System (CNS) Agents: Antipsychotics*

LENGTH OF AUTHORIZATIONS: 365 Days

GRANDFATHERING*:
Patients who have a claim for a non-preferred drug in the previous 120 days will be automatically approved to continue the drug. Patients who have taken the drug previously, but do not have claims history (e.g., new to Medicaid), will need to submit a prior authorization in order to continue coverage.

PSYCHIATRIST EXEMPTION:
Prescribers (as identified below) are exempt from prior authorization of any non-preferred second-generation antipsychotic, or step therapy of any preferred drug, in the standard tablet/capsule and long-acting injectable dosage forms. Other dosage forms may still require prior authorization. The exemption will be processed by the claims system when the pharmacy has submitted the prescriber on the claim using the individual national provider identifier (NPI) for the prescriber.

Prescribers are defined as:
Physicians with a specialty in psychiatry, nurse practitioners certified in psychiatric mental health, or clinical nurse specialists certified in psychiatric mental health, who are credentialed with the Ohio Department of Medicaid.

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

PALIPERIDONE PALMITATE (INVEGA HAFYERA) CRITERIA:
- Must have had 4 months of treatment with Invega Sustenna or 3 months with Invega Trinza

STEP THERAPY CRITERIA:
- Must have had an inadequate clinical response of at least 30 days with at least one preferred drug

NON-PREFERRED CRITERIA:
- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

ADDITIONAL ARIPIPRAZOLE (ABILIFY MYCITE) CRITERIA:

- Must be prescribed by or in consultation with a psychiatrist following an aripiprazole serum blood level draw indicating need for further investigation of adherence

ADDITIONAL OLANZAPINE/SAMIDORPHAN (LYBALVI) CRITERIA:

- Must provide documentation that patient is not using opioids or undergoing acute opioid withdrawal

ADDITIONAL PIMAVANSERIN (NUPLAZID) CRITERIA:

- For Parkinson-related Hallucinations & Delusions **ALL** of the following must be met:
  - Psychotic symptoms are severe and frequent enough to warrant treatment with an antipsychotic **AND** are not related to dementia or delirium
  - The patient's other Parkinson's Disease drugs have been reduced or adjusted and psychotic symptoms persist **OR** patient is unable to tolerate adjustment of these other drugs
  - Must have been inadequate clinical response or contraindication to at least 30 days of either quetiapine or clozapine
- An exemption to the criteria will be authorized for prescribers with a neurology specialty to a patient with a history of the related condition

ADDITIONAL FLUOXETINE/OLANZAPINE (SYMBYAX) CRITERIA

- Must provide documentation for patient's inability to use the individual drugs

ADDITIONAL INFORMATION

- Long-acting injectable antipsychotics may be billed by the pharmacy if they are not dispensed directly to the patient. If not administered by the pharmacist, the drug must be released only to the administering provider or administering provider's staff, following all regulations for a Prescription Pick-Up Station as described by the Ohio Board of Pharmacy

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

Central Nervous System (CNS) Agents: Fibromyalgia Agents

LENGTH OF AUTHORIZATIONS: 365 Days

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs in different classes (see Additional Information section below)
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

ADDITIONAL INFORMATION

- Drugs and drug classes include gabapentin, pregabalin, short- and/or long-acting opioids, skeletal muscle relaxants, SNRIs, SSRIs, trazodone, and tricyclic antidepressants
- The P&T Committee does not recommend the use of opioids for treatment of fibromyalgia

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

Central Nervous System (CNS) Agents: Medication Assisted Treatment of Opioid Addiction

LENGTH OF AUTHORIZATIONS: 180 days except 14 days for Lucemyra

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

ADDITIONAL LOFEXIDINE (LUCEMYRA) CRITERIA

- May be authorized if **ALL** of the following criteria are met:
    - Must provide medical justification supporting why an opioid taper (such as with buprenorphine or methadone) cannot be used
    - Must have had an inadequate clinical response or contraindication to clonidine
- Must provide documentation that the drug was initiated in an inpatient setting to be exempt from the above criteria

BUPRENORPHINE SAFETY EDITS AND DRUG UTILIZATION REVIEW CRITERIA:

- Prescribing for buprenorphine products must follow the requirements of Ohio Administrative Code rule 4731-33-03 *Office based treatment for opioid addiction*.
- In favor of eliminating prior authorization for all forms of oral short acting buprenorphine-containing products, ODM and the Managed Care Plans will implement safety edits and a retrospective drug utilization review process for all brand and generic forms of oral short acting buprenorphine-containing products. Safety edits are in place for dosages over 24mg of buprenorphine equivalents/day.
- Buprenorphine sublingual tablets (generic Subutex) will be restricted to pregnancy, breastfeeding, or contraindication to preferred products
- Buprenorphine injection (Sublocade) dosing schedule will be limited to 300mg/30 days

ADDITIONAL INFORMATION

- Vivitrol and Sublocade may be billed by the pharmacy if it is not dispensed directly to the patient. If not administered by the pharmacist, the drug must be released only to the administering provider or administering provider's staff, following all regulations for a Prescription Pick-Up Station as described by the Ohio Board of Pharmacy.

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

Central Nervous System (CNS) Agents: Movement Disorders

LENGTH OF AUTHORIZATIONS: 365 Days

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

CLINICAL PA CRITERIA:

- Must be prescribed by or in consultation with a neurologist or psychiatrist

STEP THERAPY CRITERIA:

- Must have an inadequate clinical response of at least 90 days to a maximally tolerated dose of tetrabenazine for Huntington's Disease only

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

Central Nervous System (CNS) Agents: Multiple Sclerosis*

LENGTH OF AUTHORIZATIONS: 365 Days

GRANDFATHERING*:
Patients who have a claim for a non-preferred drug in the previous 120 days will be automatically approved to continue the drug. Patients who have taken the drug previously, but do not have claims history (e.g., new to Medicaid), will need to submit a prior authorization in order to continue coverage.

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days with at least one preferred drug
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

ADDITIONAL SIPONIMOD (MAYZENT) CRITERIA:

- Must provide documentation of genotype, liver function tests (LFTS) complete blood count (CBC), ophthalmic examination, varicella zoster virus antibodies, and electrocardiogram (ECG)

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

Central Nervous System (CNS) Agents: Narcolepsy

LENGTH OF AUTHORIZATIONS: 365 days

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response ~~of at least 30 days~~ with at least two preferred drugs - either (1) at least 30 days of modafinil or armodafinil; or (2) at least 7 days of a preferred methylphenidate or amphetamine drug
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

ADDITIONAL OXYBATE SALTS (XYWAV) CRITERIA:

- Must have documented adherence to sodium restricted diet

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

AR – Adderall IR: a PA is required for patients younger than 3 years
AR – Adderall XR, Dexedrine ER: a PA is required for patients younger than 6 years
AR – Methylphenidate: a PA is required for patients younger than 6 years

Central Nervous System (CNS) Agents: Neuropathic Pain

LENGTH OF AUTHORIZATIONS: 365 Days

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

STEP THERAPY CRITERIA:

- Must have had an inadequate clinical response of at least 30 days with generic Lidocaine patch

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs in different drug classes
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

Central Nervous System (CNS) Agents: Parkinson's Agents

LENGTH OF AUTHORIZATIONS: 365 Days

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days with at least one preferred drug
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

ADDITIONAL APOMORPHINE (APOKIN/KYNMOBI), LEVODOPA INHALATION (INBRIJA), & ISTRADEFYLLINE (NOURIANZ) CRITERIA:

- Must have had inadequate clinical response to at least 30 days with one other drug for the treatment of "off episodes" (dopamine agonist, COMT inhibitor, or MAO-B inhibitor)

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

Central Nervous System (CNS) Agents: Restless Legs Syndrome

LENGTH OF AUTHORIZATIONS: 365 Days

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days with at least one preferred drug
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

Central Nervous System (CNS) Agents: Sedative-Hypnotics, Non-Barbiturate

LENGTH OF AUTHORIZATIONS: 180 Days

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 10 days with at least two preferred drugs
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

ADDITIONAL INFORMATION

- Non-controlled medications may be authorized if the prescriber indicates the patient has a history of addiction
- The P&T Committee does not recommend the use of flurazepam (Dalmane) or triazolam (Halcion)

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

Central Nervous System (CNS) Agents: Skeletal Muscle Relaxants, Non-Benzodiazepine

LENGTH OF AUTHORIZATIONS: 365 Days

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days with at least one preferred drug
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics, requests must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

ADDITIONAL BACLOFEN SOLUTION CRITERIA:

- Must provide documentation of trial with baclofen tablets or justification why a non-solid oral dosage form is indicated

ADDITIONAL CARISOPRODOL (SOMA) CRITERIA:

- Must provide medical justification that no other muscle relaxant or agent to treat fibromyalgia, or any musculoskeletal condition would serve the clinical needs of the patient

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

Central Nervous System (CNS) Agents: Smoking Deterrents

All products are covered without a PA

Dermatologic Agents: Oral Acne Products

LENGTH OF AUTHORIZATIONS: 150 days

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

CLINICAL PA CRITERIA:

- Must have had an inadequate clinical response of at least 90 days with at least one preferred topical **AND** one preferred oral antibiotic for acne
- Must be absent of oral tretinoin in the past 56 days
- ~~Patient must be~~ Prescriber attests that patient is registered and meets all of the requirements of the iPLEDGE program

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 90 days with at least two preferred drugs
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

ADDITIONAL INFORMATION

- Authorization length will be for no more than 150 days at a time then must take 56 days off

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

Dermatologic Agents: Topical Acne Products

LENGTH OF AUTHORIZATIONS: 365 Days

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days or (90 days for retinoids) of at least three preferred drugs
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

ADDITIONAL TRETINOIN/BENZOYL PEROXIDE (TWYNEO) CRITERIA

- Must provide documentation for patient's inability to use the individual drugs

ADDITIONAL INFORMATION

- All retinoids - May be authorized with a diagnosis of skin cancer
- Tazarotene (Tazorac) - May be authorized with a diagnosis of psoriasis

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

AR - All topical retinoids: a PA is required for patients 24 years and older

Endocrine Agents: Androgens

LENGTH OF AUTHORIZATIONS: 365 Days

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

CLINICAL PA CRITERIA:

- Must provide documentation of lab work to support the need for testosterone supplementation

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 90 days with **ALL** preferred drugs
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring (i.e., testosterone and hematocrit)

AR: All drugs: a PA is required for patients younger than 18 years

Endocrine Agents: Diabetes – Hypoglycemia Treatments

LENGTH OF AUTHORIZATIONS: 365 Days

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least ~~two~~ one preferred drug~~s~~ **OR** the inability of the member and/or caregiver to administer a preferred glucagon product in a timely fashion
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

QL – All glucagon products: 2 doses per 34 days

Endocrine Agents: Diabetes – Insulin

LENGTH OF AUTHORIZATIONS: 365 Days

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

STEP THERAPY CRITERIA:

- Must have had an inadequate clinical response of at least 120 days with at least one preferred drug having a similar duration of action

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 120 days with at least two preferred drugs having a similar duration of action
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

ADDITIONAL TEMPO PEN CRITERIA

- Must have had an inadequate clinical response or documentation of medical necessity beyond convenience for why the patient cannot use the corresponding FlexPens or Kwikpens

ADDITIONAL INHALED INSULIN (AFREZZA) CRITERIA:

- Must provide documentation of spirometry testing prior to initiation with a predicted FEV1 ≥70% - Will not be authorized for patients with asthma or COPD
- Must provide documentation of being nicotine-free for at least 180 days

ADDITIONAL INFORMATION

- An inadequate clinical response is defined as the inability to reach A1C goal after at least 120 days of current regimen with documented adherence and appropriate dose escalation.
- Requests may be authorized for patients with a condition that is difficult to control (i.e., prone to ketoacidosis, hypoglycemia)

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

Endocrine Agents: Diabetes – Non-Insulin

LENGTH OF AUTHORIZATIONS: 365 Days

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
  - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 120 days with at least three preferred drugs
  - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
  - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

ADDITIONAL ORAL AND INJECTABLE COMBINATION DRUGS CRITERIA

- Must have had a trial of at least 120 days with the individual drugs **OR** must provide documentation of medical necessity beyond convenience for patient's inability to use the individual drugs

ADDITIONAL INFORMATION

- An inadequate clinical response is defined as the inability to reach A1c goal after at least 120 days of current regimen, with use of multiple drugs concomitantly per ADA guidelines, documented adherence, and appropriate dose escalation (must achieve maximum recommended dose or document that maximum recommended dose is not tolerated or is clinically inappropriate).
  - Must document A1c goal per ADA guidelines and baseline A1c.
- ~~Requests may be authorized for patients with a condition that is difficult to control (i.e., prone to ketoacidosis, hypoglycemia)~~
- For non-preferred drugs that have preferred drugs in the same drug class: must provide documentation that there was at least one inadequate clinical response with a drug in same drug class

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring
  - Must document A1c goal per ADA guidelines and A1c trends including current value (within last 6 months).
- Must meet all initial clinical criteria for subsequent authorizations.

Endocrine Agents: Endometriosis

LENGTH OF AUTHORIZATIONS: 365 Days

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

STEP THERAPY CRITERIA:

- Must have had an inadequate clinical response of at least 84 days with at least one preferred NSAID and one ~~preferred~~ oral contraceptive

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 84 days with at least one preferred NSAID, one preferred oral contraceptive, **AND** one preferred step-therapy drug
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

Endocrine Agents: Estrogenic Agents

LENGTH OF AUTHORIZATIONS: 365 Days

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

ADDITIONAL INFORMATION:

- Requests for non-preferred drugs must have an inadequate clinical response with preferred drugs with the same delivery method

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

Endocrine Agents: Growth Hormone

LENGTH OF AUTHORIZATIONS: Initial: 180 days; Subsequent: 365 days

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

CLINICAL PA CRITERIA:

Pediatric Approvals (under 18 years of age):

- Must be treated and followed by a pediatric endocrinologist, nephrologist, clinical geneticist, endocrinologist, or gastroenterologist (or as appropriate for diagnosis)
- Must provide documentation to justify criteria being met, including height, weight, bone age (children), date and results of most current x-ray, stimulus test results, IGF-1 levels, and a growth chart (children)
- Must not being used in combination with another somatropin agent

Adult Approvals (18 years of age or older):

- Must be treated and following by an endocrinologist
- Must provide documentation of growth hormone deficiency by means of a negative response to an appropriate stimulation test (clonidine test is not acceptable for adults)
- Must provide documentation of baseline evaluation of the following clinical indicators: (1) insulin-like growth factor (IGF-1); (2) fasting lipid profile; (3) BUN; (4) fasting glucose; (5) electrolytic levels; (6) evaluation of any new osteoarthritis and joint pain; (7) bone density test
- Must have had other hormonal deficiencies addressed with adequate replacement therapy

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 90 days with at least one preferred drug
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring (i.e., height, weight gain, improved body composition)

For adults: must provide documentation by endocrinologist that discontinuing agent would have a detrimental effect on body composition or other metabolic parameters

Endocrine Agents: Osteoporosis – Bone Ossification Enhancers

LENGTH OF AUTHORIZATIONS: 365 Days

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 365 days with at least one preferred drug within the same class
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

ADDITIONAL ABALOPARATIDE (TYMLOS™) CRITERIA:

- Must have had an inadequate clinical response of at least 365 days with one bisphosphonate
- A total lifetime duration of therapy of 730 days will be authorized between any parathyroid analog

ADDITIONAL INFORMATION

- Patients should only be on ONE of the therapeutic classes (bisphosphonates, calcitonin-salmon)

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

Endocrine Agents: Progestin Agents

All products are covered without a PA

Endocrine Agents: Uterine Fibroids

LENGTH OF AUTHORIZATIONS: Up to 180 Days

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

CLINICAL PA CRITERIA:

- Must have had an inadequate clinical response of at least 90 days with at least one ~~preferred~~ oral contraceptive

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 90 days with at least one preferred drug
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

ADDITIONAL INFORMATION:

- A total lifetime duration of therapy of 730 days between Oriahnn and Myfembree or 180 days for Lupron Depot will be authorized

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

Gastrointestinal Agents: Anti-Emetics

LENGTH OF AUTHORIZATIONS: 365 Days

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least ~~7~~ 3 days with at least one preferred drug
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

Gastrointestinal Agents: Bowel Preparations

LENGTH OF AUTHORIZATIONS: 365 Days

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any solid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a non-solid oral dosage formulation
- Must have had an inadequate clinical response with at least one preferred drug
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

Gastrointestinal Agents: Crohn's Disease

LENGTH OF AUTHORIZATIONS: 365 Days; Ortikos ER – based on indication

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

Gastrointestinal Agents: Hepatic Encephalopathy

LENGTH OF AUTHORIZATIONS: 365 Days

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

STEP THERAPY CRITERIA:

- Must have had an inadequate clinical response of at least 14 days with at least one preferred drug

RIFAXAMIN (XIFAXAN) CRITERIA:

- Must have had an inadequate clinical response of at least 14 days to lactulose to be authorized for monotherapy or add on therapy

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

Gastrointestinal Agents: Irritable Bowel Syndrome (IBS) with Diarrhea

LENGTH OF AUTHORIZATIONS: 365 Days

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

STEP THERAPY CRITERIA:

- Must have had an inadequate clinical response of at least 30 days with at least one preferred drug

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

Gastrointestinal Agents: Pancreatic Enzymes

LENGTH OF AUTHORIZATIONS: 365 Days

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 14 days with at least one preferred drug
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

Gastrointestinal Agents: Proton Pump Inhibitors

LENGTH OF AUTHORIZATIONS: 180 days, except as listed under additional criteria

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

ADDITIONAL CRITERIA FOR PPI DOSES GREATER THAN ONCE DAILY

- For H. Pylori diagnosis: Must provide documentation of diagnosis
    - Authorization length: 30 days
- For any of the following diagnoses: carcinoma of GI tract, COPD, Crest Syndrome, dyspepsia, esophageal varices, gastritis, gastroparesis, scleroderma, symptomatic uncomplicated Barret's Esophagus, systemic mastocytosis, or Zollinger Ellison Syndrome: Must provide documentation of diagnosis **AND** must have failed once-daily dosing of the requested drug
    - Authorization length: 365 days

ADDITIONAL INFORMATION

- Request may be authorized If the drug was initiated in the hospital for the treatment of a condition such as a GI bleed or the presence of a gastrostomy and/or jejunostomy (G, GJ, J-tube)

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

AR - Protonix Pak/Pantoprazole Packet: a PA is required for patients 6 years and older
AR – Omeprazole & Pantoprazole Tab/Cap/ODT: a PA is required for patient 21 years and older requesting more than once daily dosing

Gastrointestinal Agents: Ulcerative Colitis

LENGTH OF AUTHORIZATIONS: 365 Days; except Uceris foam – based on indication

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

QL – Budesonide ER 9mg tablets: 56 tablets per 90 days

Gastrointestinal Agents: Unspecified GI

LENGTH OF AUTHORIZATIONS: 365 days except 3 days for Aemcolo

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

STEP THERAPY CRITERIA:

- Must have had an inadequate clinical response to at least 14 days with at least two preferred drugs

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 14 days with at least three preferred drugs, if indicated for diagnosis
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

ADDITIONAL METHYLNALTREXONE (RELISTOR) AND NALDEMEDINE (SYMPROIC) CRITERIA:

- Must have a history of chronic pain requiring continuous opioid therapy for ≥84 days

ADDITIONAL RIFAMYCIN DELAYED-RELEASE (AEMCOLO) CRITERIA:

Must have the inability to take, or failure of **ALL** of the following: a

ADDITIONAL SOMATROPIN INJECTION (ZORBTIVE) AND TEDLOGLUTIDE (GATTEX) CRITERIA:

- Must have evidence of specialized parenteral nutritional support
- Must have documentation of appropriate lab assessment (bilirubin, alkaline phosphatase, lipase, and amylase) at least 180 days prior to initiation

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring (i.e., decreased frequency of specialized nutrition support or improvement in symptoms)

Genitourinary Agents: Benign Prostatic Hyperplasia

LENGTH OF AUTHORIZATIONS: 365 Days

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

TADALAFIL (CIALIS) CRITERIA:

- Must have had an inadequate clinical response of at least 30 days with at least one alpha-1 adrenergic blocker. ~~and~~ If prostate volume of > 30cc on imaging, a prostate specific antigen (PSA) > 1.5ng/dL, or palpable prostate enlargement on digital rectal exam (DRE), then a trial of at least 90 days of finasteride is required."

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

ADDITIONAL DUTASTERIDE/TAMSULOSIN (JALYN) & FINASTERIDE/TADALAFIL (ENTADFI) CRITERIA

- Must provide documentation for patient's inability to use the individual drugs

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

Genitourinary Agents: Electrolyte Depleter Agents

LENGTH OF AUTHORIZATIONS: 365 Days

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 7 days with at least two preferred drugs
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

Genitourinary Agents: Urinary Antispasmodics

LENGTH OF AUTHORIZATIONS: 365 Days

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs with different active ingredients
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

AR – Vesicare LS: a PA is required for patients younger than 2 years old AND 5 years and older
AR – Myrbetriq Granules: a PA is required for patients younger than 3 years old AND 5 years and older

Immunomodulator Agents: Systemic Inflammatory Disease

LENGTH OF AUTHORIZATIONS: Initial: 90 days; Subsequent: 365 days

ALL AUTHORIZATIONS:

- Must be prescribed in accordance with FDA approved labeling
- First line treatment can vary based upon the severity of disease for certain diagnoses. Documentation of the patient's disease state and the criteria used to classify the severity is required.

CLINICAL PA CRITERIA:

- Must have been an inadequate clinical response of at least 90 days with at least two applicable first-line drugs indicated for diagnosis – provide documentation of the trialed drugs, dosages, dates, and durations
- Authorization of dosing regimens (loading/maintenance) will be based upon diagnosis. Document the requested loading and maintenance dosing on PA form, if applicable
- Must not have a current, active infection
- Must provide evidence of negative TB test prior to initiation of biologic therapy, if required by labeling

STEP THERAPY CRITERIA:

- Must had had an inadequate clinical response of at least 90 days with at least one preferred TNF inhibitor indicated for diagnosis

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 90 days with at least two preferred drugs, if indicated for diagnosis
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

ADDITIONAL ALOPECIA AREATA CRITERIA:

- Must be prescribed by or in consultation with a specialist (i.e., dermatologist, rheumatologist)
- Must provide documentation of an inadequate clinical response of at least 90 days with a topical steroid

ADDITIONAL ATOPIC DERMATITIS CRITERIA:

- Must have at least 10% body surface area (BSA) involvement with two of the following: topical corticosteroids or topical calcineurin inhibitors [e.g., Elidel] unless atopic dermatitis is severe and involves >25% BSA

ADDITIONAL CROHN'S DISEASE CRITERIA:

- Must provide documentation of Crohn's Disease Activity Index (CDAI) score of 220 or higher to be considered moderate to severe disease

ADDITIONAL HIDRADENTIS SUPPURATIVA CRITERIA:

- Must provide documentation of Hurley Stage III to be classified as severe disease

ADDITIONAL PLAQUE PSORIASIS CRITERIA:

- For patients currently receiving phototherapy, initial authorization for preferred drugs requires an inadequate clinical response to at least 90 days of phototherapy
- To classify as severe disease patient must present at least two of the following: Psoriasis Area and Severity Index (PASI) score ≥ 11, BSA ≥ 10%, and Static Physician's Global Assessment (sPGA) ≥ 3

ADDITIONAL ULCERATIVE COLITIS CRITERIA:

- If an inadequate clinical response after 90 days with one TNF inhibitor, further TNF inhibitors will not be authorized

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

Infectious Disease Agents: Antibiotics – Cephalosporins

LENGTH OF AUTHORIZATIONS: Based on indication

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 3 days with at least one preferred antibiotic
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

ADDITIONAL INFORMATION

- Requests may be authorized if:
    - The infection is caused by an organism resistant to **ALL** preferred antibiotics (must provide diagnosis and any culture/sensitivity results)
    - The patient is completing a course of therapy that was started in the hospital or other similar location or was started before Medicaid eligibility, only the remaining course will be authorized

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment, ongoing safety monitoring, **AND** medical necessity for continued use

AR - Cefaclor Suspension: a PA is required for patients 12 years and older
AR - Cefixime Suspension: a PA is required for patients 12 years and older
AR - Cefprozil Suspension: a PA is required for patients 12 years and older
AR - Suprax Chewable Tablet: a PA is required for patients 12 years and older

Infectious Disease Agents: Antibiotics – Inhaled

LENGTH OF AUTHORIZATIONS: Initial: 180 days; Subsequent: 365 days

ALL REQUESTS: Must be prescribed in accordance with FDA approved labeling

CLINICAL PA CRITERIA:

- Must provide documentation of cultures demonstrating drug is prescribed in alignment with approved indication

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 28 days with at least one preferred drug
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring (i.e., culture conversion, symptom improvement)

QL – Tobramycin drugs: 56 doses in 56 days

Infectious Disease Agents: Antibiotics – Macrolides

LENGTH OF AUTHORIZATIONS: Based on indication

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 3 days with at least one preferred drug
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

ADDITIONAL INFORMATION

- Requests may be authorized if:
    - The infection is caused by an organism resistant to **ALL** preferred antibiotics (must provide diagnosis and any culture/sensitivity results)
    - The patient is completing a course of therapy that was started in the hospital or other similar location or was started before Medicaid eligibility, only the remaining course will be authorized

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment, ongoing safety monitoring, **AND** medical necessity for continued use

Infectious Disease Agents: Antibiotics – Quinolones

LENGTH OF AUTHORIZATIONS: Based on indication

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 3 days with at least one preferred drug
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

ADDITIONAL INFORMATION

- Requests may be authorized if:
    - The infection is caused by an organism resistant to **ALL** preferred antibiotics (must provide diagnosis and any culture/sensitivity results)
    - The patient is completing a course of therapy that was started in the hospital or other similar location or was started before Medicaid eligibility, only the remaining course will be authorized

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment, ongoing safety monitoring, **AND** medical necessity for continued use

AR - Ciprofloxacin Suspension: a PA is required for patients 12 years and older

Infectious Disease Agents: Antibiotics – Tetracyclines

LENGTH OF AUTHORIZATIONS: Based on indication for acute infections or 365 days for acne

ALL REQUESTS: Must be prescribed in accordance with FDA approved labeling

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 3 days with at least one preferred drug for acute infections **OR** at least 90 days with at least one preferred oral drug for acne
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

ADDITIONAL INFORMATION

- Requests may be authorized if:
    - The infection is caused by an organism resistant to **ALL** preferred antibiotics (must provide diagnosis and any culture/sensitivity results)
    - The patient is completing a course of therapy that was started in the hospital or other similar location or was started before Medicaid eligibility, only the remaining course will be authorized

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment, ongoing safety monitoring, **AND** medical necessity for continued use

AR – Vibramycin Suspension: a PA is required for patients 12 years and older
AR – Doxycycline Syrup: a PA is required for patients 12 years and older

Infectious Disease Agents: Antifungals

LENGTH OF AUTHORIZATIONS: Based on indication

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 7 days with at least ~~one~~ two preferred drugs, if indicated for the diagnosis
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

ADDITIONAL OTESECONAZOLE (VIVJOA) CRITERIA:

- Must provide documentation of at least three symptomatic episodes of vulvovaginal candidiasis in the past 12 months
- Must provide documentation of non-reproductive potential (i.e., post-menopausal)
- Must have had an inadequate clinical response of at least 180 day maintenance course with oral fluconazole shown by documentation of more than one breakthrough infection

ADDITIONAL INFORMATION:

- Requests may be authorized if:
    - The infection is caused by an organism resistant to **ALL** preferred antifungals (must provide diagnosis and any culture/sensitivity results)
    - The patient is completing a course of therapy that was started in the hospital or other similar location or was started before Medicaid eligibility, only the remaining course will be authorized

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment, ongoing safety monitoring, **AND** medical necessity for continued use

Infectious Disease Agents: Antivirals – Hepatitis C Agents

LENGTH OF AUTHORIZATIONS: Dependent upon authorized course

ALL REQUESTS: Must be prescribed in accordance with FDA approved labeling

CLINICAL PA CRITERIA:

- Only regimens recommended by the American Association for the Study of Liver Diseases (AASLD) will be authorized
- Please see the Hepatitis C Direct Acting Antiviral Prior Authorization Form for criteria

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response defined as not achieving SVR with guideline-recommended preferred drugs
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

ADDITIONAL INFORMATION:

- Requests for patients established on current therapy with prior payer (i.e., Commercial, Fee-for-Service, Managed Care Plan, etc) will be authorized with documentation
- Requests for regimens including pegylated Interferons must include close monitoring with periodic clinical and laboratory evaluations
- Requests for regimens including ribavirins must include documentation of at least two reliable forms of contraception being used during therapy

Infectious Disease Agents: Antivirals – Herpes

LENGTH OF AUTHORIZATIONS: For the duration of the prescription (up to 180 days)

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 3 days with at least one preferred drug
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

Infectious Disease Agents: Antivirals – HIV*

LENGTH OF AUTHORIZATIONS: 365 Days

GRANDFATHERING*:
Patients who have a claim for a non-preferred drug in the previous 120 days will be automatically approved to continue the drug. Patients who have taken the drug previously, but do not have claims history (e.g., new to Medicaid), will need to submit a prior authorization in order to continue coverage.

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

ABACAVIR/DOLUTEGRAVIR/LAMIVUDINE (TRIUMEQ PD) CRITERIA:

- Must provide documentation of patient's weight (only authorized for those 10 – 25 kg)

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days with at least one preferred drug. If applicable, the request must address the inability to use the individual components.
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

AR – Isentress chewable tablet: a PA is required for patients 12 years and older
AR – Lamivudine solution: a PA is required for patients 3 years and older
AR – Nevirapine solution: a PA is required for patients 3 years and older

Ophthalmic Agents: Antibiotic and Antibiotic-Steroid Combination Drops and Ointments

LENGTH OF AUTHORIZATIONS: 30 days

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 3 days with at least two preferred drugs
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

ADDITIONAL INFORMATION

- Requests may be authorized if:
    - The infection is caused by an organism resistant to **ALL** preferred antibiotics (must provide diagnosis and any culture/sensitivity results)
    - The patient is completing a course of therapy that was started in the hospital or other similar location or was started before Medicaid eligibility, only the remaining course will be authorized

Ophthalmic Agents: Antihistamines & Mast Cell Stabilizers

LENGTH OF AUTHORIZATIONS: 365 Days

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

Ophthalmic Agents: Dry Eye Treatments

LENGTH OF AUTHORIZATIONS: 14 Days for Eysuvis; 365 Days for all other drugs

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

STEP THERAPY CRITERIA:

- Must have had an inadequate clinical response of at least 14 days with one artificial tear or OTC dry eye drop in the previous 120 days

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 14 days with at least one preferred drug
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

Ophthalmic Agents: Glaucoma Agents

LENGTH OF AUTHORIZATIONS: 365 Days

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

STEP THERAPY CRITERIA:

- Must have had an inadequate clinical response of at least 30 days with at least one preferred drug in the same class, if available

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs in the same class, if available
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

Ophthalmic Agents: NSAIDs

LENGTH OF AUTHORIZATIONS: 30 days

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 3 days with at least one preferred drug
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

Ophthalmic Agents: Ophthalmic Steroids

LENGTH OF AUTHORIZATIONS: 30 days

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

Otic Agents: Antibacterial and Antibacterial/Steroid Combinations

LENGTH OF AUTHORIZATIONS: 30 days

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 7 days with at least one preferred drug
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

Respiratory Agents: Antihistamines – Second Generation

LENGTH OF AUTHORIZATIONS: 365 Days

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days with at least two different preferred drugs
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

AR – Cetirizine Chewables: a PA is required for patients 6 years and older

Respiratory Agents: Cystic Fibrosis

LENGTH OF AUTHORIZATIONS: Initial: 90 days; Subsequent: 365 days

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

CLINICAL PA CRITERIA:

- Must be prescribed by or in consultation with a pulmonologist or infectious disease specialist
- Must provide documentation of the genetic mutation

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days with at least one preferred drug
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

ADDITIONAL BRONCHITOL CRITERIA:

- Must be used as an add-on maintenance therapy
- Must provide documentation of a completed Bronchitol Tolerance Test

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment (adherence to treatment demonstrated by claims history **AND** one or more of the following: FEV1, weight gain, sweat chloride, pulmonary exacerbations, etc.) and ongoing safety monitoring

AR – Trikafta Pak: a PA is required for patients 6 years and older

Respiratory Agents: Epinephrine Auto-Injectors

LENGTH OF AUTHORIZATIONS: 365 Days

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response to at least one preferred drug
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

Respiratory Agents: Hereditary Angioedema

LENGTH OF AUTHORIZATIONS: Initial: 90 days; Subsequent: 180 Days

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

CLINICAL PA CRITERIA:

- Must provide documentation of diagnosis (i.e., C1-INH deficiency or dysfunction (Type I or II HAE)) and whether the drug will be used for prophylaxis or treatment
- Must provide documentation of at-home administration

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 60 days with at least one preferred drug
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

Respiratory Agents: Inhaled Agents

LENGTH OF AUTHORIZATIONS: 365 Days

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs within the same class and duration of action
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

ADDITIONAL STEROID-CONTAINING INHALER CRITERIA

- May be authorized if documentation of one of the following is provided:
    - Patient is 12 years or younger OR is disabled and is unable to use a preferred inhaler
    - Patient has been non-compliant on a preferred inhaler due to taste, dry mouth, or infection
    - Patient is clinically unstable, as defined by current guidelines in terms of oral steroid use or patient's current symptomatology

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

AR - Albuterol Nebulizer Solution 0.021% (0.63mg/3mL), 0.042% (1.25mg/3mL): a PA is required for patients 13 years and older
AR - Budesonide Nebulizer Solution: a PA is required for patients 7 years and older

Respiratory Agents: Leukotriene Receptor Modifiers & Inhibitors

LENGTH OF AUTHORIZATIONS: 365 Days

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

STEP THERAPY CRITERIA:

- Must have had an inadequate clinical response of at least 90 days with at least one preferred drug

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 90 days with at least two preferred drugs
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

Respiratory Agents: Monoclonal Antibodies-Anti-IL/Anti-IgE

LENGTH OF AUTHORIZATIONS: Initial: 180 days; Subsequent: 365 days

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

CLINICAL PA CRITERIA:

- Must be prescribed by or in consultation with an applicable specialist (i.e., allergist/ immunologist, pulmonologist, or otolaryngologist)
- For **Asthma** – Must have had uncontrolled asthma symptoms and/or exacerbations despite at least 30 days with:
    - Medium dose preferred ICS/LABA inhaler for 6 years and older **OR** medium dose preferred ICS/LABA inhaler with tiotropium or high dose ICS/LABA inhaler if 12 years and older
- For **Chronic Rhinosinusitis with Nasal Polyposis** – Must have had an inadequate clinical response of at least 30 days to at least one oral corticosteroid AND one nasal corticosteroid spray
- For **Chronic Urticaria** – Must have had an inadequate clinical response to at least 14 days with at least two different antihistamines

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 90 days with at least one preferred drug
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics, requests must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring (i.e., PFT improvement, reduced affected BSA)

Respiratory Agents: Nasal Preparations

LENGTH OF AUTHORIZATIONS: 365 days

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs in the same class, if available
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

Respiratory Agents: Other Agents

LENGTH OF AUTHORIZATIONS: Initial: 90 days; Subsequent: 180 days

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 90 days with at least one preferred long-acting beta agonist **AND** one preferred long-acting muscarinic antagonist-containing inhalers
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

ADDITIONAL ROFLUMILAST (DALIRESP) CRITERIA:

- Must be used in addition to a long-acting beta agonist **AND** a long-acting muscarinic antagonist-containing inhalers

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment, adherence to maintenance inhaler per pharmacy claims, and ongoing safety monitoring

Topical Agents: Antifungals

LENGTH OF AUTHORIZATIONS: Up to 180 days for all agents except 365 days for Jublia

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs, if indicated for diagnosis
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

ADDITIONAL EFINACONAZOLE (JUBLIA) CRITERIA:

- Must have had an inadequate clinical response of at least 365 days with at least one preferred topical drug **AND** at least 84 days with at least one preferred oral drug indicated for diagnosis

ADDITIONAL INFORMATION

- Requests may be authorized if:
    - The infection is caused by an organism resistant to preferred antibiotics drugs (note diagnosis and any culture/sensitivity results)

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

Topical Agents: Antiparasitics

LENGTH OF AUTHORIZATIONS: 14 Days

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 14 days with at least one preferred drug
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

Topical Agents: Corticosteroids

LENGTH OF AUTHORIZATIONS: 365 days for low/med potency; 90 days for high/very high potency

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

Topical Agents: Immunomodulators

LENGTH OF AUTHORIZATIONS: 365 Days

ALL AUTHORIZATIONS: Must be prescribed in accordance with FDA approved labeling

STEP THERAPY CRITERIA:

- Must have had an inadequate clinical response of at least 30 days with at least two topical corticosteroids

NON-PREFERRED CRITERIA:

- Must provide documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances) **OR**
    - For any nonsolid oral dosage formulation: must provide documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
- Must have had an inadequate clinical response of at least 30 days with at least one preferred drug
    - For non-preferred extended-release formulations: must provide documentation of an inadequate clinical response with its immediate release formulation (if available)
    - For non-preferred brand names that have preferred generics: must provide documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

SUBSEQUENT AUTHORIZATION CRITERIA:

- Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

AR - pimecrolimus and tacrolimus: a PA is required for patients younger than 2 years old