Ohio Medicaid

Pharmacy Benefit Management Program

Unified Preferred Drug List

Medicaid Fee-for-Service and Managed Care Plans

Effective January 1, 2026

Helpful Links

Prior Authorization (PA)

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

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

General Information

- The Statewide UPDL is not an all-inclusive list of drugs covered by the Ohio Department of Medicaid (ODM). ALL authorizations must be prescribed in accordance with FDA approved labeling or listed on a CMS-supported compendia. UPDL drugs without disease-specific criteria and Non UPDL drugs receive PA in accordance with the Gainwell SPBM medical necessity policy as posted on the Gainwell SPBM website. Drug Coverage- ODM
- Medications that are new to the market will be non-preferred, PA required, until reviewed by the ODM Pharmacy and Therapeutics (P&T) Committee.
- The UPDL document is organized by therapeutic class. Brand name drugs are listed in CAPITAL letters; generic drug names are listed in lower case letters. In most cases, when a generic of a brand-name drug is available, the generic drug will be preferred and appear on the UPDL while the brand name will be non-preferred but not appear on the UPDL. The Drug Search tool is a handy reference to check the status of a drug. Some generic drugs may require a specific labeler, or the brand to be dispensed.
- ODM 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 deemed 'legacy' categories. These categories are denoted with an "*" and LEGACY CATEGORY listed next to their title on the table on contents and their place within the criteria document. Legacy is defined as: Patients who have a claim for a drug needing PA 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 to continue coverage.

- For ALL authorizations, there must be a trial and failure of preferred strengths prior to authorization of non-preferred strengths (if available).
- For ALL non-preferred authorizations, there must be documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug form (i.e., allergies, drug-drug interactions, contraindications, or intolerances). Must have had an inadequate clinical response of preferred individual components for any combination non-preferred product.
- For any nonsolid oral dosage formulation, there must be documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation (if available).
- For non-preferred extended-release formulations, there must be documentation of an inadequate clinical response with its immediate release formulation (if available).
- For non-preferred brand names that have preferred generics, there must be documentation of an inadequate clinical response or allergy to two or more generic labelers (if available).
- For ALL subsequent authorizations, there must be documentation of patient's clinical response to treatment and ongoing safety monitoring unless otherwise stated.
- Some therapeutic categories have sub-sections to divide the medications by their mechanism of action, route of administration, or duration of action. References to 'sub-section' in the Clinical Criteria shall be defined as the separate groupings that appear in that category's drug placement columns.
- Some therapeutic categories may have quantity limits on specific drugs. For a list of the quantity limits on specific drugs, please reference the Quantity Limit Document found here: Quantity Limits Document | spbm.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) – PA is required before the drug will be covered

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

UPDL Format

- With a few exceptions, the clinical criteria have a cumulative top-to-bottom format.

Example Category		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
Example Drug	Example Drug	**LENGTH OF AUTHORIZATIONS:** X days or Initial: X days; Subsequent: X days (if different) **LEGACY*:** 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. **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 have had an inadequate clinical response of at least X days with X preferred drugs **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

		AR – a PA is required for patients X years and older OR younger than X years

Interpretation of UPDL

Glossary of key Phrases:

- "of at least 120 days with at least three preferred drugs"
  - Defines the number of days of the trial period and the number of preferred drugs for the trial period
  - Each drug must be used for 120 days (or have a medical reason the patient could not take 120 days of therapy). It is acceptable for multiple drugs to be used concurrently for 120 days
- "in this UPDL category"
  - all drugs that live in the category irrespective of sub-sections
- "indicated for diagnosis"
  - all drugs must be prescribed in accordance with their FDA approved labeling or listed on a CMS-supported compendia.
  - Non-Preferred drugs that have no Preferred drugs with the same indication are exempt from the criteria
- "in this UPDL category within the same sub-section classification"
  - all drugs that live in the subsection of the category
- "if available"
  - Non-Preferred drugs that must have a trial of multiple preferred drugs in same sub-section but only one preferred drug exists in the sub-section **OR** for drugs on backorder, limited supply are not available

- The UPDL criteria is designed to have a cumulative approach from top-to-bottom. 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 AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
allopurinol 100, 300mg colchicine tab febuxostat MITIGARE [BvG] probenecid probenecid/colchicine	allopurinol 200mg colchicine cap	**LENGTH OF AUTHORIZATIONS:** 365 days **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least one preferred drug in this UPDL category and indicated for diagnosis

Analgesic Agents: NSAIDS		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
celecoxib diclofenac sodium DR, ER, gel 1% etodolac IR, ER flurbiprofen ibuprofen indomethacin IR, ER cap ketorolac mefenamic acid meloxicam tab nabumetone naproxen IR naproxen susp [AR] oxaprozin piroxicam sulindac	diclofenac/misoprostol diclofenac patch 1.3%; soln 1.5%, 2% diclofenac potassium ELYXYB fenoprofen ibuprofen/famotidine indomethacin supp, susp ketoprofen IR, ER meclofenamate meloxicam cap naproxen EC, ER naproxen/esomeprazole RELAFEN DS	**LENGTH OF AUTHORIZATIONS:** 365 days **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs in this UPDL category and indicated for diagnosis **AR** – naproxen susp: a PA is required for patients 12 years old and older

Analgesic Agents: Opioids		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
SHORT-ACTING		
APAP/codeine [AR] but/APAP/caff/cod [AR] 50/325/40/30mg but/ASA/caff/cod [AR] butorphanol codeine [AR] hydrocodone/APAP 2.5, 5, 7.5, 10-325mg hydromorphone IR morphine IR oxycodone IR cap, soln, tab oxycodone/APAP tramadol IR [AR] 50mg tramadol/APAP [AR]	APAP/caffeine/ dihydrocodeine but/APAP/caff/cod [AR] 50/300/40/30mg fentanyl buccal tab, inj, lozenge hydrocodone/APAP 5, 7.5, 10-300mg hydrocodone/ibuprofen levorphanol meperidine oxymorphone IR pentazocine/naloxone PROLATE ROXYBOND tramadol IR [AR] soln, 25, 75, 100mg tab	***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:** Initial short-acting and long-acting requests may only be authorized for up to 90 days. For reauthorization, up to 180 days. **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 30 of the last 60 days **FENTANYL PATCH AND MORPHINE SULFATE ER (MS CONTIN) 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 30 of the last 60 days • Must also meet LONG-ACTING OPIOID CRITERIA **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 7 days of at least two preferred drugs with different active ingredients of the same duration of action (SHORT-ACTING or LONG-ACTING) • Must also meet applicable SHORT-ACTING or LONG-ACTING OPIOID CRITERIA **ADDITIONAL SHORT-ACTING OPIOIDS CRITERIA:**
LONG-ACTING		
BUTRANS [BvG PA] fentanyl patch [PA] morphine ER tab [PA]	BELBUCA buprenorphine TD patch weekly hydrocodone bitartrate ER 12HR cap hydrocodone bitartrate ER 24HR tab hydromorphone ER methadone morphine ER 24HR cap oxycodone ER oxymorphone ER tramadol ER [AR]	

		• 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 screening results reviewed, concerns addressed, and no serious adverse outcomes observed
		  ○ Exemptions to the additional criteria:
		  ▪ Patients receiving short-acting opioids for cancer pain, palliative care, or end-of-life/hospice care

- Patients residing in LTC facilities are exempted from urine drug screening requirements

- **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 ≥ 30 of the last 60 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 o Exemptions to the additional criteria: ▪ Patients receiving long-acting opioids for cancer pain, palliative care, or end-of-life/hospice care ▪ Patients residing in LTC facilities are exempted from urine drug screening and opioid contract requirements • **Subsequent long-acting requests** can be authorized up to 180 days o 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 screening results reviewed, concerns addressed, and no serious adverse outcomes observed o Exemptions to the additional criteria: ▪ Patients receiving long-acting opioids for cancer pain, palliative care, or end-of-life/hospice care ▪ Patients residing in LTC facilities are exempted from urine drug screening and opioid contract requirements • **Dose escalation requests** can be authorized up to 180 days o 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

AR – All codeine and tramadol containing products: a PA is required for patients younger than 12 years old

Blood Formation, Coagulation, and Thrombosis Agents: Colony Stimulating Factors		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
FULPHILA [PA] NEUPOGEN [PA] NIVESTYM [PA] NYVEPRIA [PA]	FYLNETRA GRANIX LEUKINE NEULASTA RELEUKO ROLVEDON RYZNEUTA STIMUFEND UDENYCA ZARXIO ZIEXTENZO	**LENGTH OF AUTHORIZATIONS**: 30 days or duration of chemotherapy regimen **CLINICAL PA CRITERIA:** • Must provide documentation of diagnosis, patient's weight (for weight-based dosed medications only), and duration of treatment **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 14 days with at least one preferred drug in this UPDL category and indicated for diagnosis

Blood Formation, Coagulation, and Thrombosis Agents: Hematopoietic Agents		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
EPOGEN [PA] RETACRIT [PA]	ARANESP MIRCERA PROCRIT	**LENGTH OF AUTHORIZATIONS**: 180 days; except 365 days for patients with chronic renal failure **CLINICAL PA CRITERIA:** • Must provide documentation of baseline hemoglobin level **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs in this UPDL category and indicated for diagnosis **ADDITIONAL DARBOPOETIN ALFA (ARANESP) CRITERIA** • Must have been receiving a preferred product for ≥ 30 days with no positive response to hemoglobin levels, **OR** • Must have a documented allergy, contraindication, or side effect to preferred agents and has a hemoglobin level at initiation of therapy of < 11 g/dL in dialysis patients with chronic kidney disease, < 10 g/dL in non-dialysis patients with chronic kidney disease, or < 12 g/dL in patients treated for other indications **SUBSEQUENT AUTHORIZATION CRITERIA:** • Provide current hemoglobin lab result

Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia A, von Willebrand Disease, and Factor XIII Deficiency* LEGACY CATEGORY		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ADYNOVATE PA ALPHANATE PA ALTUVIIIO PA CORIFACT PA ELOCTATE PA ESPEROCT PA FEIBA PA HEMLIBRA PA HEMOFIL M PA HUMATE-P PA JIVI PA KOATE PA KOVALTRY PA NOVOEIGHT PA NOVOSEVEN RT PA NUWIQ KIT PA WILATE PA XYNTHA PA	ADVATE AFSTYLA ALHEMO HYMPAVZI NUWIQ INJ OBIZUR QFITLIA RECOMBINATE SEVENFACT VONVENDI	**LENGTH OF AUTHORIZATIONS**: 365 Days **CLINICAL PA CRITERIA:** • Must provide documentation of patient's body weight (for weight-based dosed medications only) • For factor products, please indicate if use is for on-hand, on-demand therapy. On-hand, on-demand therapy is defined as product kept on hand for spontaneous bleeds or injuries **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response such as increased bleeding episodes, a need for more factor replacement therapy, **OR** worsening joint health, of at least 14 days with at least one preferred drug in this UPDL category and indicated for diagnosis **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 • Must not be used as on-hand, on-demand therapy in patients receiving non-factor replacement therapies. **ADDITIONAL MARSTACIMAB-HNCQ (HYMPAVZI) CRITERIA** • Must have had an inadequate clinical response such as increased bleeding episodes, a need for more factor replacement therapy, **OR** worsening joint health, of at least 30 days with HEMLIBRA • Must have Hemophilia A **without** factor VIII inhibitors • Must be prescribed by or in consultation with a hematologist **ADDITIONAL CONCIZUMAB-MTCI (ALHEMO) CRITERIA** • Must have had an inadequate clinical response such as increased bleeding episodes, a need for more factor replacement therapy, **OR** worsening joint health, of at least 30 days with HEMLIBRA • Must have Hemophilia A **with or without** factor VIII inhibitors

		• Must be prescribed by or in consultation with a hematologist **<u>ADDITIONAL FITUSIRAN (QFITLIA) CRITERIA</u>** • Must have had an inadequate clinical response such as increased bleeding episodes, a need for more factor replacement therapy, **OR** worsening joint health, of at least 30 <u>days</u> with HEMLIBRA • Must have Hemophilia A **with or without** factor VIII inhibitors • Must be prescribed by or in consultation with a hematologist

Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia B* LEGACY CATEGORY		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ALPHANINE SD [PA] ALPROLIX [PA] BENEFIX [PA] FEIBA [PA] IDELVION [PA] IXINITY [PA] NOVOSEVEN RT [PA] PROFILNINE [PA] REBINYN [PA] RIXUBIS [PA]	ALHEMO HYMPAVZI QFITLIA SEVENFACT	**LENGTH OF AUTHORIZATIONS**: 365 Days **CLINICAL PA CRITERIA:** • Must provide documentation of patient's body weight (for weight-based dosed medications only) • For factor products, please indicate if use is for on-hand, on-demand therapy. On-hand, on-demand therapy is defined as product kept on hand for spontaneous bleeds or injuries **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response such as increased bleeding episodes, a need for more factor replacement therapy, **OR** worsening joint health, of at least 14 days with at least one preferred drug in this UPDL category and indicated for diagnosis **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 • Must not be used as on-hand, on-demand therapy in patients receiving non-factor replacement therapies.

Blood Formation, Coagulation, and Thrombosis Agents: Heparin-Related Preparations		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
enoxaparin	fondaparinux FRAGMIN	**LENGTH OF AUTHORIZATIONS**: 35 days; except 365 days for patients with cancer, pregnancy, or unable to be converted to an oral anticoagulant **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 14 days with at least one preferred drug in this UPDL category and indicated for diagnosis

Blood Formation, Coagulation, and Thrombosis Agents: Oral Anticoagulants		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
dabigatran cap ELIQUIS PRADAXA PELLET PAK [AR] warfarin XARELTO [BvG] SUSP [AR], TAB	rivaroxaban SAVAYSA	**LENGTH OF AUTHORIZATION:** 365 days **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs in this UPDL category and indicated for diagnosis **AR** – PRADAXA PELLET PAK, XARELTO SUSP: a PA is required for patients 12 years and older

Blood Formation, Coagulation, and Thrombosis Agents: Oral Antiplatelet		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
aspirin IR, ER aspirin/dipyridamole ER BRILINTA [BvG] clopidogrel 75mg prasugrel	clopidogrel 300mg ticagrelor	**LENGTH OF AUTHORIZATION:** 365 days **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least one preferred drug in this UPDL category and indicated for diagnosis

Cardiovascular Agents: Angina, Hypertension and Heart Failure		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ACE INHIBITORS/DIURETICS/COMBINATIONS		**LENGTH OF AUTHORIZATIONS:** 365 days except nimodipine: 21 days **PROPRANOLOL ORAL SOLN (HEMANGEOL) CRITERIA:** • Must provide documentation of the patient's weight **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days of at least two preferred drugs within the same sub-section classification in this UPDL category and indicated for diagnosis **ADDITIONAL APROCITENTAN (TRYVIO) CRITERIA:** • Must have had an inadequate clinical response of at least 30 days of at least four different classes of antihypertensive medications concurrently without adequate blood pressure control **ADDITIONAL FINERENONE (KERENDIA) CRITERIA:** • Must be prescribed by or in consultation with a cardiologist or nephrologist **AND** • Must be on a maximally tolerated dose of an angiotensin-converting enzyme inhibitor or angiotensin receptor blocker **AND** • 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 **ADDITIONAL MAVACAMTEN (CAMZYOS) CRITERIA:** • Must be prescribed by or in consultation with a cardiologist **AND** • Must provide documentation of NYHA Class II-III symptoms and left ventricular ejection fraction ≥55% **AND** • Must provide documentation of previous trial and therapy failure at maximally tolerated dose, or intolerance, or contraindication to at least two of the following ○ Non-vasodilating beta blocker (e.g., atenolol, metoprolol, bisoprolol, propranolol);
amlodipine/benazepril	QBRELIS	
benazepril		
benazepril/HCTZ		
captopril		
captopril/HCTZ		
enalapril soln, tab		
enalapril/HCTZ		
fosinopril		
fosinopril/HCTZ		
lisinopril		
lisinopril/HCTZ		
moexipril		
quinapril		
quinapril/HCTZ		
ramipril		
trandolapril		
trandolapril/verapamil		
ARBs/DIURETICS/COMBINATIONS		
amlodipine/olmesartan	EDARBI	
amlodipine/valsartan	EDARBYCLOR	
amlodipine/valsartan/HCTZ	valsartan soln	
candesartan		
candesartan/HCTZ		
irbesartan		
irbesartan/HCTZ		
losartan		
losartan/HCTZ		
olmesartan		
olmesartan/amlodipine/HCTZ		
olmesartan/HCTZ		
telmisartan		
telmisartan/amlodipine		
telmisartan/HCTZ		

valsartan tab	
valsartan/HCTZ	
BETA BLOCKERS/COMBINATIONS	
acebutolol	bisoprolol 2.5mg
atenolol	carvedilol ER
atenolol/chlorthalidone	INNOPRAN XL
betaxolol	KAPSPARGO
bisoprolol 5, 10mg	labetalol 400mg
bisoprolol/HCTZ	LOPRESSOR SOLN [AR]
carvedilol IR	SOTYLIZE [AR]
HEMANGEOL [PA]	
labetalol 100, 200, 300mg	
metoprolol succ	
metoprolol tart	
metoprolol/HCTZ	
nadolol	
nebivolol	
propranolol IR, ER	
sotalol	
timolol	
CALCIUM CHANNEL BLOCKERS	
amlodipine	diltiazem 24HR ER tabs
cartia XT	isradipine
diltiazem IR	KATERZIA
diltiazem 12HR ER cap	nimodipine
diltiazem 24HR ER cap	nisoldipine
felodipine ER	NORLIQVA
levamlodipine	NYMALIZE
nicardipine	verapamil ER (gen of VERELAN PM)
nifedipine IR, ER	
verapamil IR, ER, SR	
DIURETICS	
acetazolamide	HEMICLOR
amiloride	spironolactone susp
amiloride/HCTZ	
bumetanide	

- Non-dihydropyridine calcium channel blocker (e.g., verapamil, diltiazem);
- Combination therapy with disopyramide plus beta blocker or disopyramide plus a non-dihydro calcium channel blocker

ADDITIONAL SOTAGLIFLOZIN (INPEFA) CRITERIA:

- Must provide documentation of an inadequate clinical response to at least two SGLT2 Inhibitors (refer to Endocrine Agents: Diabetes – Non-Insulin class for complete list)

ADDITIONAL AMLODIPIDE (NORLIQVA) CRITERIA:

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

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

AR – INZIRQO SOLN: a PA is required for patients 12 years and older
AR – LOPRESSOR SOLN: a PA is required for patients younger than 18 years
AR – SOTYLIZE SOLN: a PA is required for patients 6 years and older

chlorthalidone DIURIL SUSP eplerenone furosemide hydrochlorothiazide indapamide INZIRQO [AR] methazolamide metolazone spironolactone tab spironolactone/HCTZ torsemide triamterene triamterene/HCTZ		
OTHER		
clonidine IR, patch doxazosin guanfacine IR, ER hydralazine methyldopa minoxidil ranolazine sacubitril/valsartan (gen of ENTRESTO) terazosin	aliskiren CAMZYOS clonidine ER (gen of NEXICLON XR) CORLANOR SOLN ENTRESTO SPRINKLE CAP INPEFA ivabradine tab (gen of CORLANOR) KERENDIA TEZRULY TRYVIO VERQUVO	

Cardiovascular Agents: Antiarrhythmics		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
amiodarone disopyramide dofetilide flecainide mexiletine MULTAQ NORPACE CR propafenone IR, ER	quinidine IR, ER	**LENGTH OF AUTHORIZATIONS:** 365 Days **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least one preferred drug in this UPDL category and indicated for diagnosis

Cardiovascular Agents: Lipotropics

PREFERRED AGENTS	NON-PREFERRED AGENTS
BILE ACID SEQUESTRANTS	
cholestyramine light, regular colesevelam tab colestipol tab prevalite	colesevelam packet colestipol granules
FIBRIC ACID DERIVATIVES	
fenofibrate 48, 54, 145, 160mg tab gemfibrozil	fenofibrate IR, DR cap fenofibrate 40, 120mg tab fenofibric acid
PCSK9 INHIBITORS	
PRALUENT [PA] REPATHA [PA]	
STATINS/COMBINATIONS	
atorvastatin ezetimibe/simvastatin lovastatin pravastatin rosuvastatin simvastatin	ALTOPREV amlodipine/atorvastatin ATORVALIQ fluvastatin IR, ER pitavastatin ZYPITAMAG
OTHER	
ezetimibe niacin IR, ER OTC omega-3-acid ethyl esters	icosapent ethyl cap JUXTAPID NEXLETOL NEXLIZET niacin ER tab

PA CRITERIA

LENGTH OF AUTHORIZATIONS: See below

JUXTAPID (Initial)	180 days
icosapent ethyl cap, LOVAZA, ACL inhibitors (Initial)	84 days
All others (Initial and Subsequent)	365 days

CLINICAL PA CRITERIA:

- Must provide baseline labs **AND** have adherence to 90 days of preferred 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 or high-potency statin (or a clinical reason that these drugs cannot be utilized)
- Must have had an inadequate clinical response of at least 90 days AND unable to reach goal LDL-C (see below) despite treatment with ezetimibe OR documentation that LDL is >25% above goal despite current statin therapy

NON-PREFERRED CRITERIA:

- Must have had an inadequate clinical response of at least 30 days (or 90 days for fibrates) with at least one preferred drug within the same sub-section classification in this UPDL category and indicated for diagnosis

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 CRITERIA:

		• Must provide documentation of baseline labs indicating triglyceride levels ≥500mg/dL after an inadequate clinical response to fibrates, niacin, and diet/exercise **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) not at very high risk: LDL ≤ 70mg/dL • LDL goals for Clinical Atherosclerotic Cardiovascular Disease (ASCVD) at very high risk: LDL ≤ 55mg/dL • Must provide documentation of multiple major ASCVD events or 1 major ASCVD event and multiple high-risk conditions if citing goal LDL ≤ 55mg/dL

Cardiovascular Agents: Pulmonary Arterial Hypertension* LEGACY CATEGORY		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ENDOTHELIN RECEPTOR ANTAGONISTS		**LENGTH OF AUTHORIZATIONS:** 365 Days
ambrisentan PA bosentan PA	OPSUMIT bosentan susp	**CLINICAL PA CRITERIA:** • Must provide documentation of NYHA Functional Class symptoms for Pulmonary Hypertension experienced by patient
PDE5 INHIBITORS		**NON-PREFERRED CRITERIA:**
sildenafil PA sildenafil susp AR PA tadalafil PA	TADLIQ AR	• Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs in this UPDL category and indicated for diagnosis, if available, one of which must be a phosphodiesterase-5 inhibitor
PROSTAGLANDINS		**ADDITIONAL TADALAFIL (TADLIQ) CRITERIA:**
epoprostenol	ORENITRAM treprostinil TYVASO VENTAVIS	• Must have had a documented side effect, allergy, or treatment failure of at least 30 days with sildenafil suspension
OTHER		**ADDITIONAL SELEXIPAG (UPTRAVI) AND SOTATERCEPT-CSRK (WINREVAIR) CRITERIA:**
	ADEMPAS OPSYNVI UPTRAVI WINREVAIR	• Must attest the patient has WHO group 1 diagnosis **AND** • Must attest the patient has WHO functional class II or III, at intermediate or high risk of disease progression **AND** • Have tried and failed preferred pulmonary hypertension medications with at least one medication from two different subclasses for ≥90 days, unless contraindicated or not tolerated **OR** • Require add-on triple or quadruple therapy, including PDE5-inhibitor for ≥90 days, unless contraindicated or not tolerated
		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
		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* LEGACY CATEGORY		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
donepezil [AR] galantamine IR tab, ER cap [AR] memantine IR, ER tab [AR] rivastigmine cap [AR] rivastigmine patch [AR]	ADLARITY [AR] galantamine soln [AR] memantine/donepezil cap [AR] 14-10, 21-10, 28-10mg memantine soln [AR] NAMZARIC [AR] ZUNVEYL	**LENGTH OF AUTHORIZATIONS**: 365 Days **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs in this UPDL category and indicated for diagnosis **AR** – All drugs: a PA is required for patients younger than 40 years

Central Nervous System (CNS) Agents: Anti-Migraine Agents, Acute		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
CGRP INHIBITORS		**LENGTH OF AUTHORIZATIONS**: 180 Days **STEP THERAPY CRITERIA:** • Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs in this UPDL category **OR** documentation why patient is unable to take product not requiring step therapy **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 14 days with at least one preferred drug and one step therapy drug in this UPDL category and indicated for diagnosis, if available **ADDITIONAL MELOXICAM/RIZATRIPTAN (SYMBRAVO) CRITERIA:** • Must have had an inadequate clinical response of at least 14 days with sumatriptan/naproxen **ADDITIONAL INFORMATION:** • NURTEC has a maximum quantity of **8** tablets per month for acute migraines
NURTEC ODT ST UBRELVY ST	ZAVZPRET	
TRIPTANS/COMBINATIONS		
naratriptan rizatriptan sumatriptan inj, nasal spray, tab	almotriptan eletriptan frovatriptan sumatriptan/naproxen SYMBRAVO TOSYMRA zolmitriptan	
OTHER		
	dihydroergotamine MIGERGOT REYVOW	

Central Nervous System (CNS) Agents: Anti-Migraine Agents, Cluster Headache		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
verapamil IR, ER	EMGALITY 100mg/ml	**LENGTH OF AUTHORIZATIONS:** 180 days **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 60 days to at least one preferred drug in this UPDL category and indicated for diagnosis **ADDITIONAL INFORMATION:** • An inadequate clinical response to verapamil is defined as a titration to at least 480mg daily or maximally tolerated dose based on blood pressure or heart rate and maintained for at least 60 days

Central Nervous System (CNS) Agents: Anti-Migraine Agents, Prophylaxis		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
AIMOVIG [ST] AJOVY [ST] EMGALITY 120mg/ml [ST] Cardiovascular Agents: Beta-Blockers CNS Agents: Anticonvulsants CNS Agents: Serotonin-Norepinephrine Reuptake Inhibitors CNS Agents: Tricyclic Antidepressants	NURTEC ODT QULIPTA	**LENGTH OF AUTHORIZATIONS:** Initial: 180 days; Subsequent: 365 days **STEP THERAPY CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least two preferred controller migraine drugs. ○ For patients already established on a serotonergic medication, only one preferred controller migraine drugs will be required • Must include objective documentation of severity, frequency, type of migraine, and number of headache days per month • Controller migraine drug classes include beta-blockers, anticonvulsants, serotonin-norepinephrine reuptake inhibitors, or tricyclic antidepressants **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 have had an inadequate clinical response of at least 30 days with at least three preferred controller migraine drugs **AND** one step therapy drug in this UPDL category **ADDITIONAL INFORMATION:** • NURTEC has a maximum quantity of **16** tablets per month for migraine prophylaxis **SUBSEQUENT AUTHORIZATION CRITERIA:** • Must provide documentation of patient's clinical response to treatment (Objective documentation of severity, frequency, and number of headache days per month).

Central Nervous System (CNS) Agents: Anticonvulsants* LEGACY CATEGORY		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**

BANZEL TAB [BvG]
BRIVIACT SOLN [AR], TAB
carbamazepine IR, ER
clobazam
clonazepam
DIACOMIT [PA]
divalproex DR, ER
EPIDIOLEX [PA]
EPRONTIA [AR BvG]
ethosuximide
FYCOMPA [BvG ST]
gabapentin
lacosamide
lamotrigine chew, IR, ODT
levetiracetam IR tab, soln
oxcarbazepine IR tab
phenobarbital
phenytoin IR, ER
pregabalin IR
primidone
topiramate IR
TRILEPTAL SUSP [BvG]
valproic acid
zonisamide cap
	CELONTIN [BvG]
	clonazepam ODT
	ELEPSIA XR
	eslicarbazepine
	felbamate
	FINTEPLA
	lamotrigine ER
	levetiracetam ER tab
	MOTPOLY XR
	oxcarbazepine susp
	OXTELLAR XR [BvG]
	perampanel
	rufinamide tab, soln
	SPRITAM [BvG]
	SYMPAZAN
	tiagabine
	topiramate ER
	topiramate soln [AR], sprinkle cap
	TROKENDI XR [BvG]
	vigabatrin
	vigabatrin powder [AR]
	VIGAFYDE [AR]
	XCOPRI
	ZONISADE SUSP
	ZTALMY
		LENGTH OF AUTHORIZATIONS: 365 days except EPIDIOLEX and DIACOMIT – Initial: 180 days
		
		STEP THERAPY CRITERIA:
		• Must have had an inadequate clinical response of at least 30 days with at least one preferred drug in this UPDL category
		
		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 criterion will not require a PA)
		
		STIRIPENTOL (DIACOMIT) CRITERIA
		• Exempt from Legacy rules
		• Must be prescribed by or in consultation with a neurologist
		• Must be concurrently 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
		
		NON-PREFERRED CRITERIA:
		• Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs in this UPDL category and indicated for diagnosis

		• 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.
		
		ADDITIONAL FENFLURAMINE (FINTEPLA) CRITERIA:
		• Prescribed by or in consultation with a neurologist
		• When prescribed for Lennox-Gastaut syndrome
		  ○ Required trial of valproic acid (or a derivative) in combination with lamotrigine for at least 30 days
		• When prescribed for Dravet syndrome
		  ○ Required trial of valproic acid (or a derivative) in combination with one other preferred agent from this UPDL category for at least 30 days
		
		ADDITIONAL CENOBAMATE (XCOPRI) CRITERIA:
		• Prescribed by or in consultation with a neurologist
		• Required trial of two preferred medications from this UPDL category in combination for at least 30 days. One of the preferred agents must be: lamotrigine, levetiracetam, oxcarbazepine, carbamazepine, or topiramate
		
		AR – BRIVIACT SOLN: a PA is required for patients 12 years and older
		AR – EPRONTIA SOLN: a PA is required for patients 12 years and older
		AR – vigabatrin powder: a PA is required for patients 2 years and older
		AR – VIGAFYDE SOLN: a PA is required for patients 2 years and older

Central Nervous System (CNS) Agents: Anticonvulsants Rescue		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
diazepam gel NAYZILAM [AR] VALTOCO [AR]		All products are covered without a PA **AR** – NAYZILAM: a PA is required for patients younger than 12 years old **AR** – VALTOCO: a PA is required for patients younger than 2 years old

Central Nervous System (CNS) Agents: Antidepressants* LEGACY CATEGORY		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
NDRIs		**LENGTH OF AUTHORIZATIONS:** 365 Days except 14 days with no renewal for ZURZUVAE **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. **CLINICAL PA CRITERIA:** • Must have a diagnosis of moderate to severe Post-Partum Depression (PPD) no earlier than the 3rd trimester OR within 12 months of pregnancy delivery **STEP THERAPY CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs in this UPDL category **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs in this UPDL category and indicated for diagnosis
bupropion bupropion SR (gen of WELLBUTRIN SR) bupropion XL (gen of WELLBUTRIN XL)	bupropion XL (gen of FORFIVO XL)	
SNRIs		
desvenlafaxine succ ER (gen of PRISTIQ) duloxetine 20, 30, 60mg venlafaxine IR tab, ER cap	desvenlafaxine ER (gen of KHEDEZLA) DRIZALMA SPRINKLE duloxetine 40mg FETZIMA venlafaxine ER tab	
SSRIs		
citalopram tab, soln escitalopram tab, soln fluoxetine IR 10, 20, 40mg fluoxetine soln fluvoxamine IR paroxetine IR tab, soln sertraline tab	citalopram cap escitalopram cap fluoxetine IR 60mg, DR fluvoxamine ER paroxetine ER tab sertraline cap	
OTHER		
mirtazapine nefazodone tranylcypromine trazodone 50, 100, 150mg vilazodone VRAYLAR ST ZURZUVAE PA	AUVELITY CAPLYTA clomipramine EMSAM MARPLAN phenelzine RALDESY REXULTI trazodone 300mg TRINTELLIX	

Central Nervous System (CNS) Agents: Attention Deficit Hyperactivity Disorder Agents		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
NON-STIMULANTS		**LENGTH OF AUTHORIZATIONS:** 365 days
atomoxetine cap [AR] clonidine ER guanfacine ER ONYDA XR SUSP [AR] QELBREE [ST]		**STEP THERAPY CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with atomoxetine **OR** at least one preferred ADHD agent.
STIMULANTS		**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs in this UPDL category and indicated for diagnosis
amphetamine/dextroamphetamine IR, ER [AR] CONCERTA dexmethylphenidate tab [AR] dexmethylphenidate ER (gen of FOCALIN XR) [AR] dextroamphetamine IR tab, ER cap [AR] DYANAVEL XR FOCALIN XR [AR] methylphenidate ER cap (gen of METADATE CD, RITALIN LA) methylphenidate ER tab (gen of CONCERTA, METHYLIN ER, RITALIN SR) methylphenidate soln [AR] methylphenidate tab PROCENTRA [BvG AR] QUILLICHEW ER [AR] QUILLIVANT XR [AR] RITALIN LA VYVANSE CAP [BvG]	amphetamine IR, ER tab AZSTARYS [AR] COTEMPLA XR ODT DAYTRANA [BvG] dextroamphetamine soln [AR] EVEKEO ODT JORNAY PM lisdexamfetamine cap methamphetamine methylphenidate chewable tab [AR] methylphenidate ER cap, tab (gen of APTENSIO XR, RELEXXII) MYDAYIS [BvG] VYVANSE CHEWABLE TAB [BvG] XELSTRYM [AR]	**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. **AR** –amphetamine/dextroamphetamine, dextroamphetamine IR: a PA is required for patients younger than 3 years **AR** –amphetamine/dextroamphetamine XR, atomoxetine, dextroamphetamine ER, dexmethylphenidate & XELSTRYM: a PA is required for patients younger than 6 years **AR** – dextroamphetamine soln: a PA is required for patients 12 years and older **AR** – methylphenidate soln/susp/chewable tab: a PA is required for patients 12 years and older **AR** – ONYDA XR SUSP: a PA is required for patients 12 years and older

Central Nervous System (CNS) Agents: Atypical Antipsychotics* LEGACY CATEGORY		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ABILIFY ASIMTUFII, MAINTENA aripiprazole ARISTADA ARISTADA INITIO asenapine [ST] clozapine ERZOFRI FANAPT [ST] GEODON INVEGA HAFYERA ER [PA] INVEGA SUSTENNA INVEGA TRINZA lurasidone olanzapine paliperidone tab PERSERIS quetiapine IR, ER RISPERDAL CONSTA [BvG] risperidone RYKINDO UZEDY VRAYLAR [ST] ziprasidone	ABILIFY MYCITE aripiprazole ODT, soln CAPLYTA clozapine ODT COBENFY EQUETRO fluoxetine/olanzapine LYBALVI NUPLAZID OPIPZA REXULTI risperidone microspheres SECUADO VERSACLOZ ZYPREXA RELPREVV	**LENGTH OF AUTHORIZATIONS:** 365 Days **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. **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 in this UPDL category **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs in this UPDL category and indicated for diagnosis **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 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

Central Nervous System (CNS) Agents: Fibromyalgia Agents		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
pregabalin IR SAVELLA		All products are covered without a PA

Central Nervous System (CNS) Agents: Medication Assisted Treatment of Opioid Addiction		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**

BRIXADI
buprenorphine/naloxone
clonidine IR, ER
SUBLOCADE
SUBOXONE
VIVITROL
ZUBSOLV
	buprenorphine
	LUCEMYRA [BvG]
		LENGTH OF AUTHORIZATIONS: 180 days except 14 days for LUCEMYRA
		
		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 allergy/contraindication to preferred products
		
		ADDITIONAL INFORMATION
		• VIVITROL, SUBLOCADE, and BRIXADI 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.

Central Nervous System (CNS) Agents: Movement Disorders		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
AUSTEDO IR, XR PA ST INGREZZA PA ST tetrabenazine		**LENGTH OF AUTHORIZATIONS:** 365 Days **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

Central Nervous System (CNS) Agents: Multiple Sclerosis* LEGACY CATEGORY		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
AVONEX BETASERON COPAXONE [BvG] dalfampridine dimethyl fumarate fingolimod GILENYA KESIMPTA PLEGRIDY REBIF teriflunomide	BAFIERTAM glatiramer glatopa MAVENCLAD MAYZENT OCREVUS PONVORY TASCENSO ODT VUMERITY ZEPOSIA	**LENGTH OF AUTHORIZATIONS**: 365 Days **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least one preferred drug in this UPDL category and indicated for diagnosis **ADDITIONAL OCRELIZUMAB (OCREVUS) CRITERIA:** • Must provide documentation of diagnosis of primary progressive multiple sclerosis **OR** must have had an inadequate clinical response of at least 30 days with at least one preferred drug in this UPDL category **ADDITIONAL SIPONIMOD (MAYZENT) CRITERIA:** • Must provide documentation of CYP2C9 genotype

Central Nervous System (CNS) Agents: Narcolepsy		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
amphetamine/ dextroamphetamine IR/ER [AR] armodafinil dextroamphetamine ER [AR] methylphenidate ER methylphenidate tab modafinil	SUNOSI WAKIX XYREM [BvG] XYWAV	**LENGTH OF AUTHORIZATIONS:** 365 days **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response with at least two preferred drugs - either at least 30 days of armodafinil or modafinil; **OR** at least 30 days of a preferred amphetamine or methylphenidate drug in this UPDL category and indicated for diagnosis **ADDITIONAL OXYBATE SALTS (XYWAV) CRITERIA:** • Must have documented adherence to sodium restricted diet **AR** –amphetamine/dextroamphetamine: a PA is required for patients younger than 3 years **AR** –amphetamine/dextroamphetamine XR, dextroamphetamine ER: a PA is required for patients younger than 6 years

Central Nervous System (CNS) Agents: Neuropathic Pain		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
DIBENZAZEPINES		**LENGTH OF AUTHORIZATIONS**: 365 Days **STEP THERAPY CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with generic lidocaine patch **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs within the same sub-section classification in this UPDL category and indicated for diagnosis
carbamazepine IR, ER oxcarbazepine tab TRILEPTAL SUSP BvG	oxcarbazepine susp	
GAPAPENTINOIDS		
gabapentin IR GRALISE BvG HORIZANT	gabapentin ER	
TRICYCLIC ANTIDEPRESSANTS		
amitriptyline desipramine doxepin 10, 25, 50, 75, 100, 150mg doxepin soln imipramine nortriptyline		
OTHER		
duloxetine 20, 30, 60mg lidocaine patch pregabalin IR ZTLIDO ST	duloxetine 40mg pregabalin ER	

Central Nervous System (CNS) Agents: Parkinson's Agents		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
COMT INHIBITORS		**LENGTH OF AUTHORIZATIONS**: 365 Days **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs within the same sub-section classification in this UPDL category and indicated for diagnosis, if available **ADDITIONAL APOMORPHINE (APOKYN/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" (COMT inhibitor, dopamine agonist, or MAO-B inhibitor) **ADDITIONAL APOMORPHINE (ONAPGO) AND FOSCARBIDOPA/FOSLEVODOPA (VYALEV) CRITERIA:** • Must have had inadequate clinical response of at least 30 days with at least two preferred drugs in this UPDL category, one of which must be carbidopa/levodopa • Must have had uncontrolled motor symptoms with current medications with a minimum of 2.5 hours of "off" time per day as assessed by using a PD diary.
entacapone	ONGENTYS tolcapone	
DOPAMINE AGONISTS		
pramipexole IR ropinirole IR, ER	apomorphine KYNMOBI NEUPRO ONAPGO pramipexole ER	
MAO-B INHIBITORS		
selegiline	rasagiline XADAGO	
OTHER		
amantadine cap, tab carbidopa carbidopa/levodopa IR, ER	amantadine soln carbidopa/levodopa dispersible carbidopa/levodopa/entacapone CREXONT GOCOVRI INBRIJA NOURIANZ RYTARY BvG VYALEV	

Central Nervous System (CNS) Agents: Restless Legs Syndrome		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
HORIZANT pramipexole IR ropinirole IR, ER	NEUPRO	**LENGTH OF AUTHORIZATIONS:** 365 Days **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least one preferred drug in this UPDL category and indicated for diagnosis

Central Nervous System (CNS) Agents: Sedative-Hypnotics, Non-Barbiturate		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
BELSOMRA estazolam eszopiclone ramelteon temazepam triazolam zaleplon zolpidem tab ER, IR	DAYVIGO doxepin 3, 6mg EDLUAR flurazepam quazepam QUVIVIQ zolpidem cap, SL ZOLPIMIST	**LENGTH OF AUTHORIZATIONS**: 180 Days **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 7 days with at least two preferred drugs in this UPDL category and indicated for diagnosis **ADDITIONAL INFORMATION** • Non-controlled medications may be authorized if the prescriber indicates the patient has a history of addiction

Central Nervous System (CNS) Agents: Skeletal Muscle Relaxants, Non-Benzodiazepine		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
baclofen susp [AR], tab chlorzoxazone 500mg cyclobenzaprine IR dantrolene metaxalone 800mg methocarbamol 500, 750mg orphenadrine tizanidine	baclofen soln carisoprodol chlorzoxazone 250, 375, 750mg cyclobenzaprine ER FLEQSUVY [AR] LYVISPAH metaxalone 400mg methocarbamol 1000mg orphenadrine/ASA/caffeine	**LENGTH OF AUTHORIZATIONS**: 365 Days **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs in this UPDL category and indicated for diagnosis **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 **AR** – FLEQSUVY (baclofen susp): a PA is required for patients 12 years and older

Central Nervous System (CNS) Agents: Smoking Deterrents		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
bupropion SR CHANTIX nicotine varenicline		All products are covered without a PA

Dermatologic Agents: Oral Acne Products		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
amnesteem [PA] claravis [PA] zenatane [PA]	ABSORICA ABSORICA LD isotretinoin	**LENGTH OF AUTHORIZATIONS:** 150 days **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 **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 90 days with at least two preferred drugs in this UPDL category and indicated for diagnosis **ADDITIONAL INFORMATION** • Authorization length will be for no more than 150 days at a time then must take 56 days off

Dermatologic Agents: Topical Acne Products		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
NON-RETINOIDS		**LENGTH OF AUTHORIZATIONS**: 365 Days **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response with at least two preferred drugs within the same sub-section classification in this UPDL category. Trials must be 30 days for preferred non-retinoids and 90 days for preferred retinoids. **ADDITIONAL INFORMATION** • All retinoids - May be authorized with a diagnosis of skin cancer • tazarotene (TAZORAC) - May be authorized with a diagnosis of psoriasis **AR** - All topical retinoids: a PA is required for patients 24 years and older
azelaic acid gel benzoyl peroxide clindamycin gel, lot, soln, swabs clind/benz perox 1-5%, 1.2-2.5%, 1.2-5% erythromycin erythromycin/benzoyl peroxide sodium sulfacetamide gel, liq	CLINDACIN KIT clindamycin foam clindamycin/benz perox 1.2-3.75% dapsone gel FINACEA FOAM NEUAC sodium sulfacetamide/sulfur sodium sulfacetamide pads WINLEVI ZMA CLEAR SUSP	
RETINOIDS/COMBINATIONS		
adapalene gel [AR] 0.1%, 0.3% adapalene/benzoyl peroxide [AR] tretinoin [AR] cream, gel	adapalene cream [AR] clindamycin/tretinoin [AR] tazarotene [AR] tretinoin micro [AR]	

Duchenne Muscular Dystrophy Agents: Corticosteroids		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
EMFLAZA [BvG PA]	AGAMREE deflazacort	**LENGTH OF AUTHORIZATIONS:** 365 Days **CLINICAL PA CRITERIA:** • Must be prescribed by or in consultation with a neurologist or specialist in Duchenne Muscular Dystrophy • Must have documented DMD diagnosis confirmed by genetic testing or muscle biopsy with dystrophin absent results • Must have had an inadequate clinical response of at least 180 days or contraindication to prednisone • Must provide documentation of patient's weight **NON-PREFERRED CRITERIA:** • Must have had unmanageable side effects, such as significant weight gain/obesity, persistent psychiatric/behavioral conditions, diabetes, growth delay, cataracts, hypertension, or cushingoid appearance **OR** intolerance of at least 30 days with at least one preferred drug in this UPDL category and indicated for diagnosis

Endocrine Agents: Androgens		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
depo-testosterone [AR PA] testosterone cypionate [AR PA] testosterone gel 1% packet [AR PA] testosterone gel 1.62% pump [AR PA]	AVEED [AR] AZMIRO [AR] JATENZO [AR] methyltestosterone [AR] NATESTO [AR] TESTOPEL [AR] testosterone gel 1% pump [AR] testosterone gel 1.62% packet [AR] testosterone gel 2% [AR] testosterone soln 30mg/ACT [AR] TLANDO [AR] XYOSTED [AR]	**LENGTH OF AUTHORIZATIONS:** 365 Days **CLINICAL PA CRITERIA:** • Must provide documentation of baseline lab work to support the need for testosterone supplementation. If baseline testosterone level is within normal limits, provide clinical justification for why replacement therapy is required. **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 90 days with **ALL** preferred drugs in this UPDL category and indicated for diagnosis **ADDITIONAL TESTOSTERONE ENANTHATE (XYOSTED) CRITERIA:** • Must have a trial and failure of a preferred testosterone cypionate injectable product **OR** • Must provide a clinical rationale why testosterone cypionate injectable product is not appropriate **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		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
BAQSIMI glucagon emerg kit [labeler 00548] GVOKE ZEGALOGUE	glucagon emerg kit [labeler 00378, 63323]	**LENGTH OF AUTHORIZATIONS**: 365 Days **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least one preferred drug in this UPDL category and indicated for diagnosis **OR** the inability of the member and/or caregiver to administer a preferred glucagon product in a timely fashion **SUBSEQUENT AUTHORIZATION CRITERIA:** • Renewal will be allowed for expired/unused products **WITHOUT** documentation of patient's clinical response to treatment

Endocrine Agents: Diabetes – Insulin		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
RAPID-ACTING		**LENGTH OF AUTHORIZATIONS**: 365 Days **STEP THERAPY CRITERIA:** • Must have had an inadequate clinical response (defined as the inability to reach target A1C) after at least 120 days with at least one preferred drug having a similar duration of action in this UPDL category **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response (defined as the inability to reach target A1C) after at least 120 days with at least two preferred drugs having a similar duration of action in this UPDL category and indicated for diagnosis, if available **ADDITIONAL INSULIN LISPRO-AABC (LYUMJEV) CRITERIA:** • Must have had an inadequate clinical response (defined as the inability to reach target A1C) after at least 120 days with HUMALOG **OR** insulin lispro **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.
APIDRA	ADMELOG	
FIASP	AFREZZA	
HUMALOG U-100 KWIKPEN, VIAL	HUMALOG U-100 TEMPO PEN	
insulin aspart	HUMALOG U-200	
insulin lispro	LYUMJEV	
	MERILOG (Bio of NOVOLOG)	
	NOVOLOG U-100	
SHORT-ACTING		
HUMULIN R U-500	HUMULIN R U-100	
	NOVOLIN R U-100	
INTERMEDIATE-ACTING		
HUMULIN N U-100	NOVOLIN N U-100	
LONG-ACTING		
LANTUS BvG	BASAGLAR	
LEVEMIR	insulin degludec	
TOUJEO BvG	insulin glargine	
TRESIBA 100U BvG ST	insulin glargine-yfgn	
	REZVOGLAR	
	TRESIBA 200U	
MIXED INSULIN		
HUMALOG 50-50	NOVOLIN 70-30	
HUMALOG 75-25	NOVOLOG 70-30	
HUMULIN 70-30		
insulin aspart pro/insulin aspart		

		○ Must include a patient specific A1C goal if less than 7% ○ Must include current A1C (within last 6 months) • 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 ○ Must submit recent hemoglobin A1C level (within 6 months) ○ Must include documentation showing improvement in current A1C (within last 6 months) if not already at goal A1C

Endocrine Agents: Diabetes – Non-Insulin		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
DPP4 INHIBITORS/COMBINATIONS		**LENGTH OF AUTHORIZATIONS:** 365 Days
JANUMET	alogliptin	
JANUMET XR	alogliptin/metformin	**NON-PREFERRED CRITERIA:**
JANUVIA	alogliptin/pioglitazone	• Must have had an inadequate clinical response of at least 120 days with at least three preferred drugs in this UPDL category and indicated for diagnosis, if available
JENTADUETO	sitagliptin	
JENTADUETO XR	sitagliptin/metformin (gen of ZITUVIMET)	**ADDITIONAL TIRZEPATIDE (MOUNJARO) CRITERIA**
KOMBIGLYZE XR		• Prior to initiation, must have hemoglobin A1C>7% **AND**
ONGLYZA		• Must have had an inadequate clinical response of at least 120 days with OZEMPIC **OR** must provide documentation of medical necessity for patient's inability to use OZEMPIC
saxagliptin		• For medical necessity requests due to OZEMPIC intolerance, must submit chart documentation that the following approaches were tried for at least 30 days:
saxagliptin/metformin		○ Dietary changes (e.g., eating apples, crackers, or mint- or ginger-based drinks 30 minutes after administering the GLP-1 Receptor Agonist)
TRADJENTA		○ Prescription antiemetics **AND**
GLP-1 RECEPTOR AGONISTS/COMBINATIONS		○ Dose adjustment to remediate side effects experienced with higher doses of the GLP-1 Receptor Agonist
BYETTA	BYDUREON BCISE	
exenatide	liraglutide	**ADDITIONAL SITAGLIPTIN (ZITUVIO) CRITERIA**
TRULICITY	MOUNJARO	• Must have had a trial of at least 120 days with JANUVIA **OR** must provide documentation of medical necessity for patient's inability to use JANUVIA
VICTOZA BvG	OZEMPIC	
	RYBELSUS	**ADDITIONAL INFORMATION**
	SOLIQUA	• An inadequate clinical response is defined as the inability to reach A1C goal after at least 120 days of current regimen, with use of two or more drugs concurrently per ADA guidelines, documented adherence, and appropriate dose escalation (must achieve
	XULTOPHY	
METFORMIN		
metformin ER (gen of GLUCOPHAGE XR)	metformin ER (gen of FORTAMET, GLUMETZA)	
metformin IR 500, 850, 1000mg	metformin IR 625, 750mg	
	metformin soln	
SGLT2 INHIBITORS/COMBINATIONS		
FARXIGA BvG	dapagliflozin	
JARDIANCE	dapagliflozin/metformin ER	
SYNJARDY	GLYXAMBI	
SYNJARDY XR	INVOKAMET	
XIGDUO XR BvG	INVOKANA	
	QTERN	
	SEGLUROMET	
	STEGLATRO	
	STEGLUJAN	

	TRIJARDY XR	maximum recommended dose or document that maximum recommended dose is not tolerated or is clinically inappropriate). ○ Must include a patient specific A1C goal if less than 7% ○ Must include current A1C (within last 6 months) • For non-preferred drugs that have preferred drugs in the same drug class: must provide documentation that there was at least <u>one</u> inadequate clinical response with a drug in same drug class
SULFONYLUREAS/COMBINATIONS		
glimepiride 1, 2, 4mg glipizide IR, ER glipizide/metformin glyburide glyburide/metformin	glimepiride 3mg glimepiride/pioglitazone	
OTHER		
acarbose miglitol nateglinide pioglitazone pioglitazone/metformin repaglinide	SYMLINPEN	**<u>SUBSEQUENT AUTHORIZATION CRITERIA:</u>** • Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring ○ Must submit recent hemoglobin A1C level (within 6 months) ○ Must include documentation showing improvement in current A1C (within last 6 months) if not already at goal A1C

Endocrine Agents: Endometriosis		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
danazol ST DEPO-SUBQ PROVERA 104 ST LUPRON DEPOT ST 3.75, 11.25mg MYFEMBREE ST ORILISSA ST	SYNAREL	**LENGTH OF AUTHORIZATIONS**: 365 Days **STEP THERAPY CRITERIA:** • Must have had an inadequate clinical response of at least 84 days with at least one preferred NSAID and one oral contraceptive **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 84 days with at least one preferred step-therapy drug in this UPDL category and indicated for diagnosis **ADDITIONAL INFORMATION:** • A total lifetime duration of therapy of 730 days between ORILISSA and MYFEMBREE or 365 days for LUPRON DEPOT will be authorized

Endocrine Agents: Estrogenic Agents		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ORAL		**LENGTH OF AUTHORIZATIONS**: 365 Days **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs in this UPDL category within the same sub-section classification and indicated for diagnosis
ANGELIQ estradiol tab ethinyl estradiol/norethindrone PREMARIN TAB [BvG] PREMPHASE PREMPRO	DUAVEE estradiol/norethindrone estrogens, conjugated tab MENEST	
TOPICAL		
DIVIGEL [BvG] ELESTRIN estradiol cream	estradiol gel 0.06% (gen of ESTROGEL)	
TRANSDERMAL		
CLIMARA COMBIPATCH dotti estradiol patch lyllana MINIVELLE VIVELLE -DOT	EVAMIST MENOSTAR	
VAGINAL		
ESTRING PREMARIN CREAM	estradiol 10mcg vag tab FEMRING	

Endocrine Agents: Growth Hormone		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
DAILY-DOSING		**LENGTH OF AUTHORIZATIONS**: Initial: 180 days; Subsequent: 365 days **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 be used in combination with another somatropin agent **Adult Approvals (18 years of age or older):** • Must be treated and followed 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) **STEP THERAPY CRITERIA:** • Must have had an inadequate clinical response of at least 90 days with at least one preferred daily-dosed growth hormone formulation **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 90 days with at least one preferred drug within the same sub-section classification in this UPDL category and indicated for diagnosis **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
GENOTROPIN PA NORDITROPIN PA	HUMATROPE NUTROPIN OMNITROPE SEROSTIM ZOMACTON	
WEEKLY-DOSING		
SKYTROFA PA ST	NGENLA SOGROYA	

Endocrine Agents: Osteoporosis – Bone Ossification Enhancers		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
BISPHOSPHONATES		**LENGTH OF AUTHORIZATIONS**: 365 Days **CLINICAL PA 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 **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 365 days with at least one preferred drug within the same sub-section classification in this UPDL category and indicated for diagnosis **ADDITIONAL "OTHER BONE RESORPTION SUPPRESSION AND RELATED AGENTS" 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 • A total lifetime duration of therapy of 365 days will be authorized for EVENITY **ADDITIONAL INFORMATION** • Patients should only be on ONE of the therapeutic classes (bisphosphonates, calcitonin-salmon)
alendronate tab ibandronate	alendronate soln BINOSTO FOSAMAX PLUS D risedronate zoledronic acid	
OTHER BONE RESORPTION SUPPRESSION AND RELATED AGENTS		
calcitonin-salmon FORTEO BvG PA raloxifene	CONEXXENCE (Bio of PROLIA) EVENITY JUBBONTI (Bio of PROLIA) PROLIA STOBOCLO (Bio of PROLIA) teriparatide TYMLOS	

Endocrine Agents: Progestin Agents		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
medroxyprogesterone acetate tab megestrol norethindrone acetate progesterone progesterone in oil		All products are covered without a PA

Endocrine Agents: Uterine Fibroids		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
LUPRON DEPOT [PA] 3.75, 11.25mg MYFEMBREE [PA] ORIAHNN [PA]		**LENGTH OF AUTHORIZATIONS**: Up to 180 Days **CLINICAL PA CRITERIA:** • Must have had an inadequate clinical response of at least 90 days with at least one oral contraceptive **ADDITIONAL INFORMATION:** • A total lifetime duration of therapy of 730 days between MYFEMBREE and ORIAHNN or 365 days for LUPRON DEPOT will be authorized

Gastrointestinal Agents: Anti-Emetics		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
5-HT3 ANTAGONISTS		**LENGTH OF AUTHORIZATIONS**: 365 Days **CLINICAL PA CRITERIA:** • dronabinol is only covered for nausea and vomiting associated with chemotherapy in adult patients who failed at least 3 days with at least one preferred drug in this UPDL category. **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 3 days with at least one preferred drug in this UPDL category within the same sub-section classification and indicated for diagnosis
granisetron tab	ondansetron 16mg
ondansetron 4, 8mg	SANCUSO
ANTICHOLINERGICS	
scopolamine	
ANTIHISTAMINES and ANTIHISTAMINE COMBINATIONS	
dimenhydrinate	BONJESTA
diphenhydramine	
doxylamine/pyridoxine	
meclizine	
trimethobenzamide	
PHENOTHIAZINES	
prochlorperazine	
promethazine	
SUBSTANCE P/NEUROKININ 1 (NK-1) ANTAGONISTS	
aprepitant 40mg, tripac	aprepitant 80, 125mg
EMEND 125mg SUSP	
OTHER	
dronabinol PA	
metoclopramide	

Gastrointestinal Agents: Bowel Preparations		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
CLENPIQ GAVILYTE -C GAVILYTE -G GAVILYTE -N GOLYTELY sod sulf-potass sulf-mag sulf soln SUFLAVE	peg/NaSul/C/ sol NaCL/Pot soln SUTAB	**LENGTH OF AUTHORIZATIONS:** 365 Days **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response with at least one preferred drug in this UPDL category and indicated for diagnosis

Gastrointestinal Agents: Crohn's Disease		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
azathioprine 50mg budesonide ER mercaptopurine tab methotrexate sulfasalazine IR, DR	azathioprine 75, 100mg	**LENGTH OF AUTHORIZATIONS**: 365 days **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs in this UPDL category and indicated for diagnosis

Gastrointestinal Agents: Hepatic Encephalopathy		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
lactulose		All products are covered without a PA

Gastrointestinal Agents: Irritable Bowel Syndrome (IBS) with Diarrhea		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
diphenoxylate/atropine loperamide CNS Agents: Tricyclic Antidepressants	alosetron VIBERZI	**LENGTH OF AUTHORIZATIONS**: 365 Days **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 14 days with at least one preferred drug and one step therapy drug in this UPDL category and indicated for diagnosis

Gastrointestinal Agents: Pancreatic Enzymes		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
CREON PERTZYE [ST] ZENPEP	VIOKACE	**LENGTH OF AUTHORIZATIONS**: 365 Days **STEP THERAPY CRITERIA:** • For a diagnosis of Cystic Fibrosis, no trials required • For all other diagnoses, must have had an inadequate clinical response of at least 14 days with at least one preferred drug in this UPDL category **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs in this UPDL category and indicated for diagnosis

Gastrointestinal Agents: Proton Pump Inhibitors		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**

esomeprazole
lansoprazole cap
NEXIUM GRANULES [BvG]
omeprazole
pantoprazole tab
PROTONIX PAK [AR BvG]
rabeprazole
	DEXILANT [BvG]
	esomeprazole granules
	KONVOMEP
	lansoprazole ODT
	omeprazole/sodium bicarbonate
	pantoprazole packet [AR]
	PRILOSEC SUSP
		LENGTH OF AUTHORIZATIONS: 180 days, except as listed under additional criteria
		
		NON-PREFERRED CRITERIA:
		• Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs in this UPDL category and indicated for diagnosis
		
		ADDITIONAL CRITERIA FOR PPI DOSES GREATER THAN ONCE DAILY
		• Must have had an inadequate clinical response of at least 30 days of once daily dosing with the requested drug **OR**
		• 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)
		
		AR – PROTONIX PAK/pantoprazole packet: a PA is required for patients 6 years and older

Gastrointestinal Agents: Ulcerative Colitis		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ORAL		**LENGTH OF AUTHORIZATIONS**: 365 Days **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs in this UPDL category within the same sub-section classification and indicated for diagnosis, if available **ADDITIONAL BUDESONIDE (UCERIS) CRITERIA:** • Must have had a documented side effect, allergy, or treatment failure of at least 30 days with mesalamine enema or suppository **ADDITIONAL OZANIMOD (ZEPOSIA) AND ETRASIMOD (VELSIPITY) CRITERIA:** • Must have had a documented side effect, allergy, or treatment failure of at least 90 days with at least one preferred Systemic Immunomodulator indicated for Ulcerative Colitis (refer to Immunomodulator Agents: Systemic Inflammatory Disease class for complete list)
balsalazide disodium budesonide ER tab mesalamine DR cap, tab 1.2gm mesalamine ER cap 0.375gm, 500mg PENTASA 250mg sulfasalazine IR, DR	DIPENTUM mesalamine DR tab 800mg VELSIPITY ZEPOSIA	
RECTAL		
mesalamine enema, supp	budesonide rectal foam mesalamine enema kit SF ROWASA	

Gastrointestinal Agents: Unspecified GI		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
bisacodyl dicyclomine diphenoxylate/atropine lactulose LINZESS loperamide lubiprostone [ST] MOVANTIK [ST] polyethylene glycol oral powder bottle senna	AEMCOLO AMITIZA GATTEX IBSRELA MYTESI polyethylene glycol oral powder packet prucalopride SYMPROIC	**LENGTH OF AUTHORIZATIONS**: 365 days except 3 days for AEMCOLO **STEP THERAPY CRITERIA:** • Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs in this UPDL category, if indicated for diagnosis **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 14 days with one step therapy drug this UPDL category and indicated for diagnosis **ADDITIONAL 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: azithromycin, ciprofloxacin, levofloxacin, or ofloxacin **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		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ALPHA BLOCKERS		**LENGTH OF AUTHORIZATIONS**: 365 Days **TADALAFIL (CIALIS) CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least one alpha-1 adrenergic blocker. 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 have had an inadequate clinical response of at least 60 days with at least two preferred drugs, with at least one preferred within the same sub-section classification and indicated for diagnosis, if available
alfuzosin	CARDURA XL	
doxazosin	TEZRULY	
prazosin		
silodosin		
tamsulosin		
terazosin		
5-ALPHA-REDUCTASE (5AR) INHIBITORS		
dutasteride		
finasteride 5mg		
ALPHA BLOCKER/5AR/PDE5 INHIBITOR COMBINATIONS		
	dutasteride/tamsulosin	
PHOSPHODIESTERASE 5 (PDE5) INHIBITORS		
tadalafil [PA] 2.5, 5mg		

Genitourinary Agents: Electrolyte Depleter Agents		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
CALCIUM BASED		**LENGTH OF AUTHORIZATIONS**: 365 Days **STEP THERAPY CRITERIA:** • Must have had an inadequate clinical response of at least 7 days with at least one preferred drug in this UPDL category **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 14 days with at least one preferred step therapy drug in this UPDL category and indicated for diagnosis, if available
calcium acetate, carbonate		
IRON BASED		
VELPHORO ST	ferric citrate tab	
OTHER		
sevelamer	FOSRENOL POWDER lanthanum carbonate XPHOZAH	

Genitourinary Agents: Urinary Antispasmodics		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ANTIMUSCARINICS		**LENGTH OF AUTHORIZATIONS**: 365 Days **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs in this UPDL category and indicated for diagnosis, one of which must be within the same sub-section classification, if available **AR** – MYRBETRIQ GRANULES: a PA is required for patients younger than 3 years old AND 5 years and older **AR** – VESICARE LS: a PA is required for patients younger than 2 years old AND 5 years and older
fesoterodine oxybutynin IR, ER OXYTROL solifenacin trospium IR, ER	darifenacin tolterodine IR, ER VESICARE LS [AR]	
BETA-3 AGONISTS		
MYRBETRIQ TAB [BvG]	GEMTESA mirabegron tab MYRBETRIQ GRANULES [AR]	

Hyperkalemia Agents: Potassium Binders		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
LOKELMA VELTASSA	kionex susp sodium polystyrene sulfonate	**LENGTH OF AUTHORIZATIONS:** 365 Days **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least one preferred drug in this UPDL category and indicated for diagnosis

Immunomodulator Agents: Systemic Inflammatory Disease		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
INTERLEUKIN ANTAGONISTS		**LENGTH OF AUTHORIZATIONS**: Initial: 90 days; Subsequent: 365 days **CLINICAL PA CRITERIA:** • 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 date of negative TB test within the past 365 days 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 in this UPDL category **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 90 days with at least two preferred drugs in this UPDL category that are not biosimilars of the same reference product and indicated for diagnosis ○ For non-preferred immunomodulators: must provide documentation of inadequate clinical response to its preferred reference product or biosimilar, in this UPDL category and indicated for the diagnosis, if available **ADDITIONAL NEMOLIZUMAB (NEMLUVIO) CRITERIA:** • Must have had an inadequate clinical response of at least 90 days with DUPIXENT and indicated for prurigo nodularis **ADDITIONAL ALOPECIA AREATA CRITERIA:** • Must be prescribed by or in consultation with a specialist (i.e., dermatologist, rheumatologist)
ADBRY PA	ACTEMRA	
DUPIXENT PA	BIMZELX	
EBGLYSS PA	COSENTYX	
KINERET PA	ILUMYA	
NEMLUVIO PA	IMULDOSA (Bio of STELARA)	
PYZCHIVA BvG PA (Bio of STELARA)	KEVZARA	
SKYRIZI PA	OMVOH	
STEQEYMA PA (Bio of STELARA)	OTULFI (Bio of STELARA)	
TALTZ PA ST	ustekinumab (gen of STELARA)	
TREMFYA PA	ustekinumab-aekn (gen of SELARSDI)	
TYENNE PA (Bio of ACTEMRA)	ustekinumab-ttwe (gen of PYZCHIVA)	
	YESINTEK (Bio of STELARA)	
JAK INHIBITORS		
RINVOQ PA	CIBINQO	
XELJANZ IR PA	LEQSELVI	
	LITFULO	
	OLUMIANT	
	XELJANZ SOLN, XR	
TNF INHIBITORS		
adalimumab-adaz PA (gen of HYRIMOZ)	ABRILADA (Bio of HUMIRA)	
adalimumab-fkjp PA [labeler 83257]	adalimumab-aacf (gen of IDACIO)	
AMJEVITA PA 10/0.1ml (Bio of HUMIRA)	adalimumab-aaty (gen of YUFLYMA)	
AVSOLA PA (Bio of REMICADE)	adalimumab-adbm (gen of CYLTEZO)	
ENBREL PA	adalimumab-fkjp [labeler 49502]	
HUMIRA PA	adalimumab-ryvk (gen of SIMLANDI)	
infliximab PA (gen of REMICADE)	AMJEVITA 10/0.2ml (Bio of HUMIRA)	
SIMLANDI BvG PA (Bio of HUMIRA)	CIMZIA	
	HADLIMA (Bio of HUMIRA)	
	HYRIMOZ (Bio of HUMIRA)	
	INFLECTRA (Bio of REMICADE)	

	RENFLEXIS (Bio of REMICADE) SIMPONI YUSIMRY (Bio of HUMIRA) ZYMFENTRA	• 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 an inadequate clinical response of at least 45 days with two of the following: topical corticosteroids or topical calcineurin inhibitors [e.g., tacrolimus, pimecrolimus] unless atopic dermatitis is severe and involves >25% BSA **ADDITIONAL CHRONIC SPONTANEOUS URTICARIA CRITERIA:** • Must be prescribed by or in consultation with a specialist (i.e. allergist/ immunologist , dermatologist, rheumatologist) • Must have had an inadequate clinical response of at least 14 days with at least two different second-generation antihistamines at 4 times standard dose **ADDITIONAL PRURIGO NODULARIS 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
OTHER		
OTEZLA PA	ENTYVIO ORENCIA SOTYKTU	

Infectious Disease Agents: Antibiotics – Cephalosporins		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
cefaclor IR cefaclor susp [AR] cefadroxil cefdinir cefprozil cefprozil susp [AR] cefuroxime cephalexin cap 250, 500mg cephalexin susp	cefaclor ER cefixime cap cefixime susp [AR] cefpodoxime cephalexin cap 750mg, tab	**LENGTH OF AUTHORIZATIONS**: Based on indication **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 3 days with at least one preferred drug in this UPDL category and indicated for diagnosis **ADDITIONAL INFORMATION** • Requests may be authorized if 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 susp: a PA is required for patients 12 years and older **AR** – cefixime susp: a PA is required for patients 12 years and older **AR** – cefprozil susp: a PA is required for patients 12 years and older

Infectious Disease Agents: Antibiotics – Inhaled		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
tobramycin 300mg/5ml neb soln [PA] tobramycin inj	ARIKAYCE BETHKIS [BvG] CAYSTON TOBI PODHALER	**LENGTH OF AUTHORIZATIONS:** Initial: 180 days; Subsequent: 365 days **CLINICAL PA CRITERIA:** • Must provide documentation of cultures demonstrating drug is prescribed in alignment with approved indication **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 28 days with at least one preferred drug in this UPDL category and indicated for diagnosis **SUBSEQUENT AUTHORIZATION CRITERIA:** • Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring (i.e., culture conversion, symptom improvement)

Infectious Disease Agents: Antibiotics – Macrolides		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
azithromycin clarithromycin IR, susp [AR]	clarithromycin ER erythromycin IR, ER	**LENGTH OF AUTHORIZATIONS**: Based on indication **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 3 days with at least one preferred drug in this UPDL category and indicated for diagnosis **ADDITIONAL INFORMATION** • Requests may be authorized if 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** – clarithromycin susp: a PA is required for patients 12 years and older

Infectious Disease Agents: Antibiotics – Quinolones		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
CIPRO ORAL SUSP [AR] ciprofloxacin ciprofloxacin susp [AR] levofloxacin soln [AR], tab moxifloxacin	BAXDELA ofloxacin	**LENGTH OF AUTHORIZATIONS**: Based on indication **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 3 days with at least one preferred drug in this UPDL category and indicated for diagnosis **ADDITIONAL INFORMATION** • Requests may be authorized if 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 susp: a PA is required for patients 12 years and older **AR** – CIPRO ORAL SUSP: a PA is required for patients 12 years and older **AR** – levofloxacin oral soln: a PA is required for patients 12 years and older

Infectious Disease Agents: Antibiotics – Tetracyclines		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
doxycycline 20, 50, 100mg doxycycline susp [AR] minocycline IR tetracycline	demeclocycline doxycycline 75, 150mg doxycycline DR minocycline ER NUZYRA	**LENGTH OF AUTHORIZATIONS**: Based on indication for acute infections or 365 days for acne **NON-PREFERRED CRITERIA:** • 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 in this UPDL category and indicated for diagnosis **ADDITIONAL INFORMATION** • Requests may be authorized if 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** – doxycycline susp: a PA is required for patients 12 years and older

Infectious Disease Agents: Antifungals		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
clotrimazole fluconazole griseofulvin itraconazole cap ketoconazole nystatin terbinafine voriconazole susp [AR], tab	BREXAFEMME CRESEMBA flucytosine itraconazole soln NOXAFIL PAK ORAVIG posaconazole TOLSURA VIVJOA	**LENGTH OF AUTHORIZATIONS**: Based on indication **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 3 days with at least two preferred drugs in this UPDL category and indicated for diagnosis **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:** • posaconazole can be approved for aspergillosis treatment and prophylaxis without trials of preferred agents • Requests may be authorized if 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** – voriconazole susp: a PA is required for patients 12 years and older

Infectious Disease Agents: Antivirals – Coronavirus Agents		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
PAXLOVID		All products are covered without a PA

Infectious Disease Agents: Antivirals – Hepatitis C Agents		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
MAVYRET [PA] PEGASYS [PA] ribavirin [PA] sofosbuvir/velpatasvir [PA]	HARVONI ledipasvir/sofosbuvir SOVALDI VOSEVI ZEPATIER	**LENGTH OF AUTHORIZATIONS:** Dependent upon authorized course **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 have had an inadequate clinical response defined as not achieving sustained virologic response (SVR) with guideline-recommended preferred drugs in this UPDL category and indicated for diagnosis

Infectious Disease Agents: Antivirals – Herpes		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
acyclovir valacyclovir	famciclovir SITAVIG	**LENGTH OF AUTHORIZATIONS**: For the duration of the prescription (up to 180 days) **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 3 days with at least one preferred drug in this UPDL category and indicated for diagnosis

Infectious Disease Agents: Antivirals – HIV* LEGACY CATEGORY		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
INTEGRASE STRAND TRANSFER INHIBITORS		**LENGTH OF AUTHORIZATIONS:** 365 Days **ABACAVIR/DOLUTEGRAVIR/LAMIVUDINE (TRIUMEQ PD) CRITERIA:** • Must provide documentation of patient's weight (only authorized for those 6 – 25 kg) **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least one preferred drug in this UPDL category and indicated for diagnosis. If applicable, the request must address the inability to use the individual components. **AR** – EDURANT SUSP: a PA is required for patients 12 years and older **AR** – ISENTRESS CHEWABLE TABLET: a PA is required for patients 12 years and older **AR** – lamivudine soln: a PA is required for patients 3 years and older **AR** – nevirapine soln: a PA is required for patients 3 years and older
APRETUDE	VOCABRIA	
ISENTRESS		
ISENTRESS CHEW TAB [AR]		
TIVICAY		
TIVICAY PD		
NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS		
abacavir	abacavir soln	
emtricitabine	EMTRIVA SOLN	
entecavir	lamivudine tab	
lamivudine soln [AR]	VIREAD 250, 300mg TAB	
tenofovir dis fum 300mg		
VIREAD 150, 200mg TAB, POWDER		
zidovudine		
NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS		
efavirenz	EDURANT SUSP [AR], TAB	
nevirapine soln [AR]	etravirine	
PIFELTRO	nevirapine IR, ER tab	
PROTEASE INHIBITORS		
atazanavir	APTIVUS	
darunavir 600, 800mg tab	fosamprenavir	
EVOTAZ	NORVIR POWDER	
PREZCOBIX	PREZISTA SUSP, 75, 150mg TAB	
REYATAZ POWDER	VIRACEPT	
ritonavir tab		
OTHER SINGLE INGREDIENT PRODUCTS		
RUKOBIA	FUZEON	
	SELZENTRY [BvG]	
	SUNLENCA	
	TYBOST	
COMBINATION PRODUCTS		

abacavir/lamivudine BIKTARVY CABENUVA COMPLERA [BvG] DELSTRIGO DESCOVY DOVATO efavirenz/emtricitabine/tenofovir emtricitabine/tenofovir dis fum GENVOYA JULUCA lopinavir/ritonavir ODEFSEY SYMFI [BvG] SYMTUZA TRIUMEQ TRIUMEQ PD [PA]	CIMDUO efavirenz/lamivudine/tenofovir dis fum emtricitabine/rilpivirine/tenofovir lamivudine/zidovudine STRIBILD SYMFI LO [BvG] YEZTUGO	

Ophthalmic Agents: Antibiotic and Antibiotic-Steroid Combination Drops and Ointments		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
bacitracin-polymyxin CILOXAN ciprofloxacin erythromycin gentamicin moxifloxacin neo/poly/bacitracin neo/poly/bacitracin/hydrocortisone neo/poly/dexamethasone neo/poly/gramicidin ofloxacin polymyxin/trimethoprim sulfacetamide sodium soln 10% sulfacetamide/prednisolone TOBRADEX OINT tobramycin tobramycin/dexameth 0.3/0.1% TOBREX OINT	AZASITE bacitracin BESIVANCE gatifloxacin moxifloxacin (gen of MOXEZA) neo/poly/hydrocortisone sulfacetamide sodium oint 10% TOBRADEX ST ZYLET	**LENGTH OF AUTHORIZATIONS**: 30 days **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 3 days with at least two preferred drugs in this UPDL category and indicated for diagnosis **ADDITIONAL INFORMATION** • Requests may be authorized if 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		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
azelastine BEPREVE [BvG] cromolyn ketotifen olopatadine	bepotastine epinastine ZERVIATE	**LENGTH OF AUTHORIZATIONS**: 365 Days **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 7 days with at least two preferred drugs in this UPDL category and indicated for diagnosis

Ophthalmic Agents: Dry Eye Treatments		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
RESTASIS TRAYS [BvG] XIIDRA [ST]	CEQUA cyclosporine MIEBO RESTASIS MULTI-DOSE TRYPTYR TYRVAYA VEVYE	**LENGTH OF AUTHORIZATIONS**: 365 days **STEP THERAPY CRITERIA:** • Must have had an inadequate clinical response of at least 14 days with at least one preferred drug in this UPDL category in the previous 120 days **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs in this UPDL category and indicated for diagnosis **ADDITIONAL ACOLTREMON (TRYPTYR) AND CYCLOSPORINE (VEVYE) CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with CEQUA and indicated for diagnosis

Ophthalmic Agents: Glaucoma Agents		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ALPHA-2 AGONISTS		**LENGTH OF AUTHORIZATIONS**: 365 Days **STEP THERAPY CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least one preferred drug in the same sub-section classification in this UPDL category and indicated for diagnosis, if available **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs within the same sub-section classification in this UPDL category and indicated for diagnosis
ALPHAGAN P 0.1% BvG	apraclonidine	
ALPHAGAN P 0.15% BvG	brimonidine 0.1%, 0.15%	
brimonidine 0.2%	IOPIDINE	
BETA BLOCKERS		
betaxolol	BETIMOL 0.25%	
carteolol	BETOPTIC S	
levobunolol	timolol hemihydrate soln 0.5%	
timolol gel, soln	timolol maleate once daily, PF	
CARBONIC ANHYDRASE INHIBITORS		
AZOPT BvG ST	brinzolamide	
dorzolamide		
PROSTAGLANDINS		
latanoprost	bimatoprost	
TRAVATAN Z BvG ST	IYUZEH	
	LUMIGAN	
	tafluprost	
	travoprost	
	VYZULTA	
	XELPROS	
OTHER		
COMBIGAN BvG ST	brimonidine/timolol	
dorzolamide/timolol		
RHOPRESSA		
ROCKLATAN		
SIMBRINZA		

Ophthalmic Agents: NSAIDs		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
diclofenac flurbiprofen ketorolac NEVANAC	ACUVAIL bromfenac ILEVRO	**LENGTH OF AUTHORIZATIONS**: 30 days **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 3 days with at least two preferred drugs in this UPDL category and indicated for diagnosis

Ophthalmic Agents: Ophthalmic Steroids		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ALREX [BvG] dexamethasone sodium phosphate DUREZOL [BvG] EYSUVIS FLAREX fluorometholone FML FORTE LOTEMAX [BvG] MAXIDEX PRED FORTE [BvG] PRED MILD prednisolone sodium phosphate	difluprednate INVELTYS LOTEMAX SM loteprednol prednisolone acetate	**LENGTH OF AUTHORIZATIONS**: 30 days **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 10 days with at least two preferred drugs in this UPDL category and indicated for diagnosis

Otic Agents: Antibacterial and Antibacterial/Steroid Combinations		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
CIPRO HC ciprofloxacin/dexamethasone CORTISPORIN-TC neomycin/poly B/hydrocortisone ofloxacin	ciprofloxacin ciprofloxacin/fluocinolone	**LENGTH OF AUTHORIZATIONS**: 30 days **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 3 days with at least two preferred drugs in this UPDL category and indicated for diagnosis

Respiratory Agents: Antihistamines – Second Generation		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
cetirizine cap, syr, tab cetirizine/pseudoephedrine desloratadine fexofenadine levocetirizine loratadine rapid dissolve loratadine syr, tab loratadine/pseudoephedrine	cetirizine chewable [AR] CLARINEX-D loratadine chewable [AR] fexofenadine/pseudoephedrine	**LENGTH OF AUTHORIZATIONS**: 365 Days **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 7 days with at least two preferred drugs in this UPDL category and indicated for diagnosis **AR** – cetirizine chewable, loratadine chewable: a PA is required for patients 6 years and older

Respiratory Agents: Cystic Fibrosis		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
CFTR MODULATORS		**LENGTH OF AUTHORIZATIONS:** Initial: 90 days; Subsequent: 365 days **CLINICAL PA CRITERIA:** • Must be prescribed by or in consultation with a pulmonologist or infectious disease specialist • For a CFTR Modulator, must provide documentation of the specific Cystic Fibrosis Transmembrane Conductance Regular (CFTR) genetic mutation **ADDITIONAL BRONCHITOL CRITERIA:** • Must be used as an add-on maintenance therapy • Must provide documentation of a completed BRONCHITOL Tolerance Test **AR** – TRIKAFTA PAK: a PA is required for patients 6 years and older
ALYFTREK [PA] KALYDECO [PA] ORKAMBI [PA] SYMDEKO [PA] TRIKAFTA [PA] PAK [AR], TAB		
NON-CFTR MODULATORS		
PULMOZYME [PA]		

Respiratory Agents: Epinephrine		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
epinephrine (labeler 49502) EPIPEN EPIPEN JR	AUVI-Q epinephrine (labeler 00093, 00115) NEFFY	**LENGTH OF AUTHORIZATIONS:** 365 Days **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response to at least one preferred drug in this UPDL category and indicated for diagnosis **SUBSEQUENT AUTHORIZATION CRITERIA:** • Subsequent reauthorizations for expired epinephrine auto-injectors are allowable

Respiratory Agents: Hereditary Angioedema		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**

ACUTE		**LENGTH OF AUTHORIZATIONS**: Acute: 30 days; Prophylaxis: 180 Days
		
		CLINICAL PA CRITERIA:
		• Acute Treatment
		  ○ Must provide documentation that diagnosis is verified by a C4 level below the lower limit of normal as defined by laboratory testing AND one of the following:
		  ▪ C1 inhibitor (C1-INH) antigenic level below the lower limit of normal as defined by laboratory testing; OR
		  ▪ C1-INH functional level below the lower limit of normal as defined by laboratory testing
		• Prophylactic Treatment
		  ○ Must not be used in combination with other prophylaxis agents
		  ○ Must provide documentation that diagnosis is verified by a C4 level below the lower limit of normal as defined by laboratory testing AND one of the following:
		  ▪ C1 inhibitor (C1-INH) antigenic level below the lower limit of normal as defined by laboratory testing; OR
		  ▪ C1-INH functional level below the lower limit of normal as defined by laboratory testing; OR
		  ▪ Presence of a known HAE-causing C1-INH mutation
		• All indications
		  ○ History of moderate or severe attacks such as airway swelling, severe abdominal pain, facial swelling, nausea and vomiting, or painful facial distortion
		
		NON-PREFERRED CRITERIA:
		• Must have had an inadequate clinical response of at least 3 days with at least one preferred acute drug in this UPDL category and indicated for diagnosis to request a non-preferred acute drug.
		• Must have had an inadequate clinical response such as lack of reduction of attacks based on patient report, frequency of ER visits, or frequency of hospitalizations with use of at least 14 days with at least two preferred prophylaxis drugs in this UPDL category and indicated

BERINERT PA icatibant acetate PA	KALBITOR RUCONEST	
PROPHYLAXIS		
HAEGARDA PA TAKHZYRO PA	ANDEMBRY CINRYZE ORLADEYO	

		for diagnosis to request a non-preferred prophylaxis drug.

Respiratory Agents: Inhaled Agents		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ANTICHOLINERGIC BRONCHODILATORS/COMBINATIONS		**LENGTH OF AUTHORIZATIONS**: 365 Days **CLINICAL PA CRITERIA:** • Must have had an inadequate clinical response of at least 14 days with an albuterol containing product **STEP THERAPY CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least one inhaled corticosteroid (ICS) **AND** at least one long-acting beta-agonist (LABA) **AND** at least one long-acting muscarinic-antagonist (LAMA) concurrently in this UPDL category and indicated for diagnosis, if available **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs in this UPDL category within the same sub-section classification and indicated for diagnosis **ADDITIONAL STEROID-CONTAINING INHALER CRITERIA:** • Must have had an inadequate clinical response of at least 14 days with at least one preferred steroid-containing drug **AR** – albuterol nebulizer soln 0.021% (0.63mg/3mL), 0.042% (1.25mg/3mL): a PA is required for patients 13 years and older **AR** – budesonide nebulizer soln: a PA is required for patients 13 years and older **AR** – fluticasone propionate: a PA is required for patients 18 years and older
ANORO ELLIPTA BvG	BEVESPI AEROSPHERE	
ATROVENT HFA	DUAKLIR PRESSAIR	
COMBIVENT RESPIMAT	tiotropium inhaled caps	
INCRUSE ELLIPTA	TUDORZA	
ipratropium	umeclidinium/vilanterol	
ipratropium/albuterol neb soln	YUPELRI	
SPIRIVA BvG		
STIOLTO		
ADRENERGIC BRONCHODILATORS		
albuterol HFA	formoterol fumarate	
albuterol neb 0.021% (0.63mg/3mL), 0.042% (1.25mg/3mL) AR	levalbuterol	
albuterol neb 0.083% (2.5mg/3mL)	PROAIR DIGIHALER	
albuterol neb 0.5% (5mg/mL) conc		
arformoterol neb		
PROAIR RESPICLICK		
SEREVENT DISKUS		
STRIVERDI RESPIMAT		
VENTOLIN HFA		
XOPENEX HFA BvG		
BRONCHODILATOR/GLUCOCORTICOID COMBINATIONS		
ADVAIR HFA BvG	BREO ELLIPTA BvG	
AIRSUPRA PA	BREYNA	
DULERA	budesonide/formoterol	
fluticasone/salmeterol diskus	fluticasone/salmeterol HFA	
SYMBICORT BvG	WIXELA INHUB	
GLUCOCORTICOIDS		
ARNUITY ELLIPTA BvG	ALVESCO	
ASMANEX TWISTHALER	ARMONAIR DIGIHALER	
budesonide neb susp AR	ASMANEX HFA	

FLOVENT fluticasone propionate [AR] PULMICORT FLEXHALER QVAR	fluticasone furoate	
TRIPLE INGREDIENT INHALERS		
BREZTRI AEROSPHERE [ST] TRELEGY ELLIPTA [ST]		
OTHER		
cromolyn neb soln		

Respiratory Agents: Leukotriene Receptor Modifiers & Inhibitors		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
montelukast zafirlukast [ST]	zileuton ER ZYFLO	**LENGTH OF AUTHORIZATIONS**: 365 Days **STEP THERAPY CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least one preferred drug in this UPDL category **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs in this UPDL category and indicated for diagnosis

Respiratory Agents: Monoclonal Antibodies-Anti-IL/Anti-IgE		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**

CINQAIR [PA]
DUPIXENT [PA]
FASENRA [PA]
NUCALA [PA]
XOLAIR [PA]
	TEZSPIRE	**LENGTH OF AUTHORIZATIONS:** Initial: 180 days; Subsequent: 365 days
		
		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 Spontaneous Urticaria** – Must have had an inadequate clinical response of at least 14 days with at least two different second-generation antihistamines at 4 times standard dose
		• For **Chronic Obstructive Pulmonary Disease (COPD)**:
		  ○ The patient must have an eosinophilic count of greater than or equal to 150 cells per mcL within 12 months prior to initiation of therapy **AND**
		  ○ The patient has a history of uncontrolled disease, as indicated by greater than or equal to 1 COPD exacerbation resulting in a hospitalization despite being on standard of care, defined as triple therapy (LAMA+LABA+ICS) for at least 3 months prior to request, and at a stable dose for at least 1 month prior.
		
		NON-PREFERRED CRITERIA:
		• Must have had an inadequate clinical response of at least 90 days with at least two preferred drugs in this UPDL category and indicated for diagnosis
		
		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		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
GLUCOCORTICOIDS/COMBINATIONS		**LENGTH OF AUTHORIZATIONS**: 365 days **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs in this UPDL category within the same sub-section classification and indicated for diagnosis
flunisolide fluticasone (gen of FLONASE)	azelastine/fluticasone spray BECONASE AQ mometasone OMNARIS QNASL RYALTRIS XHANCE ZETONNA	
OTHER		
azelastine ipratropium olopatadine		

Respiratory Agents: Pulmonary Fibrosis		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
OFEV [PA] pirfenidone [PA]		**LENGTH OF AUTHORIZATIONS:** 365 Days **CLINICAL PA CRITERIA:** • Must be prescribed by or in consultation with a pulmonologist

Sickle Cell Gene Therapy Agents		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
CASGEVY [PA] LYFGENIA [PA]		**LENGTH OF AUTHORIZATIONS:** 365 Days **CLINICAL PA CRITERIA:** • Please see the Prior Authorization Form for criteria

Topical Agents: Antifungals		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
ALEVAZOL butenafine ciclopirox clotrimazole clotrimazole/betamethasone econazole ketoconazole miconazole nystatin nystatin/triamcinolone terbinafine tolnaftate cream, powder	ciclopirox kit ketoconazole foam miconazole/zinc/white petrolatum oint naftifine oxiconazole OXISTAT tavaborole tolnaftate soln	**LENGTH OF AUTHORIZATIONS**: 365 days **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs in this UPDL category and indicated for diagnosis

Topical Agents: Antiparasitics		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
NATROBA permethrin piperonyl butoxide/pyrethrins spinosad [labeler 52246] VANALICE	CROTAN ivermectin lot malathion spinosad [labeler 28595]	**LENGTH OF AUTHORIZATIONS**: 14 Days **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 14 days with at least one preferred drug in this UPDL category and indicated for diagnosis

Topical Agents: Corticosteroids		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
LOW POTENCY		**LENGTH OF AUTHORIZATIONS**: 365 days **NON-PREFERRED CRITERIA:** ● Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs within the same sub-section classification in this UPDL category and indicated for diagnosis, if available
DERMA-SMOOTHE OIL desonide cream, oint fluocinolone acetonide 0.01% hydrocortisone	alclometasone desonide lotion TEXACORT	
MEDIUM POTENCY		
betamethasone valerate flurandrenolide fluticasone propionate cream, oint triamcinolone cream, lotion, oint	betamethasone val aerosol foam clocortolone pivalate fluocinolone acetonide 0.025% fluticasone propionate lotion hydrocortisone butyrate, valerate PANDEL triamcinolone spray	
HIGH POTENCY		
betamethasone dip/calcipotriene oint fluocinonide 0.05% mometasone furoate	betamethasone dip betamethasone dip/calcipotriene susp desoximetasone diflorasone diacetate ENSTILAR halcinonide	
ULTRA HIGH POTENCY		
clobetasol propionate	APEXICON E fluocinonide 0.1% halobetasol propionate ULTRAVATE	

Topical Agents: Immunomodulators		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
OPZELURA [ST] tacrolimus [AR] VTAMA [ST] ZORYVE CREAM, FOAM [ST]	EUCRISA HYFTOR pimecrolimus [AR] [labeler 00591, 68462]	**LENGTH OF AUTHORIZATIONS**: 365 Days **STEP THERAPY CRITERIA:** • Must have had an inadequate clinical response of at least 90 days with at least one preferred drug in this UPDL category **OR** documentation why patient is unable to take product not requiring step therapy **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 90 days with at least one preferred drug and one step therapy drug of different mechanisms of action in this UPDL category and indicated for diagnosis **AR** – tacrolimus and pimecrolimus: a PA is required for patients younger than 2 years old