Ohio Medicaid

Pharmacy Benefit Management Program

Department of Medicaid

Unified Preferred Drug List

Medicaid Fee-for-Service
and Managed Care Plans

Effective April 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 NDC or manufacturer, 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).
- For any non-preferred combination formulations, there must have had an inadequate clinical response of the preferred individual components.
- 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 manufacturers (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 subsections to divide the medications by their mechanism of action, route of administration, or duration of action. References to 'subsection' 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.

<table>
<tr><th colspan="3">Example Category</th></tr>
<tr><th>PREFERRED AGENTS</th><th>NON-PREFERRED AGENTS</th><th>PA CRITERIA</th></tr>
<tr><td>Example Drug</td><td>Example Drug</td><td><u>LENGTH OF AUTHORIZATIONS:</u> X days or Initial: X days; Subsequent: X days (if different)

<u>LEGACY*:</u>
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.

<u>CLINICAL PA CRITERIA (if applicable):</u>

<u>“DRUG” CRITERIA (if applicable):</u>

<u>STEP THERAPY CRITERIA:</u>
• Must have had an inadequate clinical response of at least <u>X days</u> with at least <u>X preferred</u> drugs

<u>NON-PREFERRED CRITERIA:</u>
• Must have had an inadequate clinical response of at least <u>X days</u> with <u>X preferred</u> drugs

<u>ADDITIONAL “DRUG” CRITERIA (if applicable):</u>

<u>ADDITIONAL INFORMATION (if applicable):</u>

<u>SUBSEQUENT AUTHORIZATION CRITERIA:</u>
• 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</td></tr>
</table>

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 subsections
- "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 subsection 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 subsection but only one preferred drug exists in the subsection **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

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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 ketorolac mefenamic acid meloxicam tab nabumetone naproxen IR, 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
SHORT-ACTING	
APAP/codeine [AR]	APAP/caffeine/ dihydrocodeine
but/APAP/caff/cod [AR] 50/325/40/30mg	but/APAP/caff/cod [AR] 50/300/40/30mg
but/ASA/caff/cod [AR]	fentanyl buccal tab, inj, lozenge
butorphanol	hydrocodone/APAP 5, 7.5, 10-300mg
codeine [AR]	hydrocodone/ibuprofen
hydrocodone/APAP 2.5, 5, 7.5, 10-325mg	levorphanol
hydromorphone IR	meperidine
morphine IR	oxymorphone IR
oxycodone IR cap, soln, tab	pentazocine/naloxone
oxycodone/APAP	PROLATE
tramadol IR [AR] 50mg	ROXYBOND
tramadol/APAP [AR]	tramadol IR [AR] soln, tab 25, 75, 100mg
LONG-ACTING	
BUTRANS [BvG PA]	BELBUCA
fentanyl patch [PA]	buprenorphine TD patch weekly
morphine ER tab [PA]	hydrocodone bitartrate ER 12HR cap
	hydrocodone bitartrate ER 24HR tab
	hydromorphone ER
	methadone
	morphine ER 24HR cap
	OXYCONTIN ER
	oxymorphone ER
	tramadol ER [AR]

PA CRITERIA

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:

- 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

		○ 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 ○ 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 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 ○ 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] (Bio of NEULASTA) NEUPOGEN [PA] NIVESTYM [PA] (Bio of NEUPOGEN) NYVEPRIA [PA] (Bio of NEULASTA)	FYLNETRA (Bio of NEULASTA) GRANIX LEUKINE NEULASTA RELEUKO (Bio of NEUPOGEN) ROLVEDON RYZNEUTA STIMUFEND (Bio of NEULASTA) UDENYCA (Bio of NEULASTA) ZARXIO (Bio of NEUPOGEN) ZIEXTENZO (Bio of NEULASTA)	**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] (Bio of EPOGEN)	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) & FITUSIRAN (QFITLIA) 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

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] rivaroxaban tab 2.5mg warfarin XARELTO SUSP [AR] [BvG] XARELTO TAB 10, 15, 20mg	rivaroxaban susp [AR] 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 aspirin/dipyridamole clopidogrel 75mg prasugrel ticagrelor	clopidogrel 300mg	**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
ACE INHIBITORS/DIURETICS/COMBINATIONS	
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	

PA CRITERIA

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 subsection 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

NON-PREFERRED FINERENONE (KERENDIA) CRITERIA:

- Must be prescribed by or in consultation with a cardiologist or nephrologist (or applicable specialist)
- For Heart Failure with Preserved Ejection Fraction (HFpEF) with LVEF >40%:
  - Must currently be on a SGLT2 inhibitor **OR**
  - 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
- For Chronic Kidney Disease associated with type 2 diabetes:
  - Must currently be on a SGLT2 inhibitor **AND**
  - Must be on a maximally tolerated dose of an angiotensin-converting enzyme inhibitor (ACEI) or angiotensin receptor blocker (ARB) **OR** have an allergy, contraindication, or intolerance to ACEI and ARB

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	

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);
  - 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

chlorthalidone eplerenone furosemide hydrochlorothiazide indapamide INZIRQO [AR] methazolamide metolazone spironolactone tab spironolactone/HCTZ torsemide triamterene triamterene/HCTZ		**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
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 tab 48, 54, 145, 160mg gemfibrozil	fenofibrate IR, DR cap fenofibrate tab 40, 120mg 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 subsection 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
ENDOTHELIN RECEPTOR ANTAGONISTS	
ambrisentan[PA] bosentan tab[PA]	bosentan susp OPSUMIT
PDE5 INHIBITORS	
sildenafil tab[PA] sildenafil susp[AR PA] tadalafil[PA]	TADLIQ[AR]
PROSTAGLANDINS	
epoprostenol	ORENITRAM treprostinil inj TYVASO YUTREPIA
OTHER	
	ADEMPAS OPSYNVI UPTRAVI WINREVAIR

PA CRITERIA

LENGTH OF AUTHORIZATIONS: 365 Days

CLINICAL PA CRITERIA:

- Must provide documentation of NYHA Functional Class symptoms for Pulmonary Hypertension experienced by patient

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, if available, one of which must be a phosphodiesterase-5 inhibitor

ADDITIONAL TREPROSTINIL INHALATION (TYVASO/YUTREPIA) CRITERIA:

- Must have had an inadequate clinical response of at least 12 weeks with ORENITRAM or treprostinil inj and indicated for diagnosis, if available

ADDITIONAL TADALAFIL (TADLIQ) CRITERIA:

- Must have had a documented side effect, allergy, or treatment failure of at least 30 days with sildenafil suspension

ADDITIONAL SELEXIPAG (UPTRAVI) AND SOTATERCEPT-CSRK (WINREVAIR) CRITERIA:

- 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 [AR] IR, ER memantine [AR] IR, ER rivastigmine [AR] cap, patch	ADLARITY [AR] galantamine soln [AR] LEQEMBI IQLIK [AR] memantine/donepezil [AR] 14-10, 21-10, 28-10mg memantine soln [AR] NAMZARIC [AR] 7-10MG ZUNVEYL [AR]	**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 **LECANEMAB-IRMB (LEQEMBI IQLIK) CRITERIA:** • Must have had at least 18 months of therapy with LEQEMBI IV • Continuation of therapy will be permitted for patients established on LEQEMBI IV **SUBSEQUENT BENZGALANTAMINE (ZUNVEYL), GALANTAMINE SOLN, LECANEMAB-IRMB (LEQEMBI IQLIK) AUTHORIZATION CRITERIA:** • Must have had a follow-up assessment including cognitive test(s) to determine if disease has not progressed to moderate or severe dementia **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 DIHYDROERGOTAMINE (BREKIYA) CRITERIA:** • Must have had an inadequate clinical response of at least 14 days with dihydroergotamine injection or nasal spray **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		
	BREKIYA 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

BRIVIACT SOLN [AR], TAB	CELONTIN [BvG]	**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

carbamazepine IR, ER	clonazepam ODT	
clobazam	ELEPSIA XR	
clonazepam tab	eslicarbazepine	
DIACOMIT [PA]	felbamate	
divalproex DR, ER	FINTEPLA	
EPIDIOLEX [PA]	lamotrigine ER	
ethosuximide	levetiracetam ER tab	
FYCOMPA [BvG ST]	levetiracetam tab for oral susp 250, 500mg (gen of SPRITAM)	
gabapentin	MOTPOLY XR	
lacosamide	OXTELLAR XR [BvG]	
lamotrigine chew, IR, ODT	perampanel	
levetiracetam IR tab, soln	rufinamide susp	
oxcarbazepine IR tab, susp	SPRITAM 750, 1000mg	
phenobarbital	SYMPAZAN	
phenytoin IR, ER	tiagabine	
pregabalin IR	topiramate ER, sprinkle cap	
primidone	TROKENDI XR [BvG]	
rufinamide tab	vigabatrin powder [AR], tab	
topiramate IR, soln [AR]	VIGAFYDE [AR]	
valproic acid	XCOPRI	
zonisamide cap	ZONISADE SUSP	
	ZTALMY	

		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
		  o Required trial of valproic acid (or a derivative) in combination with lamotrigine for at least 30 days
		• When prescribed for Dravet syndrome
		  o 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 – topiramate 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		
bupropion IR, SR (gen of WELLBUTRIN) 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 cap/tab 10, 20, 40mg; soln (gen of Prozac) 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 EXXUA MARPLAN phenelzine RALDESY REXULTI trazodone 300mg TRINTELLIX	

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

ADDITIONAL GEPIRONE (EXXUA) CRITERIA:

- Must have had an inadequate clinical response of at least 30 days with ALL of the following:
  - ONE norepinephrine/dopamine reuptake inhibitor (NDRI)
  - ONE serotonin-norepinephrine reuptake inhibitor (SNRI)

		○ TWO selective serotonin reuptake inhibitors (SSRIs) (ONE of which must be either vilazodone (VIIBRYD) OR vortioxetine (TRINTELLIX)

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

PREFERRED AGENTS	NON-PREFERRED AGENTS
NON-STIMULANTS	
atomoxetine [AR] clonidine ER (gen of KAPVAY) guanfacine ER ONYDA XR SUSP [AR] QELBREE [ST]	
STIMULANTS	
amphetamine/dextroamphetamine IR, ER (gen of ADDERALL) [AR] CONCERTA dexmethylphenidate [AR] IR, ER dextroamphetamine [AR] IR tab, ER cap 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 IR tab, soln [AR] PROCENTRA [AR] [BvG] QUILLICHEW ER [AR] QUILLIVANT XR [AR] RITALIN LA VYVANSE CAP [BvG]	amphetamine IR, ER tab amphetamine/dextroamphetamine ER (gen of MYDAYIS) AZSTARYS [AR] COTEMPLA XR ODT dextroamphetamine soln [AR] EVEKEO ODT JORNAY PM lisdexamfetamine cap methamphetamine methylphenidate chewable tab [AR] methylphenidate ER cap, tab (gen of APTENSIO XR, RELEXXII) methylphenidate TD patch VYVANSE CHEWABLE TAB [BvG] XELSTRYM [AR]

PA CRITERIA

LENGTH OF AUTHORIZATIONS: 365 days

STEP THERAPY CRITERIA:

- Must have had an inadequate clinical response of at least 30 days with atomoxetine **OR** at least one preferred ADHD agent.

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 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 – PROCENTRA 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 tab ARISTADA ARISTADA INITIO asenapine [ST] clozapine tab ERZOFRI FANAPT [ST] GEODON INVEGA HAFYERA ER [PA] INVEGA SUSTENNA INVEGA TRINZA lurasidone olanzapine paliperidone tab PERSERIS quetiapine IR, ER RISPERDAL CONSTA [BvG] risperidone ODT, soln, tab RYKINDO UZEDY VRAYLAR [ST] ziprasidone	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 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:
		  o Psychotic symptoms are severe and frequent enough to warrant treatment with an antipsychotic **AND** are not related to dementia or delirium
		  o 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
		  o 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 (gen of KAPVAY)
SUBLOCADE
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 dalfampridine dimethyl fumarate fingolimod GILENYA glatiramer glatopa KESIMPTA PLEGRIDY REBIF teriflunomide	BAFIERTAM 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 (gen of ADDERALL) AR armodafinil dextroamphetamine AR IR tab, ER cap methylphenidate ER tab (gen of METHYLIN ER, RITALIN SR) methylphenidate IR tab, soln AR modafinil PROCENTRA AR BvG	amphetamine IR tab dextroamphetamine soln AR 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 **AR** – PROCENTRA SOLN: a PA is required for patients 12 years and older **AR** – methylphenidate soln: a PA is required for patients 12 years and older

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 subsection classification in this UPDL category and indicated for diagnosis
carbamazepine IR, ER oxcarbazepine susp, tab		
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
COMT INHIBITORS	
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

PA CRITERIA

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 subsection 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.

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 IR, ER	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

<table>
<tr><th colspan="3">Dermatologic Agents: Topical Acne Products</th></tr>
<tr><th>PREFERRED AGENTS</th><th>NON-PREFERRED AGENTS</th><th>PA CRITERIA</th></tr>
<tr><td colspan="2">NON-RETINOIDS</td><td rowspan="4"><u>LENGTH OF AUTHORIZATIONS</u>: 365 Days

<u>NON-PREFERRED CRITERIA:</u>
• Must have had an inadequate clinical response with at least <u>two</u> <u>preferred</u> drugs within the same subsection classification in this UPDL category. Trials must be 30 days for preferred non-retinoids and 90 days for preferred retinoids.

<u>ADDITIONAL INFORMATION</u>
• 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</td></tr>
<tr><td>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</td><td>CLINDACIN KIT
clindamycin foam
clindamycin/benz perox 1.2-3.75%
dapsone gel
FINACEA FOAM
NEUAC
sodium sulfacetamide/sulfur
sodium sulfacetamide pads
WINLEVI</td></tr>
<tr><td colspan="2">RETINOIDS/COMBINATIONS</td></tr>
<tr><td>adapalene gel [AR] 0.1%, 0.3%
adapalene/benzoyl peroxide [AR]
tretinoin [AR] cream, gel</td><td>adapalene cream [AR]
clindamycin/tretinoin [AR]
tazarotene [AR]
tretinoin micro [AR]</td></tr>
</table>

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 (DMD) • 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 [NDC 00548] GVOKE ZEGALOGUE	glucagon emerg kit [NDC 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
RAPID-ACTING	
APIDRA FIASP HUMALOG U-100 (ALL EXC. TEMPO PEN) insulin lispro NOVOLOG U-100	ADMELOG AFREZZA HUMALOG U-100 TEMPO PEN HUMALOG U-200 KIRSTY (Bio of NOVOLOG) LYUMJEV MERILOG (Bio of NOVOLOG)
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 PEN, VIAL BvG LEVEMIR TOUJEO BvG TRESIBA U-100 BvG ST	BASAGLAR insulin degludec (gen of TRESIBA) insulin glargine vial (gen of LANTUS) insulin glargine-yfgn (gen of SEMGLEE) REZVOGLAR (Bio of LANTUS) TRESIBA U-200 BvG
MIXED INSULIN	
HUMALOG 50-50 HUMALOG 75-25 HUMULIN 70-30 insulin aspart pro/insulin aspart	NOVOLIN 70-30 NOVOLOG 70-30

PA CRITERIA

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 HIGH CONCENTRATION CRITERIA:

- Must require ≥ 80 units/dose or ≥ 200 units/day of U-100 insulin **OR**
- Patient is experiencing injection site pain due to large volume injections

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.
		  o Must include a patient specific A1C goal if less than 7%
		  o 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
		  o Must include current A1C
		    ▪ Must be from within last 6 months
		    ▪ Must demonstrate improvement from baseline when the requested medication was initiated

Endocrine Agents: Diabetes – Non-Insulin

PREFERRED AGENTS	NON-PREFERRED AGENTS
DPP4 INHIBITORS/COMBINATIONS	
JANUMET	alogliptin
JANUMET XR	alogliptin/metformin
JANUVIA	alogliptin/pioglitazone
JENTADUETO	BRYNOVIN
JENTADUETO XR	sitagliptin
KOMBIGLYZE XR	sitagliptin/metformin
ONGLYZA	
saxagliptin	
saxagliptin/metformin	
TRADJENTA	
GLP-1 RECEPTOR AGONISTS/COMBINATIONS	
BYETTA	BYDUREON BCISE
exenatide	MOUNJARO
liraglutide	OZEMPIC
TRULICITY	RYBELSUS
VICTOZA	SOLIQUA
	XULTOPHY
METFORMIN	
metformin ER (gen of GLUCOPHAGE XR)	metformin ER (gen of FORTAMET, GLUMETZA)
metformin IR 500, 850, 1000mg	metformin IR 625, 750mg; 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
SULFONYLUREAS/COMBINATIONS	
glimepiride 1, 2, 4mg	glimepiride 3mg

PA CRITERIA

LENGTH OF AUTHORIZATIONS: 365 Days

NON-PREFERRED CRITERIA:

- 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
  - Must include a patient specific A1C goal if less than 7%
  - Must include current A1C (within last 6 months)
  - Two preferred drugs must be used concurrently and one of the drugs must be in the same subsection as the requested medication
  - Three preferred drugs must be titrated to maximum treatment dose (must achieve maximum recommended dose for 120 days or document that maximum recommended dose is not tolerated or is clinically inappropriate)

ADDITIONAL TIRZEPATIDE (MOUNJARO) CRITERIA

- Prior to initiation, must have hemoglobin A1C>7% **AND**
- 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

ADDITIONAL SITAGLIPTIN (BRYNOVIN, ZITUVIO) CRITERIA

- 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

ADDITIONAL GLP-1 RECEPTOR AGONISTS/COMBINATIONS INFORMATION

- For GLP-1 receptor containing medications that were discontinued due to gastrointestinal intolerance, must submit chart documentation that the following approaches were tried for at least 30 days:

<table>
<tr><td>glipizide IR, ER
glipizide/metformin
glyburide
glyburide/metformin</td><td>glimepiride/pioglitazone</td><td rowspan="3">○ Dietary changes (e.g., eating apples, crackers, or mint- or ginger-based drinks 30 minutes after administering the GLP-1 Receptor Agonist) AND
○ Prescription antiemetics AND
○ Dose adjustment to remediate side effects experienced with higher doses of the GLP-1 Receptor Agonist

<u>SUBSEQUENT AUTHORIZATION CRITERIA:</u>
• Must provide documentation of patient’s clinical response to treatment and ongoing safety monitoring
○ Must include current A1C
▪ Must be from within last 6 months
▪ Must demonstrate improvement from baseline when the requested medication was initiated</td></tr>
<tr><td colspan="2">OTHER</td></tr>
<tr><td>acarbose
miglitol
nateglinide
pioglitazone
pioglitazone/metformin
repaglinide</td><td>SYMLINPEN</td></tr>
</table>

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 subsection 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) estradiol gel 0.1% (gen of DIVIGEL)	
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
DAILY-DOSING	
GENOTROPIN PA	HUMATROPE
NORDITROPIN PA	NUTROPIN
	OMNITROPE
	SEROSTIM
	ZOMACTON
WEEKLY-DOSING	
SKYTROFA PA ST	NGENLA
	SOGROYA

PA CRITERIA

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 subsection 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

Endocrine Agents: Osteoporosis – Bone Ossification Enhancers

PREFERRED AGENTS	NON-PREFERRED AGENTS
BISPHOSPHONATES	
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	BILDYOS (Bio of PROLIA) CONEXXENCE (Bio of PROLIA) EVENITY JUBBONTI (Bio of PROLIA) PROLIA STOBOCLO (Bio of PROLIA) teriparatide TYMLOS

PA CRITERIA

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 subsection 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)

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 subsection classification and indicated for diagnosis
granisetron tab ondansetron 4, 8mg	ondansetron 16mg SANCUSO	
ANTICHOLINERGICS		
scopolamine		
ANTIHISTAMINES and ANTIHISTAMINE COMBINATIONS		
dimenhydrinate diphenhydramine doxylamine/pyridoxine meclizine trimethobenzamide	BONJESTA	
PHENOTHIAZINES		
prochlorperazine promethazine		
SUBSTANCE P/NEUROKININ 1 (NK-1) ANTAGONISTS		
aprepitant 40mg, tripac EMEND SUSP 125mg	aprepitant 80, 125mg	
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 or an inability to tolerate a high volume preferred bowel preparation during a previous colonoscopy 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 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 cap, tab
lansoprazole cap
NEXIUM GRANULES [BvG]
omeprazole cap, tab
pantoprazole tab
PROTONIX PAK [AR BvG]
rabeprazole
	DEXILANT [BvG]
	esomeprazole granules
	KONVOMEP
	lansoprazole ODT
	omeprazole 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 subsection classification and indicated for diagnosis, if available **ADDITIONAL BUDESONIDE RECTAL FOAM 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 subsection classification and indicated for diagnosis, if available
alfuzosin doxazosin prazosin silodosin tamsulosin terazosin	CARDURA XL TEZRULY	
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 subsection 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: Monoclonal Antibody Biologics/Small-Molecule Kinase Inhibitors		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**

CINQAIR PA
DUPIXENT PA
FASENRA PA
NUCALA PA
RHAPSIDO 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, dermatologist, 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 H1 antihistamines at 4 times standard dose
		    ○ Must continue use of second-generation H1 antihistamine
		• 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)

Immunomodulator Agents: Systemic Inflammatory Disease

PREFERRED AGENTS	NON-PREFERRED AGENTS
INTERLEUKIN ANTAGONISTS	
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	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-ryvk (gen of SIMLANDI)
HUMIRA PA	AMJEVITA 10/0.2ml (Bio of HUMIRA)
infliximab PA (gen of REMICADE)	CIMZIA
SIMLANDI BvG PA (Bio of HUMIRA)	HADLIMA (Bio of HUMIRA)
	HYRIMOZ (Bio of HUMIRA)
	INFLECTRA (Bio of REMICADE)
	RENFLEXIS (Bio of REMICADE)
	SIMPONI
	YUSIMRY (Bio of HUMIRA)
	ZYMFENTRA

PA CRITERIA

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)
- Must provide documentation of an inadequate clinical response of at least 90 days with a topical steroid

OTHER		
OTEZLA PA OTEZLA XR PA	ENTYVIO ORENCIA SOTYKTU	**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

Infectious Disease Agents: Antibiotics – Cephalosporins		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
cefaclor IR, susp [AR] cefadroxil cefdinir cefprozil IR, susp [AR] cefuroxime cephalexin cap 250, 500mg; susp	cefaclor ER cefixime cap, tab, 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 susp [AR], tab 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 IR 20, 50, 100mg; susp[AR] minocycline IR tetracycline	demeclocycline doxycycline IR tab 75, 150mg; 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: Antiretrovirals (ARVs) – HIV Treatment and Prevention* LEGACY CATEGORY

PREFERRED AGENTS	NON-PREFERRED AGENTS
INTEGRASE STRAND TRANSFER INHIBITORS	
APRETUDE ISENTRESS ISENTRESS CHEW TAB [AR] TIVICAY TIVICAY PD	VOCABRIA
NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS	
abacavir emtricitabine entecavir lamivudine soln [AR] tenofovir dis fum 300mg VIREAD TAB 150, 200mg, POWDER zidovudine	abacavir soln EMTRIVA SOLN lamivudine tab VIREAD TAB 250, 300mg
NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS	
efavirenz nevirapine soln [AR] PIFELTRO	EDURANT SUSP [AR], TAB etravirine nevirapine IR, ER tab
PROTEASE INHIBITORS	
atazanavir darunavir tab 600, 800mg EVOTAZ PREZCOBIX REYATAZ POWDER ritonavir tab	APTIVUS fosamprenavir NORVIR POWDER PREZISTA SUSP; TAB 75, 150mg VIRACEPT
OTHER SINGLE INGREDIENT PRODUCTS	
RUKOBIA YEZTUGO	FUZEON maraviroc SUNLENCA TYBOST
COMBINATION PRODUCTS	
abacavir/lamivudine BIKTARVY CABENUVA	CIMDUO efavirenz/lamivudine/tenofovir dis fum emtricitabine/rilpivirine/tenofovir

PA CRITERIA

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 (such as a virological failure or confirmed resistance) 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

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

Metabolic Modifiers		
PREFERRED AGENTS	**NON-PREFERRED AGENTS**	**PA CRITERIA**
GLP-1 AGONISTS FOR NON-OBESITY INDICATIONS		**<u>LENGTH OF AUTHORIZATIONS</u>**: 180 days

WEGOVY [PA] INJ, TAB		**<u>CLINICAL PA CRITERIA:</u>**
		• Initial review for diagnosis of **Major Adverse Cardiovascular Events (MACE)**
		  ○ Age ≥18 years
		  ○ BMI ≥27 kg/m^2
		  ○ The prescriber must attest that the requested medication will not be received in combination with any other GLP-1, GLP-1/GIP
		  ○ Documentation (chart notes) must be submitted to show that the patient has history of one of the following:
		    ▪ Prior Myocardial Infarction
		    ▪ Prior stroke
		    ▪ Symptomatic peripheral artery disease (PAD) as evidenced by one or more of the following:
		      • Intermittent claudication with an ankle-brachial index (ABI) less than 0.85 (at rest)
		      • Peripheral arterial revascularization procedure (e.g., endarterectomy, angioplasty, stenting)
		      • Amputation due to Atherosclerotic Cardiovascular Disease (ASCVD)
		  ○ WEGOVY will not be authorized for patients with type 1 or type 2 diabetes. (For patients with type 1 or 2 diabetes, please see the Endocrine Agents: Non-Insulin Agents category)
		  ○ The patient is receiving standard of care for the treatment of cardiovascular disease (CVD), as appropriate/indicated, including an antiplatelet agent (aspirin or platelet aggregation inhibitor), lipid-lowering drug (statin, ezetimibe, fibrate, and/or PCSK-9 inhibitor), and an antihypertensive (beta blocker, ACEI, ARB). Documentation (chart notes) must be submitted to support current medication use or contraindications to these treatments (as applicable)

- Initial review for diagnosis of **Metabolic Dysfunction-Associated Steatohepatitis (MASH)**
  - Age ≥18 years
  - Must have documented noncirrhotic MASH with moderate to advanced liver fibrosis (stage F2 or F3) confirmed by liver biopsy within the prior 24 months **OR**
  - Must have documented noncirrhotic MASH and moderate to advanced liver fibrosis (stage F2 or F3) confirmed by **TWO** of the following:
    - Fibrosis-4 index greater than 1.3, magnetic resonance elastography (MRE), MRI aspartate aminotransferase (MAST), liver stiffness measurement (LSM) by vibration controlled transient elastography (e.g., Fibroscan)
  - Must attest that the patient has received instruction on a reduced calorie diet and increased physical activity and is adherent to these lifestyle modifications
  - Must attest that the patient has optimized care for concomitant related conditions, including coronary artery disease, dyslipidemia, hypertension
  - Not currently on another treatment for MASH (e.g., resmetirom)
  - Not currently on another GLP-1 Receptor Agonist containing agent

<u>**SUBSEQUENT AUTHORIZATION CRITERIA:**</u>

- **Major Adverse Cardiovascular Events (MACE)**
  - The prescriber attests that the patient is being monitored for efficacy and safety
  - Documentation (chart notes) must be submitted to show weight loss from baseline greater than or equal to 5%
  - Adherence documented by claims supporting an 80% proportion of days covered
  - WEGOVY will not be authorized for patients with type 1 or type 2 diabetes. (For patients with type 1 or 2 diabetes, please see the Endocrine Agents: Non-Insulin Agents category)
- **Metabolic Dysfunction-Associated Steatohepatitis (MASH)**
  - Weight loss from baseline of 5% or greater

		○ Patient has experienced a positive clinical response from WEGOVY as defined by the following: ▪ Resolution of steatohepatitis and no worsening of liver fibrosis, **OR** ▪ At least one stage improvement in liver fibrosis and no worsening of steatohepatitis ○ Must have been adherent with using WEGOVY, with claims supporting an 80% proportion of days covered

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 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
ALPHA-2 AGONISTS	
ALPHAGAN P [BvG] 0.1%, 0.15% brimonidine 0.2%	apraclonidine brimonidine 0.1%, 0.15% IOPIDINE
BETA BLOCKERS	
betaxolol carteolol levobunolol timolol gel, soln	BETOPTIC S timolol hemihydrate soln 0.5% timolol maleate once daily, PF
CARBONIC ANHYDRASE INHIBITORS	
AZOPT [BvG ST] dorzolamide	brinzolamide
PROSTAGLANDINS	
latanoprost TRAVATAN Z [BvG ST]	bimatoprost IYUZEH LUMIGAN tafluprost travoprost VYZULTA
OTHER	
COMBIGAN [BvG ST] dorzolamide/timolol RHOPRESSA ROCKLATAN SIMBRINZA	brimonidine/timolol

PA CRITERIA

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 subsection 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 subsection classification in this UPDL category and indicated for diagnosis

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 MILD prednisolone acetate prednisolone sodium phosphate	difluprednate INVELTYS LOTEMAX SM loteprednol	**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 **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 [NDC 49502] EPIPEN EPIPEN JR	AUVI-Q epinephrine [NDC 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
ACUTE	
BERINERT [PA]	EKTERLY
icatibant acetate [PA]	KALBITOR
	RUCONEST
PROPHYLAXIS	
HAEGARDA [PA]	ANDEMBRY
TAKHZYRO [PA]	CINRYZE
	DAWNZERA
	ORLADEYO

PA CRITERIA

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:

- Acute Treatment
  - Must have had an inadequate clinical response for any one acute angioedema episode defined as requiring at least two doses of rescue medication or need to be seen in the emergency department or admitted to the hospital due to persistent angioedema symptoms after the use of two rescue doses of at least one preferred drug within the same

		subsection classification in this UPDL category and indicated for diagnosis to request a non-preferred acute drug. ◦ Must be on prophylactic treatment. • Prophylactic Treatment ◦ Must have had an inadequate clinical response such as lack of reduction of attacks based on patient report, frequency of emergency department visits, or frequency of hospitalizations with use of at least 14 days with at least two preferred drugs within the same subsection classification in this UPDL category and indicated for diagnosis to request a non-preferred prophylaxis drug.

Respiratory Agents: Inhaled Agents

PREFERRED AGENTS	NON-PREFERRED AGENTS
ANTICHOLINERGIC BRONCHODILATORS/COMBINATIONS	
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
fluticasone/salmeterol respiclick	WIXELA INHUB
SYMBICORT [BvG]	
GLUCOCORTICOIDS	
ARNUITY ELLIPTA [BvG]	ALVESCO
ASMANEX TWISTHALER	ARMONAIR DIGIHALER
budesonide neb susp [AR]	ASMANEX HFA
fluticasone propionate	fluticasone furoate
QVAR	

PA CRITERIA

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 subsection 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

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: 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 subsection 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 cream, shampoo 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 [NDC 52246] VANALICE	CROTAN ivermectin lot malathion spinosad [NDC 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 subsection classification in this UPDL category and indicated for diagnosis, if available
DERMA-SMOOTHE OIL desonide cream, oint fluocinolone acetonide 0.01% hydrocortisone cream, lotion, oint	alclometasone desonide lotion hydrocortisone soln	
MEDIUM POTENCY		
betamethasone valerate cream, oint 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 [ST]	ANZUPGO EUCRISA HYFTOR pimecrolimus [AR]	**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