Department of Medicaid

Unified Preferred Drug List

Medicaid Fee-for-Service and Managed Care Plans

Effective July 1, 2026

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 Centers for Medicare & Medicaid Services (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. Throughout the UPDL document, brand name drugs are bolded and presented with standard capitalization, with the generic name listed in parentheses. 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 of 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 2 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
- To search the UPDL, press CTRL + F, click the page number on the table of contents to be brought to that page

UPDL Glossary of Key Phrases:

- "**of at least 120 days with at least 3 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

Glossary of 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

Auto-inj – auto-injector, **Cap** – capsule, **Inj** – injection, **Liq** – liquid, **Lot** – lotion, **Oint** – ointment, **Neb Soln** – nebulizing solution,
Pow – powder, **Soln** – solution, **Supp** – suppository, **Susp** – suspension, **Tab** – tablet
Chew – chewable tablet, **ODT** – orally disintegrating tablets, **SL** – sublingual, **TD** – transdermal
DR – delayed release**, ER** – extended release, **IR** – immediate release, **SR** – sustained release

UPDL Interpretation:

- 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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Example Category

Example Subsection (if applicable)

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)

Length of Authorization: X days or Initial: X days; Subsequent: X days (if different)

Clinical PA Criteria (if applicable)*:*

"Drug" Criteria (if applicable):

Step Therapy Criteria:

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

Non-Preferred Criteria:

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

Additional "Drug" Criteria (if applicable):

Subsequent Authorization Criteria:

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

Additional Information (if applicable):

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

Analgesic Agents: Gout

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
allopurinol 100, 300mg colchicine tab febuxostat **Mitigare** (colchicine cap) [BvG] probenecid probenecid/colchicine	allopurinol 200mg colchicine cap

Length of Authorization: 365 days

Non-Preferred Criteria:

- Must have had an inadequate clinical response of at least 30 days with at least 1 preferred drug in this UPDL category and indicated for diagnosis

Analgesic Agents: NSAIDs

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
celecoxib cap	diclofenac/misoprostol
diclofenac sodium DR, ER, gel 1%	diclofenac patch 1.3%; soln 1.5%, 2%
etodolac IR, ER	diclofenac potassium
flurbiprofen	**Elyxyb** (celecoxib soln)
ibuprofen cap, chew, susp; tab 200, 400, 600, 800mg	fenoprofen
indomethacin IR, ER	ibuprofen tab 300mg
ketorolac	ibuprofen/famotidine
mefenamic acid	indomethacin supp, susp
meloxicam tab	ketoprofen IR, ER
nabumetone 500, 750mg	meclofenamate
naproxen IR, susp [AR]	meloxicam cap
oxaprozin	naproxen DR, EC, ER
piroxicam	naproxen/esomeprazole
sulindac	**Relafen DS** (nabumetone) 1000mg
	tolmetin
	Vyscoxa (celecoxib susp)

Length of Authorization: 365 days

Non-Preferred Criteria:

- Must have had an inadequate clinical response of at least 30 days with at least 2 preferred drugs in this UPDL category and indicated for diagnosis

Additional Vyscoxa (celecoxib susp) Criteria:

- Must have had an inadequate clinical response of at least 30 days with naproxen susp (this may count as 1 of the 2 preferred trials listed above)

AR – a PA is required for patients 12 years old and older: naproxen susp

Analgesic Agents: Opioids

Short-Acting Opioids

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
APAP/codeine [AR]	APAP/caffeine/dihydrocodeine
butalbital/APAP/caffeine/codeine [AR] 50/325/40/30mg	butalbital/APAP/caffeine/codeine [AR] 50/300/40/30mg
butalbital/ASA/caffeine/codeine [AR]	fentanyl inj, lozenge
butorphanol	hydrocodone/APAP soln 10-300, 10-325mg; tab 5, 7.5, 10-300mg
codeine [AR]	hydrocodone/ibuprofen
hydrocodone/APAP soln 7.5-325mg; tab 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** (oxycodone/APAP)
tramadol IR [AR] tab 50mg	**Roxybond** (oxycodone coated tab)
tramadol/APAP [AR]	tramadol IR [AR] soln; tab 25, 75, 100mg

Long-Acting Opioids

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
Butrans (buprenorphine TD patch) [BvG PA]	**Belbuca** (buprenorphine buccal film)
fentanyl patch [PA]	buprenorphine TD patch
morphine ER tab [PA]	hydrocodone bitartrate ER 12HR cap
	hydrocodone bitartrate ER 24HR tab
	hydromorphone ER
	methadone
	morphine ER 24HR cap
	Oxycontin (oxycodone ER)
	oxymorphone ER
	tramadol ER [AR]

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 Authorization: Initial short-acting and long-acting requests may only be authorized for up to 90 days. For reauthorization, up to 180 days.

Buprenorphine Patch (Butrans) Criteria:

- For doses greater than 5 mcg/hour must provide documentation of an inadequate clinical response with at least 1 opioid formulation taken for at least 30 of the last 60 days

Fentanyl Patch & 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 1 opioid formulation taken for at least 30 of the last 60 days
- Must also meet Long-Acting Opioid Criteria below

Non-Preferred Criteria:

- Must have had an inadequate clinical response of at least 7 days of at least 2 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 below

Additional Short-Acting Opioid 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 Morphine Equivalent Dose (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 Opioid 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 of oral morphine daily
  - ≥ 25 mcg of transdermal fentanyl/hour
  - ≥ 30 mg of oral oxycodone daily
  - ≥ 8 mg of oral hydromorphone daily
  - ≥ 25 mg of oral oxymorphone daily
  - ≥ 60 mg of oral hydrocodone daily
  - Or ≥ 60 MED of another opioid daily

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

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

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
Fulphila (pegfilgrastim-jmdb) PA **Neupogen** (filgrastim) PA **Nivestym** (filgrastim-aafi) PA **Nyvepria** (pegfilgrastim-apgf) PA	**Fylnetra** (pegfilgrastim-pbbk) **Granix** (tbo-filgrastim) **Leukine** (sargramostim) **Neulasta** (pegfilgrastim) **Nypozi** (filgrastim-txid) **Releuko** (filgrastim-ayow) **Rolvedon** (eflapegrastim-xnst) **Ryzneuta** (efbemalenograstim alfa-vuxw) **Stimufend** (pegfilgrastim-fpgk) **Udenyca** (pegfilgrastim-cbqv) **Zarxio** (filgrastim-sndz) **Ziextenzo** (pegfilgrastim-bmez)

Length of Authorization: 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 1 preferred drug in this UPDL category and indicated for diagnosis

Blood Formation, Coagulation, and Thrombosis Agents: Hematopoietic Agents

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
Epogen (epoetin alfa) [PA] **Retacrit** (epoetin alfa-epbx) [PA]	**Aranesp** (darbepoetin alfa) **Mircera** (methoxy polyethylene glycol-epoetin beta) **Procrit** (epoetin alfa)

Length of Authorization: 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 2 preferred drugs in this UPDL category and indicated for diagnosis

Additional Aranesp (darbepoetin alfa) 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 (no PA required unless noted)	Non-Preferred Agents (PA required)
Adynovate PA	**Advate**
Alphanate PA	**Afstyla**
Altuviiio PA	**Alhemo**
Corifact PA	**Hympavzi**
Eloctate PA	**Nuwiq inj**
Esperoct PA	**Obizur**
Feiba PA	**Qfitlia**
Hemlibra PA	**Recombinate**
Hemofil M PA	**Sevenfact**
Humate-P PA	**Vonvendi**
Jivi PA	
Koate PA	
Kovaltry PA	
Novoeight PA	
Novoseven RT PA	
Nuwiq kit PA	
Wilate PA	
Xyntha PA	

Length of Authorization: 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, 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 1 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 Alhemo (concizumab-mtci) & Qfitlia (fitusiran) 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** (emicizumab-kxwh)
- Must have Hemophilia A **with or without** factor VIII inhibitors
- Must be prescribed by or in consultation with a hematologist

Additional Hympavzi (marstacimab-hncq) 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** (emicizumab-kxwh)
- Must have Hemophilia A **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 (no PA required unless noted)	Non-Preferred Agents (PA required)
Alphanine SD PA	**Alhemo**
Alprolix PA	**Hympavzi**
Benefix PA	**Qfitlia**
Feiba PA	**Sevenfact**
Idelvion PA	
Ixinity PA	
Novoseven RT PA	
Profilnine PA	
Rebinyn PA	
Rixubis PA	

Length of Authorization: 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, 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 1 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 (no PA required unless noted)	Non-Preferred Agents (PA required)
enoxaparin	fondaparinux **Fragmin** (dalteparin)

Length of Authorization: 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 1 preferred drug in this UPDL category and indicated for diagnosis

Blood Formation, Coagulation, and Thrombosis Agents: Oral Anticoagulants

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
dabigatran cap **Eliquis** (apixaban) **Pradaxa** (dabigatran) pellet pak [AR] rivaroxaban tab 2.5mg warfarin **Xarelto** (rivaroxaban) susp [AR BvG] **Xarelto** (rivaroxaban) tab 10, 15, 20mg	rivaroxaban susp [AR] **Savaysa** (edoxaban)

Length of Authorization: 365 days

Non-Preferred Criteria:

- Must have had an inadequate clinical response of at least 14 days with at least 2 preferred drugs in this UPDL category and indicated for diagnosis

AR – a PA is required for patients 12 years and older: Pradaxa (dabigatran) pellet pak, **Xarelto** (rivaroxaban) susp

Blood Formation, Coagulation, and Thrombosis Agents: Oral Antiplatelet

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
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 1 preferred drug in this UPDL category and indicated for diagnosis

Cardiovascular Agents: Angina, Hypertension and Heart Failure

Angiotensin-Converting Enzyme (ACE) Inhibitors & Combinations

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
amlodipine/benazepril	**Qbrelis** (lisinopril soln)
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	

Angiotensin II Receptor Blockers (ARBs) & Combinations

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
amlodipine/olmesartan	**Arbli** (losartan susp)
amlodipine/valsartan	**Edarbi** (azilsartan) BvG
amlodipine/valsartan/HCTZ	**Edarbyclor** (azilsartan/chlorthalidone)
candesartan	valsartan soln
candesartan/HCTZ	
irbesartan	

irbesartan/HCTZ losartan losartan/HCTZ olmesartan olmesartan/amlodipine/HCTZ olmesartan/HCTZ telmisartan telmisartan/amlodipine telmisartan/HCTZ valsartan tab valsartan/HCTZ	

Beta Blockers & Combinations

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
acebutolol atenolol atenolol/chlorthalidone betaxolol bisoprolol 5, 10mg bisoprolol/HCTZ carvedilol IR **Hemangeol** (propranolol soln) PA labetalol 100, 200, 300mg metoprolol succinate metoprolol tartrate metoprolol/HCTZ nadolol nebivolol propranolol IR, ER sotalol timolol	bisoprolol 2.5mg carvedilol ER **Innopran XL** (propranolol SR beads cap) **Kapspargo** (metoprolol succinate cap) labetalol 400mg **Lopressor** (metoprolol tartrate soln) AR **Sotylize** (sotalol soln) AR

Calcium Channel Blockers

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
amlodipine	diltiazem 24HR ER tab
cartia XT	isradipine
diltiazem IR	**Katerzia** (amlodipine susp)
diltiazem 12HR ER cap	nimodipine
diltiazem 24HR ER cap	nisoldipine
felodipine ER	**Norliqva** (amlodipine soln)
levamlodipine	**Nymalize** (nimodipine soln)
nicardipine	verapamil ER [generic **Verelan PM**]
nifedipine IR, ER	
verapamil IR, ER, SR	

Diuretics

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
acetazolamide IR, ER	**Hemiclor** (chlorthalidone tab) 12.5mg
amiloride	spironolactone susp
amiloride/HCTZ	
bumetanide	
chlorthalidone tab 25, 50mg	
eplerenone	
furosemide	
hydrochlorothiazide (HCTZ)	
indapamide	
Inzirqo (hydrochlorothiazide susp) AR	
methazolamide	
metolazone	
spironolactone tab	
spironolactone/HCTZ	
torsemide	
triamterene	
triamterene/HCTZ	

Other Agents

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
clonidine IR, patch	aliskiren
doxazosin	**Camzyos** (mavacamten)
guanfacine IR	clonidine ER [generic **Nexiclon XR**]
hydralazine	**Corlanor** (ivabradine) soln
methyldopa	**Entresto Sprinkle** (sacubitril/valsartan)
minoxidil	**Inpefa** (sotagliflozin)
prazosin	ivabradine tab
ranolazine	**Javadin** (clonidine soln)
sacubitril/valsartan tab	**Kerendia** (finerenone)
terazosin cap	**Tezruly** (terazosin soln)
	Tryvio (aprocitentan)
	Verquvo (vericiguat)

Length of Authorization: 365 days except nimodipine: 21 days

Hemangeol (propranolol soln) 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 2 preferred drugs within the same subsection classification in this UPDL category and indicated for diagnosis

Non-Preferred Kerendia (finerenone) Criteria:

- **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 **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 **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

Additional Camzyos (mavacamten) Criteria:

- Must be prescribed by or in consultation with a cardiologist **AND**
- Must provide documentation (chart notes) 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 2 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-dihydropyridine calcium channel blocker

Additional Inpefa (sotagliflozin) Criteria:

- Must have had an inadequate clinical response to at least 2 SGLT2 inhibitors (refer to Endocrine Agents: Diabetes – Non-Insulin class for complete list)

Additional Norliqva (amlodipine soln) Criteria:

- Must have had an inadequate clinical response of at least 30 days with **Katerzia** (amlodipine susp)

Additional Qbrelis (lisinopril soln) Criteria:

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

Additional Tryvio (aprocitentan) Criteria:

- Must have had an inadequate clinical response of at least 30 days of at least 4 different classes of antihypertensive medications concurrently without adequate blood pressure control

Additional Verquvo (vericiguat) Criteria:

- Must provide documentation (chart notes) of ejection fraction < 45%
- Must have been hospitalized for the treatment of heart failure in the previous 180 days or needs treatment with an outpatient intravenous diuretic in the previous 90 days
- Must be treated with an agent from **ALL** the following unless contraindicated:
    - Angiotensin-converting enzyme inhibitor, angiotensin II receptor blocker, **OR** an angiotensin receptor neprilysin inhibitor
    - Beta-blocker
    - Aldosterone antagonist and/or SGLT2 inhibitor as appropriate for renal function

AR – a PA is required for patients 6 years and older: Sotylize (sotalol soln)
AR – a PA is required for patients 12 years and older: Inzirqo (hydrochlorothiazide susp)
AR – a PA is required for patients younger than 18 years: Lopressor (metoprolol tartrate soln)

Cardiovascular Agents: Antiarrhythmics

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
amiodarone disopyramide dofetilide flecainide mexiletine **Multaq** (dronedarone) **Norpace CR** (disopyramide ER) propafenone IR, ER	quinidine IR, ER

Length of Authorization: 365 days

Non-Preferred Criteria:

- Must have had an inadequate clinical response of at least 30 days with at least 1 preferred drug in this UPDL category and indicated for diagnosis

Cardiovascular Agents: Lipotropics

Bile Acid Sequestrants

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
cholestyramine light, regular colesevelam tab colestipol tab prevalite	colesevelam packet colestipol granules

Fibric Acid Derivates

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
fenofibrate tab 48, 54, 145, 160mg gemfibrozil	fenofibrate IR, DR cap fenofibrate tab 40, 120mg fenofibric acid

Proprotein Convertase Subtilisin/Kexin Type 9 (PCSK9) Inhibitors

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
Praluent (alirocumab) PA **Repatha** (evolocumab) PA	

Statins & Combinations

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
atorvastatin	**Altoprev** (lovastatin ER)
ezetimibe/simvastatin	amlodipine/atorvastatin
lovastatin	**Atorvaliq** (atorvastatin susp)
pravastatin	fluvastatin IR, ER
rosuvastatin	pitavastatin calcium
simvastatin	**Zypitamag** (pitavastatin magnesium)

Other Agents

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
ezetimibe	icosapent ethyl cap
niacin IR, ER OTC	**Juxtapid** (lomitapide)
omega-3-acid ethyl esters	**Nexletol** (bempedoic acid)
	Nexlizet (bempedoic acid/ezetimibe)
	niacin ER tab

Length of Authorization: 365 days for all except 84 days for initial icosapent ethyl cap, **Lovaza** (omega-3-acid ethyl esters), ACL inhibitors and 180 days for initial **Juxtapid** (lomitapide) authorizations

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 1 preferred drug within the same subsection classification in this UPDL category and indicated for diagnosis

Additional Altoprev (lovastatin ER), Livalo (pitavastatin), Lescol (fluvastatin) Criteria:

- Must have had an inadequate clinical response of at least 30 days with 2 preferred drugs within the same subsection

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 Juxtapid (lomitapide) & 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 Welchol (colesevelam) Criteria:

- Must provide documentation of a Type 2 Diabetes diagnosis

Additional Information:

- High potency statins: **Lipitor** (atorvastatin) 40-80mg & **Crestor** (rosuvastatin) 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
- If citing goal LDL ≤ 55mg/dL, must provide documentation of multiple major ASCVD events or 1 major ASCVD event and multiple high-risk conditions

Cardiovascular Agents: Pulmonary Arterial Hypertension* LEGACY CATEGORY

Endothelin Receptor Antagonists

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
ambrisentan PA bosentan tab PA	bosentan susp **Opsumit** (macitentan)

Phosphodiesterase-5 (PDE-5) Inhibitors

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
sildenafil tab PA sildenafil susp AR PA tadalafil PA	**Tadliq** (tadalafil susp) AR

Prostaglandins

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
epoprostenol	**Orenitram** (treprostinil ER tab) treprostinil inj **Tyvaso** (treprostinil inhalation soln, pow) **Yutrepia** (treprostinil inhalation cap)

Other Agents

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
	Adempas (riociguat) **Opsynvi** (macitentan/tadalafil) **Uptravi** (selexipag) **Winrevair** (sotatercept-csrk)

Length of Authorization: 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 2 preferred drugs in this UPDL category and indicated for diagnosis, if available, 1 of which must be a phosphodiesterase-5 inhibitor

Additional Tadliq (tadalafil susp) Criteria:

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

Additional Tyvaso/Yutrepia (treprostinil inhalation) Criteria:

- Must have had an inadequate clinical response of at least 12 weeks with **Orenitram** (treprostinil ER tab) or treprostinil inj and indicated for diagnosis, if available

Additional Uptravi (selexipag) and Winrevair (sotatercept-csrk) 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 1 medication from 2 different subclasses for ≥ 90 days, unless contraindicated or not tolerated **OR**
- Require add-on triple or quadruple therapy, including PDE-5 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 – a PA is required for patients younger than 18 years: Tadliq (tadalafil susp)
AR – a PA is required for patients 18 years and older: sildenafil susp

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

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
donepezil [AR] galantamine [AR] cap, tab memantine [AR] cap, tab rivastigmine [AR]	galantamine soln [AR] **Leqembi IQLIK** (lecanemab-irmb) [AR] memantine/donepezil [AR] 14-10, 21-10, 28-10mg memantine soln [AR] **Namzaric** (memantine/donepezil) [AR] 7-10mg **Zunveyl** (benzgalantamine) [AR]

Length of Authorization: 365 days

Non-Preferred Criteria:

- Must have had an inadequate clinical response of at least 30 days with at least 2 preferred drugs in this UPDL category and indicated for diagnosis

Additional Leqembi IQLIK (lecanemab-irmb) Criteria:

- Must have had at least 18 months of therapy with **Leqembi** (lecanemab-irmb) IV
- Continuation of therapy will be permitted for patients established on **Leqembi** (lecanemab-irmb) IV

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

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

Calcitonin Gene-Related Peptide (CGRP) Inhibitors

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
Nurtec ODT (rimegepant) ST **Ubrelvy** (ubrogepant) ST	**Zavzpret** (zavegepant)

Triptans & Combinations

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
eletriptan naratriptan rizatriptan sumatriptan inj, nasal spray, tab zolmitriptan tab	almotriptan frovatriptan sumatriptan/naproxen **Symbravo** (rizatriptan/meloxicam) **Tosymra** (sumatriptan nasal spray) **Zembrace SYMTOUCH** (sumatriptan auto-inj) zolmitriptan nasal spray, ODT

Other Agents

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
	Brekiya (dihydroergotamine auto-inj) dihydroergotamine inj, nasal spray **Ergomar** (ergotamine) **Migergot** (ergotamine/caffeine) **Reyvow** (lasmiditan)

Length of Authorization: 180 days

Step Therapy Criteria:

- Must have had an inadequate clinical response of at least 14 days with at least 2 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 1 preferred drug and 1 step therapy drug in this UPDL category and indicated for diagnosis, if available

Additional Brekiya (dihydroergotamine auto-inj) Criteria:

- Must have had an inadequate clinical response of at least 14 days with dihydroergotamine injection or nasal spray

Additional Symbravo (rizatriptan/meloxicam) Criteria:

- Must have had an inadequate clinical response of at least 14 days with sumatriptan/naproxen

Additional Information:

- **Nurtec ODT** (rimegepant) has a maximum quantity of **8** tablets per month for acute migraines

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

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
verapamil IR, ER	**Emgality** (galcanezumab-gnlm) 100mg/ml

Length of Authorization: 180 days

Non-Preferred Criteria:

- Must have had an inadequate clinical response of at least 60 days to at least 1 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 (no PA required unless noted)	Non-Preferred Agents (PA required)
Aimovig (erenumab-aooe) ST **Ajovy** (fremanezumab-vfrm) ST **Emgality** (galcanezumab-gnlm) 120mg/ml ST Cardiovascular Agents: Beta-Blockers CNS Agents: Anticonvulsants CNS Agents: Serotonin-Norepinephrine Reuptake Inhibitors CNS Agents: Tricyclic Antidepressants	**Nurtec ODT** (rimegepant) **Qulipta** (atogepant)

Length of Authorization: Initial: 180 days; Subsequent: 365 days

Step Therapy Criteria:

- Must have had an inadequate clinical response of at least 30 days with at least 2 preferred controller migraine drugs
  - For patients already established on a serotonergic medication, only 1 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

Aimovig (erenumab-aooe) Criteria:

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

Ajovy (fremanezumab-vfrm) 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 3 preferred controller migraine drugs **AND** 1 step therapy drug in this UPDL category

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)

Additional Information:

- **Nurtec ODT** (rimegepant) has a maximum quantity of **16** tablets per month for migraine prophylaxis

Central Nervous System (CNS) Agents: Anticonvulsants* LEGACY CATEGORY

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
Briviact (brivaracetam) soln [AR], tab [NDC 72205, 73473]	brivaracetam soln [AR], tab [All other NDCs]
brivaracetam soln [AR], tab [NDC 72205, 73473]	**Celontin** (methsuximide) [BvG]
carbamazepine IR, ER	clonazepam ODT
clobazam	**Elepsia XR** (levetiracetam ER tab)
clonazepam tab	eslicarbazepine
Diacomit (stiripentol) [PA]	felbamate
divalproex DR, ER	**Fintepla** (fenfluramine)
Epidiolex (cannabidiol) [PA]	lamotrigine ER
ethosuximide	levetiracetam ER
Fycompa (perampanel) [BvG ST]	levetiracetam tab for oral susp 250, 500mg [generic **Spritam**]
gabapentin IR, soln	**Motpoly XR** (lacosamide ER cap)
lacosamide	**Oxtellar XR** (oxcarbazepine ER tab) [BvG]
lamotrigine chew, IR, ODT	perampanel
levetiracetam IR, soln	rufinamide susp
oxcarbazepine IR, susp	**Spritam** (levetiracetam tab for oral susp) 750, 1000mg
phenobarbital	**Subvenite** (lamotrigine) susp
phenytoin chew, ER	**Sympazan** (clobazam film)
pregabalin IR, soln	tiagabine
primidone	topiramate IR/ER sprinkle cap
rufinamide tab	**Trokendi XR** (topiramate ER cap) [BvG]
Subvenite (lamotrigine) tab	vigabatrin pow [AR], tab
topiramate IR, soln [AR]	**Vigafyde** (vigabatrin soln) [AR]
valproic acid	**Xcopri** (cenobamate)
zonisamide cap	**Zonisade** (zonisamide susp)
	Ztalmy (ganaxolone susp)

Length of Authorization: 365 days except **Epidiolex** (cannabidiol) and **Diacomit** (stiripentol) – Initial: 180 days

Step Therapy Criteria:

- Must have had an inadequate clinical response of at least 30 days with at least 1 preferred drug in this UPDL category

Epidiolex (cannabidiol) Criteria:

- Must have had an inadequate clinical response of at least 30 days with any 2 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)

Diacomit (stiripentol) Criteria:

- Exempt from Legacy rules
- Must be prescribed by or in consultation with a neurologist
- Must be concurrently taking **Onfi** (clobazam)
- Must provide documentation (chart notes) 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 2 preferred drugs in this UPDL category and indicated for diagnosis
- Prescriptions submitted from a prescriber who is credentialed as a neurology specialty with Ohio Medicaid AND for drugs that are used only for seizures, there must have been an inadequate clinical response of at least 30 days with 1 preferred drug. This provision applies only to the standard tablet/capsule dosage form.

Additional Fintepla (fenfluramine) Criteria:

- Prescribed by or in consultation with a neurologist
- For Lennox-Gastaut syndrome: must have had a trial of valproic acid (or a derivative) in combination with lamotrigine for at least 30 days
- For Dravet syndrome: must have had a trial of valproic acid (or a derivative) in combination with 1 other preferred agent from this UPDL category for at least 30 days

Additional Xcopri (cenobamate) Criteria:

- Prescribed by or in consultation with a neurologist
- Required trial of 2 preferred medications from this UPDL category in combination for at least 30 days. 1 of the preferred agents must be: lamotrigine, levetiracetam, oxcarbazepine, carbamazepine, or topiramate

AR – a PA is required for patients 2 years and older: vigabatrin pow, **Vigafyde** (vigabatrin soln)
AR – a PA is required for patients 12 years and older: Briviact (brivaracetam) soln, topiramate soln

Central Nervous System (CNS) Agents: Anticonvulsants Rescue

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
diazepam rectal gel **Nayzilam** (midazolam nasal spray) [AR] **Valtoco** (diazepam nasal spray) [AR]	

All products are covered without a PA

AR – a PA is required for patients younger than 2 years old: Valtoco (diazepam nasal spray)
AR – a PA is required for patients younger than 12 years old: Nayzilam (midazolam nasal spray)

Central Nervous System (CNS) Agents: Antidepressants* LEGACY CATEGORY

Norepinephrine-Dopamine Reuptake Inhibitors (NDRIs)

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
bupropion IR, SR [generic **Wellbutrin**] bupropion XL [generic **Wellbutrin XL**]	bupropion XL [generic **Forfivo XL**]

Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
desvenlafaxine succinate ER [generic **Pristiq**] duloxetine cap 20, 30, 60mg venlafaxine IR tab, ER cap	desvenlafaxine ER [generic **Khedezla**] **Drizalma Sprinkle** (duloxetine DR cap) duloxetine cap 40mg **Fetzima** (levomilnacipran) venlafaxine ER tab

Selective Serotonin Reuptake Inhibitors (SSRIs)

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
citalopram tab, soln escitalopram tab, soln fluoxetine IR cap/tab 10, 20, 40mg; soln [generic **Prozac**] fluvoxamine IR paroxetine IR tab, soln sertraline soln, tab	citalopram cap escitalopram cap fluoxetine IR 60mg, DR fluvoxamine ER paroxetine ER tab sertraline cap

Other Agents

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
mirtazapine nefazodone tranylcypromine trazodone tab 50, 100, 150mg vilazodone **Vraylar** (cariprazine) [ST] **Zurzuvae** (zuranolone) [PA]	**Auvelity** (dextromethorphan/bupropion) **Caplyta** (lumateperone) clomipramine **Emsam** (selegiline TD patch) **Exxua** (gepirone) **Marplan** (isocarboxacid) phenelzine **Raldesy** (trazodone soln) **Rexulti** (brexpiprazole) trazodone tab 300mg **Trintellix** (vortioxetine)

Length of Authorization: 365 days except 14 days with no renewal for **Zurzuvae** (zuranolone)

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 2 preferred drugs in this UPDL category

Non-Preferred Criteria:

- Must have had an inadequate clinical response of at least 30 days with at least 2 preferred drugs in this UPDL category and indicated for diagnosis

Additional Exxua (gepirone) Criteria:

- Must have had an inadequate clinical response of at least 30 days with **ALL** of the following:
  - 1 norepinephrine/dopamine reuptake inhibitor (NDRI)
  - 1 serotonin-norepinephrine reuptake inhibitor (SNRI)
  - 2 selective serotonin reuptake inhibitors (SSRIs) (1 of which must be either **Viibryd** (vilazodone) OR **Trintellix** (vortioxetine))

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

Non-Stimulants

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
atomoxetine [AR] clonidine ER tab [generic **Kapvay**] guanfacine ER **Onyda XR** (clonidine ER susp) [AR] **Qelbree** (viloxazine) [ST]	

Stimulants

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
amphetamine/dextroamphetamine IR, ER [generic **Adderall**] [AR] **Concerta** (methylphenidate ER tab) dexmethylphenidate [AR] IR, ER dextroamphetamine [AR] IR tab, ER cap **Dyanavel XR** (amphetamine ER susp) **Focalin XR** (dexmethylphenidate ER cap) [AR] **Jornay PM** (methylphenidate ER cap) lisdexamfetamine chew methylphenidate ER cap [generic **Metadate CD, Ritalin LA**] methylphenidate ER tab [generic **Concerta, Methylin ER, Ritalin SR**] methylphenidate ER tab 18, 27, 36, 54mg [generic **Relexxii**] methylphenidate IR tab, soln [AR] **Procentra** (dextroamphetamine soln) [AR BvG] **Quillichew ER** (methylphenidate ER chew) [AR] **Quillivant XR** (methylphenidate ER susp) [AR] **Ritalin LA** (methylphenidate ER cap) **Vyvanse** (lisdexamfetamine) cap [BvG]	amphetamine IR, ER tab amphetamine/dextroamphetamine ER [generic **Mydayis**] **Azstarys** (serdexmethylphenidate/dexmethylphenidate) [AR] **Cotempla XR-ODT** (methylphenidate ER ODT) dextroamphetamine soln [AR] **Evekeo ODT** (amphetamine ODT) lisdexamfetamine cap methamphetamine methylphenidate chew [AR] methylphenidate ER cap [generic **Aptensio XR**] methylphenidate ER tab 45, 63, 72mg [generic **Relexxii**] methylphenidate TD patch **Xelstrym** (dextroamphetamine TD patch) [AR]

Length of Authorization: 365 days

Step Therapy Criteria:

- Must have had an inadequate clinical response of at least 30 days with atomoxetine **OR** at least 1 preferred ADHD agent

Non-Preferred Criteria:

- Must have had an inadequate clinical response of at least 30 days with at least 2 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 – a PA is required for patients younger than 3 years: amphetamine/dextroamphetamine, dextroamphetamine IR
AR – a PA is required for patients younger than 6 years: amphetamine/dextroamphetamine XR, atomoxetine, **Azstarys** (serdexmethylphenidate/dexmethylphenidate), dextroamphetamine ER, dexmethylphenidate & **Xelstrym** (dextroamphetamine TD patch)
AR – a PA is required for patients 12 years and older: methylphenidate chew/soln, **Onyda XR** (clonidine ER susp), **Procentra** (dextroamphetamine soln), **Quillichew ER** (methylphenidate ER chew), **Quillivant XR** (methylphenidate ER susp)

Central Nervous System (CNS) Agents: Atypical Antipsychotics* LEGACY CATEGORY

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
Abilify Asimtufii, Maintena (aripiprazole ER inj)	aripiprazole ODT, soln
aripiprazole tab	**Caplyta** (lumateperone)
Aristada (aripiprazole lauroxil ER inj)	clozapine ODT
Aristada Initio (aripiprazole lauroxil ER inj)	**Cobenfy** (xanomeline/trospium)
asenapine SL tab ST	**Equetro** (carbamazepine ER cap)
clozapine tab	fluoxetine/olanzapine
Erzofri (paliperidone palmitate ER inj)	**Lybalvi** (olanzapine/samidorphan)
Fanapt (iloperidone) ST	**Nuplazid** (pimavanserin)
Geodon (ziprasidone)	**Opipza** (aripiprazole film)
Invega Hafyera ER (paliperidone ER inj) PA	**Rexulti** (brexpiprazole)
Invega Sustenna (paliperidone ER inj)	risperidone microspheres
Invega Trinza (paliperidone ER inj)	**Secuado** (asenapine TD patch)
lurasidone	**Versacloz** (clozapine susp)
olanzapine ODT, tab	**Zyprexa Relprevv** (olanzapine ER inj)
paliperidone tab	
Perseris (risperidone ER inj)	
quetiapine IR, ER	
Risperdal Consta (risperidone ER inj) BvG	
risperidone ODT, soln, tab	
Rykindo (risperidone ER inj)	
Uzedy (risperidone ER inj)	
Vraylar (cariprazine) ST	
ziprasidone	

Length of Authorization: 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.

Invega Hafyera (paliperidone palmitate) Criteria:

- Must have had 4 months of treatment with **Invega Sustenna** (paliperidone ER inj) or 3 months with **Invega Trinza** (paliperidone ER inj)

Step Therapy Criteria:

- Must have had an inadequate clinical response of at least 30 days with at least 1 preferred drug in this UPDL category

Non-Preferred Criteria:

- Must have had an inadequate clinical response of at least 30 days with at least 2 preferred drugs in this UPDL category and indicated for diagnosis

Additional Lybalvi (olanzapine/samidorphan) Criteria:

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

Additional Nuplazid (pimavanserin) Criteria:

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

Additional Information:

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

Central Nervous System (CNS) Agents: Fibromyalgia Agents

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
pregabalin IR **Savella** (milnacipran) [BvG]	milnacipran **Tonmya** (cyclobenzaprine ODT)

Length of Authorization: 365 days

Non-Preferred Criteria:

- Must have had an inadequate clinical response of at least 30 days with at least 2 preferred drugs in this UPDL category and indicated for diagnosis

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

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
Brixadi (buprenorphine ER inj) buprenorphine/naloxone SL film, SL tab clonidine IR, ER [generic **Kapvay**] **Sublocade** (buprenorphine ER inj) **Vivitrol** (naltrexone ER inj) **Zubsolv** (buprenorphine/naloxone SL tab)	buprenorphine SL tab **Lucemyra** (lofexidine) [BvG]

Length of Authorization: 180 days except 14 days for **Lucemyra** (lofexidine)

Additional Lucemyra (lofexidine) 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 & Drug Utilization 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** (naltrexone ER inj), **Sublocade** & **Brixadi** (buprenorphine ER inj) 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 (no PA required unless noted)	Non-Preferred Agents (PA required)
Austedo (deutetrabenazine) IR, XR PA ST **Ingrezza** (valbenazine) PA ST tetrabenazine	

Length of Authorization: 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 (no PA required unless noted)	Non-Preferred Agents (PA required)
Avonex (interferon beta-1a) **Betaseron** (interferon beta-1b) dalfampridine dimethyl fumarate fingolimod cap **Gilenya** (fingolimod cap) glatiramer [generic **Copaxone**] glatopa [generic **Copaxone**] **Kesimpta** (ofatumumab) **Plegridy** (peginterferon beta-1a) **Rebif** (interferon beta-1a) teriflunomide	**Bafiertam** (monomethyl fumarate) cladribine tab **Mayzent** (siponimod) **Ocrevus** (ocrelizumab) **Ponvory** (ponesimod) **Tascenso ODT** (fingolimod ODT) **Vumerity** (diroximel fumarate) **Zeposia** (ozanimod)

Length of Authorization: 365 days

Non-Preferred Criteria:

- Must have had an inadequate clinical response of at least 30 days with at least 1 preferred drug in this UPDL category and indicated for diagnosis

Additional Ocrevus (ocrelizumab) 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 1 preferred drug in this UPDL category

Additional Mayzent (siponimod) Criteria:

- Must provide documentation of CYP2C9 genotype

Central Nervous System (CNS) Agents: Narcolepsy

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
amphetamine/dextroamphetamine IR, ER [generic **Adderall**] AR armodafinil dextroamphetamine AR IR tab, ER cap methylphenidate ER tab [generic **Methylin ER, Ritalin SR**] methylphenidate IR tab, soln AR modafinil **Procentra** (dextroamphetamine soln) AR BvG	amphetamine IR tab dextroamphetamine soln AR **Sunosi** (solriamfetol) **Wakix** (pitolisant) **Xyrem** (sodium oxybate) BvG **Xywav** (calcium, magnesium, potassium, and sodium oxybates)

Length of Authorization: 365 days

Non-Preferred Criteria:

- Must have had an inadequate clinical response with at least 2 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 Xywav (calcium, magnesium, potassium, and sodium oxybates) Criteria:

- Must have documented adherence to sodium restricted diet

AR – a PA is required for patients younger than 3 years: amphetamine/dextroamphetamine:
AR – a PA is required for patients younger than 6 years: amphetamine/dextroamphetamine XR, dextroamphetamine ER
AR – a PA is required for patients 12 years and older: methylphenidate soln, **Procentra** (dextroamphetamine soln)

Central Nervous System (CNS) Agents: Neuropathic Pain

Dibenzazepines

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
carbamazepine IR, ER oxcarbazepine susp, tab	

Gabapentinoids

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
gabapentin IR **Gralise** (gabapentin ER tabs) BvG **Horizant** (gabapentin enacarbil ER)	gabapentin ER tab

Tricyclic Antidepressants

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
amitriptyline desipramine doxepin soln; tab 10, 25, 50, 75, 100, 150mg imipramine nortriptyline	

Other Agents

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
duloxetine cap 20, 30, 60mg lidocaine 5% TD patch pregabalin IR **Ztlido** (lidocaine 1.8% TD patch) ST	duloxetine cap 40mg pregabalin ER

Length of Authorization: 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 2 preferred drugs within the same subsection classification in this UPDL category and indicated for diagnosis

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

Catechol-O-methyltransferase (COMT) Inhibitors

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
entacapone	**Ongentys** (opicapone)

Dopamine Agonists

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
pramipexole IR ropinirole IR, ER	apomorphine inj **Kynmobi** (apomorphine film) **Neupro** (rotigotine TD patch) **Onapgo** (apomorphine inj) pramipexole ER

Monoamine oxidase-B (MAO-B) Inhibitors

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
selegiline	rasagiline **Xadago** (safinamide)

Other Agents

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
amantadine cap, tab carbidopa carbidopa/levodopa tab IR, ER	amantadine soln carbidopa/levodopa ODT carbidopa/levodopa/entacapone **Crexont** (carbidopa/levodopa ER cap) **Gocovri** (amantadine ER cap) **Inbrija** (levodopa inhalation) **Nourianz** (istradefylline) **Rytary** (carbidopa/levodopa ER cap) BvG **Vyalev** (foscarbidopa/foslevodopa inj)

Length of Authorization: 365 days

Non-Preferred Criteria:

- Must have had an inadequate clinical response of at least 30 days with at least 2 preferred drugs within the same subsection classification in this UPDL category and indicated for diagnosis, if available

Additional Apokyn/Kynmobi (apomorphine), Inbrija (levodopa inhalation), & Nourianz (istradefylline) Criteria:

- Must have had inadequate clinical response to at least 30 days with 1 other drug for the treatment of "off episodes" (COMT inhibitor, dopamine agonist, or MAO-B inhibitor)

Additional Onapgo (apomorphine) & Vyalev (foscarbidopa/foslevodopa) Criteria:

- Must have had inadequate clinical response of at least 30 days with at least 2 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 (no PA required unless noted)	Non-Preferred Agents (PA required)
Horizant (gabapentin enacarbil ER) pramipexole IR ropinirole IR, ER	**Neupro** (rotigotine TD patch)

Length of Authorization: 365 days

Non-Preferred Criteria:

- Must have had an inadequate clinical response of at least 30 days with at least 1 preferred drug in this UPDL category and indicated for diagnosis

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

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
Belsomra (suvorexant) estazolam eszopiclone ramelteon temazepam triazolam zaleplon zolpidem tab IR, ER	**Dayvigo** (lemborexant) doxepin 3, 6mg **Edluar** (zolpidem SL tabs) flurazepam quazepam **Quviviq** (daridorexant) zolpidem cap, SL tab

Length of Authorization: 180 days

Non-Preferred Criteria:

- Must have had an inadequate clinical response of at least 7 days with at least 2 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 (no PA required unless noted)	Non-Preferred Agents (PA required)
baclofen susp 25mg/5mL [AR], tab	baclofen soln 5mg/5mL, 10mg/5mL
chlorzoxazone 500mg	carisoprodol
cyclobenzaprine IR	chlorzoxazone 250, 375, 750mg
dantrolene	cyclobenzaprine ER
metaxalone 800mg	**Lyvispah** (baclofen granules packet)
methocarbamol 500, 750mg	metaxalone 400mg
orphenadrine	methocarbamol 1000mg
tizanidine	orphenadrine/ASA/caffeine

Length of Authorization: 365 days

Non-Preferred Criteria:

- Must have had an inadequate clinical response of at least 30 days with at least 2 preferred drugs in this UPDL category and indicated for diagnosis

Additional Soma (carisoprodol) 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 – a PA is required for patients 12 years and older: baclofen susp

Central Nervous System (CNS) Agents: Smoking Deterrents

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
bupropion SR **Chantix** (varenicline) nicotine varenicline	

All products are covered without a PA

Dermatologic Agents: Oral Acne Products

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
amnesteem [PA] claravis [PA] zenatane [PA]	**Absorica** (isotretinoin) **Absorica LD** (isotretinoin) isotretinoin

Length of Authorization: 150 days

Clinical PA Criteria:

- Must have had an inadequate clinical response of at least 90 days with at least 1 preferred topical **AND** 1 preferred oral antibiotic for acne

Non-Preferred Criteria:

- Must have had an inadequate clinical response of at least 90 days with at least 2 preferred drugs in this UPDL category and indicated for diagnosis

Additional Information:

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

Dermatologic Agents: Topical Acne Products

Non-Retinoids

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
azelaic acid gel	**Clindacin** (clindamycin) kit
benzoyl peroxide gel, liq, lot	clindamycin foam
clindamycin gel, lot, soln, swabs	clindamycin/benzoyl peroxide 1.2-3.75%
clindamycin/benzoyl peroxide 1-5%, 1.2-2.5%, 1.2-5%	dapsone gel
erythromycin 1% gel, soln	**Epsolay** (benzoyl peroxide) 5% cream
erythromycin/benzoyl peroxide	**Ery Pad** (erythromycin) 2% pads
sulfacetamide sodium gel, liq, lot	**Finacea** (azelaic acid) foam
	Neuac kit (clindamycin/benzoyl peroxide)
	sulfacetamide sodium/sulfur
	Winlevi (clascoterone)

Retinoids & Combinations

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
adapalene gel [AR]	adapalene cream [AR]
adapalene/benzoyl peroxide [AR]	clindamycin/tretinoin [AR]
tretinoin [AR] cream, gel	**Differin** (adapalene 0.1% lot) [AR]
	tazarotene [AR]
	tretinoin micro [AR]
	Twyneo (tretinoin/benzoyl peroxide) [AR]

Length of Authorization: 365 days

Non-Preferred Criteria:

- Must have had an inadequate clinical response with at least 2 preferred 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.

Additional Information:

- All retinoids - May be authorized for a diagnosis of skin cancer
- **Tazorac** (tazarotene) - May be authorized for a diagnosis of psoriasis

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

Duchenne Muscular Dystrophy Agents: Corticosteroids

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
Emflaza (deflazacort) BvG PA	**Agamree** (vamorolone) deflazacort

Length of Authorization: 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 1 preferred drug in this UPDL category and indicated for diagnosis

Endocrine Agents: Androgens

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
depo-testosterone AR PA testosterone cypionate AR PA testosterone gel 1% packet AR PA testosterone gel 1.62% pump AR PA	**Aveed** (testosterone undecanoate inj) AR **Azmiro** (testosterone cypionate inj) AR **Jatenzo** (testosterone undecanoate cap) AR methyltestosterone AR **Natesto** (testosterone nasal gel) AR **Testopel** (testosterone pellet) AR testosterone gel 1% pump AR testosterone gel 1.62% packet AR testosterone gel 2% AR testosterone soln 30mg/ACT AR **Tlando** (testosterone undecanoate cap) AR **Xyosted** (testosterone enanthate inj) AR

Length of Authorization: 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 Xyosted (testosterone enanthate inj) 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 – a PA is required for patients younger than 18 years: All drugs

Endocrine Agents: Diabetes – Hypoglycemia Treatments

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
Baqsimi (glucagon nasal spray) glucagon emergency kit [NDC 00548] **Gvoke** (glucagon inj) **Zegalogue** (dasiglucagon inj)	glucagon emergency kit [All NDCs except 00548]

Length of Authorization: 365 days

Non-Preferred Criteria:

- Must have had an inadequate clinical response of at least 1 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

Rapid-Acting

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
Apidra (insulin glulisine) **Fiasp** (insulin aspart) **Humalog U-100** (insulin lispro) [All except tempo pen] insulin lispro **Novolog U-100** (insulin aspart)	**Admelog** (insulin lispro) **Afrezza** (insulin human inhaled) **Humalog U-100** (insulin lispro) tempo pen **Humalog U-200** (insulin lispro) **Kirsty** (insulin aspart-xjhz) **Lyumjev** (insulin lispro-aabc) **Merilog** (insulin aspart-szjj)

Short-Acting

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
Humulin R U-500 (insulin human)	**Humulin R U-100** (insulin human) **Novolin R U-100** (insulin human)

Intermediate-Acting

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
Humulin N U-100 (insulin isophane human)	**Novolin N U-100** (insulin isophane human)

Long-Acting

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
Lantus U-100 (insulin glargine) pen, vial **Levemir** (insulin detemir) **Toujeo U-300** (insulin glargine) BvG **Tresiba U-100** (insulin degludec) BvG ST	**Basaglar U-100** (insulin glargine) insulin degludec U-100 [generic **Tresiba**] insulin glargine U-300 [generic **Toujeo**] insulin glargine-yfgn [generic **Semglee**] **Rezvoglar** (insulin glargine-aglr) **Tresiba U-200** (insulin degludec) BvG

Mixed Insulin

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
Humalog 50-50 (insulin lispro protamine/insulin lispro) **Humalog 75-25** (insulin lispro protamine/insulin lispro) **Humulin 70-30** (insulin isophane human/insulin human) insulin aspart protamine/insulin aspart	**Novolin 70-30** (insulin isophane human/insulin human) **Novolog 70-30** (insulin aspart protamine/insulin aspart)

Length of Authorization: 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 1 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 2 preferred drugs having a similar duration of action in this UPDL category and indicated for diagnosis, if available

Additional High Concentration Insulin 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 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 Afrezza (inhaled insulin) 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 Lyumjev (insulin lispro-aabc) Criteria:

- Must have had an inadequate clinical response (defined as the inability to reach target A1C) after at least 120 days with **Humalog** (insulin lispro) **OR** insulin lispro

Subsequent Authorization Criteria:

- 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

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.
    - Must include a patient specific A1C goal if less than 7%
    - Must include current A1C (within last 6 months)
- Requests may be authorized for patients with a condition that is difficult to control (i.e., prone to ketoacidosis, hypoglycemia)

Endocrine Agents: Diabetes – Non-Insulin

Dipeptidyl Peptidase 4 (DPP4) Inhibitors & Combinations

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
Janumet IR, XR (sitagliptin/metformin)	alogliptin
Januvia (sitagliptin phosphate tab)	alogliptin/metformin
Jentadueto IR, XR (linagliptin/metformin)	alogliptin/pioglitazone
saxagliptin	**Brynovin** (sitagliptin soln)
saxagliptin/metformin ER	sitagliptin tab [generic **Zituvio**]
Tradjenta (linagliptin)	sitagliptin/metformin IR, ER [generic **Zituvimet**]

Glucagon-Like Peptide-1 (GLP-1) Receptor Agonists & Combinations

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
Byetta (exenatide)	**Mounjaro** (tirzepatide)
exenatide	**Ozempic** (semaglutide)
liraglutide	**Rybelsus** (semaglutide)
Trulicity (dulaglutide)	**Soliqua** (insulin glargine/lixisenatide)
Victoza (liraglutide)	**Xultophy** (insulin degludec/liraglutide)

Metformin Formulations

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
metformin ER [generic **Glucophage XR**]	metformin ER [generic **Fortamet, Glumetza**]
metformin IR tab 500, 850, 1000mg	metformin IR tab 625, 750mg; soln

Sodium-Glucose Cotransporter-2 (SGLT2) Inhibitors & Combinations

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
Farxiga (dapagliflozin) [BvG] **Jardiance** (empagliflozin) **Synjardy IR, XR** (empagliflozin/metformin) **Xigduo XR** (dapagliflozin/metformin ER) [BvG]	dapagliflozin dapagliflozin/metformin ER **Glyxambi** (empagliflozin/linagliptin) **Invokamet IR, XR** (canagliflozin/metformin) **Invokana** (canagliflozin) **Segluromet** (ertugliflozin/metformin) **Steglatro** (ertugliflozin) **Steglujan** (ertugliflozin/sitagliptin) **Trijardy XR** (empagliflozin/linagliptin/metformin ER)

Sulfonylureas & Combinations

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
glimepiride 1, 2, 4mg glipizide IR, ER glipizide/metformin glyburide glyburide/metformin	glimepiride 3mg glimepiride/pioglitazone

Other Agents

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
acarbose miglitol nateglinide pioglitazone pioglitazone/metformin repaglinide	**SymlinPen** (pramlintide)

Length of Authorization: 365 days

Non-Preferred Criteria:

- Must have had an inadequate clinical response of at least 120 days with at least 3 preferred drugs in this UPDL category and indicated for diagnosis, if available
    - An inadequate clinical response is defined as the ability to reach A1C goal after at least 120 days of current regimen, with the use of 2 or more drugs concurrently per ADA guidelines, documented adherence, and appropriate dose escalation (must achieve maximum recommended dose or document that maximum recommended dose is not tolerated or is clinically inappropriate)
    - Must include a patient specific A1C goal if less than 7%
    - Must include current A1C (within last 6 months)
    - 2 preferred drugs must be used concurrently and 1 of the drugs must be in the same subsection as the requested medication
    - 3 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 Brynovin (sitagliptin soln), Zituvio (sitagliptin tab) Criteria:

- Must have had a trial of at least 120 days with **Januvia** (sitagliptin phosphate tab) **OR** must provide documentation of medical necessity for patient's inability to use **Januvia** (sitagliptin phosphate tab)

Additional GLP-1 Receptor Agonists/Combinations Criteria:

- 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:
    - 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

Additional Mounjaro (tirzepatide) Criteria:

- Prior to initiation, must have hemoglobin A1C > 7% **AND**
- Must have had an inadequate clinical response of at least 120 days with **Ozempic** (semaglutide) **OR** must provide documentation of medical necessity for patient's inability to use **Ozempic** (semaglutide)

Subsequent Authorization Criteria:

- 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

Endocrine Agents: Endometriosis

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
danazol [ST] **Depo-SubQ Provera 104** (medroxyprogesterone acetate inj) [ST] **Lupron Depot** (leuprolide acetate inj) [ST] 3.75, 11.25mg **Myfembree** (relugolix/estradiol/norethindrone acetate) [ST] **Orilissa** (elagolix) [ST]	**Synarel** (nafarelin nasal spray)

Length of Authorization: 365 days

Step Therapy Criteria:

- Must have had an inadequate clinical response of at least 84 days with at least 1 preferred NSAID and 1 oral contraceptive

Non-Preferred Criteria:

- Must have had an inadequate clinical response of at least 84 days with at least 1 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** (elagolix) and **Myfembree** (relugolix/estradiol/norethindrone acetate) or 365 days for **Lupron Depot** (leuprolide acetate inj) will be authorized

Endocrine Agents: Estrogenic Agents

Oral Agents

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
Angeliq (drospirenone/estradiol)	**Duavee** (conjugated estrogens/bazedoxifene)
estradiol tab	estradiol/norethindrone
ethinyl estradiol/norethindrone	estrogens, conjugated tablet
Premarin (conjugated estrogens) tab [BvG]	esterified estrogen/methyltestosterone
Premphase (conjugated estrogens/medroxyprogesterone acetate)	**Premarin** (estrogens, conjugated) inj
Prempro (conjugated estrogens/medroxyprogesterone acetate)	

Topical Agents

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
Divigel 0.1% (estradiol gel) [BvG]	estradiol gel 0.06% [generic **Estrogel**]
Elestrin (estradiol gel 0.06%)	estradiol gel 0.1% [generic **Divigel**]
estradiol cream	

Transdermal Agents

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
Climara (estradiol TD weekly patch)	**Evamist** (estradiol TD spray)
Climara Pro (estradiol/levonorgestrel TD weekly patch)	**Menostar** (estradiol TD weekly patch)
Combipatch (estradiol/norethindrone TD twice weekly patch)	
dotti	
estradiol TD patch	
lyllana	
Minivelle (estradiol TD twice weekly patch)	
Vivelle-Dot (estradiol TD twice weekly patch)	

Vaginal Agents

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
Estring (estradiol vaginal ring) **Premarin** (conjugated estrogens) vaginal cream	estradiol 10mcg vaginal tab **Femring** (estradiol acetate vaginal ring)

Length of Authorization: 365 days

Non-Preferred Criteria:

- Must have had an inadequate clinical response of at least 30 days with at least 2 preferred drugs in this UPDL category within the same subsection classification and indicated for diagnosis

Endocrine Agents: Growth Hormone

Daily Dosing Agents

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
Genotropin (somatropin) PA **Norditropin** (somatropin) PA	**Humatrope** (somatropin) **Nutropin** (somatropin) **Omnitrope** (somatropin) **Serostim** (somatropin) **Zomacton** (somatropin)

Weekly Dosing Agents

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
Skytrofa (lonapegsomatropin-tcgd) PA ST	**Ngenla** (somatrogon-ghla) **Sogroya** (somapacitan-beco)

Length of Authorization: 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 1 preferred daily-dosed growth hormone formulation

Non-Preferred Criteria:

- Must have had an inadequate clinical response of at least 90 days with at least 1 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

Bisphosphonates

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
alendronate tab ibandronate	alendronate soln **Binosto** (alendronate effervescent tab) **Fosamax Plus D** (alendronate/cholecalciferol) risedronate zoledronic acid

Other Bone Resorption Suppression and Related Agents

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
calcitonin-salmon **Forteo** (teriparatide) BvG PA raloxifene	**Bildyos** (denosumab-nxxp) **Bosaya** (denosumab-kyqq) **Conexxence** (denosumab-bnht) **Enoby** (denosumab-qbde) **Evenity** (romosozumab-aqqg) **Jubbonti** (denosumab-bbdz) **Prolia** (denosumab) **Stoboclo** (denosumab-bmwo) teriparatide **Tymlos** (abaloparatide)

Length of Authorization: 365 days

Clinical PA Criteria:

- Must have had an inadequate clinical response of at least 365 days with 1 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 1 preferred drug within the same subsection classification in this UPDL category and indicated for diagnosis

Additional 'Other Bone Resorption Suppression & Related Agents' Criteria:

- Must have had an inadequate clinical response of at least 365 days with 1 bisphosphonate
- A total lifetime duration of therapy of 730 days will be authorized between any parathyroid analog (e.g., teriparatide)
- A total lifetime duration of therapy of 365 days will be authorized for **Evenity** (romosozumab-aqqg)

Additional Information:

- Patients should only be on 1 of the therapeutic classes (bisphosphonates, calcitonin-salmon)

Endocrine Agents: Progestin Agents

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
medroxyprogesterone acetate tab megestrol norethindrone acetate progesterone progesterone in oil	

All products are covered without a PA

Endocrine Agents: Uterine Fibroids

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
Lupron Depot (leuprolide acetate inj) [PA] 3.75, 11.25mg **Myfembree** (relugolix/estradiol/norethindrone acetate) [PA] **Oriahnn** (elagolix/estradiol/norethindrone acetate) [PA]	

Length of Authorization: Up to 180 days

Clinical PA Criteria:

- Must have had an inadequate clinical response of at least 90 days with at least 1 oral contraceptive

Additional Information:

- A total lifetime duration of therapy of 730 days between **Myfembree** (relugolix/estradiol/norethindrone acetate) and **Oriahnn** (elagolix/estradiol/norethindrone acetate) or 365 days for **Lupron Depot** (leuprolide acetate inj) will be authorized

Gastrointestinal Agents: Anti-Emetics

Anticholinergics

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
scopolamine	

Antihistamines & Combinations

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
dimenhydrinate diphenhydramine doxylamine/pyridoxine meclizine trimethobenzamide	**Bonjesta** (doxylamine/pyridoxine ER)

Phenothiazines

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
prochlorperazine promethazine	

Serotonin 5-HT3 Receptor Antagonists

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
granisetron tab ondansetron soln; tab 4, 8mg	ondansetron 16mg **Sancuso** (granisetron TD patch)

Substance P/Neurokinin 1 (NK-1) Antagonists

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
aprepitant 40mg, tripac **Emend** (aprepitant) susp 125mg	aprepitant 80, 125mg

Other Agents

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
dronabinol [PA] metoclopramide	

Length of Authorization: 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 1 preferred drug in this UPDL category.

Non-Preferred Criteria:

- Must have had an inadequate clinical response of at least 3 days with at least 1 preferred drug in this UPDL category within the same subsection classification and indicated for diagnosis

Gastrointestinal Agents: Bowel Preparations

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
Clenpiq **Gavilyte-C** **Gavilyte-G** **Gavilyte-N** **Golytely** sod sulfate-potass sulfate-mag sulfate oral soln [generic **Suprep**] **Suflave**	peg 3350-KCl-NaCl-Na sulfate-Na ascorbate-C for soln **Sutab**

Length of Authorization: 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 1 preferred drug in this UPDL category and indicated for diagnosis

Gastrointestinal Agents: Crohn's Disease

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
azathioprine 50mg budesonide DR 3mg mercaptopurine tab methotrexate sulfasalazine IR, DR	azathioprine 75, 100mg

Length of Authorization: 365 days

Non-Preferred Criteria:

- Must have had an inadequate clinical response of at least 30 days with at least 2 preferred drugs in this UPDL category and indicated for diagnosis

Gastrointestinal Agents: Hepatic Encephalopathy

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
lactulose	

All products are covered without a PA

Gastrointestinal Agents: Irritable Bowel Syndrome (IBS) with Diarrhea

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
diphenoxylate/atropine loperamide CNS Agents: Tricyclic Antidepressants	alosetron **Viberzi** (eluxadoline)

Length of Authorization: 365 days

Non-Preferred Criteria:

- Must have had an inadequate clinical response of at least 14 days with at least 1 preferred drug in this UPDL category and indicated for diagnosis

Gastrointestinal Agents: Pancreatic Enzymes

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
Creon (pancrelipase) **Pertzye** (pancrelipase) [ST] **Zenpep** (pancrelipase)	**Viokace** (pancrelipase)

Length of Authorization: 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 1 preferred drug in this UPDL category

Non-Preferred Criteria:

- Must have had an inadequate clinical response of at least 14 days with at least 2 preferred drugs in this UPDL category and indicated for diagnosis

Gastrointestinal Agents: Proton Pump Inhibitors

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
esomeprazole cap, tab	**Dexilant** (dexlansoprazole) [BvG]
lansoprazole cap	esomeprazole granules
Nexium (esomeprazole) granules [BvG]	**Konvomep** (omeprazole/sodium bicarbonate susp)
omeprazole cap, tab	lansoprazole ODT
pantoprazole tab	omeprazole ODT
Protonix (pantoprazole) pak [AR BvG]	omeprazole/sodium bicarbonate cap, packet
rabeprazole	pantoprazole packet [AR]
	Prilosec (omeprazole) susp

Length of Authorization: 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 2 preferred drugs in this UPDL category and indicated for diagnosis

Additional Criteria for Proton Pump Inhibitor (PPI) Doses Greater Than Once Daily

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

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 – a PA is required for patients 6 years and older: Protonix (pantoprazole) pak

Gastrointestinal Agents: Ulcerative Colitis

Oral Agents

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
balsalazide disodium budesonide ER tab mesalamine DR cap, tab 1.2gm mesalamine ER cap 0.375gm, 500mg **Pentasa** (mesalamine) 250mg sulfasalazine IR, DR	**Dipentum** (olsalazine) mesalamine DR tab 800mg **Velsipity** (etrasimod) **Zeposia** (ozanimod)

Rectal Agents

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
mesalamine enema, supp	budesonide rectal foam mesalamine enema kit **SF Rowasa** (mesalamine enema sulfite-free)

Length of Authorization: 365 days

Non-Preferred Criteria:

- Must have had an inadequate clinical response of at least 30 days with at least 2 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 Velsipity (etrasimod) & Zeposia (ozanimod) Criteria:

- Must have had a documented side effect, allergy, or treatment failure of at least 90 days with at least 1 preferred Systemic Immunomodulator indicated for Ulcerative Colitis (refer to Immunomodulator Agents: Systemic Inflammatory Disease class for complete list)

Gastrointestinal Agents: Unspecified GI

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
bisacodyl	**Gattex** (teduglutide)
dicyclomine	**Ibsrela** (tenapanor)
diphenoxylate/atropine	**Mytesi** (crofelemer)
lactulose	polyethylene glycol oral powder packet
Linzess (linaclotide)	prucalopride
loperamide	**Symproic** (naldemedine)
lubiprostone ST	
Movantik (naloxegol) ST	
polyethylene glycol oral powder bottle	
senna	

Length of Authorization: 365 days

Step Therapy Criteria:

- Must have had an inadequate clinical response of at least 14 days with at least 2 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 1 step therapy drug this UPDL category and indicated for diagnosis

Additional Symproic (naldemedine) Criteria:

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

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

Alpha Blockers

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
alfuzosin doxazosin IR prazosin silodosin tamsulosin terazosin cap	**Cardura XL** (doxazosin ER) **Tezruly** (terazosin soln)

5-Alpha-Reductase (5AR) Inhibitors

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
dutasteride finasteride 5mg	

Phosphodiesterase-5 (PDE-5) Inhibitors

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
tadalafil [PA] 2.5, 5mg	

Combination Agents

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
	dutasteride/tamsulosin

Length of Authorization: 365 days

Cialis (tadalafil) Criteria:

- Must have had an inadequate clinical response of at least 30 days with at least 1 alpha blocker. If prostate volume of > 30mL 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 2 preferred drugs, with at least 1 preferred within the same subsection classification and indicated for diagnosis, if available

Genitourinary Agents: Electrolyte Depleter Agents

Calcium-Based

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
calcium acetate, carbonate	

Iron-Based

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
Velphoro (sucroferric oxyhydroxide) ST	ferric citrate

Other Agents

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
sevelamer	**Fosrenol** (lanthanum carbonate) pow lanthanum carbonate chew **Xphozah** (tenapanor)

Length of Authorization: 365 days

Step Therapy Criteria:

- Must have had an inadequate clinical response of at least 7 days with at least 1 preferred drug in this UPDL category

Non-Preferred Criteria:

- Must have had an inadequate clinical response of at least 14 days with at least 1 step therapy drug in this UPDL category and indicated for diagnosis, if available

Genitourinary Agents: Urinary Antispasmodics

Antimuscarinics

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
fesoterodine oxybutynin IR, ER **Oxytrol** (oxybutynin patch) solifenacin tab trospium IR, ER	darifenacin tolterodine IR, ER **Vesicare LS** (solifenacin) susp [AR]

Beta-3 Agonists

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
Myrbetriq (mirabegron) tab [BvG]	**Gemtesa** (vibegron) mirabegron tab **Myrbetriq** (mirabegron) granules [AR]

Length of Authorization: 365 days

Non-Preferred Criteria:

- Must have had an inadequate clinical response of at least 30 days with at least 2 preferred drugs in this UPDL category and indicated for diagnosis, 1 of which must be within the same subsection classification, if available

AR – a PA is required for patients younger than 2 years old AND 5 years and older: Vesicare LS (solifenacin) susp
AR – a PA is required for patients younger than 3 years old AND 5 years and older: Myrbetriq (mirabegron) granules

Hyperkalemia Agents: Potassium Binders

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
Lokelma (sodium zirconium cyclosilicate) **Veltassa** (patiromer)	kionex susp sodium polystyrene sulfonate

Length of Authorization: 365 days

Non-Preferred Criteria:

- Must have had an inadequate clinical response of at least 30 days with at least 1 preferred drug in this UPDL category and indicated for diagnosis

Immunomodulator Agents: Monoclonal Antibody Biologics/Small-Molecule Kinase Inhibitors

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
Cinqair (reslizumab) PA **Dupixent** (dupilumab) PA **Fasenra** (benralizumab) PA **Nucala** (mepolizumab) PA **Rhapsido** (remibrutinib) PA **Xolair** (omalizumab) PA	**Exdensur** (depemokimab) **Tezspire** (tezepelumab-ekko)

Length of Authorization: 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 1 oral corticosteroid AND 1 nasal corticosteroid spray
- For **Chronic Spontaneous Urticaria** – Must have had an inadequate clinical response of at least 14 days with at least 2 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/mcL within 12 months prior to initiation of therapy **AND**
    - The patient must have had 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 2 preferred drugs in this UPDL category and indicated for diagnosis

Additional Exdensur (depemokimab) Criteria:

- Must have had an inadequate clinical response of at least 90 days with at least 1 additional 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., PFT improvement, reduced affected BSA)

Immunomodulator Agents: Systemic Inflammatory Disease

Interleukin Antagonists

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
Adbry (tralokinumab-ldrm) PA	**Actemra** (tocilizumab)
Dupixent (dupilumab) PA	**Avtozma** (tocilizumab-anoh)
Ebglyss (lebrikizumab-lbkz) PA	**Bimzelx** (bimekizumab-bkzx)
Kineret (anakinra) PA	**Cosentyx** (secukinumab)
Nemluvio (nemolizumab-ilto) PA	**Ilumya** (tildrakizumab-asmn)
Pyzchiva (ustekinumab-ttwe) BvG PA	**Imuldosa** (ustekinumab-srlf)
Skyrizi (risankizumab-rzaa) PA	**Kevzara** (sarilumab)
Steqeyma (ustekinumab-stba) PA	**Omvoh** (mirikizumab-mrkz)
Taltz (ixekizumab) PA ST	**Starjemza** (ustekinumab-hmny)
Tremfya (guselkumab) PA	ustekinumab [generic **Stelara**]
Tyenne (tocilizumab-aazg) PA	ustekinumab-aauz [generic **Otulfi**]
	ustekinumab-aekn [generic **Selarsdi**]
	ustekinumab-ttwe [generic **Pyzchiva**]
	Yesintek (ustekinumab-kfce)

Janus Kinase (JAK) Inhibitors

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
Rinvoq (upadacitinib) PA	**Cibinqo** (abrocitinib)
Xeljanz (tofacitinib) IR PA	**Leqselvi** (deuruxolitinib)
	Litfulo (ritlecitinib)
	Olumiant (baricitinib)
	Xeljanz (tofacitinib) soln, XR

Tumor Necrosis Factor (TNF) Inhibitors

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
adalimumab-adaz [PA] [generic **Hyrimoz**]	**Abrilada** (adalimumab-afzb)
adalimumab-fkjp [PA]	adalimumab-aacf [generic **Idacio**]
Amjevita [PA] 10/0.1ml (adalimumab-atto)	adalimumab-aaty [generic **Yuflyma**]
Avsola [PA] (infliximab-axxq)	adalimumab-adbm [generic **Cyltezo**]
Enbrel (etanercept) [PA]	adalimumab-ryvk [generic **Simlandi**]
Humira (adalimumab) [PA]	**Amjevita** 10/0.2ml (adalimumab-atto)
infliximab [PA] [generic **Remicade**]	**Cimzia** (certolizumab pegol)
Simlandi [BvG PA] (adalimumab-ryvk)	**Hadlima** (adalimumab-bwwd)
	Hyrimoz (adalimumab-adaz)
	Inflectra (infliximab-dyyb)
	Renflexis (infliximab-abda)
	Simponi (golimumab)
	Yusimry (adalimumab-aqvh)
	Zymfentra (infliximab-dyyb)

Other Agents

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
Otezla IR, XR (apremilast) [PA]	**Entyvio** (vedolizumab)
	Orencia (abatacept)
	Sotyktu (deucravacitinib)

Length of Authorization: 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 1 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 2 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 Nemluvio (nemolizumab-ilto) Criteria:

- Must have had an inadequate clinical response of at least 90 days with **Dupixent** (dupilumab) 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

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 2 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 2 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 (no PA required unless noted)	Non-Preferred Agents (PA required)
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 Authorization: Based on indication

Non-Preferred Criteria:

- Must have had an inadequate clinical response of at least 3 days with at least 1 preferred drug in this UPDL category and indicated for diagnosis

Subsequent Authorization Criteria:

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

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

AR – a PA is required for patients 12 years and older: cefaclor susp, cefixime susp, cefprozil susp

Infectious Disease Agents: Antibiotics – Inhaled

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
tobramycin 300mg/5ml neb soln [PA] tobramycin inj	**Arikayce** (amikacin liposome inhalation suspension) **Bethkis** (tobramycin inhalation solution) [BvG] **Cayston** (aztreonam inhalation solution) **TOBI Podhaler** (tobramycin inhalation pow)

Length of Authorization: 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 1 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 (no PA required unless noted)	Non-Preferred Agents (PA required)
azithromycin clarithromycin IR, susp [AR]	clarithromycin ER erythromycin IR, ER

Length of Authorization: Based on indication

Non-Preferred Criteria:

- Must have had an inadequate clinical response of at least 3 days with at least 1 preferred drug in this UPDL category and indicated for diagnosis

Subsequent Authorization Criteria:

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

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

AR – a PA is required for patients 12 years and older: clarithromycin susp

Infectious Disease Agents: Antibiotics – Quinolones

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
Cipro (ciprofloxacin) susp [AR] ciprofloxacin susp [AR], tab levofloxacin soln [AR], tab moxifloxacin	**Baxdela** (delafloxacin) ofloxacin

Length of Authorization: Based on indication

Non-Preferred Criteria:

- Must have had an inadequate clinical response of at least 3 days with at least 1 preferred drug in this UPDL category and indicated for diagnosis

Subsequent Authorization Criteria:

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

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

AR – a PA is required for patients 12 years and older: Cipro (ciprofloxacin) susp, ciprofloxacin susp, levofloxacin soln

Infectious Disease Agents: Antibiotics – Tetracyclines

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
doxycycline IR tab 20, 50, 100mg; susp [AR] minocycline IR tetracycline	demeclocycline doxycycline DR; IR tab 75, 150mg minocycline ER **Nuzyra** (omadacycline)

Length of Authorization: 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 1 preferred drug for acute infections **OR** at least 90 days with at least 1 preferred oral drug for acne in this UPDL category and indicated for diagnosis

Subsequent Authorization Criteria:

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

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

AR – a PA is required for patients 12 years and older: doxycycline susp

Infectious Disease Agents: Antifungals

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
clotrimazole	**Cresemba** (isavuconazonium sulfate)
fluconazole	flucytosine
griseofulvin	itraconazole soln
itraconazole cap [generic **Sporanox**]	**Noxafil Pak** (posaconazole DR packet)
ketoconazole	**Oravig** (miconazole)
nystatin	posaconazole DR tab, susp
terbinafine	**Tolsura** (itraconazole cap)
voriconazole susp [AR], tab	**Vivjoa** (oteseconazole)

Length of Authorization: Based on indication

Non-Preferred Criteria:

- Must have had an inadequate clinical response of at least 3 days with at least 2 preferred drugs in this UPDL category and indicated for diagnosis

Additional Vivjoa (oteseconazole) Criteria:

- Must provide documentation of at least 3 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 1 breakthrough infection

Subsequent Authorization Criteria:

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

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

AR – a PA is required for patients 12 years and older: voriconazole susp

Infectious Disease Agents: Antivirals – Coronavirus Agents

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
Paxlovid (nirmatrelvir/ritonavir)	

All products are covered without a PA

Infectious Disease Agents: Antivirals – Hepatitis C Agents

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
Mavyret (glecaprevir/pibrentasvir) PA **Pegasys** (peginterferon alfa-2a) PA ribavirin PA sofosbuvir/velpatasvir tab 400-100mg PA	**Epclusa** (sofosbuvir/velpatasvir) pak, tab 200-50mg **Harvoni** (ledipasvir/sofosbuvir) pak, tab 45-200mg ledipasvir/sofosbuvir tab 90-400mg **Sovaldi** (sofosbuvir) **Vosevi** (sofosbuvir/velpatasvir/voxilaprevir) **Zepatier** (elbasvir/grazoprevir)

Length of Authorization: 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 (no PA required unless noted)	Non-Preferred Agents (PA required)
acyclovir cap, cream, oint, susp, tab valacyclovir	famciclovir **Sitavig** (acyclovir buccal tab)

Length of Authorization: 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 1 preferred drug in this UPDL category and indicated for diagnosis

Infectious Disease Agents: Antiretrovirals (ARVs) – HIV Treatment and Prevention* LEGACY CATEGORY

Integrase Strand Transfer Inhibitors

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
Apretude (cabotegravir) ER inj **Isentress** (raltegravir) tab, HD tab **Isentress** (raltegravir) [AR] chew tab, packet **Tivicay** (dolutegravir) tab **Tivicay PD** (dolutegravir) tab for susp	**Vocabria** (cabotegravir) tab

Nucleoside Reverse Transcriptase Inhibitors

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
abacavir emtricitabine cap lamivudine soln [AR] tenofovir disoproxil fumarate (TDF) 300mg **Viread** (tenofovir disoproxil fumarate) tab 150, 200mg; pow zidovudine	abacavir soln **Emtriva** (emtricitabine) soln lamivudine tab **Viread** (tenofovir disoproxil fumarate) tab 250mg

Non-Nucleoside Reverse Transcriptase Inhibitors

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
efavirenz nevirapine susp [AR] **Pifeltro** (doravirine)	**Edurant** (rilpivirine) susp [AR], tab [BvG] etravirine nevirapine tab IR, ER

Protease Inhibitors

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
atazanavir cap	**Aptivus** (tipranavir)
darunavir tab 600, 800mg	fosamprenavir
Reyataz (atazanavir) pow	**Norvir** (ritonavir) pow
ritonavir tab	**Prezista** (darunavir) susp; tab 75, 150mg
	Viracept (nelfinavir)

Other Single Ingredient Agents

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
Rukobia (fostemsavir)	maraviroc
Yeztugo (lenacapavir)	**Sunlenca** (lenacapavir)
	Tybost (cobicistat)

Combination Agents

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
abacavir/lamivudine	**Cimduo** (lamivudine/TDF)
Biktarvy (bictegravir/emtricitabine/TAF)	efavirenz/lamivudine/TDF
Cabenuva (cabotegravir/rilpivirine)	emtricitabine/rilpivirine/TDF
Complera (emtricitabine/rilpivirine/TDF) BvG	lamivudine/zidovudine
Delstrigo (doravirine/lamivudine/ TDF)	**Stribild** (elvitegravir/cobicistat/emtricitabine/TDF)
Descovy (emtricitabine/TAF)	
Dovato (dolutegravir/lamivudine)	
efavirenz/emtricitabine/TDF	
emtricitabine/TDF	
Evotaz (atazanavir/cobicistat)	
Genvoya (elvitegravir/cobicistat/emtricitabine/TAF)	
Juluca (dolutegravir/rilpivirine)	
lopinavir/ritonavir	
Odefsey (emtricitabine/rilpivirine/TAF)	

Prezcobix (darunavir/cobicistat) **Symfi** (efavirenz/lamivudine/TDF) [BvG] **Symtuza** (darunavir/cobicistat/emtricitabine/TAF) **Triumeq** (abacavir/dolutegravir/lamivudine) tab **Triumeq PD** (abacavir/dolutegravir/lamivudine) tab for susp [PA]	

* TAF - tenofovir alafenamide; TDF - tenofovir disoproxil fumarate

Length of Authorization: 365 days

Triumeq PD (abacavir/dolutegravir/lamivudine) 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 1 preferred drug in this UPDL category and indicated for diagnosis. If applicable, the request must address the inability to use the individual components.

AR – a PA is required for patients 3 years and older: lamivudine soln, nevirapine susp
AR – a PA is required for patients 12 years and older: Edurant (rilpivirine) susp, **Isentress** (raltegravir) chew tab/packet

Metabolic Modifier Agents

Glucagon-Like Peptide-1 (GLP-1) Agonists for Non-Obesity Indications

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
Wegovy (semaglutide) [PA] inj (all excluding 7.2 mg), tab	

Length of Authorization: 180 days

Clinical PA Criteria:

- 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 1 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** (semaglutide) 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 **2** 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

Subsequent Authorization Criteria:

- **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%
  - Must have documented adherence with claims supporting an 80% proportion of days covered
  - **Wegovy** (semaglutide) 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 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 documented adherence with claims supporting an 80% proportion of days covered

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

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
bacitracin/polymyxin	**Azasite** (azithromycin)
Ciloxan (ciprofloxacin)	bacitracin
ciprofloxacin	besifloxacin
erythromycin	gatifloxacin
gentamicin	levofloxacin
moxifloxacin	loteprednol etabonate/tobramycin
neomycin/polymyxin/bacitracin	neomycin/polymyxin/hydrocortisone
neomycin/polymyxin/bacitracin/hydrocortisone	**Tobradex ST** (tobramycin/dexamethasone) susp 0.3/0.05%
neomycin/polymyxin/dexamethasone	
neomycin/polymyxin/gramicidin	
ofloxacin	
polymyxin/trimethoprim	
sulfacetamide sodium soln 10%	
sulfacetamide/prednisolone	
Tobradex (tobramycin/dexamethasone) oint 0.3/0.1%	
tobramycin	
tobramycin/dexamethasone susp 0.3/0.1%	
Tobrex (tobramycin) oint	

Length of Authorization: 30 days

Non-Preferred Criteria:

- Must have had an inadequate clinical response of at least 3 days with at least 2 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 (no PA required unless noted)	Non-Preferred Agents (PA required)
azelastine **Bepreve** (bepotastine) [BvG] cromolyn ketotifen olopatadine	bepotastine epinastine **Zerviate** (cetirizine)

Length of Authorization: 365 days

Non-Preferred Criteria:

- Must have had an inadequate clinical response of at least 7 days with at least 2 preferred drugs in this UPDL category and indicated for diagnosis

Ophthalmic Agents: Dry Eye Treatments

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
Restasis Trays (cyclosporine 0.05%) [BvG] **Xiidra** (lifitegrast) [ST]	**Cequa** (cyclosporine 0.09%) cyclosporine 0.05% **Miebo** (perfluorohexyloctane) **Restasis Multi-Dose** (cyclosporine 0.05%) **Tryptyr** (acoltremon) **Tyrvaya** (varenicline nasal spray) **Vevye** (cyclosporine 0.1%)

Length of Authorization: 365 days

Step Therapy Criteria:

- Must have had an inadequate clinical response of at least 14 days with at least 1 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 2 preferred drugs in this UPDL category and indicated for diagnosis

Additional Tryptyr (acoltremon) & Vevye (cyclosporine 0.1%) Criteria:

- Must have had an inadequate clinical response of at least 30 days with **Cequa** (cyclosporine 0.09%) and indicated for diagnosis

Ophthalmic Agents: Glaucoma Agents

Alpha-2 Agonists

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
Alphagan P (brimonidine) BvG 0.1%, 0.15% brimonidine 0.2%	apraclonidine 0.5% brimonidine 0.1%, 0.15% **Iopidine** (apraclonidine) 1%

Beta Blockers

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
betaxolol soln carteolol levobunolol timolol maleate gel, soln	**Betoptic-S** (betaxolol susp) timolol hemihydrate timolol maleate soln once daily, preservative free

Carbonic Anhydrase Inhibitors

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
Azopt (brinzolamide) BvG ST dorzolamide	brinzolamide

Prostaglandins

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
latanoprost **Travatan Z** (travoprost) BvG ST	bimatoprost 0.03% **Iyuzeh** (latanoprost preservative free) **Lumigan** (bimatoprost 0.01%) BvG tafluprost travoprost **Vyzulta** (latanoprostene)

Other Agents

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
Combigan (brimonidine/timolol) BvG ST dorzolamide/timolol **Rhopressa** (netarsudil) **Rocklatan** (netarsudil/latanoprost) **Simbrinza** (brinzolamide/brimonidine)	brimonidine/timolol

Length of Authorization: 365 days

Step Therapy Criteria:

- Must have had an inadequate clinical response of at least 30 days with at least 1 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 2 preferred drugs within the same subsection classification in this UPDL category and indicated for diagnosis

Ophthalmic Agents: NSAIDs

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
diclofenac flurbiprofen ketorolac 0.5% **Nevanac** (nepafenac 0.1%)	**Acular LS** (ketorolac 0.4%) **Acuvail** (ketorolac 0.45%) bromfenac **Ilevro** (nepafenac 0.3%)

Length of Authorization: 30 days

Non-Preferred Criteria:

- Must have had an inadequate clinical response of at least 3 days with at least 2 preferred drugs in this UPDL category and indicated for diagnosis

Ophthalmic Agents: Ophthalmic Steroids

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
Alrex (loteprednol etabonate susp 0.2%) [BvG] dexamethasone sodium phosphate **Durezol** (difluprednate) [BvG] **Eysuvis** (loteprednol etabonate susp 0.25%) **Flarex** (fluorometholone acetate susp 0.1%) fluorometholone susp 0.1% **FML Forte** (fluorometholone susp 0.25%) **Lotemax** (loteprednol etabonate gel, oint, susp 0.5%) [BvG] **Maxidex** (dexamethasone) **Pred Mild** (prednisolone acetate 0.12%) prednisolone acetate 1% prednisolone sodium phosphate	difluprednate **Inveltys** (loteprednol etabonate susp 1%) **Lotemax SM** (loteprednol etabonate gel 0.38%) loteprednol etabonate gel, oint 0.5%; susp 0.2%, 0.5%

Length of Authorization: 30 days

Non-Preferred Criteria:

- Must have had an inadequate clinical response of at least 10 days with at least 2 preferred drugs in this UPDL category and indicated for diagnosis

Otic Agents: Antibacterial and Antibacterial/Steroid Combinations

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
Cipro HC (ciprofloxacin/hydrocortisone) [BvG] ciprofloxacin/dexamethasone **Cortisporin-TC** (colistin/neomycin/thonzonium/hydrocortisone) neomycin/polymyxin B/hydrocortisone ofloxacin	ciprofloxacin ciprofloxacin/fluocinolone ciprofloxacin/hydrocortisone

Length of Authorization: 30 days

Non-Preferred Criteria:

- Must have had an inadequate clinical response of at least 3 days with at least 2 preferred drugs in this UPDL category and indicated for diagnosis

Respiratory Agents: Antihistamines – Second Generation

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
cetirizine cap, soln, tab cetirizine/pseudoephedrine desloratadine fexofenadine levocetirizine loratadine rapid dissolve loratadine soln, tab loratadine/pseudoephedrine	cetirizine chew [AR] **Clarinex-D** (desloratadine/pseudoephedrine) loratadine cap, chew [AR] fexofenadine/pseudoephedrine

Length of Authorization: 365 days

Non-Preferred Criteria:

- Must have had an inadequate clinical response of at least 7 days with at least 2 preferred drugs in this UPDL category and indicated for diagnosis

AR – a PA is required for patients 6 years and older: cetirizine chew, loratadine chew

Respiratory Agents: Cystic Fibrosis

Cystic Fibrosis Transmembrane Conductance Regulator (CFTR) Modulators

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
Alyftrek (vanzacaftor/tezacaftor/deutivacaftor) [PA] **Kalydeco** (ivacaftor) [PA] **Orkambi** (lumacaftor/ivacaftor) [PA] **Symdeko** (tezacaftor/ivacaftor) [PA] **Trikafta** (elexacaftor/tezacaftor/ivacaftor) [PA] pak [AR], tab	

Non-CFTR Modulators

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
Pulmozyme (dornase alfa) [PA]	

Length of Authorization: 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 – a PA is required for patients 6 years and older: Trikafta (elexacaftor/tezacaftor/ivacaftor) pak

Respiratory Agents: Epinephrine

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
epinephrine auto-inj [NDC 49502] **Epipen** (epinephrine auto-inj) **Epipen JR** (epinephrine auto-inj)	**Auvi-Q** (epinephrine auto-inj) Epinephrine auto-inj [All NDCs except 49502] **Neffy** (epinephrine nasal spray)

Length of Authorization: 365 days

Non-Preferred Criteria:

- Must have had an inadequate clinical response to at least 1 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

Acute Agents

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
Berinert (C1 esterase inhibitor [human]) PA icatibant acetate PA	**Ekterly** (sebetralstat) **Kalbitor** (ecallantide) **Ruconest** (C1 esterase inhibitor [recombinant])

Prophylactic Agents

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
Haegarda (C1 esterase inhibitor subcutaneous [human]) PA **Takhzyro** (lanadelumab-flyo) PA	**Andembry** (garadacimab-gxii) **Cinryze** (C1 esterase inhibitor [human]) **Dawnzera** (donidalorsen) **Oraldeyo** (berotralstat)

Length of Authorization: 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 2 rescue doses of at least 1 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 2 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

Anticholinergic Bronchodilators & Combinations

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
Anoro Ellipta (umeclidinium/vilanterol) BvG	**Bevespi Aerosphere** (glycopyrrolate/formoterol)
Atrovent HFA (ipratropium) BvG	**Duaklir Pressair** (aclidinium/formoterol)
Combivent Respimat (ipratropium/albuterol)	ipratropium HFA
Incruse Ellipta (umeclidinium) BvG	tiotropium inhaled cap
ipratropium neb soln	**Tudorza** (aclidinium)
ipratropium/albuterol neb soln	umeclidinium
Spiriva (tiotropium inhaled cap) BvG	umeclidinium/vilanterol
Stiolto Respimat (tiotropium/olodaterol)	**Yupelri** (revefenacin)

Adrenergic Bronchodilators

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
albuterol HFA	formoterol fumarate
albuterol neb soln 0.021% (0.63mg/3mL), 0.042% (1.25mg/3mL) AR	levalbuterol HFA, neb soln
albuterol neb soln 0.083% (2.5mg/3mL)	
albuterol neb soln 0.5% (5mg/mL) concentrate	
arformoterol neb soln	
Proair RespiClick (albuterol)	
Serevent Diskus (salmeterol)	
Striverdi Respimat (olodaterol)	
Ventolin HFA (albuterol)	
Xopenex HFA (levalbuterol) BvG	

Bronchodilator/Glucocorticoid Combinations

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
Advair HFA (fluticasone propionate/salmeterol) BvG	**Breo Ellipta** (fluticasone furoate/vilanterol) BvG
Airsupra (albuterol/budesonide) PA	breyna [generic **Symbicort**]
Dulera (mometasone furoate/formoterol)	budesonide/formoterol [generic **Symbicort**]
fluticasone/salmeterol diskus [generic **Advair Diskus**]	fluticasone/salmeterol HFA
fluticasone/salmeterol respiclick [generic **Airduo**]	wixela inhub [generic **Advair Diskus**]
Symbicort (budesonide/formoterol) BvG	

Glucocorticoids

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
Arnuity Ellipta (fluticasone furoate) BvG	**Alvesco** (ciclesonide)
Asmanex Twisthaler (mometasone furoate)	**Asmanex HFA** (mometasone furoate)
beclomethasone dipropionate [generic **QVAR**]	fluticasone furoate
budesonide neb susp AR	
fluticasone propionate	
QVAR RediHaler (beclomethasone dipropionate)	

Triple Ingredient Inhalers

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
Breztri Aerosphere (budesonide/glycopyrrolate/formoterol) ST	
Trelegy Ellipta (fluticasone furoate/umeclidinium/vilanterol) ST	

Other Agents

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
cromolyn neb soln	**Ohtuvayre** (ensifentrine)

Length of Authorization: 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 1 inhaled corticosteroid (ICS) **AND** at least 1 long-acting beta-agonist (LABA) **AND** at least 1 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 2 preferred drugs in this UPDL category within the same subsection classification and indicated for diagnosis

Additional Ohtuvayre (ensifentrine) Criteria:

- Must have a diagnosis of moderate to severe refractory COPD, defined as a Forced Expiratory Volume (FEV_1)/Forced Vital Capacity (FVC) ratio of less than 0.70 **AND** persistent symptoms of everyday dyspnea despite optimized standard therapy **AND**
- Must have had an inadequate clinical response of at least 90 days of concurrent treatment with at least 1 LABA **AND** 1 LAMA either as individual or combination therapy **OR** triple therapy (ICS/LAMA/LABA) in this UPDL category and indicated for diagnosis, if available

Additional Steroid-Containing Inhaler Criteria:

- Must have had an inadequate clinical response of at least 14 days with at least 1 preferred steroid-containing drug

AR – a PA is required for patients 13 years and older: albuterol neb soln 0.021% (0.63mg/3mL), 0.042% (1.25mg/3mL), budesonide neb soln

Respiratory Agents: Leukotriene Receptor Modifiers & Inhibitors

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
montelukast zafirlukast [ST]	zileuton ER **Zyflo** (zileuton)

Length of Authorization: 365 days

Step Therapy Criteria:

- Must have had an inadequate clinical response of at least 30 days with at least 1 preferred drug in this UPDL category

Non-Preferred Criteria:

- Must have had an inadequate clinical response of at least 30 days with at least 2 preferred drugs in this UPDL category and indicated for diagnosis

Respiratory Agents: Nasal Preparations

Glucocorticoids & Combinations

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
flunisolide fluticasone [generic **Flonase**]	azelastine/fluticasone spray mometasone **Omnaris** (ciclesonide) **Qnasl** (beclomethasone dipropionate) **Ryaltris** (olopatadine/mometasone furoate) **Xhance** (fluticasone propionate) **Zetonna** (ciclesonide)

Other Agents

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
azelastine ipratropium olopatadine	

Length of Authorization: 365 days

Non-Preferred Criteria:

- Must have had an inadequate clinical response of at least 14 days with at least 2 preferred drugs in this UPDL category within the same subsection classification and indicated for diagnosis

Respiratory Agents: Pulmonary Fibrosis

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
Ofev (nintedanib) BvG PA pirfenidone PA	**Jascayd** (nerandomilast) nintedanib

Length of Authorization: 365 days

Clinical PA Criteria:

- Must be prescribed by or in consultation with a pulmonologist

Additional Jascayd (nerandomilast) Criteria:

- **Monotherapy**:
  - Must have had an inadequate clinical response of at least 90 days with at least 2 preferred drugs in this UPDL category and indicated for diagnosis
- **Add-on Therapy**:
  - Must provide documentation (chart notes) demonstrating that the patient has been on a stable dose of **Ofev** (nintedanib) for at least 90 days **AND** will be concomitantly taking **Ofev** (nintedanib)
  - Must provide documentation (chart notes) that demonstrates physiological or radiologic evidence of disease progression, such as:
    - Worsening respiratory symptoms **OR**
    - Decline in Forced Vital Capacity (FVC) **OR**
    - Decline in Diffusing Capacity of the Lungs for Carbon Monoxide (DLCO)

Sickle Cell Gene Therapy Agents

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
Casgevy (exagamglogene autotemcel) [PA] **Lyfgenia** (lovotibeglogene autotemcel) [PA]	

Length of Authorization: 365 days

Clinical PA Criteria:

- Please see the Prior Authorization Form for criteria

Topical Agents: Antifungals

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
Alevazol (clotrimazole oint) butenafine ciclopirox clotrimazole cream, soln clotrimazole/betamethasone econazole ketoconazole cream, shampoo miconazole nystatin nystatin/triamcinolone terbinafine tolnaftate cream, pow	ciclopirox kit ketoconazole foam miconazole/zinc/white petrolatum oint naftifine oxiconazole cream **Oxistat** (oxiconazole lot) tavaborole tolnaftate soln

Length of Authorization: 365 days

Non-Preferred Criteria:

- Must have had an inadequate clinical response of at least 14 days with at least 2 preferred drugs in this UPDL category and indicated for diagnosis

Topical Agents: Antiparasitics

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
Natroba (spinosad) permethrin piperonyl butoxide/pyrethrins spinosad [NDC 52246] **Vanalice** (piperonyl butoxide/pyrethrum)	**Crotan** (crotamiton) ivermectin lot malathion spinosad [All NDCs except 52246]

Length of Authorization: 14 days

Non-Preferred Criteria:

- Must have had an inadequate clinical response of at least 14 days with at least 1 preferred drug in this UPDL category and indicated for diagnosis

Topical Agents: Corticosteroids

Low Potency

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
Derma-Smoothe oil (fluocinolone acetonide) desonide cream, oint fluocinolone acetonide 0.01% hydrocortisone cream, lot, oint	alclometasone desonide lot hydrocortisone soln

Medium Potency

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
betamethasone valerate cream, oint flurandrenolide fluticasone propionate cream, oint triamcinolone cream, lot, oint	betamethasone valerate aerosol foam clocortolone pivalate fluocinolone acetonide 0.025% fluticasone propionate lot hydrocortisone butyrate, valerate **Pandel** (hydrocortisone probutate) triamcinolone spray

High Potency

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
betamethasone dipropionate/calcipotriene oint fluocinonide 0.05% mometasone furoate	betamethasone dipropionate betamethasone dipropionate/calcipotriene susp desoximetasone diflorasone diacetate **Enstilar** (betamethasone dipropionate/calcipotriene foam) halcinonide

Ultra-High Potency

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
clobetasol propionate	**Apexicon E** (diflorasone diacetate) fluocinonide 0.1% halobetasol propionate

Length of Authorization: 365 days

Non-Preferred Criteria:

- Must have had an inadequate clinical response of at least 14 days with at least 2 preferred drugs within the same subsection classification in this UPDL category and indicated for diagnosis, if available

Topical Agents: Immunomodulators

Preferred Agents (no PA required unless noted)	Non-Preferred Agents (PA required)
Opzelura (ruxolitinib) ST tacrolimus AR **Vtama** (tapinarof) ST **Zoryve** (roflumilast) ST	**Anzupgo** (delgocitinib) **Eucrisa** (crisaborole) **Hyftor** (sirolimus) pimecrolimus AR

Length of Authorization: 365 days

Step Therapy Criteria:

- Must have had an inadequate clinical response of at least 90 days with at least 1 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 1 preferred drug and 1 step therapy drug of different mechanisms of action in this UPDL category and indicated for diagnosis

AR – a PA is required for patients younger than 2 years old: pimecrolimus, tacrolimus