

# Nevada Medicaid and Nevada Check Up Preferred Drug List (PDL)

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Effective October 10, 2024

Preferred Drug List (PDL) drug coverage information can be found at [nv.primetherapeutics.com](https://nv.primetherapeutics.com).

- Nevada Medicaid's PDL only includes select drug classes
- PDL Preferred Products do not require Prior Authorization (PA) unless subject to additional clinical criteria (indicated by PA next to drug name)
- Non-Preferred Products require PA for approval
- Drugs not on the PDL are subject to Nevada's mandatory generic substitution requirements

PA requests may be submitted by electronic PA (ePA), fax, or phone:

- ePA: [Prime Therapeutics Prior Authorization Forms | CoverMyMeds](#)
- Fax: 844-347-3202
- PA fax forms: [nv.primetherapeutics.com](https://nv.primetherapeutics.com)
- Phone: 800-695-5526

## Key:

cap = capsule

ER = extended release

inj = injection

IR = immediate release

nebs = nebulizer

ODT = oral disintegrating tablet

oint = ointment

PA = Prior Authorization

QL = Quantity Limit

soln = solution

supp = suppository

susp = suspension

tab = tablet

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## Analgesics

Preferred Products	Non-Preferred Products	Prior Authorization Criteria
<b>Miscellaneous Analgesics</b>		
<b>Neuropathic Pain/Fibromyalgia Agents</b>		
duloxetine gabapentin lidocaine 5% patch (generic for Lidoderm®) <sup>PA QL</sup> Lyrica® IR Neurontin® Savella® <sup>PA*</sup>	Cymbalta® Gralise® Horizant® Lyrica® CR pregabalin IR pregabalin CR Qutenza®	* No PA if ICD-10 – M79.1; M60.0–M60.9, M61.1 (fibromyalgia)
<b>Mixed Acting Opioid Analgesics</b>		
Nucynta® Nucynta® ER tramadol IR tramadol/APAP	ConZip® Seglents® tramadol ER Ultracet®	
<b>Opiate Agonists</b>		
Butrans® fentanyl patch <sup>QL PA</sup> morphine sulfate SA tab (all generic extended release) <sup>QL</sup>	buprenorphine patch hydrocodone bitartrate ER cap methadone Methadose® MS Contin® <sup>QL</sup> oxycodone SR <sup>QL</sup> oxymorphone SR	
<b>Opiate Agonists – Abuse Deterrents</b>		
Xtampza® ER	hydrocodone bitartrate ER tab Hysingla® ER Oxycontin® <sup>QL</sup>	
<b>Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) – Oral</b>		
celecoxib cap <sup>QL</sup> diclofenac sodium DR tab ibuprofen susp ibuprofen tab indomethacin IR cap ketorolac tab <sup>QL PA</sup> meloxicam tab nabumetone tab	Cambia® powder diclofenac potassium diclofenac sodium tab ER diclofenac w/ misoprostol tab Duexis® tab etodolac IR cap etodolac IR tab etodolac ER tab	

## Analgesics

Preferred Products	Non-Preferred Products	Prior Authorization Criteria
naproxen susp naproxen tab naproxen DR tab piroxicam cap sulindac tab	indomethacin ER cap ketoprofen cap mefenamic cap meloxicam susp Naprelan® CR tab naproxen CR tab naproxen ER tab oxaprozin tab Sprix® spray Vimovo® tab Zipsor® cap Zorvolex® cap	

## Antihistamines

Preferred Products	Non-Preferred Products	Prior Authorization Criteria
<b>H1 Blockers – Non-Sedating</b>		
cetirizine tab, chewable OTC cetirizine soln 1 mg/1 mL levocetirizine tab, soln loratadine D OTC loratadine tab, ODT, chewable, soln OTC	Allegra® cetirizine D OTC cetirizine cap OTC cetirizine soln 5 mg/5 mL OTC Clarinex® Clarinex-D® Claritin® desloratadine fexofenadine fexofenadine D OTC Xyzal®	A two-week trial of one preferred drug is required before a non-preferred drug will be authorized.

## Anti-Infective Agents

Preferred Products	Non-Preferred Products	Prior Authorization Criteria
<b>Aminoglycosides</b>		
<b>Inhaled Aminoglycosides</b>		
Bethkis® Kitabis® Pak tobramycin 300 mg/5 mL nebulizer	Tobi Podhaler® tobramycin 300 mg/4 mL nebulizer	



## Anti-Infective Agents

Preferred Products	Non-Preferred Products	Prior Authorization Criteria
<b>Antivirals</b>		
<b><i>Alpha Interferons</i></b>		
Pegasys® Pegasys® convenient pack Peg-Intron® and Redipen		
<b><i>Anti-hepatitis Agents – Polymerase Inhibitors/Combination Products</i></b>		
Mavyret® <sup>PA</sup> sofosbuvir/velpatasvir (generic for Epclusa®) <sup>PA</sup>	Epclusa® Harvoni® <sup>QL</sup> ledipasvir/sofosbuvir <sup>QL</sup> Sovaldi® <sup>QL</sup> Viekira® Pak <sup>QL</sup> Vosevi® Zepatier®	
<b><i>Anti-hepatitis Agents – Ribavirin</i></b>		
ribavirin		
<b><i>Anti-herpetic Agents</i></b>		
acyclovir famciclovir valacyclovir		
<b><i>Influenza Agents</i></b>		
amantadine oseltamivir cap/susp rimantadine Relenza®	Rapivab® Tamiflu® Xofluza®	
<b>Cephalosporins</b>		
<b><i>Second-Generation Cephalosporins</i></b>		
cefaclor cap cefuroxime tab cefprozil tab and susp	Ceclor® Ceclor® CD cefaclor susp cefaclor ER tab Ceftin® Cefzil®	
<b><i>Third-Generation Cephalosporins</i></b>		
cefdinir cap and susp <sup>PA</sup> cefepodoxime tab and susp <sup>PA</sup>	cefixime cap and susp <sup>PA</sup> Suprax® <sup>PA</sup>	

## Anti-Infective Agents

Preferred Products	Non-Preferred Products	Prior Authorization Criteria
<b>Macrolides</b>		
azithromycin tab/susp clarithromycin tab/susp clarithromycin XL erythromycin base erythromycin ethylsuccinate Erythrocin®	Dificid® Zithromax®	
<b>Quinolones</b>		
<b>Quinolones – 2nd Generation</b>		
ciprofloxacin tabs <sup>PA</sup> Cipro® susp <sup>PA</sup>	ofloxacin <sup>PA</sup>	
<b>Quinolones – 3rd Generation</b>		
levofloxacin <sup>PA</sup> moxifloxacin <sup>PA</sup>	Avelox® <sup>PA</sup>	
<b>Topical Anti-Infectives, Vaginal</b>		
Cleocin® cream Cleocin® ovule metronidazole (generic for Vandazole®) Nuversa®	clindamycin Clindesse® Vandazole® Xaciato®	

## Autonomic Agents

Preferred Products	Non-Preferred Products	Prior Authorization Criteria
<b>Sympathomimetics</b>		
<b>Self-Injectable Epinephrine</b>		
epinephrine auto inj Epipen® Epipen Jr®	AdrenaClick® <sup>QL</sup> Auvi-Q® Symjepi®	

## Biologic Response Modifiers

Preferred Products	Non-Preferred Products	Prior Authorization Criteria
<b>Immunomodulators</b>		
<b>Immunomodulators: Atopic Dermatitis</b>		
Dupixent® <sup>PA</sup> Elidel® topical <sup>QL PA</sup> Eucrisa® topical <sup>PA</sup>	Adbry® inj Cibinqo® tab Opzelura® topical	

## Biologic Response Modifiers

Preferred Products	Non-Preferred Products	Prior Authorization Criteria
tacrolimus topical (generic for Protopic®) <sup>QL PA</sup>	pimecrolimus topical	
<b>Targeted Immunomodulator</b>		
Actemra® <sup>PA</sup> Avsola® <sup>PA</sup> Cimzia® <sup>PA</sup> Cosentyx® <sup>PA</sup> Enbrel® <sup>PA</sup> Humira® <sup>PA</sup> Inflectra® <sup>PA</sup> Infliximab <sup>PA</sup> Kevzara® <sup>PA</sup> Kineret® <sup>PA</sup> Olumiant® <sup>PA</sup> Orencia® <sup>PA</sup> Otezla® <sup>PA</sup> Renflexis® <sup>PA</sup> Simponi® <sup>PA</sup> Stelara® <sup>PA</sup> Xeljanz® IR <sup>PA</sup>	adalimumab-aacf adalimumab-aaty adalimumab-adbm adalimumab-adaz adalimumab-fkjp adalimumab-ryvk Abrilada® Amjevita® Bimzelx® Cyltezo® Enspryng® Entyvio® Hadlima® Hulio® Hyrimoz® Idacio® Ilaris® Ilumya® Omvoh® Remicade® Rinvoq® Siliq® Simlandi® Sotyktu® Spevigo® Skyrizi® Taltz® Tremfya® Uplizna® Velsipity® Yuflyma® Yusimry® Xeljanz® ER	

## Biologic Response Modifiers

Preferred Products	Non-Preferred Products	Prior Authorization Criteria
	Zeposia®	
<b>Colony Stimulating Factors</b>		
Neupogen® syringe and vial <sup>PA</sup> Nyvepria® <sup>PA</sup>	Nivestym® syringe and vial Releuko® syringe and vial Leukine® Zarxio® Granix® syringe and vial Fulphila® Ziextenzo® Udenyca® Neulasta®	
<b>Immune Globulins</b>		
Gamunex-C® Gammagard Liquid® Hizentra® Privigen®	Asceniv® Bivigam® Cutaquig® Cuvitru® Cytogam® Flebogamma® Gamastan® Gamastan S-D® Gammagard S-D® Gammaked® Gammaplex® Hepagam B® Hyperhep B S-D® Hyperrab® Hyqvia® Kedrab® Octagam® Panzyga® Varizig® Xembify®	

## Biologic Response Modifiers

Preferred Products	Non-Preferred Products	Prior Authorization Criteria
<b>Multiple Sclerosis Agents</b>		
<b><i>Injectable</i></b>		
Avonex® <sup>PA</sup> Avonex® Admin Pack <sup>PA</sup> Betaseron® <sup>PA</sup> Copaxone® <sup>QL PA</sup> Tysabri® <sup>PA</sup>	Briumvi® Extavia® glatiramer Glatopa® Kesimpta® Lemtrada® Ocrevus® Plegridy® Rebif® <sup>QL</sup>	Trial of only one agent is required before moving to a non-preferred agent.
<b><i>Oral</i></b>		
teriflunomide (generic for Aubagio®) <sup>PA</sup> dimethyl fumarate (generic for Tecfidera®) <sup>PA</sup> fingolimod (generic for Gilenya®) <sup>PA</sup>	Aubagio® Bafiertam® Gilenya® Mavenclad® Mayzent® Ponvory® Tecfidera® Vumerity® Zeposia®	
<b><i>Specific Symptomatic Treatment</i></b>		
dalfampridine <sup>QL PA</sup>	Ampyra® <sup>QL</sup>	

## Cardiovascular Agents

Preferred Products	Non-Preferred Products	Prior Authorization Criteria
<b>Antihypertensive Agents</b>		
<b><i>Angiotensin II Receptor Antagonists</i></b>		
losartan losartan HCTZ olmesartan olmesartan HCTZ valsartan valsartan HCTZ	Atacand® Avapro® Benicar® candesartan Cozaar® Diovan® Diovan HCTZ® Edarbi®	

## Cardiovascular Agents

Preferred Products	Non-Preferred Products	Prior Authorization Criteria
	Edarbyclor® eprosartan Hyzaar® irbesartan Micardis® telmisartan	
<b>Angiotensin-Converting Enzyme Inhibitors (ACE Inhibitors)</b>		
benazepril benazepril HCTZ captopril captopril HCTZ enalapril tab enalapril HCTZ enalapril soln <sup>PA*</sup> lisinopril lisinopril HCTZ ramipril	Accuretic® Epaned® soln fosinopril Mavik® moexipril perindopril Qbrelis® soln quinapril Quinaretic® trandolapril	*PA not required if age 10 and younger
<b>Beta-Blockers</b>		
acebutolol atenolol atenolol/chlorthalidone bisoprolol bisoprolol/HCTZ carvedilol IR Coreg CR® labetalol metoprolol tartrate metoprolol succinate nadolol (generic for Corgard®) nebivolol (generic for Bystolic®) metoprolol/HCTZ propranolol propranolol ER propranolol soln sotalol sotalol AF	betaxolol carvedilol ER (generic for Coreg CR®) Corgard® Kapsargo® pindolol propranolol/HCTZ Sotylize® timolol	

## Cardiovascular Agents

Preferred Products	Non-Preferred Products	Prior Authorization Criteria
<b>Calcium-Channel Blockers</b>		
amlodipine amlodipine/benazepril amlodipine/olmesartan amlodipine/valsartan Cartia XT® Diltia XT® diltiazem ER diltiazem IR felodipine ER nicardipine nifedipine ER Taztia XT® verapamil IR verapamil ER	amlodipine/valsartan/HCT Exforge® Exforge HCT® isradipine Katerzia® Lotrel® nisoldipine ER Norvasc® Nymalize® solution	
<b>Vasodilators – Inhaled</b>		
Ventavis® <sup>PA</sup> Tyvaso® <sup>PA</sup>	Tyvaso DPI®	
<b>Vasodilators – Oral</b>		
Orenitram® ER <sup>PA</sup> sildenafil tab <sup>PA</sup> sildenafil susp <sup>PA</sup> tadalafil <sup>PA</sup> Tracleer® tab <sup>PA</sup>	Adcirca® Adempas® Alyq® ambrisentan bosentan Letairis® Liqrev® suspension Opsumit® Opsynvi® Revatio® tab Revatio® susp Tadliq® suspension Tracleer® tab for susp Uptravi®	
<b>Antilipemics</b>		
<b>Bile Acid Sequestrants</b>		
colestipol	colesevelam	

## Cardiovascular Agents

Preferred Products	Non-Preferred Products	Prior Authorization Criteria
cholestyramine Welchol®	Questran®	
<b><i>Cholesterol Absorption Inhibitors</i></b>		
ezetimibe	Zetia®	
<b><i>Fibric Acid Derivatives</i></b>		
fenofibrate (generic for Antara®, Lofibra®, and Tricor®) fenofibric acid (generic for Trilipix®) gemfibrozil Lipofen®	Antara® fenofibrate (generic for Fenoglide® and Lipofen®) fenofibric acid (generic for Fibricor®) Fenoglide® Fibricor® Tricor® Triglide® Trilipix®	
<b><i>HMG-CoA Reductase Inhibitors (Statins)</i></b>		
atorvastatin ezetimibe/simvastatin lovastatin pravastatin rosuvastatin simvastatin	Altoprev® amlodipine/atorvastatin Caduet® Crestor® <sup>QL</sup> Ezallor® fluvastatin IR fluvastatin XL Lescol® Lescol XL® Lipitor® Livalo® Pravachol® Zocor® Zypitamag® Vytorin®	
<b><i>Niacin Agents</i></b>		
Niacin ER (all generics) Niaspan®	Niacor®	
<b><i>Omega-3 Fatty Acids</i></b>		
omega-3-acid	Lovaza®	



## Cardiovascular Agents

Preferred Products	Non-Preferred Products	Prior Authorization Criteria
Vascepa®	icosapent	
<b>PCSK9 Inhibitors</b>		
Praluent® <sup>PA</sup> Repatha® <sup>PA</sup>		
<b>Miscellaneous Heart Failure Agents</b>		
Entresto® tab <sup>PA QL</sup> ivabradine <sup>PA QL</sup>	Corlanor® tab and soln <sup>QL</sup> Entresto® sprinkle cap <sup>QL</sup> Verquvo®	

## Dermatological Agents

Preferred Products	Non-Preferred Products	Prior Authorization Criteria
<b>Antipsoriatic Agents</b>		
calcipotriene cream (generic for Dovonex®) calcipotriene foam (generic for Sorilux®) calcipotriene oint, soln Dovonex® cream Taclonex® susp	calcipotriene/betamethasone oint, susp Duobrii® lotion Enstilar® Sorilux® foam Taclonex® oint Vtama® Zoryve®	
<b>Topical Analgesics</b>		
capsaicin diclofenac 1% gel diclofenac 3% gel Flector® lidocaine lidocaine HC lidocaine viscous lidocaine/prilocaine lidocaine 5% patch (generic for Lidoderm®) <sup>PA QL</sup>	diclofenac solution Emla® LenzaPro® Licart® Pennsaid® ZTLido®	
<b>Topical Anti-infectives</b>		
<b>Acne Agents: Topical, Benzoyl Peroxide, Antibiotics, and Combination Products</b>		
Acanya® <sup>PA*</sup> Azelex® 20% cream <sup>PA*</sup>	Aczone® gel Amzeeq® foam	*PA not required if under 21 years old

## Dermatological Agents

Preferred Products	Non-Preferred Products	Prior Authorization Criteria
benzoyl peroxide (2.5%, 5%, and 10% only) <sup>PA*</sup> clindamycin <sup>PA*</sup> erythromycin/benzoyl peroxide sodium <sup>PA*</sup>	benzoyl per aerosol clindamycin aerosol clindamycin/benzoyl peroxide gel dapson gel Duac CS® erythromycin Onexton® gel sodium sulfacetamide/sulfur sulfacetamide Winlevi®	
<b><i>Impetigo Agents: Topical</i></b>		
mupirocin oint	Altabax® Centany® mupirocin cream	
<b><i>Topical Antivirals</i></b>		
acyclovir oint (generic for Zovirax® oint) Denavir® docosanol OTC (generic for Abreva®) Xerese® cream Zovirax® cream	acyclovir cream penciclovir (generic for Denavir®) Zovirax® oint	
<b><i>Topical Scabicides</i></b>		
lindane Natroba® Nix® permethrin Rid® Ulesfia®	Eurax® ivermectin malathion Ovide® Sklice® spinosad Vanallice® gel	
<b><i>Topical Antineoplastics</i></b>		
<b><i>Topical Retinoids</i></b>		
adapalene gel (generic for Differin® gel) <sup>PA*</sup> Retin-A <sup>PA*</sup>	Arazlo® adapalene cream adapalene/benzoyl peroxide	*PA not required if under 21 years of age

## Dermatological Agents

Preferred Products	Non-Preferred Products	Prior Authorization Criteria
Ziana® <sup>PA*</sup>	Atralin® Avita® Retin-A Micro® (pump and tube) tazarotene tretinoin Veltin®	

## Electrolytic and Renal Agents

Preferred Products	Non-Preferred Products	Prior Authorization Criteria
<b>Phosphate Binding Agents</b>		
calcium acetate cap calcium acetate tab Phoslyra® sevelamer carbonate tab sevelamer carbonate powder pack	Auryxia® Fosrenol® lanthanum carbonate PhosLo® gel cap Renvela® tab Renvela® powder pack sevelamer Hcl Velphoro® Xphozah®	
<b>Potassium-Removing Agents</b>		
Lokelma® sodium polystyrene sulfonate SPS®	Veltassa®	

## Gastrointestinal Agents

Preferred Products	Non-Preferred Products	Prior Authorization Criteria
<b>Antiemetics</b>		
<b><i>Pregnancy-induced Nausea and Vomiting Treatment</i></b>		
Bonjesta® OTC doxylamine 25 mg/pyridoxine 10 mg	Diclegis® doxylamine-pyridoxine tab 10-10	
<b><i>Serotonin-receptor Antagonists/Combo</i></b>		
granisetron <sup>QL PA</sup> ondansetron <sup>QL PA</sup>	Akynzeo® Anzemet® <sup>QL</sup> Barhemsys® Sancuso® Zofran® <sup>QL</sup>	

## Gastrointestinal Agents

Preferred Products	Non-Preferred Products	Prior Authorization Criteria
	Zuplenz® <sup>QL</sup>	
<b>Antiulcer Agents</b>		
<b>H2 Blockers</b>		
Famotidine tab and susp ranitidine tab ranitidine syrup <sup>PA*</sup>		* PA not required for < 12 years of age
<b>Proton Pump Inhibitors (PPIs)</b>		
omeprazole pantoprazole tab Protonix® susp	Aciphex® Dexilant® dexlansoprazole esomeprazole lansoprazole Nexium® cap Nexium® powder for susp pantoprazole susp Prevacid® Prilosec® Protonix® tab rabeprazole sodium	
<b>Functional Gastrointestinal Disorder Drugs</b>		
Linzess® <sup>PA</sup> lubiprostone (generic for Amitiza®) <sup>PA</sup> Movantik® <sup>PA</sup> Relistor® syringe <sup>PA</sup>	Amitiza® Ibsrela® Motegrity® Relistor® tab Symproic® Trulance® Zelnorm®	
<b>Gastrointestinal Anti-inflammatory Agents</b>		
Apriso® Canasa® supp Colazal® Delzicol® Pentasa® sulfasalazine DR	balsalazide Lialda® mesalamine (generic for Apriso) mesalamine (generic for Asacol HD) mesalamine (generic for Delzicol)	

## Gastrointestinal Agents

Preferred Products	Non-Preferred Products	Prior Authorization Criteria
sulfasalazine IR	mesalamine (generic Lialda) mesalamine enema susp mesalamine supp	
<b>Gastrointestinal Enzymes</b>		
Creon® Pancreaze® Zenpep®	Pertzye® Viokace®	

## Genitourinary Agents

Preferred Products	Non-Preferred Products	Prior Authorization Criteria
<b>Benign Prostatic Hyperplasia (BPH) Agents</b>		
<b>5-Alpha Reductase Inhibitors</b>		
dutasteride finasteride	Avodart® dutasteride/tamsulosin Jalyn® Proscar®	
<b>Alpha-Blockers</b>		
alfuzosin doxazosin tamsulosin terazosin	Cardura® Flomax® Minipress® prazosin Rapaflo® silodosin Uroxatral®	
<b>Bladder Antispasmodics</b>		
bethanechol Detrol® Detrol LA® oxybutynin IR and ER tab/syrup solifenacin Toviaz®	darifenacin ER Ditropan XL® flavoxate Gelnique® gel Gemtesa Myrbetriq® Oxytrol® Sanctura® tolterodine trospium Vesicare®	

## Genitourinary Agents

Preferred Products	Non-Preferred Products	Prior Authorization Criteria
	Vesicare® LS	

## Hematological Agents

Preferred Products	Non-Preferred Products	Prior Authorization Criteria
<b>Anticoagulants</b>		
<i>Oral</i>		
Coumadin® Eliquis® PA* Jantoven® Pradaxa® cap QL PA* Warfarin Xarelto® tab PA* Xarelto® susp PA**	Savaysa® dabigatran cap (generic for Pradaxa® cap) Pradaxa® oral pellets	* No PA required if approved diagnosis code transmitted on claim.  **Approval only in individuals unable to have oral tablets appropriately administered.
<i>Injectable</i>		
enoxaparin fondaparinux Fragmin®	Arixtra® Lovenox®	
<b>Erythropoiesis-Stimulating Agents</b>		
Aranesp® PA QL Retacrit® PA	Epogen® QL Mircera® QL Procrit® QL Reblozyl® Vafseo® QL	
<b>Platelet Inhibitors</b>		
Aggrenox® aspirin Brilinta® QL PA cilostazol clopidogrel dipyridamole prasugrel QL PA	anagrelide aspirin/dipyridamole Durlaza® Effient® QL Plavix® Yosprala® Zontivity®	

## Hormones and Hormone Modifiers

Preferred Products	Non-Preferred Products	Prior Authorization Criteria
<b>Androgens</b>		
Androderm® PA	AndroGel® gel packet	

## Hormones and Hormone Modifiers

Preferred Products	Non-Preferred Products	Prior Authorization Criteria
AndroGel® gel pump <sup>PA</sup> testosterone gel pump (generic for AndroGel®) <sup>PA</sup>	Fortesta® Natesto® Testim® testosterone gel packet testosterone solution Vogelxo®	
<b>Antidiabetic Agents</b>		
<b><i>Alpha-Glucosidase Inhibitors/Amylin Analogs/Miscellaneous</i></b>		
acarbose Glyset® Symlin® <sup>PA</sup> *	Cycloset® Precose®	* No PA required if diagnosis of Type 2 diabetes transmitted on claim.  Trial of only one agent is required before moving to a non-preferred agent.
<b><i>Biguanides</i></b>		
metformin (generic for Glucophage®) metformin ER (generic for Glucophage XR®) metformin ER (generic for Glumetza®) metformin soln (generic for Riomet®)* Riomet® ER suspension*	Glumetza® metformin ER (generic for Fortamet®) metformin 625 mg tab	Trial of only one agent is required before moving to a non-preferred agent.  * Approval only in individuals unable to have oral tablets appropriately administered.
<b><i>Dipeptidyl Peptidase-4 Inhibitors and Combinations with Metformin</i></b>		
Janumet® Janumet XR® Januvia® Jentadueto® Jentadueto XR® Tradjenta®	alogliptin alogliptin/metformin alogliptin/pioglitazone saxagliptin saxagliptin/metformin ER	Trial of only one agent is required before moving to a non-preferred agent.
<b><i>Incretin Mimetics and Combinations</i></b>		
Byetta® <sup>PA, QL</sup> Ozempic® <sup>PA, QL</sup> Rybelsus® <sup>PA, QL</sup> Trulicity® <sup>PA, QL</sup>	Bydureon BCise® <sup>QL</sup> liraglutide <sup>QL</sup> Mounjaro® <sup>QL</sup> Soliqua® <sup>QL</sup>	Trial of only one agent is required before moving to a non-preferred agent.

## Hormones and Hormone Modifiers

Preferred Products	Non-Preferred Products	Prior Authorization Criteria
Victoza® PA, QL	Xultophy® QL	
<b>Meglitinides</b>		
repaglinide	nateglinide	Trial of only one agent is required before moving to a non-preferred agent.
<b>Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitors and Combinations</b>		
Farxiga® Glyxambi® Invokamet® Invokana® Jardiance® Synjardy® Synjardy XR® Xigduo XR®	dapagliflozin (generic for Farxiga®) dapagliflozin/metformin ER (generic for Xigduo XR®) Inpefa® Invokamet XR® Qtern® Segluromet® Steglatro® Steglujan® Trijardy XR®	For Antidiabetic indication, trial of only one agent is required before moving to a non-preferred agent.
<b>Sulfonylureas</b>		
glimepiride (generic for Amaryl®) glipizide (generic for Glucotrol®) glipizide ER (generic for Glucotrol XL®) glyburide (generic for DiaBeta®, Micronase®) glyburide micronized (generic for Glynase®)	Amaryl® Glynase® Glucotrol XL® glyburide/metformin (generic for Glucovance®) glipizide/metformin (generic for Metaglip®)	Trial of only one agent is required before moving to a non-preferred agent.
<b>Thiazolidinediones and Combinations</b>		
pioglitazone	Actos® Actoplus Met® Duetact® pioglitazone/metformin pioglitazone/glimepiride	Trial of only one agent is required before moving to a non-preferred agent.
<b>Anti-Hypoglycemic Agents</b>		
Baqsimi® GlucaGen HypoKit® Gvoke® pen Zegalogue®	glucagon emergency kit Gvoke® syringe	



## Hormones and Hormone Modifiers

Preferred Products	Non-Preferred Products	Prior Authorization Criteria
<b>Insulins</b>		
<b><i>Rapid-Acting Insulins</i></b>		
Apidra® Apidra Solostar® Humalog® Humalog KwikPen® U-100 Humalog Junior KwikPen® insulin aspart (generic for Novolog®) insulin lispro (generic for Humalog®) Novolog®	Admelog® Admelog Solostar® Afrezza® Fiasp® Fiasp FlexTouch® Humalog KwikPen® U-200 Lyumjev® Lyumjev KwikPen®	Trial of only one agent is required before moving to a non-preferred agent.
<b><i>Short-Intermediate Acting Insulins</i></b>		
Humulin R® U-500 Novolin N® Novolin R®	Humulin N® Humulin N KwikPen® Humulin R® U-100	Trial of only one agent is required before moving to a non-preferred agent.
<b><i>Long-Acting Insulins</i></b>		
Lantus® Lantus SoloStar® Levemir® Toujeo Max SoloStar® Toujeo SoloStar® Tresiba® Tresiba FlexTouch®	Basaglar KwikPen® insulin glargine-YFGN Rezvoglar® Semglee®	Trial of only one agent is required before moving to a non-preferred agent.
<b><i>Pre-Mixed Insulin Combinations</i></b>		
Humulin 70/30® Humalog 75/25® Humalog 50/50® Novolog 70/30®	Novolin 70/30®	Trial of only one agent is required before moving to a non-preferred agent.
<b>Pituitary Hormones</b>		
<b><i>Growth Hormone Modifiers</i></b>		
Genotropin® <sup>PA</sup> Norditropin® <sup>PA</sup> Nutropin AQ® <sup>PA</sup>	Humatrope® Ngenla® Nutropin® Omnitrope® Saizen®	

## Hormones and Hormone Modifiers

Preferred Products	Non-Preferred Products	Prior Authorization Criteria
	Serostim® Sogroya® Skytrofa® Somavert® Tev-Tropin® Zomacton® Zorbtive®	
<b>Progestins for Cachexia</b>		
megestrol acetate susp (generic for Megace®)	Megace ES®	
<b>Uterine Disorder Treatment</b>		
Myfembree® <sup>PA</sup> Oriahnn® <sup>PA</sup> Orilissa® <sup>PA</sup>		Prior Auth required for class

## Monoclonal Antibodies for the Treatment of Respiratory Conditions

Preferred Products	Non-Preferred Products	Prior Authorization Criteria
Dupixent® <sup>PA</sup> Fasenra® <sup>PA</sup> Nucala® <sup>PA</sup> Xolair® syringe <sup>PA</sup>	Cinqair® Tezspire® Xolair® vial	

## Musculoskeletal Agents

Preferred Products	Non-Preferred Products	Prior Authorization Criteria
<b>Antigout Agents</b>		
allopurinol (100 mg, 300 mg) colchicine tab (generic for Colcrys®) <sup>PA, QL</sup> febuxostat probenecid probenecid/colchicine	allopurinol 200 mg colchicine cap <sup>QL</sup> Colcrys® <sup>QL</sup> Mitigare® <sup>QL</sup> Uloric® Zyloprim®	
<b>Bone Resorption Inhibitors</b>		
<b><i>Bisphosphonates</i></b>		
alendronate tab ibandronate tab risedronate (generic for Actonel®)	Actonel® alendronate soln Atelvia®	

## Musculoskeletal Agents

Preferred Products	Non-Preferred Products	Prior Authorization Criteria
	Binosto® Fosamax Plus D® risedronate (generic for Atelvia®)	
<b><i>Nasal Calcitonins</i></b>		
calcitonin-salmon nasal spray	Miacalcin®	
<b>Restless Leg Syndrome Agents</b>		
pramipexole IR ropinirole IR ropinirole ER		
<b>Skeletal Muscle Relaxants</b>		
baclofen carisoprodol 350 mg tab chlorzoxazone 500 mg tab cyclobenzaprine IR cyclobenzaprine ER dantrolene methocarbamol orphenadrine tizanidine	carisoprodol 250 mg tab chlorzoxazone 250 mg, 375 mg, and 750 mg tab	

## Neurological Agents

Preferred Products	Non-Preferred Products	Prior Authorization Criteria
<b><i>Alzheimer's Agents</i></b>		
<b><i>Cholinesterase Inhibitors</i></b>		
donepezil tab, ODT Exelon® patch	Adlarity® patch Aricept® galantamine galantamine ER Razadyne® ER rivastigmine	
<b><i>NMDA Receptor Antagonist</i></b>		
memantine IR tab	memantine soln memantine ER (generic for Namenda XR®) Namenda® Namenda XR®	

## Neurological Agents

Preferred Products	Non-Preferred Products	Prior Authorization Criteria
	Namzaric®	
<b>Anticonvulsants</b>		
carbamazepine carbamazepine ER cap (generic for Carbatrol®) carbamazepine ER tab (generic for Tegretol XR®) Carbatrol® Celontin® Depakene® Depakote® Depakote Sprinkle® divalproex sodium divalproex sodium ER Epidiolex® <sup>PA</sup> Epitol® ethosuximide felbamate Felbatol® Fycompa® gabapentin Gabitril® lacosamide tab lacosamide soln Lamictal® Lamictal® dose pack Lamictal ODT® lamotrigine lamotrigine ER levetiracetam levetiracetam ER levetiracetam soln Lyrica® Neurontin® oxcarbazepine Qudexy XR® Tegretol®	Aptiom® Banzel® Briviact® Depakote ER® Diacomit® Eprontia® Fintepla® Keppra® Keppra XR® Keppra® soln Lamictal XR® lamotrigine dose pack Oxtellar XR® Sabril® Spritam® Topamax® topiramate ER Trileptal® Trokendi XR® vigabatrin Vimpat® tab Vimpat® soln Xcopri®	PA required for members under 18 years old.  Trial of only one agent is required before moving to a non-preferred agent.

## Neurological Agents

Preferred Products	Non-Preferred Products	Prior Authorization Criteria
Tegretol XR® topiramate IR valproic acid valproic acid soln Zarontin® zonisamide Ztalmy®		
<b>Barbiturates</b>		
Mysoline® phenobarbital primidone		PA required for members under 18 years old.
<b>Anticonvulsants</b>		
<b>Benzodiazepines</b>		
clobazam clonazepam clorazepate Diastat® diazepam (generic for Valium®) diazepam rectal (generic for Diastat®) Nayzilam® spray <sup>PA</sup> Tranxene T-Tab® Valium® Valtoco® spray <sup>PA</sup>	Klonopin® Onfi® Sympazan®	PA required for members under 18 years of age.  Trial of only one agent is required before moving to a non-preferred agent.
<b>Hydantoins</b>		
Cerebyx® Dilantin® fosphenytoin phenytoin products	Phenytek®	Trial of only one agent is required before moving to a non-preferred agent.
<b>Anti-Migraine Agents</b>		
<b>Calcitonin Gene-Related Peptide (CGRP) Receptor Antagonists</b>		
Aimovig® <sup>PA</sup> Ajovy® <sup>PA</sup> Emgality® 120 mg <sup>PA</sup> Nurtec® ODT <sup>PA, QL</sup> Qulipta® <sup>PA, QL</sup>	Emgality® 100 mg Vyepti®	

## Neurological Agents

Preferred Products	Non-Preferred Products	Prior Authorization Criteria
Ubrelvy® <sup>PA, QL</sup>		
<b><i>Serotonin-Receptor Agonists (Triptans)</i></b>		
Frova® <sup>QL</sup> Relpax® <sup>QL</sup> rizatriptan tab (generic for Maxalt®) <sup>QL</sup> rizatriptan ODT (generic for Maxalt MLT®) <sup>QL</sup> sumatriptan nasal spray <sup>QL</sup> sumatriptan tab <sup>QL</sup>	almotriptan <sup>QL</sup> Amerge® <sup>QL</sup> eletriptan <sup>QL</sup> frovatriptan <sup>QL</sup> Imitrex® tab and inj <sup>QL</sup> Maxalt® <sup>QL</sup> Maxalt MLT® <sup>QL</sup> naratriptan <sup>QL</sup> Onzetra® Reyvow® sumatriptan inj <sup>QL</sup> sumatriptan/naproxen <sup>QL</sup> Tosymra® Treximet® Zembrace SymTouch® <sup>QL</sup> zolmitriptan tab <sup>QL</sup> zolmitriptan nasal spray <sup>QL</sup> zolmitriptan ODT (generic for Zomig ZMT®) <sup>QL</sup> Zomig® nasal spray <sup>QL</sup> Zomig® tab <sup>QL</sup> Zomig ZMT®	
<b>Antiparkinsonian Agents</b>		
<b><i>Dopamine Precursors</i></b>		
carbidopa/levodopa carbidopa/levodopa ER carbidopa/levodopa ODT carbidopa/levodopa/entacapone	Duopa® Inbrija® Lodosyn® Rytary® Stalevo®	Trial of only one preferred agent is required before moving to a non- preferred agent.
<b><i>Non-Ergot Dopamine Agonists</i></b>		
pramipexole IR ropinirole IR ropinirole ER	Apokyn® Azilect® Mirapex® Mirapex® ER	

## Neurological Agents

Preferred Products	Non-Preferred Products	Prior Authorization Criteria
	Neupro® pramipexole ER Requip® Requip XL® rasagiline	
<b>Movement Disorders</b>		
Austedo® <sup>PA</sup> Austedo XR® <sup>PA</sup> Austedo XR® titration pack <sup>PA</sup> Ingrezza® cap <sup>PA</sup> Ingrezza® sprinkle cap <sup>PA</sup> tetrabenazine	Xenazine®	

## Ophthalmic Agents

Preferred Products	Non-Preferred Products	Prior Authorization Criteria
<b>Antiglaucoma Agents</b>		
Alphagan P® Azopt® betaxolol Betoptic S® carteolol Combigan® dorzolamide dorzolamide/timolol latanoprost levobunolol Lumigan® Rhopressa® Rocklatan® Simbrinza® timolol drops, gel soln (generic for Timoptic®, Timoptic-XE®) Travatan Z®	Betagan® Betoptic® bimatoprost brimonidine brimonidine/timolol brinzolamide Cosopt® Cosopt PF® dorzolamide/timolol PF Iyuzeh™ Ocupress® Phospholine Iodide® tafluprost (generic for Zioptan®) Timoptic® Timoptic-XE® travoprost Trusopt® Vyzulta® Xalatan® Xelpros®	

## Ophthalmic Agents

Preferred Products	Non-Preferred Products	Prior Authorization Criteria
	Zioptan®	
<b>Ophthalmic Antihistamines</b>		
azelastine Bepreve® ketotifen (generic for Alaway®, Zaditor®) Lastacraft® olopatadine (generic for Pataday®) Zaditor® OTC	Alaway® OTC Alocril® Alomide® bepotastine Elestat® Optivar® Pataday® Zerviate®	
<b>Ophthalmic Anti-infectives</b>		
<b><i>Ophthalmic Macrolides</i></b>		
erythromycin oint	Azasite®	
<b><i>Ophthalmic Quinolones</i></b>		
Besivance® ciprofloxacin moxifloxacin (generic for Vigamox®) ofloxacin Zymaxid®	Ciloxan® gatifloxacin moxifloxacin (generic for Moxeza®) Ocuflox® Vigamox®	
<b>Ophthalmic Anti-infective/Anti-inflammatory Combinations</b>		
neomycin/polymyxin/dexamethasone oint, susp Pred-G® sulfacetamide/prednisolone soln TobraDex® tobramycin/dexamethasone susp (generic for TobraDex®)	Blephamide® Maxitrol® neomycin/bacitracin/polymyxin/hydrocortisone oint neomycin/polymyxin/hydrocortisone susp TobraDex ST® Zylet®	
<b>Ophthalmic Anti-inflammatory Agents</b>		
<b><i>Ophthalmic Corticosteroids</i></b>		
Alrex® difluprednate (generic for Durezol®) Flarex® FML® FML Forte®	dexamethasone Durezol® fluorometholone Inveltys® Lotemax® loteprednol	



## Ophthalmic Agents

Preferred Products	Non-Preferred Products	Prior Authorization Criteria
Maxidex® Pred Forte®	Omnipred® Pred Mild® prednisolone	
<b>Ophthalmic Nonsteroidal Anti-inflammatory Drugs (NSAIDs)</b>		
diclofenac soln flurbiprofen soln Ilevro® ketorolac soln Nevanac®	Acular® Acular LS® Acuvail® bromfenac Prolensa®	
<b>Ophthalmics for Dry Eye Disease</b>		
artificial tears Restasis® Xiidra®	Cequa® Eysuvis® Restasis Multidose® Tyrvaya®	

## Otic Agents

Preferred Products	Non-Preferred Products	Prior Authorization Criteria
<b>Otic Anti-infectives</b>		
<b>Otic Quinolones</b>		
Ciprodex® ciprofloxacin/dexamethasone (generic for Ciprodex®) Cipro HC® ofloxacin	Cetraxal® ciprofloxacin 0.2% soln Otiprio® Otovel®	

## Psychotropic Agents

Preferred Products	Non-Preferred Products	Prior Authorization Criteria
<b>ADHD Agents</b>		
Adderall XR® <sup>PA, QL</sup> amphetamine salts combo IR (generic for Adderall®) <sup>PA</sup> amphetamine salts combo ER (generic for Adderall XR®) <sup>PA, QL</sup> atomoxetine <sup>PA, QL</sup> clonidine ER <sup>PA, QL</sup> Concerta® <sup>PA, QL</sup>	Adderall® Adhansia XR® Adzenys XR ODT® amphetamine ER susp (generic for Adzenys XR ODT®) Aptensio XR® <sup>QL</sup> Azstarys® Cotempla XR-ODT®	PA required for entire class.

## Psychotropic Agents

Preferred Products	Non-Preferred Products	Prior Authorization Criteria
Daytrana® <sup>PA, QL</sup> dexmethylphenidate <sup>PA</sup> dexmethylphenidate ER <sup>PA, QL</sup> dextroamphetamine (generic for Dexedrine®, Dextrostat®) <sup>PA</sup> dextroamphetamine SR (generic for Dexedrine Spansule®) <sup>PA</sup> guanfacine ER <sup>PA</sup> Jornay PM® <sup>PA</sup> Metadate CD® <sup>PA</sup> Methylin® soln <sup>PA</sup> methylphenidate (generic for Ritalin®, Methylin®) <sup>PA</sup> methylphenidate CD (generic for Metadate CD®) <sup>PA, QL</sup> methylphenidate ER (generic for Concerta®, Aptensio XR®) <sup>PA, QL</sup> methylphenidate LA (generic for Ritalin LA®) <sup>PA, QL</sup> methylphenidate solution <sup>PA</sup> Qelbree® <sup>PA, QL</sup> Ritalin LA® <sup>PA, QL</sup> Vyvanse® <sup>PA, QL</sup>	Desoxyn® Dexedrine® <sup>QL</sup> dextroamphetamine soln (generic for ProCentra®) Dyanavel XR® <sup>QL</sup> Evekeo® Evekeo ODT® Focalin® Focalin XR® <sup>QL</sup> Intuniv® <sup>QL</sup> lisdexamfetamine (generic for Vyvanse®) <sup>QL</sup> Metadate ER® <sup>QL</sup> methamphetamine methylphenidate chew methylphenidate ER (generic for Relexxii®) <sup>QL</sup> methylphenidate patch (generic for Daytrana®) <sup>QL</sup> Mydayis® ProCentra® QuilliChew ER® <sup>QL</sup> Quillivant XR® <sup>QL</sup> Relexxii® Ritalin® Strattera® <sup>QL</sup> Xelstrym® Zenzedi®	
Antidepressants		
Other		
bupropion IR bupropion SR bupropion XL desvenlafaxine succinate ER (generic for Pristiq®) duloxetine Forfivo XL®	Aplenzin® Auvelity® bupropion XL (generic for Forfivo XL®) Cymbalta® desvenlafaxine ER Effexor XR®	PA required for members under 18 years old.

## Psychotropic Agents

Preferred Products	Non-Preferred Products	Prior Authorization Criteria
mirtazapine mirtazapine ODT Pristiq® trazodone venlafaxine venlafaxine hydrochloride ER	Fetzima® Trintellix® Viibryd® venlafaxine besylate ER Wellbutrin SR® Wellbutrin XL®	
<b><i>Selective Serotonin Reuptake Inhibitors (SSRIs)</i></b>		
citalopram escitalopram fluoxetine paroxetine IR Pexeva® sertraline	Celexa® fluvoxamine Lexapro® Luvox® paroxetine ER Paxil® Prozac® Zoloft®	PA required for members under 18 years old.
<b>Antipsychotics</b>		
<b><i>Atypical Antipsychotics – Oral/Topical</i></b>		
aripiprazole clozapine clozapine ODT Fanapt® lurasidone (generic for Latuda®) Nuplazid® <sup>PA*</sup> olanzapine olanzapine ODT paliperidone ER (generic for Invega®) quetiapine IR quetiapine ER Rexulti® risperidone risperidone ODT Saphris® Vraylar® ziprasidone	Abilify® Abilify MyCite® asenapine Caplyta® Clozaril® Fazaclo® Geodon® Invega® Latuda® Lybalvi® Risperdal® Risperdal M-Tab® Secuado® Seroquel® Seroquel XR® Zyprexa® Zyprexa Zydis®	PA required for members under 18 years old. * No PA required if Parkinson's related psychosis ICD code on claim  Trial of only one agent is required before moving to a non-preferred agent.

## Psychotropic Agents

Preferred Products	Non-Preferred Products	Prior Authorization Criteria
<b><i>Atypical Antipsychotics – Long Acting Injectable</i></b>		
Abilify Asimtufii® (aripiprazole) Abilify Maintena® (aripiprazole) Aristada® (aripiprazole lauroxil) Aristada Initio® (aripiprazole lauroxil) Invega Hafyera® (paliperidone palmitate) Invega Sustenna® (paliperidone palmitate) Invega Trinza® (paliperidone palmitate) Perseris® (risperidone) Risperdal Consta® (risperidone) Uzedy® (risperidone) Zyprexa Relprevv® (olanzapine pamoate)	Rykindo® (risperidone)	PA required for members under 18 years old.  Treatment-naïve patients must demonstrate tolerability per FDA-label prior to initiating the long-acting injectable.
<b>Anxiolytics, Sedatives, and Hypnotics</b>		
estazolam <sup>QL</sup> flurazepam <sup>QL</sup> Rozerem® <sup>QL</sup> temazepam <sup>QL</sup> triazolam <sup>QL</sup> zaleplon <sup>QL</sup> zolpidem IR <sup>QL</sup> zolpidem SL <sup>QL</sup>	Ambien® <sup>QL</sup> Ambien CR® <sup>QL</sup> Belsomra® <sup>QL</sup> Doral® <sup>QL</sup> Edluar® <sup>QL</sup> eszopiclone Hetlioz® Hetlioz LQ® Lunesta® Silenor® <sup>QL</sup> Sonata® zolpidem CR <sup>QL</sup> Zolpimist®	No PA required if approved diagnosis code transmitted on claim (all agents in this class).  PA required for members under 18 years old.
<b>Psychostimulants</b>		
<b><i>Narcolepsy Agents</i></b>		
Nuvigil® <sup>PA, QL *</sup> Provigil® <sup>PA, QL *</sup> Wakix® <sup>PA</sup>	armodafinil <sup>QL *</sup> modafinil <sup>QL *</sup> Sunosi	* No PA required for ICD-10 code G47.4

## Psychotropic Agents

Preferred Products	Non-Preferred Products	Prior Authorization Criteria
	Xyrem® <sup>QL</sup> Xywav®	

## Respiratory Agents

Preferred Products	Non-Preferred Products	Prior Authorization Criteria
<b>Nasal Antihistamines</b>		
azelastine Dymista® olopatadine	Patanase®	
<b>Respiratory Anti-inflammatory Agents</b>		
<b>Leukotriene Receptor Antagonists</b>		
montelukast zafirlukast	Accolate® Singulair® zileuton ER Zyflo®	
<b>Nasal Corticosteroids</b>		
fluticasone (generic for Flonase®) triamcinolone acetonide	Beconase AQ® Flonase® flunisolide Nasonex® Omnaris® Qnasl® Xhance® Zetonna®	
<b>Phosphodiesterase Type 4 Inhibitors or Combination</b>		
roflumilast <sup>PA, QL</sup> Ohtuvayre™ <sup>PA, QL</sup>	Daliresp® <sup>QL</sup>	
<b>Long-Acting Maintenance Therapy</b>		
<b>Inhaled Glucocorticoids</b>		
Arnuity Ellipta® budesonide nebs (generic for Pulmicort®) fluticasone propionate HFA (generic for Flovent HFA®) <sup>QL</sup> fluticasone propionate Diskus (generic for Flovent Diskus®) <sup>QL</sup>	Alvesco® ArmonAir Digihaler® Asmanex HFA® QVAR RediHaler®	

## Respiratory Agents

Preferred Products	Non-Preferred Products	Prior Authorization Criteria
Flovent Diskus® <sup>QL</sup> Flovent HFA® <sup>QL</sup> Pulmicort Flexhaler®		
<b><i>Glucocorticoids/Long-Acting Beta-2 Adrenergic (LABA) Combination Products</i></b>		
Advair® Diskus Advair HFA® Breo Ellipta® Dulera® Symbicort®	AirDuo Digihaler® AirDuo RespiClick® budesonide/formoterol (generic for Symbicort®) fluticasone propionate/salmeterol pow (generic for AirDuo®, Advair Diskus®) vilanterol/fluticasone (generic for Breo Ellipta®) Wixela Inhub®	
<b><i>Long-Acting Beta Adrenergics (LABAs)</i></b>		
Serevent Diskus® <sup>QL</sup> Striverdi Respimat®	Brovana® Perforomist®	
<b><i>Anticholinergics and Combination Products</i></b>		
Anoro Ellipta® Incruse Ellipta® Spiriva® Spiriva Respimat® Stiolto Respimat® Tudorza Pressair®	Bevespi Aerosphere® Breztri Aerosphere® Duaklir Pressair® Lonhala Magnair® Trelegy Ellipta® Yupelri®	
<b><i>Short-Acting/Rescue Therapy</i></b>		
<b><i>Short-Acting Beta Adrenergics (SABAs)</i></b>		
albuterol sulfate (generic for Proventil®, Ventolin®) <sup>QL</sup> albuterol soln (generic for AccuNeb®) <sup>QL</sup> levalbuterol <sup>PA, QL</sup> levalbuterol HFA <sup>PA, QL</sup> Proair HFA® <sup>QL</sup> Proventil HFA® <sup>QL</sup> Ventolin HFA® <sup>QL</sup>	albuterol HFA (generic for ProAir HFA®, Proventil HFA®, Ventolin HFA®) <sup>QL</sup> ProAir Digihaler® <sup>QL</sup> ProAir RespiClick® <sup>QL</sup> Xopenex® <sup>QL</sup> Xopenex HFA® <sup>QL</sup>	

## Respiratory Agents

Preferred Products	Non-Preferred Products	Prior Authorization Criteria
<b><i>Ipratropium and Combinations</i></b>		
Atrovent HFA® Combivent Respimat® ipratropium nebs ipratropium/albuterol nebs <sup>QL</sup>		

## Toxicology Agents

Preferred Products	Non-Preferred Products	Prior Authorization Criteria
<b>Antidotes</b>		
<b><i>Opiate Antagonists</i></b>		
Kloxxado® naloxone Narcan®	Zimhi®	
<b>Substance Abuse Agents</b>		
Brixadi® buprenorphine SL tab <sup>QL</sup> buprenorphine/naloxone SL tab <sup>QL</sup> naltrexone tab Sublocade® Suboxone® <sup>QL</sup> Vivitrol® <sup>PA</sup>	buprenorphine/naloxone film <sup>QL</sup> Lucemyra® Zubsolv® <sup>QL</sup>	

## Appendix A: Sickle Cell Disease and HIV Prevention

**Pursuant to NRS 422.4025, drugs essential for treating sickle cell disease and its variants are covered and preferred without PDL restrictions, including but not limited to the following:**

Droxia®

Siklos®

Endari®

**Pursuant to NRS 422.4025, prescription drugs to prevent the acquisition of human immunodeficiency virus (HIV) are covered and preferred without PDL restrictions, including but not limited to the following:**

*emtricitabine 200 mg/tenofovir 300 mg (generic for Truvada®)*

Descovy®