Idaho Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Updated February 3, 2025
Highlights indicated change from previous posting.

ALZHEIMER'S DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Cholinesterase Inhibitors		
donepezil – except 23 mg tablets donepezil ODT rivastigmine capsules	ADLARITY (donepezil) transdermal donepezil 23 mg tablets galantamine tablets, solution galantamine ER rivastigmine transdermal ZUNVEYL (benzgalantamine) CL	▪ Link to PA Form for Alzheimer's Agents (required for non-preferred drugs) ▪ Non-preferred agents will be approved for patients with a documented trial and failure to at least one preferred agent.
NMDA Receptor Antagonist		
memantine tablets	memantine ER memantine solution	▪ Link to PA Form for Alzheimer's Agents (required for non-preferred drugs) ▪ Non-preferred agents will be approved for patients with a documented trial and failure to at least one preferred agent.
Combination Products		
	NAMZARIC (donepezil/memantine)	▪ Link to PA Form for Alzheimer's Agents (required for non-preferred drugs) ▪ Please use prescriptions for individual agents
Other		
	KISUNLA (donanemab-azbt) CL LEQEMBI (lecanemab) CL	▪ Link to Universal PA Form ▪ Prior authorization requests will be evaluated on a case-by-case basis.

ANALGESICS, OPIOID – LONG-ACTING

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BUTRANS (buprenorphine transdermal) CL morphine ER CL tablets tramadol ER (ULTRAM ER) CL	BELBUCA (buprenorphine buccal film) CL buprenorphine transdermal CL hydrocodone ER (HYSINGLA ER) CL hydrocodone ER (ZOHYDRO ER) CL hydromorphone ER CL fentanyl transdermal CL methadone CL morphine ER CL capsules oxycodone ER CL OXYCONTIN (oxycodone ER) CL oxymorphone ER CL tramadol ER (CONZIP, RYZOLT) CL	▪ Link to PA Form for Methadone ▪ Link to PA Form for Opioid Analgesics (required for Non-Preferred drugs and/or combined opioid therapy > 90 MME/day) ▪ Use of long acting opioids is reserved for treatment of persistent pain which has responded inadequately with around-the-clock short acting opioids for > 3 months or pain due to active cancer. ▪ Use of long acting opioids is limited to one long acting agent at a time ▪ Non preferred agents will be approved for patients with a -Paid claims history in the last 45 days demonstrating chronic use of the requested non-preferred agent OR -Documented trial and failure of at least 30 days of a preferred long acting opioid agent within the last 180 days

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ANALGESICS, OPIOID – LONG-ACTING

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
		▪ Belbuca approval requires trial and failure of Butrans transdermal

ANALGESICS, OPIOID – SHORT-ACTING

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Oral/Rectal/Nasal/Transmucosal		
hydrocodone/acetaminophen morphine IR tablets, solution and concentrate solution oxycodone tablets, capsules, solution, concentrate and oral syringe oxycodone/acetaminophen tablets tramadol IR tablets (except 25 mg, 75 mg and 100 mg) tramadol/acetaminophen	benzhydrocodone/acetaminophen butalbital/acetaminophen/caffeine/ codeine butalbital/aspirin/caffeine/ codeine butorphanol nasal spray carisoprodol compound w/codeine (carisoprodol/aspirin/codeine) codeine codeine/acetaminophen DSUVIA (sufentanil) sublingual [CL] fentanyl OTFC [CL] FENTORA (fentanyl) [CL] hydrocodone/ibuprofen hydromorphone tablets, liquid and suppositories levorphanol meperidine morphine suppositories NALOCET (oxycodone/acetaminophen) oxycodone/acetaminophen solution oxymorphone pentazocine/naloxone PRIMLEV (oxycodone/acetaminophen) SEGLENTIS (tramadol/celecoxib) tramadol IR 25 mg, 75 mg, 100 mg tablets tramadol IR solution	▪ Link to PA Form for Opioid Analgesics (required for Non-Preferred drugs or combined opioid doses of > 90 MME/day) ▪ Non-preferred agents will be approved only after documented failure of 3 preferred agents with at least a 7 day trial of each in the past 180 days ▪ Butalbital combinations: – requires trail and failure of preferred medications appropriate to diagnosis (e.g. Triptans and NSAIDs for migraine) – Use will be limited to no more than 12 tablets per 30 days ▪ Fentanyl buccal/sublingual /transmucosal/nasal will only be approved for breakthrough cancer pain in patients already receiving, and tolerant to, opioid therapy.

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ANALGESICS, PAIN – OTHER

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
duloxetine 20 mg, 30 mg and 60 mg capsules gabapentin capsules, tablets lidocaine transdermal 5% Rx pregabalin capsules	DRIZALMA (duloxetine) SPRINKLE duloxetine 40 mg capsules gabapentin solution gabapentin ER GRALISE (gabapentin) HORIZANT (gabapentin) pregabalin ER pregabalin solution QUTENZA (capsaicin) SAVELLA (milnacipran) ZTLIDO (lidocaine)	▪ Link to PA Form for Analgesics, Topical ▪ Link to Universal PA Form for non-preferred oral drugs ▪ Non-preferred agents will be approved for patients with a documented trial and failure to at least one preferred agent.

ANDROGENIC DRUGS (TOPICAL)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ANDROGEL (testosterone) pump [CL] testosterone gel pump (generic ANDROGEL) [CL]	ANDROGEL (testosterone) packet [CL] NATESTO (testosterone) nasal [CL] testosterone gel (generic ANDROGEL, FORTESTA, TESTIM, VOGELXO) [CL] testosterone gel packet (generic ANDROGEL, VOGELXO) [CL] testosterone gel pump (generic VOGELXO) [CL]	▪ Link to PA Form for Androgenic Agents ▪ Please refer to the prior authorization form for clinical criteria.

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ANGIOTENSIN MODULATORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ACE Inhibitors		
benazepril enalapril solution enalapril tablets lisinopril ramipril	captopril fosinopril moexipril perindopril QBRELIS (lisinopril solution) quinapril trandolapril	▪ Link to PA Form for ACE Inhibitors (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved for patients with a documented failure to at least one preferred agent in the last 6 months. ▪ QBRELIS will be approved for patients who have documented inability to swallow tablets.
ACE Inhibitor / Diuretic Combinations		
benazepril/hydrochlorothiazide enalapril/hydrochlorothiazide lisinopril/hydrochlorothiazide	captopril/hydrochlorothiazide fosinopril/hydrochlorothiazide quinapril/hydrochlorothiazide	▪ Link to PA Form for ACE Inhibitors (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved for patients with a documented failure to at least one preferred agent in the last 6 months.
Angiotensin Receptor Blockers		
irbesartan losartan olmesartan telmisartan valsartan	candesartan EDARBI (azilsartan) eprosartan valsartan solution	▪ Link to PA Form for ARB-Angiotensin II Receptor Antagonists (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved for patients with a documented failure to at least one preferred agent in the last 6 months.
Angiotensin Receptor Blocker / Diuretic Combinations		
irbesartan/hydrochlorothiazide losartan/hydrochlorothiazide olmesartan/hydrochlorothiazide telmisartan/hydrochlorothiazide valsartan/hydrochlorothiazide	candesartan/hydrochlorothiazide EDARBYCLOR (azilsartan/chlorthalidone)	▪ Link to PA Form for ARB-Angiotensin II Receptor Antagonists (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved for patients with a documented failure to at least one preferred agent in the last 6 months.
Angiotensin Modulator / Calcium Chanel Blocker and Beta Blocker Combinations		
benazepril/amlodipine olmesartan/amlodipine valsartan/amlodipine	olmesartan/amlodipine/ hydrochlorothiazide telmisartan/amlodipine valsartan/amlodipine/hydrochlorothiazide	▪ Link to PA Form for Angiotensin Modulators-Calcium Channel Blockers (required for Non-preferred drugs) ▪ Non-preferred agents will be approved for patients with a documented failure to at least one preferred agent in the last 6 months.
Direct Renin Inhibitors		
	aliskiren	▪ Link to PA Form for Direct Renin Inhibitors (required for all drugs in the class) ▪ Aliskiren will only be authorized if there is a documented trial and failure of a preferred ACEI or ARB

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ANGIOTENSIN MODULATORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
		▪ Aliskiren will not be approved for concomitant use with ACEI or ARB in diabetic or kidney disease patients
Direct Renin Inhibitor Combinations		
	TEKTURNA (aliskiren/hydrochlorothiazide)	▪ Link to PA Form for Direct Renin Inhibitors (required for all drugs in the class) ▪ Aliskiren/HCT will only be authorized if there is a documented trial and failure of a preferred ACEI or ARB ▪ Aliskiren /HCT will not be approved for concomitant use with ACEI or ARB in diabetic or kidney disease patients
Neprilysin Inhibitor Combination		
sacubitril/valsartan		▪ Link to Universal PA Form

ANTI-ALLERGENS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
No agents are recommended to be preferred at this time.	GRASTEK (timothy grass pollen allergen extract) CL, ODACTRA (house dust mite) CL ORALAIR (grass pollen extract – Cocksfoot, Sweet Vernal Grass, Rye Grass, Meadow Grass, Timothy) CL PALFORZIA (peanut allergen) CL RAGWITEK (short ragweed pollen allergen extract) C	▪ Link to Universal PA Form ▪ Oral Allergy-Specific Immunotherapy agents will be approved for participants who have had an inadequate response, intolerance or contraindication to intranasal corticosteroids, leukotriene inhibitors and antihistamines. ▪ The participant must have a positive test for the specific allergen(s) covered by the specific agent and the first dose must be 12 weeks before estimated actual start of the specific pollen season if applicable.

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ANTIBIOTICS, GI

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
metronidazole 250 mg, 500 mg tablets neomycin tinidazole vancomycin capsules	AEMCOLO (rifamycin) DIFICID (fidaxomicin) CL LIKMEZ (metronidazole) metronidazole 125 mg tablets NR metronidazole capsules nitazoxanide tablets paromomycin REBYOTA ENEMA (fecal microbiota, live jslm) SOLOSEC (secnidazole) XIFAXAN (rifaximin) CL vancomycin solution (generic FIRVANQ) VOWST (fecal microbiota spores, live-brpk) CL	▪ Link to Universal PA Form ▪ Dificid will only be approved with documentation of a clostridium difficile infection. Treatment will be limited to 10 days. ▪ Link to PA Form for Xifaxan ▪ Xifaxan 200 mg will only be approved for documented traveler's diarrhea and is limited to one prescription with a 3 day supply. ▪ Xifaxan 550 mg will be approved for patients with irritable bowel syndrome with diarrhea, or documented hepatic encephalopathy who have received lactulose at least 90 ml per day for 72 of the last 90 days and are continuing on lactulose concurrently. ▪ Other non-preferred agents will only be approved after documented failure of a preferred agent. ▪ Vowst requests will be evaluated on a case-by-case basis.

ANTIBIOTICS, INHALED CL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BETHKIS (tobramycin) CL CAYSTON (aztreonam) CL KITABIS PAK (tobramycin) CL tobramycin inhaled (generic TOBI) CL	ARIKAYCE (amikacin) CL TOBI (tobramycin) CL tobramycin (BETHKIS) CL tobramycin pak (KITABIS PAK) CL	▪ Link to PA Form for Inhaled Antibiotics (required for all agents in class) ▪ Preferred agents will be approved for patients with a diagnosis of cystic fibrosis. ▪ Arikayce will be approved for patients with Mycobacterium avium complex disease. ▪ The other non-preferred agents will only be approved for patients with cystic fibrosis that have a documented failure of a preferred agent

ANTIBIOTICS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
mupirocin ointment	gentamicin ointment and cream mupirocin cream	▪ Link to PA Form for Antibiotics, Topical (required for Non-Preferred drugs) ▪ Non-preferred agents will only be approved after documented failure of a preferred agent

ANTIBIOTICS, VAGINAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CLEOCIN OVULES (clindamycin)	CLINDESSE (clindamycin)	▪ Link to PA Form for Antibiotics, Vaginal

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ANTIBIOTICS, VAGINAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
clindamycin cream metronidazole NUVESSA 1.3% gel (metronidazole)	XACIATO (clindamycin)	▪ Non-preferred agents will only be approved after documented failure of a preferred agent

ANTICOAGULANTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Oral		
ELIQUIS (apixaban) ELIQUIS (apixaban) Starter Pack PRADAXA (dabigatran) warfarin XARELTO (rivaroxaban) 10 mg, 15 mg and 20 mg tablets XARELTO (rivaroxaban) Starter Pack	dabigatran PRADAXA PELLET PACK (dabigatran) CL SAVAYSA (edoxaban) CL XARELTO (rivaroxaban) 2.5 mg tablets CL XARELTO (rivaroxaban) suspension	▪ Link to PA Form for Anticoagulants, Oral ▪ Xarelto 2.5mg tablets require documentation that this strength is being used for reduction of risk of major cardiovascular events in chronic coronary artery disease or peripheral artery disease. ▪ Other non-preferred agents will be approved after a trial and failure of a preferred agent within the last 30 days.
Injectable		
enoxaparin syringe enoxaparin vial	fondaparinux FRAGMIN (dalteparin) syringe, vial	▪ Link to PA Form for Anticoagulants, Injectable ▪ Non-preferred agents will be approved after a trial and failure of a preferred agent within the last 30 days.

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ANTICONVULSANTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Barbiturates		
phenobarbital tablets primidone	SEZABY (phenobarbital IV)	▪ Link to PA Form for Anticonvulsants for Seizure Disorder ▪ The non-preferred agents will be approved only after documented failure of a preferred agent.
Benzodiazepines		
clobazam tablets clonazepam tablets CL diazepam device rectal diazepam rectal NAYZILAM (midazolam) nasal spray CL VALTOCO (diazepam) CL	clobazam suspension CL clonazepam ODT CL diazepam syringe LIBERVANT (diazepam) buccal film SYMPAZAN (clobazam) CL	▪ Link to PA Form for Anticonvulsants for Seizure Disorder ▪ Non-preferred agents without additional clinical criteria will be approved only after documented failure of a preferred agent. ▪ Clobazam will be approved for patients with a diagnosis of seizure disorder (ICD-10= G40 or R56) within the previous 2 years. ▪ Clobazam suspension will be approved for patients meeting Onfi clinical criteria who have a documented inability to swallow tablets. ▪ Clonazepam orally disintegrating tablets (ODT) will be approved for patients that have a diagnosis of panic disorder with or without agoraphobia whose clonazepam dose is being titrated up or down or who have a documented inability to swallow other oral medication dosage forms.
Hydantoins		
phenytoin capsules, chewable tablets, suspension phenytoin sodium extended (generic PHENYTEK)		▪ Link to PA Form for Anticonvulsants for Seizure Disorder ▪ The non-preferred agents will be approved only after documented failure of a preferred agent.
Succinimides		
ethosuximide capsules, syrup	methsuximide	▪ Link to PA Form for Anticonvulsants for Seizure Disorder ▪ The non-preferred agents will be approved only after documented failure of a preferred agent.
Other		
EPIDIOLEX (cannabidiol) CL	DIACOMIT (stiripentol) CL FINTEPLA (fenfluramine) CL	▪ Link to PA Form for Anticonvulsants for Seizure Disorder ▪ Non-preferred agents require trial and failure of a preferred anticonvulsant or contra-indication to starting with a preferred anticonvulsant.

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ANTICONVULSANTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
		▪ Link to PA Form for Cannabidiols (Epidiolex) ▪ Refer to the PA form for criteria.
Adjuvants, Epilepsy		
DEPAKOTE (divalproex) sprinkle CL lacosamide tablets, solution levetiracetam ER CL levetiracetam solution, tablets CL oxcarbazepine suspension, tablets topiramate sprinkle CL zonisamide CL	APTIOM (eslicarbazepine) CL BANZEL (rufinamide) tablets, suspension CL BRIVIACT (brivaracetam) tablets, solution CL divalproex sprinkle CL ELEPSIA XR (levetiracetam) CL EPRONTIA (topiramate) solution NR felbamate tablets, suspension CL FYCOMPA (perampanel) tablets, suspension CL lamotrigine XR CL MOTPOLY XR (lacosamide) capsule CL OXTELLAR XR (oxcarbazepine) CL rufinamide suspension, tablets CL SABRIL (vigabatrin) tablets, powder pack CL SPRITAM (levetiracetam) suspension CL tiagabine CL vigabatrin powder pack, tablets CL XCOPRI (cenobamate) CL VIGAFYDE (vigabatrin) solution CL VIMPAT (lacosamide) CL ZONISADE CL ZTALMY (ganaxolone) CL	▪ Link to PA Form for Anticonvulsants for Seizure Disorder (required for Non-Preferred drugs) ▪ All agents require a seizure diagnosis (ICD-10= G40 or R56) within the last 2 years. ▪ Preferred agents will be approved within the approved dosage quantities and age limits for eligible participants with a seizure diagnosis. ▪ Non-preferred brand agents will be approved for patients with a diagnosis of seizure disorder who have been receiving the brand drug for 90 days and are compliant with therapy (72 days out of the past 90) or who have documented failure of at least two different generic formulations from different manufacturers. Generic failures must also include a copy of the FDA MedWatch form documenting reason for failure. ▪ Other non-preferred agents will be approved for patients with a documented failure of a preferred agent in the past 180 days.

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ANTICONVULSANTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Adjuvants, Pain and Mood Disorders		
carbamazepine chewable tablets carbamazepine IR carbamazepine ER (generic for CARBATROL) divalproex ER divalproex tablets gabapentin capsules, tablets lamotrigine chewable, tablets CL TEGRETOL (carbamazepine) suspension TEGRETOL XR (carbamazepine XR) topiramate tablets CL valproic acid capsules, solution	carbamazepine suspension carbamazepine XR (generic for TEGRETOL XR) CARBATROL (carbamazepine ER) EPRONTIA (topiramate solution) EQUETRO (carbamazepine ER) LAMICTAL ODT (lamotrigine) CL lamotrigine ODT CL topiramate ER (for QUDEXY XR, TROKENDI XR) CL capsules CL	▪ Link to PA Form for Anticonvulsants for Pain and Mood Disorders ▪ Preferred agents with no clinical criteria will be approved for eligible participants within the approved dosage quantities and age limits. ▪ Non-preferred brand agents will be approved for patients with a diagnosis of seizure disorder (ICD-10= G40 or R56) who have been receiving the brand drug for at least 90 days and are compliant with therapy (72 days out of the past 90 days) or who have a documented failure of at least two different generic formulations from different manufacturers. Generic failures must also include a copy of the FDA MedWatch form documenting the reason for failure. ▪ Non-preferred generic agents with no additional clinical criteria will be approved after trial and failure of a preferred agent within the approved dosage quantities and age limits. ▪ Lamotrigine and lamotrigine ODT will be approved for patients with one of the following diagnoses within the previous 2 years: seizure disorder (ICD-10 G40 or R56) or bipolar disorder (ICD-10 F31). ▪ Topiramate IR and ER will be approved for patients with at least one of the following diagnoses within the past 2 years: seizure disorder (ICD-10 G40 or R56) or migraine headaches (ICD-10 G43). ▪ Non-preferred agents meeting the above clinical criteria will be approved after trial and failure of a preferred agent.

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ANTIDEPRESSANTS, OTHER

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bupropion IR bupropion SR bupropion XL desvenlafaxine succinate (generic PRISTIQ) duloxetine 20 mg, 30 mg, 60 mg capsules mirtazapine tablets trazodone venlafaxine IR venlafaxine ER capsules vilazodone	APLENZIN (bupropion HBr) AUVELITY (dextromethorphan HBR/bupropion) bupropion XL (generic for FORFIVO XL) desvenlafaxine ER DRIZALMA sprinkles (duloxetine) duloxetine 40 mg capsules EMSAM (selegiline transdermal) FETZIMA (levomilnacipran) MARPLAN (isocarboxazid) mirtazapine ODT nefazodone phenelzine SPRAVATO (esketamine) nasal spray CL tranylcypromine TRINTELLIX (vortioxetine) venlafaxine ER tablets ZURZUVAE (zuranolone)	▪ Non-preferred agents will be approved for patients with a documented trial and failure of at least one preferred agent. ▪ Link to PA Form for Antidepressants, Other ▪ Link to PA Form for Esketamine ▪ Esketamine nasal spray (Spravato) will be approved for participants meeting all of the following criteria. -Baseline depression assessment score utilizing a validated depression rating scale -Concurrent oral antidepressant therapy (agents, dose history and duration of treatment must be included on the request) -Diagnosis of one of the following: ▪ Major Depressive Disorder with acute suicidal ideation ▪ Treatment resistant depression with trial and failure or intolerance/contraindication to at least three of the following: - SSRI at maximum FDA approved dose for 6 weeks - SNRI at maximum FDA approved dose for 6 weeks -Either of the above with an augmentation agent for 6 weeks -Another class of antidepressant at maximum FDA dose for 6 weeks -Initial approvals will be for 3 months. Renewal requests need to include a recent depression score, dose/dates already administered, and documentation that patient has been compliant with oral antidepressant therapy and has remained engaged in therapy for at least 8 weeks. -Note that esketamine is a clinician administered drug and as such is only payable through the Medicaid Medical benefit and cannot be dispensed through a pharmacy directly to the participant. ▪ Non-preferred duloxetine agents require documented failure of preferred duloxetine agents. ▪ Zuranolone requests will be reviewed on a case-by-case basis.

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ANTIDEPRESSANTS, SSRIS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
citalopram tablets, solution escitalopram tablets fluoxetine capsules (except for 90 mg), tablets, solution fluvoxamine IR paroxetine tablets IR sertraline tablets, concentrate	citalopram capsules escitalopram solution fluoxetine 90 mg capsules fluvoxamine ER paroxetine CR paroxetine capsules IR PAXIL (paroxetine) suspension sertraline capsules	▪ Link to PA Form for Antidepressants, SSRIs (required for Non-Preferred drugs – including fluoxetine weekly) ▪ Fluoxetine weekly will be approved for patients with a diagnosis of depression who are not receiving other medications at least daily. ▪ The other non-preferred agents will be approved only after documented failure of a preferred agent within the last 6 months.

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ANTIEMETIC/ANTIVERTIGO AGENTS (ORAL/INJECTABLES/TRANSDERMAL)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Cannabinoids		
	dronabinol capsules [CL]	▪ Link to PA Form for Dronabinol ▪ Non-preferred agents will be approved for patients with a documented trial and failure of at least one preferred agent. ▪ Dronabinol will be approved for patients who have received chemo-therapy in the last 12 months or have a history of HIV associated cachexia.
5HT$_3$ Receptor Blockers		
ondansetron 4 mg, 8 mg tablets ondansetron ODT 4 mg, 8mg ondansetron solution	granisetron tablets, vial ondansetron ODT 16 mg ondansetron syringe, vial SANCUSO (granisetron) transdermal	▪ Link to PA Form for Antiemetics (5HT3 Antagonists) (required for non-preferred drugs) only after documented trial and failure of any preferred antiemetic agent within the last 6 months. ▪ Non-preferred agents will be approved for patients with a documented trial and failure of at least one preferred agent.
NK1 Receptor Antagonist		
aprepitant capsules	AKYNZEO (netapitant/palonosetron) EMEND (aprepitant) powder pack	▪ Link to Universal PA Form ▪ Non-preferred agents will be approved for patients with a documented trial and failure of at least one preferred agent.
Other		
DICLEGIS (doxylamine/pyridoxine) meclizine metoclopramide tablets prochlorperazine (oral, rectal) promethazine (oral, rectal 12.5 & 25 mg) TRANSDERM-SCOP (scopolamine transdermal)	BONJESTA (doxylamine/pyridoxine) COMPRO (prochlorperazine) rectal doxylamine/pyridoxine (DICLEGIS) GIMOTI (metoclopramide) NASAL metoclopramide ODT, syringe, vial promethazine 50 mg suppositories scopolamine transdermal (TRANSDERM-SCOP) trimethobenzamide (oral)	▪ Link to Universal PA Form ▪ A prescription is required for all drugs ▪ Non-preferred agents will be approved for patients with a documented trial and failure of at least one preferred agent.

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ANTIFUNGALS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
clotrimazole troches fluconazole suspension, tablets griseofulvin suspension, tablets, ultramicrosize nystatin suspension terbinafine	BREXAFEMME (ibrexafungerp) CRESEMBA (isavuconazonium) flucytosine itraconazole 100 mg capsules itraconazole solution ketoconazole CL nystatin tablets posaconazole suspension, tablets SPORANOX (itraconazole solution) TOLSURA (itraconazole) VIVJOA (oteseconazole) voriconazole	▪ Link to PA Form for Antifungals, Oral ▪ Ketoconazole will be approved for blastomycosis, coccidiomycosis, histoplasmosis, chromomycosis, or paracoccidiomycosis, It will not be approved for fungal infections of the skin or nails. ▪ Non-preferred agents will be approved after failure of at least one preferred agent in the most recent 60 days or reason why a preferred agent cannot be tried first.

ANTIFUNGALS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Antifungals		
clotrimazole OTC and RX (except RX solution) ketoconazole cream, shampoo 2% miconazole cream, powder nystatin cream, ointment, powder terbinafine OTC tolnaftate OTC cream, powder	ALEVAZOL (clotrimazole) butenafine OTC ciclopirox cream, gel, shampoo, suspension clotrimazole RX solution econazole ERTACZO (sertaconazole) EXTINA (ketoconazole foam) ketoconazole foam luliconazole miconazole nitrate/zinc oxide/petrolatum MYCOZYL AC CREAM OTC (miconazole) naftifine oxiconazole OXISTAT (oxiconazole) tolnaftate solution VOTRIZA-AL (clotrimazole) OTC	▪ Link to PA Form for Antifungals, Topical (required for Non-Preferred drugs - except antifungal nail lacquers - see below) ▪ Non-preferred agents will be approved only after documented failure of the preferred agents within the previous six months
Antifungals – Nail Products		
ciclopirox solution nail lacquer	JUBLIA (efinaconazole) CL tavaborole CL	▪ Link to PA Form for Topical Antifungal, Nails for non-preferred agents. ▪ Non-preferred agents require trial and failure or contra-indication to using the preferred agent.
Antifungal/Steroid Combinations		
clotrimazole/betamethasone cream nystatin/triamcinolone cream, ointment	clotrimazole/betamethasone lotion	▪ Link to PA Form for Topical Antifungal Agents ▪ Non-preferred agent(s) will be approved only after documented trial and failure of at least one preferred agent.

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Idaho Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Updated February 3, 2025
Highlights indicated change from previous posting.

ANTIHISTAMINES, MINIMALLY-SEDATING

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
cetirizine solution, tablets fexofenadine tablets levocetirizine tablets loratadine chew tablets, solution, tablets	cetirizine capsules cetirizine chewable desloratadine desloratadine ODT fexofenadine suspension loratadine capsules levocetirizine solution loratadine ODT	▪ A prescription is required for all drugs. ▪ Link to PA Form for Antihistamines, Minimally Sedating (required for Non-Preferred drugs) ▪ Non-preferred agents will be authorized if a patient has failed a preferred agent within the most recent six months. ▪ Cetirizine solution is available for patients ≤ 12 years

ANTIHYPERTENSIVES, SYMPATHOLYTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
clonidine IR tablets clonidine ER transdermal guanfacine methyldopa	clonidine ER 0.17 mg (generic Nexiclon) methyldopa-hydrochlorothiazide	▪ Link to Universal PA Form ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

ANTIHYPERURICEMICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
allopurinol 100 mg, 300 tablets colchicine tablets febuxostat probenecid	allopurinol 200 mg tablets colchicine capsules probenecid/colchicine	▪ Link to PA Form for Antihyperuricemics, Oral ▪ Non-preferred agents will be approved after documented failure of a preferred agent or medical necessity documentation for starting with a non-preferred agent.

ANTIMIGRAINE AGENTS, OTHER

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Preventative Treatment AJOVY pen and autoinjector (fremanezumab-vfrm) EMGALITY 120 mg/mL (galcanezumab-gnlm) syringe and pen NURTEC ODT (rimegepant) **Acute Treatment** NURTEC ODT (rimegepant) UBRELVY (uprogepant)	**Preventative Treatment** AIMOVIG (erenumab-aooe) EMGALITY 100 mg/mL (galcanezumab-gnlm) MIGERGOT (caffeine/ergotamine) QULIPTA (atogepant) VYEPTI (eptinezumab-jjmr) **Acute Treatment** diclofenac powder pack dihydroergotamine nasal dihydroergotamine injection ELYXYB (celecoxib) REYVOW (lasmiditan) ZAVZPRET (zavegepant)	▪ Link to PA Form for Antimigraine, Other: CGRP ▪ Preferred agents will be approved for payment without prior authorization for eligible participants within the approved dosage quantities and age limits. ▪ Non-preferred agents will only be approved after documented failure of or contraindication to a preferred agent.

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ANTIMIGRAINE AGENTS, OTHER

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria

ANTIMIGRAINE AGENTS, TRIPTANS[CL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Oral		
rizatriptan oral tablets, MLT sumatriptan	almotriptan eletriptan frovatriptan naratriptan sumatriptan/naproxen [CL] zolmitriptan	▪ Link to PA Form for Triptans (required for all drugs) ▪ Sumatriptan/naproxen will be approved if patient has tried and failed therapy with separate prescriptions for sumatriptan and naproxen. ▪ Non-preferred agents will be approved only if the patient has tried and failed therapy with at least two preferred agents (different chemical entities) within the last 6 months.
Nasal		
sumatriptan	TOSYMRA (sumatriptan) zolmitriptan	▪ Link to PA Form for Triptans (required for all drugs) ▪ Non-preferred agents will be approved only if patient has tried and failed therapy with a preferred agent within the last 6 months.
Injectable		
sumatriptan vial, syringe	ZEMBRACE SYMTOUCH (sumatriptan)	▪ Link to PA Form for Triptans (required for all drugs) ▪ Non-preferred agents will be approved only if patient has tried and failed therapy with a preferred agent within the last 6 months.

ANTIPARASITICS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
NATROBA (spinosad) permethrin OTC and Rx piperonyl butoxide/pyrethrins shampoo OTC	CROTAN (crotamiton) EURAX (crotamiton) lotion & cream ivermectin lotion malathion spinosad	▪ Link to PA Form for Antiparasitics, Topical (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

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ANTIPARKINSON'S DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Anticholinergics		
benztropine trihexyphenidyl tablets, solution		▪ Link to PA Form for Antiparkinson Agents ▪ Non-preferred agents will be approved only after documented failure of any preferred antiparkinson agent.
COMT Inhibitors		
entacapone	ONGENTYS (opicapone) tolcapone	▪ Link to PA Form for Antiparkinson Agents ▪ Non-preferred agents will be approved only after documented failure of any preferred antiparkinson agent.
Dopamine Agonists		
pramipexole IR ropinirole IR	APOKYN (apomorphine subcutaneous) apomorphine subcutaneous bromocriptine NEUPRO transdermal patch (rotigotine) pramipexole ER ropinirole ER	▪ Link to PA Form for Antiparkinson Agents ▪ Link to PA Form for Restless Leg Syndrome ▪ Non-preferred agents will be approved only after documented failure of any preferred antiparkinson agent.
MAO-B Inhibitors		
selegiline capsules, tablets	AZILECT (rasagiline) rasagiline XADAGO (safinamide) ZELAPAR (selegiline disintegrating tablets)	▪ Link to PA Form for Antiparkinson Agents ▪ Non-preferred agents will be approved only after documented failure of any preferred antiparkinson agent.
Other Antiparkinson's Drugs		
amantadine capsules, syrup, tablets carbidopa/levodopa IR tablets carbidopa/levodopa ER carbidopa/levodopa/entacapone	carbidopa carbidopa/levodopa ODT CREXONT ER (carbidopa/levodopa ER) DUOPA (carbidopa/levodopa) DHIVY (carbidopa/levodopa) GOCOVRI (amantadine) INBRIJA (levodopa) inhalation CL NOURIANZ (istradefylline) OSMOLEX ER (amantadine) RYTARY (carbidopa/levodopa ER) VYALEV (foscarbidopa/foslevodopa)	▪ Link to PA Form for Antiparkinson Agents ▪ Non-preferred agents will be approved only after documented failure of any preferred antiparkinson agent.

ANTIPSYCHOTICS, FIRST GENERATION

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Oral/Intranasal		
chlorpromazine fluphenazine tablets haloperidol loxapine perphenazine	fluphenazine solution molindone perphenazine/amitriptyline thioridazine	▪ Link to PA Form for Antipsychotics, Oral ▪ A non-preferred agent will be approved only after documented failure of a preferred agent.

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ANTIPSYCHOTICS, FIRST GENERATION

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
pimozide thiothixene trifluoperazine		
Injectable (Acute Treatment)		
haloperidol lactate	chlorpromazine fluphenazine	▪ Link to Universal PA Form ▪ Non-preferred agents will be approved only after documented trial and failure or contra-indication to using a preferred agent.
Injectable (Maintenance Treatment)		
fluphenazine decanoate	haloperidol decanoate	▪ Link to Universal PA Form ▪ Non-preferred agents will be approved only after documented trial and failure or contra-indication to using a preferred agent.

ANTIPSYCHOTICS, SECOND GENERATION

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Oral/Transdermal		
aripiprazole tablets clozapine tablets lurasidone olanzapine tablets olanzapine ODT paliperidone ER quetiapine tablets quetiapine ER risperidone solution, tablets, ODT VRAYLAR (cariprazine) ziprasidone capsules	aripiprazole disintegrating tablets aripiprazole solution asenapine CAPLYTA (lumateperone) clozapine ODT FANAPT (iloperidone) LYBALVI (olanzapine/samidorphan) NUPLAZID (pimavanserin) CL olanzapine/fluoxetine (must use individual agents) REXULTI (brexpiprazole) SECUADO (asenapine) patch VERSACLOZ (clozapine)	▪ Link to PA Form for Antipsychotics, Oral ▪ A non-preferred agent will be approved only after documented failure of a preferred agent. ▪ Pimavanserin will only be approved in psychosis concurrent and due to Parkinson's disease. Refer to package insert for recommendations for patients switching to pimavanserin from haloperiodol, risperidone, olanzapine, clozapine or quetiapine for special instructions.
Injectable (Acute Treatment)		
olanzapine ziprasidone	GEODON (ziprasidone)	▪ A non-preferred agent will be approved after prior failure of a preferred agent.
Injectable (Maintenance Treatment)		
ABILIFY ASIMTUFII (aripiprazole) CL ABILIFY MAINTENA (aripiprazole) CL ARISTADA (aripiprazole) CL ARISTADA INITIO (aripiprazole) CL INVEGA HAFYERA (paliperidone) CL INVEGA SUSTENNA (paliperidone) CL INVEGA TRINZA (paliperidone) CL PERSERIS (risperidone) CL RISPERDAL CONSTA (risperidone) CL	ERZOFRI (paliperidone) risperidone (generic for Risperdal Consta) CL RYKINDO (risperidone) CL UZEDY (risperidone) SQ CL ZYPREXA RELPREVV (olanzapine) CL	▪ Link to PA Form for Injectable Long Acting Antipsychotics 2nd Generation ▪ Preferred injectable antipsychotics will be approved within FDA approved age, dosing, and diagnosis parameters. Non-preferred agents require trial and failure or contra-indication to a preferred injectable antipsychotic. ▪ Zyprexa Relprevv (olanzapine) is reimbursed as a medical benefit only and not dispensed through the outpatient pharmacy program.

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Other		
	ADASUVE (loxapine) COBENFY (xanomeline/trospium chloride) CL	▪ Cobenfy requires trial and failure of at least two preferred antispychotics.

ANTIVIRALS, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Antiherpetic Drugs		
acyclovir capsules and tablets valacyclovir	acyclovir suspension famciclovir	▪ Link to Universal PA Form ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
Antiinfluenza Drugs		
oseltamivir capsules, suspension	RELENZA (zanamivir) rimantadine XOFLUZA (baloxavir marboxil)	▪ Link to Universal PA Form ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

ANTIVIRALS, TOPICAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
acyclovir ointment	acyclovir cream DENAVIR (penciclovir) XERESE (acyclovir/hydrocortisone)	▪ Link to Form for Antivirals, Topical ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

ANXIOLYTICS/BENZODIAZEPINES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
buspirone clonazepam tablets diazepam tablets, solution lorazepam tablets	alprazolam alprazolam ER alprazolam intensol, ODT chlordiazepoxide clonazepam ODT clorazepate diazepam syringe, vial diazepam intensol lorazepam intensol LOREEV XR (lorazepam) meprobamate oxazepam	▪ Link to Universal PA Form ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

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BETA BLOCKERS (ORAL)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Beta Blockers		
atenolol bisoprolol metoprolol metoprolol XL nadolol propranolol propranolol ER (generic for INDERAL LA) sotalol	acebutolol betaxolol HEMANGEOL(propranolol) CL INDERAL XL (propranolol) INNOPRAN XL (propranolol) KAPSPARGO (metoprolol) nebivolol pindolol SOTYLIZE solution (sotalol) CL timolol	▪ Link to PA Form for Beta Adrenergic Blockers (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved for patients with a documented failure to at least one preferred agent within the last 6 months. ▪ Hemangeol will be approved for patients with proliferating infantile hemangioma requiring systemic therapy. ▪ Sotylize will be approved for patients who are unable to swallow tablets.
Beta Blocker/Diuretic Combinations		
atenolol/chlorthalidone bisoprolol/hydrochlorothiazide	metoprolol/hydrochlorothiazide propranolol/hydrochlorothiazide	▪ Link to PA Form for Beta Adrenergic Blockers (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved for patients with a documented failure to at least one preferred agent within the last 6 months.
Beta- and Alpha- Blockers		
carvedilol carvedilol ER (COREG CR) labetalol		▪ Link to PA Form for Beta Adrenergic Blockers (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved for patients with a documented failure to at least one preferred agent within the last 6 months.

BLADDER RELAXANT PREPARATIONS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
fesoterodine ER MYRBETRIQ (mirabegron) oxybutynin ER oxybutynin IR 5 mg tablets oxybutynin IR syrup solifenacin TOVIAZ (fesoterodine)	darifenacin ER flavoxate GELNIQUE (oxybutynin) GEMTESA (vibegron) oxybutynin IR 2.5 mg OXYTROL transdermal (oxybutynin) tolterodine tolterodine ER trospium trospium ER VESICARE LS suspension (solifenacin suspension)	▪ Link to PA Form for Bladder Relaxants (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

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BONE RESORPTION SUPPRESSION AND RELATED AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Bisphosphonates		
alendronate tablets ibandronate tablets	alendronate solution ATELVIA (risedronate) FOSAMAX Plus D (alendronate/cholecalciferol) risedronate	▪ Link to PA Form for Bone Resorption Suppression and Related Agents (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent
Other Bone Resorption Suppression and Related Drugs		
calcitonin-salmon	EVENITY (romosozumab) FORTEO (teriparatide) CL PROLIA (denosumab) raloxifene teriparatide (FORTEO biosimilar) TYMLOS (abaloparatide)	▪ Link to PA Form for Bone Resorption Suppression and Related Agents for Non-Preferred drugs ▪ Non-preferred agents will be approved only after documented failure of a preferred agent. ▪ Forteo will also be approved for patients that have a diagnosis of glucocorticoid-induced osteoporosis: ICD-10 M81.8 plus history of glucocorticoid prescription use OR documented failure of a Preferred agent

BOTULINUM TOXINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BOTOX (onabotulinumtoxinA) – (except for cervical dystonia) CL DYSPORT (abobotulinumtoxinA) CL	BOTOX (onabotulinumtoxinA) – (for cervical dystonia) CL MYOBLOC (rimabotulinumtoxinB) CL XEOMIN (incobotulinumtoxinA) CL	▪ Link to PA Form for Botulinum toxin, Other ▪ Link to PA Form for Botox for Migraines ▪ onabotulinumtoxinA (Botox) is approved for the following indications – Chronic daily headaches defined as > 15 days/month lasting > 4 hours/day for patients who have failed at least two oral prophylactic medications and at least two rescue medications (e.g. triptans). – Spasticity in patients who have failed at least two oral skeletal muscle relaxants. – Overactive bladder in patients who have failed at least two oral anticholinergic agents. – Urinary incontinence due to detrusor overactivity associated with a neurologic condition in patients who have failed

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BOTULINUM TOXINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
		at least two oral anticholinergic agents. – Blepharospasm and strabismus. – Cervical dystonia, trial and failure of a preferred botulinum toxin. ■ abobotulinumtoxinA (Dysport): – Cervical dystonia in patients who have tried and failed at least two oral skeletal muscle relaxants. – Spasticity in patients who have failed at least two oral skeletal muscle relaxants. ■ icobotulinumtoxinA (Xeomin) – Blepharospasm – Cervical dystonia in patients who have tried and failed at least two oral skeletal muscle relaxants. – Chronic Sialorrhea – Spasticity in patients who have failed at least two oral skeletal muscle relaxants. ■ rimabotulinumtoxB (Myobloc) – Cervical dystonia in patients who have tried and failed at least two oral skeletal muscle relaxants. – Chronic Sialorrhea

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BPH TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Alpha Blockers		
alfuzosin doxazosin tamsulosin terazosin	CARDURA XL (doxazosin) RAPAFLO (silodosin) silodosin	▪ Link to PA Form for BPH Agents ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
5-Alpha-Reductase (5AR) Inhibitors		
dutasteride finasteride 5 mg tablets		▪ Link to PA Form for BPH Agents ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
Combination Agents		
	dutasteride/tamsulosin	▪ Link to PA Form for BPH Agents ▪ Non-preferred agents will be approved only after documented failure of individual agents.

BRONCHODILATORS, BETA AGONIST

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Inhalers, Short-Acting		
albuterol HFA (generic PROAIR) albuterol HFA (generic PROVENTIL) VENTOLIN HFA (albuterol) XOPENEX HFA (levalbuterol)	albuterol HFA (generic for VENTOLIN) levalbuterol HFA PROAIR RESPICLICK (albuterol)	▪ Link to PA Form for Short-Acting Beta-2 Agonists (required for Non-preferred drugs) ▪ The non-preferred agents will be approved only after documented failure of a preferred agent.
Bronchodilators, Beta Agonist Inhalers, Long-Acting		
SEREVENT (salmeterol)	STRIVERDI RESPIMAT (olodaterol)	▪ Link to PA Form for Long-Acting Beta-2 Agonists (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved in participants > 17 years old that have failed a preferred agent.
Inhalation Solution		
albuterol	arformoterol formoterol levalbuterol BROVANA (arformoterol)	▪ Link to PA Form for Short-Acting Beta-2 Agonists (required for Non-preferred drugs) ▪ Link to PA Form for Long-Acting Beta-2 Agonists (Brovana/Perforomist) (required for Non-preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
Oral		
	albuterol tablets, solution albuterol ER terbutaline	▪ Link to Universal PA Form (required for Non-Preferred drugs) ▪ Non-preferred agents require medical justification for using an oral beta agonist rather than an inhaled beta agonist.

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CALCIUM CHANNEL BLOCKERS (ORAL)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Short-Acting		
diltiazem nifedipine verapamil	isradipine nicardipine	▪ Link to PA Form for Calcium Channel Blockers ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
Long-Acting		
amlodipine diltiazem ER capsules (generic for CARDIZEM CD or TIAZAC) nifedipine ER verapamil ER tablets	diltiazem ER tablets (generic for CARDIZEM LA) felodipine ER KATERZIA (amlodipine) levamlodipine solution, tablets nimodipine nisoldipine NORLIQVA (amlodipine) NYMALIZE (nimodipine) verapamil ER PM verapamil ER capsules	▪ Link to PA Form for Calcium Channel Blockers ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

CEPHALOSPORINS AND RELATED AGENTS (ORAL)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Beta Lactam/Beta-Lactamase Inhibitor Combinations		
amoxicillin/clavulanate IR tablets amoxicillin/clavulanate suspension except 125 mg/31.25 mg/5 mL	amoxicillin/clavulanate chew tablets amoxicillin/clavulanate XR	▪ Link to PA Form for Cephalosporins Oral and Related Agents (required for Non-preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
Cephalosporins – First Generation		
cefadroxil capsules cephalexin capsules, suspension	cefadroxil suspension, tablets cephalexin tablets	▪ Link to PA Form for Cephalosporins Oral and Related Agents (required for Non-preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
Cephalosporins – Second Generation		
cefprozil tablets cefuroxime tablets	cefaclor capsules, suspension cefprozil suspension cefaclor ER	▪ Link to PA Form for Cephalosporins Oral and Related Agents (required for Non-preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

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CEPHALOSPORINS AND RELATED AGENTS (ORAL)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Cephalosporins – Third Generation		
cefdinir capsules, suspension cefixime capsules cefixime suspension	cefpodoxime suspension, tablets	▪ Link to PA Form for Cephalosporins Oral and Related Agents (required for Non-preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

COLONY STIMULATING FACTORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
FULPHILA (pegfilgrastim-jmdb) GRANIX vial (tbo-filgrastim) NEUPOGEN (filgrastim)	FYLNETRA (pegfilgrastim-PBBK) GRANIX syringe (tbo-filgrastim) LEUKINE (sargramostim) NEULASTA (pegfilgrastim) NIVESTYM (filgrastim–aafi) NYVEPRIA (pegfilgrastim-apgf) RELEUKO (filgrastim-ayow) ROLVEDON (eflapegrastim-xnst) STIMUFEND (pegfilgrastim-fpgk) UDENYCA (pegfilgrastim-cbqv) ZARXIO (filgrastim-sndz) ZIEXTENZO (pegfilgrasti)	▪ Link to Universal PA Form ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

COPD AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Anticholinergics		
ATROVENT HFA (ipratropium) ipratropium nebulizer solution SPIRIVA capsules (tiotropium) SPIRIVA RESPIMAT (tiotropium)	INCRUSE ELLIPTA (umeclidinium) TIOTROPIUM (tiotropium bromide) TUDORZA PRESSAIR (aclidinium) YUPELRI (revefenacin)	▪ Link to PA Form for COPD Agents ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
Anticholinergic-Beta Agonist Combinations		
ANORO ELLIPTA (umeclidinium /vilanterol) albuterol/ipratropium COMBIVENT RESPIMAT (albuterol/ipratropium) STIOLTO RESPIMAT(tiotropium/olodaterol)	BEVESPI AEROSPHERE (glycopyrrolate/formoterol) DUAKLIR PRESSAIR (aclidinium/formoterol)	▪ Link to PA Form for COPD Agents ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

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COPD AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
PDE-4 Inhibitors		
roflumilast CL	OHTUVAYRE (ensifentrine) CL	▪ Link to PA Form for roflumilast ▪ Roflumilast will be approved for adults with severe COPD associated with chronic bronchitis and a history of exacerbations. ▪ Ohtuvayre requires trial and failure to at least one preferred anticholinergic agent.

CYSTIC FIBROSIS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
KALYDECO (ivacaftor) CL SYMDEKO(ivacaftor/tezacaftor) CL TRIKAFTA tablets (elexacaftor/tezacaftor and ivacaftor) CL	BRONCHITOL (mannitol) ORKAMBI (lumacaftor/ivacaftor) CL TRIKAFTA packet (elexacaftor/tezacaftor and ivacaftor) CL	▪ Link to Universal PA Form ▪ Agents will be approved for cystic fibrosis (CF) patients with documentation of the drug specific FDA approved mutation of the CFTR gene within age and quantity parameters.

CYTOKINE & CAM ANTAGONISTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Anti-Tumor Necrosis Factor (TNF) Biologics		
ENBREL (etanercept) ENBREL (etanercept) MINI CARTRIDGE HUMIRA (adalimumab) infliximab	adalimumab biosimilars, all infliximab biosimilars, all	▪ Link to PA Form for Cytokine & CAM Antagonists (required for Non-Preferred drugs) ▪ Non-preferred agents may be approved after documented failure of a preferred agent or contra-indication to starting with a preferred agent.
Other Biologic Agents		
	ACTEMRA (tocilizumab) ARCALYST (rilonacept) BIMZELX (bimekizumab) COSENTYX pen, syringe (secukinumab) ENSPRYNG (satralizumab) ENTYVIO (vedolizumab) ILARIS (canakinumab) ILUMYA (tildrakizumab -asmn) KEVZARA (sarilumab) KINERET (anakinra) OMVOH (mirikizumab) ORENCIA (abatacept) SILIQ (brodalumab) SKYRIZI (risankizumab) pen, SC, syringe, vial SOTYKTU (deucravacitinib) SPEVIGO (spesolimab-sbzo) STELARA (ustekinumab) TALTZ (ixekizumab) TOFIDENCE (tocilizumab) TREMFYA (guselkumab) UPLIZNA (inebilizumab-cdon)	▪ Link to PA Form for Cytokine & CAM Antagonists (required for Non-Preferred drugs) ▪ Non-preferred agents may be approved after documented failure of a preferred agent or contra-indication to starting with a preferred agent.
Non-Biologic Agents		
OTEZLA (apremilast) XELJANZ (tofacitinib) tablets	CIBINQO (abrocitinib LITFULO (ritlecitinib) OLUMIANT (baricitinib) 1 mg, 2 mg tablets RINVOQ ER, solution (upadacitinib) XELJANZ (tofacitinib) solution XELJANZ XR (tofacitinib)	▪ Link to PA Form for Cytokine & CAM Antagonists (required for Non-Preferred drugs) ▪ Non-preferred agents may be approved after documented failure of a preferred agent or contra-indication to starting with a preferred agent.

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EPINEPHRINE, SELF-INJECTED

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
AUVI-Q (epinephrine) 0.1 mg epinephrine (authorized generic for EPIPEN, EPIPEN JR) EPIPEN (epinephrine) EPIPEN JR (epinephrine)	AUVI-Q (epinephrine) 0.15 mg and 0.3 mg epinephrine (ADRENACLICK) epinephrine (generic for EPIPEN, EPIPEN JR) NEFFY (epinephrine nasal spray)	▪ Link to Universal PA Form ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

ERYTHROPOIESIS STIMULATING PROTEINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ARANESP (darbepoetin) RETACRIT (epoetin alfa-epbx)	EPOGEN (rHuEPO) MIRCERA (methoxy PEG-epoetin beta) PROCRIT (rHuEPO) REBLOZYL (luspatercept) RETACRIT (epoetin alfa-epbx by Vifor) VAFSEO (vadadustat)	▪ Link to PA Form for Erythropoiesis Stimulating Proteins ▪ Non-preferred agents will only be authorized if there is documented failure of one preferred agent within the past 180 days.

FLUOROQUINOLONES, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ciprofloxacin tablets CIPRO suspension (ciprofloxacin) levofloxacin tablets moxifloxacin	BAXDELA (delafloxacin) ciprofloxacin suspension levofloxacin solution ofloxacin	▪ Link to PA Form for Fluoroquinolones (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

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GI MOTILITY, CHRONIC

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Constipation Agents		
AMITIZA (lubiprostone) CL lubiprostone CL LINZESS (linaclotide) CL TRULANCE (plecanatide) CL	IBSRELA (tenapanor) CL MOTEGRITY (prucalopride) CL MOVANTIK (naloxegol) CL RELISTOR (methylnaltrexone) oral, syringe, vial CL SYMPROIC (naldemedine) CL	▪ Link to PA Form for GI Motility ▪ Linzess or Trulance will be approved for participants with a diagnosis of chronic idiopathic constipation or irritable bowel syndrome. Trulance will also require a failure of Linzess or Amitiza 24 mg. ▪ Amitiza 8 mcg capsules will be approved for female participants with irritable bowel syndrome with constipation. ▪ Amitiza 24 mcg capsules will be approved for participants with chronic idiopathic constipation or participants with chronic constipation that have been on opioids continuously for at least four weeks. ▪ Movantik will be approved for participants with chronic constipation that have been on opioids continuously for at least four weeks. ▪ Relistor will be approved for participants with chronic constipation that have been on opioids continuously for at least four weeks and have tried and failed Amitiza 24 mcg or Movantik. ▪ Trulance will be approved for participants with chronic idiopathic constipation who have failed Linzess or Amitiza 24 mg.
Diarrhea Agents		
	alosetron CL LOTRONEX (alosetron) CL VIBERZI (eluxadoline) CL	▪ Link to PA Form for GI Motility ▪ Lotronex/alosetron will be approved for female participants with diarrhea-predominant irritable bowel syndrome. ▪ Viberzi will be approved for participants with diarrhea-predominant irritable bowel syndrome.

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GLUCOCORTICOIDS, INHALED

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Glucocorticoids		
ARNUITY ELLIPTA (fluticasone) ASMANEX Twisthaler (mometasone) budesonide respules 0.25, 0.5 mg [CL] fluticasone HFA	ALVESCO (ciclesonide) ARMONAIR DIGIHALER (fluticasone) ASMANEX HFA (mometasone) budesonide respules 1 mg fluticasone DISKUS PULMICORT (budesonide) FLEXHALER QVAR (beclomethasone) REDIHALER	▪ Link to PA Form for Inhaled Glucocorticoids (required for Non-Preferred drugs) ▪ Non-preferred agents will only be approved if patient has tried and failed therapy with a preferred agent within the last 6 months. ▪ Pulmicort/budesonide Respules are only preferred for the treatment of asthma in children 8 years and younger.
Glucocorticoid/Bronchodilator Combinations		
ADVAIR (fluticasone/salmeterol) BREO ELLIPTA (fluticasone/vilanterol) DULERA (mometasone/formoterol) SYMBICORT (budesonide/formoterol) TRELEGY ELLIPTA (fluticasone/umeclidinium/vilanterol)	AIRDUO (fluticasone/salmeterol) RESPICLICK AIRSUPRA HFA (albuterol/budesonide) BREZTRI AEROSPHERE (budesonide/formoterol/glycopyrrolate) budesonide/formoterol fluticasone/salmeterol fluticasone/salmeterol HFA fluticasone/vilanterol	▪ Link to PA Form for Inhaled Glucocorticoid/Bronchodilator Combinations (required for non-preferred drugs) ▪ Non-preferred agents will only be approved if patient has tried and failed therapy with a preferred agent within the last 6 months.

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GROWTH HORMONE

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
GENOTROPIN (somatropin) CL NORDITROPIN (somatropin) CL NUTROPIN AQ (somatropin) CL	HUMATROPE (somatropin) CL NGENLA (somatrogon-ghla) CL OMNITROPE (somatropin) CL SAIZEN (somatropin) CL SEROSTIM (somatropin) CL SKYTROFA (lonapegsomatropin-tcgd) CL SOGROYA (somapacitan-beco) CL ZOMACTON (somatropin) CL	▪ Link to PA Form for Growth Hormone (required for all drugs) ▪ Growth hormone will be approved for patients with any of the following diagnoses and meeting the criteria defined on the PA Form: ❖ Chronic Renal Impairment awaiting renal transplantation (ICD-10 N18.9) ❖ Growth Hormone Deficiency (ICD-10 E23.0) ❖ Prader-Willi Syndrome (ICD-10 Q87.1) ❖ Turner Syndrome (ICD-10 Q96.0) ❖ HIV plus Cachexia (ICD-10 B20) ▪ Non-preferred agents will be approved only after documented failure of one preferred agent or medical necessity documentation for using a non-preferred agent. Weekly growth hormone products also require patient specific medical necessity documentation for why a daily growth hormone product cannot be used.

H. PYLORI TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
PYLERA (bismuth subcitrate potassium, metronidazole, tetracycline)	bismuth subsalicylate, metronidazole, tetracycline OMECLAMOX-PAK (omeprazole, amoxicillin, clarithromycin) TALICIA (omeprazole, amoxicillin, rifabutin) VOQUEZNA (vonoprazan) VOQUEZNA DUAL PAK (vonoprazan, amoxicillin) VOQUEZNA TRIPLE PAK (vonoprazan, amoxicillin, clarithromycin)	▪ Link to PA Form for H. Pylori Treatment ▪ Non-preferred agents will only be approved after the documented trial and failure of a preferred agent. ▪ Individual agents should be used in place of combination agents of omeprazole or lansoprazole with amoxicillin and clarithromycin.

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HEPATITIS C TREATMENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Direct-Acting Anti-Viral Agents		
MAVYRET (glecaprevir/pibrentasvir) sofosbuvir/velpatasvir VOSEVI (sofosbuvir/velpatasvir/voxilaprevir)	HARVONI (ledipasvir/sofosbuvir) pellet pack ledipasvir/sofosbuvir SOVALDI (sofosbuvir) SOVALDI (sofosbuvir) pellet pack ZEPATIER (elbasvir/grazoprevir)	▪ Link to PA Form for Treatment of Hepatitis C Virus ▪ Non-preferred agents will only approve if patient has tried and failed therapy with a preferred agent within the last 6 months.

HEREDITARY ANGIOEDEMA

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Acute Treatment		
icatibant [CL] KALBITOR (ecallantide) [CL]	BERINERT (C1-esterase inhibitor) [CL] RUCONEST (recombinant C1 esterase) [CL]	▪ Link to Universal PA Form ▪ Treatment of Acute Attacks: ❖ All agents require documentation of diagnosis. ❖ Non-preferred agents require trial and failure to a preferred agent or medical necessity documentation for starting with a non-preferred agent.
Prophylaxis		
HAEGARDA (C1-esterase inhibitor) [CL]	CINRYZE (C1- esterase inhibitor) [CL] ORLADEYO (berotralstat) [CL] TAKHZYRO (lanadelumab-FLYO) [CL]	▪ Link to Universal PA Form ▪ Prophylaxis: ❖ All agents require documentation of diagnosis. ❖ Prophylactic agents require medical necessity documentation for prophylaxis. ❖ Non-preferred agents require trial and failure to a preferred agent or medical necessity documentation for starting with a non-preferred agent.

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HIV AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Capsid Inhibitor		
	SUNLENCA (lenacapavir)	• Non-preferred agents require trial and failure to a preferred agent or medical necessity documentation for starting with a non-preferred agent.
CCR5 Antagonists		
maraviroc tablets SELZENTRY (maraviroc) solution		▪ Link to PA Form for HIV Agents ▪ Non-preferred agents require trial and failure to a preferred agent or medical necessity documentation for starting with a non-preferred agent.
Combination-Nucleos(t)ide Reverse Transcriptase Inhibitors		
abacavir/lamivudine CIMDUO (lamivudine/tenofovir disoproxil fumarate) DESCOVY (emtricitabine/tenofovir alafenamide) emtricitabine/tenofovir disoproxil fumarate (TRUVADA) lamivudine/zidovudine		▪ Link to PA Form for HIV Agents ▪ Non-preferred agents require trial and failure to a preferred agent or medical necessity documentation for starting with a non-preferred agent.
Combination Products – Multiple Classes		
BIKTARVY (bictegravir/emtricitabine/tenofovir alafenamide) CABENUVA (cabotegravir/rilpivirine) COMPLERA (tenofovir disoproxil fumarate/efavirenz) DELSTRIGO (doravirine/lamivudine/tenofovir disoproxil fumarate) DOVATO (dolutegravir/lamivudine) efavirenz/emtricitabine/tenofovir disoproxil fumarate (ATRIPLA) GENVOYA (elvitegravir /cobicistat/emtricitabine/tenofovir alafenamide) JULUCA (dolutegravir/rilpivirine) ODEFSEY (emtricitabine/rilpivirine/tenofovir alafenamide) STRIBILD (elvitegravir/cobicistat/emtricitabine/tenofovir disoproxil fumarate) SYMFI (efavirenz/lamivudine/tenofovir disoproxil fumarate) SYMFI LO (efavirenz/lamivudine/tenofovir disoproxil fumarate) SYMTUZA (darunavir/cobicistat/ emtricitabine/tenofovir alafenamide)	efavirenz/lamivudine/tenofovir disoproxil fumarate (SYMFI) efavirenz/lamivudine/tenofovir disoproxil fumarate (SYMFI LO) TRIUMEQ (dolutegravir/abacavir/lamivudine)	▪ Link to PA Form for HIV Agents ▪ Non-preferred agents require trial and failure to a preferred agent or medical necessity documentation for starting with a non-preferred agent.
Combination Products – Protease Inhibitors or Protease Inhibitors + Pharmacokinetic Enhancer		
EVOTAZ (atazanavir/cobicistat)		▪ Link to PA Form for HIV Agents

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Idaho Medicaid Preferred Drug List with Prior Authorization Criteria

PDL Updated February 3, 2025
Highlights indicated change from previous posting.

HIV AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
lopinavir/ritonavir tablets, solution PREZCOBIX (darunavir/cobicistat)		▪ Non-preferred agents require trial and failure to a preferred agent or medical necessity documentation for starting with a non-preferred agent.
Fusion Inhibitor		
FUZEON (enfuvirtide)	RUKOBIA (fostemsavir)	▪ Link to PA Form for HIV Agents ▪ Non-preferred agents require trial and failure to a preferred agent or medical necessity documentation for starting with a non-preferred agent.
Intergrase Strand Transfer Inhibitors (INSTI)		
ISENTRESS (raltegravir) ISENTRESS HD (raltegravir) TIVICAY (dolutegravir)	APRETUDE (cabotegravir) TIVICAY PD (dolutegravir) VOCABRIA (cabotegravir)	▪ Link to PA Form for HIV Agents ▪ Non-preferred agents require trial and failure to a preferred agent or medical necessity documentation for starting with a non-preferred agent.
Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTI)		
efavirenz INTELENCE (etravirine) nevirapine tablets, extended release PIFELTRO (doravirine)	EDURANT (rilpivirine) etravirine nevirapine suspension	▪ Link to PA Form for HIV Agents ▪ Non-preferred agents require trial and failure to a preferred agent or medical necessity documentation for starting with a non-preferred agent.
Nucleos(t)ide Reverse Transcriptase Inhibitors (NRTI)		
abacavir emtricitabine lamivudine tenofovir zidovudine	didanosine stavudine	▪ Link to PA Form for HIV Agents ▪ Non-preferred agents require trial and failure to a preferred agent or medical necessity documentation for starting with a non-preferred agent.
Pharmacokinetic Enhancer		
	TYBOST (cobicistat)	▪ Link to PA Form for HIV Agents ▪ Non-preferred agents require trial and failure to a preferred agent or medical necessity documentation for starting with a non-preferred agent.
Protease Inhibitors		
atazanavir darunavir PREZISTA (darunavir) ritonavir	fosamprenavir VIRACEPT (nelfinavir)	▪ Link to PA Form for HIV Agents ▪ Non-preferred agents require trial and failure to a preferred agent or medical necessity documentation for starting with a non-preferred agent.
Recombinant Monoclonal Antibody		
	TROGARZO (ibalizumab-uiyk) IV	▪ Link to PA Form for HIV Agents ▪ Non-preferred agents require trial and failure to a preferred agent or medical necessity documentation for starting with a non-preferred agent.

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HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
INCRETIN ENHANCERS		
Dipeptidyl Peptidase-4 (DDP4) Enzyme Inhibitors		
JANUVIA (sitagliptin) TRADJENTA (linagliptin)	alogliptin alogliptin/pioglitazone saxagliptin ZITUVIO (sitagliptin)	▪ Link to PA Form for Hypoglycemics – Incretin Enhancers ▪ Non-preferred agents will be approved for patients with Type 2 Diabetes and have tried and failed therapy with any preferred DPP4 inhibitor or combination within the last 6 months.
DDP4/Metformin Combinations		
JANUMET (sitagliptin/metformin) JANUMET XR (sitagliptin/metformin) JENTADUETO (linagliptin/metformin)	alogliptin/metformin JENTADUETO XR (linagliptin/metformin) saxagliptin/metformin ER	▪ Link to PA Form for Hypoglycemics – Incretin Enhancers ▪ Non-preferred agents will be approved if patient has tried and failed therapy with any preferred DPP4 inhibitor or combination within the last 6 months.
DDP4/SGLT		
	GLYXAMBI (empagliflozin/linagliptin) QTERN (dapagliflozin/saxagliptin) STEGLUJAN (ertugliflozin/sitagliptin)	▪ Link to PA Form for Hypoglycemics – Incretin Enhancers ▪ Non-preferred agents will be approved if patient has tried and failed therapy with any preferred DPP4 inhibitor or combination within the last 6 months.
DDP4/Metformin/SGLT		
	TRIJARDY XR (empagliflozin/linagliptin/metformin)	▪ Link to PA Form for Hypoglycemics – Incretin Enhancers ▪ Non-preferred agents will be approved if patient has tried and failed therapy with any preferred DPP4 inhibitor or combination within the last 6 months.
INCRETIN MIMETICS		
Glucagon-like Peptide-1 (GLP-1) Receptor Agonists		
OZEMPIC (semaglutide) CL TRULICITY (dulaglutide) CL VICTOZA (liraglutide) CL	BYDUREON BCISE (exenatide) CL BYETTA (exenatide) CL MOUNJARO (tirzepatide) CL RYBELSUS (semaglutide) CL	▪ Link to PA Form for Hypoglycemics, Incretin Mimetics ▪ Preferred agents will be approved for eligible participants with type 2 diabetes who are within age and quantity parameters. ▪ Non-preferred agents will be approved for eligible participants with type 2 diabetes who have tried and failed an adequate trial of a preferred agent or who have a contraindication to starting with any preferred agent.

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HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
GLP-1 Insulin Combinations		
	SOLIQUA (Insulin glargine/lixisenatide) XULTOPHY (Insulin degludec/liraglutide)	▪ Link to PA Form for Hypoglycemics, Incretin Mimetics ▪ Non-preferred agents will be approved if patient has tried and failed therapy with any preferred GLP-1 receptor agonist or combination within the last 6 months.

HYPOGLYCEMICS, METFORMINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
metformin tablets (except 625 mg) metformin ER (GLUCOPHAGE XR)	glipizide-metformin glyburide-metformin metformin ER (FORTAMET) metformin ER (GLUMETZA) metformin 625 mg tablets metformin oral solution RIOMET ER (metformin) oral solution	▪ Link to PA Form for Hypoglycemics, Metformins ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

HYPOGLYCEMICS, SGLT2

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
FARXIGA (dapagliflozin) INVOKANA (canagliflozin) INVOKAMET (canagliflozin/metformin) JARDIANCE (empagliflozin) SYNJARDY (empagliflozin/metformin) XIGDUO XR (dapagliflozin/metformin XR)	dapagliflozin dapagliflozin/metformin XR INPEFA (sotagliflozin) INVOKAMET XR (canagliflozin/metformin SEGLUROMET (ertugliflozin/metformin) STEGLATRO (ertugliflozin) SYNJARDY XR (empagliflozin/metformin)	▪ Link to PA Form for SGLT2 Inhibitors (required for non-preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent

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HYPOGLYCEMICS, TZDS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Thiazolidinediones		
pioglitazone		▪ Link to Universal PA Form ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
Thiazolidinedione Combinations		
	pioglitazone/glimepiride CL pioglitazone/metformin CL	▪ Link to Universal PA Form ▪ Combination agent will only be approved after trial and failure of at least one of the individual components of the combination agent

IMMUNE GLOBULINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Primary Immunodeficiency Products		
GAMMAGARD LIQUID injection solution CL GAMMAGARD S/D powder for intravenous solution CL GAMMAPLEX intravenous solution CL GAMUNEX-C injection solution CL HIZENTRA subcutaneous solution (syringe) CL HYQVIA subcutaneous solution CL OCTAGAM intravenous solution CL PRIVIGEN intravenous solution CL	ALYGLO intravenous solution CL ASCENIV intravenous solution CL BIVIGAM intravenous solution CL CUTAQUIG subcutaneous solution CL CUVITRU subcutaneous solution CL FLEBOGAMMA DIF IV solution CL GAMMAKED injection solution CL GAMASTAN intramuscular CL PANZYGA intravenous solution CL XEMBIFY subcutaneous solution CL YIMMUGO intravenous solution CL	▪ Link to Immune Globulin PA Form ▪ Preferred immune globulin products will be approved for FDA indications or for diagnoses that have evidence-based documentation to support their usage for which there are no therapeutic alternatives. Usual age, dosage, and frequency limitations apply as well as reasonable dosage rounding (+/- 10%) to utilize whole vials to minimize wastage. ▪ Non-preferred agents require either trial and failure of a preferred agent or documentation of medical necessity.
Virus Products		
CYTOGAM (cytomegalovirus immune globulin) intravenous solution CL HYPERHEP B S-D injection solution CL HYPER RAB KED RAB	HEPAGAM B (hepatitis B immune globulin) intramuscular CL VARIZIG (Varicella-Zoster immune globulin) intramuscular CL	▪ Link to Immune Globulin PA Form ▪ Please provide medical necessity documentation for the particular immune globulin product that is being requested.

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IMMUNOMODULATORS FOR ATOPIC DERMATITIS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Injectable		
ADBRY (tralokinumab-ldrm) CL DUPIXENT (dupilumab) CL pen, syringe		▪ Link to PA Form for Immunomodulators, Injectable ▪ Adbry and Dupixent will be approved for participants with FDA approved indications. ▪ Non-preferred agents will be approved after documented failure of a preferred agent or medical necessity documentation for starting therapy with a preferred agent.
Topical		
EUCRISA (crisaborole) pimecrolimus	OPZELURA (ruxolitinib)CL tacrolimus ZORYVE (roflumilast) cream, foam	▪ Link to PA Form for Immunomodulators, Topical ▪ Non-preferred agents will be approved after documented failure of a preferred agent or medical necessity documentation for starting therapy with a preferred agent.

IMMUNOMODULATORS, ASTHMA

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
DUPIXENT (dupilumab) CL FASENRA (benralizumab) CL XOLAIR (omalizumab) CL	CINQAIR (reslizumab) CL NUCALA (mepolizumab) CL vial, auto-injector, syringe TEZSPIRE (tezepelumab-ekko) pen CL TEZSPIRE (tezepelumab-ekko) syringe CL	▪ Link to PA Form for Immunomodulators, Injectable ▪ Non-preferred agents will be approved after documented failure of a preferred agent or medical necessity documentation for starting therapy with a preferred agent.

IMMUNOSUPPRESSIVES, ORAL

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
azathioprine cyclosporine modified capsules everolimus tablets mycophenolate mofetil capsules, tablets mycophenolic acid sirolimus solution, tablets tacrolimus	ASTAGRAF (tacrolimus XL) AZASAN (azathioprine) CELLCEPT (mycophenolate mofetil) cyclosporine capsules cyclosporine modified solution ENVARSUS XR (tacrolimus) mycophenolate mofetil suspension PROGRAF granules (tacrolimus) REZUROCK (belumosudil) TAVNEOS (avacopan)	▪ Link to PA Form for Immunosuppressives, Oral ▪ Non-preferred agents will be approved after documented failure of a preferred agent or medical necessity documentation for starting therapy with a preferred agent.

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INTRANASAL RHINITIS AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Anticholinergics		
ipratropium		▪ Link to PA Form for Intranasal Rhinitis Agents (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
Antihistamines		
azelastine (for ASTELIN, ASTEPRO)	olopatadine	▪ Link to PA Form for Intranasal Rhinitis Agents (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
Corticosteroids		
fluticasone Rx	budesonide nasal OTC flunisolide fluticasone OTC mometasone OTC mometasone Rx NASONEX OTC (mometasone fumarate) OMNARIS (ciclesonide) QNASL (beclomethasone) SINUVA sinus implant (mometasone furoate) CL triamcinolone nasal OTC XHANCE (fluticasone) ZETONNA (ciclesonide)	▪ Link to PA Form for Intranasal Rhinitis Agents (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent. ▪ Sinuva (mometasone furoate) sinus implant prior auth requests will be evaluated on a case-by-case basis. Please use the Physician Administered Drugs prior authorization form
Antihistamine / Corticosteroid Combinations		
	azelastine/fluticasone RYALTRIS (olopatadine/mometasone) nasal	▪ Link to PA Form for Intranasal Rhinitis Agents (required for Non-Preferred drugs) ▪ Combination medications will be approved only after documented failure of any preferred intranasal rhinitis agent.

LEUKOTRIENE MODIFIERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
montelukast tablets, chewable tablets	montelukast granules zafirlukast zileuton ER ZYFLO (zileuton)	▪ Link to PA Form for Leukotriene Modifiers (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved after documented failure to a preferred agent or contra-indication to starting with a preferred agent.

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LIPOTROPICS, OTHER (NON-STATINS)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Adenosine Triphosphate-Citrate Lyase (ACL) Inhibitors		
	NEXLETOL (bempedoic acid) NEXLIZET (bempedoic acid/ezetimibe)	▪ Link to Universal PA Form ▪ Diagnosis of primary hyperlipidemia including heterozygous familial hypercholesterolemia (HeFH) or cardiovascular disease (CVD) or at high risk for a CVD event AND documented intolerance to preferred statins.
Apolipoprotein B Synthesis Inhibitors		
	JUXTAPID (lomitapide mesylate) CL	▪ Link to Universal PA Form ▪ Juxtapid may be approved for patients with homozygous familial hypercholesterolemia.
Bile Acid Sequestrants		
cholestyramine colestipol granules, tablets	colesevelam WELCHOL (colesevelam)	▪ Link to PA Form for Non-Statin Lipotropics (required for Non-Preferred drugs - except for ezetimibe - see below) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
Fibric Acid Derivatives		
fenofibrate (generic LOFIBRA, TRICOR) gemfibrozil 600 mg	fenofibrate (generic ANTARA, FENOGLIDE, LIPOFEN) fenofibric acid (generic FIBRICOR, TRILIPIX) FENOGLIDE (fenofibrate)	▪ Link to PA Form for Non-Statin Lipotropics (required for Non-Preferred drugs - except for ezetimibe - see below) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent
Niacin		
	niacin niacin ER	▪ Link to PA Form for Non-Statin Lipotropics ▪ Non-preferred agents will be approved only after documented failure of a preferred agent in the Lipotropics, Other drug class.
Omega-3 Fatty Acids		
omega-3 acid ethyl esters (generic for LOVAZA)	icosapent ethyl	▪ Link to PA Form for Non-Statin Lipotropics ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.
Cholesterol Absorption Inhibitors		
ezetimibe		▪ Link to Universal PA Form ▪ Prior authorization is not needed within age and quantity parameters.

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LIPOTROPICS, OTHER (NON-STATINS)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
PCSK9 Inhibitors		
PRALUENT (alirocumab) CL REPATHA (evolocumab) CL	LEQVIO (inclisiran) CL	▪ Link to PCSK9 Inhibitors Form ▪ Prescribed in consultation with a cardiologist, lipidologist or endocrinologist. ▪ Must meet FDA approved age and dosing recommendations. ▪ Praluent (alirocumab) or Repatha (evolucumab) are preferred. Clinical criteria must be submitted for approval. ▪ Leqvio (inclisiran) is non-preferred agent and documentation of failure of preferred agent or medical necessity documentation for starting with a non-preferred agent is required. ▪ Chart notes must be submitted reporting failure to reach LDL-C goal of < 70 mg/dl in clinically significant ASCVD or < 100 mg/dl in HeFH or HoFH with either the highest available dose or maximally tolerated dose of a high intensity statin (rosuvastatin or atorvastatin) in combination with ezetimibe for at least 8 weeks. ▪ PCSK9 inhibitors must be prescribed in combination with other lipid lowering agents (statin or ezetimibe).

LIPOTROPICS, STATINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
STATINS		
atorvastatin lovastatin pravastatin rosuvastatin simvastatin (except 80 mg tablets)	ALTOPREV (lovastatin) ATORVALIQ (atorvastatin) EZALLOR SPRINKLE (rosuvastatin) fluvastatin fluvastatin ER LIVALO (pitavastatin) pitavastatin simvastatin 80 mg tablets ZYPITAMAG (pitavastatin)	▪ Link to PA Form for Statins (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved for patients with a documented failure to at least one preferred agent within the last 6 months. ▪ Simvastatin 80 mg will only be approved for patients who have been on this dose for more than one year without muscle toxicity.
Statin Combinations		
	atorvastatin/amlodipine CADUET (atorvastatin/amlodipine) simvastatin/ezetimibe (VYTORIN) VYTORIN (simvastatin/ezetimibe)	▪ Link to PA Form for Statins (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved for patients with a documented failure to at least one single entity agent within the last 6 months. ▪ Please use individual prescriptions for atorvastatin/amlodipine.

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LIPOTROPICS, STATINS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria

MACROLIDES (ORAL)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
azithromycin clarithromycin IR tablets erythromycin base capsules erythromycin ethylsuccinate 200 mg suspension	clarithromycin ER clarithromycin suspension E.E.S. 400 mg tablets (erythromycin ethylsuccinate) ERYPED suspension (erythromycin ethylsuccinate) ERY-TAB (erythromycin) erythromycin base tablets erythromycin ethylsuccinate 400 mg suspension	▪ Link to PA Form for Macrolides (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

MOVEMENT DISORDERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
AUSTEDO (deutetrabenazine) CL AUSTEDO XR (deutetrabenazine) CL INGREZZA (valbenazine) CL sprinkles, tablets tetrabenazine CL	INGREZZA (valbenazine) Initiation Packet CL	▪ Link to Movement Disorders PA Form ▪ Preferred agents will be approved for participants with the FDA approved indications and clinical criteria listed below. ▪ **Huntington's Chorea:** – Genetic documentation of diagnosis – Clinically significant chorea document in chart note – Unified Huntington's Disease Rating Scale (or equivalent test) documenting chorea ▪ **Tardive Dyskinesia:** – Documentation of diagnosis of clinically significant tardive dyskinesia with drug(s) that are suspected to have caused the disease state. – Documentation of steps that have been taken to reduce the risk for tardive dyskinesia such as discontinuing drug, changing drug therapy, reducing drug dosage unless clinically inappropriate. – AIMS (or equivalent test) documenting tardive dyskinesia

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MULTIPLE SCLEROSIS DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Injectable Disease Modifying Therapies		
AVONEX (interferon beta-1a) BETASERON (interferon beta-1b) COPAXONE 20 mg syringe (glatiramer) KESIMPTA (ofatumumab)	BRIUMVI (ublituximab-xiiy) COPAXONE 40 mg syringe (glatiramer) CL EXTAVIA (interferon beta-1b) glatiramer 20 mg, 40 mg syringe LEMTRADA (alemtuzamab) IV CL OCREVUS (ocrelizumab) CL PLEGRIDY (peginterferon beta-1 a) IM, SQ REBIF (interferon beta-1a) REBIF REBIDOSE (interferon beta-1a) TYSABRI (natalizumab)	▪ Link to PA Form for Multiple Sclerosis Agents, Injectable ▪ Non-preferred agents will be approved after documented failure of a preferred agent or medical necessity documentation for starting therapy with a preferred agent.
Oral Disease Modifying Therapies		
dimethyl fumarate DR fingolimod teriflunomide	BAFIERTAM (monomethyl fumarate) DR MAVENCLAD (cladribine) MAYZENT (siponimod) PONVORY (ponesimod) TASCENSO ODT (fingolimod) VUMERITY (diroximel fumarate) ZEPOSIA (ozanimod hydrochloride)	▪ Link to PA Form for Multiple Sclerosis Agents, Oral ▪ Non-preferred agents require a documented trial and failure to a preferred agent or medical necessity documentation for starting with a non-preferred agent.
Other		
dalfampridine ER [CL]		▪ Link to PA form for dalfampridine ▪ Dalfampridine will be approved for patients with multiple sclerosis who are ambulatory, have a creatinine clearance of greater than 50 ml/min and no history of seizure disorder. ▪ Chart note documentation of the medical necessity is required.

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[CL] – Prior Authorization / Class Criteria apply
[NR] – New drug that has not been reviewed by P & T Committee
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NSAIDS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Nonselective		
diclofenac potassium IR tablets 50 mg diclofenac sodium DR tablets ibuprofen Rx indomethacin IR capsules indomethacin rectal nabumetone naproxen Rx sulindac	diclofenac sodium ER tablets diclofenac potassium IR capsules diclofenac potassium IR tablets 25mg diflunisal etodolac IR etodolac SR fenoprofen flurbiprofen INDOCIN (indomethacin) suspension ibuprofen capsules, chewable tablets, drops suspension, tablets OTC Ibuprofen/acetaminophen OTC indomethacin ER indomethacin suspension ketoprofen ER ketoprofen IR ketorolac nasal ketorolac tablets meclofenamate mefenamic acid naproxen CR naproxen EC naproxen sodium naproxen sodium OTC naproxen suspension oxaprozin piroxicam RELAFEN DS (nabumetone) tolmetin ZIPSOR (diclofenac) ZORVOLEX (diclofenac)	▪ Link to PA Form for NSAIDs (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a non-selective or COX-II selective preferred agent. ▪ If the non-preferred agent ketorolac is approved, it will be for a maximum of 5 days of treatment per FDA warnings that longer courses of therapy are associated with increased frequency and severity of adverse reactions including bleeding.
NSAID/GI Protectant Combinations		
	diclofenac/misoprostol CL ibuprofen/famotidine CL naproxen/esomeprazole CL	▪ Please use prescriptions for individual agents.

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NSAIDS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
COX-II Selective		
celecoxib meloxicam tablets	meloxicam capsules	▪ Link to PA Form for NSAIDs ▪ Non-preferred agents will be approved only after documented failure of a non-selective or COX-II selective preferred agent.
NSAIDS, TOPICAL		
diclofenac gel 1% Rx diclofenac sodium gel 1% OTC	diclofenac 1.3% patch diclofenac sodium pump 2% diclofenac solution 1.5%	▪ Link to PA form for Analgesics, Topical (required for non-preferred agents) ▪ Non-preferred agents will be approved if the patient has a history of at least one preferred agent in the last 6 months. ▪ Diclofenac sodium 3% gel will only be approved for treatment of actinic keratosis and not for topical pain treatment.

OPHTHALMIC ANTIBIOTIC-STEROID COMBINATIONS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
neomycin/polymyxin/dexamethasone sulfacetamide/prednisolone TOBRADEX (tobramycin/dexamethasone) ointment tobramycin/dexamethasone suspension	neomycin/bacitracin/polymyxin/ hydrocortisone neomycin/polymyxin/ hydrocortisone TOBRADEX ST (tobramycin/dexamethasone) ZYLET (loteprednol/tobramycin)	▪ Link to PA Form for Ophthalmic Antibiotic-Steroid Combinations (required for Non-preferred drugs). ▪ Non-preferred agents will be approved for participants failing to respond to a preferred agent.

OPHTHALMIC ANTIBIOTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
bacitracin/polymyxin B CILOXAN (ciprofloxacin) ointment ciprofloxacin drops erythromycin gentamicin moxifloxacin (VIGAMOX) ofloxacin polymyxin/trimethoprim tobramycin solution	AZASITE (azithromycin) bacitracin BESIVANCE (besifloxacin) gatifloxacin levofloxacin moxifloxacin (MOXEZA) NATACYN (natamycin) neomycin/bacitracin/polymyxin neomycin/polymyxin/gramicidin sulfacetamide ointment sulfacetamide solution TOBREX (tobramycin) ointment	▪ Link to PA Form for Ophthalmic Antibiotics (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

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OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
cromolyn olopatadine 0.1% OTC olopatadine 0.2% OTC	ALOCRIL (nedocromil) ALOMIDE (lodoxamide) ALREX (loteprednol) azelastine BEPREVE (bepotastine) bepotastine epinastine loteprednol olopatadine 0.1% Rx olopatadine 0.2% Rx ZERVIATE (cetirizine)	▪ Link to PA Form for Ophthalmics for Allergic Conjunctivitis (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved only after documented failure of a preferred agent.

OPHTHALMIC ANTI-INFLAMMATORIES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
dexamethasone diclofenac fluorometholone flurbiprofen ketorolac 0.5 % ketorolac LS 0.4% LOTEMAX drops (loteprednol) MAXIDEX (dexamethasone) PRED MILD (prednisolone acetate) prednisolone acetate	ACUVAIL (ketorolac 0.45%) bromfenac 0.09% BROMSITE (bromfenac 0.075%) FLAREX (fluorometholone) FML FORTE (fluorometholone) FML S.O.P. (fluorometholone) ILEVRO (nepafenac 0.3%) INVELTYS (loteprednol) LOTEMAX gel and ointment (loteprednol) NEVANAC (nepafenac 0.1%) prednisolone sodium phosphate PROLENSA (bromfenac 0.07%)	▪ Link to PA Form for Ophthalmic Anti-Inflammatories (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved for patients failing to respond to a preferred agent.

OPHTHALMICS, ANTI-INFLAMMATORY/IMMUNOMODULATORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
RESTASIS (cyclosporine) XIIDRA (lifitegrast)	CEQUA (cyclosporine) cyclosporine (generic for RESTASIS) EYSUVIS (loteprednol) MIEBO (perfluorohexyloctane) TYRVAYA SPRAY (varenicline) VERKAZIA (cyclosporine) VEVYE (cyclosporine)	▪ Link to PA form for Ophthalmics, Anti-Inflammatory/Immunomodulators ▪ Non-preferred agents will be approved for patients failing to respond to a preferred agent.

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OTIC ANTIBIOTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CIPRO HC (ciprofloxacin/hydrocortisone) ciprofloxacin/dexamethasone CORTISPORIN – TC (colistin/hydrocortisone/neomycin/thonzonium) neomycin/polymyxin/hydrocortisone ofloxacin	ciprofloxacin ciprofloxacin/fluocinolone	▪ Link to PA Form for Otic Antibiotics (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved for patients failing to respond to a preferred agent.

PANCREATIC ENZYMES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
CREON ZENPEP	PERTZYE VIOKACE	▪ Link to PA Form for Pancreatic Enzymes ▪ Non-preferred agents will be approved for patients failing to respond to a preferred agent within the last 6 months

PHOSPHATE BINDERS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
calcium acetate capsules (generic for PhosLo) RENVELA (sevelamer carbonate)	AURYXIA (ferric citrate) calcium acetate tablets FOSRENOL (lanthanum) lanthanum MAGNEBIND Rx (calcium carbonate/magnesium carbonate) PHOSLYRA (calcium acetate) sevelamer carbonate (generic for RENVELA) sevelamer HCL (generic for RENAGEL) VELPHORO (sucroferric oxyhydroxide) XPHOZAH (tenapanor)	▪ Link to PA Form for Phosphate Binders (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved for patients failing to respond to a preferred agent.

PLATELET AGGREGATION INHIBITORS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
BRILINTA (ticagrelor) clopidogrel dipyridamole prasugrel	aspirin/dipyridamole ZONTIVITY (vorapaxar)	▪ Link to PA Form for Platelet Aggregation Inhibitors (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved for patients failing to respond to a preferred agent.

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PROTON PUMP INHIBITORS (ORAL)

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
DEXILANT (dexlansoprazole) lansoprazole capsules Rx NEXIUM suspension (esomeprazole) omeprazole Rx pantoprazole tablets PROTONIX (pantoprazole) suspension	dexlansoprazole capsules esomeprazole magnesium OTC esomeprazole suspension KONVOMEP (omeprazole/sodium bicarbonate) lansoprazole capsules OTC lansoprazole solutab omeprazole OTC omeprazole magnesium OTC omeprazole/sodium bicarbonate pantoprazole suspension PREVACID SOLUTAB (lansoprazole) PRILOSEC suspension (omeprazole) rabeprazole	▪ Link to PA Form for PPIs (required for Non-Preferred drugs) ▪ Prevacid SoluTabs will be approved for patients who cannot swallow tablets or capsules and are not a candidate for a preferred liquid preparation. ▪ Other non-preferred agents will only be approved if patient has tried and failed therapy with two preferred agents within the last six months. ▪ Two fills of twice daily dosing within a rolling 365 days does not require prior authorization – additional fills for twice daily dosing require a quantity override prior authorization with medical necessity documentation. ❖ Quantity Override PA Form

PULMONARY ARTERIAL HYPERTENSION AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Endothelin Receptor Antagonists		
ambrisentan CL bosentan tablets CL	OPSUMIT (macitentan) CL TRACLEER (bosentan) suspension, tablets CL	▪ Non-preferred agents will be approved for patients with a documented failure to at least one preferred agent in the last 6 months. ▪ Link to PA Form for Pulmonary Arterial Hypertension Agents (required for Non-Preferred drugs)
Prostacyclin Receptor Agonist		
	UPTRAVI (selexipag) CL	▪ Non-preferred agents will be approved for patients with a documented failure to at least one preferred agent in the last 6 months. ▪ Link to PA Form for Pulmonary Arterial Hypertension Agents (required for Non-Preferred drugs)
Prostanoids		
	ORENITRAM ER (treprostinil)) CL ORENITRAM TITRATION KIT (treprostinil)CL TYVASO (treprostinil) CL TYVASO DPI (treprostinil) CL VENTAVIS (iloprost) CL	▪ Non-preferred agents will be approved for patients with a documented failure to at least one preferred agent in the last 6 months. ▪ Link to PA Form for Pulmonary Arterial Hypertension Agents (required for Non-Preferred drugs)

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PULMONARY ARTERIAL HYPERTENSION AGENTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
PDE-5 Inhibitors		
sildenafil suspension, tablets CL tadalafil CL	LIQREV (sildenafil) CL	▪ Link to PA Form for Pulmonary Arterial Hypertension Agents (required for Non-Preferred drugs) ▪ Sildenafil and tadalafil will only be approved for diagnosis of pulmonary artery hypertension (ICD-9 416xx) ▪ Non-preferred agents will be approved for patients with a documented failure to at least one preferred agent in the last 6 months.
Soluble Guanylate Cyclase Stimulators		
	ADEMPAS (riociguat) CL	▪ Link to PA Form for Pulmonary Arterial Hypertension Agents (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved for patients with a documented failure to at least one preferred agent in the last 6 months.

SEDATIVE HYPNOTICS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Benzodiazepines		
	estazolam flurazepam quazepam temazepam triazolam	▪ Link to PA Form for Sedative Hypnotics (required for Non-Preferred drugs) ▪ Non-preferred agents will only be approved if patient has tried and failed therapy with a preferred sedative-hypnotic within the last 6 months.
Others		
doxepin 10 mg eszopiclone ramelteon zolpidem IR	BELSOMRA (suvorexant) DAYVIGO (lemborexant) doxepin 3mg, 6 mg tablets EDLUAR (zolpidem) HETLIOZ (tasimelteon) CL HETLIOZ LQ (tasimelteon) CL IGALMI (dexmedetomidine) QUVIVIQ (daridorexant) ROZEREM (ramelteon) tasimelteon zaleplon zolpidem capsules zolpidem ER zolpidem SL	▪ Link to PA Form for Sedative Hypnotics (required for Non-Preferred drugs) ▪ Non-preferred agents will only be approved if patient has tried and failed therapy with a preferred agent within the last 6 months. ▪ Link to PA Form for Hetlioz ▪ Hetlioz (tasimelteon) will be approved for adult patients with a documented non-24-hour sleep-wake disorder or for nighttime dyssomnia (Smith-Magenis syndrome) diagnosis in adults and children. The suspension will be approved for ages 3 to 15 years old and the capsules for patients 16 years or older. Please see PA form for more detailed criteria.

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Idaho Medicaid Preferred Drug List with Prior Authorization Criteria

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Highlights indicated change from previous posting.

SKELETAL MUSCLE RELAXANTS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
baclofen 5 mg, 10 mg tablets cyclobenzaprine IR 5, 10 mg tablets methocarbamol tizanidine tablets	baclofen ER 15 mg tablets baclofen suspension carisoprodol [CL] carisoprodol compound [CL] chlorzoxazone cyclobenzaprine ER cyclobenzaprine IR 7.5 mg tablets dantrolene FLEQSUVY (baclofen) LORZONE (chlorzoxazone) LYVISPAH (baclofen) metaxalone NORGESIC FORTE (orphenadrine/aspirin/caffeine) orphenadrine tizanidine capsules	▪ Link to PA Form for Skeletal Muscle Relaxants (required for Non-Preferred drugs) ▪ The non-preferred agents will be approved for patients with documented failure of at least a one week trial each of two preferred agents. ▪ For carisoprodol: ❖ Use will be limited to no more than 21 days ❖ Additional authorization will not be granted for at least six months following the last day of the previous course of therapy ❖ Approval will not be granted for patients concurrently using opioids

SPINAL MUSCULAR ATROPHY

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
ZOLGENSMA (onasemnogene abeparvovec-xioi) [CL]	EVRYSDI (risdiplam) [CL] SPINRAZA (nusinersen sodium) [CL]	▪ Link to Universal PA Form ▪ All requests will be reviewed on a case-by-case basis, taking into consideration FDA approved indications.

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[CL] – Prior Authorization / Class Criteria apply
[NR] – New drug that has not been reviewed by P & T Committee
Non-preferred brand name drugs with generic equivalents will require failure of a preferred agent plus meet all the requirements of the brand-generic rule (i.e., failure of two generics from different manufacturers and submission of a MedWatch Form).

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STIMULANTS AND RELATED DRUGS[CL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
amphetamine salt combination ER [CL] amphetamine salt combination IR [CL] CONCERTA (methylphenidate ER) dexmethylphenidate ER [CL] dexmethylphenidate IR [CL] methylphenidate CD [CL] methylphenidate ER (generic for CONCERTA) [CL] methylphenidate ER (generic for METADATE) [CL] methylphenidate IR tablets [CL] methylphenidate solution [CL] VYVANSE (lisdexamfetamine) [CL]	ADDERALL XR (amphetamine salt combination) [CL] ADZENYS XR ODT (amphetamine) [CL] amphetamine salt combination ER (generic for MYDAYIS) [CL] APTENSIO XR (methylphenidate) [CL] AZSTARYS (serdexmethylphenidate/dexmethylphenidate) [CL] COTEMPLA XR-ODT (methylphenidate) [CL] DAYTRANA (methylphenidate) [CL] dextroamphetamine IR, ER [CL] dextroamphetamine solution [CL] DYANAVEL XR (amphetamine) [CL] EVEKEO (amphetamine) [CL] EVEKEO ODT (amphetamine) [CL] lisdexamphetamine capsules, chewable tablets JORNAY PM (methylphenidate) [CL] methylphenidate chewable tablets [CL] methylphenidate (APTENSIO XR) [CL] methylphenidate ER (generic Concerta) [CL] methylphenidate ER (generic Ritalin LA) [CL] methylphenidate patch TD24 (transdermal) MYDAYIS (amphetamine salt combination ER) [CL] PROCENTRA (dextroamphetamine sulfate) [CL] QUILLICHEW ER (methylphenidate) [CL] QUILLIVANT XR (methylphenidate) solution [CL] RELEXXI (methylphenidate) [CL] XELSTRYM (dextroamphetamine) transdermal ZENZEDI (dextroamphetamine) [CL]	▪ Link to PA Form for Stimulants - ADD/ADHD Drugs (required for Non-Preferred drugs) ▪ Stimulants for adults (> or = to 18 years) will be approved for patients with a diagnosis of ADHD (ICD-10 = F90) in the previous two years. ▪ Daytrana will only be approved for patients who are unable to take oral therapy. ▪ Non-preferred agents will be approved for payment only after documented failure of at least one preferred agent. ▪ Modafanil and Nuvigil will be approved for patients > 16 years old with narcolepsy (MSLT required), obstructive sleep apnea (sleep study required), or shift work sleep disorder.
Non-Stimulants		
atomoxetine clonidine ER 0.1 mg clonidine IR guanfacine ER guanfacine IR QELBREE (viloxazine)	ONYDA XR (clonidine ER)	▪ Link to PA Form for Non-Stimulant Therapy for ADHD ▪ Non-preferred agents will be approved for patients with a documented failure to at least one preferred agent in the last 6 months.

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STIMULANTS AND RELATED DRUGS[CL]

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Narcolepsy-Specific Agents		
	armodafinil [CL] modafinil [CL] NUVIGIL (armodafinil) [CL] SUNOSI (solriamfetol) [CL] WAKIX (pitolisant) [CL] XYREM (sodium oxybate) [CL] XYWAV (calcium, magnesium, potassium, sodium oxybate) [CL]	▪ Link to PA Form for Obstructive Sleep Apnea - Narcolepsy ❖ For clinical criteria for modafinil, Nuvigil, Sunosi,and Wakix ▪ Link to PA Form for Oxybate Salts ❖ For clinical criteria for sodium oxybate, Xyrem, and Xywav

SUBSTANCE USE DISORDER TREATMENT

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Alcohol Treatment		
naltrexone oral [CL] VIVITROL (naltrexone) injection [CL]		▪ Link to Universal PA Form ▪ Vivitrol (naltrexone) injectable or naltrexone oral will be approved for patients with alcohol dependence (ICD-10 = F10) with adequate clinical documentation for need.
Opiate Use Disorder Treatments		
BRIXADI (buprenorphine) monthly BRIXADI (buprenorphine) weekly buprenorphine SL tablets buprenorphine/naloxone SL tablets SUBLOCADE (buprenorphine) injection SUBOXONE film (buprenorphine/naloxone)	BUNAVAIL(buprenorphine/naloxone) buccal buprenorphine/naloxone SL film LUCEMYRA (lofexidine) [CL] VIVITROL (naltrexone) injection [CL] ZUBSOLV (buprenorphine/naloxone tablets)	▪ Link to PA Form for Opioid Use Disorder Treatment ▪ Oral buprenorphine/naloxone combination products are recommended except in pregnant women to minimize the possibility of diversion of buprenorphine single entity via the injection route. ▪ LUCEMYRA will be approved for opioid withdrawal syndrome in patients who have received initial treatment with Lucemyra in an acute care setting. ▪ VIVITROL (naltrexone) injectable will be approved for patients with a diagnosis of opioid dependence/abuse (ICD-10 = F11) who are currently stable on Vivitrol, have a documented rationale for receiving non-buprenorphine based treatment or have a documented inadequate response to prior treatment with buprenorphine-based treatment.
Opioid Reversal Agents		
naloxone vial, syringe NARCAN (naloxone) nasal spray	KLOXXADO (naloxone) nasal spray naloxone nasal spray OPVEE (nalmefene) nasal spray ZIMHI (naloxone) injection	▪ No prior authorization required for preferred naloxone agents ▪ Naloxone may be prescribed and dispensed by an authorized pharmacist using the pharmacist's individual NPI

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SUBSTANCE USE DISORDER TREATMENT

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
		(not the pharmacy NPI) as prescriber. Reimbursement will be to the pharmacy.

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TETRACYCLINES

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
doxycycline hyclate IR: 20mg, 50mg, 100 mg doxycycline monohydrate: 50mg and 100 mg capsules doxycycline monohydrate tablets minocycline capsules tetracycline capsules	demeclocycline DORYX (doxycycline hyclate) doxycycline hyclate DR doxycycline hyclate IR: 75mg, 150mg doxycycline monohydrate: 40 mg, 75 mg, 150 mg capsules doxycycline monohydrate suspension minocycline ER minocycline tablets NUZYRA (omadacycline) ORACEA (doxycycline) SOLODYN (minocycline) tetracycline tablets XIMINO (minocycline)	▪ Link to PA Form for Tetracyclines ▪ Non-preferred agents will be approved only after documented failure of a preferred agent ▪ An age override is required for patients less than 9 years of age

TOBACCO CESSATION

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
bupropion SR 150 MG nicotine gum OTC buccal (nicotine polacrilex) nicotine lozenge OTC buccal (nicotine polacrilex) nicotine patch OTC (nicotine) varenicline	NICOTROL inhalation (nicotine) NICOTROL NS nasal (nicotine)	▪ Link to PA Form for Tobacco Cessation ▪ Non-preferred agents will be approved for patients failing to respond to a preferred agent.

ULCERATIVE COLITIS DRUGS

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
Oral		
APRISO (mesalamine) LIALDA (mesalamine) sulfasalazine DR sulfasalazine IR	balsalazide budesonide budesonide DR DIPENTUM (olsalazine) mesalamine (ASACOL HD, DELZICOL, LIALDA) mesalamine ER (APRISO) PENTASA (mesalamine)	▪ Link to PA Form for Ulcerative Colitis Drugs (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved for patients failing to respond to a preferred agent
Rectal		
mesalamine (generic for CANASA)	mesalamine (generic for SFROWASA) UCERIS (budesonide)	▪ Link to PA Form for Ulcerative Colitis Drugs (required for Non-Preferred drugs) ▪ Non-preferred agents will be approved for patients failing to respond to a preferred agent

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VASODILATORS, CORONARY

Preferred Agents	Non-Preferred Agents	Prior Authorization/Class Criteria
isosorbide mononitrate tablets isosorbide mononitrate SR tablets NITRO-BID (nitroglycerin) transdermal ointment NITRO-DUR 0.3 mg and 0.8 mg nitroglycerin ER oral capsules nitroglycerin sublingual nitroglycerin transdermal patch	BIDIL (isosorbide dinitrate/hydralazine) isosorbide dinitrate tablets isosorbide dinitrate/hydralazine tablets nitroglycerin translingual spray NITROLINGUAL spray (nitroglycerin lingual spray) VERQUVO (vericiguat)	▪ Link to PA Form for Vasodilators, Coronary ▪ Non-preferred agents will be approved for patients failing to respond to a preferred agent. ▪ Individual agents must be used prior to use of isosorbide dinitrate/hydralazine (BiDil).

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