

**Colorado Department of Health Care Policy and Financing**

**Preferred Drug List (PDL)**

Effective April 1, 2025

**Prior Authorization Forms:** Available online at <https://hcpf.colorado.gov/pharmacy-resources>

**Prior Authorization (PA) Requests:** Colorado Pharmacy Call Center Phone Number: 800-424-5725 | Fax Number: 800-424-5881

**Electronic Prior Authorization (ePA):** Electronic Prior Authorization Requests are supported by CoverMyMeds and may be submitted via Electronic Health Record (EHR) systems or through the CoverMyMeds provider portal.

The PDL applies to Medicaid fee-for-service members. It does not apply to members enrolled in Rocky Mountain Health HMO or Denver Health Medicaid Choice.

**Initiation of pharmaceutical product subject to Prior Authorization:** Please note that starting the requested drug, including a non-preferred drug, prior to a PA request being reviewed and approved, through either inpatient use, by using office “samples,” or by any other means, does not necessitate Medicaid approval of the PA request.

Health First Colorado, at section 25.5-5-501, C.R.S., requires the generic of a brand name drug be prescribed if the generic is therapeutically equivalent to the brand name drug. Exceptions to this rule are: 1) If the brand name drug is more cost effective than the generic as determined by the Department, 2) If the patient has been stabilized on a brand name drug and the prescriber believes that transition to a generic would disrupt care, and 3) If the drug is being used for treatment of mental illness, cancer, epilepsy, or human immunodeficiency virus and acquired immune deficiency syndrome.

Please see th[e **Brand Favored Product List**](https://www.colorado.gov/hcpf/pharmacy-resources)for a list of medications where the brand name drug is more cost effective than the generic drug.

A provider may request a step therapy exception for the treatment of a serious or complex medical condition pursuant to section 25.5-4-428, C.R.S. Serious or complex medical condition means the following medical conditions: serious mental illness, cancer, epilepsy, multiple sclerosis, or human immunodeficiency virus (HIV)/ acquired immune deficiency syndrome (AIDS), or a condition requiring medical treatment to avoid death, hospitalization, or a worsening or advancing of disease progression resulting in significant harm or disability. The step therapy exception request form is available by visiting <https://hcpf.colorado.gov/pharmacy-resources>

**Brand Name Required = BNR, Prior Authorization = PA, AutoPA = authorization can be automated at the point-of-sale transaction if criteria are met Preferred drug list applies only to prescription (RX) products, unless specified.**

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| **Preferred Agents** | **Non-preferred Agents** | **Prior Authorization Criteria**  **(All Non-preferred products will be approved for one year unless otherwise stated.)** | |
| **I. Analgesics** | | | |
| Therapeutic Drug Class: **NON-OPIOID ANALGESIA AGENTS - Oral -** *Effective 4/1/2025* | | | |
| **No PA Required**    Duloxetine 20 mg, 30 mg, 60 mg capsule    Gabapentin capsule, tablet, solution    Pregabalin capsule    SAVELLA (milnacipran) tablet, titration pack | **PA Required**  CYMBALTA (duloxetine) capsule  DRIZALMA (duloxetine DR) sprinkle capsules  Duloxetine 40 mg capsule  GRALISE (gabapentin ER) tablet  Gabapentin ER tablet  HORIZANT (gabapentin ER) tablet  JOURNAVX (suzetrigine) tablet  LYRICA (pregabalin) capsule, solution, CR tablet  NEURONTIN (gabapentin) capsule, tablet, solution  Pregabalin solution, ER tablet | | JOURNAVX (suzetrigine) may be approved if the following criteria are met:   * Member is ≥ 18 years of age AND * Member is being prescribed suzetrigine for up to 14 days of treatment for moderate-to- severe acute pain AND * Prescriber attests that the member’s pain is unable to be managed with an NSAID, acetaminophen, or other non-opioid analgesic AND * Journavx (suzetrigine) is not being prescribed to treat chronic pain AND * The medication is not being prescribed to treat pain associated with migraine   AND   * Member does not have severe hepatic impairment (Child-Pugh Class C) AND * Member has been counseled to avoid food or drink containing grapefruit during treatment with Journavx (suzetrigine) AND * Member is not concurrently taking a strong CYP3A inhibitor (such as ketoconazole, itraconazole, posaconazole, ritonavir, indinavir, saquinavir, clarithromycin, fluvoxamine) AND * Member is not concurrently taking a strong or moderate CYP3A inducer (such as carbamazepine, phenytoin, rifampin, efavirenz, rifabutin, St. John’s Wort) · Members using hormonal contraceptives containing progestins other than levonorgestrel and norethindrone have been counseled regarding alternative or additional contraception, if appropriate, per product labeling.     Duration of Approval: 3 months  Dosing Limit: One 14-day course per approval on file Quantity limit: 29 tablets/14 days    All other non-preferred oral non-opioid analgesic agents may be approved if member meets all of the following criteria:  ● Member has trialed and failed duloxetine (20mg, 30mg, or 60mg) AND has trialed and failed gabapentin OR pregabalin capsule (Failure is defined as lack of efficacy with 8-week trial, allergy, intolerable side effects, or significant drug-drug interaction)    Prior authorization will be required for Lyrica (pregabalin) capsule dosages > 600mg per day (maximum of 3 capsules daily) and gabapentin dosages > 3600mg per day. |
| Therapeutic Drug Class: **NON-OPIOID ANALGESIA AGENTS - Topical -** *Effective 4/1/2025* | | | |
| **No PA Required**    Lidocaine patch | **PA Required**    Lidocaine patch (Puretek) | | Non-preferred topical products require a trial/failure with an adequate 8-week trial of gabapentin AND pregabalin AND duloxetine AND a preferred lidocaine 5% patch. |

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| LIDODERM (lidocaine) patch | ZTLIDO (lidocaine) topical system | Failure is defined as lack of efficacy with an 8-week trial, allergy, intolerable side effects, or significant drug-drug interaction.    **Lidocaine 5% patch *(Puretek manufacturer only)*** may be approved if the following criteria are met:   * Member is ≥ 18 years of age **AND** * Member has had an adequate 8-week trial and failure of: gabapentin **AND** pregabalin **AND** duloxetine **AND** a preferred lidocaine 5% patch. Failure is defined as lack of efficacy with an 8-week trial, allergy, intolerable side effects, or significant drug-drug interaction **AND** * Prescriber has provided a justification of clinical necessity indicating that an alternative generic lidocaine 5% patch formulation cannot be used. |
| Therapeutic Drug Class: **NON-STEROIDAL ANTI-INFLAMMATORIES (NSAIDS) - Oral** - *Effective 4/1/2025* | | |
| **No PA Required**      Celecoxib capsule    Diclofenac potassium 50 mg  tablet    Diclofenac sodium EC/DR tablet    Ibuprofen suspension, tablet (RX)    Indomethacin capsule, ER capsule    Ketorolac tablet\*    Meloxicam tablet    Nabumetone tablet    Naproxen DR/ER, tablet (RX)    Naproxen suspension    Sulindac tablet | **PA Required**  ARTHROTEC (diclofenac sodium/ misoprostol)  tablet  CELEBREX (celecoxib) capsule  DAYPRO (oxaprozin) caplet  Diclofenac potassium capsule, powder pack  Diclofenac potassium 25 mg tablet  Diclofenac sodium ER/SR tablet  Diclofenac sodium/misoprostol tablet  Diflunisal tablet  DUEXIS (ibuprofen/famotidine) tablet  ELYXYB (celecoxib) solution  Etodolac capsule; IR, ER tablet  FELDENE (piroxicam) capsule  Fenoprofen capsule, tablet  Flurbiprofen tablet | **DUEXIS (ibuprofen/famotidine)** or **VIMOVO (naproxen/esomeprazole)** may be approved if the member meets the following criteria:   * Trial and failure‡ of all preferred NSAIDs at maximally tolerated doses **AND** * Trial and failure‡ of three preferred proton pump inhibitors in combination with NSAID within the last 6 months **AND** * Has a documented history of gastrointestinal bleeding     **Diclofenac potassium 25 mg immediate-release tablets** may be approved if the following criteria are met:   * Member is ≥ 18 years of age **AND** * Member does not have any of the following medical conditions:   + History of recent coronary artery bypass graft (CABG) surgery o History of myocardial infarction o Severe heart failure o Advanced renal disease   + History of gastrointestinal bleeding   **AND**   * Member has trial and failure‡ of four preferred oral NSAIDs at maximally tolerated doses     **ELYXYB (celecoxib) oral solution** may be approved if the following criteria are met:   * Member is ≥ 18 years of age AND * Requested medication is being prescribed for acute treatment of migraine (with or without aura) AND * Member does not have any of the following medical conditions: o History of asthma, urticaria, or other allergic-type reactions after taking aspirin or other NSAIDs   o History of recent coronary artery bypass graft (CABG) surgery |

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|  | Ibuprofen/famotidine tablet  Ketoprofen IR, ER capsule  LOFENA (diclofenac) tablet  Meclofenamate capsule  Mefenamic acid capsule  Meloxicam submicronized capsule, suspension  NALFON (fenoprofen) capsule, tablet  NAPRELAN (naproxen CR) tablet  Naproxen sodium CR, ER, IR tablet  Naproxen/esomeprazole DR tablet  Oxaprozin tablet  Piroxicam capsule  RELAFEN DS (nabumetone) tablet  Tolmetin tablet  VIMOVO (naproxen/esomeprazole) DR tablet | * History of allergic-type reactions to sulfonamides o Severe heart failure o History of myocardial infarction o History of gastrointestinal bleeding o Advanced renal disease * Pregnancy past 30 weeks gestation   **AND**   * Member is unable to take an alternative NSAID in a solid oral dosage form   AND   * Member has tried and failedǂ one preferred NSAID oral liquid AND * Member is unable to use celecoxib capsules, opened and sprinkled into applesauce or other soft food     ǂFailure is defined as lack of efficacy, contraindication to therapy, allergy, intolerable side effects, or significant drug-drug interactions.    Maximum dose: 120 mg/day    All other non-preferred oral agents may be approved following trial and failure‡ of four preferred agents. ‡Failure is defined as lack of efficacy, contraindication to therapy, allergy, intolerable side effects, or significant drug-drug interactions.    \*Ketorolac tablets quantity limit: 5-day supply per 30 days and 20 tablets per 30 days |
| Therapeutic Drug Class: **NON-STEROIDAL ANTI-INFLAMMATORIES (NSAIDS) - Non-Oral -** *Effective 4/1/2025* | | |
| **No PA Required**    Diclofenac 1.5% topical solution    Diclofenac sodium 1% gel (OTC/Rx) | **PA Required**    Diclofenac 1.3% topical patch, 2% pump    FLECTOR (diclofenac) 1.3% topical patch    Ketorolac nasal spray    LICART (diclofenac) 1.3% topical patch    PENNSAID (diclofenac solution) 2% pump, 2% solution packet | **SPRIX (ketorolac)** may be approved if meeting the following criteria:   * Member is unable to tolerate, swallow or absorb oral NSAID formulations **OR** * Member has trialed and failed three preferred oral or topical NSAID agents (failure is defined as lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions) * Quantity limit: 5-single day nasal spray bottles per 30 days     All other non-preferred topical agents may be approved for members who have trialed and failed one preferred agent. Failure is defined as lack of efficacy with 14-day trial, allergy, intolerable side effects, or significant drug-drug interaction.    **Diclofenac topical patch** quantity limit: 2 patches per day |

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|  |  | Diclofenac 3% gel (generic Solaraze) prior authorization criteria can be found in the Antineoplastic agents, topical, section of the PDL. |
| **Opioid Utilization Policy (long-acting and short-acting opioids):**    It is highly encouraged that the healthcare team utilize the Prescription Drug Monitoring Program (PDMP) to aid in ensuring safe and efficacious therapy for members using controlled substances.    Total Morphine Milligram Equivalent Policy Effective 10/1/17:   * The maximum allowable morphine milligram equivalent (MME) is 200 MME. Prescriptions for short-acting (SA) and long-acting (LA) opioids are cumulatively included in this calculation. The prescription that exceeds the cumulative MME limit of 200 MME for a member will require prior authorization and may require a provider-toprovider telephone consultation with the pain management physician (free of charge and provided by Health First Colorado). * Prior authorization will be granted to allow for tapering * Prior authorization for 1 year will be granted for diagnosis of sickle cell anemia * Prior authorization for 1 year will be granted for admission to or diagnosis of hospice or end of life care * Prior authorization for 1 year will be granted for pain associated with cancer     MME calculation is conducted using conversion factors from the following link:<https://pharmacypmp.az.gov/resources/mme-calculator>    Only one long-acting opioid agent (including different strengths) and one short-acting opioid agent (including different strengths) will be considered for a prior authorization.    Medicaid provides guidance on the treatment of pain, including tapering, on our webpage under the heading Pain Management Resources and Opioid Use at:  <https://www.colorado.gov/pacific/hcpf/pain-management-resources-and-opioid-use>    Opioid Naïve Policy Effective 8/1/17 (*Update effective 04/01/23 in Italics*):  Members who have not filled a prescription for an opioid within the past 180 days will be identified as “opioid treatment naïve” and have the following limitations placed on the initial prescription(s):   * The prescription is limited to short-acting opioid agents *or Butrans (buprenorphine)*. Use of other long-acting opioid agents will require prior authorization approval for members identified as opioid treatment naïve. * The days’ supply of the first, second, and third prescription for an opioid will be limited to 7 days, the quantity will be limited to 8 dosage forms per day (tablets, capsules), maximum #56 tablets/capsules for a 7-day supply * The fourth prescription for an opioid will require prior authorization, filling further opioid prescriptions may require a clinical pharmacist review or provider to provider telephone consultation with a pain management physician (free of charge and provided by Health First Colorado). * If a member has had an opioid prescription filled within the past 180 days, then this policy would not apply to that member and other opioid policies would apply as applicable.     Dental Prescriptions Opioid Policy Effective 11/15/18 (implemented in the claims system 01/07/19):  Members who receive an opioid prescribed by a dental provider will be subject to day supply limits and quantity per day limits for short acting opioids.   * The prescription is limited to short-acting opioid agents only. Use of long-acting opioid agents and short acting fentanyl agents will require prior authorization approval for members’ prescriptions written by a dental provider. * The days’ supply of the first, second, and third prescription for an opioid will be limited to 4 days, the quantity will be limited to 6 dosage forms per day (tablets, capsules), maximum #24 tablets/capsules for a 4-day supply * The fourth prescription for an opioid will require prior authorization. A prior authorization for the fourth fill may be approved for up to a 7-day supply and the quantity will be limited to 8 dosage forms per day (#56 tablets/capsules) for members with any of the following diagnoses/undergoing any of the following procedures:   + Traumatic oro-facial tissue injury with major mandibular/maxillary surgical procedures o Severe cellulitis of facial planes   + Severely impacted teeth with facial space infection necessitating surgical management | | |

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| * Other potential exemptions that exceed the first 3 fill limits (day supply and quantity) may be evaluated with a provider-to-provider telephone consult with a pain management specialist (free of charge and provided by Health First Colorado)     If a member has had an opioid prescription prescribed by a non-dental provider, then this policy would not apply to that member and other opioid policies would apply as applicable. Dental prescriptions do not impact the opioid treatment naïve policy, but the prescriptions will be counted towards the Morphine Milligram Equivalent (MME) daily dose.    Opioid and Benzodiazepine Combination Effective 9/15/19:  Prior authorization will be required for members receiving long-term therapy with an opioid medication who are newly started on a benzodiazepine medication OR for members receiving long-term therapy with a benzodiazepine medication who are newly started on an opioid medication. Prior authorization may be approved if meeting the following:   * The member discontinued or is no longer taking either the opioid or benzodiazepine medication and will not be using these in combination **OR** * The member will not be taking the prescribed opioid and benzodiazepine medications at the same time based on prescribed dosing interval (such as prn administration) for the regimen AND the prescriber attests that the member has received appropriate counseling\* regarding the risks associated with combining opioid and benzodiazepine medications including increased risk for sedation, respiratory depression, overdose, and overdose-related death and counseling regarding the FDA Boxed Warning for combining these medications **OR** * The prescriber has evaluated the regimen and attests that it is appropriate for the member to continue use of the concomitant opioid and benzodiazepine medication regimen as prescribed AND the prescriber attests that the member has received appropriate counseling\* regarding the risks associated with combining opioid and benzodiazepine medications including increased risk for sedation, respiratory depression, overdose, and overdose-related death and counseling regarding the FDA Boxed Warning for combining these medications **OR** * Prior authorization may be approved for members receiving palliative or hospice care **OR** * For benzodiazepine prior authorizations, approval may be granted if the benzodiazepine is being prescribed for seizure disorder or convulsions.   *\*If counseling has not been provided, the prescriber attests that a reasonable effort will be made to contact the member or the member’s pharmacy to ensure that counseling is provided.*    Opioid and Quetiapine Combination Effective 9/15/19:  Pharmacy claims for members receiving opioid and quetiapine medications in combination will require entry of point-of-sale DUR service codes (Reason for Service, Professional Service, Result of Service) for override of drug-drug interaction (DD) related to risk of increased sedation from concomitant use of this drug combination.    Opioid and Buprenorphine-Containing substance use disorder (SUD) Product Combination Effective 06/01/21:  Opioid claims submitted for members currently receiving buprenorphine-containing SUD medications will require entry of point-of-sale DUR service codes (Reason for Service, Professional Service, Result of Service) for override of drug-drug interaction (DD) with use of this drug combination. | | |
| Therapeutic Drug Class: **OPIOIDS, Short Acting -** *Effective 4/1/2025* | | |
| **Preferred**  **No PA Required\***  **(If criteria and quantity limit are met)**    \*Acetaminophen/codeine tablets    Hydrocodone/acetaminophen solution, tablet    Hydromorphone tablet | **Non-Preferred**  **PA Required**      Acetaminophen / codeine elixir  ASCOMP WITH CODEINE (codeine/butalbital/aspirin/caffeine)  \*Butalbital/caffeine/acetaminophen/codeine capsule | \*Preferred codeine and tramadol products do not require prior authorization for adult members (18 years of age or greater) if meeting all other opioid policy criteria.    Preferred codeine or tramadol products prescribed for members < 18 years of age must meet the following criteria:  • **Preferred tramadol and tramadol-containing products** may be approved for members < 18 years of age if meeting the following: o Member is 12 years to 17 years of age **AND**   * Tramadol is NOT being prescribed for post-surgical pain following tonsil or adenoid procedure AND * Member’s BMI-for-age is not > 95th percentile per CDC guidelines AND o Member does not have obstructive sleep apnea or severe lung disease OR |

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| Morphine IR solution, tablet    Oxycodone solution, tablet    Oxycodone/acetaminophen tablet    \*Tramadol 25mg, 50mg    \*Tramadol/acetaminophen tablet | Butalbital/caffeine/aspirin/codeine capsule  Butalbital compound/codeine  Butorphanol tartrate (nasal) spray  Carisoprodol/aspirin/codeine  Codeine tablet  Dihydrocodeine/acetaminophen/caffeine tablet  DILAUDID (hydromorphone) solution, tablet  FIORICET/CODEINE (codeine/  butalbital/acetaminophen/caffeine) capsule  Hydrocodone/ibuprofen tablet  Hydromorphone solution  Levorphanol tablet  Meperidine solution, tablet  Morphine concentrated solution, oral syringe  NALOCET (oxycodone/acetaminophen) tablet  Oxycodone capsule, syringe, concentrated solution  Oxycodone/acetaminophen solution    Oxycodone/acetaminophen tablet (generic  PROLATE)  Oxymorphone tablet    Pentazocine/naloxone tablet    PERCOCET (oxycodone/ acetaminophen) tablet    ROXICODONE (oxycodone) tablet    ROXYBOND (oxycodone) tablet | o For members < 12 years of age with complex conditions or life-limiting illness who are receiving care under a pediatric specialist, tramadol and tramadolcontaining products may be approved on a case-by-case basis   * **Preferred Codeine and codeine-containing products** will receive prior authorization approval for members meeting the following criteria may be approved for members < 18 years of age if meeting the following:   + Member is 12 years to 17 years of age AND   + Codeine is NOT being prescribed for post-surgical pain following tonsil or adenoid procedure AND   + Member’s BMI-for-age is not > 95th percentile per CDC guidelines AND o Member does not have obstructive sleep apnea or severe lung disease AND o Member is not pregnant, or breastfeeding AND o Renal function is not impaired (GFR > 50 ml/min) AND   + Member is not receiving strong inhibitors of CYP3A4 (such as erythromycin, clarithromycin, itraconazole, ketoconazole, posaconazole, fluconazole [≥200mg daily], voriconazole, delavirdine, and milk thistle) AND o Member meets one of the following: * Member has trialed codeine or codeine-containing products in the past with no history of allergy or adverse drug reaction to codeine * Member has not trialed codeine or codeine-containing products in the past and the prescriber acknowledges reading the following statement:   “Approximately 1-2% of the population metabolizes codeine in a manner that exposes them to a much higher potential for toxicity. Another notable proportion of the population may not clinically respond to codeine. We ask that you please have close follow-up with members newly starting codeine and codeine-containing products to monitor for safety and efficacy.”    Non-preferred tramadol products may be approved following trial and failure of generic tramadol 50mg tablet AND generic tramadol/acetaminophen tablet.    All other non-preferred short-acting opioid products may be approved following trial and failure of three preferred products. Failure is defined as allergy‡, lack of efficacy, intolerable side effects, or significant drug-drug interaction.    ‡Allergy: hives, maculopapular rash, erythema multiforme, pustular rash, severe hypotension, bronchospasm, and angioedema    Quantity Limits: Short-acting opioidswill be limited to a total of 120 tablets per 30 days (4/day) per member for members who are not included in the opioid treatment naive policy.   * Exceptions will be made for members with a diagnosis of a terminal illness (hospice or palliative care) or sickle cell anemia. * For members who are receiving more than 120 tablets currently and who do not have a qualifying exemption diagnosis, a 6-month prior authorization can be granted via the prior authorization process for providers to taper members. |

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|  | SEGLENTIS (tramadol/celecoxib) tablet    Tramadol 100mg tablet    Tramadol solution | • Please note that if more than one agent is used, the combined total utilization may not exceed 120 units in 30 days. There may be allowed certain exceptions to this limit for acute situations (for example: post-operative surgery, fractures, shingles, car accident).      Maximum Doses:  Tramadol: 400mg/day  Codeine: 360mg/day  Butorphanol intranasal: 10ml per 30 days (four 2.5ml 10mg/ml package units per 30 days) |
| Therapeutic Drug Class: **FENTANYL PREPARATIONS (buccal, transmucosal, sublingual) -** *Effective 4/1/2025* | | |
| **PA Required**  Fentanyl buccal, intranasal, transmucosal, and sublingual products:  ACTIQ (fentanyl citrate) lozenge  Prior authorization approval may be granted for members experiencing breakthrough  Fentanyl citrate lozenge, buccal tablet cancer pain and those that have already received and are tolerant to opioid drugs for the  cancer pain AND are currently being treated with a long-acting opioid drug. The prior  FENTORA (fentanyl citrate) buccal tablet authorization may be granted for up to 4 doses per day. For patients in hospice or  palliative care, prior authorization will be automatically granted regardless of the number of doses prescribed. | | |
| Therapeutic Drug Class: **OPIOIDS, Long Acting -** *Effective 4/1/2025* | | |
| **Preferred**  **No PA Required**  **(unless indicated by \* criteria)**    BELBUCABNR (buprenorphine) buccal film    BUTRANSBNR (buprenorphine) transdermal patch    \*Fentanyl 12mcg, 25mcg, 50mcg, 75mcg, 100mcg transdermal  patch    Morphine ER (generic MS Contin) tablet    Tramadol ER (generic Ultram ER) tablet | **Non-Preferred**  **PA Required**    \*\*OXYCONTIN (oxycodone ER) tablet    Buprenorphine buccal film, transdermal patch    CONZIP (tramadol ER) capsule    Fentanyl 37mcg, 62mcg, 87mcg transdermal patch    Hydrocodone ER capsule, tablet    Hydromorphone ER tablet    HYSINGLA (hydrocodone ER) tablet    Methadone (all forms)    Morphine ER capsule    MS CONTIN (morphine ER) tablet | **\*Belbuca (buprenorphine)** buccal film may be approved for members who have trialed and failed‡ treatment with Butrans (buprenorphine) patch at a dose of 20 mcg/hr **OR** with prescriber confirmation that the maximum dose of Butrans 20 mcg/hr will not provide adequate analgesia. Quantity limit: 60 films/30 days.    **Oxycontin** **(oxycodone ER)** may be approved for members who have trialed and failed‡ treatment with TWO preferred agents.    All other non-preferred products may be approved for members who have trialed and failed‡ three preferred products.    ‡Failure is defined as lack of efficacy with 14-day trial, allergy (hives, maculopapular rash, erythema multiforme, pustular rash, intolerable application site skin reactions, severe hypotension, bronchospasm, and angioedema), intolerable side effects, or significant drug-drug interaction.    Methadone: Members may receive 30-day approval when prescribed for neonatal abstinence syndrome without requiring trial and failure of preferred agents or opioid prescriber consultation. |

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|  | Oxycodone ER tablet    Oxymorphone ER tablet    Tramadol ER capsule | Methadone Continuation:  Members who have been receiving methadone for pain indications do not have to meet non-preferred criteria. All new starts for methadone will require prior authorization under the non-preferred criteria listed above.    *If a prescriber would like to discuss strategies for tapering off methadone or transitioning to other pain management therapies for a Health First Colorado member, consultation with the Health First Colorado pain management physician is available free of charge by contacting the pharmacy call center helpdesk and requesting an opioid prescriber consult.*      Reauthorization:  Reauthorization for a non-preferred agent may be approved if the following criteria are met:   * Provider attests to continued benefit outweighing risk of opioid medication use   AND   * Member met original prior authorization criteria for this drug class at time of original authorization     Quantity/Dosing Limits:   * **Oxycontin** and **Hydrocodone ER (generic Zohydro ER)** will only be approved for twice daily dosing. * **Hysingla** will only be approved for once daily dosing. * **Fentanyl patches** will require a PA for doses of more than 15 patches/30 days (if using one strength) or 30 patches for 30 days (if using two strengths). For fentanyl patch strengths of 37mcg/hr, 62mcg/hr, and 87mcg/hr, member must trial and fail two preferred strengths of separate patches that will provide the desired dose (such as 12mcg/hr + 50mcg/hr = 62mcg/hr). |
| **II. Anti-Infectives** | | |
| Therapeutic Drug Class: **ANTIBIOTICS, INHALED -***Effective 1/1/2025* | | |
| **Preferred**  **No PA Required**  **(\*Must meet eligibility criteria)**    Tobramycin inhalation solution  (generic TOBI)    \*CAYSTON (aztreonam) inhalation solution | **Non-Preferred**  **PA Required**    ARIKAYCE (amikacin liposomal) inhalation vial    BETHKIS (tobramycin) inhalation ampule    KITABIS (tobramycin) nebulizer pak    TOBI (tobramycin) inhalation solution | \***CAYSTON (aztreonam)** inhalation solution may be approved if the following criteria are met:   * Member has a history of trial and failure of preferred tobramycin solution for inhalation (failure is defined as lack of efficacy with a 4-week trial, intolerable side effects, or significant drug-drug interactions) **OR** provider attests that member cannot use preferred tobramycin solution for inhalation due to documented allergy or contraindication to therapy **AND** * The member has known colonization of *Pseudomonas aeruginosa* in the lungs   **AND** |

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|  | TOBI PODHALER (tobramycin) inhalation capsule    Tobramycin inhalation ampule (generic Bethkis)    Tobramycin nebulizer pak (generic Kitabis) | * The member has been prescribed an inhaled beta agonist to use prior to nebulization of Cayston (aztreonam).     **ARIKAYCE (amikacin)** may be approved if the following criteria are met:   * Member has refractory mycobacterium avium complex (MAC) lung disease with limited or no alternative treatment options available **AND** * Member has trialed and failed 6 months of therapy with a 3-drug regimen that includes a macrolide (failure is defined as lack of efficacy, contraindication to therapy, allergy, intolerable side effects, or significant drug-drug interactions).     All other non-preferred inhaled antibiotic agents may be approved if the following criteria are met:   * The member has a diagnosis of cystic fibrosis with known colonization of *Pseudomonas aeruginosa* in the lungs **AND** * Member has history of trial and failure of preferred tobramycin solution for inhalation (failure is defined as lack of efficacy with a 4-week trial, contraindication to therapy, allergy, intolerable side effects or significant drugdrug interactions).      |  |  |  |  | | --- | --- | --- | --- | | **Table 1: Minimum Age, Maximum Dose, and Quantity Limitations** | | | | | **Drug Name** | **Minimum**  **Age** | **Maximum Dose** | **Quantity Limit**  **(Based on day supply limitation for pack size dispensed)** | | ARIKAYCE  (amikacin) | ≥ 18 years | 590 mg once daily | Not applicable | | BETHKIS  (tobramycin) | Age ≥ 6 years | 300 mg twice  daily | 28-day supply per 56-day period | | CAYSTON  (aztreonam) | ≥ 7 years | 75 mg three times daily | 28-day supply per 56-day period | | KITABIS  PAK  (tobramycin) | Age ≥ 6 years | 300 mg twice  daily | 28-day supply per 56-day period | | TOBI Ϯ  (tobramycin) | Age ≥ 6 years | 300 mg twice  daily | 28-day supply per 56-day period | | TOBI  PODHALER  (tobramycin) | Age ≥ 6 years | 112 mg twice daily | 28-day supply per 56-day period | | *Ϯ Limitations apply to brand product formulation only* | | | | |

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|  |  | Members currently stabilized on any inhaled antibiotic agent in this class may receive approval to continue that agent. |
| Therapeutic Drug Class: **ANTI-HERPETIC AGENTS - Oral -** *Effective 1/1/2025* | | |
| **No PA Required**    Acyclovir tablet, capsule    \*Acyclovir suspension (*members under 18 years or cannot*  *swallow a solid dosage form*)    Famciclovir tablet    Valacyclovir tablet | **PA Required**    Acyclovir suspension *(all other members)*    SITAVIG (acyclovir) buccal tablet    VALTREX (valacyclovir) tablet | Non-preferred products may be approved for members who have failed an adequate trial with two preferred products with different active ingredients. Failure is defined as lack of efficacy with 14-day trial, allergy, intolerable side effects, or significant drug-drug interaction.    **Sitavig** (acyclovir) buccal tablet may be approved for diagnosis of recurrent herpes labialis (cold sores) if member meets non-preferred criteria listed above AND has failed trial with oral acyclovir suspension. Failure is defined as lack of efficacy with 14-day trial, allergy, intolerable side effects, or significant drug-drug interaction.    \*Acyclovir suspension does not require prior authorization for members < 18 years of age and may be approved for members ≥ 18 years of age who cannot swallow an oral dosage form.     |  |  |  | | --- | --- | --- | |  | **Maximum Dose Table** | | |  | **Adult** | **Pediatric** | | Acyclovir | 4,000 mg/day | 3,200 mg/day | | Famciclovir | 2,000 mg/day |  | | Valacyclovir | 4,000 mg/day | Age 2-11 years: 3,000 mg/day  Age ≥ 12 years: 4,000 mg/day | |
| Therapeutic Drug Class: **ANTI-HERPETIC AGENTS- Topical -** *Effective 1/1/2025* | | |
| **No PA Required PA Required**  **Non-Preferred Zovirax and acyclovir ointment/cream** formulations may be approved  Acyclovir cream (*Teva only*) Acyclovir cream (*all other manufacturers*) for members who have failed an adequate trial with the preferred topical  acyclovir ointment/cream product (diagnosis, dose and duration) as deemed by approved  Acyclovir ointment Penciclovir cream compendium. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or  significant drug-drug interaction)  DENAVIRBNR (penciclovir) XERESE (acyclovir/ hydrocortisone) cream  cream **Xerese** (acyclovir/hydrocortisone) prior authorization may be approved for members that  ZOVIRAX (acyclovir) cream, ointment meet the following criteria:   * Documented diagnosis of recurrent herpes labialis AND * Member is immunocompetent AND * Member has failed treatment of at least 10 days with acyclovir (Failure is defined as significant drug-drug interaction, lack of efficacy, contraindication to or intolerable side effects) AND * Member has failed treatment of at least one day with famciclovir 1500 mg OR valacyclovir 2 grams twice daily (Failure is defined as significant drug-drug interaction, lack of efficacy, contraindication to or intolerable side effects) | | |
| Therapeutic Drug Class: **FLUOROQUINOLONES – Oral -** *Effective 1/1/2025* | | |

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| **Preferred**  **No PA Required**  **(\*if meeting eligibility criteria)**    \*CIPRO (ciprofloxacin) oral suspensionBNR    Ciprofloxacin tablet    Levofloxacin tablet    Moxifloxacin tablet | **Non-Preferred**  **PA Required**    BAXDELA (delafloxacin) tablet    CIPRO (ciprofloxacin) tablet    Ciprofloxacin oral suspension    Levofloxacin oral solution    Ofloxacin tablet | | \***CIPRO suspension** does not require prior authorization for members < 18 years of age and may be approved for members ≥ 18 years of age    Non-preferred products may be approved for members who have failed an adequate trial (7 days) with at least one preferred product. (Failure is defined as: lack of efficacy, contraindication to therapy, allergy, intolerable side effects, or significant drug-drug interaction).    **Levofloxacin solution** may be approved for members with prescriber attestation that member:   * is unable to take Cipro (ciprofloxacin) crushed tablet or suspension **OR** * is < 5 years of age and being treated for pneumonia **OR** * has failed† an adequate trial (7 days) of ciprofloxacin suspension   †Failure is defined as lack of efficacy, allergy, intolerable side effects, significant drug-drug interaction, or contraindication to therapy. | | |
| Therapeutic Drug Class: **HEPATITIS C VIRUS TREATMENTS -** *Effective 1/1/2025* | | | | | |
|  | | **Direct Acting Antivirals (DAAs)** | | |  |
| **Preferred**  **No PA Required for initial treatment**  **(\*must meet eligibility criteria)**    EPCLUSA  (sofosbuvir/velpatasvir) 200 mg -50 mg, 150 mg-37.5  mg tablet, pellet pack    HARVONI  (ledipasvir/sofosbuvir) 45mg-200mg tablet, pellet  pack    Ledipasvir/Sofosbuvir 90 mg-400 mg tablet (*Asegua only)*    MAVYRET  (glecaprevir/pibrentasvir) tablet, pellet pack    Sofosbuvir/Velpatasvir 400mg-  100mg (*Asegua only)*    \*VOSEVI tablet  (sofosbuvir/velpatasvir/voxila previr) | **Non-Preferred**  **PA Required**    EPCLUSA 400 mg-100 mg  (sofosbuvir/velpatasvir) tablet    HARVONI 90 mg-400 mg (ledipasvir/sofosbuvir)  tablet    SOVALDI (sofosbuvir) tablet, pellet packet    ZEPATIER (elbasvir/grazoprevir) tablet | | | Pharmacy claims for **preferred products** prescribed for initial treatment will be eligible for up to a 90-day supply fill allowing for the appropriate days’ duration for completing the initial treatment regimen (with no PA required). Subsequent fills will require prior authorization meeting re-treatment criteria below.    \***Second line preferred agents** (Vosevi) may be approved for members 18 years of age or older with chronic HCV infection who are non-cirrhotic or have compensated cirrhosis (Child-Pugh A) AND meet the following criteria:   * GT 1-6 and has previously failed treatment with a regimen containing an NS5A inhibitor (such as ledipasvir, daclatasvir, or ombitasvir) **OR** * GT 1a or 3 and has previously failed treatment with a regimen containing sofosbuvir without an NS5A inhibitor **AND** * Request meets the applicable criteria below for re-treatment.     **Re-treatment:**  All requests for HCV re-treatment for members who have failed therapy with a DAA will be reviewed on a case-by-case basis. Additional information may be requested for re-treatment requests including:   * Assessment of member readiness for re-treatment * Previous regimen medications and dates treated * Genotype of previous HCV infection * Any information regarding adherence to previously trialed regimen(s) and current chronic medications * Adverse effects experienced from previous treatment regimen * Concomitant therapies during previous treatment regimen | |

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|  |  | | • Vosevi regimens will require verification that member has been tested for evidence of active hepatitis B virus (HBV) infection and for evidence of prior HBV infection prior to initiating treatment.    **Non-preferred** agents may be approved if documentation is provided indicating an acceptable rationale for not prescribing a preferred treatment regimen (acceptable rationale may include patient-specific medical contraindications to a preferred treatment or cases where a member has initiated treatment on a non-preferred drug and needs to complete therapy).    Members currently receiving treatment with a non-preferred agent will receive approval to finish their treatment regimen, provided required documentation is sent via normal prior authorization request process. | |
| **Ribavirin Products** | | | | |
| **No PA Required**    Ribavirin capsule    Ribavirin tablet |  | | Preferred products are eligible for up to a 90-day supply fill.    Non-preferred ribavirin products require prior authorizations which will be evaluated on a case-by-case basis. | |
| Therapeutic Drug Class: **HUMAN IMMUNODEFICIENCY VIRUS (HIV) TREATMENTS, ORAL -** *Effective 1/1/2025*  **Oral products indicated for HIV pre-exposure prophylaxis (PrEP) or post-exposure prophylaxis (PEP) are eligible for coverage with a written prescription by an enrolled pharmacist. Additional information regarding pharmacist enrollment can be found at** [**https://hcpf.colorado.gov/pharm-serv.**](https://hcpf.colorado.gov/pharm-serv) | | | | |
| **Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTIs)** | | | | |
| **No PA Required**  All products are preferred and do not require prior authorization.    EDURANT (rilpivirine) tablet    Efavirenz capsule, tablet    Etravirine tablet    INTELENCE (etravirine) tablet    Nevirapine suspension, IR tablet, ER tablet    PIFELTRO (doravirine) tablet | | | | |
| **Nucleoside/Nucleotide Reverse Transcriptase Inhibitors (NRTIs)** | | | | |
| **No PA Required**  Abacavir solution, tablet | |  | | All products are preferred and do not require prior authorization. |

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| Didanosine DR capsule    Emtricitabine capsule    EMTRIVA (emtricitabine) capsule, solution    EPIVIR (lamivudine) solution, tablet    Lamivudine solution, tablet    RETROVIR (zidovudine) capsule, syrup    Stavudine capsule    Tenofovir disoproxil fumarate (TDF) tablet    VIREAD (TDF) oral powder, tablet    ZIAGEN (abacavir) solution, tablet    Zidovudine capsule, syrup, tablet |  |  |
| **Protease Inhibitors (PIs)** | | |
| **No PA Required**    APTIVUS (tipranavir) capsule    Atazanavir capsule    Darunavir tablet    Fosamprenavir tablet    LEXIVA (fosamprenavir) suspension, tablet    NORVIR (ritonavir) powder packet, tablet    PREZISTA (darunavir) suspension, tablet    REYATAZ (atazanavir) capsule, powder pack    Ritonavir tablet    VIRACEPT (nelfinavir) tablet |  | All products are preferred and do not require prior authorization. |
| **Other Agents** | | |

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| **No PA Required**    ISENTRESS (raltegravir) chewable, powder pack, tablet    ISENTRESS HD (raltegravir) tablet    Maraviroc tablet    RUKOBIA (fostemsavir tromethamine ER)  tablet    SELZENTRY (maraviroc) solution, tablet    SUNLENCA (lenacapavir) tablet    TIVICAY (dolutegravir) tablet    TIVICAY PD (dolutegravir) tablet for suspension    TYBOST (cobicistat) tablet    VOCABRIA (cabotegravir) tablet |  | All products are preferred and do not require prior authorization. |
| **Combination Agents** | | |
| **No PA Required**    Abacavir/Lamivudine tablet    ATRIPLA (efavirenz/Emtricitabine/TDF) tablet    BIKTARVY (bictegravir/emtricitabine/TAF)  tablet    CIMDUO (lamivudine/TDF) tablet    COMBIVIR (lamivudine/zidovudine) tablet    COMPLERA (emtricitabine/rilpivirine/TDF)  tablet    DELSTRIGO (doravirine/lamivudine/TDF)  tablet    DESCOVY (emtricitabine/TAF) tablet |  | All products are preferred and do not require prior authorization. |

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| DOVATO (dolutegravir/lamivudine) tablet    Efavirenz/Emtricitabine/TDF tablet    Efavirenz/Lamivudine/TDF tablet    Emtricitabine/TDF tablet    EPZICOM (abacavir/lamivudine) tablet    EVOTAZ (atazanavir/cobicistat) tablet    GENVOYA (elvitegravir/cobicistat/ emtricitabine/TAF) tablet    JULUCA (dolutegravir/rilpivirine) tablet    KALETRA (lopinavir/ritonavir) solution, tablet    Lamivudine/Zidovudine tablet    Lopinavir/Ritonavir solution, tablet    ODEFSEY (emtricitabine/rilpivirine/TAF)  tablet    PREZCOBIX (darunavir/cobicistat) tablet    STRIBILD (elvitegravir/cobicistat/ emtricitabine/TDF) tablet    SYMFI/SYMFI LO  (efavirenz/lamivudine/TDF) tablet    SYMTUZA (darunavir/cobicistat/ emtricitabine/TAF) tablet    TRIUMEQ (abacavir/dolutegravir/ lamivudine)  tablet    TRIUMEQ PD (abacavir/dolutegravir) tablet for suspension    TRIZIVIR (abacavir/lamivudine/zidovudine)  tablet |  |  |

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| \*TRUVADA (emtricitabine/TDF) tablet | |  | |  |
| Therapeutic Drug Class: **TETRACYCLINES -** *Effective 7/1/2024* | | | | |
| **No PA Required**    Doxycycline hyclate capsules    Doxycycline hyclate tablets    Doxycycline monohydrate 50mg,  100mg capsule    Doxycycline monohydrate tablets    Minocycline capsules | **PA Required**    Demeclocycline tablet    DORYX (doxycycline DR) tablet    Doxycycline hyclate DR tablet    Doxycycline monohydrate 75mg, 150mg capsule    Doxycycline monohydrate suspension    Minocycline IR, ER tablet    MINOLIRA (minocycline ER) tablet    MORGIDOX (doxycycline/skin cleanser) kit    NUZYRA (omadacycline) tablet    SOLODYN ER (minocycline ER) tablet    Tetracycline capsule    XIMINO (minocycline ER) capsule | | Prior authorization for non-preferred tetracycline agents may be approved if member has trialed/failed a preferred doxycycline product AND preferred minocycline. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.    Prior authorization for liquid oral tetracycline formulations may be approved if member is unable to take a solid oral dosage form.    **Nuzyra** (omadacycline) prior authorization may be approved if member meets all of the following criteria: the above “non-preferred” prior authorization criteria and the following:   * Member has trialed and failed† therapy with a preferred doxycycline product and preferred minocycline OR clinical rationale is provided describing why these medications cannot be trialed (including resistance and sensitivity) AND • Member has diagnosis of either Community Acquired Bacterial Pneumonia (CABP) or Acute Bacterial Skin and Skin Structure Infection (ABSSSI) or clinical rationale and supporting literature describing/supporting intended use AND one of the following:   + If member diagnosis is ABSSSI, member must have trial and failure† of sulfamethoxazole/trimethoprim product in addition to preferred tetracyclines OR   + If member diagnosis is CABP, member must have trial and failure† of either a beta-lactam antibiotic (amoxicillin/clavulanic acid) or a macrolide (azithromycin)   AND   * Maximum duration of use is 14 days     †Failure is defined as lack of efficacy with 7-day trial, allergy, intolerable side effects, or significant drug-drug interaction. | |
| **III. Cardiovascular** | | | | |
| Therapeutic Drug Class: **ALPHA-BLOCKERS -** *Effective 7/1/2024* | | | | |
| **No PA Required**    Prazosin capsule | **PA Required**    MINIPRESS (prazosin) capsule | | Non-preferred products may be approved following trial and failure of one preferred product (failure is defined as lack of efficacy with 4-week trial, allergy or intolerable side effects). | |
| Therapeutic Drug Class: **BETA-BLOCKERS -** *Effective 7/1/2024* | | | | |
| **Beta-Blockers, Single Agent** | | | | |

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| **No PA Required**  **(\*Must meet eligibility criteria)**      Acebutolol capsule    Atenolol tablet    Bisoprolol tablet    Carvedilol IR tablet    \*HEMANGEOL (propranolol) solution    Labetalol tablet    Metoprolol tartrate tablet    Metoprolol succinate ER tablet    Nadolol tablet  Nebivolol tablet    Propranolol IR tablet, solution    Propranolol ER capsule | **PA Required**    Betaxolol tablet    BYSTOLIC (nebivolol) tablet    CORGARD (nadolol) tablet    COREG (carvedilol) tablet    COREG CR (carvedilol ER) capsule    Carvedilol ER capsule    INDERAL LA/XL (propranolol ER) capsule    INNOPRAN XL (propranolol ER) capsule    KASPARGO (metoprolol succinate) sprinkle capsule    LOPRESSOR (metoprolol tartrate) tablet    Pindolol tablet    TENORMIN (atenolol) tablet    Timolol tablet    TOPROL XL (metoprolol succinate) tablet | **\*HEMANGEOL (propranolol) oral solution** may be approved for members between 5 weeks and 1 year of age with proliferating infantile hemangioma requiring systemic therapy.  Maximum dose: 1.7 mg/kg twice daily    Non-preferred products may be approved following trial and failure with two preferred products (failure is defined as lack of efficacy with 4-week trial, allergy, intolerable side effects or significant drug-drug interactions).    **INNOPRAN XL** (propranolol ER) capsule brand product formulation may be approved if meeting the following:   * Request meets non-preferred criteria listed above AND * Member has trialed and failed therapy with a generic propranolol ER capsule formulation OR prescriber provides clinical rationale supporting why generic propranolol ER capsule product formulations cannot be trialed. Failure is defined as lack of efficacy with 4-week trial, allergy, intolerable side effects or significant drug-drug interactions.     **KAPSPARGO SPRINKLE (metoprolol succinate)** extended-release capsule may be approved for members ≥ 6 years of age that have difficulty swallowing or require medication administration via a feeding tube.  Maximum dose: 200mg/day (adult); 50mg/day (pediatric)    Members currently stabilized on timolol oral tablet non-preferred products may receive approval to continue on that product.    Members currently stabilized on the non-preferred Bystolic (nebivolol) tablets may receive approval to continue on that product.    Members currently stabilized on the non-preferred carvedilol ER capsules may receive approval to continue on that product. | | | | | | |
|  | **Table 1: Receptor Selectivity and Other Properties of Preferred Beta Blockers** | | | | |  |
|  | ß1 | ß2 | Alpha-1 receptor antagonist | Intrinsic  sympathomimetic activity (ISA) |
| Acebutolol | X |  |  | X |
| Atenolol | X |  |  |  |
| Betaxolol | X |  |  |  |
| Bisoprolol | X |  |  |  |
| Carvedilol | X | X | X |  |
| Labetalol | X | X | X |  |

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|  |  |  |  | Metoprolol succinate | X |  |  |  |  |
| Metoprolol  tartrate | X |  |  |  |
| Nadolol | X | X |  |  |
| Nebivolol | X |  |  |  |
| Pindolol | X | X |  | X |
| Propranolol | X | X |  |  |
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|  | **Beta-Blockers, Anti-Arrhythmics** | | | | | | | | |
| **No PA Required**    Sotalol tablet |  | **PA Required**    BETAPACE/AF (sotalol) tablet    SOTYLIZE (sotalol) solution | **SOTYLIZE (sotalol)** oral solution may be approved for members 3 days to < 5 years of age. For members ≥ 5 years of age, SOTYLIZE (sotalol) oral solution may be approved for members who are unable to take a solid oral dosage form OR members that have trialed and failed therapy with one preferred product. (Failure is defined as allergy or intolerable side effects.)    Maximum dose: 320 mg/day | | | | | | |
|  | **Beta-Blockers, Combinations** | | | | | | | | |
| **No PA Required**    Atenolol/Chlorthalidone tablet    Bisoprolol/HCTZ tablet    Metoprolol/HCTZ tablet |  | **PA Required**    TENORETIC (atenolol/chlorthalidone) tablet    ZIAC (bisoprolol/HCTZ) tablet | Non-preferred products may be approved following trial and failure with two preferred products (failure is defined as lack of efficacy with 4-week trial, allergy, intolerable side effects or significant drug-drug interactions). | | | | | | |
|  | Therapeutic Drug Class: **CALCIUM CHANNEL-BLOCKERS -** *Effective 7/1/2024* | | | | | | | | |
|  | **Dihydropyridines (DHPs)** | | | | | | | | |
| **No PA Required**    Amlodipine tablet    Felodipine ER tablet    Nifedipine ER tablet    Nifedipine IR capsule | **PA Required**    ADALAT CC (nifedipine ER) tablet    NORLIQVA (amlodipine) suspension    KATERZIA (amlodipine) suspension    Isradipine capsule    Levamlodipine tablet | | Non-preferred products may be approved following trial and failure of two preferred agents. Failure is defined as lack of efficacy, contraindication to therapy, allergy, intolerable side effects, or significant drug-drug interactions.    **Nimodipine oral capsule** oral capsule may be approved for adult members (≥ 18 years of age) with subarachnoid hemorrhage    **NYMALIZE (nimodipine)** oral syringemay be approved for adult members (≥ 18 years of age) with subarachnoid hemorrhage who also have a feeding tube or have difficulty swallowing solid dosage forms. | | | | | | |

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|  | Nicardipine capsule    Nimodipine capsule    Nisoldipine ER tablet    NORVASC (amlodipine) tablet    NYMALIZE (nimodipine) solution, oral syringe    PROCARDIA XL (nifedipine ER) tablet    SULAR (nisoldipine ER) tablet | | Maximum dose: 360 mg/day for 21 days (6 syringes/day or 126 syringes/21 days)    **KATERZIA (amlodipine)** suspensionmay be approved if meeting the following:   * The member has a feeding tube or confirmed difficulty swallowing solid oral dosage forms OR cannot obtain the required dose through crushed amlodipine tablets AND * For members < 6 years of age, the prescriber confirms that the member has already been receiving the medication following initiation in a hospital or other clinical setting |
| **Non-Dihydropyridines (Non-DHPs)** | | | |
| **No PA Required PA Required**  Non-preferred products may be approved following trial and failure of three preferred  Diltiazem IR tablet CALAN SR (verapamil ER) tablet agents. Failure is defined as lack of efficacy, contraindication to therapy, allergy, intolerable side effects, or significant drug-drug interactions.  Diltiazem CD/ER capsule CARDIZEM (diltiazem) tablet    Verapamil IR, ER tablet CARDIZEM CD/LA (diltiazem CD/ER) capsule, tablet  Verapamil ER 120 mg, 180 mg, 240 mg capsule Diltiazem ER/LA tablet    TIAZAC ER (diltiazem ER) capsule    Verapamil ER 360 mg capsule    Verapamil PM ER 100 mg, 200 mg, 300 mg capsule    VERELAN/PM (verapamil ER) pellet capsule | | | |
| Therapeutic Drug Class: **ANGIOTENSIN MODIFIERS -** *Effective 7/1/2024* | | | |
| **Angiotensin-converting enzyme inhibitors (ACE Inh)** | | | |
| **No PA Required**    Benazepril tablet    Enalapril tablet    Fosinopril tablet    Lisinopril tablet | | **PA Required**    ACCUPRIL (quinapril) tablet    ALTACE (ramipril) capsule    Captopril tablet    Enalapril solution | Non-preferred ACE inhibitors, ACE inhibitor combinations, ARBs, ARB combinations, renin inhibitors, and renin inhibitor combination products may be approved for members who have trialed and failed treatment with three preferred products (failure is defined as lack of efficacy with a 4-week trial, allergy, intolerable side effects, or significant drugdrug interaction).    **\*Enalapril solution** may be approved without trial and failure of three preferred agents for members who are unable to take a solid oral dosage form. |

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| Quinapril tablet    Ramipril tablet | EPANED (enalapril) solution    LOTENSIN (benazepril) tablet    Moexipril tablet    Perindopril tablet    PRINIVIL (lisinopril) tablet    QBRELIS (lisinopril) solution    Trandolapril tablet    VASOTEC (enalapril) tablet    ZESTRIL (lisinopril) tablet | | **\*QBRELIS (lisinopril) solution** may be approved for members 6 years of age or older who are unable to take a solid oral dosage form and have trialed and failed Epaned (enalapril) solution. Failure is defined as lack of efficacy with a 4-week trial, allergy, intolerable side effects, or significant drug-drug interaction. | |
| **ACE Inhibitor Combinations** | | | | |
| **No PA Required**    Amlodipine/Benazepril capsule    Benazepril/HCTZ tablet    Enalapril/HCTZ tablet    Lisinopril/HCTZ tablet | **PA Required**    ACCURETIC (quinapril/HCTZ) tablet    Captopril/HCTZ tablet    Fosinopril/HCTZ tablet    LOTENSIN HCT (benazepril/HCTZ) tablet    LOTREL (amlodipine/benazepril) capsule    Quinapril/HCTZ tablet    VASERETIC (enalapril/HCTZ) tablet    ZESTORETIC (lisinopril/HCTZ) tablet | | Non-preferred ACE inhibitors, ACE inhibitor combinations, ARBs, ARB combinations, renin inhibitors, and renin inhibitor combination products may be approved for members who have trialed and failed treatment with three preferred products (failure is defined as lack of efficacy with a 4-week trial, allergy, intolerable side effects, or significant drugdrug interaction). | |
|  | | **Angiotensin II receptor blockers (ARBs)** | |  |
| **No PA Required**    Irbesartan tablet    Losartan tablet    Olmesartan tablet | **PA Required**    ATACAND (candesartan) tablet    AVAPRO (irbesartan) tablet    BENICAR (olmesartan) tablet | | Non-preferred ACE inhibitors, ACE inhibitor combinations, ARBs, ARB combinations, renin inhibitors, and renin inhibitor combination products may be approved for members who have trialed and failed treatment with three preferred products (failure is defined as lack of efficacy with a 4-week trial, allergy, intolerable side effects, or significant drugdrug interaction). | |

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| Telmisartan tablet    Valsartan tablet | Candesartan tablet    COZAAR (losartan) tablet    DIOVAN (valsartan) tablet    EDARBI (azilsartan) tablet    Eprosartan tablet    MICARDIS (telmisartan) tablet    Valsartan solution |  |
| **ARB Combinations** | | |
| **Preferred**  **No PA Required**  **(Unless indicated\*)**    \*ENTRESTO  (sacubitril/valsartan) tabletBNR    Irbesartan/HCTZ tablet    Losartan/HCTZ tablet    Olmesartan/Amlodipine tablet    Olmesartan/HCTZ tablet    Valsartan/Amlodipine tablet    Valsartan/HCTZ tablet | **Non-Preferred**  **PA Required**  ATACAND HCT (candesartan/HCTZ) tablet    AVALIDE (irbesartan/HCTZ) tablet    AZOR (olmesartan/amlodipine) tablet    BENICAR HCT (olmesartan/HCTZ) tablet    Candesartan/HCTZ tablet    DIOVAN HCT (valsartan/HCTZ) tablet    EDARBYCLOR (azilsartan/chlorthalidone) tablet    ENTRESTO (sacubitril/valsartan) sprinkles    EXFORGE (valsartan/amlodipine) tablet    EXFORGE HCT (valsartan/amlodipine/HCTZ)  tablet    HYZAAR (losartan/HCTZ) tablet    MICARDIS HCT (telmisartan/HCTZ) tablet    Olmesartan/amlodipine/HCTZ tablet    Telmisartan/amlodipine tablet | Non-preferred ACE inhibitors, ACE inhibitor combinations, ARBs, ARB combinations, renin inhibitors, and renin inhibitor combination products may be approved for members who have trialed and failed treatment with three preferred products (failure is defined as lack of efficacy with a 4-week trial, allergy, intolerable side effects, or significant drugdrug interaction).    **\*ENTRESTO** (sacubitril/valsartan) may be approved for members if the following criteria are met:   * Member is 1 to 17 years of age and has a diagnosis of symptomatic heart failure with systemic left ventricular systolic dysfunction (LVSD) and/or has chronic heart failure with a below-normal left ventricular ejection fraction (LVEF) OR * Member is ≥ 18 years of age and has a diagnosis of chronic heart failure. * Diagnosis will be verified through automated verification (AutoPA) of the appropriate corresponding ICD-10 diagnosis codes related to the indicated use of the medication. |

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|  | Telmisartan/HCTZ tablet    TRIBENZOR (olmesartan/amlodipine/HCTZ)  tablet    Valsartan/Amlodipine/HCTZ tablet | |  |
| **Renin Inhibitors & Renin Inhibitor Combinations** | | | |
|  | **PA Required**    Aliskiren tablet    TEKTURNA (aliskiren) tablet    TEKTURNA HCT (aliskiren/HCTZ) tablet | | Non-preferred renin inhibitors and renin inhibitor combination products may be approved for members who have failed treatment with three preferred products from the angiotensin modifier class (failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction).    Renin inhibitors and combinations will not be approved in patients with diabetes. Renin inhibitors are contraindicated when used in combination with an ACE-inhibitor, ACEinhibitor combination, ARB, or ARB-combination. |
| Therapeutic Drug Class: **PULMONARY ARTERIAL HYPERTENSION THERAPIES -** *Effective 7/1/2024* | | | |
| **Phosphodiesterase Inhibitors** | | | |
| **Preferred**  **\*Must meet eligibility criteria**      \*Sildenafil tablet, oral suspension    \*Tadalafil 20mg tablet | **Non-Preferred**  **PA Required**      ADCIRCA (tadalafil) tablet    ALYQ (tadalafil) tablet    LIQREV (sildenafil) suspension    REVATIO (sildenafil) suspension, tablet    TADLIQ suspension | **\*Eligibility criteria for preferred products:**    Preferred sildenafil and tadalafil tablet formulations may be approved for a diagnosis of pulmonary hypertension or right-sided heart failure.    **Sildenafil suspension** may be approved for a diagnosis of pulmonary hypertension for members < 5 years of age or members ≥ 5 years of age who are unable to take/swallow tablets.    Non-preferred oral tablet products may be approved if meeting the following:   * Member has a diagnosis of pulmonary hypertension **AND** * Member has trialed and failed treatment with preferred sildenafil tablet **AND** preferred tadalafil tablet. Failure is defined as lack of efficacy with 4-week trial, allergy, intolerable side effects, or significant drug-drug interaction.     Members who have been previously stabilized on a non-preferred product may receive approval to continue on the medication.    Non-preferred oral liquid products may be approved if meeting the following: • Member has a diagnosis of pulmonary hypertension AND   * Request meets one of the following: | |

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|  |  | * Member has trialed and failed treatment with one preferred oral liquid formulation (failure is defined as lack of efficacy with a 4-week trial, allergy, intolerable side effects, or significant drug-drug interaction) OR * Prescriber verifies that the member is unable to take a solid oral dosage form that there is clinical necessity for use of a regimen with a less frequent dosing interval. | | |
| **Endothelin Receptor Antagonists** | | | | |
| **Preferred Non-Preferred**  **\*Must meet eligibility criteria PA Required \*Eligibility Criteria for all agents in the class**  Approval may be granted for a diagnosis of pulmonary hypertension. Member and  \*Ambrisentan tablet LETAIRIS (ambrisentan) tablet prescriber should be enrolled in applicable REMS program for prescribed medication.    \*Bosentan 62.5mg, 125mg tablet OPSUMIT (macitentan) tablet Non-preferred agents may be approved for members who have trialed and failed two  preferred agents. Failure is defined as lack of efficacy, allergy, intolerable side effects, or TRACLEER (bosentan) 32mg tablet for suspension significant drug-drug interaction.    TRACLEER (bosentan) 62.5mg, 125mg tablet Members who have been previously stabilized on a non-preferred product may receive approval to continue the medication. | | | | |
| **Prostacyclin Analogues and Receptor Agonists** | | | | |
| **Preferred**  **(\*Must meet eligibility criteria)**    \*FLOLAN (epoprostenol) vial    \*ORENITRAM (treprostinil ER)  tablet, titration kit    \*VENTAVIS (iloprost) inhalation solution | **Non-Preferred**  **PA Required**    Epoprostenol vial    REMODULIN (treprostinil) vial    Treprostinil vial    TYVASO (treprostinil) inhaler, inhalation solution    UPTRAVI (selexipag) tablet, dose pack, vial    VELETRI (epoprostenol) vial | | | **\*Eligibility Criteria for all agents in the class**  Approval will be granted for a diagnosis of pulmonary hypertension.    Non-preferred products may be approved for members who have failed treatment with a Preferred Product. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, contraindication to IV therapy or significant drug-drug interaction).    Members who have been previously stabilized on a non-preferred product may receive approval to continue on the medication. |
| **Guanylate Cyclase (sGC) Stimulator** | | | | |
|  | **Non-Preferred**  **PA Required**    ADEMPAS (riociguat) tablet | | **ADEMPAS (riociguat)** may be approved for members who meet the following criteria:  • For members of childbearing potential:  o Member is not pregnant and is able to receive monthly pregnancy tests while taking ADEMPAS and one month after stopping therapy **AND** | |

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|  |  | | o Member and their partners are utilizing one of the following contraceptive methods during treatment and for one month after stopping treatment (IUD, contraceptive implants, tubal sterilization, a hormone method with a barrier method, two barrier methods, vasectomy with a hormone method, or vasectomy with a barrier method)  **AND**   * Member has a CrCl ≥ 15 mL/min and is not on dialysis **AND** * Member does not have severe liver impairment (Child Pugh C) **AND** * Member has a diagnosis of persistent/recurrent chronic thromboembolic pulmonary hypertension   (CTEPH) (WHO Group 4) after surgical treatment or has inoperable CTEPH **OR**   * Member has a diagnosis of pulmonary hypertension and has failed treatment with a preferred product for pulmonary hypertension. (Failure is defined as a lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction). | | | | |
| Therapeutic Drug Class: **LIPOTROPICS** - *Effective 7/1/2024* | | | | | | | |
|  | | **Bile Acid Sequestrants** | | | | |  |
| **No PA Required**    Colesevelam tablet    Colestipol tablet    Cholestyramine packet, light packet, powder | **PA Required**    Colesevelam packet    COLESTID (colestipol) tablet, granules    Colestipol granules    QUESTRAN (cholestyramine/sugar) packet, powder    QUESTRAN LIGHT (cholestyramine/ aspartame) packet, powder    WELCHOL (colesevelam) packet, tablet | | | | Non-preferred bile acid sequestrants may be approved if the member has failed treatment with 2 preferred products in the last 12 months (failure is defined as lack of efficacy with 4-week trial, allergy, intolerable side effects or significant drug-drug interactions).    Non-preferred lipotropic agents with a preferred product with same strength, dosage form, and active ingredient may be approved with adequate trial and/or failure of the preferred product with the same ingredient (such as preferred ezetimibe and Zetia) and 2 additional agents. (Failure is defined as: lack of efficacy with 4-week trial, allergy, intolerable side effects or significant drug-drug interactions). | | |
|  | | | | **Fibrates** | |  | |
| **No PA Required**    Fenofibric acid DR (generic Trilipix) capsule    Fenofibrate capsule, tablet  (generic Lofibra/Tricor)    Gemfibrozil tablet | **PA Required**    ANTARA (fenofibrate) capsule    Fenofibric acid tablet    Fenofibrate capsule  (generic Antara/Fenoglide/Lipofen)    FENOGLIDE (fenofibrate) tablet    LIPOFEN (fenofibrate) capsule | | | | Non-preferred fibrates may be approved if the member has failed treatment with generic gemfibrozil or generic fenofibrate and niacin ER in the last 12 months (failure is defined as lack of efficacy with 4-week trial of each drug, allergy, intolerable side effects or significant drug-drug interactions).    Non-preferred lipotropic agents with a preferred product with same strength, dosage form, and active ingredient may be approved with adequate trial and/or failure of the preferred product with the same ingredient (such as preferred ezetimibe and Zetia) and 2 additional agents. (Failure is defined as: lack of efficacy with 4-week trial, allergy, intolerable side effects or significant drug-drug interactions). | | |

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|  | LOPID (gemfibrozil) tablet    TRICOR (fenofibrate nano) tablet    TRILIPIX (fenofibric acid) capsule | |  | |
|  | | **Other Lipotropics** | |  |
| **No PA Required**  **(\*Must meet eligibility criteria)**    Ezetimibe tablet    Niacin ER tablet    \*Omega-3 ethyl esters capsule (generic Lovaza) | **PA Required**      Icosapent ethyl capsule    LOVAZA (omega-3 ethyl esters) capsule    NEXLETOL (bempedoic acid) tablet    NEXLIZET (bempedoic acid/ezetimibe) tablet    ZETIA (ezetimibe) tablet | | Non-preferred lipotropic agents with a preferred product with same strength, dosage form, and active ingredient may be approved with adequate trial and/or failure of the preferred product with the same ingredient (such as preferred ezetimibe and Zetia) and 2 additional agents. (Failure is defined as: lack of efficacy with 4-week trial, allergy, intolerable side effects or significant drug-drug interactions).    **\*Omega-3 ethyl esters** (generic Lovaza)may be approved for members who have a baseline triglyceride level ≥ 500 mg/dL    **Lovaza** (brand name) may be approved if meeting the following:   * Member has a baseline triglyceride level > 500 mg/dl AND * Member has failed an adequate trial of omega-3 Ethyl Esters AND an adequate trial of gemfibrozil or fenofibrate (failure is defined as lack of efficacy with 4week trial, allergy, intolerable side effects or significant drug-drug interactions)   **Nexletol** (bempedoic acid) or **Nexlizet** (bempedoic acid/ezetimibe) may be approved if meeting the following criteria:   * Member is ≥ 18 years of age **AND** * Member is not pregnant **AND** * Member is not receiving concurrent simvastatin > 20 mg daily or pravastatin > 40 mg daily **AND** * Member has a diagnosis of either heterozygous familial hypercholesterolemia or established atherosclerotic cardiovascular disease (see definition below), **AND**  |  | | --- | | Conditions Which Define Clinical Atherosclerotic Cardiovascular Disease | | * Acute Coronary Syndrome * History of Myocardial Infarction * Stable or Unstable Angina * Coronary or other Arterial Revascularization * Stroke * Transient Ischemic Attack * Peripheral Arterial Disease of Atherosclerotic Origin |      * Member is concurrently adherent (> 80% of the past 180 days) on a maximally tolerated dose of a high intensity statin therapy (atorvastatin ≥ 40 mg daily **OR** | |

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|  |  | rosuvastatin ≥ 20 mg daily [as a single-entity or as a combination product]) **AND** ezetimibe (as a single-entity or as a combination product) concomitantly for ≥ 8 continuous weeks), **AND**   * If intolerant to a statin due to side effects, member must have a one month documented trial with at least two other maximally dosed statins in addition to ezetimibe. For members with a past or current incidence of rhabdomyolysis, a one-month trial and failure of a statin is not required, **AND** * Member has a treated LDL > 70 mg/dL for a clinical history of ASCVD **OR** LDL > 100 mg/dL if familial hypercholesterolemia   Initial Approval: 1 year    Reauthorization: Reauthorization may be approved for 1 year with provider attestation of medication safety and efficacy during the initial treatment period |
| Therapeutic Drug Class: **STATINS** -*Effective 7/1/2024* | | |
| **No PA Required**    Atorvastatin tablet    Lovastatin tablet    Pravastatin tablet    Rosuvastatin tablet    Simvastatin tablet | **PA Required**    ALTOPREV (lovastatin ER) tablet    ATORVALIQ (atorvastatin) suspension    CRESTOR (rosuvastatin) tablet    EZALLOR (rosuvastatin) sprinkle capsule    FLOLIPID (simvastatin) suspension  Fluvastatin capsule, ER tablet    LESCOL XL (fluvastatin ER) tablet    LIPITOR (atorvastatin) tablet    LIVALO (pitavastatin) tablet    Pitavastatin tablet    ZOCOR (simvastatin) tablet    ZYPITAMAG (pitavastatin) tablet | Non-preferred Statins may be approved following trial and failure of treatment with two preferred products (failure is defined as lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions).    Age Limitations:Altoprev will not be approved for members < 18 years of age. Fluvastatin will not be approved for members < 10 years of age. Livalo will not be approved for members < 8 years of age. |
| Therapeutic Drug Class: **STATIN COMBINATIONS** -*Effective 7/1/2024* | | |
| **No PA Required**    Simvastatin/Ezetimibe tablet | **PA Required**    Atorvastatin/Amlodipine tablet | Non-preferred Statin combinations may be approved following trial and failure of treatment with two preferred products (failure is defined as lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions). |

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|  | CADUET (atorvastatin/amlodipine) tablet    VYTORIN (simvastatin/ezetimibe) tablet | Age Limitations: Vytorin and generic ezetimibe/simvastatin will not be approved for members < 18 years of age. Caduet and generic amlodipine/atorvastatin will not be approved for members < 10 years of age. |
| Therapeutic Drug Class: **Movement Disorders** -*Effective 7/1/2024* | | |
| **No PA Required**  **(\*Must meet eligibility criteria)**    \*Austedo (deutetrabenazine) tablet    \*Austedo (deutetrabenazine) XR tablet, titration pack    \*Ingrezza (valbenazine) capsule, initiation pack    \* Tetrabenazine tablet | **PA Required**      Xenazine (tetrabenazine) tablet | **\*Eligibility Criteria for all agents in the class**   * Member is ≥18 years of age AND * Member has been diagnosed with tardive dyskinesia or chorea associated with   Huntington’s disease AND   * If the member has hepatic impairment, FDA labeling for use has been evaluated   AND   * For chorea associated with Huntington’s disease:   + Member has been evaluated for untreated or inadequately treated depression and member has been counseled regarding the risks of depression and suicidality associated with agents in this therapeutic class.   AND   * For tardive dyskinesia: o If applicable, the need for ongoing treatment with 1st and 2nd generation antipsychotics, metoclopramide, or prochlorperazine has been evaluated AND   + A baseline Abnormal Involuntary Movement Scale (AIMS) has been performed.     Xenazine (tetrabenazine)  Maximum dose 50 mg/day (PA available for extensive metabolizers of CYP2D6)    Ingrezza (valbenazine) Quantity limits:   * 40 mg: 1.767 capsules/day * 60 mg: 1 capsule/day * 80 mg: 1 capsule/day   Austedo (deutetrabenazine)  Maximum dose: 48 mg/day    Non-preferred Movement Disorder Agents may be approved for members ≥18 years of age after trial and failure of two preferred products. Failure is defined as lack of efficacy, allergy, intolerable side effects or significant drug-drug interaction. |

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| **IV. Central Nervous System** | | |
| Therapeutic Drug Class: **ANTICONVULSANTS** -**Oral**-*Effective 4/1/2025* | | |
| **No PA Required** | **PA Required**  ***Non-preferred brand name medications do not require a prior authorization when the equivalent generic is preferred and “dispense as written” is indicated on the prescription.*** | Members currently stabilized (in outpatient or acute care settings) on any non-preferred medication in this class may receive prior authorization approval to continue on that medication.    Non-preferred brand name medications do not require a prior authorization when the equivalent generic is preferred and “dispense as written” is indicated on the prescription.    Non-Preferred Products Newly Started for Treating Seizure Disorder or Convulsions: Non-preferred medications newly started for members with a diagnosis of seizure disorder/convulsions may be approved if the following criteria are met:   * The requested medication is being prescribed by a practitioner who has sufficient education and experience to safely manage treatment **AND** * The request meets minimum age and maximum dose limits listed in Table 1   **AND**   * For medications indicated for use as adjunctive therapy, the medication is being used in conjunction with another medication indicated for treatment of seizure disorder/convulsions **AND** * The request meets additional criteria listed for any of the following:     **APTIOM (eslicarbazepine)**   * Member has history of trial and failure‡ of any carbamazepine-containing product     **BRIVIACT (brivaracetam)**   * Member has history of trial and failure‡ of any levetiracetam-containing product     **DIACOMIT (stiripentol)**   * Member is concomitantly taking clobazam **AND** * Member has diagnosis of seizures associated with Dravet syndrome     **ELEPSIA XR (levetiracetam ER) tablet**   * Member has history of trial and failure‡ of levetiracetam ER (KEPPRA XR)     **EPIDIOLEX (cannabidiol**)   * Member has diagnosis of seizures associated with Lennox-Gastaut syndrome (LGS) or Dravet Syndrome **OR** * Member has a diagnosis of seizures associated with tuberous sclerosis complex (TSC).     **FINTEPLA (fenfluramine)**   * Member has a diagnosis of seizures associated with Dravet syndrome or |
| **Barbiturates** | |
| Phenobarbital elixir, solution, tablet    Primidone tablet | MYSOLINE (primidone) tablet |
| **Hydantoins** | |
| DILANTIN (phenytoin) 30 mg capsules, Infatab, suspension    PHENYTEK (phenytoin ER) capsule    Phenytoin suspension, chewable, ER capsule | DILANTIN (phenytoin ER), 100 mg capsules |
| **Succinamides** | |
| Ethosuximide capsule, solution | CELONTIN (methsuximide) Kapseal  Methsuximide capsule    ZARONTIN (ethosuximide) capsule, solution |
| **Benzodiazepines** | |
| Clobazam tablet, suspension    Clonazepam tablet, ODT | KLONOPIN (clonazepam) tablet    ONFI (clobazam) suspension, tablet    SYMPAZAN (clobazam) SL film |
| **Valproic Acid and Derivatives** | |

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| DEPAKOTE (divalproex DR) sprinkle capsule    Divalproex sprinkle capsule, DR tablet, ER tablet    Valproic acid capsule, solution | DEPAKOTE (divalproex DR) tablet    DEPAKOTE ER (divalproex ER) tablet | Lennox-Gastaut syndrome    **OXTELLAR XR (oxcarbazepine ER)**   * Member is being treated for partial-onset seizures **AND** * Member has history of trial and failure‡ of any carbamazepine or oxcarbazepine-containing product     **SPRITAM (levetiracetam) tablet for suspension**   * Member has history of trial and failure‡ of levetiracetam solution     **SYMPAZAN (clobazam**) **film**   * Member has history of trial and failure‡ of clobazam tablet or solution **OR** ● Provider attests that member cannot take clobazam tablet or solution     Non-Preferred Products Newly Started for Non-Seizure Disorder Diagnoses: Non-preferred medications newly started for non-seizure disorder diagnoses may be approved if meeting the following criteria:   * Member has history of trial and failure‡ of two preferred agents AND * The prescription meets minimum age and maximum dose limits listed in Table   1.  ‡Failure is defined as lack of efficacy, allergy, intolerable side effects, significant drugdrug interaction, documented contraindication to therapy, or inability to take preferred formulation. Members identified as HLA-B\*15:02 positive, carbamazepine and oxcarbazepine should be avoided per Clinical Pharmacogenetics Implementation  Consortium Guideline. This may be considered a trial for prior authorization approvals of a non-preferred agent. | | | | |
| **Carbamazepine Derivatives** | |
| Carbamazepine IR tablet, ER tablet, chewable, ER capsule, suspension    CARBATROL ER  (carbamazepine) capsule    Oxcarbazepine tablet    TEGRETOL (carbamazepine) suspension, tablet    TEGRETOL XR (carbamazepine  ER) tablet    TRILEPTALBNR (oxcarbazepine) suspension | APTIOM (eslicarbazepine) tablet    EQUETRO (carbamazepine) capsule    Oxcarbazepine suspension    Oxcarbazepine ER (generic Oxtellar XR) tablet    OXTELLAR XR (oxcarbazepine) tablet    TRILEPTAL (oxcarbazepine) tablet |
|  | **Table 1: Non-preferred Product Minimum Age and Maximum Dose** | | |  |
|  | **Minimum**  **Age\*\*** | **Maximum Dose\*\*** |
| **Lamotrigines** | |
| **Barbiturates** |  |  |
| Lamotrigine IR tablet, ER tablet, chewable/dispersible tablet,  ODT | LAMICTAL (lamotrigine) chewable/dispersible dose pack, tablet    LAMICTAL (lamotrigine) ODT, ODT dose pack    LAMICTAL XR (lamotrigine ER) tablet, dose pack    Lamotrigine ER/IR/ODT dose packs |
| primidone (MYSOLINE) |  | 2,000 mg per day |
| **Benzodiazepines** |  |  |
| clobazam (ONFI) suspension, tablet | 2 years | 40 mg per day |
| clobazam film (SYMPAZAN) | 2 years | 40 mg per day |
| clonazepam (KLONOPIN) |  | 20 mg per day |
| **Brivaracetam/Levetiracetam** |  |  |
| brivaracetam (BRIVIACT) | 1 month | 200 mg per day |
| levetiracetam (KEPPRA) | 1 month | 3,000 mg per day |
| levetiracetam (SPRITAM) | 4 years | 3,000 mg per day |
| levetiracetam ER (ELEPSIA XR) | 12 years | 3,000 mg per day |

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| **Topiramates** | |  | levetiracetam ER (KEPPRA XR) | 12 years | 3,000 mg per day |  |
| **Carbamazepine Derivatives** |  |  |
| Topiramate tablet, sprinkle capsule | EPRONTIA (topiramate) solution    QUDEXY XR (topiramate) capsule    TOPAMAX (topiramate) tablet, sprinkle capsule    Topiramate ER capsule    TROKENDI XR (topiramate ER) capsule |
| carbamazepine (EPITOL) |  | 1,600 mg per day |
| carbamazepine ER (EQUETRO) |  | 1,600 mg per day |
| eslicarbazepine (APTIOM) | 4 years | 1,600 mg per day |
| oxcarbazepine ER (OXTELLAR XR) | 6 years | 2 ,400 mg per day |
| **Hydantoins** |  |  |
| phenytoin ER (DILANTIN) 100mg capsules, suspension, Infatab |  | 1,000 mg loading dose  600 mg/day maintenance dose |
| **Lamotrigines** |  |  |
| lamotrigine IR (LAMICTAL) | 2 years | 500 mg per day |
| **Brivaracetam/Levetiracetam** | | lamotrigine (LAMICTAL ODT) | 2 years | 500 mg per day |
| lamotrigine ER (LAMICTAL XR) | 13 years | 600 mg per day |
| Levetiracetam IR tablet, ER tablet, solution | BRIVIACT (brivaracetam) solution, tablet    ELEPSIA XR (levetiracetam ER) tablet    KEPPRA (levetiracetam) tablet, solution    KEPRA XR (levetiracetam ER) tablet    Levetiracetam 250mg tablets for suspension    SPRITAM (levetiracetam) tablet | **Succinamides** |  |  |
| ethosuximide (ZARONTIN) | 3 years | 1,500 mg/day |
| methsuximide (CELONTIN) |  | Not listed |
| **Valproic Acid and Derivatives** |  |  |
| divalproex ER (DEPAKOTE ER) | 10 years | 60 mg/kg/day |
| **Topiramates** |  |  |
| topiramate (TOPAMAX) | 2 years | 400 mg per day |
| topiramate ER (QUDEXY XR) | 2 years | 400 mg per day |
| topiramate ER (TROKENDI XR) | 6 years | 400 mg per day |
| **Other** |  |  |
| cannabidiol (EPIDIOLEX) | 1 year | 25 mg/kg/day |
| **Other** | | cenobamate (XCOPRI) | 18 years | 400 mg per day |
| felbamate tablet, suspension | 2 years | 3,600 mg per day |
| \*Felbamate suspension    FELBATOL (felbamate) suspension    FELBATOL (felbamate) BNR  tablet    Lacosamide solution, tablet    Rufinamide tablet    Zonisamide capsule | BANZEL (rufinamide) suspension, tablet    DIACOMIT (stiripentol) capsule, powder packet    EPIDIOLEX (cannabidiol) solution    Felbamate tablet    FINTEPLA (fenfluramine) solution    FYCOMPA (perampanel) suspension, tablet    GABITRIL (tiagabine) tablet    Lacosamide UD solution |
| fenfluramine (FINTEPLA) | 2 years | 26 mg per day |
| lacosamide (VIMPAT) | 1 month | 400 mg per day |
| perampanel (FYCOMPA) | 4 years | 12 mg per day |
| rufinamide (BANZEL) tablet and suspension | 1 year | 3,200 mg per day |
| stiripentol (DIACOMIT) | 1. months   (weighing >   1. kg) | 3,000 mg per day |
| tiagabine | 12 years | 56 mg per day |
| tiagabine (GABITRIL) | 12 years | 56 mg per day |
| vigabatrin | 1 month | 3,000 mg per day |
| vigabatrin (SABRIL) | 1 month | 3,000 mg per day |
| vigabatrin (VIGADRONE) powder packet | 1 month | 3,000 mg per day |
| zonisamide (ZONEGRAN) | 16 years | 600 mg per day |
| \*\*Limits based on data from FDA package insert. Approval for age/dosing that falls outside of the indicated range may be evaluated on a case-by-case basis. | | |

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|  | MOTPOLY XR (lacosamide) capsule    Rufinamide suspension    SABRIL (vigabatrin) powder packet, tablet    Tiagabine tablet    Vigabatrin tablet, powder packet    VIGAFYDE (vigabatrin) solution    VIMPAT (lacosamide) solution, kit, tablet    XCOPRI (cenobamate) tablet, pack    ZONISADE (zonisamide) suspension    ZTALMY (ganaxolone) suspension |  |
| Therapeutic Drug Class: **NEWER GENERATION ANTI-DEPRESSANTS** -*Effective 4/1/2025* | | |
| **No PA Required**    Bupropion IR, SR, XL tablet    Citalopram solution, tablet    Desvenlafaxine succinate ER  (generic Pristiq) tablet    Duloxetine (generic Cymbalta) capsule    Escitalopram tablet    Fluoxetine capsule, solution, 60 mg tablet    Fluvoxamine tablet    Mirtazapine tablet, ODT    Paroxetine IR tablet    Sertraline solution, tablet | **PA Required**  ***Non-preferred brand name medications do not require a prior authorization when the***  ***equivalent generic is preferred and “dispense as written” is indicated on the prescription.***  APLENZIN (bupropion ER) tablet  AUVELITY ER (dextromethorphan/bupropion)  tablet  Bupropion XL (generic Forfivo XL) tablet  CELEXA (citalopram) tablet  Citalopram hydrobromide capsule  CYMBALTA (duloxetine) capsule  Desvenlafaxine fumarate ER tablet  DRIZALMA (duloxetine) sprinkle capsule  EFFEXOR XR (venlafaxine ER) capsule  Escitalopram solution | Non-preferred products may be approved for members who have failed adequate trial with two preferred newer generation anti-depressant products. If two preferred newer generation anti-depressant products are not available for indication being treated, approval of prior authorization for non-preferred products will require adequate trial of all preferred products FDA approved for that indication (failure is defined as lack of efficacy with 6-week trial, allergy, intolerable side effects, or significant drug-drug interaction).    **Zurzuvae** (zuranolone) may be approved if meeting the following criteria:   * Member is ≥ 18 years of age **AND** * Member has a diagnosis of postpartum depression based on Diagnostic and Statistical Manual of Mental Disorders (DSM-5) criteria for a major depressive episode **AND** * Member is not currently pregnant **AND** * Prescriber attests that the member has been counseled and has been engaged in shared decision making with regard to:   + The importance of effective contraception during zuranolone treatment, as zuranolone may cause fetal harm **AND**   + Zuranolone is present in low levels in human breast milk and there are limited data on its effects on a breastfed infant **AND**   + Consideration for the favorable long-term safety data associated with use of SSRIs as first-line, recommended therapies for perinatal |

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| Trazodone tablet    Venlafaxine IR tablet    Venlafaxine ER capsules    Vilazodone tablet |  | FETZIMA (levomilnacipran ER) capsule, titration pack  Fluoxetine IR tablet, DR capsule  Fluvoxamine ER capsule  FORFIVO XL (bupropion ER) tablet  LEXAPRO (escitalopram) tablet  Nefazodone tablet  Paroxetine CR/ER tablet, suspension  Paroxetine mesylate capsule  PAXIL (paroxetine) tablet, suspension  PAXIL CR (paroxetine ER) tablet  PEXEVA (paroxetine mesylate) tablet  PRISTIQ (desvenlafaxine succinate ER) tablet  PROZAC (fluoxetine) Pulvule  REMERON (mirtazapine) Soltab (ODT), tablet  Sertraline capsule  TRINTELLIX (vortioxetine) tablet  Venlafaxine ER tablet  Venlafaxine besylate ER tablet  VIIBRYD (vilazodone) tablet, dose pack  WELLBUTRIN SR, XL (bupropion) tablet  ZOLOFT (sertraline) tablet, oral concentrate  ZURZUVAE (zuranolone) capsule | depressive disorders by the American College of Obstetricians and  Gynecologists (ACOG) or SNRIs as reasonable ACOG-recommended  alternatives  **AND**   * Prescriber attests that the member has been counseled to refrain from engaging in potentially hazardous activities requiring mental alertness, including driving, for ≥ 12 hours after each zuranolone dose **AND** * The member has been counseled to take the medication with 400 to 1,000 calories of food containing 25% to 50% fat **AND** * Prescriber verifies that concomitant medications have been assessed for potential drug interactions (CNS depressants, CYP3A4 inhibitors, CYP3A4 inducers) and any needed dosage adjustments for zuranolone have been made in accordance with package labeling **AND** * Baseline renal and hepatic function have been assessed and prescriber verifies   that dosing is appropriate in accordance with package labeling.    Quantity Limit:   * Zurzuvae 20 mg and 25 mg: 28 capsules/14 days * Zurzuvae 30 mg: 14 capsules/14 days   Maximum dose: 50 mg once daily  Duration of Approval: Approval will allow 30 days to fill for one 14-day course of treatment per postpartum period    **Citalopram** doses higher than 40mg/day for ≤60 years of age and 20mg/day for >60 years of age will require prior authorization. Please see the FDA guidance at:  <https://www.fda.gov/drugs/drugsafety/ucm297391.htm>for important safety information.    Members currently stabilized on a non-preferred newer generation antidepressant may receive approval to continue on that agent for one year if medically necessary.  **Verification may be provided from the prescriber or the pharmacy.** |
|  | Therapeutic Drug Class: **MONOAMINE OXIDASE INHIBITORS (MAOIs)** -*Effective 4/1/2025* | | |
|  |  | **PA Required**    EMSAM (selegiline) patch    MARPLAN (isocarboxazid) tablet    NARDIL (phenelzine) tablet    Phenelzine tablet | Non-preferred products may be approved for members who have failed adequate trial (8 weeks) with two preferred anti-depressant products. If two preferred anti-depressant products are not available for indication being treated, approval of prior authorization for non-preferred products will require adequate trial of all preferred anti-depressant products FDA approved for that indication. (Failure is defined as: lack of efficacy after 8-week trial, allergy, intolerable side effects, or significant drug-drug interaction) |

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|  | Tranylcypromine tablet | Members currently stabilized on a Non-preferred MAOi antidepressant may receive approval to continue that agent for one year if medically necessary. **Verification may be provided from the prescriber or the pharmacy.** |
| Therapeutic Drug Class: **TRICYCLIC ANTI-DEPRESSANTS (TCAs)** -*Effective 4/1/2025* | | |
| **No PA Required**      Amitriptyline tablet    Clomipramine capsule    Desipramine tablet    Doxepin 10mg, 25mg, 50mg, 75mg, 100mg, 150mg  capsule, oral concentrate    Imipramine HCl tablet    Nortriptyline capsule | **PA Required**  ***Non-preferred brand name medications do not require a prior authorization when the***  ***equivalent generic is preferred and “dispense as written” is indicated on the prescription.***    Amoxapine tablet    ANAFRANIL (clomipramine) capsule    Imipramine pamoate capsule    NORPRAMIN (desipramine) tablet    Nortriptyline solution    PAMELOR (nortriptyline) capsule    Protriptyline tablet    Trimipramine capsule | Non-preferred products may be approved for members who have failed adequate trial (8 weeks) with three preferred tricyclic products. If three preferred products are not available for indication being treated, approval of prior authorization for non-preferred products will require adequate trial of all tricyclic preferred products FDA approved for that indication. (Failure is defined as: lack of efficacy after 8-week trial, allergy, intolerable side effects, or significant drug-drug interaction)    Members currently stabilized on a non-preferred tricyclic antidepressant may receive approval to continue on that agent for one year if medically necessary. **Verification may be provided from the prescriber or the pharmacy.** |
| Therapeutic Drug Class: **ANTI-PARKINSON’S AGENTS** -*Effective 4/1/2025* | | |
| **Dopa decarboxylase inhibitors, dopamine precursors and combinations** | | |
| **No PA Required**    Carbidopa/Levodopa IR, ER  tablet    Carbidopa/Levodopa/Entacapone  tablet | **PA Required**    Carbidopa tablet    Carbidopa/Levodopa ODT    CREXONT ER (carbidopa/levodopa) capsule    DHIVY (carbidopa/levodopa) tablet    DUOPA (carbidopa/levodopa) suspension    INBRIJA (levodopa) capsule for inhalation    LODOSYN (carbidopa) tablet    RYTARY ER (carbidopa/levodopa) capsule | Non-preferred agents may be approved with adequate trial and failure of carbidopalevodopa IR and ER formulations (failure is defined as lack of efficacy with a 4-week trial, allergy, intolerable side effects or significant drug-drug interactions).    Carbidopa or levodopa single agent products may be approved for members with diagnosis of Parkinson’s Disease as add-on therapy to carbidopa-levodopa.    Non-preferred medications that are not prescribed for Parkinson’s Disease (or an indication related to Parkinson’s Disease) may receive approval for other FDA-labeled indications without meeting trial and failure step therapy criteria.    Members with history of trial and failure of a non-preferred Parkinson’s Disease agent that is the brand/generic equivalent of a preferred product (same strength, dosage form and active ingredient) may be considered as having met a trial and failure of the equivalent preferred. |

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|  | SINEMET (carbidopa/levodopa) IR tablet    STALEVO (carbidopa/levodopa/ entacapone)  tablet | Members currently stabilized on a non-preferred product may receive approval to continue therapy with that product. |
| **MAO-B inhibitors** | | |
| **No PA Required**    Rasagiline tablet    Selegiline capsule, tablet | **PA Required**    AZILECT (rasagiline) tablet    XADAGO (safinamide) tablet    ZELAPAR (selegiline) ODT | Non-preferred agents may be approved with adequate trial and failure of selegiline capsule or tablet (failure is defined as lack of efficacy with a 4-week trial, allergy, intolerable side effects or significant drug-drug interactions).    Non-preferred medications that are not prescribed for Parkinson’s Disease (or an indication related to Parkinson’s Disease) may receive approval for other FDA-labeled indications without meeting trial and failure step therapy criteria.    Members with history of trial and failure of a non-preferred Parkinson’s Disease agent that is the brand/generic equivalent of a preferred product (same strength, dosage form and active ingredient) may be considered as having met a trial and failure of the equivalent preferred.    Members currently stabilized on a non-preferred product may receive approval to continue therapy with that product. |
| **Dopamine Agonists** | | |
| **No PA Required**    Pramipexole IR tablet    Ropinirole IR tablet | **PA Required**    APOKYN (apomorphine) SC cartridge    Apomorphine SC cartridge    Bromocriptine capsule, tablet    KYNMOBI (apomorphine) SL film    MIRAPEX (pramipexole) ER tablet    NEUPRO (rotigotine) patch    PARLODEL (bromocriptine) capsule, tablet    Pramipexole ER tablet    Ropinirole ER tablet | Non-preferred agentsmay be approved with adequate trial and failure of ropinirole IR AND pramipexole IR (failure is defined as lack of efficacy with 4-week trial, documented contraindication to therapy, allergy, intolerable side effects or significant drug-drug interactions).    **APOKYN (apomorphine subcutaneous cartridge)** may be approved if meeting the following:   * APOKYN (apomorphine) is being used as an adjunct to other medications for acute, intermittent treatment of hypomobility, “off” episodes ("end-of-dose wearing off" and unpredictable "on/off" episodes) in patients with advanced Parkinson’s disease AND * Due to the risk of profound hypotension and loss of consciousness, member is not concomitantly using a 5HT3 antagonist such as ondansetron, granisetron, dolasetron, palonosetron or alosetron.     Maximum dose: 6mg (0.6mL) three times per day    **KYNMOBI (apomorphine sublingual film)** may be approved if meeting the following:   * KYNMOBI (apomorphine) is being used for the acute, intermittent treatment of   “off” episodes in patients with Parkinson's disease AND   * Due to the risk of profound hypotension and loss of consciousness, member must not be concomitantly using a 5HT3 antagonist such as ondansetron, granisetron, dolasetron, palonosetron or alosetron. |

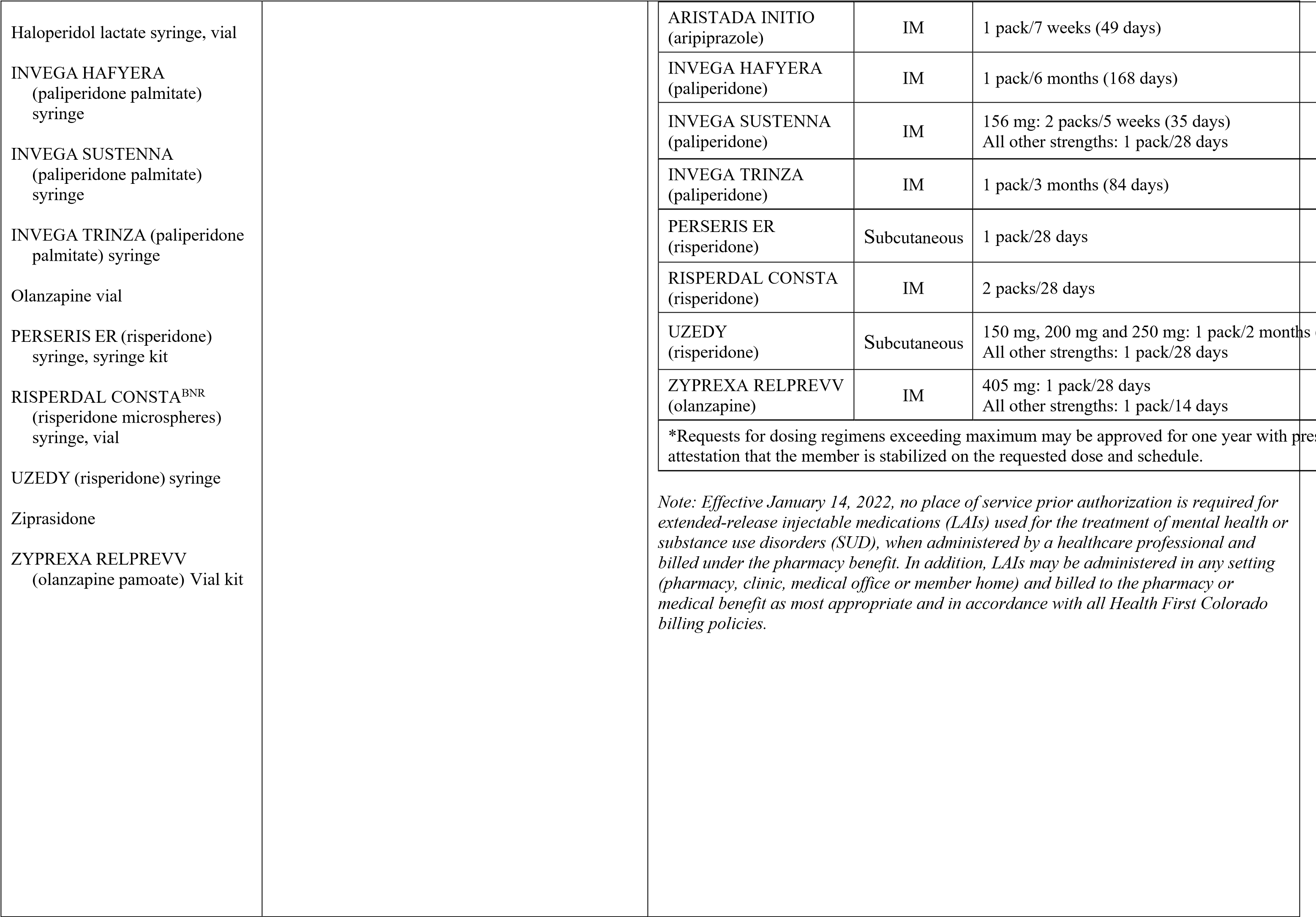
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|  |  | | Maximum dose: 30mg five times per day    Non-preferred medications that are not prescribed for Parkinson’s Disease (or an indication related to Parkinson’s Disease) may receive approval for other FDA-labeled indications without meeting trial and failure step therapy criteria.    Members with history of trial and failure of a non-preferred Parkinson’s Disease agent that is the brand/generic equivalent of a preferred product (same strength, dosage form and active ingredient) may be considered as having met a trial and failure of the equivalent preferred.    Members currently stabilized on a non-preferred product may receive approval to continue therapy with that product. |
| **Other Parkinson’s agents** | | | |
| **No PA Required** **PA Required**  Non-preferred agents may be approved with adequate trial and failure of two preferred  Amantadine capsule, Amantadine tablet agents (failure is defined as lack of efficacy with 4-week trial, documented solution/syrup contraindication to therapy, allergy, intolerable side effects or significant drug-drug  COMTAN (entacapone) tablet interactions).  Benztropine tablet  Entacapone tablet Non-preferred medications that are not prescribed for Parkinson’s Disease (or an  Trihexyphenidyl tablet, elixir indication related to Parkinson’s Disease) may receive approval for other FDA-labeled GOCOVRI ER (amantadine ER) capsule indications without meeting trial and failure step therapy criteria.    NOURIANZ (istradefylline) tablet Members with history of trial and failure of a non-preferred Parkinson’s Disease agent that is the brand/generic equivalent of a preferred product (same strength, dosage form  ONGENTYS (opicapone) capsule and active ingredient) may be considered as having met a trial and failure of the equivalent preferred.  OSMOLEX ER (amantadine) tablet  Members currently stabilized on a non-preferred product may receive approval to TASMAR (tolcapone) tablet continue therapy with that product.    Tolcapone tablet | | | |
| Therapeutic Drug Class: **BENZODIAZEPINES (NON-SEDATIVE HYPNOTIC)** *Effective 4/1/2025* | | | |
| **No PA Required**  **(\*may be subject to age limitations)**    Alprazolam IR, ER tablet\*    Chlordiazepoxide capsule\* | **PA Required**    Alprazolam ODT, oral concentrate    ATIVAN (lorazepam) tablet    Diazepam Intensol | Non-preferred products may be approved following trial and failure of three preferred agents. Failure is defined as lack of efficacy, contraindication to therapy, allergy, intolerable side effects, or significant drug-drug interactions.    Children: Prior authorization will be required for all agents when prescribed for children <18 years of age (with the exception of oral solution products) and may be approved with prescriber verification of necessity of use for member age. | |

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| Clonazepam tablet, ODT    Clorazepate tablet\*    Diazepam tablet\*, solution    Lorazepam tablet\*, oral concentrate    Oxazepam capsule\* | KLONOPIN (clonazepam) tablet    LOREEV (lorazepam ER) capsule    XANAX (alprazolam) tablet    XANAX XR (alprazolam ER) tablet | **Diazepam Intensol** may be approved following trial and failure of the preferred 5 mg/5 mL oral solution. Failure is defined as intolerable side effects, drug-drug interaction, or lack of efficacy.  All benzodiazepine anxiolytics will require prior authorization for members ≥ 65 years of age when exceeding 90 days of therapy.  Continuation of Therapy:   * Members < 65 years of age who are currently stabilized on a non-preferred benzodiazepine medication may receive approval to continue that medication. * Members < 18 years of age who are currently stabilized on a non-preferred oral solution product may receive authorization to continue that medication.     Prior authorization will be required for prescribed doses that exceed the maximum (Table 1). | | | | |
|  | **Table 1 Maximum Doses** | | |  |
| **Product** | **Maximum Daily Dose** | **Maximum Monthly Dose** |
| Alprazolam tablet | Adults ≥ 18 years: 10 mg/day | Total of 300 mg from all dosage forms per 30 days |
| Alprazolam ER tablet |
| Alprazolam ODT |
| XANAX (alprazolam)  tablet |
| XANAX XR  (alprazolam ER) tablet |
| Alprazolam Intensol oral concentrate 1 mg/mL |
| Clorazepate tablet | >12 years: 90 mg/day Children 9-12 years: up to 60 mg/day | Total of 2,700 mg  (adults) and 1,800 mg (children) from all tablet strengths per 30 days |
| TRANXENE  (clorazepate) T-Tab |
| Chlordiazepoxide capsule | Adults ≥ 18 years: 300 mg/day  Children 6-17 years: up to 40 mg/day (preoperative apprehension and anxiety) | Total of 9,000 mg  (adults) and 120 mg (children, pre-op therapy) from all tablet strengths per 30 days |
| Diazepam Intensol oral  concentrate 5 mg/mL    Diazepam solution 5 mg/5 mL | Adults ≥ 18 years: 40 mg/day  Members age 6 months  to 17 years: up to 10 mg/day | Total of 1200 mg  (adults) and 300 mg (pediatrics) from all dosage forms per 30 days |

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|  |  |  | Diazepam tablet |  |  |  |
| ATIVAN (lorazepam) Intensol concentrate 2 mg/mL | Adults ≥ 18 years: 10  mg/day Children: N/A | Total of 300 mg from all dosage forms per 30 days |
| ATIVAN (lorazepam)  tablet |
| Lorazepam oral  concentrated soln 2 mg/mL |
| Lorazepam tablet |
| Oxazepam capsule | Adults ≥ 18 years: 120 mg/day  Children 6-18 years: absolute dosage not established | Total of 3600 mg from all dosage forms per 30 days |
| Therapeutic Drug Class: **ANXIOLYTIC, NON- BENZODIAZEPINES -** *Effective 4/1/2025* | | | | | | |
| **No PA Required**    Buspirone tablet |  | | Non-preferred products may be approved following trial and failure of buspirone. Failure is defined as lack of efficacy, contraindication to therapy, allergy, intolerable side effects, or significant drug-drug interactions. | | | |
| Therapeutic Drug Class: **ATYPICAL ANTI-PSYCHOTICS - Oral** **and Topical**- *Effective 4/1/2025* | | | | | | |
| **No PA Required**  (unless indicated by \* in criteria; all products subject to dose and age limitations)    Aripiprazole tablet    Asenapine SL tablet    Clozapine tablet    Lurasidone tablet    Olanzapine tablet, ODT    Paliperidone ER tablet    Quetiapine IR tablet\*\*    Quetiapine ER tablet | **PA Required**    ***Non-preferred brand name medications do not require a prior authorization when the equivalent generic is preferred and “dispense as written” is indicated on the prescription.***    ABILIFY (aripiprazole) tablet, MyCite    Aripiprazole oral solution, ODT    CAPLYTA (lumateperone) capsule    COBENFY (xanomeline/trospium) capsule, starter pack    Clozapine ODT    CLOZARIL (clozapine) tablet, ODT    FANAPT (iloperidone tablet, titration pack) | | **\*Vraylar (cariprazine) or Rexulti (brexpiprazole)** may be approved for members after trial and failure of one preferred agent. Failure is defined as contraindication, lack of efficacy with 6-week trial, allergy, intolerable side effects, significant drug-drug interactions, or known interacting genetic polymorphism that prevents safe preferred product dosing.    Non-preferred products may be approved for members meeting all of the following:   * Medication is being prescribed for an FDA-Approved indication AND • Prescription meets dose and age limitations (Table 1) AND * Request meets one of the following: o Member has history of trial and failure of two preferred products with FDA approval for use for the prescribed indication (failure defined as lack of efficacy with 6-week trial, allergy, intolerable side effects (including rapid weight gain), contraindication, significant drug-drug interactions, or known interacting genetic polymorphism that prevents safe preferred product dosing) **OR**   o Prescriber attests that within the last year (365 days) the member has trialed and failed (been unsuccessfully treated with) a preferred antipsychotic medication that was used to treat the member’s diagnosis (failure defined as lack of efficacy with 6-week trial, allergy, intolerable side effects  (including rapid weight gain), significant drug-drug interactions, or known interacting genetic polymorphism that prevents safe preferred product | | | |

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| REXULTI (brexpiprazole) dose  pack, tablet\*    Risperidone ODT, oral solution, tablet    VRAYLAR (cariprazine) capsule\*    Ziprasidone capsule | GEODON (ziprasidone) capsule    INVEGA ER (paliperidone) tablet    LATUDA (lurasidone) tablet    LYBALVI (olanzapine/samidorphan) tablet    NUPLAZID (pimavanserin) capsule, tablet    Olanzapine/Fluoxetine capsule    OPIPZA (aripiprazole) film    RISPERDAL (risperidone) tablet, oral solution    SAPHRIS (asenapine) SL tablet    SECUADO (asenapine) patch    SEROQUEL IR (quetiapine IR) tablet\*\*\*    SEROQUEL XR (quetiapine ER) tablet    SYMBYAX (olanzapine/fluoxetine) capsule    VERSACLOZ (clozapine) suspension    ZYPREXA (olanzapine) tablet    ZYPREXA ZYDIS (olanzapine) ODT | dosing). Treatment must be under an FDA approved indication for a mental health condition or disorder.    Age Limits: All products including preferred products will require a PA for members younger than the FDA approved age for the agent (Table 1). Members younger than the FDA approved age for the agent who are currently stabilized on an atypical antipsychotic will be eligible for approval.  **Atypical Antipsychotic prescriptions for members under 5 years of age may require a provider-provider telephone consult with a child and adolescent psychiatrist (provided at no cost to provider or member).**    **\*\*Quetiapine IR** when given at subtherapeutic doses may be restricted for therapy. Low-dose quetiapine (<150mg/day) is only FDA approved as part of a drug titration schedule to aid patients in getting to the target quetiapine dose. PA will be required for quetiapine < 150mg per day except for utilization (when appropriate) in members 65 years or older. PA will be approved for members 10-17 years of age with approved diagnosis (Table 1) stabilized on <150mg quetiapine IR per day.    **Aripiprazole solution**: Aripiprazole tablet quantity limit is 2 tablets/day for pediatric members to allow for incremental dose titration and use of the preferred tablet formulation should be considered for dose titrations when possible and clinically appropriate. If incremental dose cannot be achieved with titration of the aripiprazole tablet for members < 18 years of age OR for members unable to swallow solid tablet dosage form, aripiprazole solution may be approved. For all other cases, aripiprazole solution is subject to meeting non-preferred product approval criteria listed above.    **Nuplazid (pimavanserin tartrate)** may be approved for the treatment of hallucinations and delusions associated with Parkinson’s Disease psychosis **AND** following trial and failure of therapy with quetiapine or clozapine, or clinical rationale is provided supporting why these medications cannot be trialed. Failure will be defined as contraindication, intolerable side effects, drug-drug interaction, or lack of efficacy.    **Abilify MyCite** may be approved if meeting all of the following:   * Member has history of adequate trial and failure of 5 preferred agents (one trial must include aripiprazole tablet). Failure is defined as lack of efficacy with 6week trial on maximally tolerated dose, allergy, intolerable side effects, significant drug-drug interactions AND * Information is provided regarding adherence measures being recommended by provider and followed by member (such as medication organizer or digital medication reminders) AND * Member has history of adequate trial and failure of 3 long-acting injectable formulations of atypical antipsychotics, one of which must contain aripiprazole (failure is defined as lack of efficacy with 8-week trial, contraindication, allergy, intolerable side effects, significant drug-drug interactions) AND * Abilify MyCite is being used with a MyCite patch and member is using a compatible mobile application. AND |

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|  |  | • Medication adherence information is being shared with their provider via a web portal or dashboard.    Quantity Limits: Quantity limits will be applied to all products (Table 1). In order to receive approval for off-label dosing, the member must have an FDA approved indication and must have tried and failed on the FDA approved dosing regimen.    Members currently stabilized on a non-preferred atypical antipsychotic may receive approval to continue therapy with that agent for one year. | | | |
| Therapeutic Drug Class: **ATYPICAL ANTI-PSYCHOTICS – Long Acting Injectables**- *Effective 10/1/2024* | | | | | |
| **No PA Required**    ABILIFY ASIMTUFII  (aripiprazole) syringe, vial    ABILIFY MAINTENA  (aripiprazole) syringe, vial    ARISTADA ER (aripiprazole lauroxil) syringe    ARISTADA INITIO (aripiprazole lauroxil) syringe    Chlorpromazine ampule, vial    Fluphenazine vial    Fluphenazine decanoate vial    HALDOL (haloperidol decanoate) ampule    Haloperidol decanoate ampule, vial | **PA Required**  ***Non-preferred brand name medications do not require a prior authorization when the equivalent generic is preferred and “dispense as written” is indicated on the prescription.***    GEODON (ziprasidone) vial    Risperidone microspheres ER vial    RYKINDO (risperidone microspheres) vial, vial kit    ZYPREXA (olanzapine) vial | Preferred products do not require prior authorization. All products are subject to meeting FDA-labeled dosing quantity limits listed in Table 1.    Non-preferred products may be approved for members meeting the following:   * Medication is being prescribed for an FDA-Approved indication AND * Prescription meets dose limitations (Table 1) AND * Member has history of trial and failure of one preferred product with FDA approval for use for the prescribed indication (failure is defined as lack of efficacy with 6-week trial, allergy, intolerable side effects, contraindication, significant drug-drug interactions, or known interacting genetic polymorphism that prevents safe preferred product dosing). | | | |
|  | **Table 1: FDA-Labeled Dosing Quantity Limits** | | |
| **Long-Acting injectable** | **Route** | **Quantity Limit** |
| ABILIFY ASIMTUFII  (aripiprazole) | IM | 1 pack/2 months (56 days) |
| ABILIFY MAINTENA  (aripiprazole) | IM | 1 pack/28 days |
| ARISTADA ER  (aripiprazole) | IM | 1,064 mg: 1 pack/2 months (56 days)  All other strengths: 1 pack/28 days |
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|  | **Table 1 Atypical Antipsychotics – FDA Approved Indication, Age Range, Quantity and Maximum Dose** | | | | | |  |
| **Brand** | **Generic** | **Approved Indications** | **Age Range** | **Maximum Daily**  **Dose by**  **Age/Indication** | **Quantity and Maximum Dose**  **Limitations** |
| ABILIFY | aripiprazole | Schizophrenia  Bipolar I Disorder  Bipolar I Disorder  Irritability w/autistic disorder  Tourette’s disorder  Adjunctive treatment of MDD | ≥ 13 years  ≥ 18 years  10-17 years  6-17 years  6-18 years  ≥ 18 years | 30 mg  30 mg  30 mg  15 mg  20 mg (weight-based) 15 mg | Maximum one tablet per day (maximum of two tablets per day allowable for members < 18 years of age to accommodate for incremental dose changes) |
| CAPLYTA | lumateperone | Schizophrenia  Bipolar I Disorder  Bipolar II Disorder | ≥ 18 years | 42 mg | Maximum dosage of 42mg per day |
| CLOZARIL | clozapine | Treatment-resistant schizophrenia  Recurrent suicidal behavior in schizophrenia or schizoaffective disorder | ≥ 18 years | 900 mg | Maximum dosage of 900mg per day |
| COBENFY | xanomeline and trospium | Schizophrenia | ≥ 18 years | 250 mg xanomeline and 60 mg trospium | Maximum two capsules per day |
| FANAPT | iloperidone | Schizophrenia  Bipolar I Disorder | ≥ 18 years | 24 mg | Maximum two tablets per day |
| GEODON | ziprasidone | Schizophrenia  Bipolar I Disorder | ≥ 18 years  ≥ 18 years | 200 mg  160 mg | Maximum two capsules per day |
| INVEGA ER | paliperidone | Schizophrenia & schizoaffective disorder | ≥ 12 years and weight  ≥ 51 kg ≥ 12 years and weight < 51 kg | 12 mg    6 mg | Maximum two 6mg tablets per day; all other strengths 1 tablet per day |
| LATUDA | lurasidone | Schizophrenia  Schizophrenia  Bipolar I disorder  Bipolar I disorder | ≥ 18 years  13-17 years  ≥ 18 years  10–17 years | 160 mg  80 mg  120 mg  80 mg | Maximum one tablet per day (If dosing 160mg for schizophrenia, then max of two tablets per day) |
| LYBALVI | olanzapine and samidorphan | Schizophrenia in adults  Bipolar I disorder in adults | ≥ 18 years  ≥ 18 years | 20 mg olanzapine and 10 mg samidorphan | Maximum one tablet per day |
| NUPLAZID | pimavanserin | Parkinson's disease psychosis | ≥ 18 years | 34 mg | Maximum dosage of 34mg per day |
| RISPERDAL | risperidone | Schizophrenia  Schizophrenia  Bipolar mania  Irritability w/autistic disorder | ≥ 18 years  13-17 years  ≥ 10 years  5–17 years | 16 mg  6 mg  6 mg  3 mg | Maximum dosage of 16mg/day (4 tablet/day limitation applied in claims system to allow for dose escalation and tapering) |
| REXULTI | brexpiprazole | Schizophrenia  Adjunctive treatment of MDD | ≥ 13 years  ≥ 18 years | 4 mg  3 mg | Maximum of 3mg/day for MDD  adjunctive therapy, and agitation due to |

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|  |  |  | | Agitation associated with Alzheimer's disease (AD) | |  |  | AD, Maximum of 4mg/day for schizophrenia |  |
| SAPHRIS | asenapine | | Schizophrenia  Bipolar mania or mixed episodes | | ≥ 18 years  ≥ 10 years | 20 mg  20 mg | Maximum two tablets per day |
| SECUADO | asenapine patch | | Schizophrenia | | ≥ 18 years | 7.6 mg/ 24 hours | Maximum 1 patch per day |
| SEROQUEL | quetiapine | | Schizophrenia  Schizophrenia  Bipolar I mania or mixed  Bipolar I mania or mixed  Bipolar I depression  Bipolar I Disorder Maintenance | | ≥ 18 years  13-17 years  ≥ 18 years  10-17 years  ≥ 18 years  ≥ 18 years | 750 mg  800 mg  800 mg  600 mg  300 mg  800 mg | Maximum three tablets per day |
| SEROQUEL XR | quetiapine ER | | Schizophrenia  Bipolar I mania  Bipolar I mania  Bipolar I depression  Adjunctive treatment of MDD | | ≥ 13 years  ≥ 18 years  10-17 years  ≥ 18 years  ≥ 18 years | 800 mg  800 mg  600 mg  300 mg  300 mg | Maximum one tablet per day (for 300mg & 400mg tablets max 2 tablets per day) |
| SYMBYAX | olanzapine/ fluoxetine | | Acute depression in Bipolar I Disorder Treatment resistant depression (MDD) | | ≥ 10 years | 12 mg olanzapine/  50 mg fluoxetine | Maximum three capsules per day (18mg olanzapine/75mg fluoxetine) |
| VERSACLOZ | clozapine | | Treatment-resistant schizophrenia Recurrent suicidal behavior in  schizophrenia or schizoaffective disorder | | ≥ 18 years  ≥ 18 years | 900 mg | Maximum dosage of 900 mg per day |
| VRAYLAR | cariprazine | | Schizophrenia  Acute manic or mixed episodes with Bipolar I disorder  Depressive episodes with Bipolar I disorder  Adjunctive treatment of MDD | | ≥ 18 years  ≥ 18 years    ≥ 18 years  ≥ 18 years | 6 mg  6 mg    3 mg  3 mg | Maximum dosage of 6mg/day |
| ZYPREXA ZYPREXA  ZYDIS | olanzapine | | Schizophrenia  Acute manic or mixed episodes with Bipolar I disorder | | ≥ 13 years | 20 mg | Maximum one tablet per day |
| Therapeutic Drug Class: **CALCITONIN GENE – RELATED PEPTIDE INHIBITORS (CGRPis)** -*Effective 4/1/2025* | | | | | | | | | |
| **PA Required for all agents** | | | | | \*Preferred agents may be approved if meeting the following criteria:    Preferred Medications for Migraine Prevention (must meet all of the following):   * The requested medication is being used as preventive therapy for episodic or chronic migraine AND * Member has diagnosis of migraine with or without aura AND | | | | |
| **Preferred**    \* AIMOVIG (erenumab-aooe) auto-injector | | | **Non-Preferred**    EMGALITY (galcanezumab-gnlm)  100 mg syringe    QULIPTA (atogepant) tablet | |

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| * AJOVY (fremanezumab-vfrm) auto-injector, syringe      * EMGALITY (galcanezumabgnlm) pen, 120 mg syringe      * NURTEC (rimegepant) ODT      * UBRELVY (ubrogepant) tablet | ZAVZPRET (zavegepant) nasal | * Member has tried and failed 2 oral preventive pharmacological agents listed as Level A per the most current American Headache Society/American Academy of Neurology guidelines (such as divalproex, topiramate, metoprolol, propranolol). Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction OR * If the prescribed medication is Nurtec, the member has tried and failed two preferred injectable product formulations. Failure is defined as lack of efficacy, contraindication to therapy, allergy, intolerable side effects, significant drug-drug interaction, severe needle phobia, or member (or parent/caregiver) is unable to administer preferred CGRP inhibitor injectable formulation due to limited functional ability (such as vision impairment, limited manual dexterity and/or limited hand strength).     Preferred Medications for Acute Migraine Treatment (must meet all of the following):   * The requested medication is being used as acute treatment for migraine headache AND * Member has history of trial and failure of two triptans (failure is defined as lack of efficacy with 4-week trial, contraindication to therapy, allergy, intolerable side effects, or significant drug-drug interaction, severe needle phobia, or member (or parent/caregiver) is unable to administer preferred triptan injectable formulation due to limited functional ability (such as vision impairment, limited manual dexterity and/or limited hand strength).     Non-Preferred Medications for Migraine Prevention (must meet all of the following):     * The requested medication is being used as preventive therapy for episodic or chronic migraine AND * Member has diagnosis of migraine with or without aura AND * Member has tried and failed two oral preventive pharmacological agents listed as Level A per the most current American Headache Society/American Academy of Neurology guidelines (such as divalproex, topiramate, metoprolol, propranolol). Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction AND * The requested medication is not being used in combination with another CGRP medication   AND   * The member has history of adequate trial and failure of three preferred products indicated for preventive therapy (failure is defined as lack of efficacy with 4-week trial, contraindication to therapy, allergy, intolerable side effects, significant drug-drug interaction, severe needle phobia, or member (or parent/caregiver) is unable to administer preferred triptan injectable formulation due to limited functional ability (such as vision impairment, limited manual dexterity and/or limited hand strength).     Non-Preferred Medications for Acute Migraine Treatment (must meet all of the following):   * Member is 18 years of age or older AND * Medication is being prescribed to treat migraine headache with moderate to severe pain   AND   * The requested medication is not being used in combination with another CGRP medication   AND   * Member has history of trial and failure with all of the following (failure is defined as lack of |

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|  |  | efficacy with 4-week trial, allergy, contraindication, intolerable side effects, or significant drug-drug interaction):   * Two triptans AND * One NSAID agent AND * One preferred agent indicated for acute migraine treatment     Non-Preferred Medications for Treatment of Episodic Cluster Headache (must meet all of the following):   * Member is 19-65 years of age AND * Member meets diagnostic criteria for episodic cluster headache (has had no more than 8 attacks per day, a minimum of one attack every other day, and at least 4 attacks during the week prior to this medication being prescribed) AND * Member is not taking other preventive medications to reduce the frequency of cluster headache attacks AND * Member has history of trial and failure of all of the following (failure is defined as lack of efficacy with 4-week trial, contraindication to therapy, allergy, intolerable side effects, or significant drug-drug interaction): o Oxygen therapy AND   o Sumatriptan subcutaneous or intranasal OR zolmitriptan intranasal   * Initial authorization will be limited to 8 weeks. Continuation (12-month authorization) will require documentation of clinically relevant improvement with no less than 30% reduction in headache frequency in a 4-week period.     Age Limitations:    All products: ≥ 18 years     |  |  | | --- | --- | | **Table 1. Calcitonin Gene-Related Peptide Inhibitor Quantity Limits** | | | **Drug Name** | **Maximum Dosing** | | Aimovig (erenumab) | one 140 mg autoinjector per 30 days | | Ajovy (fremanezumab) | one 225 mg autoinjector or syringe per 30 days or three 225 mg autoinjectors or syringes every 90 days | | Emgality 100mg (galcanezumab) | three 100 mg prefilled syringes per 30 days | | Emgality 120 mg (galcanezumab) | two 120 mg pens or prefilled syringes once as first loading dose then one 120 mg pen or prefilled syringe per 30 days | | Nurtec (rimegepant) | Prevention: 16 tablets/30 days; Acute Treatment: 8 tablets/30 days | | Qulipta (atogepant) | 30 tablets/30 days | | Ubrelvy 50 mg (ubrogepant) | 16 tablets/30 days | | Ubrelvy 100 mg (ubrogepant) | 16 tablets/30 days | | ZAVZPRET (zavegepant) | 6 unit-dose nasal spray devices per 30 days |     Members with current prior authorization approval on file for a preferred agent may receive approval |

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|  |  | for continuation of therapy with the preferred agent. | | |
| Therapeutic Drug Class: **LITHIUM AGENTS** -*Effective 4/1/2025* | | | | |
| **No PA Required**    Lithium carbonate capsule, tablet    Lithium citrate solution    Lithium ER tablet | **PA Required**    ***Non-preferred brand name medications do not require a prior authorization when the equivalent generic is preferred and “dispense as written” is indicated on the prescription.***    LITHOBID ER (lithium ER) tablet | | Non-preferred products may be approved with trial and failure of one preferred agent (failure is defined as lack of efficacy with 6-week trial, allergy, intolerable side effects, significant drug-drug interactions, intolerance to dosage form).  Members currently stabilized on a non-preferred product may receive approval to continue therapy with that product. | |
| Therapeutic Drug Class: **NEUROCOGNITIVE DISORDER AGENTS** -*Effective 4/1/2025* | | | | |
| **Preferred**  **\*Must meet eligibility criteria**    \*Donepezil 5mg, 10mg tablet    \*Donepezil ODT    \*Galantamine IR tablet    \*Memantine IR tablet, dose pack    \*Memantine ER capsule    \*Rivastigmine capsule, patch | **Non-Preferred**  **PA Required**    ADLARITY (donepezil) patch    ARICEPT (donepezil) tablet    Donepezil 23mg tablet    EXELON (rivastigmine) patch    Galantamine solution, ER capsule    Memantine IR solution    MESTINON (pyridostigmine) IR/ER tablet, syrup    Nemantine/donepezil ER capsule,    NAMZARIC (memantine/donepezil ER) capsule, dose pack    Pyridostigmine syrup, IR/ER tablet | | | **\*Eligibility criteria for Preferred Agents –** Preferred products may be approved for a diagnosis of neurocognitive disorder (eligible for AutoPA automated approval).    Non-preferred products may be approved if the member has failed treatment with one of the preferred products in the last 12 months. (Failure is defined as lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions)    Members currently stabilized on a non-preferred product may receive approval to continue on that agent for one year if medically necessary and if there is a diagnosis of neurocognitive disorder. |
| Therapeutic Drug Class: **SEDATIVE HYPNOTICS** *-Effective 4/1/2025* | | | | |

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|  | | **Non-Benzodiazepines** | |
| **Preferred**  **No PA Required\***  **(Unless age, dose, or duplication criteria apply)**    Eszopiclone tablet    Ramelteon tablet    Zaleplon capsule    Zolpidem IR, ER tablet | **Non-Preferred**  **PA Required**    AMBIEN (zolpidem) tablet    AMBIEN CR (zolpidem ER) tablet    BELSOMRA (suvorexant) tablet    DAYVIGO (lemoborexant) tablet    Doxepin tablet    EDLUAR (zolpidem) SL tablet    HETLIOZ (tasimelteon) capsule    HETLIOZ LQ (tasimelteon) suspension    LUNESTA (eszopiclone) tablet    QUVIVIQ (daridorexant) tablet    ROZEREM (ramelteon) tablet    SILENOR (doxepin) tablet    Tasimelteon capsule    Zolpidem capsule, SL tablet |  | Non-preferred non-benzodiazepine sedative hypnotics may be approved for members who have failed treatment with two preferred non-benzodiazepine agents (failure is defined as lack of efficacy with a 2-week trial, allergy, intolerable side effects, or significant drug-drug interaction).    Children: Prior authorization will be required for all agents for members < 18 years of age.    Duplications: Only one agent in the sedative hypnotic drug class will be approved at a time (concomitant use of agents in the same sedative hypnotic class or differing classes will not be approved).    All sedative hypnotics will require prior authorization for members ≥ 65 years of age when exceeding 90 days of therapy.    **Belsomra** (suvorexant) may be approved for adult members that meet the following:   * Member has trialed and failed therapy with two preferred agents (failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction)   AND   * Member is not receiving strong CYP3A4 inhibitors (such as erythromycin, clarithromycin, telithromycin, itraconazole, ketoconazole, posaconazole, fluconazole, voriconazole, delavirdine, and milk thistle) or strong CYP3A4 inducers (such as carbamazepine, oxcarbazepine, phenobarbital, phenytoin, rifampin, rifabutin, rifapentine, dexamethasone, efavirenz, etravirine, nevirapine, darunavir/ritonavir, ritonavir, and St John’s Wort) AND * Member does not have a diagnosis of narcolepsy     **Dayvigo** (lemborexant) may be approved for adult member that meet the following:   * Member has trialed and failed therapy with two preferred agents AND Belsomra (surovexant). Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction AND * Member is not receiving strong CYP3A4 inhibitors (such as erythromycin, clarithromycin, telithromycin, itraconazole, ketoconazole, posaconazole, fluconazole, voriconazole, delavirdine, and milk thistle) or strong CYP3A4 inducers (such as carbamazepine, oxcarbazepine, phenobarbital, phenytoin, rifampin, rifabutin, rifapentine, dexamethasone, efavirenz, etravirine, nevirapine, darunavir/ritonavir, ritonavir, and St John’s Wort) AND * Member does not have a diagnosis of narcolepsy     **Hetlioz (tasimelteon) capsules** may be approved for members meeting the following criteria:   * Member is ≥18 years of age and has a documented diagnosis of Non-24-hour sleep wake disorder (Non-24) OR * Member is ≥16 years of age and has a documented diagnosis of nighttime sleep disturbances in Smith-Magenis syndrome (SMS)   AND |

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|  |  | * The requested medication is being prescribed by a sleep specialist or a practitioner who has sufficient education and experience to safely prescribe tasimelteon   **Hetlioz LQ (tasimelteon) oral suspension** may be approved for members meeting the following criteria:   * Member is 3 to 15 years of age and has a documented diagnosis of nighttime sleep disturbances in Smith-Magenis Syndrome (SMS) * AND the requested medication is being prescribed by a sleep specialist or a practitioner who has sufficient education and experience to safely prescribe tasimelteon.   **Silenor** (**doxepin)** may be approved for adult members that meet ONE of the following criteria:   * Member has tried and failed two preferred oral sedative hypnotics (Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) OR * Provider attests to the medical necessity of prescribing individual doxepin doses of less than 10 mg, OR * Member’s age is ≥ 65 years   Prior authorization will be required for prescribed doses exceeding maximum (Table 1) below. |
| **Benzodiazepines** | | |
| **Preferred**  **No PA Required\***  **(Unless age, dose, or duplication criteria apply)**    Temazepam 15mg, 30mg capsule    Triazolam tablet | **Non-Preferred**  **PA Required**    DORAL (quazepam) tablet    Estazolam tablet    Flurazepam capsule    HALCION (triazolam) tablet    Quazepam tablet    RESTORIL (temazepam) capsule    Temazepam 7.5mg, 22.5mg capsule | Non-preferred benzodiazepine sedative hypnotics may be approved for members who have trialed and failed therapy with two preferred benzodiazepine agents (failure is defined as lack of efficacy with a 2-week trial, allergy, intolerable side effects, or significant drug-drug interaction).    Temazepam 22.5 mg may be approved if the member has trialed and failed temazepam 15mg or 30mg AND one other preferred product (failure is defined as lack of efficacy with a 2-week trial, allergy, intolerable side effects, or significant drug-drug interaction).    Temazepam 7.5 mg may be approved if provider attests to the medical necessity of prescribing individual temazepam doses of less than 15 mg.    Children: Prior authorization will be required for all sedative hypnotic agents when prescribed for members < 18 years of age.    Duplications: Only one agent in the sedative hypnotic drug class will be approved at a time (concomitant use of agents in the same sedative hypnotic class or differing classes will not be approved).    All sedative hypnotics will require prior authorization for member’s ≥ 65 years of age when exceeding 90 days of therapy.    Members currently stabilized on a non-preferred benzodiazepine medication may receive authorization to continue that medication. |

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|  |  | Prior authorization will be required for prescribed doses exceeding maximum (Table 1). | |
| |  |  |  | | --- | --- | --- | | **Table 1: Sedative Hypnotic Maximum Dosing** | | | | **Brand** | **Generic** | **Maximum Dose** | | Non-Benzodiazepine | | | | Ambien CR | Zolpidem CR | 12.5 mg/day | | Ambien IR | Zolpidem IR | 10 mg/day | | Belsomra | Suvorexant | 20 mg/day | | Dayvigo | Lemborexant | 10 mg/day | | Edluar | Zolpidem sublingual | 10 mg/day | | - | Zolpidem sublingual | Men: 3.5mg/day Women: 1.75 mg/day | | Hetlioz | Tasimelteon capsule | 20 mg/day | | Hetlioz LQ | Tasimelteon liquid | ≤ 28 kg: 0.7 mg/kg/day  > 28 kg : 20 mg/day | | Lunesta | Eszopiclone | 3 mg/day | | Quviviq | Daridorexant | 50 mg/day | | - | Zaleplon | 20 mg/day | | Rozerem | Ramelteon | 8 mg/day | | Benzodiazepine | | | | Halcion | Triazolam | 0.5 mg/day | | Restoril | Temazepam | 30 mg/day | | Silenor | Doxepin | 6mg/day | | - | Estazolam | 2 mg/day | | - | Flurazepam | 30 mg/day | | Doral | Quazepam | 15 mg/day | | | | |
| Therapeutic Drug Class: **SKELETAL MUSCLE RELAXANTS** -*Effective 4/1/2025* | | | |
| **No PA Required**  **(\*if under 65 years of age)**    Baclofen tablet    Cyclobenzaprine tablet    Methocarbamol tablet    Tizanidine tablet | **PA Required**    AMRIX ER (cyclobenzaprine ER) capsule    Baclofen solution, suspension    Carisoprodol tablet    Carisoprodol/Aspirin tablet    Chlorzoxazone tablet    Cyclobenzaprine ER capsule | | All agents in this class will require a PA for members 65 years of age and older. The maximum allowable approval will be for a 7-day supply.    Authorization for any **CARISOPRODOL** product will be given for a maximum 3-week one-time authorization for members with acute, painful musculoskeletal conditions who have failed treatment with three preferred products within the last 6 months.    \***Dantrolene** may be approved for members who have trialed and failed‡ one preferred agent and meet the following criteria:   * Documentation of age-appropriate liver function tests AND * One of following diagnoses: Multiple Sclerosis, Cerebral Palsy, stroke, upper motor neuron disorder, or spinal cord injury * Dantrolene will be approved for the period of one year |

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|  | DANTRIUM (dantrolene) capsule    \*Dantrolene capsule    FEXMID (cyclobenzaprine) tablet    FLEQSUVY (baclofen) solution    LORZONE (chlorzoxazone) tablet    LYVISPAH (baclofen) granules    Metaxalone tablet    NORGESIC/NORGESIC FORTE  (orphenadrine/aspirin/ caffeine) tablet    Orphenadrine ER tablet    Orphenadrine/Aspirin/Caffeine tablet    SOMA (carisoprodol) tablet    Tizanidine capsule    ZANAFLEX (tizanidine) capsule, tablet | ● If a member is stabilized on dantrolene, they may continue to receive approval    All other non-preferred skeletal muscle relaxants may be approved for members who have trialed and failed‡ three preferred agents. ‡Failure is defined as: lack of efficacy with 14-day trial, allergy, intolerable side effects, contraindication to, or significant drugdrug interactions. |
| Therapeutic Drug Class: **STIMULANTS AND RELATED AGENTS** -*Effective 4/1/2025* | | |
| **Preferred**  **\*No PA Required (if age, max daily dose, and diagnosis met)**    *Brand/generic changes effective*  *08/08/2024*    Amphetamine salts, mixed ER  (generic Adderall XR) capsule    Amphetamine salts, mixed  (generic Adderall IR) tablet    Armodafinil tablet    Atomoxetine capsule    Clonidine ER tablet | **Non-Preferred**  **PA Required**    ADDERALL IR (amphetamine salts, mixed IR)  tablet    ADDERALL XR (amphetamine salts, mixed ER) capsule    ADZENYS XR-ODT (amphetamine)    Amphetamine tablet (generic Evekeo)    APTENSIO XR (methylphenidate ER) capsule    AZSTARYS (serdexmethylphenidate/ dexmethylphenidate) capsule | \*Preferred medications may be approved through AutoPA for indications listed in Table  1 (preferred medications may also receive approval for off-label use for fatigue associated with multiple sclerosis).    Non-preferred medications may be approved for members meeting the following criteria (for Sunosi (solriamfetol) and Wakix (pitolisant), refer to specific criteria listed below):   * Prescription meets indication/age limitation criteria (Table 1) **AND** • If member is ≥ 6 years of age: o Has documented trial and failure‡ with three preferred products in the last 24 months **AND**   o If the member is unable toswallow solid oral dosage forms, two of the trials must be methylphenidate solution, dexmethylphenidate ER, Vyvanse, Adderall XR, or any other preferred product that can be taken without the need to swallow a whole capsule.  **OR**   * If member is 3–5 years of age: |

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| DAYTRANABNR  (methylphenidate) patch    Dexmethylphenidate IR tablet    Dexmethylphenidate ER capsule    Guanfacine ER tablet    Methylphenidate (generic Methylin/Ritalin) solution, tablet    Methylphenidate ER tablet  (generic Concerta)    Modafinil tablet    VYVANSEBNR  (lisdexamfetamine) capsule | CONCERTA (methylphenidate ER) tablet    COTEMPLA XR-ODT (methylphenidate ER)    DESOXYN (methamphetamine) tablet    DEXEDRINE (dextroamphetamine) Spansule    Dextroamphetamine ER capsule, solution, tablet    DYANAVEL XR (amphetamine) suspension, tablet    EVEKEO (amphetamine) ODT, tablet    FOCALIN (dexmethylphenidate) tablet, XR capsule    INTUNIV (guanfacine ER) tablet    JORNAY PM (methylphenidate) capsule    Lisdexamfetamine capsule, chewable tablet    Methamphetamine tablet    METHYLIN (methylphenidate) solution    Methylphenidate CD/ER/LA capsule, chewable tablet, ER tablet (generic Relexxi/Ritalin), patch    MYDAYIS ER (dextroamphetamine/ amphetamine) capsule    NUVIGIL (armodafinil) tablet      ONYDA XR (clonidine) suspension  PROCENTRA (dextroamphetamine) solution    PROVIGIL (modafinil) tablet    QELBREE (viloxazine ER) capsule | o Has documented trial and failure‡ with one preferred product in the last  24 months **AND** o **If the member is unable to** swallow solid oral dosage forms, the trial must be methylphenidate solution, dexmethylphenidate ER, Vyvanse, Adderall XR, or any other preferred product that can be taken without the need to swallow a whole capsule.    **SUNOSI** (solriamfetol) prior authorization may be approved if member meets the following criteria:   * Member is 18 years of age or older AND * Member has diagnosis of either narcolepsy or obstructive sleep apnea (OSA) and is experiencing excessive daytime sleepiness AND * Member does not have end stage renal disease AND * If Sunosi is being prescribed for OSA, member has 1 month trial of CPAP AND * Member has trial and failure‡ of modafinil AND armodafinil AND one other agent in stimulant PDL class.     **WAKIX** (pitolisant) prior authorization may be approved if member meets the following criteria:   * Member is 6 years of age or older **AND** * Member has diagnosis of narcolepsy and is experiencing excessive daytime sleepiness **AND** * Member does not have end stage renal disease (eGFR <15 mL/minute) **AND** * Member does not have severe hepatic impairment **AND** * Member has trial and failure‡ of modafinil **AND** armodafinil **AND** one other agent in the stimulant PDL class **AND** * Member has been counseled that Wakix may reduce the efficacy of hormonal contraceptives and counseled regarding use of an alternative non-hormonal method of contraception during Wakix therapy and for at least 21 days after discontinuing treatment.     Maximum Dose (all products): See Table 2    **Exceeding Maximum Dose:** Prior authorization may be approved for doses that are higher than the listed maximum dose (Table 2) for members meeting the following criteria:   * + Member is taking medication for indicated use listed in Table 1 **AND**   + Member has 30-day trial and failure‡ of three different preferred or nonpreferred agents at maximum doses listed in Table 2 **AND**   + Documentation of member’s symptom response to maximum doses of three other agents is provided **AND**   + Member is not taking a sedative hypnotic medication (such as temazepam, triazolam, or zolpidem from the Sedative Hypnotic PDL class). |

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|  | | QUILLICHEW ER (methylphenidate) chewable tablet, XR suspension    RELEXXII (methylphenidate ER) tablet    RITALIN (methylphenidate) IR/ER tablet, ER capsule    STRATTERA (atomoxetine) capsule    SUNOSI (solriamfetol) tablet    VYVANSE (lisdexamfetamine) chewable tablet    WAKIX (pitolisant) tablet    XELSTRYM (dextroamphetamine) patch    ZENZEDI (dextroamphetamine) tablet | | ‡Failure is defined as: lack of efficacy with 4-week trial, allergy, intolerable side effects, or significant drug-drug interaction. | |
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|  | **Table 1: Diagnosis and Age Limitations** | | | |  |
| * Approval for medically accepted indications not listed in Table 1 may be given with prior authorization review and may require submission of peer-reviewed literature or medical compendia showing safety and efficacy of the medication used for the prescribed indication. * Preferred medications may also receive approval for off-label use for fatigue associated with multiple sclerosis if meeting all other criteria for approval. * **Bolded drug names are preferred** (subject to preferential coverage changes for brand/generic equivalents) | | | |
| **Drug** | | **Diagnosis and Age Limitations** | |
| **Stimulants–Immediate Release** | | | |
| Amphetamine sulfate (EVEKEO) | | ADHD (Age ≥ 3 years), Narcolepsy (Age ≥ 6 years) | |
| **Dexmethylphenidate IR** (FOCALIN) | | ADHD (Age ≥ 6 years) | |
| Dextroamphetamine IR tablet (ZENZEDI) | | ADHD (Age 3 to16 years), Narcolepsy (Age ≥ 6 years) | |
| Dextroamphetamine solution (PROCENTRA) | | ADHD (Age 3 to 16 years), Narcolepsy (Age ≥ 6 years) | |
| Methamphetamine (DESOXYN) | | ADHD (Age ≥ 6 years) | |
| **methylphenidate IR** (generic METHYLIN, RITALIN) | | ADHD (Age ≥ 6 yearsϮ), Narcolepsy (Age ≥ 6 years), OSA.    ϮPrior Authorization for members 3-6 years of age with a diagnosis of ADHD may be approved with prescriber attestation to the following:   * Member’s symptoms have not significantly improved despite adequate behavior interventions AND * Member experiences moderate-to-severe continued disturbance in functioning AND * Prescriber has determined that the potential benefits of starting methylphenidate before the age of 6 years outweigh the potential harm of delaying treatment. | |
| **Mixed amphetamine salts** **IR** (generic ADDERALL) | | ADHD (Age ≥ 3 years), Narcolepsy (Age ≥ 6 years) | |

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|  | **Stimulants –Extended-Release** | |  |
| Amphetamine ER (ADZENYS XR-ODT and ADZENYS ER suspension) | ADHD (Age ≥ 6 years) |
| Amphetamine ER (DYANAVEL XR) | ADHD (Age ≥ 6 years) |
| Mixedamphetamine salts ER (**ADDERALL XR**) | ADHD (Age ≥ 6 years) |
| **Dexmethylphenidate ER** (generic Focalin XR) | ADHD (Age ≥ 6 years) |
|  | ADHD (Age 6 to 16 years), Narcolepsy (Age ≥ 6 years) |
|  | ADHD (Age ≥ 13 years) |
|  | ADHD (Age ≥ 6 years) |
| Lisdexamfetamine dimesylate (**VYVANSE capsule**, Vyvanse chewable) | ADHD (Age ≥ 6 years), Moderate to severe binge eating disorder in adults (Age ≥ 18 years) |
| Methylphenidate ER OROS **(CONCERTA)** | ADHD (Age ≥ 6 years), Narcolepsy (Age ≥ 6 years), OSA |
| Methylphenidate patch (DAYTRANA) | ADHD (Age ≥ 6 years) |
| Methylphenidate SR (METADATE ER) | ADHD (Age ≥ 6 years), Narcolepsy (Age ≥ 6 years) |
| Methylphenidate ER (METADATE CD) | ADHD (Age ≥ 6 years) |
| Methylphenidate ER (QUILLICHEW ER) | ADHD (Age 6 years to ≤ 65 years), Narcolepsy (Age ≥ 6 years) |
| Methylphenidate ER (QUILLIVANT XR) | ADHD (Age ≥ 6 years), Narcolepsy (Age ≥ 6 years) |
| Methylphenidate ER (RELEXXI ER) | ADHD (Age 6 to 65 years) |
| Methylphenidate ER (RITALIN LA) | ADHD (Age ≥ 6 years)    ϮPrior Authorization for members 4-6 years of age with a diagnosis of ADHD may be approved with prescriber attestation to the following:   * Member’s symptoms have not significantly improved despite adequate behavior interventions AND * Member experiences moderate-to-severe continued disturbance in functioning AND Prescriber has determined that the potential benefits of starting methylphenidate before the age of 6 years outweigh the potential harm of delaying treatment. |
| Methylphenidate ER (ADHANSIA XR) | ADHD (Age ≥ 6 years) |
| Methylphenidate ER (JORNAY PM) | ADHD (Age ≥ 6 years) |
| Methylphenidate XR (APTENSIO XR) | ADHD (Age ≥ 6 years) |
| Methylphenidate XR ODT (COTEMPLA XR-ODT) | ADHD (Age 6 to 17 years) |
| Serdexmethylphenidate/dexmethylphenidate (AZSTARYS) | ADHD (Age ≥ 6 years) |
| **Non-Stimulants** | |
| **Atomoxetine** (generic STRATTERA) | ADHD (Age ≥ 6 years) |
| Clonidine ER | ADHD as monotherapy or adjunctive therapy to stimulants (Age ≥ 6 years) |
| **Guanfacine ER** (generic INTUNIV) | ADHD as monotherapy or adjunctive therapy to stimulants (Age ≥ 6 years) |
| Viloxazine ER (QELBREE) | ADHD (Age ≥ 6 years) |

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|  | **Wakefulness-promoting Agents** | | | |  |
| **Armodafinil** (generic NUVIGIL) | | Excessive sleepiness associated with narcolepsy, OSA, SWD, and adjunct therapy to treat fatigue and sleepiness in patients with major depressive disorder (MDD) (Age ≥ 18 years) | |
| **Modafinil** (PROVIGIL) | | Excessive sleepiness associated with narcolepsy, OSA, SWD, and adjunct therapy to treat fatigue and sleepiness in patients with major depressive disorder (MDD), antipsychotic medication-related fatigue (Age ≥ 18 years) | |
| Pitolisant (WAKIX) | | Excessive sleepiness associated with narcolepsy (Age ≥ 6 years) | |
| Solriamfetol (SUNOSI) | | Excessive sleepiness associated with narcolepsy, OSA (Age ≥ 18 years) | |
| KEY: **ADHD**–attention-deficit/hyperactivity disorder, **OSA**–obstructive sleep apnea, **SWD**–shift work disorder | | | |
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| **Table 2: Maximum Dose** | | |  |
| **Drug** | **Maximum Daily Dose** | |
| ADDERALL | 60 mg | |
| ADDERALL XR | 60 mg | |
| ADHANSIA XR | 85 mg | |
| ADZENYS XR ODT ADZENYS ER SUSPENSION | 18.8 mg (age 6-12)  12.5 mg (age ≥ 13) | |
| AMPHETAMINE SALTS | 40 mg | |
| APTENSIO XR | 60 mg | |
| CONCERTA | 54 mg (age 6-12) or 72 mg (≥ age 13) | |
| AZSTARYS | 52.3 mg serdexmethylphenidate and  10.4 mg dexmethylphenidate | |
| CLONIDINE ER | 0.4 mg | |
| COTEMPLA XR-ODT | 51.8 mg | |
| DEXTROAMPHETAMINE ER | 60 mg | |
| DAYTRANA | 30 mg/9 hour patch (3.3 mg/hr) | |
| DESOXYN | 25 mg | |
| DEXEDRINE | 60 mg | |
| DYANAVEL XR | 20 mg | |
| EVEKEO | 60 mg | |
| FOCALIN | 20 mg | |
| FOCALIN XR | 40 mg | |
| GUANFACINE ER | 4 mg (age 6-12) or 7 mg (age ≥ 13) | |
| INTUNIV ER | 4 mg (age 6-12) or 7 mg (age ≥ 13) | |
| JORNAY PM | 100 mg | |
| METADATE CD | 60 mg | |
| METADATE ER | 60 mg | |
| METHYLIN | 60 mg | |
| METHYLIN ER | 60 mg | |
| METHYLIN SUSPENSION | 60 mg | |
| METHYLPHENIDATE | 60 mg | |
| METHYLPHENIDATE ER | 60 mg | |

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|  | MYDAYIS ER | | 25 mg (age 13-17) or 50 mg (age ≥ 18) | |  |
| NUVIGIL | | 250 mg | |
| PROCENTRA | | 60 mg | |
| PROVIGIL | | 400 mg | |
| QELBREE | | 400 mg (age 6-17) or 600 mg (age ≥ 18) | |
| QUILLICHEW ER | | 60 mg | |
| QUILLIVANT XR | | 60 mg | |
| RELEXXII | | 54 mg (ages 6-12) or 72 mg (≥ age 13) | |
| RITALIN IR | | 60 mg | |
| RITALIN SR | | 60 mg | |
| RITALIN LA | | 60 mg | |
| STRATTERA | | 100mg | |
| SUNOSI | | 150 mg | |
| VYVANSE CAPSULES AND CHEWABLE TABLETS | | 70 mg | |
| WAKIX | | 35.6 mg | |
| XELSTRYM ER PATCH | | 18 mg/9 hours | |
| ZENZEDI | | 60 mg | |
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| Therapeutic Drug Class: **TRIPTANS, DITANS AND OTHER MIGRAINE TREATMENTS - Oral -***Effective 4/1/2025* | | | | | |
| **No PA Required**  **(Quantity limits may apply)**    Eletriptan tablet (generic Relpax)    Naratriptan tablet (generic Amerge)    Rizatriptan tablet, ODT (generic Maxalt)    Sumatriptan tablet (generic Imitrex)    Zolmitriptan tablet (generic Zomig) | | **PA Required**    Almotriptan tablet    FROVA (frovatriptan) tablet    Frovatriptan tablet    IMITREX (sumatriptan) tablet    MAXALT/MAXALT MLT (rizatriptan) tablet, ODT    RELPAX (eletriptan) tablet    REYVOW (lasmiditan) tablet    Sumatriptan/Naproxen tablet    Zolmitriptan ODT    ZOMIG (zolmitriptan) tablet | | **Reyvow (lasmiditan)** may be approved if meeting the following:   * Member has trialed and failed three preferred products **OR** member is unable to use triptan therapy due to cardiovascular risk factors   **AND**   * Member has trialed and failed two preferred agents in the CGRP Inhibitors drug class indicated for the acute treatment of migraine.     All other non-preferred oral products may be approved for members who have trialed and failed three preferred oral products. Failure is defined as lack of efficacy with 4week trial, allergy, documented contraindication to therapy, intolerable side effects, or significant drug-drug interaction.    **Quantity Limits:**   |  |  | | --- | --- | | Amerge (naratriptan), Frova (frovatriptan), Imitrex (sumatriptan), Zomig (zolmitriptan) | 9 tabs/30 days | | Treximet (sumatriptan/naproxen) | 9 tabs/30 days | | Axert (almotriptan) and Relpax (eletriptan) | 6 tabs/30 days | | Maxalt (rizatriptan) | 12 tabs/30 days | | Reyvow (lasmiditan) | 8 tabs/30 days | | |
| Therapeutic Drug Class: **TRIPTANS, DITANS, AND OTHER MIGRAINE TREATMENTS - Non-Oral -***Effective 4/1/2025* | | | | | |
| **No PA Required** | | **PA Required** | |  | |

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| **(Quantity limits may apply)**    IMITREX (sumatriptan) nasal spray    Sumatriptan cartridge, pen injector    MIGRANALBNR  (dihydroergotamine) nasal spray    Sumatriptan nasal spray\*, vial | Dihydroergotamine injection, nasal spray    IMITREX (sumatriptan) cartridge, pen injector    TOSYMRA (sumatriptan) nasal spray    TRUDHESA (dihydroergotamine) nasal spray    ZEMBRACE SYMTOUCH (sumatriptan) auto-  injector    Zolmitriptan nasal spray    ZOMIG (zolmitriptan) nasal spray | **Zembrace Symtouch injection**, **Tosymra nasal spray**, or **Onzetra Xsail nasal powder** may be approved for members who have trialed and failed one preferred non-oral triptan products AND two oral triptan agents with different active ingredients. Failure is defined as lack of efficacy with 4-week trial, allergy, intolerable side effects, significant drugdrug interaction, or documented inability to take alternative dosage form.    All other non-preferred products may be approved for members who have trialed and failed one preferred non-oral triptan product AND one preferred oral triptan product. Failure is defined as lack of efficacy with 4-week trial, allergy, intolerable side effects or significant drug-drug interactions, documented inability to tolerate dosage form.    **Quantity Limits:**   |  |  | | --- | --- | | Dihydroergotamine mesylate vial 1mg/mL | 24 vials/ 28 days | | Imitrex (sumatriptan) injection | 4 injectors / 30 days | | Imitrex (sumatriptan) nasal spray | 6 inhalers / 30 days | | Migranal (dihydroergotamine mesylate) nasal spray | 8 nasal spray devices/ 30 days | | Onzetra Xsail (sumatriptan) nasal powder | 16 nosepieces / 30 days | | Tosymra (sumatriptan) nasal spray | 12 nasal spray devices / 30 days | | Zembrace Symtouch (sumatriptan) injection | 36mg / 30 days | | Zomig (zolmitriptan) nasal spray | 6 inhalers / 30 days |     Members currently utilizing a non-oral dihydroergotamine product formulation (based on recent claims history) may receive one year approval to continue therapy with that medication. |
| **V. Dermatological** | | |
| Therapeutic Drug Class: **ACNE AGENTS– Topical -***Effective 7/1/2024* | | |
| **Preferred**  **No PA Required (if age and diagnosis criteria are met\*)**    \*Adapalene gel    \*Adapalene/benzoyl peroxide gel  (generic Epiduo), gel pump  (generic Epiduo Forte)    \*Clindamycin phosphate gel, lotion, solution, medicated swab/pledget    \*Clindamycin/benzoyl peroxide gel jar (generic Benzaclin) | **Non-Preferred**  **PA Required**    ACANYA (clindamycin/benzoyl peroxide) gel, pump    Adapalene cream, gel pump, solution    ALTRENO (tretinoin) lotion    ARAZLO (tazarotene) lotion    ATRALIN (tretinoin) gel    BENZAMYCIN (erythromycin/benzoyl peroxide) gel | Authorization for all acne agents prescribed solely for cosmetic purposes will not be approved.    Preferred topical clindamycin and erythromycin products may be approved by AutoPA  verification of ICD-10 diagnosis code for acne vulgaris, psoriasis, cystic acne, comedonal acne, disorders of keratinization, neoplasms, folliculitis, hidradenitis suppurativa, or perioral dermatitis (erythromycin only). Approval of preferred topical clindamycin and erythromycin products for other medically accepted indications may be considered following clinical prior authorization review by a call center pharmacist.    All other preferred topical acne agents may be approved if meeting the following criteria:  • For members > 25 years of age, may be approved following prescriber verification that the medication is not being utilized for cosmetic purposes AND prescriber verification that the indicated use is for acne vulgaris, psoriasis, cystic acne, disorders of keratinization, neoplasms, or comedonal acne. These |

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| \*Clindamycin/benzoyl peroxide gel tube (generic Duac)    \*Dapsone gel    \*Erythromycin solution    \*Erythromycin/Benzoyl peroxide gel (generic Benzamycin)    \*Sulfacetamide sodium suspension    \*Sulfacetamide sodium/sulfur cleanser,    \*RETIN-ABNR (tretinoin) cream, gel | BP (sulfacetamide sodium/sulfur/urea) cleansing wash    CABTREO (adapalene/benzoyl peroxide/clindamycin) gel    CLEOCIN-T (clindamycin) lotion    CLINDACIN ETZ/PAC (clindamycin phosphate)  kit    CLINDAGEL gel    Clindamycin phosphate foam    Clindamycin/Benzoyl peroxide gel pump    Clindamycin/tretinoin gel    Dapsone gel pump    ERY/ERYGEL (erythromycin/ethanol) gel, medicated swabs/pads    Erythromycin gel    EVOCLIN (clindamycin) foam    FABIOR (tazarotene) foam    KLARON (sulfacetamide) suspension    NEUAC (clindamycin/benzoyl peroxide/emollient)  kit    ONEXTON (clindamycin/benzoyl peroxide) gel, gel pump    RETIN-A MICRO (tretinoin) (all products)    ROSULA (sulfacetamide sodium/sulfur) cloths, wash    SSS 10-5 (sulfacetamide sodium/sulfur) foam | medications are only eligible for prior authorization approval for the aforementioned diagnoses.   * For members ≤ 25 years of age, may be approved for a diagnosis of acne vulgaris, psoriasis, cystic acne, disorders of keratinization, neoplasms, or comedonal acne. Diagnosis will be verified through automated verification (AutoPA) of the appropriate corresponding ICD-10 diagnosis code related to the indicated use of the medication.     Non-preferred topical products may be approved for members meeting all of the following criteria:   * Member has trialed/failed three preferred topical products with different mechanisms (such as tretinoin, antibiotic). Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction AND * Prescriber verification that the medication is being prescribed for one of the following diagnoses: acne vulgaris, psoriasis, cystic acne, disorders of keratinization, neoplasms, or comedonal acne. |

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|  | Sulfacetamide sodium cleanser, cleansing gel, lotion, shampoo, wash    Sulfacetamide sodium/sulfur cream, pad, suspension, wash    SUMADAN/XLT (sulfacetamide sodium/sulfur) kit, wash    SUMAXIN/ CP/TS (sulfacetamide sodium/sulfur) kit, pads, suspension, wash  Tazarotene cream, foam, gel    Tretinoin (all products)    Tretinoin microspheres (all products)    WINLEVI (clascoterone) cream    ZIANA (clindamycin/tretinoin) gel |  |
| Therapeutic Drug Class: **ACNE AGENTS– ORAL ISOTRETINOIN -***Effective 7/1/2024* | | |
| **PA Required for all agents** | | Preferred products may be approved for adults and children ≥ 12 years of age for treating severe acne vulgaris or for treating moderate acne vulgaris in members unresponsive to conventional therapy.    Non-preferred products may be approved for members meeting the following:   * Member has trialed/failed one preferred agent (failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction)   AND   * Member is an adult or child ≥ 12 years of age with severe, recalcitrant nodulocystic acne and has been unresponsive to conventional therapy. |
| **Preferred**    AMNESTEEM capsule    CLARAVIS capsule    Isotretinoin 10 mg, 20 mg, 30 mg, 40 mg capsule (*Mayne-*  *Pharma, Upsher-Smith, Zydus only)*    ZENATANE capsule | **Non-Preferred**    ABSORICA capsule    ABSORICA LD capsule    Isotretinoin 10 mg, 20 mg, 30 mg, 40 mg capsule  (*All manufacturers except* *Mayne-*  *Pharma, Upsher-Smith, Zydus)*    Isotretinoin 25 mg, 35 mg capsule    MYORISAN capsule |
| Therapeutic Drug Class: **ANTI-PSORIATICS - Oral -***Effective 7/1/2024* | | |
| **No PA Required**  Acitretin capsule | **PA Required**  Methoxsalen capsule | Prior authorization for non-preferred oral agents may be approved with failure of two preferred anti-psoriatic agents, one of which must be a preferred oral agent. Failure is |

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|  |  | defined as lack of efficacy of a 4-week trial, allergy, intolerable side effects or significant drug-drug interaction. |
| Therapeutic Drug Class: **ANTI-PSORIATICS -Topical -***Effective 7/1/2024* | | |
| **No PA Required**  Calcipotriene cream, solution  TACLONEX SCALP BNR  (calcipotriene/betamethasone) suspension  TACLONEX  (calcipotriene/betamethasone) ointment | **PA Required**    Calcipotriene foam, ointment    Calcipotriene/betamethasone dipropionate ointment, suspension    Calcitriol ointment    DUOBRII (halobetasol/tazarotene) lotion    ENSTILAR (calcipotriene/betamethasone) foam    SORILUX (calcipotriene) foam    VTAMA (tapinarof) cream    ZORYVE 0.3% (roflumilast) cream | **ZORYVE (roflumilast)** may receive approval if meeting the following based on prescribed indication:    Seborrheic dermatitis (0.3% foam formulation)   * Member is ≥ 9 years of age AND * Member has a diagnosis of seborrheic dermatitis AND * Member does not have moderate or severe hepatic impairment (Child-Pugh B or   C) AND   * Medication is being prescribed by or in consultation with a dermatologist AND * If the affected area is limited to the scalp:   + Prescriber attests that member has been counseled regarding alternative treatment options, including over-the-counter (OTC) antifungal shampoo (such as selenium sulfide, zinc pyrithione) and OTC coal tar shampoo, when appropriate)   AND   * + Member has documented trial and failure (with a minimum 2-week treatment period) of at least one prescription product for seborrheic dermatitis, such as ketoconazole 2% antifungal shampoo or a topical corticosteroid. Failure is defined as lack of efficacy, allergy, intolerable side effects or significant drug-drug interaction. * If the affected area includes the face or body:   Member has documented trial and failure (with a minimum 2-week treatment period) with at least one product from ALL of the following categories (Failure is defined as lack of efficacy, allergy, intolerable side effects or significant drugdrug interaction):   * + Topical antifungal (such as ketoconazole, ciclopirox)   + Topical corticosteroid   + Topical calcineurin inhibitor (such as pimecrolimus, tacrolimus)   **AND**   * Member has been counseled that Zoryve foam is flammable. Fire, flame, or smoking during and immediately following application must be avoided. |

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|  |  | Plaque psoriasis (0.3% cream formulation)   * Member is ≥ 6 years of age AND * Member has a diagnosis of plaque psoriasis AND * Member has body surface area (BSA) involvement of ≤20% AND * Member does not have moderate or severe hepatic impairment (Child-Pugh B or   C) AND   * Medication is being prescribed by or in consultation with a dermatologist AND * If the affected area is limited to the scalp:   + Prescriber attests that member has been counseled regarding alternative treatment options, including over-the-counter (OTC) emollients, vitamin D analogs, and coal tar shampoo when appropriate   **AND**   * + Member has documented trial and failure (with a minimum 2-week treatment period) of a topical corticosteroid. Failure is defined as lack of efficacy, allergy, intolerable side effects or significant drug-drug interaction. * If the affected area includes the face or body:   o Member has documented trial and failure (with a minimum 2-week treatment period) of at least one product from ALL of the following categories. (Failure is defined as lack of efficacy, allergy, intolerable side effects or significant drug-drug interaction):     * + - Topical corticosteroid     - Topical calcineurin inhibitor (such as pimecrolimus, tacrolimus)     Quantity limit:  Foam or cream - 60 grams/30 days    Initial approval:  Foam or cream: 8 weeks  Reauthorization: Reauthorization for one year may be approved based on provider attestation that member’s symptoms improved during the initial 8 weeks of treatment and continuation of therapy is justified. |

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|  |  | Prior authorization for all other non-preferred topical agents may be approved with failure of two preferred topical agents. If non-preferred topical agent being requested is a combination product, trial of two preferred agents must include a preferred combination agent. Failure is defined as lack of efficacy of a 4-week trial, allergy, intolerable side effects or significant drug-drug interaction.    Preferred and non-preferred products that contain a corticosteroid ingredient (such as betamethasone) will be limited to 4 weeks of therapy. Continued use will require one week of steroid-free time in between treatment periods.    Members with >30% of their body surface area affected may not use Enstilar  (calcipotriene/betamethasone DP) foam or Taclonex (calcipotriene/betamethasone DP) ointment products as safety and efficacy have not been established. Members may not apply Zoryve (roflumilast) cream to >20% of affected body surface area, as safety and efficacy have not been established. |
| Therapeutic Drug Class: **IMMUNOMODULATORS, TOPICAL** – *Effective 7/1/2024* | | |
| **Atopic Dermatitis** | | |
| **No PA Required**    ELIDEL (pimecrolimus) creamBNR  Tacrolimus ointment | **PA Required**    EUCRISA (crisaborole) ointment    OPZELURA (ruxolitinib) cream    Pimecrolimus cream    ZORYVE (tapinarof) 0.15% cream, foam | **EUCRISA** (crisaborole) may be approved if the following criteria are met:   * Member is at least 3 months of age and older AND * Member has a diagnosis of mild to moderate atopic dermatitis AND * Member has a history of failure, contraindication, or intolerance to at least two medium-to high-potency topical corticosteroids for a minimum of 2 weeks OR is not a candidate for topical corticosteroids AND * Member must have tried and failed pimecrolimus and tacrolimus. Failure is defined as a lack of efficacy, allergy, intolerable side effects, contraindication to, or significant drug-drug interactions. AND * Eucrisa (crisaborole) must be prescribed by or in consultation with a dermatologist or allergist/immunologist.     **OPZELURA (ruxolitinib)** cream may be approved if the following criteria are met based on prescribed indication:    Atopic Dermatitis |

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|  |  | * Member is ≥ 12 years of age AND * Member is immunocompetent AND * Member has a diagnosis of mild to moderate atopic dermatitis AND * Member has body surface area (BSA) involvement of ≤20% AND * Medication is being prescribed by or in consultation with a dermatologist or allergist/immunologist AND * Member has a history of failure, contraindication, or intolerance to at least two medium-to high   potency topical corticosteroids for a minimum of 2 weeks OR is not a candidate for topical corticosteroids AND   * Member must have trialed and failed twice-daily pimecrolimus and tacrolimus. Failure is defined as a lack of efficacy, allergy, intolerable side effects, contraindication to, or significant drug-drug interaction AND * Member is not using Opzelura (ruxolitinib) cream along with a strong inhibitor of CYP3A4 (such as fluconazole ≥ 200 mg/day, ketoconazole, itraconazole, voriconazole, ritonavir) due to the potential for increased systemic exposure to ruxolitinib.     Nonsegmental Vitiligo   * Member is ≥ 12 years of age AND * Member is immunocompetent AND * Member has a diagnosis of stable nonsegmental vitiligo, defined as no increase in the size of existing lesions and the absence of new lesions in the previous 3 to 6 months, AND * Medication is being prescribed by or in consultation with a dermatologist   AND   * Member will be applying Opzelura (ruxolitinib) to ≤10% of body surface area (BSA) per application AND * Member has a history of failure, contraindication, or intolerance to at least two medium-to high-potency topical corticosteroids for a minimum of 2 weeks OR is not a candidate for topical corticosteroids AND * Member must have trialed and failed twice-daily pimecrolimus OR tacrolimus. Failure is defined as a lack of efficacy, allergy, intolerable side effects, contraindication to, or significant drug-drug interaction AND * Member is not using Opzelura (ruxolitinib) cream along with a strong inhibitor of CYP3A4 (such as fluconazole ≥ 200 mg/day, ketoconazole, itraconazole, voriconazole, ritonavir) due to the potential for increased systemic exposure to ruxolitinib.     Quantity limit: 60 grams/week |

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|  |  | All other non-preferred topical immunomodulator products may be approved for atopic dermatitis following adequate trial and failure‡ of one prescription topical corticosteroid AND two preferred agents. ‡Failure is defined as a lack of efficacy with one month trial, allergy, intolerable side effects, contraindication to, or significant drug-drug interactions. |
| **Antineoplastic Agents** | | |
| **Preferred**  **No PA Required**  **(Unless indicated\*)**    \*Diclofenac 3% gel (generic Solaraze)    Fluorouracil 5% cream (generic  Efudex)    Fluorouracil 2%, 5% solution | **Non-Preferred**  **PA Required**    Bexarotene gel    CARAC (fluorouracil) cream    EFUDEX (fluorouracil) cream    Fluorouracil 0.5% (generic Carac) cream    PANRETIN (alitretinoin) gel    TARGRETIN (bexarotene) gel    VALCHLOR (mechlorethamine) gel | \***Diclofenac 3% gel** (generic Solaraze) may be approved if the member has a diagnosis of actinic keratosis (AK).    **TARGRETIN** (bexarotene) gel or **VALCHLOR** (mechlorethamine) gel may be approved for members who meet the following criteria:   * Member is ≥ 18 years of age **AND** * Member has been diagnosed with Stage IA or IB cutaneous T-cell lymphoma (CTCL) **AND** * Member has refractory or persistent CTCL disease after other therapies OR has not tolerated other therapies **AND** * Member and partners have been counseled on appropriate use of contraception     Non-preferred agents may be approved for members who have failed an adequate trial of all preferred products FDA-approved for that indication. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction. |
| **Other Agents** | | |
| **No PA Required**    Imiquimod (generic Aldara) cream    Podofilox gel, solution | **PA Required**    CONDYLOX (podofilox) gel    HYFTOR (sirolimus) gel    Imiquimod (generic Zyclara) cream, cream pump    VEREGEN (sinecatechins) ointment    ZYCLARA (imiquimod) cream, cream pump | **Hyftor** (sirolimus) gel   * Member has a diagnosis of facial angiofibroma associated with tuberous sclerosis AND * Member is ≥ 6 years of age AND * Provider has evaluated, and member has received, all age-appropriate vaccinations as recommended by current immunization guidelines prior to initiating treatment with HYFTOR     Initial approval: 6 months    Reauthorization: An additional 6 months may be approved based on provider attestation that symptoms improved during the initial 6 months of treatment and the provider has assessed use of all vaccinations recommended by current immunization guidelines.    Maximum dose: one 10-gram tube/28 days    **Veregen** (sinecatechins) may be approved if the following criteria are met:   * Member has a diagnosis of external genital and/or perianal warts (Condylomata acuminata) AND |

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|  |  | * Member is ≥ 18 years of age AND Member is immunocompetent AND * Member has tried and failed two preferred products. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.     **Zyclara** (imiquimod) **2.5% cream** may be approved if the following criteria are met:   * Member has a diagnosis of clinically typical visible or palpable actinic keratoses (AK) of the full face or balding scalp AND * Member is ≥ 18 years of age AND * Member is immunocompetent AND * Member has tried and failed one preferred product in the Antineoplastic Agents class (such as diclofenac gel or fluorouracil) AND the preferred imiquimod (generic Aldara) product. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.   **Zyclara** (imiquimod) **3.75% cream** may be approved for:   * Treatment of clinically typical visible or palpable, actinic keratoses (AK) of the full face or balding scalp if the following criteria are met: * Member is ≥ 18 years of age AND * Member is immunocompetent AND * Member has tried and failed one preferred product from the   Antineoplastic Agents class (such as diclofenac gel or fluorouracil) AND the preferred imiquimod (generic Aldara) product. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.  **OR**   * Treatment of external genital and/or perianal warts (Condylomata acuminata) if the following criteria are met: * Member is ≥ 12 years of age AND * Member has tried and failed two preferred products. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.     All other non-preferred products may be approved for members who have trialed and failed all preferred products that are FDA-approved for use for the prescribed indication. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drugdrug interaction.    Quantity Limits: Aldara (imiquimod) cream has a quantity limit of 12 packets/28 days. |
| Therapeutic Drug Class: **ROSACEA AGENTS -***Effective 7/1/2024* | | |
| **No PA Required**    Azelaic acid gel (*Sandoz only)* | **PA Required**    Azelaic acid gel *(All other manufacturers)* | Prior authorization for non-preferred products in this class may be approved if meeting the following criteria for the prescribed diagnosis: |

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| FINACEA (azelaic acid) gel    FINACEA (azelaic acid) foam  Metronidazole cream, lotion    Metronidazole 0.75% gel | Brimonidine gel pump    \*Doxycycline monohydrate DR capsule (generic Oracea)    Ivermectin cream    Metronidazole 1% gel, gel pump    NORITATE (metronidazole) cream    RHOFADE (oxymetazoline) cream    ROSADAN (metronidazole/skin cleanser) cream  kit, gel kit | Rosacea:   * Member has a diagnosis of persistent (non-transient) facial erythema with inflammatory papules and pustules due to rosacea AND * Prescriber attests that medication is not being used solely for cosmetic purposes   AND   * Member has tried and failed two preferred agents of different mechanisms of action (Failure is defined as lack of efficacy with 4-week trial, allergy, intolerable side effects)     Demodex Blepharitis:  • Requests for non-preferred topical ivermectin cream may be approved for treatment of moderate to severe Demodex blepharitis    \*Doxycycline monohydrate DR (generic Oracea) may be approved if the following criteria are met:   * Member has taken generic doxycycline for a minimum of three months and failed therapy in the last 6 months. Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions AND * Member has history of an adequate trial/failure (8 weeks) of 2 other preferred agents (oral or topical). Failure is defined as lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions AND * Member is ≥ 18 years of age and has been diagnosed with rosacea with inflammatory lesions (papules and pustules) | |
| Therapeutic Drug Class: **TOPICAL STEROIDS** – *Effective 7/1/2024* | | | |
| **Low potency** | | | |
| **No PA Required**    DERMA-SMOOTHE-FS  (fluocinolone) 0.01% body  oil/scalp oilBNR    Desonide 0.05% cream, ointment    Fluocinolone 0.01% cream    Hydrocortisone (Rx) cream, lotion, ointment | **PA Required**  Alclometasone 0.05% cream, ointment    CAPEX (fluocinolone) 0.01% shampoo    Desonide 0.05% lotion    Fluocinolone 0.01% body oil, 0.01% scalp oil, 0.01% solution    PROCTOCORT (hydrocortisone) (Rx) 1% cream    SYNALAR (fluocinolone) 0.01% solution | | Non-preferred Low Potency topical corticosteroids may be approved following adequate trial and failure of two preferred agents in the Low Potency class (failure is defined as lack of efficacy with 4-week trial, allergy, intolerable side effects or significant drug-drug interactions). |

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|  | SYNALAR TS (fluocinolone/skin cleanser) Kit    TEXACORT (hydrocortisone) 2.5% solution |  |
| **Medium potency** | | |
| **No PA Required**    Betamethasone dipropionate  0.05% cream, lotion, ointment    Betamethasone valerate 0.1% cream, ointment    Fluocinolone 0.025% cream, 0.05% cream, 0.005%  ointment    Fluticasone cream, ointment    Hydrocortisone valerate 0.2% cream    Mometasone 0.1% cream, 0.1% ointment, 0.1% solution    Triamcinolone acetonide 0.025% cream, 0.1% cream, 0.025% ointment, 0.05% ointment, 0.1% ointment, 0.025%  lotion, 0.1% lotion    Triamcinolone 0.1% dental paste | **PA Required**    BESER (fluticasone) lotion, emollient kit    Betamethasone valerate 0.1% lotion, 0.12% foam    Clocortolone 0.1% cream, cream pump    CLODERM (clocortolone) 0.1% cream, cream pump    CUTIVATE (fluticasone) 0.05% cream, lotion    Diflorasone 0.05% cream    Fluocinolone 0.025% ointment    Fluocinonide-E 0.05% cream    Flurandrenolide 0.05% cream, lotion, ointment    Fluticasone 0.05% lotion    Hydrocortisone butyrate 0.1% cream, lotion, solution, ointment, lipid/lipocream    Hydrocortisone valerate 0.2% ointment    KENALOG (triamcinolone) spray    LOCOID (hydrocortisone butyrate) 0.1% lotion    LOCOID LIPOCREAM (hydrocortisone butyrateemollient) 0.1% cream    LUXIQ (betamethasone valerate) 0.12% foam    PANDEL (hydrocortisone probutate) 0.1% cream    Prednicarbate 0.1% cream, ointment | Non-preferred Medium Potency topical corticosteroids may be approved following adequate trial and failure of two preferred agents in the Medium Potency class (failure is defined as: lack of efficacy with 4-week trial, allergy, intolerable side effects or significant drug-drug interactions). |

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|  | PSORCON (diflorasone) 0.05% cream    SYNALAR (fluocinolone) 0.025% cream/kit, ointment/kit    Triamcinolone 0.147 mg/gm spray |  |
| **High potency** | | |
| **No PA Required**  **(\*unless exceeds duration of therapy)**    \* Betamethasone dipropionate  0.05% ointment    \*Betamethasone dipropionate/propylene glycol (augmented) 0.05% cream    \*Fluocinonide 0.05% cream,  0.05% gel, 0.05% solution,  0.05% ointment    \*Triamcinolone acetonide 0.5% cream, 0.5% ointment | **PA Required**    Amcinonide 0.1% cream, lotion    APEXICON-E (diflorasone/emollient) 0.05% cream    Desoximetasone 0.05%, 0.25% cream, 0.05% gel, 0.05%,  0.25% ointment    Diflorasone 0.05% ointment    Halcinonide 0.1% cream    HALOG (halcinonide) 0.1% cream, ointment, solution    TOPICORT (desoximetasone) 0.05%, 0.25% cream, 0.05% gel, 0.05%, 0.25% ointment | Non-preferred High Potency topical corticosteroids may be approved following adequate trial and failure of two preferred agents in the High Potency class (failure is defined as lack of efficacy with 4-week trial, allergy, intolerable side effects or significant drug-drug interactions).  \*All High Potency topical corticosteroids will require prior authorization beyond 4 weeks of therapy. The provider will be encouraged to transition to a medium or low potency topical steroid after this time has elapsed.  Claims for compounded products containing high-potency topical steroids will be limited to a maximum of 60 grams or 60 mL of a high-potency ingredient per 4-week treatment period. Claims exceeding this quantity limit will require prior authorization with prescriber’s justification for use of the product at the prescribed dose. |
| **Very high potency** | | |
| **No PA Required**  **(Unless exceeds duration of therapy\*)**    \*Betamethasone dipropionate/propylene glycol  (augmented) ,0.05% lotion  0.05% ointment    \*Clobetasol 0.05% cream, 0.05% gel, 0.05% ointment, 0.05%  solution    \*Fluocinonide 0.1% cream | **PA Required**    Betamethasone dipropionate/propylene glycol (augmented)  0.05% gel    BRYHALI (halobetasol) 0.01% lotion    Clobetasol emollient/emulsion 0.05% cream, foam    Clobetasol 0.05% lotion, foam, spray, shampoo    CLODAN (clobetasol) 0.05% cleanser kit    Desoximetasone 0.25% spray | Non-preferred Very High Potency topical corticosteroids may be approved following adequate trial and failure of clobetasol propionate in the same formulation as the product being requested (if the formulation of the requested non-preferred product is not available in preferred clobetasol product options, then trial and failure of any preferred clobetasol product formulation will be required). Failure is defined as lack of efficacy with 2-week trial, allergy, intolerable side effects or significant drug-drug interactions.  \*All Very High Potency topical corticosteroids will require prior authorization beyond 2 weeks of therapy. If clobetasol propionate shampoo is being used to treat plaque psoriasis, then prior authorization will be required beyond 4 weeks of therapy. The provider will be encouraged to transition to a medium or low potency topical steroid after this time has elapsed. |

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|  | DIPROLENE (betamethasone dipropionate/propylene glycol, augmented) 0.05% ointment    Halobetasol 0.05% cream, foam, ointment    IMPEKLO (clobetasol) 0.05% lotion    LEXETTE (halobetasol) 0.05% foam    OLUX (clobetasol) 0.05% foam    TOPICORT (desoximetasone) 0.25% spray    TOVET EMOLLIENT (clobetasol) 0.05% foam    ULTRAVATE (halobetasol) 0.05% lotion    VANOS (fluocinonide) 0.1% cream | |  |
| **VI. Endocrine** | | | |
| Therapeutic Drug Class: **ANDROGENIC AGENTS, Topical, Injectable, Oral** **-***Effective 10/1/2024* | | | |
| **PA Required for all agents in this class** | | Hypogonadotropic or Primary Hypogonadism (may be secondary to Klinefelter Syndrome):  Preferred products may be approved for members meeting the following:   * Member is a male patient > 16 years of age with a documented diagnosis of hypogonadotropic or primary hypogonadism OR ≥ 12 years of age with a diagnosis of hypogonadotropic or hypogonadism secondary to Klinefelter Syndrome (all other diagnoses will require manual review) AND * Member has two documented low serum testosterone levels below the lower limit of normal range for testing laboratory prior to initiation of therapy AND * Member does not have a diagnosis of breast or prostate cancer AND * If the member is > 40 years of age, has prostate-specific antigen (PSA) < 4 ng/mL or has no palpable prostate nodule AND | |
| **Preferred**    Testosterone cypionate IM injection    Testosterone gel packet    Testosterone 1.62% gel pump    ***Injectable testosterone cypionate is a pharmacy benefit when self-administered.*** | **Non-Preferred**    ANDROGEL (testosterone) gel packet  ANDROGEL (testosterone) gel 1.62% pump    DEPO-TESTOSTERONE (testosterone cypionate) IM injection    JATENZO (testosterone undecanoate) capsule    KYZATREX (testosterone undecanoate) capsule |

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| ***Administration in an office setting is a medical benefit.*** | METHITEST (methyltestosterone) tablet    Methyltestosterone capsule    NATESTO (testosterone) nasal spray    TESTIM (testosterone) gel    Testosterone 1% gel tube, 30 mg/1.5 ml pump    Testosterone enanthate IM injection    TLANDO (testosterone undecanoate) capsule    UNDECATREX (testosterone undecanoate) capsule    XYOSTED (testosterone enanthate) SC injection | * Member has baseline hematocrit < 50%     Reauthorization Criteria (requests for renewal of a currently expiring prior authorization for a preferred product may be approved for members meeting the following criteria):   * Member is a male patient > 16 years of age with a documented diagnosis of hypogonadotropic or primary hypogonadism OR ≥ 12 years of age with a diagnosis of hypogonadotropic or hypogonadism secondary to Klinefelter Syndrome AND * Serum testosterone is being regularly monitored (at least annually) to achieve total testosterone level in the middle tertile of the normal reference range AND * Member does not have a diagnosis of breast or prostate cancer AND * Member has a hematocrit < 54%   Gender Transition/Affirming Hormone Therapy:  Preferred androgenic drugs may be approved for members meeting the following:   1. Female sex assigned at birth and has reached Tanner stage 2 of puberty AND 2. Is undergoing female to male transition AND 3. Has a negative pregnancy test prior to initiation AND 4. Hematocrit (or hemoglobin) is being monitored.     **Non-Preferred Products:**  Non-preferred **topical** androgenic agents may be approved for patients meeting the above criteria with trial and failed‡ therapy with two preferred topical androgen formulations.  Non-preferred **injectable** androgenic agents may be approved for patients meeting the above criteria with trial and failed‡ therapy with a preferred injectable androgenic drug.  Prior authorization for **oral** androgen agents (tablet, capsule, buccal) may be approved if member has trialed and failed‡ therapy with a preferred topical agent AND testosterone cypionate injection.  ‡Failure is defined as lack of efficacy with 8 week trial, allergy, intolerable side effects, contraindication to, or significant drug-drug interaction.  For all agents and diagnoses, members < 16 years of age will require a manual prior authorization review by a pharmacist (with exception of members ≥ 12 years of age with a diagnosis of hypogonadotropic or hypogonadism secondary to Klinefelter Syndrome). |
| Therapeutic Drug Class: **BONE RESORPTION SUPPRESSION AND RELATED AGENTS -***Effective 10/1/2024* | | |
| **Bisphosphonates** | | |
| **No PA Required**    Alendronate tablet, solution    Ibandronate tablet | **PA Required**    ACTONEL (risedronate) tablet    ATELVIA (risedronate) tablet | Non-preferred bisphosphonates may be approved for members who have failed treatment with one preferred product at treatment dose. Failure is defined as lack of efficacy with a 12-month trial, allergy, intolerable side effects, or significant drug-drug interaction. |

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| Risedronate tablet | BINOSTO (alendronate) effervescent tablet    FOSAMAX (alendronate) tablet    FOSAMAX plus D (alendronate/vit D) tablet | | For members who have a low risk of fracture, discontinuation of bisphosphonate therapy and drug holiday should be considered following 5 years of treatment. Low risk is defined as having a bone mineral density, based on the most recent T-score, of greater than (better than) -2.5 AND no history of low trauma or fragility fracture. |
| **Non-Bisphosphonates** | | | |
| **No PA Required**    Raloxifene tablet | **PA Required**    Calcitonin salmon nasal spray    EVISTA (raloxifene) tablet    FORTEO (teriparatide) SC pen    Teriparatide SC pen    TYMLOS (abaloparatide) SC pen | **CALCITONIN SALMON (nasal)** may be approved if the member meets the following criteria:   * Member has a diagnosis of post-menopausal osteoporosis (BMD T-scores of -2.5 or less)   **AND**   * Has trial and failure of one preferred bisphosphonate or non-bisphosphonate product for 12 months (failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) **OR** * Member is unable to use a solid oral dosage form.   Quantity limit: One spray daily    **FORTEO** (teriparatide) or generic teriparatide may be approved if the member meets the following criteria:   * Member has one of the following diagnoses: * Male primary or hypogonadal osteoporosis (BMD T-scores of -2.5 or less). * Osteoporosis due to corticosteroid use ● Postmenopausal osteoporosis   **AND**   * Member is at very high risk for fracture\* **OR** member has history of trial and failure of one preferred bisphosphonate or non-bisphosphonate product for 12 months. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction **AND** * Prior authorization will be given for one year and total exposure of parathyroid hormone analogs (Forteo and Tymlos) shall not exceed two years Maximum dose: 20mcg daily     **TYMLOS** (abaloparatide)may be approved if the member meets the following criteria:   * Member has a diagnosis of postmenopausal osteoporosis (BMD T-scores of -2.5 or less)   **AND**   * Member is post-menopausal with very high risk for fracture\* OR member has history of trial and failure of one preferred bisphosphonate or non-bisphosphonate product for 12 months (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drugdrug interaction) **AND**   Prior authorization will be given for one year and total exposure of parathyroid hormone analogs (Forteo and Tymlos) shall not exceed two yearsMaximum dose: 80 mcg daily      All other non-preferred non-bisphosphonates may be approved for members who have failed treatment with one preferred bisphosphonate or non-bisphosphonate product at treatment dose. | |

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|  |  | Failure is defined as lack of efficacy with a 12-month trial, allergy, unable to use oral therapy, intolerable side effects, or significant drug-drug interaction.    \*Members at very high risk for fracture: Members will be considered at very high risk for fracture if they meet one of the following:   * A history of fracture within the past 12 months **OR** * Fractures experienced while receiving guideline-supported osteoporosis therapy **OR** * A history of multiple fractures **OR** * A history of fractures experienced while receiving medications that cause skeletal harm (such as long-term glucocorticoids) **OR** * A very low T-score (less than -3.0) **OR** * A high risk for falls or a history of injurious falls **OR** * A very high fracture probability by FRAX (> 30% for a major osteoporosis fracture or >   4.5% for hip fracture)    Raloxifene maximum dose: 60mg daily    *Note: Prior authorization criteria for Prolia (denosumab) and other injectable bone resorption and related agents are listed on Appendix P.* | |
| Therapeutic Drug Class: **CONTRACEPTIVES - Topical** *Effective 10/1/2024*  **Effective 01/14/22, topical contraceptive patch products are eligible for coverage with a written prescription by an enrolled pharmacist. Additional information regarding pharmacist enrollment can be found at** [**https://hcpf.colorado.gov/pharm-serv.**](https://hcpf.colorado.gov/pharm-serv) | | | |
| **No PA Required**    ANNOVERA (segesterone  acetate/EE) vaginal ring    Norelgestromin/EE TD patch    NUVARINGBNR  (etonorgestrel/EE) vaginal ring    \*PHEXXI (lactic acid/citric/potassium) vaginal gel | **PA Required**    Etonorgestrel/EE vaginal ring    XULANE (norelgestromin/EE) TD patch    ZAFEMY (norelgestromin/EE) TD patch | | Non-preferred topical contraceptive products may be approved following a trial and failure of one preferred topical contraceptive product. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.  \***PHEXXI** (lactic acid/citric/potassium) vaginal gel quantity limit: 120 grams per 30 days    Continuation of therapy: Members who are currently using Annovera  (segesterone/ethinyl estradiol) vaginal ring may receive approval to continue use of the product.    Effective 7/1/2022: Prescriptions are eligible to be filled for up to a twelve-month supply. |

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| TWIRLA (levonorgestrel/EE) TD patch |  | | *Note: IUD and select depot product formulations are billed through the medical benefit* | |
| Therapeutic Drug Class: **DIABETES MANAGEMENT CLASSES, INSULINS***- Effective 02/27/2025* | | | | |
| **Rapid-Acting** | | | | |
| **No PA Required**  Insulin aspart cartridge, pen, vial  Insulin lispro Kwikpen, Jr. Kwikpen, vial (*Eli Lilly*) | | **PA Required**  ADMELOG (insulin lispro) Solostar pen, vial  AFREZZA (regular insulin) cartridge, unit  APIDRA (insulin glulisine) Solostar pen, vial  FIASP (insulin aspart) FlexPen, PenFill, pump cartridge, vial  HUMALOG (insulin lispro) 200 U/mL pen,  Tempo pen  HUMALOG 100U/mL KwikPen, vial  HUMALOG (insulin lispro) cartridge  HUMALOG Jr. (insulin lispro) KwikPen  NOVOLOG (insulin aspart) cartridge,  FlexPen, vial  LYUMJEV (insulin lispro-aabc) Kwikpen, vial, Tempo pen | All non-preferred products may be approved following trial and failure of treatment with two preferred products, one of which is the same rapid-acting insulin analog (lispro or aspart) as the non-preferred product being requested. (Failure is defined as allergy [hives, maculopapular rash, erythema multiforme, pustular rash, severe hypotension, bronchospasm, and angioedema] or intolerable side effects).    **Afrezza** (human insulin) may be approved if meeting the following criteria:   * Member is 18 years or older AND * Member has trialed and failed treatment with two preferred products (failure is defined as allergy [hives, maculopapular rash, erythema multiforme, pustular rash, severe hypotension, bronchospasm, or angioedema] or intolerable side effects) AND * Member must not have chronic lung disease such as COPD or asthma AND * If member has type 1 diabetes, must use in conjunction with long-acting insulin   AND   * Prescriber acknowledges that Afrezza is not recommended in patients who smoke or have recently stopped smoking. | |
| **Short-Acting** | | | | |
| **No PA Required PA Required**  Non-preferred products may be approved following trial and failure of  HUMULIN R U-100 (insulin regular) vial NOVOLIN R U-100 (insulin regular) vial (OTC) treatment with one preferred product (failure is defined as allergy or  (OTC) intolerable side effects).    NOVOLIN R U-100 (insulin regular) FlexPen (OTC) | | | | |
| **Intermediate-Acting** | | | | |
| **No PA Required**  HUMULIN N U-100 (insulin NPH) vial  (OTC) | | **PA Required**  HUMULIN N U-100 (insulin NPH) KwikPen (OTC)  NOVOLIN N U-100 (insulin NPH) vial (OTC) | | Non-preferred products may be approved following trial and failure of treatment with one preferred product (failure is defined as allergy or intolerable side effects). |

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| NOVOLIN N U-100 (insulin NPH) FlexPen (OTC) |  |  |
| **Long-Acting** | | |
| **No PA Required**  LANTUSBNR (insulin glargine) Solostar, vial    Insulin degludec vial\*    TRESIBA BNR (insulin degludec) FlexTouch\* | **PA Required**    BASAGLAR (insulin glargine) Kwikpen, Tempo pen    Insulin degludec FlexTouch  Insulin glargine solostar, vial  Insulin glargine MAX solostar  Insulin glargine-yfgn pen, vial  LEVEMIR (insulin detemir) FlexTouch, vial  REZVOGLAR (insulin glargine-aglr) Kwikpen  SEMGLEE (insulin glargine-yfgn) pen, vial TOUJEO (insulin glargine) Solostar  TOUJEO MAX (insulin glargine) Solostar  TRESIBA (insulin degludec) vial | \*Preferred Tresiba pen and insulin degludec vial formulations may be approved for members who have trialed and failed‡ Lantus.    Non-preferred products may be approved if the member has tried and failed‡ treatment with Lantus **AND** a preferred insulin degludec product.    ‡Failure is defined as lack of efficacy, allergy, or intolerable side effects. |
| **Concentrated** | | |
| **No PA Required**    HUMULIN R U-500 (insulin regular)  concentrated vial, Kwikpen | **PA Required** | Non-preferred products may be approved following trial and failure of treatment with one preferred product (failure is defined as allergy or intolerable side effects). |
| **Mixtures** | | |
| **No PA Required**    HUMULIN 70/30 (OTC) Kwikpen, vial  Insulin aspart protamine/insulin aspart  70/30 FlexPen, vial (generic Novolog Mix) | **PA Required**    HUMALOG MIX 50/50 Kwikpen, vial    HUMALOG MIX 75/25 Kwikpen, vial  NOVOLIN 70/30 FlexPen, vial (OTC) | Non-preferred products may be approved if the member has failed treatment with two of the preferred products (failure is defined as: allergy or intolerable side effects). |

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| Insulin lispro protamine/insulin lispro 75/25 Kwikpen (generic Humalog  Mix) | | NOVOLOG MIX 70/30 FlexPen, vial | | | | |  | | |
| Therapeutic Drug Class: **DIABETES MANAGEMENT CLASSES, NON- INSULINS***- 10/1/2024* | | | | | | | | | |
| **Amylin** | | | | | | | | | |
|  | **PA Required**    SYMLIN (pramlintide) pen | | **SYMLIN** (pramlintide) may be approved following trial and failure of metformin AND trial and failure of a DPP4-inhibitor or GLP-1 analogue. Failure is defined as lack of efficacy (such as not meeting hemoglobin A1C goal despite adherence to regimen) following 3-month trial, allergy, intolerable side effects, or a significant drug-drug interaction. Prior authorization may be approved for Symlin (pramlintide) products for members with a diagnosis of Type 1 diabetes without requiring trial and failure of other products.    Maximum Dose: Prior authorization will be required for doses exceeding FDA-approved dosing listed in product package labeling. | | | | | | |
| **Biguanides** | | | | | | | | | |
| **No PA Required**    Metformin IR tablets    Metformin ER 500mg, 750mg tablets (generic Glucophage  XR) | **PA Required**    GLUMETZA ER (metformin) tablet    Metformin 625 mg tablets    Metformin ER (generic Fortamet, Glumetza)    Metformin solution (generic Riomet)    RIOMET (metformin) solution    RIOMET ER (metformin) suspension | | | | | Non-preferred products may be approved for members who have failed treatment with two preferred products. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.    Liquid metformin may be approved for members that are unable to use a solid oral dosage form. | | | |
| **Dipeptidyl Peptidase-4 Enzyme inhibitors (DPP-4is)** | | | | | | | | | |
| **Preferred**    JANUVIA (sitagliptin) tablet    TRADJENTA (linagliptin) tablet | **Non-Preferred**  **PA Required**    Alogliptin tablet    NESINA (alogliptin) tablet    ONGLYZA (saxagliptin) tablet  Saxagliptin tablet    Sitagliptin (generic Zituvio) | | | Non-preferred DPP-4 inhibitors may be approved after a member has failed a 3-month trial of two preferred products. Failure is defined as lack of efficacy (such as not meeting hemoglobin A1C goal despite adherence to regimen), allergy, intolerable side effects, or a significant drug-drug interaction.  Maximum Dose:  Prior authorization will be required for doses exceeding the FDA-approved maximum dosing listed in the following table: | | | | | |
|  | **DPP-4 Inhibitor** | | | **FDA-Approved Maximum Daily**  **Dose** |  |
| Alogliptin (generic Nesina) | | | 25 mg/day |

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|  | ZITUVIO (sitagliptin tablet) | |  | Januvia (sitagliptin) | | 100 mg/day |  |
| Nesina (alogliptin) | | 25 mg/day |
| Onglyza (saxagliptin) | | 5 mg/day |
| Tradjenta (linagliptin) | | 5 mg/day |
| Zituvio (sitagliptin) | | 100 mg/day |
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| **DPP-4 Inhibitors – Combination with Metformin** | | | | | | | |
| **Preferred**  JANUMET (sitagliptin/metformin) tablet  JANUMET XR (sitagliptin/metformin) tablet  JENTADUETO (linagliptin/metformin) tablet  JENTADUETO XR (linagliptin/metformin)  tablet | | **Non-Preferred PA Required**  Alogliptin/metformin tablet  KAZANO (alogliptin/metformin)  tablet  KOMBIGLYZE XR (saxagliptin/metformin)  Saxagliptin/metformin tablet  Sitagliptin/metformin (generic Zituvimet) | | | Non-preferred combination products may be approved for members who have been stable on the two individual ingredients of the requested combination for three months AND have had adequate three-month trial and failure of a preferred combination agent. Failure is defined as lack of efficacy (such as not meeting hemoglobin A1C goal despite adherence to regimen), allergy, intolerable side effects, or a significant drug-drug interaction.    Maximum Dose:  Prior authorization will be required for doses exceeding the FDA-approved maximum dosing listed in the following table:   |  |  | | --- | --- | | **DPP-4 Inhibitor Combination** | **FDA Approved Maximum Daily**  **Dose** | | Alogliptin/metformin tablet | 25 mg alogliptin/2,000 mg metformin | | Janumet and Janumet XR (sitagliptin/metformin) | 100 mg sitagliptin/  2,000 mg of metformin | | Jentadueto and Jentadueto XR (linagliptin/metformin) | 5 mg linagliptin/ 2,000 mg metformin | | Kazano (alogliptin/metformin) | 25 mg alogliptin/ 2,000 mg metformin | | Kombiglyze XR (saxagliptin ER/metformin ER) tablet | 5 mg saxagliptin/  2,000 mg metformin | | | |

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| **Glucagon-like Peptide-1 Receptor Agonists (GLP-1 Analogues)** | | | | |
| **Preferred**  **\*Must meet eligibility criteria**    \*BYETTABNR (exenatide) pen    \*TRULICITY (dulaglutide) pen    \*VICTOZABNR (liraglutide) pen    \*\*BYDUREON BCISE  (exenatide ER) autoinjector  *(changes effective 08/08/2024)* | **Non-Preferred**  **PA Required**    Exenatide pen    Liraglutide pen    MOUNJARO (tirzepatide) pen    OZEMPIC (semaglutide) pen    RYBELSUS (semaglutide) oral  tablet    WEGOVY (semaglutide) pen | | \*Preferred products may be approved for members with a diagnosis of type 2 diabetes.    **\*\*BYDUREON BCISE (**exenatide ER): may be approved for members with a diagnosis of Type 2 diabetes following a 3-month trial and failure‡ of ONE other preferred product.    **WEGOVY (semaglutide)** may be approved if meeting the following criteria:   * Member is 18 years of age or older AND * Member has established cardiovascular disease (history of myocardial infarction, stroke, or   symptomatic peripheral arterial disease) and either obesity or overweight (defined as a BMI ≥25 kg/m2 ) AND   * Member does not have a diagnosis of Type 1 or Type 2 diabetes AND * Wegovy (semaglutide) is being prescribed to decrease the risk of adverse cardiovascular events   (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke) AND   * Member has been counseled regarding implementation of lifestyle interventions (diet modification and exercise) to promote weight loss.     **Note: Prior authorization requests for Wegovy (semaglutide) prescribed solely for weight loss will not be approved.**      All other non-preferred products may be approved for members with a diagnosis of type 2 diabetes following a 3-month trial and failure‡ of two preferred products .  Maximum Dose:  Prior authorization is required for all products exceeding maximum dose listed in product package labeling.  Table 1: GLP  -  1  Analogue Maximum Dose    Bydureon Bcise (exenatide)    2  mg weekly    Byetta  )  (  exenatide    mcg daily  20    Mounjaro (tirzepatide)    mg weekly  15    Ozempic (semaglutide)    mg weekly  2    Rybelsus (semaglutide)    mg daily  14    Trulicity (dulaglutide)    4.5  mg weekly    Victoza (liraglutide)    1.8  mg daily    Wegovy (semaglutide)    mg weekly  2.4      ‡Failure is defined as lack of efficacy (such as not meeting hemoglobin A1C goal despite adherence to regimen), allergy, intolerable side effects, limited dexterity resulting in the inability to administer doses of a preferred product, or a significant drug-drug interaction.    ***Note: Prior Authorization for GLP-1 analogues prescribed solely for weight loss will not be approved.*** | |

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|  | **Other Hypoglycemic Combinations** | | | |
|  | **PA Required**    Alogliptin/pioglitazone tablet    Glipizide/metformin tablet    Glyburide/metformin tablet    GLYXAMBI (empagliflozin/linagliptin) tablet    OSENI (alogliptin/pioglitazone) tablet    Pioglitazone/glimepiride tablet    QTERN (dapagliflozin/saxagliptin) tablet    SOLIQUA (insulin glargine/lixisenatide) pen    STEGLUJAN (ertugliflozin/sitagliptin) tablet    TRIJARDY XR  tablet(empagliflozin/linagliptin/metformin)    XULTOPHY (insulin degludec/liraglutide) pen | | | Non-preferred products may be approved for members who have been stable on each of the individual ingredients in the requested combination for 3 months (including cases where the ingredients are taken as two separate 3-month trials or when taken in combination for at least 3 months). |
|  | **Meglitinides** | | | |
|  | **PA Required**  Nateglinide tablet    Repaglinide tablet | | Non-preferred products may be approved for members who have failed treatment with one sulfonylurea. Failure is defined as: lack of efficacy (such as not meeting hemoglobin A1C goal despite adherence to regimen), allergy, intolerable side effects, or significant drug-drug interaction. | |
|  | **Meglitinides Combination with Metformin** | | | |
|  | **PA Required**    Repaglinide/metformin | | Non-preferred products may be approved for members who have been stable on the two individual ingredients of the requested combination for 3 months. | |
|  | **Sodium-Glucose Cotransporter Inhibitors (SGLT inhibitors)** | | | |
| **No PA Required**    FARXIGABNR (dapagliflozin)  tablet | **PA Required**    Dapagliflozin tablet    INPEFA (sotagliflozin) tablet | | Non-preferred products may receive approval following trial and failure with two preferred products. Failure is defined as lack of efficacy with 3-month trial (such as not meeting hemoglobin A1C goal despite adherence to regimen), allergy, intolerable side effects, or a significant drug-drug interaction. | |

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| JARDIANCE (empagliflozin)  tablet | INVOKANA (canagliflozin) tablet    STEGLATRO (ertugliflozin) tablet |  | **SGLT Inhibitor** | **Clinical Setting** | **Renal Dosing Recommendations (FDA labeling )** | |
| **FARXIGA**  **(dapagliflozin)** | Glycemic control in patients without established CV disease  or CV risk factors | Initiation of therapy not recommended when eGFR is less than 45 mL/min/1.73 m2 | |
| Reduce risk of CV death;  Chronic kidney disease (CKD);  Reduce risk of CV death, hospitalization or urgent visit for heart failure (HF) | Initiation of therapy not recommended when eGFR is less than 25 mL/min/1.73 m2 | |
| **INPEFA**  **(sotagliflozin)** | Reduce risk of CV death, HF hospitalization and urgent HF  visit in adults with HF or Type  2 DM, chronic kidney disease and other CV risk factors | Safety and efficacy of initiating therapy when eGFR is less than 25  mL/min/1.73 m2 or on dialysis has not  been established | |
| **INVOKANA**  **(canagliflozin)** | Glycemic control in adults with Type 2 DM | Safety and efficacy of initiating therapy when eGFR is less than 30  mL/min/1.73 m2 or on dialysis has not  been established | |
| Reduce risk of major CV events in adults with Type 2 DM and established CVD; Reduce risk  of ESKD, doubling of serum creatinine, CV death, and  hospitalization for HF in adults with Type 2 DM and diabetic nephropathy (albuminuria  > 300 mg/day) | Initiation of therapy not recommended when eGFR is less than 30 mL/min/1.73 m2 | |
| **JARDIANCE**  **(empagliflozin)** | Glycemic control in patients  10 years and older with Type 2  DM without established CV disease or CV risk factors | Not recommended when eGFR is less than 30 mL/min/1.73 m2 | |
| Reduce risk of CV death and hospitalization for HF; Chronic kidney disease (CKD); Reduce  risk of CV death in adults with  Type 2 DM and established  CVD | Initiation of therapy not recommended when eGFR is less than 20 mL/min/1.73 m2or on dialysis | |
| **STEGLATRO**  **(ertugliflozin**) | Adjunct to diet and exercise in patients with Type 2 DM | Not recommended when eGFR is less than 45 mL/min/1.73 m2 | |
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|  |  | Maximum Dose:  Prior authorization is required for all products exceeding maximum dose listed in product package labeling. |
|  | **SGLT Inhibitor Combinations with Metformin** | |
| **No PA Required**    SYNJARDY  (empagliflozin/metformin) tablet    SYNJARDY XR  (empagliflozin/metformin) tablet    XIGDUO XRBNR  (dapagliflozin/metformin)  tablet | **PA Required**    Dapagliflozin/Metformin XR tablet    INVOKAMET (canagliflozin/metformin) tablet    INVOKAMET XR (canagliflozin/metformin)  tablet    SEGLUROMET (ertugliflozin/metformin) tablet | Non-preferred products may be approved for members who have been stable on the two individual ingredients of the requested combination for 3 months.    INVOKAMET, INVOKAMET XR, SEGLUROMET, SYNJARDY, SYNJARDY XR  and XIGDUO XR are contraindicated in patients with an eGFR less than 30 mL/min/1.73 m2 or on dialysis. |
|  | **Thiazolidinediones (TZDs)** | |
| **No PA Required**    Pioglitazone tablet | **PA Required**    ACTOS (pioglitazone) tablet | Non-preferred agents may be approved following trial and failure of one preferred product. Failure is defined as lack of efficacy (such as not meeting hemoglobin A1C goal despite adherence to regimen) with a 3-month trial, allergy, intolerable side effects, or a significant drug-drug interaction. |
|  | **Thiazolidinediones Combination with Metformin** | |
|  | **PA Required**    ACTOPLUS MET (pioglitazone/metformin)  TABLET    Pioglitazone/metformin tablet | Non-preferred products may be approved for members who have been stable on the two individual ingredients of the requested combination for 3 months. |
|  | Therapeutic Drug Class: **ESTROGEN AGENTS** *-Effective 10/1/2024* | |
| **No PA Required** | **PA Required** | Non-preferred parenteral estrogen agents may be approved with trial and failure of one preferred parenteral agent. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.    Non-preferred oral estrogen agents may be approved with trial and failure of one preferred oral agent. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction. |
|  | **Parenteral** |
| DELESTROGENBNR (estradiol valerate) vial    DEPO-ESTRODIOL (estradiol cypionate) vial | Estradiol valerate 10mg/mL vial, 20mg/mL vial |

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| Estradiol valerate 40mg/mL vial |  | Non-preferred transdermal estrogen agents may be approved with trial and failure of two preferred transdermal agents. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.       |  |  | | --- | --- | | **Table 1: Transdermal Estrogen FDA-Labeled Dosing** |  | | ALORA (estradiol) patch | 2/week | | CLIMARA (estradiol) patch | 1/week | | DOTTI (estradiol) patch | 2/week | | Estradiol patch (once weekly) | 1/week | | Estradiol patch (twice weekly) | 2/week | | LYLLANA (estradiol) patch | 2/week | | MENOSTAR (estradiol) patch | 1/week | | MINIVELLE (estradiol) patch | 2/week | | VIVELLE-DOT (estradiol) patch | 2/week |   *Note: Estrogen agents are a covered benefit for gender affirming hormone therapy and treating clinicians and mental health providers should be knowledgeable about the diagnostic criteria for gender-affirming hormone treatment and have sufficient training and experience in assessing related mental health conditions.* |
| **Oral/Transdermal** | |
| Estradiol oral tablet    Estradiol (generic Climara) weekly patch    MINIVELLEBNR (estradiol) patch    VIVELLE-DOTBNR (estradiol) patch | CLIMARA (estradiol) patch    DOTTI (estradiol) patch    ESTRACE (estradiol) oral tablet    Estradiol bi-weekly patch    LYLLANA (estradiol) patch    MENOSTAR (estradiol) patch |
| Therapeutic Drug Class: **GLUCAGON, SELF-ADMINISTERED** *-Effective 11/8/2024* | | |
| **Preferred**  **No PA Required**    BAQSIMI (glucagon) nasal spray    Glucagon Emergency Kit (*Eli Lilly, Fresenius, Amphastar)*    ZEGALOGUE (dasiglucagon) autoinjector | **Non-Preferred**  **PA Required**    GVOKE (glucagon) Hypopen, Syringe, vial    ZEGALOGUE (dasiglucagon) syringe | Non-preferred products may be approved if the member has failed treatment with two preferred products (failure is defined as allergy to ingredients in product, intolerable side effects, contraindication, or inability to administer dosage form).    Quantity limit for all products: 2 doses per year unless used/ damaged/ lost |
| Therapeutic Drug Class: **GROWTH HORMONES -***Effective 10/1/2024* | | |
| **Preferred**  **No PA Required**  **(If diagnosis and dose met)**    GENOTROPIN (somatropin) cartridge, Miniquick pen | **Non-Preferred**  **PA Required**    HUMATROPE (somatropin) cartridge    NGENLA (somatrogon-ghla) pen | All preferred products may be approved if the member has one of the qualifying diagnoses listed below (diagnosis may be verified through AutoPA) AND if prescription does not exceed limitations for maximum dosing (Table 1).    Non-preferred Growth Hormone products may be approved if the following criteria are met: |

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| NORDITROPIN (somatropin) Flexpro pen | NUTROPIN AQ (somatropin) Nuspin injector    OMNITROPE (somatropin) cartridge, vial    SAIZEN (somatropin) cartridge, vial    SEROSTIM (somatropin) vial    SKYTROFA (lonapegsomatropin-tcgd) cartridge    SOGROYA (somapacitan-beco) pen    ZOMACTON (somatropin) vial | * Member failed treatment with one preferred growth hormone product (failure is defined as lack of efficacy, allergy, intolerable side effects or signific * ant drug-drug interactions) AND * Member has a qualifying diagnosis that includes any of the following conditions:   + Prader-Willi Syndrome (PWS)   + Chronic renal insufficiency/failure requiring transplantation (defined as Creatinine Clearance < 30mL/min)   + Turner’s Syndrome   + Hypopituitarism: as a result of pituitary disease, hypothalamic disease, surgery, radiation therapy or trauma verified by one of the following:     - Has failed at least one GH stimulation test (peak GH level < 10 ng/mL) o Has at least one documented low IGF-1 level (below normal range for patient’s age – refer to range on submitted lab document)     - Has deficiencies in ≥ 3 pituitary axes (such as TSH, LH, FSH, ACTH, ADH)   + Cachexia associated with AIDS   + Noonan Syndrome   + Short bowel syndrome   + Neonatal symptomatic growth hormone deficiency (limited to 3-month PA approval) AND * Prescription does not exceed limitations for FDA-labeled maximum dosing for prescribed indication (Table 1) based on prescriber submission/verification of patient weight from most recent clinical documentation | | | |
|  | Table 1: Growth Hormone Product Maximum Dosing\* | | |
| Medication | Pediatric Maximum  Dosing per week (age < 18 years) | Adult Maximum Dosing per week (age ≥ 18 years) |
| Genotropin | 0.48 mg/kg/week | 0.08 mg/kg/week |
| Humatrope | 0.47 mg/kg/week | 0.0875 mg/kg/week |
| Ngenla | 0.66 mg/kg/week | Not Indicated |
| Norditropin Flexpro | 0.47 mg/kg/week | 0.112 mg/kg/week |
| Nutropin AQ Nuspin | 0.7 mg/kg/week | 0.175 mg/kg/week for |
| Omnitrope | 0.48 mg/kg/week |
| Saizen | 0.18 mg/kg/week | 0.07 mg/kg/week |



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|  |  | o Member has diagnosis of peroxisomal disorders (PDs) including  Zellweger spectrum disorders AND o Member has manifestations of liver disease, steatorrhea or complications from decreased fat-soluble vitamin absorption.    **Ocaliva** (obeticholic acid)may be approved for members meeting the following criteria:   * Member is > 18 years of age AND * Medication is prescribed by or in consultation with a gastroenterologist, hepatologist, or liver transplant provider AND * Member has the diagnosis of primary biliary cholangitis without cirrhosis OR a diagnosis of primary biliary cholangitis with compensated cirrhosis with no evidence of portal hypertension AND * Member has failed treatment with a preferred ursodiol product for at least 6 months due to an inadequate response, intolerable side effects, drug-drug interaction, or allergy to preferred ursodiol formulations.     **Reltone** (ursodiol) may be approved for members meeting the following criteria:   * Member is ≥ 18 years of age AND * The requested medication is prescribed by or in consultation with a gastroenterologist, hepatologist, or liver transplant provider AND * The requested medication is being prescribed for one of the following: o Treatment of radiolucent, noncalcified gallbladder stones < 20 mm in greatest diameter AND elective cholecystectomy would be undertaken except for the presence of increased surgical risk due to systemic disease, advanced age, idiosyncratic reaction to general anesthesia, or for those patients who refuse surgery OR | |
|  |  | o | Prevention of gallstone formation in obese patients experiencing rapid weight loss |
|  |  | AND   * No compelling reasons for the member to undergo cholecystectomy exist, including unremitting acute cholecystitis, cholangitis, biliary obstruction, gallstone pancreatitis, or biliary-gastrointestinal fistula, **AND** * Member has trialed and failed treatment with a preferred ursodiol product for at least 6 months due to an inadequate response, intolerable side effects, drug-drug interaction, or allergy to inactive ingredients contained in the preferred ursodiol formulations.     Initial approval: 1 year    Reauthorization: May be reauthorized for 1 additional year with provider attestation that partial or complete stone dissolution was observed after completion of the initial year of Reltone therapy. Maximum cumulative approval per member is 24 months.    **Urso** (ursodiol) and **Urso Forte** (ursodiol) may be approved for members meeting the following criteria:   * Member is ≥ 18 years of age AND | |

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|  |  | * Medication is prescribed by or in consultation with a gastroenterologist, hepatologist, or liver transplant provider AND * Member has the diagnosis of Primary Biliary Cholangitis as evidenced by two of the following at the time of diagnosis:   + Evidence of cholestasis with an alkaline phosphatase elevation of at least 1.5 times the upper limit of normal   + Presence of antimitochondrial antibody with titer of 1:40 or higher o Histologic evidence of nonsuppurative destruction cholangitis and destruction of interlobular bile ducts AND * Member has failed treatment with a preferred ursodiol product for at least 6 months due to an inadequate response, intolerable side effects, drug-drug interaction, or allergy to inactive ingredients contained in the preferred ursodiol formulations.     **Requests for drug products that are FDA-indicated for the treatment of nonalcoholic steatohepatitis (NASH) may be approved if meeting the following:**   * A diagnosis of NASH has been confirmed through liver biopsy AND * Member meets the FDA-labeled minimum age requirement for the prescribed product AND * Member does not have significant liver disease other than NASH, AND * The requested medication is being prescribed for use for the FDA-labeled indication and as outlined in product package labeling AND * Medication is prescribed by or in consultation with a gastroenterologist, hepatologist, or liver transplant provider.     Non-preferred products prescribed for FDA-labeled indications not identified above may receive approval for use as outlined in product package labeling. |
| Therapeutic Drug Class: **ANTI-EMETICS, Oral -***Effective 7/1/2024* | | |
| **No PA Required**    DICLEGIS DRBNR tablet  (doxylamine/pyridoxine)    Meclizine (Rx) 12.5 mg, 25 mg  tablet    Metoclopramide solution, tablet    Ondansetron ODT; 4mg, 8mg  tablet | **PA Required**    AKYNZEO (netupitant/palonosetron) capsule    ANTIVERT (meclizine) 50 mg tablet    ANZEMET (dolasetron) tablet    Aprepitant capsule, tripack    BONJESTA ER (doxylamine/pyridoxine) tablet    Doxylamine/pyridoxine tablet (generic Diclegis) | **Emend (aprepitant) TriPack** or **Emend (aprepitant) powder kit** may be approved following trial and failure of two preferred products AND Emend (aprepitant) capsule. Failure is defined as lack of efficacy with 14-day trial, allergy, intolerable side effects, or significant drug-drug interaction.  **Doxylamine/pyridoxine tablet (generic)** or **Bonjesta (doxylamine/pyridoxine)** may be approved for 9 months if meeting the following criteria:   * Member has nausea and vomiting associated with pregnancy **AND** * Member has trialed and failed DICLEGIS DR tablet **AND** one of the following (failure is defined as lack of efficacy with a 7-day trial, allergy, intolerable side effects, or significant drug-drug interaction):   o Antihistamine (such as diphenhydramine, dimenhydrinate, meclizine)  **OR** |

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| Ondansetron oral suspension/ solution    Prochlorperazine tablet    Promethazine syrup, tablet | Dronabinol capsule    EMEND (aprepitant) capsule, powder for suspension, dose/tri-pack    Granisetron tablet    MARINOL (dronabinol) capsule    Ondansetron 16mg tablet    REGLAN (metoclopramide) tablet    Trimethobenzamide capsule    ZOFRAN (ondansetron) tablet | o Dopamine antagonist (such as metoclopramide, prochlorperazine, promethazine) **OR** o Serotonin antagonist (ondansetron, granisetron)  All other non-preferred products may be approved for members who have trialed and failed treatment with two preferred products. Failure is defined as lack of efficacy with 14-day trial, allergy, intolerable side effects, or significant drug-drug interaction.    **Dronabinol** prior authorization may be approved for members meeting above nonpreferred criteria OR via AutoPA for members with documented HIV diagnosis.    **Promethazine** product formulations require prior authorization for members < 2 years of age due to risk of fatal respiratory depression. | |
| Therapeutic Drug Class: **ANTI-EMETICS, Non-Oral -***Effective 7/1/2024* | | | |
| **No PA Required**    Prochlorperazine 25 mg suppository    Promethazine 12.5 mg, 25 mg suppository    Scopolamine patch | **PA Required**    PROMETHEGAN 50 mg (Promethazine) suppository    SANCUSO (granisetron) patch    TRANSDERM-SCOP (scopolamine) patch | | Non-preferred products may be approved for members who have trialed and failed treatment with two preferred products. Failure is defined as lack of efficacy with 14-day trial, allergy, intolerable side effects, or significant drug-drug interaction. |
| Therapeutic Drug Class: **GI MOTILITY, CHRONIC -***Effective 7/1/2024* | | | |
| **PA Required for all agents in this class** | | | All agents will only be approved for FDA labeled indications and up to FDA approved maximum doses listed below.    Preferred agents may be approved if the member meets the following criteria:   * Has diagnosis of Irritable Bowel Syndrome – Constipation (IBS-C), Chronic Idiopathic Constipation (CIC), or Opioid Induced Constipation (OIC) in patients with opioids prescribed for noncancer pain **AND** * Member does not have a diagnosis of GI obstruction **AND** * For indication of OIC, member opioid use must exceed 4 weeks of treatment * For indications of CIC, OIC, IBS-C; member must have documentation of adequate trial of two or more over-the-counter motility agents (polyethylene |
| **Preferred**      LINZESS (linaclotide) capsule    Lubiprostone capsule    MOVANTIK (naloxegol) tablet | **Non-Preferred**    Alosetron tablet    AMITIZA (lubiprostone) capsule    IBSRELA tablet    LOTRONEX (alosetron) tablet    MOTEGRITY (prucalopride) tablet | |

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|  | | Prucalopride tablet    RELISTOR (methylnaltrexone) syringe, tablet, vial    SYMPROIC (naldemedine)tablet    TRULANCE (plecanatide) tablet    VIBERZI (eluxadoline) tablet | | glycol, docusate or bisacodyl, for example). OR If the member cannot take oral medications, then the member must fail a 7-day trial with a nonphosphate enema (docusate or bisacodyl enema). Failure is defined as a lack of efficacy for a 7day trial, allergy, intolerable side effects, contraindication to, or significant drugdrug interaction **AND**   * For indication of IBS-D, must have documentation of adequate trial and failure with loperamide and trial and failure with dicyclomine orhyoscyamine. Failure is defined as a lack of efficacy for a 7-day trial, allergy, intolerable side effects, contraindication to, or significant drug-drug interaction.     Non-preferred agents may be approved if the member meets the following criteria:   * Member meets all listed criteria for preferred agents **AND** * Member has trialed and failed two preferred agents OR if the indication is OIC caused by methadone, then a non-preferred agent may be approved after an adequate trial of MOVANTIK (naloxegol). Failure is defined as a lack of efficacy for a 7-day trial, allergy, intolerable side effects, contraindication to, or significant drug-drug interaction **AND** * If prescribed Viberzi (eluxadoline) or Lotronex (alosetron), member meets the additional criteria for those agents listed below.     **VIBERZI (eluxadoline)** may be approved for members who meet the following additional criteria:   * Diagnosis of Irritable Bowel Syndrome – Diarrhea (IBS-D) **AND** * Member has a gallbladder **AND** * Member does not have severe hepatic impairment (Child-Pugh C), history of severe constipation, known mechanical gastrointestinal obstruction, biliary duct obstruction, history of pancreatitis or structural disease of the pancreas **AND** * Member does not drink more than 3 alcoholic drinks per day     **LOTRONEX (alosetron)** and genericalosetron may be approved for members who meet the following additional criteria:   * Member is a female with Irritable Bowel Syndrome – Diarrhea (IBS-D) with symptoms lasting 6 months or longer **AND** * Member does not have severe hepatic impairment (Child-Pugh C), history of severe constipation or ischemic colitis, hypercoagulable state, Crohn’s disease or ulcerative colitis, or known mechanical gastrointestinal obstruction. | | |
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|  | **Medication** | | **FDA approved indication** | | **FDA Max Dose** |  |
| Amitiza (lubiprostone) | | IBS-C (females only), CIC, OIC (not caused by methadone) | | 48mcg/day |
| Linzess (linaclotide) | | IBS-C, CIC | | 290mcg/day |
| Movantik (naloxegol) | | OIC | | 25mg/day |

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|  | Viberzi (eluxadoline) | | IBS-D | | 200mg/day |  |
| Relistor subcutaneous injection (methylnaltrexone) | | OIC | | 12mg/day |
| Relistor oral (methylnaltrexone) | | OIC | | 450mg/day |
| Lotronex (alosetron) | | IBS-D (females only) | | 2mg/day (females only) |
| Symproic (Naldemedine) | | OIC | | 0.2mg/day |
| Trulance (plecanatide) | | CIC, IBS-C | | 3mg/day |
| Motegrity (prucalopride) | | CIC | | 2mg/day |
| *CIC – chronic idiopathic constipation, OIC – opioid induced constipation, IBS – irritable bowel syndrome, D – diarrhea predominant,*  *C – constipation predominant* | | | | |
| Therapeutic Drug Class: **H. PYLORI TREATMENTS -***Effective 7/1/2024* | | | | | | |
| **No PA Required**    PYLERABNR capsule (bismuth subcitrate/metronidazole  tetracycline) | | **PA Required**    Amoxicillin/lansoprazole/clarithromycin pack    Bismuth subcitrate/metronidazole tetracycline capsule  OMECLAMOX-PAK (amoxicillin/ omeprazole/clarithromycin)    TALICIA (omeprazole/amoxicillin/ rifabutin) tablet    VOQUEZNA DUAL (vonoprazan/amoxicillin)  dose pack    VOQUEZNA TRIPLE (vonoprazan/amoxicillin/ clarithromycin dose pack | | Non-preferred *H. pylori* treatments should be used as individual product ingredients unless one of the individual products is not commercially available, then a PA for the combination product may be given. | | |
| Therapeutic Drug Class: **HEMORRHOIDAL, ANORECTAL, AND RELATED TOPICAL ANESTHETIC AGENTS -** *Effective 7/1/2024* | | | | | | |
| **Hydrocortisone single agent** | | | | Non-preferred products may be approved following trial and failure of therapy with 3 preferred products (failure is defined as lack of efficacy with 4-week trial, allergy, intolerable side effects or significant drug-drug interactions). | | |
| **No PA Required**    ANUSOL-HC (hydrocortisone)  2.5% cream with applicator    CORTIFOAM (hydrocortisone)  10% aerosol    Hydrocortisone 1% cream with applicator | | **PA Required**    CORTENEMA (hydrocortisone) enema    PROCORT cream | |

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| Hydrocortisone 2.5% cream with applicator    Hydrocortisone enema |  | **Rectiv** (nitroglycerin) ointment may be approved if meeting the following:   * Member has a diagnosis of anal fissure **AND** * Prescriber attests that member has trialed and maximized use of appropriate supportive therapies including sitz bath, fiber, topical analgesics (such as lidocaine), and stool softeners/laxatives. |
| **Lidocaine single agent** | |
| **No PA Required**  Lidocaine 5% ointment | **PA Required**  Lidocaine 3% cream |
| **Other and Combinations** | |
| **No PA Required**    Hydrocortisone-Pramoxine 1%-  1% cream    Lidocaine-Hydrocortisone 3-  0.5% cream with applicator    Lidocaine-Prilocaine Cream *(all other manufacturers)*    PROCTOFOAM-HC  (hydrocortisone-pramoxine)  1%-1% foam | **PA Required**    ANALPRAM HC (Hydrocortisone-Pramoxine)  1%-1% cream, 2.5%-1% cream    EPIFOAM (Hydrocortisone-Pramoxine) 1%-1% foam    Hydrocortisone-Pramoxine 2.5%-1% cream    Lidocaine-Hydrocortisone in Coleus 2%-2% cream  kit    Lidocaine-Hydrocortisone 2.8%-0.55% gel    Lidocaine-Hydrocortisone 3%-0.5% cream w/o applicator, cream kit    Lidocaine-Hydrocortisone 3%-1% cream kit    Lidocaine-Hydrocortisone 3%-2.5% gel kit    Lidocaine-Prilocaine Cream *(Fougera only)*    PLIAGIS (lidocaine-tetracaine) 7%-7% cream    PROCORT (Hydrocortisone-Pramoxine) 1.85%-  1.15% cream    RECTIV (nitroglycerin) 0.4% ointment |
| Therapeutic Drug Class: **PANCREATIC ENZYMES -***Effective 7/1/2024* | | |
| **No PA Required**    CREON (pancrelipase) capsule | **PA Required**    PERTZYE (pancrelipase) capsule | Non-preferred products may be approved for members who have failed an adequate trial (4 weeks) with at least two preferred products. (Failure is defined as lack of efficacy, allergy, intolerable side effects or significant drug-drug interaction.) |

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| VIOKACE (pancrelipase) tablet    ZENPEP (pancrelipase) capsule |  |  |
| Therapeutic Drug Class: **PROTON PUMP INHIBITORS** -*Effective 7/1/2024* | | |
| **No PA Required**    Esomeprazole DR packet for oral suspension, capsule (RX)    Lansoprazole DR capsules (RX)    Lansoprazole ODT (lansoprazole)  (*for members under 2 years*)    Omeprazole DR capsule (RX)    Pantoprazole tablet    PROTONIX (pantoprazole DR) packet for oral suspensionBNR | **PA Required**    ACIPHEX (rabeprazole) tablet, sprinkle capsule    DEXILANT (dexlansoprazole) capsule    Dexlansoprazole capsule    Esomeprazole DR 49.3 capsule (RX), (OTC) capsule    KONVOMEP (Omeprazole/Na bicarbonate) suspension    Lansoprazole DR capsule OTC    NEXIUM (esomeprazole) capsule (RX), oral suspension packet, 24HR (OTC)    Omeprazole/Na bicarbonate capsule, packet for oral suspension    Omeprazole DR tablet (OTC), ODT (OTC)    Pantoprazole packet for oral suspension    PREVACID (lansoprazole) capsule, Solutab, suspension    PRILOSEC (omeprazole) suspension    PROTONIX (pantoprazole DR) tablet    Rabeprazole tablet    VOQUEZNA (vonoprazan) tablet    ZEGERID (omeprazole/Na bicarbonate) capsule, packet for oral suspension | For members treating GERD symptoms that are controlled on PPI therapy, it is recommended that the dose of the PPI be re-evaluated or step-down with an H2 blocker (such as famotidine) be trialed in order to reduce long-term PPI use.  Prior authorization for non-preferred proton pump inhibitors may be approved if all of the following criteria are met:   * Member has a qualifying diagnosis (below) **AND** * Member has trialed and failed therapy with three preferred agents within the last 24 months. (Failure is defined as: lack of efficacy following 4-week trial, allergy, intolerable side effects, or significant drug-drug interaction) **AND** * Member has been diagnosed using one of the following diagnostic methods: o Diagnosis made by GI specialist   + Endoscopy o X-ray o Biopsy o Blood test   + Breath Test         **Qualifying Diagnoses:** Barrett’s esophagus, duodenal ulcer, erosive esophagitis, gastric ulcer, GERD, GI Bleed, H. pylori infection, hypersecretory conditions (Zollinger-Ellison), NSAID-induced ulcer, pediatric esophagitis, requiring mechanical ventilation, requiring a feeding tube    **Quantity Limits:**  All agents will be limited to once daily dosing except when used for the following diagnoses: Barrett’s esophagus, GI Bleed, H. pylori infection, hypersecretory conditions (Zollinger-Ellison), or members who have spinal cord injury with associated acid reflux.    **Adult members with GERD** on once daily, high-dose PPI therapy who continue to experience symptoms may receive initial prior authorization approval for a 4-week trial of twice daily, high-dose PPI therapy. Continuation of the twice daily dosing regimen for GERD beyond 4 weeks will require additional prior authorization approval verifying adequate member response to the dosing regimen and approval may be placed for one year. If a member with symptomatic GERD does not respond to twice daily, high-dose PPI therapy, this should be considered a treatment failure.    **Pediatric members (< 18 years of age)** on once daily dosing of a PPI who continue to experience symptoms may receive one-year prior authorization approval for twice daily PPI therapy.    **Age Limits:** |

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|  |  | **Nexium 24H** and **Zegerid** will not be approved for members less than 18 years of age.    **Prevacid Solutab** may be approved for members < 2 years of age OR for members ≥ 2 years of age with a feeding tube.    Continuation of Care: Members currently taking Dexilant (dexlansoprazole) capsules may continue to receive approval for that medication. |
| Therapeutic Drug Class: **NON-BIOLOGIC ULCERATIVE COLITIS AGENTS- Oral -***Effective 7/1/2024* | | |
| **No PA Required**  *Brand/generic changes effective*  *08/08/2024*    APRISO (mesalamine ER) capsule    Mesalamine DR tablet (generic Lialda) (*Takeda only*)    Mesalamine ER tablet (generic Apriso) (*Teva only*)    PENTASABNR (mesalamine) capsule    Sulfasalazine IR and DR tablet | **PA Required**    AZULFIDINE (sulfasalazine) Entab, tablet    Balsalazide capsule    Budesonide DR tablet    COLAZAL (balsalazide) capsule    DELZICOL (mesalamine DR) capsule    DIPENTUM (olsalazine) capsule    LIALDA (mesalamine DR) tablet    Mesalamine DR tablet (generic Asacol HD, Lialda)    Mesalamine DR/ER capsule (generic Apriso, Delzicol, Pentasa)    UCERIS (budesonide) tablet | Prior authorization for non-preferred oral formulations will require trial and failure of two preferred oral products with different active ingredients AND one preferred rectal product. If inflammation is not within reach of topical therapy, trial of preferred rectal product is not required. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.    **Uceris (budesonide) tablet**: Prior authorization may be approved following trial and failure of one preferred oral product AND one preferred rectal product. If inflammation is not within reach of topical therapy, trial of preferred rectal product is not required. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drugdrug interaction. Approval will be placed for 8 weeks. Further prior authorization may be approved if 7 days of steroid-free time has elapsed, and member continues to meet the above criteria. |
| Therapeutic Drug Class: **NON-BIOLOGIC ULCERATIVE COLITIS AGENTS- Rectal -***Effective 7/1/2024* | | |
| **No PA Required**    Mesalamine suppository    Mesalamine 4gm/60 ml enema  (generic SF ROWASA) | **PA Required**    Budesonide foam    CANASA (mesalamine) suppository    Mesalamine enema, kit    ROWASA/SF ROWASA enema, kit (mesalamine)    UCERIS (budesonide) foam | Prior authorization for non-preferred rectal formulations will require trial and failure of one preferred rectal formulation and one preferred oral formulation (Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction).    **Uceris (budesonide) foam**: If the above criteria are met, Uceris (budesonide) foam prior authorization may be approved for 6 weeks. Further prior authorization may be approved if 7 days of steroid-free time has elapsed, and member continues to meet the above criteria. |

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| **VIII. Hematological** | | |
| Therapeutic Drug Class: **ANTICOAGULANTS- Oral -***Effective 7/1/2024* | | |
| **No PA Required PA Required**  **SAVAYSA** (edoxaban) may be approved if all the following criteria have been met:  Dabigatran capsule PRADAXA (dabigatran) capsule, pellet ● The member has failed therapy with two preferred agents. (Failure is defined as  lack of efficacy, allergy, intolerable side effects, or significant drug-drug  ELIQUIS (apixaban) tablet, tablet SAVAYSA (edoxaban) tablet interaction) **AND**  pack ● Member is not on dialysis **AND**  XARELTO (rivaroxaban) 2.5 mg tablet ● Member does not have CrCl > 95 mL/min **AND**  Warfarin tablet ● The member has a diagnosis of deep vein thrombosis (DVT), pulmonary  XARELTO (rivaroxaban) oral suspension embolism (PE) **OR**  XARELTO (rivaroxaban) ● The member has a diagnosis of non-valvular atrial fibrillation **AND**  10 mg, 15 mg, 20 mg tablet, ● The member does not have a mechanical prosthetic heart valve  dose pack  **XARELTO 2.5mg** (rivaroxaban) may be approved for members meeting all of the  following criteria:   * Xarelto 2.5mg is being prescribed to reduce major CV events in members diagnosis of chronic coronary artery disease (CAD) or peripheral artery disease   **AND**   * Xarelto 2.5mg is being taken twice daily and in combination with aspirin 75100mg daily **AND** * Member must not be receiving dual antiplatelet therapy, other non-aspirin antiplatelet therapy, or other oral anticoagulant **AND** * Member must not have had an ischemic, non-lacunar stroke within the past month **AND** * Member must not have had a hemorrhagic or lacunar stroke at any time     **XARELTO** (rivaroxaban) oral suspension may be approved without prior authorization for members <18 years of age who require a rivaroxaban dose of less than 10 mg **OR** with prior authorization verifying the member is unable to use the solid oral dosage form.  All other non-preferred oral agents require trial and failure of two preferred oral agents. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drugdrug interaction.    Continuation of Care: Members with current prior authorization approval on file for a non-preferred oral anticoagulant medication may continue to receive approval for that medication | | |
| Therapeutic Drug Class: **ANTICOAGULANTS- Parenteral -***Effective 7/1/2024* | | |
| **No PA Required**    Enoxaparin syringe | **PA Required**    ARIXTRA (fondaparinux) syringe | Non-preferred parenteral anticoagulants may be approved if member has trial and failure  of one preferred parenteral agent. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction |

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| Enoxaparin vial | Fondaparinux syringe    FRAGMIN (dalteparin) vial, syringe    LOVENOX (enoxaparin) syringe, vial | **ARIXTRA** (fondaparinux) may be approved if the following criteria have been met:   * Member is 18 years of age or older **AND** * Member has a CrCl > 30 ml/min **AND** * Member weighs > 50 kg **AND** * Member has a documented history of heparin induced-thrombocytopenia **OR** * Member has a contraindication to enoxaparin   Members currently stabilized on fondaparinux (Arixtra) or dalteparin (Fragmin) may receive prior authorization approval to continue receiving that medication. |
| Therapeutic Drug Class: **ANTI-PLATELETS -***Effective 7/1/2024* | | |
| **No PA Required**    Aspirin/dipyridamole ER capsule    BRILINTA (tigacrelor) tablet    Cilostazol tablet    Clopidogrel tablet    Dipyridamole tablet    Pentoxifylline ER tablet    Prasugrel tablet | **PA Required**    EFFIENT (prasugrel) tablet    PLAVIX (clopidogrel) tablet | **Zontivity (vorapaxar)** may be approved for patients with a diagnosis of myocardial infarction or peripheral artery disease without a history of stroke, transient ischemic attack, intracranial bleeding, or active pathological bleeding. Patients must also be taking aspirin and/or clopidogrel concomitantly.    Non-preferred products without criteria will be reviewed on a case-by-case basis. |
| Therapeutic Drug Class: **COLONY STIMULATING FACTORS -***Effective 7/1/2024* | | |
| **PA Required for all agents in this class\*** | | \*Prior authorization for preferred agents may be approved if meeting the following criteria:  • Medication is being used for one of the following indications:   * Patient with cancer receiving myelosuppressive chemotherapy –to reduce incidence of infection (febrile neutropenia) (Either the post nadir ANC is less than 10,000 cells/mm3 or the risk of neutropenia for the member is calculated to be greater than 20%) * Acute Myeloid Leukemia (AML) patients receiving chemotherapyo Bone Marrow Transplant (BMT) * Peripheral Blood Progenitor Cell Collection and Therapyo Hematopoietic Syndrome of Acute Radiation Syndrome * Severe Chronic Neutropenia (Evidence of neutropenia infection exists or ANC is below 750 cells/mm3)   ▪  Prior authorization for non-preferred agents may be approved if meeting the following criteria: |
| **Preferred**    FULPHILA (pegfilgrastim-jmdb) syringe    NEUPOGEN (filgrastim) vial, syringe | **Non-Preferred**    FYLNETRA (pegfilgrastim-jmdb) syringe    GRANIX (tbo-filgrastim) syringe, vial    LEUKINE (sargramostim) vial    NEULASTA (pegfilgrastim) kit, syringe    NIVESTYM (filgrastim-aafi) syringe, vial    NYVEPRIA (pegfilgrastim-apgf) syringe    RELEUKO (filgrastim-ayow) syringe, vial |

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|  | STIMUFEND (pegfilgrastim-fpgk) syringe    UDENYCA (pegfilgrastim-cbqv) autoinjector, OnBody, syringe    ZARXIO (filgrastim-sndz) syringe    ZIEXTENZO (pegfilgrastim-bmez) syringe | • | Medicati o  o o o | | on is being used for one of the following indications:  Patient with cancer receiving myelosuppressive chemotherapy –to reduce incidence of infection (febrile neutropenia) (Either the post nadir ANC is less than 10,000 cells/mm3 or the risk of neutropenia for the member is calculated to be greater than 20%)  Acute Myeloid Leukemia (AML) patients receiving chemotherapy  Bone Marrow Transplant (BMT)  Peripheral Blood Progenitor Cell Collection and Therapy | |
|  |  |  | o | | Hematopoietic Syndrome of Acute Radiation Syndrome | |
|  |  |  | o  **AND** | | Severe Chronic Neutropenia (Evidence of neutropenia infection exists or ANC is below 750 cells/mm3) | |
|  |  | • | Member has history of trial and failure of Neupogen AND one other preferred agent. Failure is defined as a lack of efficacy with a 3-month trial, allergy, intolerable side effects, significant drug-drug interactions, or contraindication to therapy. Trial and failure of Neupogen will not be required if meeting one of the following:   * Member has limited access to caregiver or support system for assistance with medication administration **OR** * Member has inadequate access to healthcare facility or home care interventions. | | | |
| Therapeutic Drug Class: **ERYTHROPOIESIS STIMULATING AGENTS** *Effective 7/1/2024* | | | | | | |
| **PA Required for all agents in this class\*** | | followin  ●  ● | | g:  facility  Member  o   * o * o   **AND** | | \*Prior Authorization is required for all products and may be approved if meeting the  Medication is being administered in the member’s home or in a long-term care  **AND**  meets one of the following:  A diagnosis of cancer, currently receiving chemotherapy, with chemotherapy-induced anemia, and hemoglobin† of 10g/dL or lower  **OR**  A diagnosis of chronic renal failure, and hemoglobin† below 10g/dL **OR**  A diagnosis of hepatitis C, currently taking ribavirin and failed response to a reduction of ribavirin dose, and hemoglobin† less than  10g/dL (or less than 11g/dL if symptomatic) **OR**  A diagnosis of HIV, currently taking zidovudine, hemoglobin† less than 10g/dL, and serum erythropoietin level of 500 mU/mL or less **OR** Member is undergoing elective, noncardiac, nonvascular surgery and medication is given to reduce receipt of allogenic red blood cell transfusions, hemoglobin† is greater than 10g/dL, but less than or equal to 13g/dL and high risk for perioperative blood loss. Member is not willing or unable to donate autologous blood pre-operatively |
| **Preferred**    EPOGEN (epoetin alfa) vial    RETACRIT (epoetin alfa-epbx)  (*Pfizer only)* vial | **Non-Preferred**    ARANESP (darbepoetin alfa) syringe, vial    MIRCERA (methoxy peg-epoetin beta) syringe    PROCRIT (epoetin alfa) vial    RETACRIT (epoetin alfa-epbx) (*Vifor only)* vial |

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|  |  | ● For any non-preferred product, member has trialed and failed treatment with one preferred product. Failure is defined as lack of efficacy with a 6-week trial, allergy, intolerable side effects, or significant drug-drug interaction.    †Hemoglobin results must be from the last 30 days. |
| **IX. Immunological** | | |
| Therapeutic Drug Class: **IMMUNE GLOBULINS -***Effective 1/1/2025* | | |
| **PA Required for all agents in this class\*** | | Preferred agents may be approved for members meeting at least one of the approved conditions listed below for prescribed doses not exceeding maximum (Table 1).    Non-preferred agents may be approved for members meeting the following:   * Member meets at least one of the approved conditions listed below AND * Member has history of trial and failure of two preferred agents (failure is defined as lack of efficacy with 4-week trial, allergy, intolerable side effects or significant drug-drug interactions) AND * Prescribed dose does not exceed listed maximum (Table 1) Approved Conditions for Immune Globulin Use: * Primary Humoral Immunodeficiency disorders including: o Common Variable Immunodeficiency (CVID) o Severe Combined Immunodeficiency (SCID) o X-Linked Agammaglobulinemia   + X-Linked with Hyperimmunoglobulin M (IgM) Immunodeficiency o Wiskott-Aldrich Syndrome   + Members < 13 years of age with pediatric Human Immunodeficiency Virus (HIV) and CD-4 count > 200/mm3 * Neurological disorders including: o Guillain-Barré Syndrome   + Relapsing-Remitting Multiple Sclerosis   + Chronic Inflammatory Demyelinating Polyneuropathy o Myasthenia Gravis o Polymyositis and Dermatomyositis o Multifocal Motor Neuropathy * Kawasaki Syndrome * Chronic Lymphocytic Leukemia (CLL) * Autoimmune Neutropenia (AN) with absolute neutrophil count < 800 mm and history of recurrent bacterial infections * Autoimmune Hemolytic Anemia (AHA) * Liver or Intestinal Transplant * Immune Thrombocytopenia Purpura (ITP) including: o Requiring preoperative therapy for undergoing elective splenectomy with platelet count < 20,000/mcL   + Members with active bleeding & platelet count <30,000/mcL |
| **Preferred**    CUVITRU 20% SQ liquid    GAMMAGARD 10% IV/SQ liquid    GAMUNEX-C 10% IV/SQ liquid    HIZENTRA 20% SQ syringe,  vial    PRIVIGEN 10% IV liquid      *If immune globulin is being administered in a long-term care facility or in a member’s home by a home healthcare provider, it should be billed as a pharmacy claim. All other claims must be submitted through the medical benefit.* | **Non-Preferred**    ALYGLO 10% IV liquid    BIVIGAM 10% IV liquid    CUTAQUIG 16.5% SQ liquid    FLEBOGAMMA DIF 5%, 10% IV liquid    GAMMAGARD S/D vial    GAMMAKED 10% IV/SQ liquid    GAMMAPLEX 5%, 10% IV liquid    HYQVIA 10% SQ liquid    OCTAGAM 5%, 10% IV liquid    PANZYGA 10% IV liquid    XEMBIFY 20% IV liquid |

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|  |  | * Pregnant members with platelet counts <10,000/mcL in the third trimester * Pregnant members with platelet count 10,000 to 30,000/mcL who are bleeding   • Multisystem Inflammatory Syndrome in Children (MIS-C)     |  |  | | --- | --- | | Table 1: FDA-Approved Maximum Immune Globulin Dosing | | | Asceniv – IV admin | 800 mg/kg every 3 to 4 weeks | | Bivigam – IV admin | 800 mg/kg every 3 to 4 weeks | | Cuvitru –subcutaneous admin | 12 grams protein/site for up to four sites weekly (48grams/week) | | Flebogamma DIF – IV admin | 600 mg/kg every 3 weeks | | Gammaplex 5% – IV admin | 1 gram/kg for 2 consecutive days | | Gammagard liquid subcutaneous or IV admin | 2.4 grams/kg/month | | Gammaked –subcutaneous or IV admin | 600 mg/kg every 3 weeks | | Gamunex-C –subcutaneous or IV admin | 600 mg/kg every 3 weeks | | Hizentra –subcutaneous admin | 0.4 g/kg per week | | Octagam – IV admin | 2 grams/kg every 4 weeks | | Panzyga – IV admin | 2 g/kg every 3 weeks | | Privigen – IV admin | 2 g/kg over 2 to 5 consecutive days |     Members currently receiving a preferred or non-preferred immunoglobulin product may receive approval to continue therapy with that product at prescribed doses not exceeding maximum (Table 1). |
| Therapeutic Drug Class: **NEWER GENERATION ANTIHISTAMINES -***Effective 1/1/2025* | | |
| **No PA Required**    Cetirizine (OTC) syrup/solution  (OTC/RX), tablet    Desloratadine tablet (RX)    Levocetirizine tablet (RX/OTC)    Loratadine tablet (OTC), syrup/solution (OTC) | **PA Required**    Cetirizine (OTC) chewable tablet, softgel, UD cups solution    CLARINEX (desloratadine) tablet    Desloratadine ODT (RX)    Fexofenadine tablet (OTC), suspension (OTC)    Levocetirizine solution (RX) | Non-preferred single agent antihistamine products may be approved for members who have failed treatment with two preferred products in the last 6 months. For members with respiratory allergies, an additional trial of an intranasal corticosteroid will be required in the last 6 months.    Failure is defined as lack of efficacy with a 14-day trial, allergy, intolerable side effects, or significant drug-drug interaction. |

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|  | | Loratadine chewable (OTC), ODT (OTC) | |  | | |
| Therapeutic Drug Class: **ANTIHISTAMINE/DECONGESTANT COMBINATIONS -** *Effective 1/1/2025* | | | | | | |
| **No PA Required**    Loratadine-D (OTC) tablet | **PA Required**    Cetirizine-PSE (OTC)    CLARINEX-D (desloratadine-D)    Fexofenadine/PSE (OTC) | | Non-preferred antihistamine/decongestant combinations may be approved for members who have failed treatment with the preferred product in the last 6 months. For members with respiratory allergies, an additional trial of an intranasal corticosteroid will be required in the last 6 months.    Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction. | | | |
| Therapeutic Drug Class: **INTRANASAL RHINITIS AGENTS -***Effective 1/1/2025* | | | | | | |
| **No PA Required**    Azelastine 137 mcg    Budesonide (OTC)    DYMISTA (azelastine/ fluticasone) BNR    Fluticasone (RX)    Ipratropium    Olopatadine    Triamcinolone acetonide (OTC) | | **PA Required**    Azelastine (Astepro) 0.15%    Azelastine/Fluticasone    BECONASE AQ (beclomethasone dipropionate)    Flunisolide 0.025%    Fluticasone (OTC)    Mometasone    NASONEX (mometasone)    OMNARIS (ciclesonide)    PATANASE (olopatadine)    QNASL (beclomethasone)    RYALTRIS (olopatadine/mometasone)    XHANCE (fluticasone)    ZETONNA (ciclesonide) | | | Non-preferred products may be approved following trial and failure of treatment with three preferred products (failure is defined as lack of efficacy with a 2-week trial, allergy, intolerable side effects or significant drug-drug interactions).    Non-preferred combination agents may be approved following trial of individual products with same active ingredients AND trial and failure of one additional preferred agent (failure is defined as lack of efficacy with 2-week trial, allergy, intolerable side effects or significant drug-drug interactions). | |
| Therapeutic Drug Class: **LEUKOTRIENE MODIFIERS -***Effective 1/1/2025* | | | | | | |
| **No PA Required** | | **PA Required** | | | | Non-preferred products may be approved if meeting the following criteria: |

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| Montelukast tablet, chewable |  | ACCOLATE (zafirlukast) tablet  Montelukast granules    SINGULAIR (montelukast) tablet, chewable, granules    Zafirlukast tablet    Zileuton ER tablet    ZYFLO (zileuton) tablet | | * Member has trialed and failed treatment with one preferred product (failure is defined as lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions) AND * Member has a diagnosis of asthma.     **Montelukast granules** may be approved if a member has tried and failed montelukast chewable tablets AND has difficulty swallowing. |
|  | Therapeutic Drug Class: **METHOTREXATE PRODUCTS -***Effective 1/1/2025* | | | |
| **No PA Required**    Methotrexate oral tablet, vial | **PA Required**    JYLAMVO (methotrexate) oral solution    OTREXUP (methotrexate) auto-injector    RASUVO (methotrexate) auto-injector    REDITREX (methotrexate) syringe    TREXALL (methotrexate) oral tablet    XATMEP (methotrexate) oral solution | | **OTREXUP,** **REDITREX** or **RASUVO** may be approved if meeting the following criteria:   * Member has diagnosis of severe, active rheumatoid arthritis OR active polyarticular juvenile idiopathic arthritis (pJIA) OR inflammatory bowel disease (IBD) **AND** * Member has trialed and failed preferred methotrexate tablet formulation (failure is defined as lack of efficacy, allergy, intolerable side effects, inability to take oral product formulation, or   member has a diagnosis of pJIA and provider has determined that the subcutaneous formulation is necessary to optimize methotrexate therapy) **AND**   * Member (or parent/caregiver) is unable to administer preferred methotrexate vial formulation due to limited functional ability (such as vision impairment, limited manual dexterity and/or limited hand strength).       **TREXALL** may be approved if meeting the following criteria:   * Member has trialed and failed preferred methotrexate tablet formulation. Failure is defined as allergy or intolerable side effects.       **XATMEP** may be approved for members who meet the following criteria:   * Member is < 18 years of age * Member has a diagnosis of acute lymphoblastic leukemia **OR** * Member has a diagnosis of active polyarticular juvenile idiopathic arthritis (pJIA) and has had an insufficient therapeutic response to, or is intolerant to, an adequate trial of first-line therapy including full dose non-steroidal anti-inflammatory agents (NSAIDs) **AND** * Member has a documented swallowing difficulty due to young age and/or a medical condition and is unable to use the preferred methotrexate tablet formulation     *Methotrexate can cause serious embryo-fetal harm when administered during pregnancy and it is contraindicated for use during pregnancy for the treatment of non-malignant diseases. Advise members of reproductive potential to use effective contraception during and after treatment with methotrexate, according to FDA product labeling.* | |

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|  |  | | Members currently stabilized on a non-preferred methotrexate product may receive approval to continue that agent. | |
|  | Therapeutic Drug Class: **MULTIPLE SCLEROSIS AGENTS -***Effective 4/1/2025* | | | |
|  | **Disease Modifying Therapies** | | | |
| **Preferred**  **No PA Required**  **(Unless indicated\*)**    AVONEX (interferon beta 1a) pen, syringe    BETASERON (interferon beta  1b) injection    COPAXONEBNR (glatiramer) injection    Dimethyl fumarate tablet, starte pack    Fingolimod capsule    \*KESIMPTA (ofatumumab)  pen**\*\*2nd Line\*\***    Teriflunomide tablet | r | **Non-Preferred**  **PA Required**    AUBAGIO (teriflunomide) tablet    BAFIERTAM (monomethyl fumarate DR) capsule  EXTAVIA (interferon beta 1b) kit, vial  GILENYA (fingolimod) capsule  Glatiramer 20mg, 40mg injection    GLATOPA (glatiramer) injection    MAVENCLAD (cladribine) tablet    MAYZENT (siponimod) tablet, pack    PLEGRIDY (peg-interferon beta 1a) pen, syringe  PONVORY (ponesimod) tablet, pack  REBIF (interferon beta 1a) syringe    REBIF REDIDOSE (interferon beta 1a) pen  TASCENSO ODT (fingolimod) tablet  TECFIDERA(dimethyl fumarate) tablet, pack    VUMERITY (diroximel DR) capsule    ZEPOSIA (ozanimod) capsule, kit, starter pack | | \*Kesimpta (ofatumumab) may be approved if member has trialed and failed treatment with one preferred agent (failure is defined as intolerable side effects, contraindication to therapy, drug-drug interaction, or lack of efficacy).    Non-Preferred Products:  Non-preferred products may be approved if meeting the following:   * Member has a diagnosis of a relapsing form of multiple sclerosis AND * Member has previous trial and failure with three preferred agents. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drugdrug interaction AND * Prescribed dose does not exceed the maximum FDA-approved dose for the medication being ordered AND * If indicated in the product labeling, a negative pre-treatment pregnancy test has been documented, AND * If indicated in the product labeling, an ophthalmologic examination has been performed and documented prior to medication initiation, AND * The request meets additional criteria listed for any of the following:         **Mayzent (siponimod):**   * Member has previous trial and failure of three preferred agents, one of which must be Gilenya (fingolimod). Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.     **Mavenclad (cladribine):**   * Member has history of ≥ 1 relapse in the 12 months preceding initiation of therapy   AND   * Member has previous trial and failure of three other therapies for relapsing forms of multiple sclerosis (failure is defined as lack of efficacy with 3-month trial, allergy, intolerable side effects, or significant drug-drug interactions)     **Vumerity (diroximel fumarate)** or **Bafiertam (monomethyl fumarate DR)**:   * Member has previous trial and failure of three preferred agents, one of which must be Tecfidera (dimethyl fumarate). Failure is defined as lack of efficacy, allergy, significant drug-drug interactions, intolerable side effects (if GI adverse events, must meet additional criteria below) AND |

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|  |  | • If the requested medication is being prescribed due to GI adverse events with Tecfidera therapy (and no other reason for failure of Tecfidera is given), then the following additional criteria must be met:   * Member has trialed a temporary dose reduction of Tecfidera (with maintenance dose being resumed within 4 weeks) AND * Member has trialed taking Tecfidera with food AND o GI adverse events remain significant despite maximized use of gastrointestinal symptomatic therapies (such as calcium carbonate, bismuth subsalicylate, PPIs, H2 blockers, anti-bloating/anti-constipation agents, antidiarrheal, and centrally acting anti-emetics) AND * Initial authorization will be limited to 3 months. Continuation (12-month authorization) will require documentation of clinically significant reduction in GI adverse events.     Members currently stabilized on a preferred second line (Kesimpta) or non-preferred product (may receive approval to continue therapy with that agent. | |
| **Symptom Management Therapies** | | | |
| **No PA Required**    Dalfampridine ER tablet | **PA Required**    AMPYRA ER (dalfampridine) tablet | Non-preferred products may be approved with prescriber attestation that there is clinical rationale supporting why the preferred brand/generic equivalent product formulation is unable to be used.    Maximum Dose:  Ampyra (dalfampridine) 10mg twice daily | |
| Therapeutic Drug Class: **TARGETED IMMUNE MODULATORS** **-***Effective 1/1/2025*  *Preferred agents:* Adalimumab-aaty and adbm; ADBRY (tralokinumab-ldrm); Cyltezo (adalimumab-adbm); DUPIXENT (dupilumab); ENBREL (etanercept);  FASENRA (benralizumab) pen; HADLIMA (adalimumab- bwwd); HUMIRA (adalimumab); OTEZLA (apremilast) tablet; KEVZARA (sarilumab); TALTZ (ixekizumab); TEZSPIRE (tezepelumab-ekko) pen; XELJANZ IR (tofacitinib) tablet; XOLAIR (omalizumab) syringe | | | |
| **Rheumatoid Arthritis, all other Arthritis (except psoriatic arthritis, see below), and Ankylosing Spondylitis** | | | |
| **Preferred**  No PA Required  (If diagnosis met)  (\*Must meet eligibility criteria)    Adalimumab-aaty pen, syringe    Adalimumab-adbm pen, syringe    CYLTEZO (adalimumab-adbm) pen, syringe    ENBREL (etanercept) | **Non-Preferred**  PA Required    ABRILADA (adalimumab-afzb) pen, syringe    ACTEMRA (tocilizumab) syringe, Actpen    Adalimumab-aacf pen, syringe    Adalimumab-adaz pen, syringe    Adalimumab-fkjp pen, syringe | | First line preferred agents (preferred adalimumab products, ENBREL, and XELJANZ IR) may receive approval for use for FDA-labeled indications.    **\*TALTZ (ixekizumab)** may receive approval for use for FDA-labeled indications following trial and failure‡ of a preferred adalimumab product or ENBREL.    **\*KEVZARA (sarilumab)** may receive approval for use for FDA-labeled indications following trial and failure‡ of:   * A preferred adalimumab product or ENBREL **AND** * XELJANZ IR. |

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| HADLIMA (adalimumab-bwwd)  Pushtouch, syringe    HUMIRA (adalimumab)    \*KEVZARA (sarilumab) pen, syringe    \*TALTZ (ixekizumab) 80 mg syringe, autoinjector    \*TYENNE (tocilizumab-aazg) pen, syringe    XELJANZ IR (tofacitinib) tablet | Adalimumab-ryvk auto-injector    AMJEVITA (adalimumab-atto) auto-injector, syringe    BIMZELX (bimekizumab-bkzx) pen    CIMZIA (certolizumab pegol) syringe, vial    COSENTYX (secukinumab) syringe, pen-injector      HULIO (adalimumab-fkjp) pen, syringe    HYRIMOZ (adalimumab-adaz) pen, syringe    IDACIO (adalimumab-aacf) pen, syringe    ILARIS (canakinumab) vial    KINERET (anakinra) syringe    OLUMIANT (baricitinib) tablet    ORENCIA (abatacept) clickject, syringe    RINVOQ (upadacitinib), solution, tablet    SIMLANDI (adalimumab-ryvk) auto-injector    SIMPONI (golimumab) pen, syringe    SKYRIZI (risankizumab-rzaa) OnBody, SC pen, syringe    XELJANZ (tofacitinib) solution    XELJANZ XR (tofacitinib ER) tablet    YUFLYMA (adalimumab-aaty) auto-injector, syringe      YUSIMRY (adalimumab-aqvh) pen | **\*TYENNE (tocilizumab-aazg)** may receive approval for use for FDA-labeled indications following trial and failure‡ of:   * A preferred adalimumab product or ENBREL **AND** * XELJANZ IR.     Quantity Limit: XELJANZ IR is limited to 2 tablets per day or 60 tablets for a 30-day supply    **Non-Preferred Agents:**    **COSENTYX (secukinumab)** may receive approval for:   * FDA-labeled indications following trial and failure‡ of all indicated preferred agents OR * Treatment of enthesitis-related arthritis if meeting the following: o Member is ≥ 4 years of age and weighs ≥ 15 kg **AND**   o Member has had trialed and failed‡ NSAID therapy and ENBREL and a preferred adalimumab product    **KINERET (anakinra)** may receive approval for:   * Treatment of systemic juvenile idiopathic arthritis (sJIA) or Adult-Onset Still’s Disease (AOSD) **OR** * Treatment of rheumatoid arthritis following trial and failure‡ of o A preferred adalimumab product or ENBREL **AND** o XELJANZ IR     **ILARIS (canakinumab)** may receive approval if meeting the following:   * Medication is being prescribed for systemic juvenile idiopathic arthritis (sJIA) or Adult-Onset Still’s Disease (AOSD), **AND** * Member has trialed and failed‡ a tocilizumab product.     Quantity Limit: 300mg (2mL) every 4 weeks    **XELJANZ (tofacitinib) XR** approval will require verification of the clinically relevant reason for use of the XELJANZ XR formulation versus the  XELJANZ IR formulation, in addition to meeting non-preferred criteria listed below.    **XELJANZ (tofacitinib) oral solution** may be approved when the following criteria are met:   * Member has a diagnosis of polyarticular course juvenile idiopathic arthritis (pJIA) who require a weight-based dose for <40 kg following trial and failure‡ of a preferred adalimumab product or ENBREL **OR** * Member cannot swallow a tofacitinib tablet |

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|  | ***Note: Product formulations in the physician administered drug (PAD) category are located on*** [***Appendix P***](https://hcpf.colorado.gov/pharmacy-resources#PDLP) | All other non-preferred agents may receive approval for FDA-labeled indications following trial and failure‡ of all preferred agents that are FDA-indicated or have strong evidence supporting use for the prescribed indication from clinically recognized guideline compendia (only one preferred adalimumab product trial required).    Non-preferred agents that are being prescribed per FDA labeling to treat nonradiographic axial spondyloarthritis (nr-axSpA) will require trial and failure‡ of preferred agents that are FDA-labeled for treating an axial spondyloarthritis condition, including ankylosing spondylitis (AS) or nr-axSpA.    Continuation of therapy: Members currently taking a preferred agent may receive approval to continue therapy with that agent. Members with current prior authorization approval on file for a non-preferred agent may receive approval for continuation of therapy with the prescribed agent.    ‡Failure is defined as lack of efficacy, contraindication to therapy, allergy, intolerable side effects, or significant drug-drug interaction. Note that trial and failure of preferred TNF inhibitors will not be required when prescribed to treat polyarticular juvenile idiopathic arthritis (pJIA) in members with documented clinical features of lupus.    *The Department would like to remind providers that many products are associated with patient-centered programs that are available to assist with drug administration, education, and emotional support related to our members’ various disease states.* |
| **Psoriatic Arthritis** | | |
| **Preferred**  **No PA Required**  **(If diagnosis met)**  **(\*Must meet eligibility criteria)**    Adalimumab-aaty pen, syringe    Adalimumab-adbm pen, syringe    CYLTEZO (adalimumab-adbm) pen, syringe    ENBREL (etanercept)    HADLIMA (adalimumab-bwwd)  Pushtouch, syringe    HUMIRA (adalimumab)    \*OTEZLA (apremilast) tablet | **Non-Preferred**  **PA Required**    ABRILADA (adalimumab-afzb) pen, syringe    Adalimumab-aacf pen, syringe    Adalimumab-adaz pen, syringe    Adalimumab-fkjp pen, syringe    Adalimumab-ryvk auto-injector    AMJEVITA (adalimumab-atto) auto-injector, syringe    BIMZELX (bimekizumab-bkzx) pen    CIMZIA (certolizumab pegol) syringe, vial | First line preferred agents (HADLIMA, HUMIRA, ENBREL, XELJANZ IR) may receive approval for psoriatic arthritis indication.    **\*OTEZLA (apremilast)** may receive approval for psoriatic arthritis indication following trial and failure‡ of:   * A preferred adalimumab product or ENBREL **AND** * XELJANZ IR or TALTZ.     **\*TALTZ (ixekizumab)** may receive approval for psoriatic arthritis indication following trial and failure‡ of:   * A preferred adalimumab product or ENBREL **AND** * XELJANZ IR or OTEZLA.     Quantity Limit: XELJANZ IR is limited to 2 tablets per day or 60 tablets for a 30-day supply      **Non-Preferred Agents:** |

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| \*TALTZ (ixekizumab) 80 mg syringe    XELJANZ IR (tofacitinib) tablet | COSENTYX (secukinumab) syringe, pen-injector      HULIO (adalimumab-fkjp) pen, syringe    HYRIMOZ (adalimumab-adaz) pen, syringe    IDACIO (adalimumab-aacf) pen, syringe    ORENCIA (abatacept) syringe, clickject    RINVOQ (upadacitinib) tablet    RINVOQ LQ (upadacitinib) solution    SIMLANDI (adalimumab-ryvk) auto-injector    SIMPONI (golimumab) pen, syringe    SKYRIZI (risankizumab-rzaa) OnBody, pen, syringe    STELARA (ustekinumab) syringe    TREMFYA (guselkumab) injector, syringe    XELJANZ (tofacitinib) solution    XELJANZ XR (tofacitinib ER) tablet    YUFLYMA (adalimumab-aaty) auto-injector, syringe    YUSIMRY (adalimumab-aqvh) pen    ***Note: Product formulations in the physician administered drug (PAD) category are located on*** [***Appendix P***](https://hcpf.colorado.gov/pharmacy-resources#PDLP) | **COSENTYX (secukinumab)** may receive approval for psoriatic arthritis indication  for members ≥ 2 years of age and weighing ≥ 15 kg following trial and failure‡ of:   * A preferred adalimumab product or ENBREL **AND** * XELJANZ IR **AND** * TALTZ or OTEZLA.     **STELARA (ustekinumab)** syringe for subcutaneous use may receive approval if meeting the following:   * Member has trial and failure‡ of:   + A preferred adalimumab product or ENBREL **AND**   + XELJANZ IR **AND** o TALTZ or OTEZLA   **AND**   * Prior authorization approval may be given for an initial 16-week supply and authorization approval for continuation may be provided based on clinical response.     **XELJANZ (tofacitinib) XR** approval will require verification of the clinically relevant reason for use of the XELJANZ XR formulation versus the  XELJANZ IR formulation, in addition to meeting non-preferred criteria listed below.    All other non-preferred agents may receive approval for psoriatic arthritis following trial and failure‡ of:   * A preferred adalimumab product or ENBREL **AND** * XELJANZ IR **AND** * TALTZ or OTEZLA.       ‡Failure is defined as lack of efficacy, contraindication to therapy, allergy, intolerable side effects, or significant drug-drug interaction.    Continuation of therapy: Members currently taking a preferred agent may receive approval to continue therapy with that agent. Members with current prior authorization approval on file for a non-preferred agent may receive approval for continuation of therapy with the prescribed agent.    *The Department would like to remind providers that many products are associated with patient-centered programs that are available to assist with drug administration, education, and emotional support related to our members’ various disease states.* |
| **Plaque Psoriasis** | | |

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| **Preferred**  **No PA Required**  **(If diagnosis met)**  **(\*Must meet eligibility criteria)**    Adalimumab-aaty pen, syringe    Adalimumab-adbm pen, syringe    CYLTEZO (adalimumab-adbm) pen, syringe    ENBREL (etanercept)    HADLIMA (adalimumab-bwwd)  Pushtouch, syringe    HUMIRA (adalimumab)    \*OTEZLA (apremilast) tablet    \*TALTZ(ixekizumab) 80 mg syringe    TYENNE (tocilizumab-aazg) pen, syringe | **Non-Preferred**  **PA Required**      ABRILADA (adalimumab-afzb) pen, syringe    Adalimumab-aacf pen, syringe    Adalimumab-adaz pen, syringe    Adalimumab-fkjp pen, syringe    Adalimumab-ryvk auto-injector    AMJEVITA (adalimumab-atto) auto-injector, syringe    BIMZELX (bimekizumab-bkzx) pen    CIMZIA (certolizumab pegol) syringe, vial    COSENTYX (secukinumab) syringe, pen-injector      HULIO (adalimumab-fkjp) pen, syringe    HYRIMOZ (adalimumab-adaz) pen, syringe    IDACIO (adalimumab-aacf) pen, syringe    ORENCIA (abatacept) syringe, clickject    SILIQ (brodalumab) syringe    SIMLANDI (adalimumab-ryvk) auto-injector    SKYRIZI (risankizumab-rzaa) OnBody, pen, syringe    SOTYKTU (ducravacitinib) oral tablet    STELARA (ustekinumab) syringe    TALTZ (ixekizumab) 20mg, 40mg syringe    TREMFYA (guselkumab) injector, syringe | First line preferred agents (preferred adalimumab products, ENBREL) may receive approval for plaque psoriasis indication.    \*Second line preferred agents (TALTZ, OTEZLA) may receive approval for plaque psoriasis indication following trial and failure‡ of a preferred adalimumab product OR  ENBREL.    **Non-Preferred Agents:**    **STELARA (ustekinumab) syringe for subcutaneous use** may receive approval if meeting the following:   * Member has trial and failure‡ of one indicated first line agent (preferred adalimumab products, ENBREL) **AND** two indicated second line agents (TALTZ, OTEZLA), **AND** * Prior authorization approval may be given for an initial 16-week supply and authorization approval for continuation may be provided based on clinical response.     All other non-preferred agents may receive approval for plaque psoriasis indication following trial and failure‡ of one indicated first line agent (a preferred adalimumab product, ENBREL) AND two second line agents (TALTZ, OTEZLA).    ‡Failure is defined as lack of efficacy, contraindication to therapy, allergy, intolerable side effects, or significant drug-drug interaction.    Continuation of therapy: Members currently taking a preferred agent may receive approval to continue therapy with that agent. Members with current prior authorization approval on file for a non-preferred agent may receive approval for continuation of therapy with the prescribed agent.    *The Department would like to remind providers that many products are associated with patient-centered programs that are available to assist with drug administration, education, and emotional support related to our members’ various disease states.* |

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|  | YUFLYMA (adalimumab-aaty) auto-injector, syringe    YUSIMRY (adalimumab-aqvh) pen    ***Note: Product formulations in the physician administered drug (PAD) category are located on***  [***Appendix P***](https://hcpf.colorado.gov/pharmacy-resources#PDLP) |  |
| **Crohn’s Disease and Ulcerative Colitis** | | |
| **Preferred**  **No PA Required**  **(If diagnosis met)**  **(\*Must meet eligibility criteria)**    Adalimumab-aaty pen, syringe    Adalimumab-adbm pen, syringe    CYLTEZO (adalimumab-adbm) pen, syringe    HADLIMA (adalimumab-bwwd)  Pushtouch, syringe    HUMIRA (adalimumab)    \*XELJANZ IR (tofacitinib) tablet | **Non-Preferred**  **PA Required**    ABRILADA (adalimumab-afzb) pen, syringe    Adalimumab-aacf pen, syringe    Adalimumab-adaz pen, syringe    Adalimumab-fkjp pen, syringe    Adalimumab-ryvk auto-injector    AMJEVITA (adalimumab-atto) auto-injector, syringe    CIMZIA (certolizumab pegol) syringe, vial    COSENTYX (secukinumab) syringe, pen-injector    ENTYVIO (vedolizumab) pen    HULIO (adalimumab-fkjp) syringe    HYRIMOZ (adalimumab-adaz) pen, syringe    IDACIO (adalimumab-aacf) pen, syringe  OLUMIANT (baricitinib) tablet    OMVOH (mirikizumab-mrkz) pen    RINVOQ (upadacitinib) tablet    RINVOQ LQ (upadacitinib) solution | Preferred agents (preferred adalimumab products, XELJANZ IR) may receive approval for Crohn’s disease and ulcerative colitis indications.    Quantity Limit: XELJANZ IR is limited to 2 tablets per day or 60 tablets for a 30-day supply      **Non-Preferred Agents:**  **ENTYVIO (vedolizumab) pen for subcutaneous injection** may receive approval if the following criteria are met:   * For treatment of moderately-to-severely active Crohn’s disease, member has trial and failure‡ of one preferred adalimumab product **OR** for treatment of   moderately-to-severely active ulcerative colitis, member has trial and failure‡ of one preferred adalimumab product and XELJANZ IR **AND**   * Member is ≥ 18 years of age **AND** * Prescriber acknowledges that administration of IV induction therapy prior to approval of ENTYVIO (vedolizumab)pen for subcutaneous injection using the above criteria should be avoided and will not result in an automatic approval of requests for these formulations.     **OMVOH (mirikizumab-mrkz)** **pen for subcutaneous injection** may receive approval if the following criteria are met:   * The requested medication is being prescribed for treatment of moderately-toseverely active ulcerative colitis **AND** * Member is ≥ 18 years of age **AND** * Member has trial and failure‡ of one preferred adalimumab product AND XELJANZ IR AND ENTYVIO (vedolizumab) **AND** * Prescriber acknowledges that administration of IV induction therapy prior to approval of OMVOH (mirikizumab-mrkz) pen for subcutaneous injection using the above criteria should be avoided and will not result in an automatic approval of requests for these formulations.     **SKYRIZI (risankizumab) syringe for subcutaneous use** and **on-body injector formulations** may receive approval if meeting the following: |

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|  | SIMLANDI (adalimumab-ryvk) auto-injector    SIMPONI (golimumab) pen, syringe    SKYRIZI (risankizumab-rzaa) OnBody, pen, syringe    STELARA (ustekinumab) syringe    VELSIPITY (etrasimod) tablet    XELJANZ (tofacitinib) solution    XELJANZ XR (tofacitinib ER) tablet    YUFLYMA (adalimumab-aaty) auto-injector    YUSIMRY (adalimumab-aqvh) pen    ZYMFENTRA (infliximab-dyyb) pen kit, syringe  kit    ***Note: Product formulations in the physician administered drug (PAD) category are located on*** [***Appendix P***](https://hcpf.colorado.gov/pharmacy-resources#PDLP) | * The requested medication is being prescribed for use for treating moderately-toseverely active Crohn’s disease or for treating moderate-to-severly ulcerative colitis **AND** * Member is ≥ 18 years of age **AND** * Request meets one of the following based on prescribed indication: o For treatment of moderately-to-severely active Crohn’s disease, member has trial and failure‡ of one preferred adalimumab product and   ENTYVIO (vedolizumab) **OR**   * + For treatment of moderately-to-severely active ulcerative colitis, member has trial and failure‡ of one preferred adalimumab product and XELJANZ IR and ENTYVIO (vedolizumab) **AND** * Prescriber acknowledges that administration of IV induction therapy prior to approval of SKYRIZI (risankizumab) prefilled syringe or on-body injector formulation using the above criteria should be avoided and will not result in an automatic approval of requests for these formulations.     **Dosing Limit:** SKYRIZI on-body formulation maintenance dosing is limited to one 360 mg/2.4 mL single-dose prefilled cartridge or one 180 mg/1.2mL prefilled cartridge every 8 weeks.    **STELARA (ustekinumab) syringe for subcutaneous use** may receive approval if meeting the following:   * The requested medication is being prescribed for use for treating moderately-toseverely active Crohn’s disease or for treating moderately-to-severely active ulcerative colitis **AND** * Request meets one of the following based on prescribed indication: o For treatment of moderately-to-severely active Crohn’s disease, member has trial and failure‡ of one preferred adalimumab product and   ENTYVIO (vedolizumab) **OR**   * + For treatment of moderately-to-severely active ulcerative colitis, member has trial and failure‡ of one preferred adalimumab product and XELJANZ IR and ENTYVIO (vedolizumab) **AND** * The member is ≥ 18 years of age **AND** * Prescriber acknowledges that loading dose administration prior to approval of STELARA for maintenance therapy using the above criteria should be avoided and will not result in an automatic approval of STELARA for maintenance therapy **AND** * Prior authorization approval may be given for an initial 16-week supply and authorization approval for continuation may be provided based on clinical response.     **TREMFYA (guselkumab) pen for subcutaneous injection** may receive approval if the following criteria are met: |

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|  |  | * For treatment of moderately-to-severely active ulcerative colitis, member has trial and failure‡ of one preferred adalimumab product and XELJANZ IR **AND** * Member is ≥ 18 years of age **AND** * Prescriber acknowledges that administration of IV induction therapy prior to approval of TREMFYA (guselkumab) pen for subcutaneous injection using the above criteria should be avoided and will not result in an automatic approval of requests for these formulations.     **XELJANZ (tofacitinib) XR** approval will require verification of the clinically relevant reason for use of the XELJANZ XR formulation versus the XELJANZ IR formulation, in addition to meeting non-preferred criteria listed below.      All other non-preferred agents may receive approval for FDA-labeled indications if meeting the following:   * The requested medication is being prescribed for treating moderately-toseverely active Crohn’s disease or moderately-to-severely active Ulcerative Colitis in alignment with indicated use outlined in FDA-approved product labeling **AND** * The requested medication meets FDA-labeled indicated age for prescribed use   **AND**   * For treatment of moderately-to-severely active Crohn’s disease, member has trial and failure‡ of one preferred adalimumab product **OR** for treatment of moderately-to-severely active ulcerative colitis, member has trial and failure‡ of one preferred adalimumab product and XELJANZ IR.     Continuation of therapy: Members currently taking a preferred agent may receive approval to continue therapy with that agent. Members with current prior authorization approval on file for a non-preferred agent may receive approval for continuation of therapy with the prescribed agent.    ‡Failure is defined as lack of efficacy, contraindication to therapy, allergy, intolerable side effects, or significant drug-drug interaction. Note that trial and failure of Xeljanz IR will not be required when prescribed for ulcerative colitis for members ≥ 50 years of age that have an additional CV risk factor.    *The Department would like to remind providers that many products are associated with patient-centered programs that are available to assist with drug administration, education, and emotional support related to our members’ various disease states.* |
| **Asthma** | | |
| **Preferred**  **PA Required**  **(\*Must meet eligibility criteria)** | **Non-Preferred**  **PA Required**      NUCALA (mepolizumab) auto-injector, syringe | \*Preferred products (Dupixent, Fasenra, Tezspire, Xolair) may receive approval if meeting the following:    **DUPIXENT (dupilumab):**  • Member is 6 years of age or older **AND** |

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| \*DUPIXENT (dupilumab) pen, syringe    \*FASENRA (benralizumab) pen    \*TEZSPIRE (tezepelumab-ekko) pen    \*XOLAIR (omalizumab) syringe, autoinjector | ***Note: Product formulations in the physician administered drug (PAD) category are located on*** [***Appendix P***](https://hcpf.colorado.gov/pharmacy-resources#PDLP) | * Member has an FDA-labeled indicated use for treating one of the following: o Moderate to severe asthma (on medium to high dose inhaled corticosteroid and a long-acting beta agonist) with eosinophilic phenotype based on a blood eosinophil level of ≥ 150/mcL **OR**   o Oral corticosteroid dependent asthma  **AND**   * Member’s asthma has been refractory to recommended evidence-based, guideline-supported pharmacologic therapies **AND** * Medication is being prescribed as add-on therapy to existing asthma regimen.     Quantity Limit: 2 syringes every 28 days after initial 14 days of therapy (first dose is twice the regular scheduled dose)    **FASENRA (benralizumab):**   * Member is ≥ 6 years of age **AND** * Member has an FDA-labeled indicated use for treating severe asthma with an eosinophilic phenotype based on a blood eosinophil level of ≥ 150/mcL **AND** * Member’s asthma has been refractory to recommended evidence-based, guideline-supported pharmacologic therapies **AND** * The requested medication is being prescribed as add-on therapy to existing asthma regimen.   Quantity Limit: One 30 mg unit dose pack every 28 days for the first 3 doses and then every 8 weeks thereafter    **TEZSPIRE (tezepelumab-ekko):**   * Member is ≥ 12 years of age **AND** * Member has a diagnosis of severe asthma **AND** * Member’s asthma has been refractory to recommended evidence-based, guideline-supported pharmacologic therapies **AND** * The requested medication is being prescribed as add-on therapy to existing asthma regimen.     Quantity Limit: Four 210 mg unit dose packs every 28 days    **XOLAIR (omalizumab)** may receive approval if meeting the following based on prescribed indication:   * Member is ≥ 6 years of age **AND** * Member has an FDA-labeled indicated use for treating asthma **AND** * Member has a positive skin test or in vitro reactivity to a perennial inhaled allergen or has a pre-treatment IgE serum concentration ≥ 30 IU/mL **AND** * Member’s asthma has been refractory to recommended evidence-based, guideline-supported pharmacologic therapies **AND** |

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|  |  |  | * The requested medication is being prescribed as add-on therapy to existing asthma regimen.   **Non-Preferred Agents:**    Non-preferred FDA-indicated biologic agents for asthma may receive approval if meeting the following:   * The requested medication is being prescribed for treating asthma in alignment with indicated use outlined in FDA-approved product labeling (including asthma type and severity) **AND** * If prescribed for use for asthma with eosinophilic phenotype, member has a blood eosinophil count ≥ 150 cells/mcL **AND** * The requested medication meets FDA-labeled indicated age for prescribed use   **AND**   * Member’s asthma has been refractory to recommended evidence-based, guideline-supported pharmacologic therapies **AND** * The requested medication is being prescribed as add-on therapy to existing asthma regimen **AND** * Member has trialed and failed‡ two preferred agents.     Quantity Limits:  Non-preferred medications will be subject to quantity limitations in alignment with FDAapproved dosing per product package labeling.  **Nucala (mepolizumab)** is limited to 100mg every 4 weeks (members ≥ 12 years of age) or 40mg every 4 weeks (members 6-11 years of age).    ‡Failure is defined as a lack of efficacy, allergy, intolerable side effects, contraindication to, or significant drug-drug interactions.    Continuation of therapy: Members currently taking a preferred agent may receive approval to continue therapy with that agent. Members with current prior authorization approval on file for a non-preferred agent may receive approval for continuation of therapy with the prescribed agent. |
|  | | **Atopic Dermatitis** | |
| **Preferred**    **(\*Must meet eligibility criteria)**    \*ADBRY (tralokinumab-ldrm) syringe, autoinjector    \*DUPIXENT (dupilumab) pen, syringe | **Non-Preferred**  **PA Required**      CIBINQO (abrocitinib) tablet    RINVOQ (upadacitinib) tablet |  | \*Preferred products (Adbry and Dupixent) may receive approval if meeting the following:    **ADBRY (tralokinumab-ldrm):**   * The requested drug is being prescribed for moderate-to-severe atopic dermatitis   **AND**   * Member has trialed and failed‡ the following agents: |

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|  | ***Note: Product formulations in the physician administered drug (PAD) category are located on***  [***Appendix P***](https://hcpf.colorado.gov/pharmacy-resources#PDLP) | o One medium potency to very-high potency topical corticosteroid (such as mometasone furoate, betamethasone dipropionate) **AND** o One topical calcineurin inhibitor (such as pimecrolimus or tacrolimus)  Maximum Dose: 600 mg/2 weeks    Quantity Limit: Four 150 mg/mL prefilled syringes/2 weeks    **DUPIXENT (dupilumab):**   * Member has a diagnosis of moderate to severe atopic dermatitis **AND** * Member has trialed and failed‡ the following agents: o One medium potency to very-high potency topical corticosteroid [such as mometasone furoate, betamethasone dipropionate, or fluocinonide   (see PDL for list of preferred products) **AND** o One topical calcineurin inhibitor (such as pimecrolimus or tacrolimus)    Quantity Limit: 2 syringes every 28 days after initial 14 days of therapy (first dose is twice the regular scheduled dose)    **Non-Preferred Agents:**    Non-preferred agents indicated for the treatment of atopic dermatitis may receive approval if meeting the following:   * Member has a diagnosis of moderate to severe chronic atopic dermatitis **AND** * Member has trialed and failed‡ therapy with two preferred agents for the prescribed indication **AND** * Member has trialed and failed‡ the following agents: o One medium potency to very-high potency topical corticosteroid (such as mometasone furoate, betamethasone dipropionate, or fluocinonide)   o One topical calcineurin inhibitor (such as pimecrolimus and tacrolimus)  **AND**   * The medication is being prescribed by or in consultation with a dermatologist, allergist, immunologist, or rheumatologist.     Approval: One year    ‡Failure is defined as a lack of efficacy, allergy, intolerable side effects, contraindication to, or significant drug-drug interactions.    Continuation of therapy: Members currently taking a preferred agent may receive approval to continue therapy with that agent. Members with current prior authorization approval on file for a non-preferred agent may receive approval for continuation of therapy with the prescribed agent. |

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| **Other indications** | | |
| **Preferred**  **(If diagnosis met, No PA required)**  **(Must meet eligibility criteria\*)**    \*DUPIXENT (dupilumab) pen, syringe    ENBREL (etanercept)    \*FASENRA (benralizumab) pen    HUMIRA (adalimumab)    \*KEVZARA (sarilumab)    OTEZLA (apremilast) tablet    XELJANZ IR (tofacitinib) tablet    \*XOLAIR (omalizumab) syringe, autoinjector | **Non-Preferred**  **PA Required**    ACTEMRA (tocilizumab) syringe, Actpen    ARCALYST (rilonacept) injection    CIMZIA (certolizumab pegol) syringe    COSENTYX (secukinumab) syringe, pen-injector    CYLTEZO (adalimumab-adbm) pen, syringe    ILARIS (canakinumab) vial    KINERET (anakinra) syringe    NUCALA (mepolizumab) auto-injector, syringe    OLUMIANT (baricitinib) tablet    YUFLYMA (adalimumab-aaty) auto-injector    ***Note: Product formulations in the physician administered drug (PAD) category are located on***  [***Appendix P***](https://hcpf.colorado.gov/pharmacy-resources#PDLP) | **\*DUPIXENT (dupilumab)** may receive approval if meeting the following based on prescribed indication:    Chronic Obstructive Pulmonary Disease   * Member is ≥ 18 years of age **AND** * Medication is being prescribed by or in consultation with a pulmonologist or allergist **AND** * Requested medication is being prescribed as an add-on maintenance treatment for inadequately controlled chronic obstructive pulmonary disease (COPD)   **AND**   * Member’s COPD is an eosinophilic phenotype based on a blood eosinophil level of ≥ 300 cells/mcL **AND** * Member is receiving, and will continue, standard maintenance triple therapy for COPD (inhaled corticosteroid, long-acting muscarinic agent, long-acting beta agonist) as recommended by the current Global Initiative for Chronic Obstructive Lung Disease (GOLD) guidelines **AND** * Member has experienced at least 2 moderate OR 1 severe COPD exacerbation during the past 12 months     Chronic Rhinosinusitis with Nasal Polyposis   * Member is ≥ 12 years of age **AND** * Medication is being prescribed as an add-on maintenance treatment for inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP)   **AND**   * Member has trialed and failed‡ therapy with at least two intranasal corticosteroid regimens     Eosinophilic Esophagitis (EoE):   * Member is ≥ 1 year of age **AND** * Member weighs at least 15 kg **AND** * Member has a diagnosis of eosinophilic esophagitis (EoE) with ≥ 15 intraepithelial eosinophils per high-power field (eos/hpf), with or without a history of esophageal dilations **AND** * Member is following appropriate dietary therapy interventions **AND** * Medication is being prescribed by or in consultation with a gastroenterologist, allergist or immunologist **AND** * Member has trialed and failed‡ one of the following treatment options for EoE: o Proton pump inhibitor trial of at least eight weeks in duration if reflux is a contributing factor **OR** |

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|  |  | o Minimum four-week trial of local therapy with a corticosteroid medication    Prurigo Nodularis:   * Member is ≥ 18 years of age AND * Medication is being prescribed as treatment for prurigo nodularis AND * Member has trialed and failed‡ therapy with at least two corticosteroid regimens (topical or intralesional injection).     **\*FASENRA (benralizumab)** may be approved for the treatment of adult patients with eosinophilic granulomatosis with polyangiitis (EGPA).    **\*KEVZARA (sarilumab)** treatment of adult patients with polymyalgia rheumatica who have had an inadequate response to corticosteroids or who cannot tolerate corticosteroid taper.    **TYENNE (tocilizumab-aazg)** may receive approval for use for FDA-label indications following trial and failure‡ of a preferred adalimumab product or ENBREL    **\*XOLAIR (omalizumab)** may receive approval if meeting the following based on prescribed indication:    Chronic Rhinosinusitis with Nasal Polyps:   * Member is 18 years of age or older **AND** * Medication is being prescribed as add-on maintenance treatment of chronic rhinosinusitis with nasal polyps (CRSwNP) in adult patients 18 years of age and older with inadequate response to nasal corticosteroids **AND** * Member has tried and failed‡ therapy with at least two intranasal corticosteroid regimens     Chronic Idiopathic Urticaria (CIU):   * Member is 12 years of age or older **AND** * Member is diagnosed with chronic idiopathic urticaria **AND** * Member is symptomatic despite H1 antihistamine treatment **AND** * Member has tried and failed‡ at least three of the following:     o High-dose second generation H1 antihistamine o H2 antihistamine o First-generation antihistamine o Leukotriene receptor antagonist o Hydroxyzine or doxepin (must include)  **AND** |

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|  |  | * Prescriber attests that the need for continued therapy will be periodically reassessed (as the appropriate duration of Xolair therapy for CIU has currently not been evaluated).     IgE-Mediated Food Allergy:   * Medication is being prescribed for reduction of allergic reactions (Type I), including anaphylaxis, that may occur with accidental exposure to one or more foods in adult and pediatric patients aged 1 year and older with IgE-mediated food allergy.     All other preferred agents (preferred adalimumab products, ENBREL, OTEZLA) may receive approval for use for FDA-labeled indications.    **Non-Preferred Agents:**    **ARCALYST (rilonacept)** may receive approval if meeting the following:   * Medication is being prescribed for one of the following autoinflammatory periodic fever syndromes (approval for all other indications is subject to meeting non-preferred criteria listed below):   o Cryopyrin-associated Autoinflammatory Syndrome (CAPS), including:   * + Familial Cold Autoinflammatory Syndrome (FCAS)   + Muckle-Wells Syndrome (MWS) | |
|  |  | o | Maintenance of remission of Deficiency of Interleukin-1 Receptor Antagonist (DIRA) in adults and pediatric patients weighing at least 10 kg |
|  |  | o | Treatment of recurrent pericarditis and reduction in risk of recurrence in adults and children ≥ 12 years of age |
|  |  | **AND**   * Member has trialed and failed‡ colchicine **AND** * Initial approval will be given for 12 weeks and authorization approval for continuation will be provided based on clinical response.     **ILARIS (canakinumab)** may receive approval if meeting the following:   * Medication is being prescribed for one of the following (approval for all other indications is subject to meeting non-preferred criteria listed below):   + Familial Mediterranean Fever (FMF) o Hyperimmunoglobulinemia D syndrome (HIDS) o Mevalonate Kinase Deficiency (MKD) o Neonatal onset multisystem inflammatory disease (NOMID) o TNF Receptor Associated Periodic Syndrome (TRAPS)   + Cryopyrin-associated Autoinflammatory Syndrome (including Familial   Cold Autoinflammatory Syndrome and Muckle-Wells Syndrome) o Symptomatic treatment of adult patients with gout flares in whom  NSAIDs and colchicine are contraindicated, are not tolerated, or do not | |

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|  |  | provide an adequate response, and in whom repeated courses of corticosteroids are not appropriate (limited to four 150mg doses per one year approval)  **AND**   * Member has trialed and failed‡ colchicine.      * Quantity Limits: o Cryopyrin-associated periodic syndrome: 600mg (4mL) every 8 weeks o All other indications: 300mg (2mL) every 4 weeks     **KINERET (anakinra)** may receive approval if meeting the following:   * Medication is being prescribed for one of the following indications (approval for all other indications is subject to meeting non-preferred criteria below):   + Neonatal onset multisystem inflammatory disease (NOMID). o Familial Mediterranean Fever (FMF)   **AND**   * Member has trialed and failed‡ colchicine.     **NUCALA (mepolizumab)** may receive approval if meeting the following based on prescribed indication (for any FDA-labeled indications in this subclass category that are not listed, approval is subject to meeting non-preferred criteria listed below):    Chronic Rhinosinusitis with Nasal Polyps:   * Member is 18 years of age or older **AND** * Medication is being prescribed as an add-on maintenance treatment in adult patients with inadequately controlled chronic rhinosinusitis with nasal polyposis   (CRSwNP) **AND**   * Member has a baseline bilateral endoscopic nasal polyps score (NPS; scale 0-8) **AND** nasal congestion/obstruction score (NC; scale 0-3) averaged over 28-day period **AND** * Member has trialed and failed‡ therapy with three intranasal corticosteroids (see PDL Class) **AND** * Medication is being prescribed by or in consultation with a rheumatologist, allergist, ear/nose/throat specialist or pulmonologist **AND** * Initial authorization will be for 24 weeks, for additional 12-month approval member must meet the following criteria:    + NC and NPS scores are provided and show a 20% reduction in symptoms from baseline **AND**   + Member continues to use primary therapies such as intranasal corticosteroids.     Eosinophilic Granulomatosis with polyangiitis (EGPA):   * Member is 18 years of age or older **AND** |

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|  |  | • | Member has been diagnosed with relapsing or refractory EGPA at least 6 months prior to request as demonstrated by ALL the following:   * Member has a diagnosis of asthma **AND** * Member has a blood eosinophil count of greater than or equal to 1000 cells/mcL or a blood eosinophil level of 10%   **AND** | |
|  |  | • | Member  o | has the presence of two of the following EGPA characteristics:Histopathological evidence of eosinophilic vasculitis, perivascular eosinophilic infiltration, or eosinophil-rich granulomatous inflammation |
|  |  |  | o | Neuropathy |
|  |  |  | o | Pulmonary infiltrates |
|  |  |  | o | Sinonasal abnormality |
|  |  |  | o | Cardiomyopathy |
|  |  |  | o | Glomerulonephritis |
|  |  |  | o | Alveolar hemorrhage |
|  |  |  | o | Palpable purpura |
|  |  |  | o  **AND** | Antineutrophil cytoplasmic antibody (ANCA) positive |
|  |  | • | Member has trialed and failed‡ Fasenra (benralizumab) **AND** | |
|  |  | • | Dose of NUCALA (mepolizumab) 300 mg once every 4 weeks is being prescribed. | |
|  |  | Hypereosinophilic Syndrome (HES):   * Member is 12 years of age or older **AND** * Member has a diagnosis for HES for at least 6 months that is nonhematologic secondary HES **AND** * Member has a blood eosinophil count of greater than or equal to 1000 cells/mcL   **AND**   * Member has a history of two or more HES flares (defined as worsening clinical symptoms or blood eosinophil counts requiring an increase in therapy) **AND**      * Member has been on stable dose of HES therapy for at least 4 weeks, at time of request, including at least one of the following:   + Oral corticosteroids o Immunosuppressive therapy   + Cytotoxic therapy **AND** * Dose of 300 mg once every 4 weeks is being prescribed.     All other non-preferred agent indications may receive approval for FDA-labeled use following trial and failure‡ of all preferred agents that are FDA-indicated or have strong | | |

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|  |  | evidence supporting use for the prescribed indication from clinically recognized guideline compendia (only one preferred adalimumab product trial required).    ‡Failure is defined as lack of efficacy, contraindication to therapy, allergy, intolerable side effects, or significant drug-drug interaction.    Continuation of therapy: Members currently taking a preferred agent may receive approval to continue therapy with that agent. Members with current prior authorization approval on file for a non-preferred agent will be subject to meeting reauthorization criteria above when listed for the prescribed indication, or if reauthorization criteria are not listed for the prescribed indication, may receive approval for continuation of therapy.    *Note: Prior authorization requests for OLUMIANT (baricitinib) prescribed solely for treating alopecia areata will not be approved.*    *The Department would like to remind providers that many products are associated with patient-centered programs that are available to assist with drug administration, education, and emotional support related to our members’ various disease states.* |
| **X. Miscellaneous** | | |
| Therapeutic Drug Class: **EPINEPHRINE PRODUCTS -***Effective 1/1/2025* | | |
| **No PA Required**  *Brand/generic changes effective*  *02/22/2024\**    \*Epinephrine 0.15mg/0.15ml,  0.3mg/0.3ml auto-injector  *(Mylan only)*    EPIPEN 0.3 mg/0.3 ml  (epinephrine) auto-injector    EPIPEN JR 0.15 mg/0.15 ml,  (epinephrine) auto-injector | **PA Required**    AUVI-Q (epinephrine) auto-injector    Epinephrine 0.15mg/0.15ml, 0.3mg/0.3ml autoinjector (All other manufacturers; generic  Adrenaclick, Epipen)    SYMJEPI 0.15mg/0.3ml, 0.3mg/0.3ml  (epinephrine) syringe | Non-preferred products may be approved if the member has failed treatment with one of the preferred products. Failure is defined as allergy to ingredients in product or intolerable side effects.    Quantity limit: 4 auto-injectors per year unless used / damaged / lost |
| Therapeutic Drug Class: **NEWER HEREDITARY ANGIOEDEMA PRODUCTS** -*Effective 1/1/2025* | | |
| **PA Required for all agents in this class** | | Medications Indicated for Routine Prophylaxis:    Members are restricted to coverage of one medication for routine prophylaxis at one time. Prior authorization approval will be for one year.    **HAEGARDA** (C1 esterase inhibitor - human)may be approved for members meeting the following criteria: |
| **Preferred**    *Prophylaxis:*    CINRYZE (C1 esterase inhibitor) kit | **Non-Preferred**    *Prophylaxis:*    ORLADEYO (berotralstat) oral capsule    TAKHZYRO (lanadelumab-flyo) syringe, vial |

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| HAEGARDA (C1 esterase  inhibitor) vial    *Treatment:*    BERINERT (C1 esterase  inhibitor) kit, vial    FIRAZYR (icatibant acetate) syringe BNR | *Treatment:*    Icatibant syringe (generic FIRAZYR)    RUCONEST (C1 estera se inhibitor, recomb) vial | * Member has a diagnosis of HAE Type I or Type II confirmed by laboratory tests obtained on two separate instances at least one month apart (C4 level, C1-INH level) OR has a diagnosis of HAE Type III based on clinical presentation **AND** * Member has a documented history of at least one symptom of a moderate to severe HAE attack (moderate to severe abdominal pain, facial swelling, airway swelling) in the absence of hives or a medication known to cause angioedema AND * Member meets at least one of the following:   ▪ Haegarda is being used for short-term prophylaxis to undergo a surgical procedure or major dental work **OR**  ▪ Haegarda is being used for long-term prophylaxis and member meets one of the following:   * History of ≥1 attack per month resulting in documented ED admission or hospitalization **OR** * History of laryngeal attacks **OR** * History of ≥2 attacks per month involving the face, throat, or abdomen **AND** * Member is not taking medications that may exacerbate HAE including ACE inhibitors and estrogen-containing medications **AND** * Prescriber acknowledges that the member will receive information and/or counseling regarding the information from the FDA-labeled package insert outlining transmission of infectious agents with a medication made from human blood.   Maximum Dose: 60 IU/kg  Minimum Age: 6 years    **CINRYZE** (C1 esterase inhibitor - human) may be approved for members meeting the following criteria:   * Member has history of trial and failure of Haegarda. Failure is defined as lack of efficacy allergy, intolerable side effects, or a significant drug-drug interaction   **AND**   * Member has a diagnosis of HAE Type I or Type II confirmed by laboratory tests obtained on two separate instances at least one month apart (C4 level, C1-INH level) OR has a diagnosis of HAE Type III based on clinical presentation **AND** * Member has a documented history of at least one symptom of a moderate to severe HAE attack (moderate to severe abdominal pain, facial swelling, airway swelling) in the absence of hives or a medication known to cause angioedema AND * Member meets at least one of the following:   ▪ Cinryze is being used for short-term prophylaxis to undergo a surgical procedure or major dental work **OR**  ▪ Cinryze is being used for long-term prophylaxis and member meets one of the following: |

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|  |  | * History of ≥1 attack per month resulting in documented ED admission or hospitalization **OR** * History of laryngeal attacks **OR** * History of ≥2 attacks per month involving the face, throat, or abdomen **AND** * Member is not taking medications that may exacerbate HAE including ACE inhibitors and estrogen-containing medications **AND** * Prescriber acknowledges that the member will receive information and/or counseling regarding the information from the FDA-labeled package insert outlining transmission of infectious agents with a medication made from human blood.   Minimum age: 6 years  Maximum dose: 100 Units/kg    **ORLADEYO** (berotralstat) may be approved for members meeting the following criteria:   * Member has history of trial and failure of HAEGARDA. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction **AND** * Member has a diagnosis of HAE Type I or Type II confirmed by laboratory tests obtained on two separate instances at least one month apart (C4 level, C1-INH level) OR has a diagnosis of HAE Type III based on clinical presentation **AND** * Member has a documented history of at least one symptom of a moderate to severe HAE attack (moderate to severe abdominal pain, facial swelling, airway swelling) in the absence of hives or a medication known to cause angioedema   **AND**   * ORLADEYO is prescribed by or in consultation with an allergist or immunologist **AND** * Appropriate drug interaction interventions will be made for members using concomitant medications that may require dose adjustments (such as cyclosporine, fentanyl, pimozide, digoxin) **AND** * Member meets at least one of the following:   + ORLADEYO is being used for short-term prophylaxis to undergo a surgical procedure or major dental work   + ORLADEYO is being used for long-term prophylaxis and member meets one of the following:     - History of ≥ 1 attack per month resulting in documented ED admission or hospitalization **OR**     - History of laryngeal attacks **OR**     - History of ≥ 2 attacks per month involving the face, throat, or abdomen **AND**     - Member is not taking medications that may exacerbate HAE, including ACE inhibitors and estrogen-containing medications Minimum age:12 years |

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|  |  | Maximum dose: 150 mg once daily    **TAKHZYRO** (lanadelumab-flyo) may be approved for members meeting the following criteria:   * Member has history of trial and failure of Haegarda. Failure is defined as: lack of efficacy, allergy, intolerable side effects, or a significant drug-drug interaction **AND** * Member has a diagnosis of HAE Type I or Type II confirmed by laboratory tests obtained on two separate instances at least one month apart (C4 level, C1-INH level) OR has a diagnosis of HAE Type III based on clinical presentation **AND** * Member has a documented history of at least one symptom of a moderate to severe HAE attack (moderate to severe abdominal pain, facial swelling, airway swelling) in the absence of hives or a medication known to cause angioedema   **AND**   * Member is not taking medications that may exacerbate HAE including ACE inhibitors and estrogen-containing medications     Minimum age: 2 years  Maximum dose: The recommended starting dose is 300mg every 2 weeks. A dosing interval of 300 mg every 4 weeks is also effective and may be considered if the patient is well-controlled (attack free) for more than 6 months    **Medications Indicated for Treatment of Acute Attacks:**    Members are restricted to coverage of one medication for treatment of acute attacks at one time. Prior authorization approval will be for one year.    **FIRAZYR** (icatibant acetate) may be approved for members meeting the following criteria:o Member has a diagnosis of HAE Type I or Type II confirmed by laboratory tests obtained on two separate instances at least one month apart (C4 level, C1-INH level) OR has a diagnosis of HAE Type III based on clinical presentation **AND** | |
|  |  | o | Member has a documented history of at least one symptom of a moderate to severe HAE attack (moderate to severe abdominal pain, facial swelling, airway swelling) in the absence of hives or a medication known to cause angioedema AND |
|  |  | o Member is not taking medications that may exacerbate HAE including ACE inhibitors and estrogen-containing medications  Minimum age: 18 years  Maximum dose: 30mg    **BERINERT** (C1 esterase inhibitor - human) may be approved for members meeting the following criteria: | |

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|  |  | * Member has a diagnosis of HAE Type I or Type II confirmed by laboratory tests obtained on two separate instances at least one month apart (C4 level, C1-INH level) OR has a diagnosis of HAE Type III based on clinical presentation **AND** * Member has a documented history of at least one symptom of a moderate to severe HAE attack (moderate to severe abdominal pain, facial swelling, airway swelling) in the absence of hives or a medication known to cause angioedema AND * Member is not taking medications that may exacerbate HAE including   ACE inhibitors and estrogen-containing medications **AND** o Prescriber acknowledges that the member will receive information and/or counseling regarding the information from the FDA-labeled package insert outlining transmission of infectious agents with a medication made from human blood.    Minimum age: 6 years  Max dose: 20 IU/kg    **RUCONEST** (C1 esterase inhibitor - recombinant) may be approved for members meeting the following criteria:o Member has a history of trial and failure of Firazyr OR Berinert. Failure is defined as lack of efficacy, allergy, intolerable side effects, or a significant drug-drug interaction **AND**   * Member has a diagnosis of HAE Type I or Type II confirmed by laboratory tests obtained on two separate instances at least one month apart (C4 level, C1-INH level) OR has a diagnosis of HAE Type III based on clinical presentation **AND** * Member has a documented history of at least one symptom of a moderate to severe HAE attack (moderate to severe abdominal pain, facial swelling, airway swelling) in the absence of hives or a medication known to cause angioedema AND * Member is not taking medications that may exacerbate HAE including ACE inhibitors and estrogen-containing medications   Minimum age: 13 years  Maximum dose: 4,200 Units/dose    All other non-preferred agents may be approved if the member has trialed and failed at least two preferred agents with the same indicated role in therapy as the prescribed medication (prophylaxis or treatment). Failure is defined as lack of efficacy, allergy, intolerable side effects, or a significant drug-drug interaction. |
| Therapeutic Drug Class: **PHOSPHATE BINDERS -***Effective 10/1/2024* | | |
| **No PA Required** | **PA Required** | Prior authorization for non-preferred products in this class may be approved if member meets all the following criteria: |

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| Calcium acetate capsule    PHOSLYRA (calcium acetate) solution    Sevelamer carbonate tablet, powder pack | AURYXIA (ferric citrate) tablet    Calcium acetate tablet    CALPHRON (calcium acetate) tablet    FOSRENOL (lanthanum carbonate) chewable tablet, powder pack    Lanthanum carbonate chewable tablet    RENVELA (sevelamer carbonate) powder pack,  tablet    Sevelamer HCl tablet    VELPHORO (sucroferric oxide) chewable tablet    XPHOZAH (tenapanor) tablet | | * Member has diagnosis of end stage renal disease AND * Member has elevated serum phosphorus [> 4.5 mg/dL or > 1.46 mmol/L] AND * Provider attests to member avoidance of high phosphate containing foods from diet AND * Member has trialed and failed‡ one preferred agent (lanthanum products require   trial and failure‡ of a preferred sevelamer product).    **Auryxia** (ferric citrate) may be approved if the member meets all the following criteria:   * Member is diagnosed with end-stage renal disease, receiving dialysis, and has elevated serum phosphate (> 4.5 mg/dL or > 1.46 mmol/L). AND * Provider attests to counseling member regarding avoiding high phosphate containing foods from diet AND * Member has trialed and failed‡ three preferred agents with different mechanisms of action prescribed for hyperphosphatemia in end stage renal disease   **OR**   * Member is diagnosed with chronic kidney disease with iron deficiency anemia and is not receiving dialysis AND * Member has tried and failed‡ at least two different iron supplement product formulations (OTC or RX)     **Velphoro** (sucroferric oxyhydroxide tablet, chewable) may be approved if the member meets all of the following criteria:   * Member is diagnosed with chronic kidney disease and receiving dialysis and has elevated serum phosphate (> 4.5 mg/dL or > 1.46 mmol/L). AND * Provider attests to counseling member regarding avoiding high phosphate containing foods from diet AND * Member has trialed and failed‡ two preferred agents, one of which must be a preferred sevelamer product   Maximum Dose: Velphoro 3000mg daily    Members currently stabilized on a non-preferred lanthanum product may receive approval to continue therapy with that product.    ‡Failure is defined as lack of efficacy with 6-week trial, allergy, intolerable side effects, or significant drug-drug interaction.    *Note: Medications administered in a dialysis unit or clinic are billed through the Health First Colorado medical benefit or Medicare with members with dual eligibility.* |
| Therapeutic Drug Class: **PRENATAL VITAMINS / MINERALS** -*Effective 10/1/2024* | | | |
| **Preferred**  **\*Must meet eligibility criteria** | | **Non-Preferred PA Required** |  |

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| COMPLETE NATAL DHA pack    M-NATAL PLUS tablet    NESTABS tablets    PRENATAL VITAMIN PLUS LOW IRON tablet  (*Patrin Pharma only)*    SE-NATAL 19 chewable tabletBNR    TARON-C DHA capsule    THRIVITE RX tablet    TRINATAL RX 1 tablet    VITAFOL gummies    WESNATAL DHA COMPLETE tablet    WESTAB PLUS tablet | | All other rebateable prescription products are non-preferred | \*Preferred and non-preferred prenatal vitamin products are a benefit for members from 11-60 years of age who are pregnant, lactating, or trying to become pregnant.    Prior authorization for non-preferred agents may be approved if member fails 7-day trial with four preferred agents. Failure is defined as: allergy, intolerable side effects, or significant drug-drug interaction. |
| **XI. Ophthalmic** | | | |
| Therapeutic Drug Class: **OPHTHALMIC, ALLERGY -***Effective 4/1/2025* | | | |
| **No PA Required**    ALREXBNR (loteprednol) 0.2%    Azelastine 0.05%    Cromolyn 4%    Ketotifen 0.025% (OTC)    LASTACAFT (alcaftadine)  0.25% (OTC) | **PA Required**    ALAWAY (ketotifen) 0.025% (OTC)    ALOCRIL (nedocromil) 2%    ALOMIDE (lodoxamide) 0.1%    Bepotastine 1.5%    BEPREVE (bepotastine) 1.5% | | Non-preferred products may be approved following trial and failure of therapy with two preferred products (failure is defined as lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions). |

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| Olopatadine 0.1%, 0.2% (OTC)  (generic Pataday Once/Twice  Daily) | Epinastine 0.05%    Loteprednol 0.2%    Olopatadine 0.1%, 0.2% (RX)    PATADAY ONCE DAILY (olopatadine) 0.2% (OTC)    PATADAY TWICE DAILY (olopatadine) 0.1% (OTC)    PATADAY XS ONCE DAILY (olopatadine) 0.7% (OTC)    ZADITOR (ketotifen) 0.025% (OTC)    ZERVIATE (cetirizine) 0.24% |  |
| Therapeutic Drug Class: **OPHTHALMIC, IMMUNOMODULATORS -***Effective 4/1/2025* | | |
| **No PA Required**    RESTASISBNR (cyclosporine  0.05%) vials | **PA Required**    CEQUA (cyclosporine) 0.09% solution    Cyclosporine 0.05% vials    MIEBO (Perfluorohexyloctane/PF)    RESTASIS MULTIDOSE (cyclosporine) 0.05%    TYRVAYA (varenicline) nasal spray    VERKAZIA (cyclosporin emulsion)    VEVYE (cyclosporine) 0.1%    XIIDRA (lifitegrast) 5% solution | Non-preferred products may be approved for members meeting all of the following criteria:   * Member is 18 years and older **AND** * Member has a diagnosis of chronic dry eye **AND** * Member has failed a 3-month trial of one preferred product. Failure is defined as a lack of efficacy, allergy, intolerable side effects, contraindication to, or significant drug-drug interactions **AND** * Prescriber is an ophthalmologist, optometrist or rheumatologist   Maximum Dose/Quantity:  60 single use containers for 30 days  5.5 mL/20 days for Restasis Multi-Dose and Vevye  3mL/30 days for Miebo    **Verkazia (cyclosporine ophthalmic emulsion)** may be approved if the following criteria are met:   * + Member is ≥ 4 years of age AND   + Verkazia is being used for the treatment of vernal keratoconjunctivitis (VKC)   AND   * + Member has trialed and failed therapy with three agents from the following pharmacologic categories: preferred dual-acting mast cell   stabilizer/antihistamine from the Ophthalmics-Allergy PDL class, oral |

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|  |  | antihistamine, preferred topical ophthalmic corticosteroid from the Ophthalmics-Anti-inflammatories PDL class. Failure is defined as lack of efficacy with 2-week trial, allergy, contraindication to therapy, intolerable side effects, or significant drug-drug interaction  • Quantity limit: 120 single-dose 0.3 mL vials/15 days |
| Therapeutic Drug Class: **OPHTHALMIC, ANTI-INFLAMMATORIES -***Effective 4/1/2025* | | |
| **NSAIDs** | | **Durezol (difluprednate)** may be approved if meeting the following criteria:   * Member has a diagnosis of severe intermediate uveitis, severe panuveitis, or severe uveitis with the complication of uveitic macular edema AND has trialed and failed prednisolone acetate 1% (failure is defined as lack of efficacy, allergy, contraindication to therapy, intolerable side effects, or significant drugdrug interaction) OR * Members with a diagnosis other than those listed above require trial and failure of three preferred agents (failure is defined as lack of efficacy, contraindication to therapy, allergy, intolerable side effects, or significant drug-drug interaction).   **Eysuvis (loteprednol etabonate)** may be approved if meeting all of the following:   * Member is ≥ 18 years of age AND * Eysuvis (loteprednol etabonate)is being used for short-term treatment (up to two weeks) of the signs and symptoms of dry eye disease AND * Member has failed treatment with one preferred product in the Ophthalmic Immunomodulator therapeutic class. Failure is defined as lack of efficacy with a 3-month trial, contraindication to therapy, allergy, intolerable side effects, or significant drug-drug interaction) AND * Member does not have any of the following conditions: * Viral diseases of the cornea and conjunctiva including epithelial herpes simplex keratitis (dendritic keratitis), vaccinia, and varicella OR * Mycobacterial infection of the eye and fungal diseases of ocular structures * Quantity limit: one bottle/15 days   **Lotemax SM (loteprednol etabonate)** or **Inveltys (loteprednol etabonate)** may be approved if meeting all of the following:   * Member is ≥ 18 years of age AND * Lotemax SM or Inveltys (loteprednol etabonate) is being used for the treatment of post-operative inflammation and pain following ocular surgery AND |
| **No PA Required**    Diclofenac 0.1%    Flurbiprofen 0.03%    Ketorolac 0.5%, Ketorolac LS  0.4%    NEVANAC (nepafenac) 0.1% | **PA Required**    ACULAR (ketorolac) 0.5%, LS 0.4%    ACUVAIL (ketorolac/PF) 0.45%    Bromfenac 0.07%, 0.075%, 0.09%    BROMSITE (bromfenac) 0.075%    ILEVRO (nepafenac) 0.03%    PROLENSA (bromfenac) 0.07% |
| **Corticosteroids** | |
| **No PA Required**    FLAREX (fluorometholone)  0.1%    Fluorometholone 0.1% drops    FML FORTE (fluorometholone)  0.25% drops    LOTEMAXBNR (loteprednol)  0.5% drops, gel    LOTEMAX (loteprednol) 0.5% ointment    MAXIDEX (dexamethasone)  0.1% | **PA Required**    Dexamethasone 0.1%    Difluprednate 0.05%    DUREZOL (difluprednate) 0.05%    EYSUVIS (loteprednol) 0.25%    FML LIQUIFILM (fluorometholone) 0.1% drop    FML S.O.P (fluorometholone) 0.1% ointment    INVELTYS (loteprednol) 1%    LOTEMAX SM (loteprednol) 0.38% gel    Loteprednol 0.5% drops, 0.5% gel    PRED FORTE (prednisolone) 1% |

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| PRED MILD (prednisolone)  0.12%    Prednisolone acetate 1% | Prednisolone sodium phosphate 1% | * Member has trialed and failed therapy with two preferred loteprednol formulations (failure is defined as lack of efficacy with 2-week trial, allergy, contraindication to therapy, intolerable side effects, or significant drug-drug interaction) AND * Member has trialed and failed therapy with two preferred agents that do not contain loteprednol (failure is defined as lack of efficacy with 2-week trial, contraindication to therapy, allergy, intolerable side effects, or significant drugdrug interaction) AND * Member does not have any of the following conditions:   + Viral diseases of the cornea and conjunctiva including epithelial herpes simplex keratitis (dendritic keratitis), vaccinia, and varicella OR   + Mycobacterial infection of the eye and fungal diseases of ocular structures     All other non-preferred products may be approved with trial and failure of three preferred agents (failure is defined as lack of efficacy with 2-week trial, allergy, contraindication, intolerable side effects, or significant drug-drug interaction). |
| Therapeutic Drug Class: **OPHTHALMIC, GLAUCOMA -***Effective 4/1/2025* | | |
| **Beta-blockers** | | Non-preferred products may be approved following trial and failure of therapy with three preferred products, including one trial with a preferred product having the same general mechanism (such as prostaglandin analogue, alpha2-adrenergic agonist, beta-blocking agent, or carbonic anhydrase inhibitor). Failure is defined as lack of efficacy with 4week trial, allergy, intolerable side effects or significant drug-drug interactions.    Non-preferred combination products may be approved following trial and failure of therapy with one preferred combination product AND trial and failure of individual products with the same active ingredients as the combination product being requested (if available) to establish tolerance. Failure is defined as lack of efficacy with 4-week trial, allergy, intolerable side effects or significant drug-drug interactions.    Preservative free products may be approved with provider documentation of adverse effect to preservative-containing product. |
| **No PA Required**    Carteolol 1%    Levobunolol 0.5%    Timolol (generic Timoptic)  0.25%, 0.5% | **PA Required**    Betaxolol 0.5%    BETIMOL (timolol) 0.25%, 0.5%    BETOPIC-S (betaxolol) 0.25%    ISTALOL (timolol) 0.5%    Timolol (generic Istalol) 0.5% drops    Timolol GFS 0.25%, 0.5%    Timolol/PF (generic Timoptic Ocudose) 0.25%,  0.5%    TIMOPTIC, TIMOPTIC OCUDOSE (timolol)  0.25%, 0.5%    TIMOPTIC-XE (timolol GFS) 0.25%, 0.5% |

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| **Carbonic anhydrase inhibitors** | |  |
| **No PA Required**    Brinzolamide 1%    Dorzolamide 2% | **PA Required**    AZOPT (brinzolamide) 1% |
| **Prostaglandin analogue** | |
| **No PA Required**    Latanoprost 0.005%    LUMIGANBNR (bimatoprost)  0.01%    TRAVATAN ZBNR (travoprost)  0.004% | **PA Required**    Bimatoprost 0.03%    IYUZEH (latanoprost/PF) 0.005%    Tafluprost 0.0015%    Tafluprost PF 0.0015%    Travoprost 0.004%    VYZULTA (latanoprostene) 0.024%    XALATAN (latanoprost) 0.005%    XELPROS (latanoprost) 0.005%    ZIOPTAN (tafluprost PF) 0.0015% |
| **Alpha-2 adrenergic agonists** | |
| **No PA Required**    ALPHAGAN PBNR 0.1%, 0.15%  (brimonidine)    Brimonidine 0.2% | **PA Required**    Apraclonidine 0.5%    Brimonidine 0.1%, 0.15%    IOPIDINE (apraclonidine) 0.5%, 1% |
| **Other ophthalmic, glaucoma and combinations** | |
| **No PA Required** | **PA Required**    Brimonidine/Timolol 0.2%-0.5% |

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| COMBIGANBNR 0.2%-0.5%  (brimonidine/timolol)    Dorzolamide/Timolol 2%-0.5%    RHOPRESSA (netarsudil) 0.02%    ROCKLATAN  (netarsudil/latanoprost)  0.02%-0.005% | | COSOPT/COSOPT PF (dorzolamide/timolol) 2%-  0.5%    Dorzolamide/Timolol PF 2%-0.5%    PHOSPHOLINE IODIDE (echothiophate) 0.125%    Pilocarpine 1%, 2%, 4%      SIMBRINZA (brinzolamide/brimonidine) 1%-  0.2%    VUITY (pilocarpine) 1.25% | |  |
| **XII. Renal/Genitourinary** | | | | |
| Therapeutic Drug Class: **BENIGN PROSTATIC HYPERPLASIA (BPH) AGENTS -***Effective 10/1/2024* | | | | |
| **No PA Required**    Alfuzosin ER tablet    Doxazosin tablet    Dutasteride capsule    Finasteride tablet    Tamsulosin capsule    Terazosin capsule | **PA Required**    AVODART (dutasteride) softgel    CARDURA (doxazosin) tablet    CARDURA XL (doxazosin ER) tablet    \*CIALIS (tadalafil) 2.5 mg, 5 mg tablet    Dutasteride/tamsulosin capsule    FLOMAX (tamsulosin) capsule    PROSCAR (finasteride) tablet    RAPAFLO (silodosin) capsule    Silodosin capsule    \*Tadalafil 2.5 mg, 5 mg tablet | | Prior authorization for non-preferred products in this class may be approved if member meets all of the following criteria:   * Member has tried and failed‡ three preferred agents AND * For combinations agents, member has tried and failed‡ each of the individual agents within the combination agent and one other preferred agent.     ‡Failure is defined as lack of efficacy with 8-week trial, allergy, intolerable side effects, contraindication to, or significant drug-drug interaction.    **\*CIALIS** (tadalafil) may be approved for members with a documented diagnosis of BPH who have failed a trial of finasteride (at least 3 months in duration) AND either a trial of a nonselective alpha blocker (therapeutic dose for at least two months) OR a trial of tamsulosin (therapeutic dose for at least one month).  Documentation of BPH diagnosis will require BOTH of the following:   * AUA Prostate Symptom Score ≥ 8 AND ● Results of a digital rectal exam.   Cialis (tadalafil) will not be approved for any patient continuing alpha-blocker therapy as this combination is contraindicated in this population.  Doses exceeding 5mg per day of Cialis (tadalafil) will not be approved. | |
| Therapeutic Drug Class: **ANTI-HYPERURICEMICS -***Effective 10/1/2024* | | | | |

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| **No PA Required**    Allopurinol 100 mg, 300 mg  tablets    Colchicine tablet    Febuxostat tablet    Probenecid tablet    Probenecid/Colchicine tablet | **PA Required**    Allopurinol 200 mg tablets    Colchicine capsule    COLCRYS (colchicine) tablet    GLOPERBA (colchicine) oral solution    MITIGARE (colchicine) capsule    ULORIC (febuxostat) tablet | | Non-preferred xanthine oxidase inhibitor products (allopurinol or febuxostat formulations) may be approved following trial and failure of preferred allopurinol. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction. If member has tested positive for the HLA-B\*58:01 allele, it is not recommended that they trial allopurinol. A positive result on this genetic test will count as a failure of allopurinol.    Prior authorization for all other non-preferred agents (non-xanthine oxidase inhibitors) may be approved after trial and failure of two preferred products. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.    **GLOPERBA (colchicine)** oral solution may be approved for members who require individual doses <0.6 mg **OR** for members who are unable to use a solid oral dosage form.    Colchicine tablet quantity limits:  • Chronic hyperuricemia/gout prophylaxis: 60 tablets per 30 days • Familial Mediterranean Fever: 120 tablets per 30 days | |
| Therapeutic Drug Class: **OVERACTIVE BLADDER AGENTS -***Effective 10/1/2024* | | | | |
| **No PA Required**    Fesoterodine ER tablet    GELNIQUE (oxybutynin) gel    MYRBETRIQ (mirabegron) tablet BNR    Oxybutynin IR, ER tablets, syrup    Solifenacin tablet    Tolterodine tablet, ER capsule | | **PA Required**    Darifenacin ER tablet    DETROL (tolterodine) tablet    DETROL LA (tolterodine) ER capsule    Flavoxate tablet    GEMTESA (vibegron) tablet    Mirabegron tablet    MYRBETRIQ (mirabegron) suspension    Oxybutynin 2.5 mg tablet    OXYTROL (oxybutynin patch)    TOVIAZ (Fesoterodine ER) tablet    Trospium ER capsule, tablet    VESICARE (solifenacin) tablet    VESICARE LS (solifenacin) suspension | | Non-preferred products may be approved for members who have failed treatment with two preferred products. Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.    Members with hepatic failure can receive approval for trospium (Sanctura) or trospium extended release (Sanctura XR) products without a trial on a Preferred product. |

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|  | **XIII. RESPIRATORY** | | |
|  | Therapeutic Drug Class: **RESPIRATORY AGENTS -***Effective 1/1/2025* | | |
|  | **Inhaled Anticholinergics** | | |
| **Preferred**  **No PA Required**  **(Unless indicated\*)**    **Solutions**  Ipratropium solution    **Short-Acting Inhalation Devices**  ATROVENT HFA (ipratropium)    **Long-Acting Inhalation Devices**    SPIRIVA HandihalerBNR  (tiotropium)    \*SPIRIVA RESPIMAT  (tiotropium) | **Non-Preferred**  **PA Required**    **Solutions**  YUPELRI (revefenacin) solution    **Short-Acting Inhalation Devices**    **Long-Acting Inhalation Devices**    INCRUSE ELLIPTA (umeclidinium)    Tiotropium DPI    TUDORZA PRESSAIR (aclidinium) | | **\*SPIRIVA RESPIMAT (tiotropium) 1.25 mcg** may be approved for members ≥ 6 years of age with a diagnosis of asthma (qualifying diagnosis verified by AutoPA). SPIRIVA RESPIMAT is intended to be used by members whose asthma is not controlled with regular use of a combination medium-dose inhaled corticosteroid and long-acting beta agonist (LABA).    **\*SPIRIVA RESPIMAT (tiotropium)** 2.5 mcg may be approved for members with a diagnosis of COPD who have trialed and failed SPIRIVA HANDIHALER. Failure is defined as intolerable side effects or inability to use dry powder inhaler (DPI) formulation.    **LONHALA MAGNAIR** (glycopyrrolate) may be approved for members ≥ 18 years of age with a diagnosis of COPD including chronic bronchitis and emphysema who have trialed and failed‡ treatment with two preferred anticholinergic agents.    Non-preferred single agent anticholinergic agents may be approved for members with a diagnosis of COPD including chronic bronchitis and/or emphysema who have trialed and failed‡ treatment with two preferred agents, one of which must be SPIRIVA  HANDIHALER.    ‡Failure is defined as lack of efficacy with 6-week trial, allergy, intolerable side effects, or significant drug-drug interaction. |
|  | **Inhaled Anticholinergic Combinations** | | |
| **No PA Required**  **Solutions**  Ipratropium/Albuterol solution    **Short-Acting Inhalation Devices**  COMBIVENT RESPIMAT  (albuterol/ipratropium)    **Long-Acting Inhalation Devices** | **PA Required**  **Solutions**    **Short-Acting Inhalation Devices**    **Long-Acting Inhalation Devices**  BEVESPI AEROSPHERE (glycopyrrolate  /formoterol fumarate)    BREZTRI AEROSPHERE  (budesonide/glycopyrrolate/ formoterol) | | **BREZTRI AEROSPHERE** (budesonide/glycopyrrolate/formoterol)may be approved for members ≥ 18 years of age with a diagnosis of COPD who have trialed and failed‡ treatment with two preferred anticholinergic-containing agents.    **DUAKLIR PRESSAIR** (aclidinium/formoterol)may be approved for members ≥ 18 years of age with a diagnosis of COPD who have trialed and failed‡ treatment with two preferred anticholinergic-containing agents.    All other non-preferred inhaled anticholinergic combination agents may be approved for members with a diagnosis of COPD including chronic bronchitis and/or emphysema who |

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| ANORO ELLIPTA  (umeclidinium/vilanterol) | DUAKLIR PRESSAIR (aclidinium/formoterol)    STIOLTO RESPIMAT (tiotropium/olodaterol) | have trialed and failed‡ treatment with two preferred inhaled anticholinergic combination agents OR three preferred inhaled anticholinergic-containing agents (single ingredient or combination).    Members who are currently stabilized on Bevespi Aerosphere may receive approval to continue therapy with that product.    ‡Failure is defined as lack of efficacy with 6-week trial, allergy, intolerable side effects, or significant drug-drug interaction. |
|  | **Inhaled Beta2 Agonists (short acting)** | |
| **No PA Required**  **Solutions**  Albuterol solution, for nebulizer    **Inhalers**  VENTOLIN BNR HFA (albuterol) | **PA Required**  **Solutions**  Levalbuterol solution    **Inhalers**  AIRSUPRA (budesonide/albuterol)    Albuterol HFA    Levalbuterol HFA    PROAIR RESPICLICK (albuterol)    XOPENEX (levalbuterol) Inhaler | Non-preferred short acting beta-2 agonists may be approved for members who have failed treatment with one preferred agent. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.    MDI formulation quantity limits: 2 inhalers / 30 days        **AIRSUPRA** (budesonide/albuterol)  Airsupra minimum age: 18 years old |
|  | **Inhaled Beta2 Agonists (long acting)** | |
| **Preferred**    **Solutions**      **Inhalers**  SEREVENT DISKUS  (salmeterol) inhaler | **Non-Preferred**  **PA Required**  **Solutions**  Arformoterol solution    BROVANA (arformoterol) solution    Formoterol solution    PERFOROMIST (formoterol) solution    **Inhalers**  STRIVERDI RESPIMAT (olodaterol) | Non-preferred agents may be approved for members with moderate to severe COPD, AND members must have failed a trial of Serevent. Failure is defined as lack of efficacy with a 6-week trial, allergy, intolerable side effects, or significant drug-drug interaction.    For treatment of members with diagnosis of asthma needing add-on therapy, please refer to preferred agents in combination Long-Acting Beta Agonist/Inhaled Corticosteroid therapeutic class. |
|  | **Inhaled Corticosteroids** | |
| **No PA Required**  **Solutions**  Budesonide nebules | **PA Required**  **Solutions**  PULMICORT (budesonide) respules | Non-preferred inhaled corticosteroids may be approved in members with asthma who have failed an adequate trial of two preferred agents. An adequate trial is defined as at |

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| **Inhalers**  ARNUITY ELLIPTA  (fluticasone furoate)    ASMANEX HFA (mometasone furoate) inhaler    ASMANEX Twisthaler  (mometasone)    PULMICORT FLEXHALER  (budesonide)    QVAR REDIHALER  (beclomethasone) | **Inhalers**  ALVESCO (ciclesonide) inhaler    Fluticasone propionate diskus    \*Fluticasone propionate HFA | least 6 weeks. (Failure is defined as: lack of efficacy with a 6-week trial, allergy, contraindication to, intolerable side effects, or significant drug-drug interactions, or dexterity/coordination limitations (per provider notes) that significantly impact appropriate use of a specific dosage form.)    **\*FLUTICASONE PROPIONATE HFA** is available to members without prior authorization for:   * Members with a diagnosis of eosinophilic esophagitis (EoE) **OR** * Members ≤ 12 years of age.     Maximum Dose:  Pulmicort (budesonide) nebulizer suspension: 2mg/day    Quantity Limits:  Pulmicort flexhaler: 2 inhalers / 30 days |
| **Inhaled Corticosteroid Combinations** | | |
| **No PA Required**  **(\*Must meet eligibility criteria)**    ADVAIR DISKUSBNR  (fluticasone/salmeterol)    ADVAIR HFA**BNR**  (fluticasone/salmeterol)    AIRDUO RESPICLICKBNR  (fluticasone/salmeterol)    DULERA  (mometasone/formoterol)    SYMBICORTBNR  (budesonide/formoterol)  inhaler    \*TRELEGY ELLIPTA  (fluticasone furoate/  umeclidinium/vilanterol) | **PA Required**    BREO ELLIPTA (vilanterol/fluticasone furoate)    Budesonide/formoterol (generic Symbicort)    Fluticasone/salmeterol (generic Airduo/Advair Diskus)    Fluticasone/salmeterol HFA (generic Advair HFA)    Fluticasone/vilanterol (generic Breo Ellipta)    WIXELA INHUB (fluticasone/salmeterol) | **\*TRELEGY ELLIPTA** (fluticasone furoate/umeclidinium/vilanterol) may be approved if the member has trialed/failed one preferred agent. Failure is defined as lack of efficacy with a 6-week trial, allergy, intolerable side effects, significant drug-drug interactions, or dexterity/coordination limitations (per provider notes) that significantly impact appropriate use of a specific dosage form.    Non-preferred inhaled corticosteroid combinations may be approved for members meeting both of the following criteria:   * Member has a qualifying diagnosis of asthma or severe COPD; **AND** * Member has failed two preferred agents (Failure is defined as lack of efficacy with a 6-week trial, allergy, intolerable side effects, significant drug-drug interactions, or dexterity/coordination limitations (per provider notes) that significantly impact appropriate use of a specific dosage form. |
| **Phosphodiesterase Inhibitors (PDEIs)** | | |
| **No PA Required**    Roflumilast tablet | **PA Required**    DALIRESP (roflumilast) tablet    OHTUVAYRE (ensifentrine) suspension | Requests for use of the non-preferred brand product formulation may be approved if meeting criteria outlined in the [Appendix P](https://hcpf.colorado.gov/pharmacy-resources#PDLP) “Generic Mandate” section. |