

**2025 Delaware Medicaid**

**Preferred Drug List (PDL)**

* Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
* Be advised that any prior authorization criterion provided here is for **FEE-FOR-SERVICE** (FFS) MEMBERS **ONLY**. Prior authorization forms for FFS members can be found on the Pharmacy Corner at: <https://medicaid.dhss.delaware.gov/provider/Home/PharmacyCornerLanding/tabid/2096/Default.aspx>
* Prior authorizations for members enrolled with a Managed Care Organization (MCO) should be processed through the MCO following MCO criteria. o Highmark Health Options (HHO) criteria can be reviewed at <https://client.formularynavigator.com/Search.aspx?siteCode=9768635417> o AmeriHealth Caritas criteria can be reviewed at <http://www.amerihealthcaritasde.com/provider/resources/pharmacy-prior-auth.aspx>o Delaware First Health criteria can be reviewed at <https://www.delawarefirsthealth.com/providers/resources/clinical-payment-policies.html>

**The DMAP may limit the duration of time that a member may receive medication during a 12-month period or may establish a lifetime limit for particular classes of drugs or specific products.**

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS**  **Prior authorization is required** |  | **CRITERION** |
|  | **ACNE AGENTS** |  |  |
| **ORAL** |  |  | **Review Schedule: 2nd Quarter** |
| AMNESTEEM (isotretinoin) CLARAVIS (isotretinoin) isotretinoin  ZENATANE (isotretinoin) | ABSORICA (isotretinoin)  ABSORICA LD (isotretinoin, micronized) | •  • | Two (2) preferred products required before a non-preferred product will be approved.    Class only covered up to 20 years old; use in older patients is considered cosmetic. |
| **TOPICAL** |  |  | **Review Schedule 1st Quarter** |
| adapalene 0.3% gel/gel pump RX adapalene/benzoyl peroxide benzoyl peroxide  clindamycin gel, lotion, solution, swab  clindamycin/benzoyl peroxide gel 1.2/5% (generic  DUAC)  erythromycin gel, solution tretinoin cream tretinoin 0.01 %, 0.025% gel | ACANYA (clindamycin/benzoyl peroxide) adapalene 0.1% cream, 0.1% gel OTC  AKLIEF (trifarotene)  ALTRENO (tretinoin)  ARAZLO (tazarotene)  ATRALIN (tretinoin)  AVAR (sulfacetamide sodium/sulfur)  AVITA (tretinoin)  BENZAMYCIN (erythromycin/benzoyl peroxide) BP 10-1 (sulfacetamide sodium/sulfur)  BPO (benzoyl peroxide)  CABTREO (clindamycin/adapalene/benzoyl peroxide)  CLEOCIN T (clindamycin)  CLINDACIN ETZ/PAC (clindamycin)  CLINDACIN P (clindamycin) CLINDAGEL (clindamycin)  clindamycin foam  clindamycin/benzoyl peroxide gel 1/5% (generic  BENZACLIN), 1.5/2.5% (generic ACANYA),  1.2/3.75% (generic ONEXTON) clindamycin/tretinoin dapsone  DIFFERIN (adapalene)  EPIDUO (adapalene/benzoyl peroxide)  EPIDUO FORTE (adapalene/benzoyl peroxide) ERY/ERYGEL (erythromycin) erythromycin swab  erythromycin/benzoyl peroxide  EVOCLIN (clindamycin)  FABIOR (tazarotene)  KLARON (sulfacetamide sodium)  LINTERA (benzoyl peroxide)  NEUAC (benzoyl peroxide/clindamycin)  ONEXTON (benzoyl peroxide/clindamycin)  RETIN-A (tretinoin) cream, gel  RETIN-A MICRO (tretinoin) | •  • | Two (2) preferred products required before a non-preferred product will be approved.    Class only covered up to 20 years old; use in older patients is considered cosmetic. |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS**  **Prior authorization is required** | **CRITERION** |
|  | sodium sulfacetamide/sulfur SSS (sulfacetamide sodium/sulfur) sulfacetamide sodium  SUMADAN (sulfacetamide sodium/sulfur)  SUMADAN XLT (sulfacetamide sodium/sulfur) SUMAXIN (sulfacetamide sodium/sulfur) tazarotene foam tretinoin 0.05% gel tretinoin microsphere  TWYNEO (tretinoin/benzoyl peroxide)  WINLEVI (clascoterone)  ZIANA (clindamycin/tretinoin)  ZMA CLEAR (sulfacetamide sodium/sulfur) |  |
| **ANALGESICS** | |  |
| **ANALGESICS, NARCOTIC LONG-ACTING**  **(Clinical criteria applies to class. All agents require a prior authorization.)** | | Review Schedule: 1st Quarter |
| BUTRANS (buprenorphine) fentanyl transdermal 12, 25, 50, 75, 100 mcg/hr morphine ER tablets tramadol ER tablets \* | BELBUCA (buprenorphine buccal film)  buprenorphine patches CONZIP (tramadol)  fentanyl transdermal 37.5, 62.5, 87.5 mcg/hr  hydrocodone ER hydromorphone ER  HYSINGLA ER (hydrocodone) morphine ER capsules MS CONTIN (morphine) oxycodone ER  OXYCONTIN (oxycodone) oxymorphone ER  tramadol ER capsules \* | * Two (2) preferred products required before a non-preferred product will be approved.      * **DMMA recommends that first fill of new pain medication be limited to 15-day supply.**      * \* Tramadol quantity limits – 240 units per 30 days |
| **ANALGESICS, NARCOTIC SHORT-ACTING, NON-INJECTABLE** | | **Review Schedule: 2nd Quarter** |
| acetaminophen/codeine butalbital/ASA/caffeine/codeine #3 butalbital/acetaminophen/caffeine/codeine butalbital compound/codeine  codeine  ENDOCET (oxycodone/acetaminophen) hydrocodone/APAP solution, tablets hydromorphone tablets morphine concentrate, tablets, solution oxycodone capsules, solution, tablets oxycodone/APAP solution, tablets tramadol 50 mg tablets \* tramadol/APAP \* | ACTIQ (fentanyl) buccal butorphanol nasal spray dihydrocodeine/APAP/caffeine DILAUDID (hydromorphone) fentanyl  FENTORA (fentanyl) buccal  FIORICET-CODEINE  (butalbital/acetaminophen/caffeine/codeine) hydrocodone/ibuprofen  hydromorphone liquid, suppositories levorphanol  meperidine solution, tablets  morphine concentrate, suppositories  NALOCET (oxycodone/acetaminophen) oxycodone concentrate | * Two (2) preferred products required before a non-preferred product will be approved.      * **DMMA recommends that first fill of new pain medication be limited to 7-day supply.**      * **ᶺ** PA required, to include reason tramadol 50 mg tablets, cannot be used, before product will be approved.     **QUANTITY LIMITS IN PLACE:**   * **Oxycodone 15 mg maximum of 240 units per year** * **Oxycodone 20 mg maximum of 120 units per year** * **Oxycodone 30 mg maximum of 60 units per year** |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS**  **Prior authorization is required** | **CRITERION** |
|  | oxycodone/ASA oxymorphone  pentazocine HCl/naloxone HCl  PERCOCET (oxycodone/acetaminophen)  PROLATE (oxycodone/acetaminophen)  ROXICODONE (oxycodone)  ROXYBOND (oxycodone)  SEGLENTIS (tramadol/celecoxib)  tramadol 25 mg, 75 mg ᶺ, 100 mg tablets, solution \* | * **120 short-acting units per 30 days with a total of 720 shortacting units per year**      * \* Tramadol quantity limits – 240 units per 30 days |
| **ANTIHYPERURICEMICS, ORAL** | | **Review Schedule: 2nd Quarter** |
| allopurinol 100 mg, 300 mg tablets  colchicine tablets febuxostat probenecid  probenecid with colchicine | allopurinol 200 mg tablets \* colchicine capsules COLCRYS (colchicine)  GLOPERBA (colchicine)  LODOCO (colchicine) \*\* MITIGARE (colchicine)  ULORIC (febuxostat) | * Two (2) preferred products required before a non-preferred product will be approved.      * \* PA required, to include reason allopurinol 2 x 100 mg tablets cannot be used, before product will be approved.      * \*\* Step through preferred colchicine product required. |
| **ANTIMIGRAINE AGENTS, PROPHYLAXIS**  **(Clinical criteria applies to individual agents in class.)** | | **Review Schedule: 4th Quarter** |
| AIMOVIG (erenumab-aooe) \*  AJOVY (fremanezumab) \*  EMGALITY (galcanezumab-gnlm) 120 mg pen/syringe\*  NURTEC ODT (rimegepant) \*\* | BOTOX (onabotulinumtoxinA)  EMGALITY (galcanezumab) 100 mg syringe \*  QULIPTA (atogepant)  VYEPTI (eptinezumab-jjmr) | * Two (2) preferred products required before a non-preferred product will be approved.      * \* Product will be approved. for patients with chronic migraine with inadequate response to two (2) preferred anti-migraine agents (acute and/or prophylaxis).      * \*\* One (1) CGRP receptor antagonists required before product will be approved.     Abbreviation:  CGRP = calcitonin gene-related peptide |
| **ANTIMIGRAINE AGENTS, TREATMENT**  **(Clinical criteria applies to individual agents in class.)** | | **Review Schedule: 4th Quarter** |
| naratriptan  NURTEC ODT (rimegepant) \* rizatriptan ODT, tablets sumatriptan nasal spray, syringe, tablets, vial zolmitriptan ODT, tablets | almotriptan dihydroergotamine eletriptan  FROVA (frovatriptan) frovatriptan  IMITREX (sumatriptan)  MAXALT (rizatriptan)  MIGERGOT (ergotamine tartrate/caffeine)  MIGRANAL (dihydroergotamine mesylate)  RELPAX (eletriptan) | * Two (2) preferred products required before a non-preferred product will be approved.      * Quantity limits on Triptans – 9 units per 45 days      * **\*** Nurtec ODT will be approved. for patients failing a trial of two preferred triptans and for patients with contraindications to triptans**.** |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS**  **Prior authorization is required** |  | **CRITERION** |
|  | REYVOW (lasmiditan)  sumatriptan cartridge, pen injector  sumatriptan/naproxen  SYMBRAVO (rizatriptan/meloxicam) \*\*  TOSYMRA (sumatriptan)  UBRELVY (ubrogepant)  VYEPTI (eptinezumab-jjmr)  ZAVZPRET (zavegepant) ZEMBRACE (sumatriptan) zolmitriptan nasal spray ZOMIG (zolmitriptan) | • | \*\* PA required, to include reason separate ingredients cannot be used concurrently, before product will be approved |
| **CYTOKINE AND CAM ANTAGONISTS, ORAL/SUBCUTANEOUS**  **(Clinical criteria applies to class. All agents require a prior authorization.)** | | | **Review Schedule: 4th Quarter** |
| AVSOLA (infliximab-axxq)  ENBREL (etanercept)  ENTYVIO (vedolizumab) HUMIRA (adalimumab)  infliximab  KINERET (anakinra)  ORENCIA (abatacept)  OTEZLA (apremilast) 30 mg tablet, starter pack RINVOQ (upadactinib)  TALTZ (ixekizumab)  TYENNE (tocilizumab)  XELJANZ IR (tofacitinib)  XELJANZ XR (tofacitinib) 11 mg tablet | ABRILADA (adalimumab-afzb) ACTEMRA (tocilizumab) adalimumab-aacf adalimumab-adaz adalimumab-adbm adalimumab-fkjp adalimumab-ryvk  AMJEVITA (adalimumab-atto)  ARCALYST (rilonacept)  BIMZELX (bimekizumab-bkzx)  CIMZIA (certolizumab pegol)  COSENTYX (secukinumab) CYLTEZO (adalimumab-adbm)  HADLIMA (adalimumab-bwwd)  HULIO (adalimumab-fkjp)  HYRIMOZ (adalimumab-adaz)  IDACIO (adalimumab-aacf)  ILARIS (canakinumab)  ILUMYA (tildrakizumab-asmn)  INFLECTRA (infliximab-dyyb)  KEVZARA (sarilumab)  LITFULO (ritlecitinib)  OLUMIANT (baricitinib)  OMVOH (mirikizumab-mrkz)  OTEZLA (apremilast) 20 mg tablet, starter pack  OTULFI (ustekinumab -aauz)  PYZCHIVA (ustekinumab-ttwe)  REMICADE (infliximab)  RENFLEXIS (infliximab-abdb)  RINVOQ LQ (upadactinib)  SELARSDI (ustekinumab-aekn)  SILIQ (brodalumab)  SIMLANDI (adalimumab-ryvk)  SIMPONI (golimumab)  SIMPONI ARIA (golimumab)  SKYRIZI (risankizumab-rzaa) | • | Two (2) preferred products required before a non-preferred product will be approved. |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS**  **Prior authorization is required** |  | **CRITERION** |
|  | SOTYKTU (deucravacitinib)  SPEVIGO (spesolimab-sbzo)  STELARA (ustekinumab)  STEQEYMA (ustekinumab-stba) TOFIDENCE (tocilizumab) TREMFYA (guselkumab)  ustekinumab ustekinumab-ttwe  VELSIPITY (etrasimod arginine)  XELJANZ (tofacitinib) solution  XELJANZ XR (tofacitinib) 22 mg tablet  YESINTEK (ustekinumab-kfce)  YUFLYMA (adalimumab-aaty)  YUSIMRY (adalimumab-aqvh)  ZYMFENTRA (infliximab-dyyb) |  |  |
| **NSAIDs, NASAL/ORAL/TOPICAL**  **(Clinical criteria applies to individual agents in class.)** | | | **Review Schedule: 3rd Quarter** |
| celecoxib  diclofenac sodium 1.5% solution drops, 1% gel  OTC, tablets ibuprofen indomethacin capsules ketorolac tablets meloxicam tablets nabumetone naproxen IR tablets sulindac | ARTHROTEC (diclofenac sodium/misoprostol)  CATAFLAM (diclofenac potassium)  CELEBREX (celecoxib) DAYPRO (oxaprozin) diclofenac epolamine patch diclofenac potassium  diclofenac sodium 1% gel RX, 2% solution pump diclofenac/misoprostol diflunisal  DOLOBID (diflunisal) \* etodolac  ELYXYB (celecoxib) FELDENE (piroxicam)  fenoprofen flurbiprofen ibuprofen/famotidine  indomethacin suppositories, suspension  INDOCIN (indomethacin)  ketoprofen  LOFENA (diclofenac potassium) meclofenamate mefenamic acid meloxicam capsules NALFON (fenoprofen) NAPRELAN (naproxen) naproxen DR, suspension naproxen/esomeprazole naproxen sodium oxaprozin  PENNSAID (diclofenac) piroxicam  RELAFEN (nabumetone) | •  • | Two (2) preferred products required before a non-preferred product will be approved.    \* Five (5) preferred products required before Dolobid will be approved. |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS**  **Prior authorization is required** |  | **CRITERION** |
|  | RELAFEN DS (nabumetone)  tolmetin  VOLTAREN (diclofenac sodium) 1% GEL |  |  |
| **OPIATE DEPENDENCE TREATMENTS** | | | **Review Schedule: 4th Quarter** |
| BRIXADI (buprenorphine) buprenorphine buprenorphine/naloxone  naltrexone  SUBLOCADE (buprenorphine)  VIVITROL (naltrexone) | lofexidine  LUCEMYRA (lofexidine)  SUBOXONE films (buprenorphine/naloxone)  ZUBSOLV (buprenorphine/naloxone) | • | Two (2) preferred products required before a non-preferred product will be approved. |
| **ANTIDOTES** | | |  |
| **CHELATING AGENTS** | | | **Review Schedule: 4th Quarter** |
| CHEMET (succimer) deferasirox tablets | deferasirox granules, ODT EXJADE (deferasirox)  FERRIPROX (deferiprone)  JADENU (deferasirox) | • | Two (2) preferred products required before a non-preferred product will be approved. |
| **OPIATE OVERDOSE TREATMENTS** | | | **Review Schedule: 4th Quarter** |
| KLOXXADO (naloxone) naloxone injection  naloxone nasal spray RX, OTC  NARCAN nasal spray RX, OTC (naloxone) | nalmefene injection  OPVEE (nalmefene)  ZIMHI (naloxone hydrochloride) | • | Two (2) preferred products required before a non-preferred product will be approved. |
| **OTHER** | | | **Review Schedule: 4th Quarter** |
| deferoxamine mesylate vials | DESFERAL (deferoxamine mesylate) vials deferoxamine mesylate vials (00409-2337-25 only) | • | One (1) preferred product required before a non-preferred product will be approved. |
| **ANTI-INFECTIVE AGENTS** | | |  |
| *ANTIBIOTICS, GI* **(Clinical criteria applies to individual agents in class.)** | | | **Review Schedule: 4th Quarter** |
| metronidazole 250 mg, 500 mg tablets neomycin tinidazole vancomycin capsules, solution  XIFAXAN 200 mg (rifaximin) | AEMCOLO (rifamycin)  DIFICID (fidaxomicin) \* FIRVANQ (vancomycin)  FLAGYL (metronidazole) LIKMEZ (metronidazole) metronidazole 125 mg tablets, capsules \*\* nitazoxanide tablets | •  • | Two (2) preferred products required before a non-preferred product will be approved.    \* Step through one (1) preferred vancomycin product required before product will be approved. |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS**  **Prior authorization is required** |  | **CRITERION** |
|  | paromomycin capsules VANCOCIN (vancomycin)  VOWST (fecal microbiota spores, live-brpk)  XIFAXAN 550 mg (rifaximin) | • | \*\* PA required, to include reason metronidazole 250 mg tablets cannot be used, before product will be approved. |
| **ANTIBIOTICS, INHALED** | | | **Review Schedule: 4th Quarter** |
| tobramycin 300 mg/5 mL (gen TOBI PODHALER) | ARIKAYCE (amikacin)  BETHKIS (tobramycin)  CAYSTON (aztreonam)  KITABIS PAK (tobramycin) TOBI PODHALER (tobramycin) tobramycin 300 mg/4 ml tobramycin 300 mg/5 mL (gen KITABIS PAK) | • | One (1) preferred product required before a non-preferred product will be approved. |
| **ANTIBIOTICS, VAGINAL** | | | **Review Schedule: 4th Quarter** |
| CLEOCIN ovules (clindamycin) clindamycin metronidazole 0.75% gel NUVESSA (metronidazole) | CLINDESSE (clindamycin) metronidazole 1.3% gel SOLOSEC (secnidazole)  VANDAZOLE (metronidazole) XACIATO (clindamycin) | • | Two (2) preferred products required before a non-preferred product will be approved. |
| **ANTIFUNGALS, ORAL** | | | **Review Schedule: 4th Quarter** |
| fluconazole  griseofulvin suspension  nystatin terbinafine | ANCOBON (flucytosine)  BREXAFEMME (ibrexafungerp) clotrimazole  CRESEMBA (isavuconazonium) DIFLUCAN (fluconazole)  flucytosine griseofulvin tablets itraconazole ketoconazole  NOXAFIL (posaconazole) suspension, PowderMix  ORAVIG (miconazole) posaconazole  SPORANOX (itraconazole)  TOLSURA (itraconazole)  VFEND (voriconazole) VIVJOA (oteseconazole)  voriconazole | • | Two (2) preferred products required before a non-preferred product will be approved. |
| **ANTIVIRALS, ANTIRETROVIRALS** | | | **Review Schedule: 4th Quarter** |
| abacavir  abacavir/lamivudine  APRETUDE (cabotegravir extended-release) atazanavir  BIKTARVY (bictegravir/emtricabine/ | abacavir/lamivudine/zidovudine  APTIVUS (tipranavir)  CIMDUO (lamivudine/tenofovir) COMBIVIR (lamivudine/zidovudine) darunavir | • | Two (2) preferred products required before a non-preferred product will be approved. |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS**  **Prior authorization is required** |  | **CRITERION** |
| tenofovir AF)  CABENUVA (cabotegravir/rilpivirine)  COMPLERA (emtricitabine/relpivirine/tenofovir) DELSTRIGO (doravirine/lamivudine/tenofovir) darunavir  DESCOVY (emtricitabine/tenofovir AF)  DOVATO (dolutegravir/lamivudine)  EDURANT (rilpivirine) efavirenz  efavirenz-emtricitabine-tenofovir emtricitabine  emtricitabine-tenofovir disoproxil fumarate  EVOTAZ (atazanavir/cobicistat)  GENVOYA (elvitegravir/cobicistat/emtricitabine/ tenofovir AF)  ISENTRESS (raltegravir potassium) lamivudine lamivudine-zidovudine lopinavir-ritonavir nevirapine  ODEFSEY (emtricitabine/relpivirine/tenofovir AF)  PREZCOBIX (darunavir/cobicistat)  RETROVIR injection (zidovudine) REYATAZ powder pack (atazanavir) ritonavir  SYMTUZA (darunavir/cobicistat/emtricitabine/ tenofovir AF) tenofovir disoproxil fumarate TIVICAY (dolutegravir sodium)  TIVICAY PD (dolutegravir sodium)  TRIUMEQ (abacavir/lamivudine/dolutegravir)  TRIUMEQ PD (abacavir/lamivudine/dolutegravir)  TYBOST (cobicistat)  VIREAD (except 300 mg tablets) (tenofovir  disoproxil fumarate)  zidovudine | efavirenz/lamivudine/tenofovir  EMTRIVA (emtricitabine)  EPIVIR (lamivudine)  EPZICOM (abacavir/lamivudine) etravirine fosamprenavir FUZEON (enfuvirtide)  INTELENCE (etravirine)  ISENTRESS HD (raltegravir potassium)  JULUCA (dolutegravir/rilpivirine)  KALETRA (lopinavir/ritonavir) LEXIVA (fosamprenavir) maraviroc nevirapine ER  NORVIR (ritonavir) 100 mg tablet, powder pack  PIFELTRO (doravirine)  PREZISTA (darunavir)  RUKOBIA (fostemsavir)  SELZENTRY (maraviroc)  STRIBILD (elvitegravir/cobicistat/emtricitabine/ tenofovir)  SUNLENCA (lenacapavir sodium) tablets, vial  SYMFI (efavirenz/lamivudine/tenofovir)  SYMFI LO (efavirenz/lamivudine/tenofovir)  TRIZIVIR (abacavir/lamivudine/zidovudine)  TROGARZO (ibalizumab-uiyk)  TRUVADA (emtricitabine/tenofovir DF)  VIRACEPT (nelfinavir mesylate)  VIREAD 300 mg tablets (tenofovir disoproxil fumarate)  ZIAGEN (abacavir) |  |  |
| **ANTIVIRALS, COVID - 19** | | | **Review Schedule: 4th Quarter** |
| PAXLOVID (nirmatrelvir/ritonavir) | LAGEVRIO (molnupiravir) | • | One (1) preferred product required before a non-preferred product will be approved. |
| **ANTIVIRALS, HEPATITIS C AGENTS** | | | **Review Schedule: 4th Quarter** |
| MAVYRET (glecaprevir/pibrentasvir) ribavirin  sofosbuvir/velpatasvir | EPCLUSA (sofosbuvir/velpatasvir) pellet pack, tablets  HARVONI (ledipasvir/sofosbuvir) ledipasvir/sofosbuvir  PEGASYS (peginterferon alfa-2a)  SOVALDI (sofosbuvir) | •    • | Two (2) preferred products required before a non-preferred product will be approved.  **Limited to one treatment cycle every 365 days** |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS**  **Prior authorization is required** |  | **CRITERION** |
|  | VOSEVI (sofosbuvir/velpatasvir/voxilaprevir)  ZEPATIER (elbasvir/grazoprevir) |  |  |
| **ANTIVIRALS, ORAL/INHALATION** | |  | **Review Schedule: 4th Quarter** |
| acyclovir amantadine capsules, solution  famciclovir oseltamivir \* valacyclovir valganciclovir | amantadine tablets LIVTENCITY (maribavir)  PREVYMIS (letermovir) RELENZA (zanamivir) \* rimantadine  SITAVIG (acyclovir)  TAMIFLU (oseltamivir) \*  VALCYTE (valganciclovir)  VALTREX (valacyclovir)  XOFLUZA (baloxavir marboxil) | •  •    • | Two (2) preferred products required before a non-preferred product will be approved.    Liquid medications require prior authorization for members over 10-years old  **\* Quantity limits in place for oseltamivir and RELENZA** |
| **CEPHALOSPORINS, ORAL** | |  | **Review Schedule: 3rd Quarter** |
| cefaclor IR capsules  cefdinir  cefprozil cefuroxime  cephalexin capsules, suspension | cefaclor ER tablet cefaclor suspension  cefadroxil cefixime cefpodoxime  cephalexin tablets | • | Two (2) preferred products required before a non-preferred product will be approved. |
| **FLUOROQUINOLONES, ORAL** | |  | **Review Schedule: 3rd Quarter** |
| ciprofloxacin IR tablets levofloxacin tablets | BAXDELA (delafloxacin) CIPRO (ciprofloxacin) ciprofloxacin ER ciprofloxacin suspension levofloxacin solution moxifloxacin  ofloxacin | • | Two (2) preferred products required before a non-preferred product will be approved. |
| **LINCOSAMIDES/OXAZOLIDINONES/STREPTOGRAMINS**  **(Clinical criteria applies to individual agents in class.)** | |  | **Review Schedule: 2nd Quarter** |
| clindamycin capsules  clindamycin solution (for member < 10 years old) | CLEOCIN (clindamycin)  linezolid \*  SIVEXTRO (tedizolid) \*  ZYVOX (linezolid) \* | •  • | One (1) preferred product required before a non-preferred product will be approved.    Liquid medications require prior authorization for members over 10 years old. |
|  |  | • | \* Clinical criteria applies |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS**  **Prior authorization is required** |  | **CRITERION** |
| **MACROLIDES** | | | **Review Schedule: 4th Quarter** |
| azithromycin clarithromycin tablets erythromycin suspension | clarithromycin suspension clarithromycin ER  E.E.S. 400  ERY-TAB (erythromycin)  ERYPED (erythromycin ethylsuccinate) ERYTHROCIN (erythromycin stearate) erythromycin (all other salts/formulations)  ZITHROMAX (azithromycin) | • | Two (2) preferred products required before a non-preferred product will be approved. |
| **PENICILLINS, ORAL/IM** | | | **Review Schedule: 3rd Quarter** |
| amoxicillin  amoxicillin/clavulanate (except 250 mg suspension, tablets)  ampicillin  BICILLIN C-R BICILLIN L-A  dicloxacillin penicillin  penicillin G procaine | amoxicillin/clavulanate 250 mg suspension, tablets amoxicillin/clavulanate XR  AUGMENTIN (amoxicillin/potassium clavulanate)  AUGMENTIN ES (amoxicillin/potassium clavulanate) | • | Two (2) preferred products required before a non-preferred product will be approved. |
| **TETRACYCLINES** | | | **Review Schedule: 4th Quarter** |
| doxycycline hyclate 20, 100 mg tablets doxycycline hyclate capsule  doxycycline monohydrate 50, 100 mg capsules doxycycline monohydrate tablets minocycline capsules | demeclocycline  DORYX (doxycycline hyclate) doxycycline DR doxycycline hyclate 50, 75, 150 mg tablets doxycycline monohydrate 75, 150 mg capsules doxycycline suspension minocycline ER minocycline tablets  MINOLIRA ER (minocycline)  NUZYRA (omadacycline)  SOLODYN (minocycline)  TARGADOX (doxycycline hyclate) tetracycline  XIMINO (minocycline) | • | Two (2) preferred products required before a non-preferred product will be approved. |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS**  **Prior authorization is required** |  | **CRITERION** |
| **URINARY ANTI-INFECTIVES** | | | **Review Schedule: 1st Quarter** |
| methenamine hippurate  methenamine mandelate  nitrofurantoin macrocrystals (generic  MACRODANTIN)  nitrofurantoin monohydrate-macrocrystals  (generic MACROBID) | fosfomycin tromethamine  MACROBID (nitrofurantoin monohydratemacrocrystals)  nitrofurantoin suspension | • | Two (2) preferred products required before a non-preferred product will be approved. |
| **ANTINEOPLASTICS** | | |  |
| *ONCOLOGY AGENTS* **(Clinical criteria apply to individual agents in class.)** | | | **Review Schedule: 3rd Quarter** |
| all other drug products | AFINITOR (everolimus)  AFINITOR DISPERZ (everolimus) ALKERAN (melphalan)  CASODEX (bicalutamide)  CYTOXAN (cyclophosphamide)  DANZITEN (nilotinib) \* dasatinib  EULEXIN (flutamide)  FARESTON (toremifene)  GILOTRIF (afatinib)  GLEEVEC (imatinib)  GLEOSTINE (lomustine)  HYDREA (hydroxyurea) INLYTA (axitinib)  IRESSA (gefitinib)  MESNEX (mesna)  NEXAVAR (sorafenib)  NOLVADEX (tamoxifen)  PURINETHOL (mercaptopurine)  REVLIMID (lenalidomide)  SUTENT (sunitinib)  TARGRETIN (bexarotene)  TEMODAR (temozolomide)  THALOMID (thalidomide)  TYKERB (lapatinib)  VOTRIENT (pazopanib)  XELODA (capecitabine) | •  •    •    • | Effective January 1, 2025, any member starting a new prescription for an oral oncology medication with an AB-rated generic must attempt a 30-day supply of the generic before brand name medications will be considered, unless the brand name medication is on the Brand over Generic (BoG) list. This change does NOT impact those currently on oral oncology medications.    For brand-name medications not on the BoG list to be considered, providers must submit a prior authorization form with documentation of medical trial of the generic and outcome electronically via the DMAP Provider Portal.  Please refer to the Delaware Pharmacy Corner website for the BoG list.  [https://medicaid.dhss.delaware.gov/provider/Home/PharmacyCor nerLanding/tabid/2096/Default.aspx](https://medicaid.dhss.delaware.gov/provider/Home/PharmacyCornerLanding/tabid/2096/Default.aspx)  \* PA required, to include reason Tasigna cannot be used, before product will be approved. |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS**  **Prior authorization is required** |  | **CRITERION** |
|  | ZORTRESS (everolimus)  ZYTIGA (abiraterone acetate) |  |  |
| **CARDIOVASCULAR AGENTS** | | |  |
| **ANGIOTENSIN MODULATORS** | | | **Review Schedule: 1st Quarter** |
| benazepril  benazepril/HCTZ enalapril  enalapril/HCTZ fosinopril irbesartan  irbesartan/HCTZ  lisinopril lisinopril/HCTZ losartan losartan/HCTZ olmesartan  olmesartan/HCTZ  quinapril quinapril/HCTZ  ramipril trandolapril valsartan valsartan/HCTZ | ACCUPRIL (quinapril)  ACCURETIC (quinapril/HCTZ)  aliskerin  ALTACE (ramipril)  ATACAND (candesartan)  ATACAND HCT (candesartan/HCTZ)  AVALIDE (irbesartan/HCTZ)  AVAPRO (irbesartan)  BENICAR (olmesartan)  BENICAR HCT (olmesartan/HCTZ)  candesartan  candesartan/HCTZ  captopril captopril/HCTZ COZAAR (losartan)  DIOVAN (valsartan)  DIOVAN HCT (valsartan/HCTZ)  EDARBI (azilsartan)  EDARBYCLOR (azilsartan/chlorthalidone)  EPANED (enalapril) eprosartan fosinopril/HCTZ  HYZAAR (losartan/HCTZ)  LOTENSIN (benazepril)  LOTENSIN HCT (benazepril/HCTZ)  MICARDIS (telmisartan)  MICARDIS HCT (telmisartan/HCTZ) moexipril perindopril  QBRELIS (lisinopril) TEKTURNA (aliskiren)  telmisartan telmisartan/HCTZ  VASERETIC (enalapril/HCTZ)  VASOTEC (enalapril)  ZESTORETIC (lisinopril/HCTZ)  ZESTRIL (lisinopril) | •  • | Two (2) preferred products required before a non-preferred product will be approved.    Dose optimization required when applicable. |
| **ANGIOTENSIN MODULATOR/CALCIUM CHANNEL BLOCKER COMBINATIONS** | | | **Review Schedule: 1st Quarter** |
| amlodipine/benazepril amlodipine/valsartan amlodipine/valsartan/ HCTZ | AZOR (amlodipine/olmesartan)  EXFORGE (amlodipine/valsartan)  EXFORGE HCT (amlodipine/valsartan/HCTZ) | • | Two (2) preferred products required before a non-preferred product will be approved. |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS**  **Prior authorization is required** |  | **CRITERION** |
| olmesartan/amlodipine  olmesartan/amlodipine/HCTZ | LOTREL (amlodipine/benazepril)  telmisartan/amlodipine trandolapril/verapamil  TRIBENZOR (olmesartan/amlodipine/HCTZ) | • | Dose optimization required when applicable. |
| **ANTIHYPERTENSIVES, SYMPATHOLYTIC** | | | **Review Schedule: 1st Schedule** |
| clonidine patches, IR tablets  doxazosin guanfacine methyldopa prazosin terazosin | CARDURA (doxazosin)  clonidine ER (generic NEXICLON XR)  MINIPRESS (prazosin)  NEXICLON XR (clonidine)  TEZRULY (terazosin) \* | •    • | Two (2) preferred products required before a non-preferred product will be approved.  \* PA required, to include reason terazosin capsules cannot be used, before product will be approved. |
| **BETA BLOCKERS** | | | **Review Schedule: 2nd Quarter** |
| atenolol  atenolol/chlorthalidone bisoprolol bisoprolol/HCTZ carvedilol IR  labetalol 100 mg, 200 mg, 300 mg tablets metoprolol metoprolol ER nadolol nebivolol propranolol propranolol ER SORINE (sotalol)  sotalol | acebutolol  BETAPACE (sotalol) betaxolol  BYSTOLIC (nebivolol) carvedilol ER  CORGARD (nadolol)  HEMANGEOL (propranolol)  INDERAL LA (propranolol)  INDERAL XL (propranolol)  INNOPRAN XL (propranolol) KAPSPARGO (metoprolol) labetalol 400 mg tablets \*  LOPRESSOR (metoprolol)  LOPRESSOR HCT (metoprolol/HCTZ)  metoprolol/HCTZ pindolol  SOTYLIZE (sotalol)  TENORETIC (atenolol/chlorthalidone) TENORMIN (atenolol)  timolol  TOPROL XL (metoprolol ER) ZIAC (bisoprolol/HCTZ) | •    • | Two (2) preferred products required before a non-preferred product will be approved.  \* PA required, to include reason labetalol 2 x 200 mg tablets cannot be used, before product will be approved. |
| **CALCIUM CHANNEL BLOCKERS** | | | **Review Schedule: 3rd Quarter** |
| amlodipine  CARTIA XT (diltiazem ER) DILT-XR (diltiazem ER) diltiazem ER capsules  diltiazem IR felodipine nifedipine ER nifedipine IR nimodipine \* | CARDIZEM (diltiazem)  CARDIZEM CD (diltiazem ER) CARDIZEM LA (diltiazem ER)  diltiazem ER tablets isradipine  KATERZIA (amlodipine) levamlodipine maleate MATZIM LA (diltiazem ER) nicardipine | •  •    • | Two (2) preferred products required before a non-preferred product will be approved.    Dose optimization required when applicable.  **\* ICD-10 code for SAH may create system-generated approval for nimodipine.** |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS**  **Prior authorization is required** |  | **CRITERION** |
| TAZTIA XT (diltiazem ER) TIADYLT ER (diltiazem ER) verapamil ER tablets, capsules verapamil IR | nisoldipine  NORLIQVA (amlodipine)  NORVASC (amlodipine)  NYMALIZE (nimodipine)  PROCARDIA (nifedipine)  PROCARDIA XL (nifedipine ER)  SULAR (nisoldipine) TIAZAC (diltiazem) verapamil ER PM  verapamil SR pellet  VERELAN PM (verapamil) |  |  |
| **DIURETICS** | | | **Review Schedule: 1st Quarter** |
| acetazolamide tablets acetazolamide ER capsules  amiloride amiloride/HCTZ bumetanide chlorothiazide chlorthalidone  DIURIL (chlorothiazide) suspension furosemide  hydrochlorothiazide (HCTZ) indapamide metolazone spironolactone spironolactone/HCTZ torsemide triamterene/HCTZ | ALDACTAZIDE (spironolactone/HCTZ)  ALDACTONE (spironolactone) CAROSPIR (spironolactone) dichlorphenamide  EDECRIN (ethacrynic acid)  ethacrynic acid  INZIRQO (HCTZ) \*  KERENDIA (finerenone)  KEVEYIS (dichlorphenamide)  LASIX (furosemide)  MAXZIDE (triamterene/HCTZ) methazolamide  THALITONE (chlorthalidone)  triamterene | •    • | Two (2) preferred products required before a non-preferred product will be approved.  \* Step through Diuril suspension required. |
| **EPINEPHRINE, SELF-INJECTED** | | | **Review Schedule: 4th Quarter** |
| epinephrine auto-injector AG (Mylan Specialty – AUVI-Q (epinephrine) • labeler 49502) EPI-PEN (epinephrine)  epinephrine auto-injector (other than Mylan  Specialty – labeler 49502)  NEFFY (epinephrine) | | | One (1) preferred product required before a non-preferred product will be approved. |
| **HEART FAILURE DRUGS** | | | **Review Schedule: 4th Quarter** |
| ENTRESTO (valsartan/sacubitril) TABLET | INPEFA (sotagliflozin)  VERQUVO (vericiguat)  ENTRESTO (valsartan/sacubitril) SPRINKLE valsartan/sacubitril | • | One (1) preferred product required before a non-preferred product will be approved. |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS**  **Prior authorization is required** |  | **CRITERION** |
| **LIPOTROPICS, OTHER (Clinical criteria applies to individual agents in class.)** | | | **Review Schedule: 4th Quarter** |
| cholestyramine cholestyramine light colesevelam tablets  colestipol ezetimibe  fenofibrate (gen LOFIBRA) fenofibrate (gen TRICOR)  gemfibrozil niacin ER omega-3 acid ethyl esters PRALUENT (alirocumab) \*  PREVALITE (cholestyramine) POWDER, POWDER PACK  REPATHA (evolocumab) \* | ANTARA (fenofibrate) colesevalam powder COLESTID (colestipol)  EVKEEZA (evinacumab-dgnb) ezetimibe/simvastatin fenofibrate (gen FENOGLIDE) fenofibrate (gen LIPOFEN)  fenofibrate, micronized (gen ANTARA) fenofibric acid (gen FIBRICOR) fenofibric acid (gen TRILIPIX) FENOGLIDE (fenofibrate) icosapent ethyl  JUXTAPID (lomitapide)  LEQVIO (inclisiran)  LIPOFEN (fenofibrate)  LOPID (gemfibrozil)  NEXLETOL (bempedoic acid)  NEXLIZET (bempedoic acid/ezetimibe)  TRICOR (fenofibrate)  TRILIPIX (fenofibric acid)  TRYNGOLZA (olesarzen)  VYTORIN (ezetimibe/simvastatin) WELCHOL (colesevelam)  ZETIA (ezetimibe) | •    • | Two (2) preferred products required before a non-preferred product will be approved.  **\* Clinical criteria applies** |
| **LIPOTROPICS, STATINS** | | | **Review Schedule: 2nd Quarter** |
| atorvastatin lovastatin pravastatin rosuvastatin simvastatin | ALTOPREV (lovastatin) amlodipine/atorvastatin  ATORVALIQ (atorvastatin) suspension  CADUET (amlodipine/atorvastatin) CRESTOR (rosuvastatin)  EZALLOR (rosuvastatin) FLOLIPID (simvastatin)  fluvastatin fluvastatin ER  LESCOL XL (fluvastatin)  LIPITOR (atorvastatin)  LIVALO (pitavastatin)  ZOCOR (simvastatin)  ZYPITAMAG (pitavastatin) | •  • | Two (2) preferred products required before a non-preferred product will be approved.    Once daily dosing required. |
| **PAH AGENTS, ORAL & INHALED**  **(Clinical criteria applies to class. All agents require a prior authorization.)** | | | **Review Schedule: 4th Quarter** |
| ambrisentan bosentan  sildenafil 20 mg tablets | ADCIRCA (tadalafil)  ADEMPAS (riociguat)  ALYQ (tadalafil) | • | Two (2) preferred products required before a non-preferred product will be approved. |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS**  **Prior authorization is required** | **CRITERION** |
| sildenafil 10mg/ml suspension \*  tadalafil 20 mg tablets (generic ADCIRCA)  VENTAVIS (iloprost) | LETAIRIS (ambrisentan)  OPSUMIT (macitentan)  OPSYNVI (macitentan/tadalafil)  ORENITRAM ER (treprostinil)  REVATIO (sildenafil)  TADLIQ (tadalafil) suspension  TRACLEER tablets for suspension (bosentan) treprostinil  TYVASO DPI (treprostinil)  UPTRAVI (selexipag)  WINREVAIR (sotatercept) | • \* PA required, to include reason sildenafil tablets cannot be used, if member is > 10-years old. |
| **VASODILATORS, CORONARY****Review Schedule: 1st Quarter** | | |
| isosorbide dinitrate isosorbide mononitrate isosorbide mononitrate ER nitroglycerin patches, tablets  ranolazine ER | ASPRUZYO (ranolazine)  BIDIL (isosorbide dinitrate/hydralazine) ISORDIL (isosorbide dinitrate tablet) isosorbide dinitrate/hydralazine NITRO-BID (nitroglycerin) ointment NITRO-DUR (nitroglycerin) patches nitroglycerin translingual spray  NITROLINGUAL (nitroglycerin) spray NITROMIST (nitroglycerin)  NITROSTAT (nitroglycerin) tablets | • Two (2) preferred products required before a non-preferred product will be approved. |
| **CENTRAL NERVOUS SYSTEM DRUGS** | | |
| **ANTIDEPRESSANTS, OTHER**  **Review Schedule: 4th Quarter (Clinical criteria applies to individual agent in class.)** | | |
| amitriptyline bupropion IR bupropion SR  bupropion XL 150, 300 mg clomipramine desvenlafaxine ER (gen PRISTIQ) doxepin  duloxetine 20 mg, 30 mg, 60 mg imipramine HCl  MARPLAN (isocarboxazid)  mirtazapine tablet nortriptyline phenelzine  SPRAVATO (esketamine) \* tranylcypromine trazodone 50, 100, 150 mg venlafaxine ER capsules venlafaxine IR | amitriptyline/chlordiazepoxide amoxapine  ANAFRANIL (clomipramine)  APLENZIN (bupropion hbr)  AUVELITY (dextromethorphan HBr/bupropion)  bupropion XL 450 mg CYMBALTA (duloxetine)  desipramine  desvenlafaxine ER 50 mg, 100 mg (unbranded)  DRIZALMA (duloxetine)  duloxetine 40 mg  EFFEXOR XR (venlafaxine ER) CAPSULES EMSAM (selegiline)  FETZIMA (levomilnacipran) FORFIVO XL (bupropion) imipramine pamoate mirtazapine ODT NARDIL (phenelzine) nefazodone  NORPRAMIN (desipramine) | * Two (2) preferred products required before a non-preferred product will be approved.      * DMAP requires prior authorization for all antidepressants for patients under six (6) years of age.      * **\* Clinical criteria applies** |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS**  **Prior authorization is required** |  | **CRITERION** |
|  | PAMELOR (nortriptyline) PRISTIQ (desvenlafaxine) protriptyline  RALDESY (trazodone)  REMERON (mirtazapine)  REMERON SOLUTAB (mirtazapine)  trazodone 300 mg trimipramine  TRINTELLIX (vortioxetine) venlafaxine HCL ER tablets venlafaxine besylate ER VIIBRYD (vilazodone HCl) vilazodone  WELLBUTRIN SR (bupropion)  WELLBUTRIN XL (bupropion)  ZURZUVAE (zuranolone) |  |  |
| **ANTIDEPRESSANTS, SSRIs** | | | **Review Schedule: 4th Quarter** |
| citalopram solution, tablets escitalopram tablets fluoxetine capsules, solution fluvoxamine tablets paroxetine IR tablets  sertraline concentrate, tablets | CELEXA (citalopram) citalopram capsules escitalopram solution fluoxetine tablets fluoxetine DR fluvoxamine ER  LEXAPRO (escitalopram) paroxetine CR, ER  paroxetine capsules, suspension PAXIL (paroxetine)  PEXEVA (paroxetine) PROZAC (fluoxetine) sertraline capsules ZOLOFT (sertraline) | •  •    • | Two (2) preferred products required before a non-preferred product will be approved.    DMAP requires prior authorization for all antidepressants for patients under six (6) years of age.  Liquid medications require prior authorization for members over 10-years old. |
| **ANTIPSYCHOTICS, ORAL/INHALATION**  **(Clinical criteria applies to individual agents in class.)** | | | **Review Schedule: 4th Quarter** |
| amitriptyline/perphenazine aripiprazole solution, tablets  clozapine haloperidol concentrate, solution, tablets loxapine lurasidone olanzapine tablets paliperidone ER perphenazine pimozide quetiapine  risperidone solution, tablets thioridazine | ABILIFY (aripiprazole) TABLETS  ABILIFY MYCITE (aripiprazole) TABLETS aripiprazole ODT asenapine sublingual tablets CAPLYTA (lumateperone)  chlorpromazine clozapine ODT  CLOZARIL (clozapine) TABLETS  COBENFY (xanomeline/trospium) \*\*  FANAPT (iloperidone)  fluphenazine  GEODON (ziprasidone) CAPSULES  INVEGA (paliperidone) TABLETS | •  •  •  • | Two (2) preferred products required before a non-preferred product will be approved.    \* Two (2) preferred products, one (1) of which must be aripiprazole solution, required before product will be approved.    \*\* Three (3) preferred products, one (1) of which must be Vraylar (cariprazine), required and member must not be taking other antipsychotics before product will be approved.    PA required for all antipsychotics for patients under eighteen (18) years of age. |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS**  **Prior authorization is required** |  | **CRITERION** |
| thiothixene  trifluoperazine  VRAYLAR (cariprazine)  ziprasidone | LATUDA (lurasidone)  LYBALVI (olanzapine/samidorphan) TABLETS molindone  NUPLAZID (pimavanserin tartrate) OPIPZA (aripiprazole) \* olanzapine ODT olanzapine/fluoxetine REXULTI (brexpiprazole)  RISPERDAL (risperidone) TABLETS  risperidone ODT SAPHRIS (asenapine)  SECUADO (asenapine)  SEROQUEL (quetiapine) TABLETS  SEROQUEL XR (quetiapine) TABLETS VERSACLOZ (clozapine)  ZYPREXA (olanzapine) TABLETS |  |  |
| **ANTIPSYCHOTICS, INJECTABLE/INHALATION** | | | **Review Schedule: 4th Quarter** |
| ABILIFY ASIMTUFII (aripiprazole)  ABILIFY MAINTENA (aripiprazole) ARISTADA (aripiprazole) chlorpromazine fluphenazine fluphenazine decanoate haloperidol decanoate  haloperidol lactate  INVEGA HAFYERA (paliperidone)  INVEGA SUSTENNA (paliperidone) INVEGA TRINZA (paliperidone) olanzapine  RISPERDAL CONSTA (risperidone)  ziprasidone mesylate IM | ADASUVE (loxapine)  ERZOFRI (paliperidone)  GEODON IM (ziprasidone)  HALDOL (haloperidol decanoate) PERSERIS (risperidone) risperidone ER vials  RYKINDO (risperidone microspheres)  UZEDY (risperidone) | •  • | Two (2) preferred products required before a non-preferred product will be approved.    PA required for all antipsychotics for patients under eighteen (18) years of age. |
| **ANXIOLYTICS** | | | **Review Schedule: 2nd Quarter** |
| buspirone chlordiazepoxide clorazepate diazepam solution, tablets hydroxyzine pamoate  hydroxyzine HCl solution, tablets lorazepam tablets | alprazolam ER/XR, IR, intensol, ODT  ATIVAN (lorazepam) diazepam intensol  LIBRIUM (chlordiazepoxide) lorazepam intensol  LOREEV XR (lorazepam) meprobamate oxazepam  VALIUM (diazepam)  VISTARIL (hydroxyzine pamoate)  XANAX (alprazolam)  XANAX XR (alprazolam) | •    • | Two (2) preferred products required before a non-preferred product will be approved.  **Quantity Limits of 120 units of benzodiazepines per 30 days** |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS**  **Prior authorization is required** |  |  | **CRITERION** |
| **MOOD STABILIZERS** | | |  | **Review Schedule: 4th Quarter** |
| carbamazepine 100 mg chewable tablets, tablets  carbamazepine ER, XR carbamazepine suspension  divalproex sodium lamotrigine IR lithium IR lithium ER  SUBVENITE (lamotrigine)  valproic acid | carbamazepine 200 mg chewable tablets \*  DEPAKOTE (divalproex)  DEPAKOTE ER (divalproex)  LAMICTAL (lamotrigine)  LAMICTAL ODT (lamotrigine) LAMICTAL XR (lamotrigine) lamotrigine ER, ODT  LITHOBID (lithium)  TEGRETOL (carbamazepine) suspension, tablets  TEGRETOL-XR (carbamazepine) tablets TERIL (carbamazepine) suspension |  | •  • | Two (2) preferred products required before a non-preferred product will be approved.  \* PA required, to include reason carbamazepine 2 x 100 mg chewable tablets cannot be used, before product will be approved. |
| **SEDATIVE HYPNOTICS** | | |  | **Review Schedule: 2nd Quarter** |
| temazepam 15mg, 30mg zaleplon  zolpidem IR tablets | AMBIEN (zolpidem)  AMBIEN CR (zolpidem)  BELSOMRA (suvorexant) DAYVIGO (lemborexant) doxepin 3mg, 6 mg EDLUAR (zolpidem)  estazolam eszopiclone flurazepam  HALCION (triazolam)  HETLIOZ (tasimelteon) capsules, suspension  IGALMI (dexmedetomidine HCl)  LUNESTA (eszopiclone) QUVIVIQ (daridorexant HCl) ramelteon  RESTORIL (temazepam)  ROZEREM (ramelteon)  SILENOR (doxepin) SONATA (zaleplon)  tasimelteon  temazepam 7.5mg, 22.5mg  triazolam zolpidem ER  zolpidem IR capsules |  | •  •  • | Two (2) preferred products required before a non-preferred product will be approved.    Dose optimization required when applicable.    Quantity limits – 30 units per 30 days |
| **DIABETIC SUPPLY LIST** | | |  |  |
| Please refer to the Delaware Pharmacy Corner website for covered Diabetic Supply products. [https://medicaid.dhss.delaware.gov/provider/H ome/PharmacyCornerLanding/tabid/2096/Def ault.aspx](https://medicaid.dhss.delaware.gov/provider/Home/PharmacyCornerLanding/tabid/2096/Default.aspx) |  |  |  |  |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS**  **Prior authorization is required** | **CRITERION** |
| **ENDOCRINE AND METABOLIC DRUGS** | | |
| **ANDROGENIC AGENTS th Quarter**  **Review Schedule: 4 (Clinical criteria applies to class. All agents require a prior authorization.)** | | |
| DEPO-TESTOSTERONE (testosterone cypionate)  testosterone cypionate testosterone enanthate testosterone gel pump 20.25/1.25 | AMZIRO (testosterone cyprionate)  ANDROID 25 (methyltestosterone)  ANDROGEL (testosterone)  AVEED (testosterone undecanoate)  JATENZO (testosterone undecanoate)  KYZATREX (testosterone undecanoate) METHITEST (methyltestosterone)  methyltestosterone NATESTO (testosterone) TESTIM (testosterone)  testosterone gel (except preferred formulation) TLANDO (testosterone undecanoate)  UNDECATREX (testosterone undecanoate)  VOGELXO (testosterone)  XYOSTED (testosterone enanthate) | • Two (2) preferred products required before a non-preferred product will be approved. |
| **BONE RESORPTION SUPPRESSION AND RELATED AGENTS Review Schedule: 4th Quarter**  **(Clinical criteria applies to individual agents in class)** | | |
| alendronate tablets  calcitonin-salmon nasal spray FORTEO (teriparatide) \* ibandronate  PROLIA (denosumab) \* raloxifene  XGEVA (denosumab) \* | ACTONEL (risedronate) alendronate solution ATELVIA (risedronate)  BINOSTO (alendronate)  BONSITY (teriparatide) \*  EVENITY (romosozumab-aqqg) \*  EVISTA (raloxifene)  FOSAMAX (alendronate)  FOSAMAX PLUS D (alendronate/vitamin D)  NATPARA \*  risedronate teriparatide \*  TYMLOS (abaloparatide) \*  YORVIPATH (palopegteriparatide) \* | * Two (2) preferred products required before a non-preferred product will be approved.      * **\* Clinical PA is required for injectable medications in this class** |
| CONTRACEPTIVES**, ORAL – BIPHASICReview Schedule: 1st Quarter** | | |
| desogestrel-ethinyl estradiol-eth estradiol | LO LOESTRIN FE (norethindrone-ethinyl estradiolFE) | • One (1) preferred product required before a non-preferred product will be approved. |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS**  **Prior authorization is required** |  | **CRITERION** |
| **CONTRACEPTIVES, ORAL - COMBINATION** | | | **Review Schedule: 1st Quarter** |
| desogestrel-ethinyl estradiol drosperinone-ethinyl estradiol  ENSKYCE (desogestrel-ethinyl estradiol) ethynodiol-ethinyl estradiol  ICLEVIA (levonorgestrel-ethinyl estradiol) levonorgestrel-ethinyl estradiol norethindrone-ethinyl estradiol  norethindrone-ethinyl estradiol-FE tablets, capsule, chewables  norgestimate-ethinyl estradiol norgestrel-ethinyl estradiol  OCELLA (drosperinone-ethinyl estradiol) SETLAKIN (levonorgestrel-ethinyl estradiol)  TRI-NYMYO (norgestimate-ethinyl estradiol)  TYBLUME (levonorgestrel-ethinyl estradiol) chewable  VOLNEA (desogestrel-ethinyl estradiol/ethinyl estradiol)  WYMZYA FE (norethindrone-ethinyl estradiol-FE) chewable | BALCOLTRA (levonorgestrel-ethinyl estradiol-FE)  BEYAZ (drosperinone-ethinyl estradiollevomefolate)  drosperinone-ethinyl estradiol-levomefolate FEMLYV (norethindrone-ethinyl estradiol)  GEMMILY (norethindrone-ethinyl estradiol-FE)  GENERESS FE (norethindrone-ethinyl estradiol-  FE) chewable  KAITLIB FE (norethindrone-ethinyl estradiol) chewable  LAYOLIS FE (norethindrone-ethinyl estradiol-FE) chewable levonorgestrel-ethinyl estradiol 90-20  levonorgestrel-ethinyl estradiol-FE (gen  BALCOLTRA)  LOESTRIN (norethindrone-ethinyl estradiol)  LOESTRIN-FE (norethindrone-ethinyl estradiol-FE)  MERZEE (norethindrone-ethinyl estradiol-FE) MINASTRIN (norethindrone-ethinyl estradiol)  MINZOYA (levonorgestrel-ethinyl estradiol-FE)  NEXTSTELLIS (drospirenone-estetrol)  SAFYRAL (drosperinone-ethinyl estradiollevomefolate)  TAYSOFY (norethindrone-ethinyl estradiol-FE)  TAYTULLA (norethindrone-ethinyl estradiol)  YASMIN (drosperinone-ethinyl estradiol) YAZ (drosperinone-ethinyl estradiol) | • | Two (2) preferred products required before a non-preferred product will be approved. |
| **CONTRACEPTIVES, ORAL - EXTENDED CYCLE** | | | **Review Schedule: 1st Quarter** |
| AMETHIA LO (levonorgestrel-ethinyl estradiol)  CAMRESE (levonorgestrel-ethinyl estradiol)  CAMRESE LO (levonorgestrel-ethinyl estradiol- ethinyl estradiol)  JOLESSA (levonorgestrel-ethinyl estradiol) levonorgestrel-ethinyl estradiol 0.15-0.03, 0.1-  0.02 levonorgestrel-ethinyl estradiol-ethinyl estradiol 150-30, 100-20 | levonorgestrel-ethinyl estradiol-ethinyl estradiol 0.15 LOSEASONIQUE (levonorgestrel-ethinyl estradiol)  SEASONIQUE (levonorgestrel-ethinyl estradiol) | • | Two (2) preferred products required before a non-preferred product will be approved. |
| **CONTRACEPTIVES, ORAL - PROGESTINS** | | | **Review Schedule: 1st Quarter** |
| EMZAHH (norethindrone)  LYLEQ (norethindrone) NORA-BE (norethindrone) norethindrone  SLYND (drospirenone) |  |  |  |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS**  **Prior authorization is required** |  | **CRITERION** |
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| **CONTRACEPTIVES, ORAL – TRIPHASIC** | | | **Review Schedule: 1st Quarter** |
| ALYACEN (norethindrone-ethinyl estradiol)  ARANELLE (norethindrone-ethinyl estradiol) CAZIANT (desogestrel-ethinyl estradiol)  DASETTA (norethindrone-ethinyl estradiol)  ENPRESSE (levonorgestrel-ethinyl estradiol)  FINZALA (norethindrone-ethinyl estradiol-iron) LEENA (norethindrone-ethinyl estradiol) LEVONEST (levonorgestrel-ethinyl estradiol) levonorgestrel-ethinyl estradiol  NORTREL (norethindrone-ethinyl estradiol) NYLIA (norethindrone-ethinyl estradiol) norethindrone-ethinyl estradiol-iron norgestimate-ethinyl estradiol  TILIA FE (norethindrone-ethinyl estradiol-iron)  TRI-ESTARYLLA (norgestimate-ethinyl estradiol)  TRI-LINYAH (norgestimate-ethinyl estradiol)  TRI-MILI (norgestimate-ethinyl estradiol) TRY-NYMYO (norgestimate-ethinyl estradiol)  TRI-SPRINTEC (norgestimate-ethinyl estradiol)  TRI-VYLIBRA (norgestimate-ethinyl estradiol)  TRIVORA (levonorgestrel-ethinyl estradiol) VELIVET (desogestrel-ethinyl estradiol) | TRI-LEGEST (norethindrone-ethinyl estradiol-iron) | • | Two (2) preferred products required before a non-preferred product will be approved. |
| **CONTRACEPTIVES – IUDs / IMPLANTS** | | | **Review Schedule: 1st Quarter** |
| KYLEENA (levonorgestrel)  LILETTA (levonorgestrel)  MIRENA (levonorgestrel)  NEXPLANON (etonogestrel) PARAGARD |  |  |  |
| **CONTRACEPTIVES – PATCHES** | | | **Review Schedule: 1st Quarter** |
| ethinyl estradiol-norelgestromin | TWIRLA (levonorgestrel-ethinyl estradiol)  XULANE (ethinyl estradiol-norelgestromin)  ZAFEMY (ethinyl estradiol-norelgestromin) | • | One (1) preferred product required before a non-preferred product will be approved. |
| **CONTRACEPTIVES – VAGINAL RINGS** | | | **Review Schedule: 1st Quarter** |
| NUVARING (etonogestrel-ethinyl estradiol) | ANNOVERA (ethinyl estradiol-segesterone)  ELURYNG (etonogestrel-ethinyl estradiol) ENILLORING (etonogestrel-ethinyl estradiol) etonogestrel-ethinyl estradiol  HALOETTE (etonogestrel-ethinyl estradiol) | • | One (1) preferred product required before a non-preferred product will be approved. |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS**  **Prior authorization is required** | **CRITERION** |
| **GROWTH HORMONES**  **(Clinical criteria applies to class. All agents require a prior authorization.)** | | **Review Schedule: 4th Quarter** |
| GENOTROPIN (somatropin)  NORDITROPIN (somatropin)  SKYTROFA (lonapegsomatropin-tcgd) \* | NGENLA (somatrogon-ghla) NUTROPIN AQ (somatropin)  OMNITROPE (somatropin)  SAIZEN (somatropin)  SEROSTIM (somatropin)  SOGROYA (somapacitan-beco)  ZOMACTON (somatropin) ZORBTIVE (somatropin) | * Two (2) preferred products required before a non-preferred product will be approved.      * \* Step through 6-month trial of SAGH required.     Abbreviation:  SAGH – short-acting growth hormone |
| **HYPOGLYCEMIA TREATMENTS** | | **Review Schedule: 4th Quarter** |
| BAQSIMI (glucagon) (Amphastar – labeler code  000548) glucagon  ZEGALOGUE autoinjector (dasiglucagon)  ZEGALOGUE syringe (dasiglucagon) | BAQSIMI (glucagon) (Lilly – labeler code 00002)  GVOKE HYPOPEN (glucagon)  GVOKE PFS (glucagon)  GVOKE kit (glucagon) | • Two (2) preferred products required before a non-preferred product will be approved. |
| **HYPOGLYCEMICS, ALPHA-GLUCOSIDASE INHIBITORS** | | **Review Schedule: 1st Quarter** |
| acarbose | GLYSET (migitol)  miglitol | • One (1) preferred product required before a non-preferred product will be approved. |
| **HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS: AMYLIN ANALOGS**  **(Clinical criteria applies to class. All agents require a prior authorization.)** | | **Review Schedule: 4th Quarter** |
|  | SYMLIN (pramlintide) |  |
| **HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS: DPP-4 INHIBITORS**  **(Clinical criteria applies to class. All agents require a prior authorization.)** | | **Review Schedule: 4th Quarter** |
| JANUMET (sitagliptin phos/metformin)  JANUMET XR (sitagliptin phos/metformin)  JANUVIA (sitagliptin phos)  JENTADUETO (linagliptin/metformin)  TRADJENTA (linagliptin) | alogliptin  alogliptin-metformin  alogliptin-pioglitazone  JENTADUETO XR (linagliptin/metformin)  KOMBIGLYZE XR (saxagliptin/metformin)  NESINA (alogliptin)  OSENI (alogliptin/pioglitazone) saxagliptin saxagliptin/metformin sitagliptin (gen ZITUVIO) sitagliptin/metformin (gen ZITUVIMET) | • Two (2) preferred products required before a non-preferred product will be approved. |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS**  **Prior authorization is required** |  | **CRITERION** |
|  | ZITUVIO (sitagliptin)  ZITUVIMET (sitagliptin/metformin)  ZITUVIMET XR (sitagliptin/metformin) |  |  |
| **HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS: GLP-1 RAs**  **(Clinical criteria applies to class. All agents require a prior authorization.)** | | | **Review Schedule: 4th Quarter** |
| OZEMPIC (semaglutide)  TRULICITY (dulaglutide)  VICTOZA (liraglutide) | BYDUREON BCISE (exenatide)  BYETTA (exenatide)  exenatide  liraglutide  MOUNJARO (tirzepatide)  RYBELSUS (semaglutide) \*  SOLIQUA (insulin glargine/lixisenatide)  XULTOPHY (insulin degludec/liraglutide) | •    • | Two (2) preferred products required before a non-preferred product will be approved.  **\*** PA required for R2 formulation, to include reason R1 formulation cannot be used, before product will be approved |
| **HYPOGLYCEMICS, INSULINS** | | | **Review Schedule: 4th Quarter** |
| HUMALOG MIX 50-50 (insulin lispro/lispro protamine)  HUMALOG MIX 75-25 (insulin lispro/lispro protamine) vial  HUMULIN R U-500 (insulin)  HUMULIN R vial HUMULIN 70-30 vial insulin aspart insulin aspart mix insulin lispro insulin lispro mix  LANTUS (insulin glargine)  NOVOLIN N (insulin isophane)  NOVOLIN R (insulin)  TOUJEO SOLOSTAR (insulin glargine)  TOUJEO SOLOSTAR MAX (insulin glargine) | ADMELOG (insulin lispro)  AFREZZA (insulin)  APIDRA (insulin glulisine)  BASAGLAR (insulin glargine)  BASAGLAR TEMPO (insulin glargine) FIASP (insulin aspart)  HUMALOG U-100 (insulin lispro)  HUMALOG U-200 (insulin lispro)  HUMALOG JUNIOR (insulin lispro)  HUMALOG MIX 75-25 (insulin lispro/lispro protamine) pen  HUMULIN N  HUMULIN 70/30 pen insulin degludec  insulin glargine SOLOSTAR (gen TOUJEO) Insulin glargine SOLOSTAR MAX (gen TOUJEO) insulin glargine-YFGN insulin glargine  LYUMJEV (insulin lispro)  NOVOLIN N (insulin isophane) vial  NOVOLIN R (insulin) vial  NOVOLIN 70/30  NOVOLOG (insulin aspart)  NOVOLOG MIX 70/30  REZVOGLAR KWIKPEN (insulin glargine-aglr)  SEMGLEE (insulin glargine)  TRESIBA (insulin degludec) | • | Two (2) preferred products required before a non-preferred product will be approved. |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS**  **Prior authorization is required** |  | **CRITERION** |
| **HYPOGLYCEMICS, MEGLITINIDES** |  |  | **Review Schedule: 1st Quarter** |
| nateglinide  repaglinide |  |  |  |
| **HYPOGLYCEMICS, METFORMINS** |  |  | **Review Schedule: 4th Quarter** |
| glipizide-metformin glyburide-metformin metformin IR 500 mg, 850 mg, 1000 mg metformin ER (generic GLUCOPHAGE XR) | GLUMETZA (metformin ER)  metformin ER (generic FORTAMET, GLUMETZA) metformin IR solution metformin IR 625 mg  RIOMET (metformin IR solution) | • | Two (2) preferred products required before a non-preferred product will be approved. |
| **HYPOGLYCEMICS, SGLT2 INHIBITORS** |  |  | **Review Schedule: 4th Quarter** |
| FARXIGA (dapagliflozin)  INVOKAMET (canagliflozin/metformin)  INVOKAMET XR (canagliflozin/metformin) INVOKANA (canagliflozin)  JARDIANCE (empagliflozin)  SYNJARDY (empagliflozin/metformin)  XIGDUO XR (dapagliflozin/metformin) | dapagliflozin  dapagliflozin/metformin  GLYXAMBI (empagliflozin/linagliptin) QTERN (dapagliflozin/saxagliptin)  SEGLUROMET (ertugliflozin/metformin)  STEGLATRO (ertugliflozin)  STEGLUJAN (ertugliflozin/sitagliptin)  SYNJARDY XR (empagliflozin/metformin)  TRIJARDY XR (empagliflozin/linagliptin/metformin) | • | Two (2) preferred products required before a non-preferred product will be approved. |
| **HYPOGLYCEMICS, TZDs** |  |  | **Review Schedule: 1st Quarter** |
| pioglitazone | ACTOPLUS MET (pioglitazone/metformin)  ACTOS (pioglitazone)  DUETACT (pioglitazone/glimepiride)  pioglitazone/glimepiride pioglitazone/metformin | • | One (1) preferred product required before a non-preferred product will be approved. |
| **HYPERPARATHYROIDS** |  |  |  |
| cinacalcet tablets | paricalcitol capsules  SENISPAR (cinacalcet)  RAYALDEE (calcifediol)  ZEMPLAR (paricalcitol) capsules, vials | • | One (1) preferred product required before a non-preferred product will be approved. |
| **GLUCOCORTICOIDS, ORAL** |  |  | **Review Schedule: 4th Quarter** |
| budesonide ER capsules  dexamethasone elixir, intensol, solution, tablets fludrocortisone hydrocortisone  methylprednisolone dose pack | AGAMREE (vamorolone**)**  ALKINDI SPRINKLES (hydrocortisone) granules budesonide ER tablet CORTEF (hydrocortisone) cortisone | • | Two (2) preferred products required before a non-preferred product will be approved. |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS**  **Prior authorization is required** |  | **CRITERION** |
| methylprednisolone 4mg tablets prednisolone solution prednisolone sodium phosphate solution prednisone dose pack, tablets | deflazacort  dexamethasone dose pack  EMFLAZA (deflazacort) tablets, suspension  EOHILIA (budesonide)  HEMADY (dexamethasone)  MEDROL (methylprednisolone) methylprednisolone 8, 16, 32 mg tablet prednisolone tablets  prednisolone sodium phosphate ODT  prednisone intensol, solution  RAYOS (prednisone)  TARPEYO (budesonide) |  |  |
| **NON-ALCOHOLIC STEATOHEPATITIS (NASH) TREATMENT AGENTS**  **(Clinical criteria applies to class.)** | |  | **Review Schedule: 2nd Quarter** |
|  | REZDIFFRA (resmetriom) |  |  |
| **PELVIC DISORDERS – ENDOMETRIOSIS, UTERINE FIBROIDS** | |  | **Review Schedule: 4th Quarter** |
| danazol  DEPO-SUBQ PROVERA 104  (medroxyprogesterone)  LUPRON DEPOT (leuprolide)  MYFEMBREE (relugolix-estradiol-norethindrone acetate)  norethindrone acetate ORILISSA (elagolix)  SYNAREL (nafarelin) | ORIAHNN (elagolix-estradiol-norethindrone) | • | Two (2) preferred products required before a non-preferred product will be approved. |
| **PITUITARY SUPPRESSANTS, CENTRAL PRECOCIOUS PUBERTY (CPP)** | |  | **Review Schedule: 4th Quarter** |
| FENSOLVI (leuprolide acetate) leuprolide acetate 22.5 mg vial  LUPRON DEPOT–PED (leuprolide)  SUPPRELIN LA (histrelin)  SYNAREL (nafarelin) | TRIPTODUR (triptorelin) | • | Two (2) preferred products required before a non-preferred product will be approved. |
| **POTASSIUM REMOVING AGENTS** | |  | **Review Schedule: 4th Quarter** |
| LOKELMA (sodium zirconium cyclosilicate) | VELTASSA (patiromer calcium sorbitex) | • | One (1) preferred product required before a non-preferred product will be approved. |
| **PROGESTATIONAL AGENTS** | |  | **Review Schedule: 2nd Quarter** |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS**  **Prior authorization is required** |  | **CRITERION** |
| DEPO-PROVERA (medroxyprogesterone) medroxyprogesterone acetate tablets medroxyprogesterone acetate IM norethindrone acetate tablets progesterone capsule  progesterone IM | CRINONE (progesterone)  PROMETRIUM (progesterone)  PROVERA (medroxyprogesterone) | • | Two (2) preferred products required before a non-preferred product will be approved. |
| **THYROID HORMONES** | | | **Review Schedule: 4th Quarter** |
| ARMOUR THYROID (thyroid desiccated) ERMEZA (levothyroxine sodium)  EUTHYROX (levothyroxine sodium) LEVO-T (levothyroxine sodium) levothyroxine sodium tablets liothyronine sodium tablets NP THYROID (thyroid desiccated) | ADTHYZA (thyroid desiccated) CYTOMEL (liothyronine sodium) levothyroxine sodium injection levothyroxine sodium capsules LEVOXYL (levothyroxine sodium) liothyronine sodium injection  SYNTHROID (levothyroxine sodium)  THYQUIDITY (levothyroxine sodium) UNITHROID (levothyroxine sodium) | • | Two (2) preferred products required before a non-preferred product will be approved. |
| **UREA CYCLE DISORDER AGENTS** | | | **Review Schedule: 4th Quarter** |
| carglumic acid (Eton – labeler code 71863) PHEBURANE (sodium phenylbutyrate) sodium phenylbutyrate powder, tabs | BUPHENYL powder, tabs (sodium phenylbutyrate)  CARBAGLU (carglumic acid)  carglumic acid (Burel – labeler code 35573)  OLPRUVA (sodium phenylbutyrate)  RAVICTI (sodium phenylbutyrate) | • | Two (2) preferred products required before a non-preferred product will be approved. |
| **VASOMOTOR SYMPTOMS** | | | **Review Schedule: 4th Quarter** |
|  | VEOZAH (fezolinetant) |  |  |
| **GASTROINTESTINAL AGENTS** | | |  |
| **ANTIEMETICS, ORAL/TRANSDERMAL**  **(Clinical criteria applies to individual agents in class.)** | | | **Review Schedule: 4th Quarter** |
| DICLEGIS (doxylamine/pyridoxine) ondansetron tablets, ODT (4mg, 8 mg), solution scopolamine patch | AKYNZEO (netupitant/palonosetron)  ANZEMET (dolasetron)  aprepitant  BONJESTA (doxylamine/pyridoxine) \* doxylamine/pyridoxine  dronabinol \*  EMEND (aprepitant) capsules, suspension granisetron  MARINOL (dronabinol) \* ondansetron ODT 16 mg SANCUSO (granisetron)  TRANSDERM-SCOP (scopolamine) | •    • | Two (2) preferred products required before a non-preferred product will be approved.  **\* Clinical criteria applies** |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS**  **Prior authorization is required** |  | **CRITERION** |
|  | trimethobenzamide VARUBI (rolapitant) |  |  |
| **BILE SALTS** |  |  | **Review Schedule: 4th Quarter** |
| ursodiol capsules, tablets | CHENODAL (chenodiol)  CHOLBAM (cholic acid)  IQIRVO (elafibranor)  LIVDELZI (seladelpar)  LIVMARLY (maralixibat)  OCALIVA (obeticholic acid)  RELTONE (ursodiol)  URSO FORTE (ursodiol) | • | Two (2) preferred products required before a non-preferred product will be approved. |
| **BOWEL PREP** |  |  | **Review Schedule: 4th Quarter** |
| CLENPIQ GAVILYTE-C GAVILYTE-G GOLYTELY  MOVIPREP  NULYTELY  PEG 3350  PEG 3350-ELECTROLYTE  PEG 3350-Sod Sul-NACL-KCL- ASB-C  PLENVU  SODIUM SULF-POTASSIUM SULF-MAG SULF SUPREP | SUFLAVE  SUTAB | • | Two (2) preferred products required before a non-preferred product will be approved. |
| **CONSTIPATION – IBS, ORAL** |  |  | **Review Schedule: 4th Quarter** |
| LINZESS (linaclotide) lubiprostone  MOVANTIK (naloxegol)  TRULANCE (plecanatide) | AMITIZA (lubiprostone)  ISBRELA (tenapanor) MOTEGRITY (prucalopride) prucalopride  RELISTOR (methylnaltrexone) SYMPROIC (naldemedine) | • | Two (2) preferred products required before a non-preferred product will be approved. |
| **DIARRHEA – IBS, ORAL** |  |  | **Review Schedule: 4th Quarter** |
|  | alosetron  LOTRONEX (alosetron)  MYTESI (crofelemer)  VIBERZI (eluxadoline) |  |  |
| **H. PYLORI TREATMENTS** |  |  | **Review Schedule: 4th Quarter** |
| PYLERA (bismuth subcitrate potassiummetronidazole-tetracycline) | bismuth-metronidazole- tetracycline lansoprazole-amoxicillin-clarithromycin | • | One (1) preferred product required before a non-preferred product will be approved. |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS**  **Prior authorization is required** |  | **CRITERION** |
|  | OMECLAMOX PAK (omeprazole-clarithromycinamoxicillin)  TALICIA (omeprazole magnesium-amoxicillinrifabutin)  VOQUEZNA DUAL PAK (vonoprazan-amoxicillin)  VOQUEZNA TRIPLE PAK (vonoprazan-amoxicillinclarithromycin) |  |  |
| **HISTAMINE II RECEPTOR BLOCKERS** | |  | **Review Schedule: 1st Quarter** |
| famotidine nizatidine | cimetidine | • | Two (2) preferred products required before a non-preferred product will be approved. |
| **HYPERPHOSPHATEMIA AGENTS, OTHER** | |  | **Review Schedule: 1st Quarter** |
|  | XPHOZAH (tenapanor) | • | Two (2) preferred phosphate binder products required before a non-preferred product will be approved. |
|  |  | • | PA required for all non-calcium-based products. |
| **HYPERPHOSPHATEMIA AGENTS, PHOSPHATE BINDERS** | |  | **Review Schedule: 1st Quarter** |
| calcium acetate capsules sevelamer carbonate tablet | AURYXIA (ferric citrate) calcium acetate tablets  ferric citrate  FOSRENOL (lanthanum carbonate)  lanthanum  RENAGEL (sevelamer HCl) RENVELA (sevelamer carbonate)  sevelamer HCl tablet sevelamer powder  VELPHORO (sucroferric oxyhydroxide) | •  • | Two (2) preferred products required before a non-preferred product will be approved.    PA required for all non-calcium based products. |
| **PANCREATIC ENZYMES** | |  | **Review Schedule: 4thQuarter** |
| CREON (pancrelipase)  ZENPEP (pancrelipase) | PERTZYE (pancrelipase) VIOKACE (pancrelipase) | • | Two (2) preferred products required before a non-preferred product will be approved. |
| **PROTON PUMP INHIBITORS** | |  | **Review Schedule: 1st Quarter** |
| omeprazole RX pantoprazole tablets  PROTONIX (pantoprazole) granules | DEXILANT (dexlansoprazole) dexlansoprazole esomeprazole  KONVOMEP (omeprazole/sodium bicarbonate) lansoprazole  NEXIUM (esomeprazole) omeprazole OTC  omeprazole/sodium bicarbonate | •  •    • | Two (2) preferred products required before a non-preferred product will be approved.    Quantity limits apply to class.  Liquid medications require prior authorization for members over 10 years old. |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS**  **Prior authorization is required** |  | **CRITERION** |
|  | pantoprazole granules PREVACID (lansoprazole) PRILOSEC (omeprazole) packets PROTONIX (pantoprazole) tablets  rabeprazole  VOQUENZA (vonoprazan)  ZEGRID (omeprazole/sodium bicarbonate) |  |  |
| **ULCERATIVE COLITIS AGENTS** | | | **Review Schedule: 3rd Quarter** |
| APRISO (mesalamine) balsalazide  DELZICOL (mesalamine) mesalamine enema, suppository mesalamine DR 1.2 gm PENTASA (mesalamine) sulfasalazine sulfasalazine DR | AZULFIDINE (sulfasalazine) budesonide foam CANASA (mesalamine)  COLAZAL (balsalazide)  DIPENTUM (olsalazine) LIALDA (mesalamine)  mesalamine DR 400 mg, 800 mg, 1.2 g mesalamine enema kit  mesalamine ER 375 mg, 500 mg ROWSA (mesalamine)  SFROWSA (mesalamine)  UCERIS (budesonide) | • | Two (2) preferred products required before a non-preferred product will be approved. |
| **GENE THERAPY** | | |  |
| **CENTRAL NERVOUS SYSTEM: SPINAL MUSCULAR ATROPHY**  **(Clinical criteria applies to class. All agents require a prior authorization.)** | | |  |
| ZOLGENSMA (onasemnogene abeparvovec) |  |  |  |
| **GENITOURINARY PRODUCTS** | | |  |
| **BLADDER RELAXANT PREPARATIONS** | | | **Review Schedule: 4th Quarter** |
| MYRBETRIQ (mirabegron) tablets oxybutynin 5 mg oxybutynin ER oxybutynin syrup solifenacin | darifenacin  DETROL (tolterodine) DETROL LA (tolterodine) fesoterodine  GEMTESA (vibegron) mirabegron tablets  MYRBETRIQ (mirabegron) suspension  oxybutynin 2.5 mg OXYTROL (oxybutynin) tolterodine  TOVIAZ (fesoterodine)  trospium  VESICARE (solifenacin) tablets  VESICARE LS (solifenacin) suspension | • | Two (2) preferred products required before a non-preferred product will be approved. |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS**  **Prior authorization is required** |  | **CRITERION** |
| **BPH TREATMENTS** |  | | **Review Schedule: 2nd Quarter** |
| alfuzosin doxazosin finasteride 5 mg tamsulosin terazosin | CARDURA (doxazosin) CARDURA XL (doxazosin) dutasteride dutasteride/tamsulosin  finasteride/tadalafil  PROSCAR (finasteride) RAPAFLO (silodosin)  silodosin tadalafil 5 mg \* | •    • | Two (2) preferred products required before a non-preferred product will be approved.  \* For BPH diagnosis only |
|  | **HEMATOLOGICAL AGENTS** | |  |
| **ANTICOAGULANTS, ORAL/SQ** |  | | **Review Schedule: 4th Quarter** |
| ELIQUIS (apixaban) enoxaparin  JANTOVEN (warfarin)  PRADAXA (dabigatran) capsules warfarin  XARELTO (rivaroxaban) tablets | ARIXTRA (fondaparinux) dabigatran etexilate fondaparinux  FRAGMIN (dalteparin)  LOVENOX (enoxaparin) PRADAXA (dabigatran) pellets  rivaroxaban  SAVAYSA (edoxaban)  XARELTO (rivaroxaban) suspension | •  • | Two (2) preferred products required before a non-preferred product will be approved.    Quantity limits in place on injectable formulations: 6 weeks allowed without prior authorization. |
| **HEMOPHILIA A/VWD** |  | | **Review Schedule: 4th Quarter** |
| AFSTYLA (antihemophilic factor – recombinant)  ALPHANATE (antihemophilic factor/von Willebrand factor complex- human)  FEIBA (anti-inhibitor coagulant complex)  HEMLIBRA (emicizumab-kxwh)  HEMOFIL M (antihemophilic factor – human)  HUMATE-P (antihemophilic factor/von Willebrand factor complex- human)  JIVI (antihemophilic factor – recombinant)  KOATE (antihemophilic factor – recombinant)  KOVALTRY (antihemophilic factor – recombinant)  NOVOSEVEN (coagulation factor VIIa – recombinant)  NOVOEIGHT (antihemophilic factor – recombinant)  NUWIQ (antihemophilic factor – recombinant)  OBIZUR (antihemophilic factor – recombinant)  WILATE (von Willebrand factor/coagulation factor VIII complex – human)  XYNTHA (antihemophilic factor – recombinant) | ADVATE (antihemophilic factor – recombinant)  ADYNOVATE (antihemophilic factor – recombinant)  ALHEMO (concizumab-mtci) \*  ALTUVIIIO (antihemophilic factor – recombinant) ELOCTATE (antihemophilic factor – recombinant)  ESPEROCT (antihemophilic factor – recombinant)  HYMPAVZI (marstacimab-hncq) \*  KOGENATE FS (antihemophilic factor – recombinant)  QFITLIA (fitusiran) \*  RECOMBINATE (antihemophilic factor – recombinant)  SEVENFACT (coagulation factor VIIa – recombinant)  VONVENDI (von Willebrand factor – recombinant) | •    • | Two (2) preferred products required before a non-preferred product will be approved.  \* Approval criteria dependent on diagnosis (Dx) o Dx hemophilia B – use of preferred product not required prior to approval.  o Dx hemophilia A – use of or contraindication to  Hemlibra required before non-preferred product will be approved. |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS**  **Prior authorization is required** |  | **CRITERION** |
| XYNTHA SOLOFUSE (antihemophilic factor – recombinant) |  |  |  |
| **HEMOPHILIA B** | |  | **Review Schedule: 4th Quarter** |
| ALPHANINE SD (coagulation factor IX – human)  ALPROLIX (coagulation factor IX – recombinant)  BENEFIX (coagulation factor IX – recombinant)  IXINITY (coagulation factor IX – recombinant)  REBINYN (coagulation factor IX – recombinant)  PROFILNINE (factor IX complex)  RIXUBIS (coagulation factor IX – recombinant) | IDELVION (coagulation factor IX – recombinant) | • | Two (2) preferred products required before a non-preferred product will be approved. |
| **COLONY STIMULATING FACTORS** | |  | **Review Schedule: 4th Quarter** |
| FULPHILA (pegfilgrastim-jmdb)  NEUPOGEN (filgrastim)  NYVEPRIA (pegfilgrastim-apgf) | FYLNETRA (pegfilgrastim-pbbk)  GRANIX (tbo-filgrastim) LEUKINE (sargramostim)  NEULASTA (pegfilgrastim)  NIVESTYM (figrastim-aafi) vial, syringe  RELEUKO (filgrastim-ayow)  ROLVEDON (eflapegrastim-xnst) STIMUFEND (pegfilgrastim-fpgk)  UDENYCA (pegfilgrastim-cbqv) ZARXIO (filgrastim-sndz)  ZIEXTENZO (pegfilgrastim-bmez) | • | Two (2) preferred products required before a non-preferred product will be approved. |
| **ERYTHROPOIESIS STIMULATING PROTEINS**  **(Clinical criteria applies to class. All agents require a prior authorization.)** | |  | **Review Schedule: 4th Quarter** |
| MIRCERA (methoxy polyethylene glycol-epoetin beta)  RETACRIT (epoetin alfa-epbx) (Pfizer – labeler code 00069) | ARANESP (darbepoetin alfa)  EPOGEN (epoetin alfa)  PROCRIT (epoetin alfa)  RETACRIT (epoetin alfa-epbx) (Vifor – labeler code 59353) | • | Two (2) preferred products required before a non-preferred product will be approved. |
| **HAE TREATMENTS**  **(Clinical criteria applies to class. All agents require a prior authorization.)** | |  | **Review Schedule: 4th Quarter** |
| BERINERT (human C1 inhibitor) CINRYZE (human C1 inhibitor) danazol  HAEGARDA (human C1 inhibitor) icatibant  KALBITOR (escallantide)  ORLADEYO (berotralstat)  RUCONEST (recombinant C1 esterase inhibitor) SAJAZIR (icatibant)  TAKHZYRO (lanadelumab-flyo) | FIRAZYR (icatibant) | • | Two (2) preferred products required before a non-preferred product will be approved. |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS**  **Prior authorization is required** |  |  | **CRITERION** |
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| **PLATELET AGGREGATION INHIBITORS** |  | |  | **Review Schedule: 4th Quarter** |
| aspirin/dipyridamole BRILINTA (ticagrelor) clopidogrel dipyridamole prasugrel | aspirin/omeprazole EFFIENT (prasugrel) PLAVIX (clopidogrel)  ticagrelor ticlopidine  YOSPRALA (aspirin/omeprazole)  ZONTIVITY (vorapaxar) |  | • | Two (2) preferred products required before a non-preferred product will be approved. |
| **SICKLE CELL ANEMIA AGENTS** |  | |  | **Review Schedule: 4th Quarter** |
| DROXIA (hydroxyurea) hydroxyurea | ADAKVEO (crizanlizumab-tmca) vials  ENDARI (glutamine)  HYDREA (hydroxyurea) SIKLOS (hydroxyurea) |  | • | Two (2) preferred products required before a non-preferred product will be approved. |
| **THROMBOPOIETICS** |  | |  | **Review Schedule: 2nd Quarter** |
| NPLATE (romiplostim)  PROMACTA (eltrombopag olamine) tablets | ALVAIZ (eltrombopag)  DOPTELET (avatrombopag maleate)  MULPLETA (lusutrombopag)  PROMACTA (eltrombopag maleate) powder packs  TAVALISSE (fostanatiniv disodium) |  | • | Two (2) preferred products required before a non-preferred product will be approved. |
|  | **IMMUNE GLOBULINS** | |  |  |
| **IMMUNE GLOBULINS** |  | |  | **Review Schedule: 4th Quarter** |
| BIVIGAM  GAMMAGARD  GAMMAGARD S-D GAMUNEX-C OCTAGAM  PRIVIGEN  XEMBIFY | ALYGLO  ASCENIV  CUTAQUIG  CUVITRU  GAMASTAN GAMMAKED  GAMMAPLEX HIZENTRA  HYQVIA  PANZYGA |  | • | Two (2) preferred products required before a non-preferred product will be approved. |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS**  **Prior authorization is required** | **CRITERION** |
| **MEDICAL DEVICES AND SUPPLIES** | | |
| **BLOOD GLUCOSE METERS, TEST STRIPS** | | |
| Please refer to the Delaware Pharmacy Corner website for covered Diabetic Supply products. [https://medicaid.dhss.delaware.gov/provider/H ome/PharmacyCornerLanding/tabid/2096/Def ault.aspx](https://medicaid.dhss.delaware.gov/provider/H%20ome/PharmacyCornerLanding/tabid/2096/Def%20ault.aspx) | All other blood glucose meters and test strips are non-preferred | Two (2) preferred products required before a non-preferred product will be approved. |
| **CONTINUOUS GLUCOSE MONITORS (CGMs)** | | |
| Please refer to the Delaware Pharmacy Corner website for covered Diabetic Supply products. [https://medicaid.dhss.delaware.gov/provider/H ome/PharmacyCornerLanding/tabid/2096/Def ault.aspx](https://medicaid.dhss.delaware.gov/provider/H%20ome/PharmacyCornerLanding/tabid/2096/Def%20ault.aspx) | All other CGM devices are non-preferred | • Two (2) preferred products required before a non-preferred product will be approved. |
| **INSULIN PUMPS (Clinical criteria applies to class. All preferred agents require prior authorization. All non-preferred insulin pumps are not covered under pharmacy)** | | |
| Please refer to the Delaware Pharmacy Corner website for covered Diabetic Supply products. [https://medicaid.dhss.delaware.gov/provider/H ome/PharmacyCornerLanding/tabid/2096/Def ault.aspx](https://medicaid.dhss.delaware.gov/provider/H%20ome/PharmacyCornerLanding/tabid/2096/Def%20ault.aspx) | All other insulin pumps are non-preferred. | • All other insulin pumps are not payable under the pharmacy benefit. These claims need to be billed under the Durable Medical Equipment benefit. |
| **RESPIRATORY DEVICES** | | |
| ACE AEROSOL CLOUD ENHANCER SPACER  EASIVENT  EASIVENT SPACER  OPTICHAMBER  OPTICHAMBER DIAMOND | AEROCHAMBER PLUS FLOW-VU  FLEXICHAMBER MASK  FLEXICHAMBER SPACER  SPACE CHAMBER  COMPACT SPACE CHAMBER | • Two (2) preferred products required before a non-preferred product will be approved. |
| **NEUROMUSCULAR DRUGS** | | |
| **ANTICONVULSANTS, ORAL/RECTAL/NASAL Review Schedule: 4th Quarter** | | |
| BRIVIACT (brivaracetam)  carbamazepine 100 mg chewable tablets, tablets  carbamazepine ER, XR carbamazepine suspension clobazam clonazepam tablets diazepam rectal  DILANTIN (phenytoin) 30 mg capsules divalproex sodium | APTIOM (eslicarbazepine acetate) BANZEL (rufinamide)  carbamazepine 200 mg chewable tablets  CARBATROL (carbamazepine) CELONTIN (methsuxamide)  clonazepam ODT  DEPAKOTE (divalproex sodium) tablet, sprinkles  DEPAKOTE ER (divalproex sodium) DIACOMIT (stiripentol) | * Two (2) preferred products required before a non-preferred product will be approved.      * Quantity limits in place: 240 adjunctive anticonvulsants per 30 days. Greater quantities require prior authorization.      * \* PA required, to include reason topiramate 2 x 25 mg capsules cannot be used, before product will be approved. |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS**  **Prior authorization is required** |  | **CRITERION** |
| EPITOL (carbamazepine) ethosuximide solution gabapentin  lacosamide solution, tablets  lamotrigine IR tablets, chewable tablets levetiracetam IR tablets, solution  NAYZILAM (midazolam) oxcarbazepine tablets, suspension phenobarbital phenytoin pregabalin primidone  SUBVENITE (lamotrigine)  topiramate tablets valproic acid  VALTOCO (diazepam)  zonisamide | DIASTAT (diazepam) rectal  DIASTAT ACUDIAL (diazepam) rectal  DILANTIN (phenytoin) 100 mg capsules, chewable tablets, suspension  EPIDIOLEX (cannabidiol)  EPRONTIA (topiramate) EQUETRO (carbamazepine) ethosuximide capsules felbamate  FELBATOL (felbamate)  FINTEPLA (fenfluramine)  FYCOMPA (perampanel)  GABITRIL (tiagabine)  KEPPRA (levetiracetam)  KEPPRA XR (levetiracetam)  KLONOPIN (clonazepam)  LAMICTAL (lamotrigine) LAMICTAL XR (lamotrigine) lamotrigine ER, ODT  levetiracetam ER, tablets for oral suspension LIBERVANT (diazepam)  LYRICA (pregabalin) LYRICA CR (pregabalin) methsuxamide  MOTPOLY XR (lacosamide)  MYSOLINE (primidone)  NEURONTIN (gabapentin) ONFI (clobazam) oxcarbazapine ER  OXTELLAR XR (oxcarbazapine)  PHENYTEK (phenytoin) QUDEXY XR (topiramate)  rufinamide  SABRIL (vigabatrin)  SPRITAM (levetiracetam) SYMPAZAN (clobazam)  TEGRETOL (carbamazepine) suspension, tablets  TEGRETOL XR (carbamazepine)  tiagabine tablets  TOPAMAX (topiramate)  topiramate ER topiramate sprinkle capsules \*  TRILEPTAL (oxcarbazepine) suspension, tablets  TROKENDI XR (topiramate) vigabatrin  VIGADRONE (vigabatrin)  VIGAFYDE (vigabatrin) \*\*  VIMPAT (lacosamide)  XCOPRI (cenobamate) ZARONTIN (ethosuximide)  ZONISADE (zonisamide) | • | \*\* Step through vigabatrin powder packets required. |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS**  **Prior authorization is required** |  | **CRITERION** |
|  | ZTALMY (ganaxolone) |  |  |
| **ANTIPARKINSON’S AGENTS, ORAL/TRANSDERMAL** | | | **Review Schedule: 1st Quarter** |
| amantadine capsules, solution benztropine bromocriptine  carbidopa/levodopa IR, ER  entacapone pramipexole IR ropinirole IR selegiline capsules, tablets trihexyphenidyl | amantadine tablets AZILECT (rasagiline) carbidopa  carbidopa/levodopa ODT carbidopa/levodopa/entacapone  COMTAN (entacapone)  CREXONT ER (carbidopa/levodopa)  DHIVY (carbidopa/levodopa)  DUOPA (carbidopa/levodopa)  GOCOVRI (amantadine)  INBRIJA (levodopa)  LODOSYN (carbidopa)  NEUPRO (rotigotine)  NOURIANZ (istradefylline)  ONAPGO (apomorphine)  ONGENTYS (opicapone) OSMOLEX ER (amantadine)  pramipexole ER rasagiline ropinirole ER  RYTARY (carbidopa/levodopa)  SINEMET 10-100 (carbidopa/levodopa)  STALEVO (carbidopa/levodopa/entacapone)  TASMAR (tolcapone)  tolcapone  VYALEV (foscarbidopa/foslevodopa)  XADAGO (safinamide)  ZELAPAR (selegiline) | • | Two (2) preferred products required before a non-preferred product will be approved. |
| **SKELETAL MUSCLE RELAXANTS**  **(Clinical criteria applies to individual agents in class.)** | | | **Review Schedule: 3rd Quarter** |
| baclofen 5 mg, 10 mg, 20 mg tablets \*\* cyclobenzaprine 5 mg, 10 mg tablets  methocarbamol  tizanidine tablets | AMRIX (cyclobenzaprine)  baclofen 15 mg tablets, solution, suspension \*\* carisoprodol \*\*\*  carisoprodol compound with codeine \* chlorzoxazone cyclobenzaprine 7.5 mg tablets  cyclobenzaprine ER DANTRIUM (dantrolene) dantrolene  FEXMID (cyclobenzaprine)  FLEQSUVY (baclofen) LYVISPAH (baclofen)  metaxalone ᶺ | •  •  •  •    • | Two (2) preferred products required before a non-preferred product will be approved.    Total quantity limit of 120 units of muscle relaxants per 30 rolling days.    \* Clinical PA required    \*\* Baclofen – no quantity limits  \*\*\*Carisoprodol quantity limit – 84 units per 90 days |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS**  **Prior authorization is required** |  | **CRITERION** |
|  | orphenadrine orphenadrine, aspirin, caffeine SOMA (carisoprodol) \*\*\*  TANLOR (methocarbamol) tizanidine capsules ZANAFLEX (tizanidine) | • | ᶺ PA required for 640 mg, to include reason 400 mg or 800 mg tablets cannot be used, before product will be approved. |
| **NUTRITIONAL PRODUCTS** | | |  |
| **PRENATAL VITAMINS** | | | **Review Schedule: 1st Quarter** |
| COMPLETE NATAL DHA  M-NATAL PLUS  NIVA-PLUS PNV 29-1  PRENATAL PLUS  PRENATAL VITAMIN plus LOW IRON  PREPLUS  PRETAB THRIVITE RX  TRINATAL RX 1  TRIVEEN-DUO DHA  VIRT-C DHA  VOL-PLUS  VP-PNV-DHA  WESNATAL DHA COMPLETE WESTAB PLUS | All other prenatal products non-preferred | • | Two (2) preferred products required before a non-preferred product will be approved. |
| **OBESITY TREATMENT AGENTS**  **(Clinical criteria applies to class. All agents require a prior authorization.)** | | | **Review Schedule: 4th Quarter** |
| CONTRAVE ER (naltrexone/bupropion ER) tablets  phentermine capsules, tablets WEGOVY (semaglutide) pen injectors ZEPBOUND (tirzepatide) | ADIPEX-P (phentermine) capsules, tablets benzphetamine HCl tablets diethylpropion HCl tablets diethylpropion HCl ER tablets LOMAIRA (phentermine) tablet orlistat  phendimetrazine tartrate tablets phendimetrazine tartrate ER capsules  SAXENDA (liraglutide) pen injectors  XENICAL (orlistat) capsules | • | Two (2) preferred products required before a non-preferred product will be approved. |
| **OVER THE COUNTER DRUGS** | | |  |
|  | | | **Review Schedule: 3rd Quarter** |
| Please refer to the Delaware Pharmacy Corner website for covered OTC products. |  |  |  |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS**  **Prior authorization is required** | **CRITERION** |
| [https://medicaid.dhss.delaware.gov/provider/H ome/PharmacyCornerLanding/tabid/2096/Def ault.aspx](https://medicaid.dhss.delaware.gov/provider/H%20ome/PharmacyCornerLanding/tabid/2096/Def%20ault.aspx) |  |  |
| **PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS** | | |
| **ALZHEIMER’S AGENTS Review Schedule: 3rd Quarter** | | |
| donepezil 5 mg, 10 mg tablets memantine tablets rivastigmine patch | ADLARITY (donepezil) ARICEPT (donepezil) donepezil ODT donepezil 23 mg  EXELON (rivastigmine) patches galantamine memantine capsules, solution memantine/donepezil ER NAMENDA (memantine)  NAMENDA XR (memantine)  NAMZARIC (memantine/donepezil) RAZADYNE ER (galantamine)  rivastigmine capsules | • Two (2) preferred products required before a non-preferred product will be approved. |
| **MOVEMENT DISORDER****Review Schedule: 4th Quarter** | | |
| AUSTEDO (deutetrabenazine) INGREZZA (valbenazine) \* tetrabenazine | AUSTEDO XR (deutetrabenazine)  INGREZZA SPRINKLE (valbenazine)  XENAZINE (tetrabenazine) | * Two (2) preferred products required before a non-preferred product will be approved.      * \* Ingrezza quantity limit – 1 capsule per day |
| MULTIPLE SCLEROSIS **(Clinical criteria applies to individual agents in class.)** **Review Schedule: 4th Quarter** | | |
| AVONEX (interferon beta-1a) \*dalfampridine dimethyl fumarate fingolimod glatiramer  GLATOPA (glatiramer acetate)  KESIMPTA (ofatumumab)  REBIF (interferon beta-1a) \*  REBIF REBIDOSE (interferon beta-1a) \*teriflunomide  TYSABRI (natalizumab) \* | AMPYRA (dalfampridine)  AUBAGIO (teriflunomide)  BAFIERTAM (monomethyl fumarate)  BETASERON (interferon beta-1b) \*BRIUMVI (ublituximab-xiiy)  COPAXONE (glatiramer acetate)  EXTAVIA (interferon beta-1b) GILENYA (fingolimod)  LEMTRADA (alemtuzumab)  MAVENCLAD (cladribine) MAYZENT (siponimod)  OCREVUS (ocrelizumab)  OCREVUS ZUNOVO (ocrelizumab)  PLEGRIDY (peginterferon beta-1a)  PONVORY (ponesimod)  TASCENSO ODT (fingolimod)  TECFIDERA (dimethyl fumarate)  VUMERITY (diroximel fumarate)  ZEPOSIA (ozanimod) | * Two (2) preferred products required before a non-preferred product will be approved.      * \* Clinical criteria applies |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS**  **Prior authorization is required** |  |  | **CRITERION** |
| **NEUROPATHIC PAIN** |  | |  | **Review Schedule: 1st Quarter** |
| gabapentin lidocaine patch 4%, 5% lidocaine/prilocaine cream pregabalin | GRALISE (gabapentin)  HORIZANT (gabapentin enacarbil)  LIDODERM (lidocaine) patches  LYRICA CR (pregabalin) NEURONTIN (gabapentin)  pregabalin ER  QUTENZA KIT (capsaicin/skin cleanser)  SAVELLA (milnacipran HCl)  ZTLIDO (lidocaine) |  | • | Two (2) preferred products required before a non-preferred product will be approved. |
|  | **RESPIRATORY AGENTS** | |  |  |
| **ANTIHISTAMINES, MINIMALLY SEDATING** |  | |  | **Review Schedule: 3rd Quarter** |
| cetirizine solution, tablets loratadine solution, tablets | cetirizine capsules, chewable tablets cetirizine-D  CLARINEX (desloratadine)  CLARINEX-D (desloratadine/pseudoephedrine) desloratadine fexofenadine fexofenadine-D levocetirizine  loratadine chewable tablets, ODT loratadine-D |  | • | Two (2) preferred products required before a non-preferred product will be approved. |
| **BRONCHODILATORS, BETA AGONIST** |  | |  | **Review Schedule: 4th Quarter** |
| albuterol HFA (gen ProAir HFA, PROVENTIL  HFA)  albuterol nebulizer solution, syrup SEREVENT (salmeterol)  STRIVERDI RESPIMAT (olodaterol) terbutaline  VENTOLIN HFA (albuterol sulfate) | albuterol HFA (gen VENTOLIN HFA) albuterol tablets arformoterol vials  BROVANA (arformoterol tartrate)  formoterol vials levalbuterol HFA, vials  PERFOROMIST (formoterol fumarate)  PROAIR RESPICLICK (albuterol sulfate)  XOPENEX HFA (levalbuterol) |  | • | Two (2) preferred products required before a non-preferred product will be approved. |
| **COPD AGENTS** |  | |  | **Review Schedule: 4th Quarter** |
| albuterol/ipratropium nebulizer solution ANORO ELLIPTA (umeclidinium/vilanterol)  ATROVENT HFA (ipratropium bromide)  COMBIVENT (ipratropium bromide/albuterol)  INCRUSE ELLIPTA (umeclidinium)  ipratropium nebulizer solution  SPIRIVA HANDIHALER (tiotropium bromide)  SPIRIVA RESPIMAT (tiotropium bromide) | BEVESPI (glycopyrrolate/formoterol fumarate)  BREZTRI (budesonide, glycopyrrolate, formoterol fumarate)  DALIRESP (roflumilast)  DUAKLIR (aclidinium/formoterol) OHTUVAYRE (ensifentrine) \* roflumilast tablets tiotropium bromide inhaler |  | •  • | Two (2) preferred products required before a non-preferred product will be approved.    \* Step through 3-month trial LABA + LAMA dual therapy, with or without ICS, required. |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS**  **Prior authorization is required** | **CRITERION** |
| STIOLTO RESPIMAT (tiotropium bromide/olodaterol) | TRELEGY (fluticasone furoate, umeclidinium, vilanterol)  TUDORZA (aclidinium bromide)  umeclidinium/vilanterol  YUPELRI (revefenacin) | Abbreviations:  LABA – long-acting beta2 agonist  LAMA – long-acting muscarinic antagonist  ICS – inhaled corticosteroid |
| **COUGH AND COLDReview Schedule: 3rd Quarter** | | |
| benzonatate  BROMFED DM (brompheniramine/ dextromethorphan/pseudoephedrine) syrup  brompheniramine/pseudoephedrine/DM syrup guaifenesin liquid guaifenesin DM liquid guaifenesin ER tablets guaifenesin/codeine syrup hydrocodone/homatropine syrup promethazine DM syrup promethazine/codeine syrup phenylephrine tablets  pseudoephedrine liquid, tablets | All other cough and cold products are non-preferred | * Two (2) preferred products required before a non-preferred product will be approved.      * Quantity limits in place: o Narcotic antitussives – 240ml per 30 days and 480ml per 90 days without a comorbid diagnosis   o Tussionex – 120ml per 84 days and 480ml per year     * Additional preferred OTC Cough and Cold agents may be found on the OTC List on the pharmacist corner |
| **GLUCOCORTICOIDS, INHALEDReview Schedule: 4th Quarter** | | |
| ADVAIR DISKUS, HFA (fluticasone propionate/salmeterol)  ARNUITY ELLIPTA (fluticasone furoate)  ASMANEX HFA (mometasone furoate)  ASMANEX TWISTHALER (mometasone furoate) budesonide inhalation solution 0.25 mg, 0.5 mg \*  DULERA (mometasone furoate/formoterol fumarate)  fluticasone proprionate HFA \*  PULMICORT FLEXHALER (budesonide)  QVAR REDIHALER (beclomethasone dipropionate)  SYMBICORT (budesonide/formoterol fumarate dihydrate) | AIRDUO RESPICLICK (fluticasone propionate/salmeterol)  AIRSUPRA (albuterol sulfate/budesonide)  ALVESCO (ciclesonide)  BREO ELLIPTA (fluticasone furoate/vilanterol) BREYNA (budesonide/formoterol fumarate) budesonide inhalation solution 1 mg budesonide/formoterol fumarate dihydrate fluticasone/salmeterol diskus, HFA  fluticasone/vilanterol  PULMICORT (budesonide) inhalation solution  WIXELA INHUB (fluticasone propionate/salmeterol) | * Two (2) preferred products required before a non-preferred product will be approved.      * \* Approval for budesonide may be generated by system for patients:   + Aged 6 years and older AND with   + Diagnosis on file indicating developmental delay      * \* Prior authorization required for ≥ 18 years of age. |
| **INTRANASAL RHINITIS AGENTS** **Review Schedule: 1st Quarter** | | |
| azelastine 0.1% fluticasone RX  ipratropium | azelastine 0.15%  azelastine/fluticasone  BECONASE AQ (beclomethasone dipropionate) budesonide OTC  DYMISTA (azelastine/fluticasone)  FLONASE SENSIMIST OTC (fluticasone) flunisolide  fluticasone OTC mometasone | • Two (2) preferred products required before a non-preferred product will be approved. |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS**  **Prior authorization is required** | **CRITERION** |
|  | NASACORT OTC (triamcinolone) NASONEX OTC (mometasone)  olopatadine  OMNARIS (ciclesonide)  QNASL (beclomethasone dipropionate)  RYALTRIS (olopatadine HCl/mometasone)  SINUVA (mometasone) triamcinolone  XHANCE (fluticasone propionate)  ZETONNA (ciclesonide) |  |
| **LEUKOTRIENE RECEPTOR ANTAGONISTS Review Schedule: 4th Quarter** | | |
| montelukast tablets, chewable tablets | ACCOLATE (zafirlukast) montelukast granules SINGULAIR (montelukast)  zafirlukast zileuton ER ZYFLO (zileuton) | • One (1) preferred product required before a non-preferred will be approved. |
| **MABs-ANTI-IL, ANTI-IGE th Quarter**  **Review Schedule: 4 (Clinical criteria applies to class. All agents require a prior authorization.)** | | |
| DUPIXENT (dupilumab)  FASENRA (benralizumab)  NUCALA (mepolizumab)  TEZSPIRE (tezepelumab-ekko)  XOLAIR (omalizumab) | CINQAIR (reslizumab) | • Two (2) preferred products required before a non-preferred product will be approved. |
| **STIMULANTS AND RELATED AGENTS** | | |
| **NARCOLEPTIC AGENTS** **Review Schedule: 4th Quarter** | | |
| armodafinil modafinil | NUVIGIL (armodafinil) PROVIGIL (modafinil) sodium oxybate SUNOSI (solriamfetol)  WAKIX (pitolisant)  XYREM (sodium oxybate)  XYWAV (sodium oxybate) | • Two (2) preferred products required before a non-preferred product will be approved. |
| **STIMULANTS AND RELATED AGENTS - SHORT ACTING** **Review Schedule: 4th Quarter**  **(Clinical criteria applies for members over age 21.)** | | |
| dexmethylphenidate IR  dextroamphetamine/amphetamine IR dextroamphetamine IR tablets methylphenidate IR methylphenidate solution | ADDERALL (amphetamine/dextroamphetamine) amphetamine tablets dextroamphetamine solution  EVEKEO ODT, TABLETS (amphetamine)  FOCALIN (dexmethylphenidate) | * Two (2) preferred products required before a non-preferred product will be approved.      * Dose optimization required |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS**  **Prior authorization is required** |  |  | **CRITERION** |
| PROCENTRA (dextroamphetamine) | methamphetamine  METHYLIN (methylphenidate) solution methylphenidate chewable tablets RITALIN (methylphenidate)  ZENZEDI (dextroamphetamine) |  |  |  |
| **STIMULANTS AND RELATED AGENTS - LONG ACTING**  **(Clinical criteria applies for members over age 21.)** | | |  | **Review Schedule: 4th Quarter** |
| atomoxetine  clonidine ER 0.1 mg tablet  DAYTRANA (methylphenidate) patches dexmethylphenidate ER dextroamphetamine ER  dextroamphetamine-amphetamine ER  DYANAVEL XR  (amphetamine/dextroamphetamine  SR) suspension guanfacine ER methylphenidate CD (generic METADATE CD) methylphenidate ER (generic RITALIN SR) methylphenidate ER 24 (generic CONCERTA) methylphenidate LA (generic RITALIN LA) QUILLICHEW ER (methylphenidate IR/ER,  30:70%)  QUILLIVANT XR (methylphenidate IR/ER,  20:80%)  VYVANSE (lisdexamfetamine) capsules | ADDERALL XR (amphetamine/ dextroamphetamine SR 24 HR, IR/ER, 50:50%)  ADZENYS XR ODT (amphetamine SR 24 HR,  IR/ER, 50:50%) amphetamine ER suspension APTENSIO XR (methylphenidate)  AZSTARYS (serdexmethylphenidate/ dexmethylphenidate)  CONCERTA (methylphenidate SA OSM IR/ER, 22:78%)  COTEMPLA XR (methylphenidate IR/ER 25:75%)  DYANAVEL XR  (amphetamine/dextroamphetamine  SR) tablets  FOCALIN XR (dexmethylphenidate SR 24 HR)  INTUNIV (guanfacine ER)  JORNAY PM (methylphenidate ER)  lisdexamfetamine methylphenidate XR (generic Aptensio XR) methylphenidate (transdermal) patch TD24  MYDAYIS (mixed amphetamine salts) ONYDA XR (clonidine hydrochloride)  QELBREE (viloxazine hydrochloride)  RELEXXII ER 24 (methylphenidate ER OSM  IR/ER, 22:78%  RITALIN LA (methylphenidate)  STRATTERA (atomoxetine)  VYVANSE (lisdexamfetamine) chewable tablets  XELSTRYM (dextroamphetamine) patches |  | • | Two (2) preferred products required before a non-preferred product will be approved. |
| **SMOKING CESSATION** | | |  |  |
| **SMOKING CESSATION PRODUCTS** | | |  | **Review Schedule: 1st Quarter** |
| bupropion SR nicotine lozenge, gum, patch varenicline | CHANTIX (varenicline)  NICOTROL NS |  | • | Please refer to th[e Delaware OTC Rebate List](https://medicaidpublications.dhss.delaware.gov/docs/search?Command=Core_Download&EntryId=1655) on the DMAP Provider Pharmacy Portal. |
|  |  |  | • | Two (2) preferred products required before a non-preferred product will be approved. |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS**  **Prior authorization is required** |  |  | **CRITERION** |
|  | **TOPICAL PRODUCTS** | |  |  |
| **ANTIBIOTICS, TOPICAL** |  | |  | **Review Schedule: 1st Quarter** |
| bacitracin bacitracin/polymyxin gentamicin mupirocin ointment  neomycin/bacitracin/polymyxin | CENTANY (mupirocin) mupirocin cream  neomycin/bacitracin/polymyxin/pramoxine neomycin/polymyxin/pramoxine  NEO-SYNALAR (fluocinolone/neomycin) XEPI (ozenoxacin) |  | • | Two (2) preferred products required before a non-preferred product will be approved. |
| **ANTIFUNGALS, TOPICAL** |  | |  | **Review Schedule: 4th Quarter** |
| butenafine  ciclopirox cream, solution clotrimazole cream  clotrimazole/betamethasone cream, lotion econazole  ketoconazole cream, shampoo miconazole nitrate solution w/ applicator nystatin  nystatin/triamcinolone ointment | ALEVAZOL (clotrimazole) CICLODAN (ciclopirox)  ciclopirox gel, shampoo, suspension  clotrimazole solution  ERTACZO (sertaconazole)  EXELDERM (sulconazole) JUBLIA (efinaconazole) ketoconazole foam KETODAN (ketoconazole) LOPROX (ciclopirox) luliconazole LUZU (luliconazole) miconazole  miconazole/zinc/petrolatum  NAFTIN (naftifine)  naftifine  nystatin/triamcinolone cream oxiconazole  OXISTAT (oxiconazole)  terbinafine tolnaftate  VOTRIZA-AL (clotrimazole) lotion  VUSION (miconazole/zinc/petrolatum) |  | • | Two (2) preferred products required before a non-preferred product will be approved. |
| **ANTIPARASITICS, TOPICAL** |  | |  | **Review Schedule: 4th Quarter** |
| NATROBA (spinosad)  permethrin  piperonyl butoxide/pyrethrins | CROTAN (crotamiton) ivermectin lotion malathion  OVIDE (malathion) lotion SKLICE (ivermectin)  spinosad  VANALICE (pyrethrins/piperonyl butoxide) |  | • | Two (2) preferred products required before a non-preferred product will be approved. |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS**  **Prior authorization is required** |  | **CRITERION** |
| **ANTIPSORIATIC AGENTS, ORAL** | |  | **Review Schedule: 3rd Quarter** |
| acitretin | methoxsalen | • | One (1) preferred product required before a non-preferred product will be approved. |
| **ANTIPSORIATIC AGENTS, TOPICAL** | |  | **Review Schedule: 3rd Quarter** |
| calcipotriene cream, ointment, solution | calcipotriene foam calcipotriene/betamethasone calcitriol  DUOBRII (halobetasol propionate/tazarotene)  ENSTILAR (calcipotriene/betamethasone)  SORILUX (calcipotriene) tazarotene cream, gel TAZORAC (tazarotene)  VECTICAL (calcitriol)  VTAMA (tapinarof)  ZORYVE 0.3% (roflumilast) | • | One (1) preferred product required before a non-preferred product will be approved. |
| **ANTIVIRALS, TOPICAL** | |  | **Review Schedule: 4th Quarter** |
| acyclovir ointment docosanol | acyclovir cream DENAVIR (penciclovir) penciclovir cream  XERESE (acyclovir/hydrocortisone)  ZOVIRAX (acyclovir) | • | Two (2) preferred products required before a non-preferred product will be approved. |
| **IMMUNOMODULATORS, ATOPIC DERMATITIS**  **(Clinical criteria applies to class. All agents require a prior authorization.)** | |  | **Review Schedule: 4th Quarter** |
| ADBRY (tralokinumab-ldrm) EUCRISA (crisaborole) \* pimecrolimus  tacrolimus | CIBINQO (abrocitinib)  EBGLYSS (lebrikizumab-lbkz) ELIDEL (pimecrolimus)  NEMLUVIO (nemolizumab-ilto)  OPZELURA (ruxolitinib)  ZORYVE 0.15% (roflumilast) | •  • | Quantity limits are in place: 400 grams per year    \* Eucrisa will be electronically approved after trial of a preferred topical steroid or immunomodulator |
| **IMMUNOMODULATORS, TOPICAL** | |  | **Review Schedule: 3rd Quarter** |
| imiquimod 3.75% cream  imiquimod 5% cream packet | imiquimod cream pump VEREGEN (sinecatechins)  ZYCLARA (imiquimod) | • | Two (2) preferred products required before a non-preferred product will be approved. |
| **OPHTHALMICS, ALLERGIC CONJUNCTIVITIS** | |  | **Review Schedule: 3rd Quarter** |
| ALAWAY (ketotifen)  azelastine cromolyn | ALOMIDE (lodoxamide) ALREX (loteprednol) bepotastine | • | Two (2) preferred products required before a non-preferred product will be approved. |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS**  **Prior authorization is required** |  | **CRITERION** |
| ketotifen olopatadine 0.1%, 0.2% OTC olopatadine 0.2% RX | BEPREVE (bepotastine)  epinastine  LASTACAFT OTC (alcaftadine) olopatadine 0.1% RX PATADAY (olopatadine)  ZADITOR (ketotifen)  ZERVIATE (cetirizine) |  |  |
| **OPHTHALMICS, ANTIBIOTICS** | | | **Review Schedule: 3rd Quarter** |
| bacitracin/polymyxin  CILOXAN (ciprofloxacin) ointment  ciprofloxacin erythromycin gentamicin  moxifloxacin (generic VIGAMOX) ofloxacin  POLYCIN (bacitracin/polymyxin) polymyxin/trimethoprim tobramycin | AZASITE (azithromycin)  bacitracin  bacitracin/polymyxin BESIVANCE (besifloxacin)  gatifloxacin levofloxacin moxifloxacin viscous (generic MOXEZA) NATACYN (natamycin) neomycin/bacitracin/polymyxin neomycin/polymyxin/gramicidin  OCUFLOX (ofloxacin)  POLYTRIM (polymyxin/trimethoprim)  sulfacetamide  TOBREX (tobramycin)  VIGAMOX (moxifloxacin)  XDEMVY (lotilaner)  ZYMAXID (gatifloxacin) | • | Two (2) preferred products required before a non-preferred product will be approved. |
| **OPHTHALMICS, ANTIBIOTIC-STEROID COMBINATION** | | | **Review Schedule: 3rd Quarter** |
| neomycin/polymyxin/dexamethasone  sulfacetamide/prednisolone  TOBRADEX (tobramycin/dexamethasone) ointment | MAXITROL (neomycin/polymyxin/dexamethasone)  neomycin/bacitracin/polymyxin/HC neomycin/polymyxin/HC  NEO-POLYCIN HC (neomycin/bacitracin/ polymyxin/HC)  TOBRADEX ST (tobramycin/dexamethasone)  tobramycin/dexamethasone ZYLET (loteprednol/tobramycin) | • | Two (2) preferred products required before a non-preferred product will be approved. |
| **OPHTHALMICS, ANTI-INFLAMMATORIES** | | | **Review Schedule: 3rd Quarter** |
| dexamethasone diclofenac  DUREZOL (difluprednate) FLAREX (fluorometholone) fluorometholone flurbiprofen  FML FORTE (fluorometholone) ketorolac (all strengths) LOTEMAX (loteprednol) | ACULAR (ketorolac)  ACULAR LS (ketorolac) ACUVAIL (ketorolac) bromfenac  BROMSITE (bromfenac) clobetasol  DEXTENZA (dexamethasone)  difluprednate  EYSUVIS (loteprednol etabonate) | • | Two (2) preferred products required before a non-preferred product will be approved. |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS**  **Prior authorization is required** |  | **CRITERION** |
| MAXIDEX (dexamethasone) NEVANAC (nepafenac)  PRED FORTE (prednisolone) PRED MILD (prednisolone)  prednisolone | FML LIQUFILM (fluorometholone)  ILEVRO (nepafenac)  ILUVIEN (fluocinolone acetate)  INVELTYS (loteprednol etabonate) LOTEMAX SM (loteprednol etabonate) loteprednol  OZURDEX (dexamethasone) PROLENSA (bromfenac)  RETISERT (fluocinolone acetonide)  TRIESENCE (triamcinolone acetonide) XIPERE (triamcinolone acetonide)  YUTIQ (fluocinolone acetonide) |  |  |
| **OPHTHALMICS, GLAUCOMA AGENTS** | | | **Review Schedule: 3rd Quarter** |
| ALPHAGAN P (brimonidine)  brimonidine 0.2%  carteolol  COMBIGAN (brimonidine/timolol) dorzolamide dorzolamide/timolol drops ISTALOL (timolol maleate)  latanoprost levobunolol pilocarpine  SIMBRINZA (brinzolamide/brimonidine)  timolol maleate solution travoprost | apraclonidine  AZOPT (brinzolamide)  betaxolol  BETIMOL (timolol hemihydrate)  BETOPTIC (betaxolol) BETOPTIC S (betaxolol)  brimatoprost brimonidine/timolol brimonidine 0.1%, 0.15% brinzolamide  COSOPT (dorzolomide/timolol) COSOPT PF (dorzolomide/timolol) dorzolamide/timolol droperette iDOSE (travoprost)  iopidine  IYUZEH (latanoprost/PF)  LUMIFY (brimonidine tartrate) LUMIGAN (bimatoprost) phospholine iodine  RHOPRESSA (netarsudil)  ROCKLATAN (netarsudil/latanoprost)  tafluprost droperette timolol hemihydrate timolol maleate gel timolol maleate drop daily timolol maleate droperette TIMOPTIC (timolol)  TIMOPTIC XE (timolol)  TRAVATAN Z (travoprost)  VYZULTA (latanoprostene bunod)  XALATAN (latanoprost)  XELPROS (latanoprost)  ZIOPTAN (tafluprost) | • | Two (2) preferred products required before a non-preferred product will be approved. |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS**  **Prior authorization is required** | **CRITERION** |
| **OPHTHALMICS, IMMUNOMODULATORS** |  | **Review Schedule: 4thQuarter** |
| RESTASIS (cyclosporine) vials | CEQUA (cyclosporine) cyclosporine droperettes MIEBO (perfluorohexyloctane)  RESTASIS MULTIDOSE (cyclosporine)  TYRVAYA (varenicline)  VERKAZIA (cyclosporine)  VEVYE (cyclosporine) XIIDRA (lifitegrast) | • One (1) preferred product required before a non-preferred product will be approved. |
| **OTIC ANTIBIOTICS** |  | **Review Schedule: 3rd Quarter** |
| CIPRO HC (ciprofloxacin/hydrocortisone)  CORTISPORIN-TC  (neomycin/colistin/hydrocortisone/thonzonium) neomycin/polymyxin/hydrocortisone ofloxacin | ciprofloxacin  ciprofloxacin/dexamethasone ciprofloxacin/fluocinolone  OTOVEL (ciprofloxacin/fluocinolone acetate) | • Two (2) preferred products required before a non-preferred product will be approved. |
| **OTIC ANTI-INFECTIVES, ANESTHETICS** |  | **Review Schedule: 1st Quarter** |
| acetic acid | acetic acid/hydrocortisone | • One (1) preferred product required before a non-preferred product will be approved. |
| **ROSACEA AGENTS, TOPICAL** |  | **Review Schedule: 1st Quarter** |
| azelaic acid (generic FINACEA) metronidazole 0.75% cream, 0.75% gel metronidazole 1% gel pump | brimonidine  EPSOLAY (benzoyl peroxide) FINACEA (azelaic acid) ivermectin cream  METROCREAM (metronidazole) METROGEL (metronidazole) metronidazole 0.75% lotion metronidazole 0.1% gel MIRVASO (brimonidine)  NORITATE (metronidazole)  RHOFADE (oxymetazoline)  ROSADAN (metronidazole)  SOOLANTRA (ivermectin) | • Two (2) preferred products required before a non-preferred product will be approved. |
| **STEROIDS, TOPICAL** |  | **Review Schedule: 3rd Quarter** |
| clobetasol ointment, solution fluocinolone topical solution, oil fluocinonide ointment 0.05% fluticasone cream, ointment hydrocortisone (except 2.5% solution) hydrocortisone acetate  mometasone  SCALPICIN (hydrocortisone) |  | alclometasone amcinonide  APEXICON E (diflorasone diacetate) betamethasone dipropionate  betamethasone dipropionate/propylene glycol  betamethasone valerate  BRYHALI (halobetasol propionate)  clobetasol cream, foam, gel, lotion, shampoo, spray |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS**  **Prior authorization is required** | **CRITERION** |
| triamcinolone cream, lotion, 0.025%, 0.1%, 0.5% oi | ntment | clocortolone  CLOBEX (clobetasol)  CLODAN (clobetasol)  CORDRAN (fludroxycortide) DERMACINRX  DERMA-SMOOTHE FS (fluocinolone) DERMASORB (triamcinolone)  desonide  DESOWEN (desonide)  desoximetasone diflorasone  fluocinolone cream, ointment fluocinonide (except 0.05% ointment) flurandrenolide fluticasone lotion halcinonide halobetasol hydrocortisone 2.5% solution hydrocortisone butyrate hydrocortisone valerate  LEXETTE (halobetasol propionate)  MICORT-HC (hydrocortisone acetate)  OLUX-E (clobetasol)  PANDEL (hydrocortisone probutate) prednicarbate  SERNIVO (betamethasone dipropionate)  SYNALAR (fluocinolone) TEXACORT (hydrocortisone)  TOPICORT (desoximetasone) TOVET (clobetasol)  triamcinolone 0.05% ointment, aerosol  ULTRAVATE (halobetasol)  • |