**4/01/2025**

**5**

**05/30/2025**

**General Preferred Drug List Information**

* Gainwell Technologies’ DUR+ process is a proprietary electronic prior authorization system used for Medicaid pharmacy claims.

* Drug coverage subject to the rules and regulations set forth in Sec. 1927 of Social Security Act. This is not an allinclusive list of available covered drugs and includes only managed categories. Unless otherwise stated, the listing of a particular brand or generic name includes all dosage forms of that drug. NR indicates a new drug that has not yet been reviewed by the P&T Committee.

* **PREFERRED BRANDS** will not count toward the two-brand monthly Rx Limit.

* Drugs highlighted in yellow denote change in PDL status.

* To search the PDL, **press CTRL + F**.

# Medication Coverage Status Search Tool - [Pharmacy Drug Coverage Inquiry](https://portal.ms-medicaid-mesa.com/ms/provider/Resources/SearchDrugCode/tabid/526/Default.aspx)

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **ACNE AGENTS** | | |
| **ANTI-INFECTIVES** | | **Maximum Age Limit**   * **21 years**: all acne agents except isotretinoin products     **Topical Clindamycin 1% lotion**   * **21 years** and older **AND** * Documented diagnosis of hidradenitis suppurativa     Note:   * Isotretinoin products available for all ages * Clindamycin 1% lotion only available for ages 21 years and older with approvable diagnosis * Preferred clindamycin 1% lotion for ages < 21 years does not require PA     **Maximum Age Limit**   * **21 years**: all acne agents except isotretinoin products |
| clindamycin gel (generic CLEOCIN-T) | azelaic acid |
| clindamycin lotion, medicated swab, solution | CLEOCIN T (clindamycin) |
|  | CLINDACIN (clindamycin) |
|  | CLINDAGEL (clindamycin) |
|  | clindamycin foam |
|  | clindamycin gel (generic CLINDAGEL) |
|  | dapsone |
|  | ERY (erythromycin) |
|  | ERYGEL (erythromycin) |
|  | erythromycin |
|  | EVOCLIN (clindamycin) |
|  | KLARON (sulfacetamide) |
|  | MORGIDOX (doxycycline) |
|  | sulfacetamide sodium suspension |
|  | WINLEVI (clascoterone) cream |
| **ISOTRETINOIN PRODUCTS** | |
| AMNESTEEM (isotretinoin) | ABSORBICA (isotretinoin) |
| CLARAVIS (isotretinoin) | isotretinoin |
| ZENATANE (isotretinoin) |  |
| **KERATOLYTICS (BENZOYL PEROXIDES)** | |
| ACNE MEDICATION (benzoyl peroxide) | BPO towelette (benzoyl peroxide) |
| benzoyl peroxide |  |
| LINTERA (benzoyl peroxide) |  |
|  |  |
|  |  |
| **RETINOIDS** | |
| adapalene gel, gel with pump | adapalene cream |
| RETIN-A (tretinoin) | AKLIEF (trifarotene) |
| tretinoin cream | ALTRENO (tretinoin) |
|  | ARAZLO (tazarotene) |
|  | ATRALIN (tretinoin) |
|  | DIFFERIN (adapalene) |
|  | FABIOR (tazarotene) |
|  | RETIN-A MICRO (tretinoin) |
|  | RETIN-A MICRO PUMP (tretinoin) |
|  | tretinoin gel |
|  | tretinoin microsphere |
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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** | | | |
| **ACNE AGENTS** (*continued*) | | | | | |
| **OTHERS/COMBINATION PRODUCTS** | |  | See previous page for additional PA Criteria/DUR+ Rules | |  |
| adapalene/benzoyl peroxide gel | ACANYA (benzoyl peroxide/clindamycin) gel |  | |
| clindamycin/benzoyl peroxide 1%-5% gel w/pump | CABTREO (clindamycin/adapalene/benzoyl peroxide) gel |
| sodium sulfacetamide w/sulfur 8%-4%, 9%-  4.25%, 10-5% suspension | CLEANSING WASH (sulfacetamide sodium/sulfur/urea) cleanser |
|  | clindamycin phosphate/benzoyl peroxide 1.2%-  2.5% gel |
|  | clindamycin phosphate/tretinoin 1.2%-0.025% gel |
|  | clindamycin/benzoyl peroxide 1%-5% gel |
|  | clindamycin/benzoyl peroxide 1.2%-3.75% gel w/pump (generic ONEXTON) |
|  | EPIDUO FORTE (adapalene/benzoyl peroxide) gel |
|  | erythromycin/benzoyl peroxide gel |
|  | NEUAC (benzoyl peroxide/clindamycin) cream, gel |
|  | ONEXTON (benzoyl peroxide/clindamycin) gel |
|  | sodium sulfacetamide w/sulfur 8%-4% cleanser |
|  | sodium sulfacetamide w/sulfur 10%-2% cream |
|  | sodium sulfacetamide w/sulfur 10%-5% cream, lotion |
|  | SSS (sodium sulfacetamide/sulfur)10-5 cream, foam |
|  | TWYNEO (benzoyl peroxide/tretinoin) cream |
|  | ZIANA (clindamycin/tretinoin) gel |
|  | ZMA CLEAR (sodium sulfacetamide/sulfur) suspension |
| **ALPHA-1 PROTEINASE INHIBITORS** | | | | | |
| ARALAST NP |  |  | | | |
| GLASSIA |  |
| PROLASTIN C |  |
| ZEMAIRA |  |
| **ALZHEIMER’S AGENTS DUR+** | | | | | |
| **CHOLINESTERASE INHIBITORS** | | **Preferred Criteria**   * Documented approvable diagnosis     **Non-Preferred Criteria**   * Documented approvable diagnosis **AND** | | | |
| donepezil 5 mg, 10 mg ODT, tablets | ADLARITY (donepezil) |
| galantamine | ARICEPT (donepezil) |
| galantamine ER | donepezil 23 mg tablet |
| rivastigmine | EXELON (rivastigmine) |  | See next page for additional PA Criteria/DUR+ Rules |  | |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** | | |
| **ALZHEIMER’S AGENTS DUR+** *(continued)* | | | | |
|  | Zunveyl (benzgalantamine gluconate)NR | • Have    **NAMZARIC**  •    **ZUNVEYL**  • | See previous page for additional PA Criteria/DUR+ Rules |  |
| tried 2 different preferred agents in the past 6 months    Requires clinical review    Requires clinical review |
| **NMDA RECETPOR ANTAGONISTS** | |
| memantine | memantine ER |
|  | NAMENDA (memantine) |
|  | NAMENDA XR (memantine ER) |
| **COMBINATION AGENTS** | |
|  | NAMZARIC (memantine/donepezil) |
|  | memantine/donepezil ER |
| **ANALGESICS, OPIOID-SHORT ACTING DUR+** | | | | |
| acetaminophen/caffeine/dihydrocodeine | ACTIQ (fentanyl) | **MS DOM Opioid Initiative** [– **Criteria details found here**](https://medicaid.ms.gov/wp-content/uploads/2025/04/OPIOID-PACKET-Effective-4-28-2025-to-Current.V10.pdf)   * Morphine Equivalent Daily Dose * Concomitant use of Opioids and Benzodiazepines     **Minimum Age Limit**   * **18 years**: codeine-containing products and tramadol-containing products     **Quantity Limit** (per 31 rolling days)   * **62 tablets**: butalbital/codeine combinations, codeine combinations, dihydrocodeine combinations, fentanyl, hydrocodone, hydromorphone, levorphanol, meperidine, morphine, oxycodone, oxymorphone, pentazocine, tapentadol, tramadol * **186 tablets**: butalbital/acetaminophen, butalbital/aspirin * **5 mL**: butorphanol nasal * **180 mL**: oxycodone liquid * **280 mL**: QDOLO     **Non-Preferred Criteria**   * Have tried 2 different preferred agents in the past 6 months   **MS DOM Opioid Initiative** [– **Criteria details found here**](https://medicaid.ms.gov/wp-content/uploads/2025/04/OPIOID-PACKET-Effective-4-28-2025-to-Current.V10.pdf)   * Morphine Equivalent Daily Dose * Concomitant use of Opioids and Benzodiazepines     **Minimum Age Limit**   * **18 years**: BUTRANS and tramadol-containing products | | |
| acetaminophen/codeine | aspirin/butalbital/caffeine/codeine |
| codeine | butalbital/acetaminophen/caffeine/codeine |
| ENDOCET (oxycodone/acetaminophen) | butorphanol |
| hydrocodone/acetaminophen | DILAUDID (hydromorphone) |
| hydromorphone | fentanyl citrate |
| morphine sulfate | FENTORA (fentanyl) |
| oxycodone | FIORICET W/CODEINE  (butalbital/acetaminophen/codeine) |
| oxycodone/acetaminophen (325 mg acetaminophen formulations) | hydrocodone/ibuprofen |
| tramadol 50 mg tablet | meperidine |
| tramadol/acetaminophen | NALOCET (oxycodone/acetaminophen) |
|  | levorphanol |
|  | oxymorphone |
|  | pentazocine/naloxone |
|  | PERCOCET (oxycodone/acetaminophen) |
|  | PROLATE (oxycodone/acetaminophen) |
|  | ROXICODONE (oxycodone) |
|  | ROXYBOND (oxycodone) |
|  | SEGLENTIS (tramadol/celecoxib) |
|  | tramadol 25 mg, 75 mg, 100 mg tablet |
|  | tramadol solution |
| **ANALGESICS, OPIOID-LONG ACTING DUR+** | | | | |
| BUTRANS (buprenorphine) | BELBUCA (buprenorphine) | See next page for additional PA Criteria/DUR+ Rules | | |
| fentanyl patch | buprenorphine patch |
| morphine sulfate ER tablet | CONZIP (tramadol) |
|  | hydrocodone bitartrate ER |
|  | hydromorphone ER |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** | | | | |
|  | **ANALGESICS, OPIOID-LONG ACTING DUR+** *(continued)* | | | | | |
|  | HYSINGLA ER (hydrocodone) | **Quantity Limit**   * **31** * **62** * **62 films** * **10** * **4 patches**     **Non-** | | See previous page for additional PA Criteria/DUR+ Rules | |  |
| (per 31 rolling days)  **tablets**: AVINZA, hydromorphone ER, HYSINGLA ER, tramadol ER  **tablets**: methadone, morphine ER, OXYCONTIN, oxymorphone ER, ZOHYDRO ER  : BELBUCA  **patches**: fentanyl  : BUTRANS  **Preferred Criteria**  Have tried 2 different preferred agents in the past 6 months | |
|  | methadone |
|  | methadone intensol |
|  | METHADOSE (methadone) |
|  | morphine sulfate ER capsule |
|  | MS CONTIN (morphine) |
|  | oxycodone ER |
|  | OXYCONTIN (oxycodone) |
|  | oxymorphone ER |
|  | tramadol ER |
|  | **ANALGESICS/ANESTHETICS (TOPICAL)** | | | | | |
| diclofenac 1%, 3% gel | DERMACINRX LIDOCAN (lidocaine) | **Quantity Limit** (per 31 days)   * **1 bottle (112 mL)**: diclofenac 2% solution pump * **1 bottle (150 mL)**: diclofenac 1.5% solution       **Non-Preferred Criteria**   * Have tried 2 preferred agents in the past 6 months     **Lidocaine 5% Patch**   * Documented diagnosis of Herpetic Neuralgia **OR** * Documented diagnosis of Diabetic Neuropathy     **ZTLIDO**   * Documented diagnosis of postherpetic neuralgia **OR** * History of 3 claims with preferred lidocaine 5% patch in the past 6 months | | | | |
| lidocaine 4% cream, patch, solution | DERMACINRX LIDOGEL (lidocaine) |
| lidocaine 5% cream, ointment, patch | DERMACINRX LIDOREX (lidocaine) |
| lidocaine 40 mg/mL solution | diclofenac epolamine |
| lidocaine/prilocaine cream | diclofenac sodium 2% solution pump |
| TRIDACAINE (lidocaine) patch | DICLOGEN (diclofenac/menthol/camphor) kit |
| TRIDACAINE XL (lidocaine) patch | DOLOGESIC PAIN RELIEF (lidocaine) |
| ULTRA LIDO (lidocaine) cream, gel | LIDAFLEX (lidocaine) |
|  | lidocaine 3% cream |
|  | lidocaine 4% kit, liquid |
|  | lidocaine/hydrocortisone |
|  | lidocaine/prilocaine kit |
|  | LIDOCAN II, III, IV, V (lidocaine) |
|  | LIDOCORT (lidocaine/hydrocortisone) |
|  | LIDODERM (lidocaine) |
|  | LIDOTRAL (lidocaine) |
|  | LIXOFEN (diclofenac) |
|  | PENNSAID (diclofenac) |
|  | PLIAGLIS (lidocaine/tetracaine) |
|  | TRIDACAINE II, III (lidocaine) patch |
|  | ZTLIDO (lidocaine) |
|  | **ANDROGENIC AGENTS DUR+** | | | | | |
| testosterone | ANDROGEL (testosterone) | **All Agents**   * Limited to male gender     **Non-Preferred Criteria**   * Have tried 2 different preferred agents in the past 6 months | | | | |
|  | JATENZO (testosterone undecanoate) |
|  | NATESTO (testosterone) |
|  | TESTIM (testosterone) |
|  | TLANDO (testosterone undecanoate) |
|  | VOGELXO (testosterone) |  | See next page for additional PA Criteria/DUR+ Rules | |  | |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** | | |
| **ANDROGENIC AGENTS DUR+** *(continued)* | | | | |
|  | UNDECATREX (testosterone undecanoate) | **TLANDO**  • | See previous page for additional PA Criteria/DUR+ Rules |  |
| Requires clinical review |
| **ANGIOTENSIN MODULATORS DUR+** | | | | |
| **ANGIOTENSIN CONVERTING ENZYME (ACE) INHIBITORS** | | **EPANED**   * Automatic approval issued for 0-6 years of age     **ENTRESTO**   * Age > 1 year **and** documented diagnosis of Heart Failure with Systemic Ventricular Systolic Dysfunction   **OR**   * Age > 18 years **and** documented diagnosis of Heart Failure     **Non-Preferred Criteria**   * **ACEIs**:   + Have tried 2 different preferred single entity agents in the past 6 months **OR** o 90 days of therapy with the requested agent in the past 105 days * **ACEI/CCB Combinations**:   + Have tried 2 different preferred ACEI/CCB agents in the past 6 months **OR** o 90 days of therapy with the requested agent in the past 105 days * **ACEI/Diuretic Combinations**:   + Have tried 2 different preferred ACEI/Diuretic agents in the past 6 months **OR** o 90 days of therapy with the requested agent in the past 105 days * **ARBs**:   + Have tried 2 different preferred single entity agents in the past 6 months **OR** o 90 days of therapy with the requested agent in the past 105 days * **ARB/CCB and ARB/CCB/Diuretic Combinations**:   + Have tried 1 preferred ARB/CCB agent in the past 6 months **OR** o 90 days of therapy with the requested agent in the past 105 days * **ARB/Diuretic Combinations**:   + Have tried 2 different preferred ARB/Diuretic agents in the past 6 months **OR** o 90 days of therapy with the requested agent in the past 105 days * **Direct Renin Inhibitors**:   + Documented diagnosis of Hypertension **AND**   + Have tried 2 different preferred ACEI or ARB single-entity agents in the past 6 months **OR** o 90 days of therapy with the requested agent in the past 105 days * **Direct Renin Inhibitor Combinations**:   + Documented diagnosis of Hypertension **AND**   + Have tried 2 different preferred ACEI or ARB diuretic agents in the past 6 months **OR** • 90 days of therapy with the requested agent in the past 105 days | | |
| benazepril | ACCUPRIL (quinapril) |
| captopril | ALTACE (ramipril) |
| enalapril | EPANED (enalapril) |
| **ANGIOTENSIN CONVERTING ENZYME (ACE) INHIBITORS** | |
| fosinopril | LOTENSIN (benazepril) |
| lisinopril | moexipril |
| quinapril | perindopril |
| ramipril | QBRELIS (lisinopril) |
| trandolapril | VASOTEC (enalapril) |
|  | ZESTRIL (lisinopril) |
| **ACE INHIBITOR (ACEI) COMBINATIONS** | |
| benazepril/amlodipine | ACCURETIC (quinapril/hydrochlorothiazide) |
| benazepril/hydrochlorothiazide | LOTENSIN HCT  (benazepril/hydrochlorothiazide) |
| captopril/hydrochlorothiazide | LOTREL (benazepril/amlodipine) |
| enalapril/hydrochlorothiazide | VASERETIC (enalapril/hydrochlorothiazide) |
| fosinopril/hydrochlorothiazide | ZESTORETIC (lisinopril/hydrochlorothiazide) |
| lisinopril/hydrochlorothiazide |  |
| quinapril/hydrochlorothiazide |  |
| trandolapril/verapamil ER |  |
| **ANGIOTENSIN II RECEPTOR BLOCKERS (ARBs)** | |
| irbesartan | ATACAND (candesartan) |
| losartan | AVAPRO (irbesartan) |
| olmesartan | BENICAR (olmesartan) |
| telmisartan | candesartan |
| valsartan tablet | COZAAR (losartan) |
|  | EDARBI (azilsartan) |
|  | eprosartan |
|  | MICARDIS (telmisartan) |
| **ANGIOTENSIN II RECEPTOR BLOCKERS (ARBs)** | |
|  | valsartan solution |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** | | |
| **ANGIOTENSIN MODULATORS DUR+** *(continued)* | | | | |
| **ARB COMBINATIONS** | |  | See previous page for additional PA Criteria/DUR+ Rules |  |
| ENTRESTO (valsartan/sacubitril) tablet DUR+ | ATACAND HCT (candesartan/hydrochlorothiazide) |  |
| irbesartan/hydrochlorothiazide | AVALIDE (irbesartan/hydrochlorothiazide) |
| losartan/hydrochlorothiazide | AZOR (olmesartan/hydrochlorothiazide) |
| olmesartan/amlodipine | BENICAR HCT (olmesartan/hydrochlorothiazide) |
| olmesartan/hydrochlorothiazide | candesartan/hydrochlorothiazide |
| telmisartan/hydrochlorothiazide | DIOVAN-HCT (valsartan/hydrochlorothiazide) |
| valsartan/amlodipine | EDARBYCLOR (azilsartan/chlorthalidone) |
| valsartan/amlodipine/hydrochlorothiazide | ENTRESTO (valsartan/sacubitril) sprinkle capsule |
| valsartan/hydrochlorothiazide | EXFORGE (valsartan/amlodipine) |
|  | EXFORGE HCT  (valsartan/amlodipine/hydrochlorothiazide) |
|  | olmesartan/amlodipine/hydrochlorothiazide |
|  | telmisartan/amlodipine |
|  | TRIBENZOR  (olmesartan/amlodipine/hydrochlorothiazide) |
|  | valsartan/sacubitril |
| **DIRECT RENIN INHIBITORS** | |
|  | aliskiren |
|  | TEKTURNA (aliskiren) |
|  |  |
| **DIRECT RENIN INHIBITOR COMBINATIONS** | |
|  | TEKTURNA HCT (aliskiren/hydrochlorothiazide) |
| **ANTIBIOTICS (GI) & RELATED AGENTS** | | | | |
| metronidazole tablet | AEMCOLO (rifamycin) |  | | |
| neomycin | DIFICID (fidaxomicin) |
| tinidazole | FIRVANQ (vancomycin) |
| vancomycin oral solution | FLAGYL (metronidazole) |
|  | LIKMEZ (metronidazole) |
|  | metronidazole 125 mg tablet, 375 mg capsule |
|  | nitazoxanide |
|  | paromomycin |
|  | REBYOTA (fecal microbiota, live-jslm) |
|  | VANCOCIN (vancomycin) |
|  | vancomycin capsule |
|  | VOWST (fecal microbio spore, live-brpk) |
|  | XIFAXAN (rifaximin) |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **ANTIBIOTICS (MISCELLANEOUS)** | | |
| **LINCOSAMIDE ANTIBIOTICS** | | **Quantity Limit**  • **6 tablets/month**: SIVEXTRO    **SIVEXTRO** [– **MANUAL PA**](https://medicaid.ms.gov/wp-content/uploads/2019/01/Sivextro.pdf)    **ZYVOX** [– **MANUAL PA**](https://medicaid.ms.gov/wp-content/uploads/2021/02/Zyvox.pdf) |
| clindamycin | CLEOCIN (clindamycin) |
|  | CELOCIN PEDIATRIC (clindamycin) |
| **MACROLIDES** | |
| azithromycin | ERYPED (erythromycin ethylsuccinate) suspension |
| clarithromycin | ERYTHROCIN (erythromycin stearate) |
| clarithromycin ER | ZITHROMAX (azithromycin) |
| E.E.S (erythromycin ethylsuccinate) suspension |  |
| ERY-TAB (erythromycin) |  |
| erythromycin |  |
| erythromycin ethylsuccinate |  |
| **NITROFURANTOIN DERIVATIVES** | |
| nitrofurantoin capsule | FURADANTIN (nitrofurantoin) suspension |
| nitrofurantoin monohydrate macrocrystals | MACROBID (nitrofurantoin monohydrate macrocrystals) |
|  | nitrofurantoin suspension |
| **OXAZOLIDINONES** | |
|  | linezolid |
|  | SIVEXTRO (tedizolid) |
|  | ZYVOX (linezolid) |
| **ANTIBIOTICS (TOPICAL)** | | |
| bacitracin OTC | CENTANY (mupirocin) |  |
| bacitracin/polymyxin OTC | CENTANY AT (mupirocin) |
| gentamicin sulfate | mupirocin cream |
| mupirocin ointment | XEPI (ozenoxacin) |
| neomycin/bacitracin/polymyxin OTC |  |
| **ANTIBIOTICS (VAGINAL)** | | |
| CLEOCIN (clindamycin) | clindamycin phosphate |  |
| NUVESSA (metronidazole) | CLINDESSE (clindamycin) |
|  | SOLOSEC (secnidazole) |
|  | XACIATO (clindamycin) |
| **ANTICOAGULANTS** | | |
| **LOW MOLECULAR WEIGHT HEPARIN (LMWH)** | | **Non-Preferred Criteria**  • **LMWH**:  o Have tried 1 preferred agent in the past 6 months **OR**  See next page for additional PA Criteria/DUR+ Rules |
| enoxaparin | ARIXTRA (fondaparinux) |
|  | fondaparinux |
|  | FRAGMIN (dalteparin) |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | | | **PA CRITERIA** | | |
| **ANTICOAGULANTS** *(continued)* | | | | | | |
|  | LOVENOX (enoxaparin) | | | o 90    • **Oral**:o  90 | See previous page for additional PA Criteria/DUR+ Rules |  |
| **ORAL** | | | | days of therapy with the requested agent in the past 105 days  Have tried 2 different preferred oral agents in the past 6 months **OR** days of therapy with the requested agent in the past 105 days |
| ELIQUIS (apixaban) | dabigatran | | |
| JANTOVEN (warfarin) | PRADAXA (dabigatran) pellet pack | | |
| PRADAXA (dabigatran) capsule | SAVAYSA (edoxaban) | | |
| warfarin |  | rivaroxaban |  |
| XARELTO (rivaroxaban) |  | | |
| **ANTICONVULSANTS DUR+** | | | | | | |
| **ADJUVANTS** | | | | **Minimum Age Limit**   * **6 months**: DIACOMIT * **1 year**: BANZEL, EPIDIOLEX * **2 years**: ONFI, SYMPAZAN * **2 years**: VALTOCO * **12 years**: NAYZILAM     **Maximum Age Limit**   * **2 years**: VIGAFYDE     **Quantity Limit** (per 31 days)   * **2 twin packs**: DIASTAT * **2 packages**:NAYZILAM * **2 cartons**: VALTOCO     **Non-Preferred Criteria**   * Have tried 2 different preferred agents in the past 6 months **OR** * Documented diagnosis of Seizure **AND** * 90 days of therapy with the requested agent in the past 105 days     **Banzel, Onfi, and Sympazan**   * Documented diagnosis of Lennox-Gastaut Syndrome **and** have tried 1 preferred agent for Lennox-Gastaut Syndrome in the past 6 months **OR** * Documented diagnosis of Seizure **and** 90 days of therapy with the requested agent in the past 105 days     **DIACOMIT**   * Documented diagnosis of Dravet Syndrome **AND** * 1 claim for clobazam in the past 30 days     See next page for additional PA Criteria/DUR+ Rules | | |
| carbamazepine | APTIOM (eslicarbazepine acetate) | | |
| carbamazepine ER 12-hour capsule | BANZEL (rufinamide) | | |
| DEPAKOTE ER (divalproex) | BRIVIACT (brivaracetam) | | |
| DEPAKOTE SPRINKLE (divalproex) | carbamazepine ER 12-hour tablet | | |
| divalproex | CARBATROL (carbamazepine) | | |
| divalproex ER | DEPAKOTE (divalproex) | | |
| divalproex sprinkle | DIACOMIT (stiripentol) | | |
| EPIDIOLEX (cannabidiol) | ELEPSIA XR (levetiracetam) | | |
| lacosamide | EPRONTIA (topiramate) | | |
| lamotrigine | EQUETRO (carbamazepine) | | |
| lamotrigine blue, green, orange dose pack | felbamate | | |
| levetiracetam | FELBATOL (felbamate) | | |
| levetiracetam ER | FINTEPLA (fenfluramine) | | |
| oxcarbazepine tablet | FYCOMPA (perampanel) | | |
| tiagabine | KEPPRA (levetiracetam) | | |
| topiramate | KEPPRA XR (levetiracetam) | | |
| topiramate sprinkle 15, 25 mg (generic Topamax) | LAMICTAL (lamotrigine) | | |
| TRILEPTAL (oxcarbazepine) suspension | LAMICTAL XR (lamotrigine) | | |
| valproic acid | lamotrigine ER | | |
| zonisamide | lamotrigine ODT | | |
|  | lamotrigine ODT blue, green, orange dose pack | | |
|  | MOTPOLY XR (lacosamide) | | |
|  | oxcarbazepine suspension | | |
|  | oxcarbazepine ER | | |
|  | OXTELLAR XR (oxcarbazepine) | | |
|  | QUDEXY XR (topiramate) | | |
|  | ROWEEPRA (levetiracetam) | | |
|  | rufinamide | | |
|  | SABRIL (vigabatrin) | | |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **ANTICONVULSANTS DUR+** (*continued*) | | |
| **ADJUVANTS** *(continued)* | | See previous page for additional PA Criteria/DUR+ Rules      **EPIDIOLEX**   * Documented diagnosis of Dravet Syndrome, Lennox-Gastaut Syndrome, or Seizures associatedwith Tuberous Sclerosis Complex **OR** * 1claim for EPIDIOLEX in the past 30 days     **FINTEPLA**   * Requires clinical review     **SABRIL Powder for Oral Solution**   * Documented diagnosis of Infantile Spasms **OR** * Have tried 2 different preferred agents in the past 6 months **OR** * Documented diagnosis of Seizure **AND** * 90 days of therapy with the requested agent in the past 105 days     **Topiramate ER**   * Documented diagnosis of Seizure **AND** * 90 days of therapy with the requested agent in the past 105 days **OR** * 30 days of therapy with topiramate IR in the past 6 months     **VIGAFYDE**   * Age < 2 years **AND** * Documented diagnosis of infantile spasms |
|  | SPRITAM (levetiracetam) |
|  | SUBVENITE (lamotrigine) |
|  | SUBVENITE (lamotrigine) blue, green, orange dose pack |
|  | TEGRETOL (carbamazepine) |
|  | TEGRETOL XR (carbamazepine) |
|  | TOPAMAX TABLET (topiramate) |
|  | TOPAMAX SPRINKLE (topiramate) |
|  | topiramate ER capsule (generic Trokendi XR) |
|  | topiramate ER sprinkle capsule (generic Qudexy XR) |
|  | topiramate sprinkle 50 mg |
|  | TRILEPTAL (oxcarbazepine) tablet |
|  | TROKENDI XR (topiramate) |
|  | vigabatrin |
|  | VIGADRONE (vigabatrin) |
|  | VIGAFYDE (vigabatrin) |
|  | VIGPODER (vigabatrin) |
|  | VIMPAT (lacosamide) |
|  | XCOPRI (cenobamate) |
|  | ZONISADE (zonisamide) suspension |
|  | ZTALMY (ganaxolone) |
| **HYDANTOINS** | |
| DILANTIN (phenytoin) |  |
| DILANTIN-125 (phenytoin) |  |
| PHENYTEK (phenytoin) |  |
| phenytoin |  |
| phenytoin ER |  |
| **SELECTED BENZODIAZEPINES** | |
| clobazam | DIASTAT (diazepam) rectal gel |
| diazepam rectal gel | LIBERVANT (diazepam) |
| NAYZILAM (midazolam) | ONFI (clobazam) |
| VALTOCO (diazepam) | SYMPAZAN (clobazam) |
| **SUCCINIMIDES** | |
| ethosuximide | CELONTIN (methsuximide) |
|  | methsuximide |
|  | ZARONTIN (ethosuximide) |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **ANTIDEPRESSANTS, OTHER DUR+** | | |
| bupropion | APLENZIN (bupropion) | **Minimum Age Limit**   * **18 years**:all agents     **Non-Preferred Criteria**   * Have tried 2 different preferred agents in the past 6 months **OR** * Have tried 1 preferred agent and 1 SSRI in the past 6 months **OR** * 90 days of therapy with the requested agent in the past 105 days     **AUVELITY and RALDESY**   * Requires clinical review   **DRIZALMA Sprinkles**   * Automatic approval issued with a diagnosis of Generalized Anxiety Disorder for 7-11 years of age   **DULOXETINE**   * Automatic approval issued with a diagnosis of Generalized Anxiety Disorder for 7-17 years of age     **ZURZUVAE** [– **MANUAL PA**](https://medicaid.ms.gov/wp-content/uploads/2024/04/Zurzuvae_Criteria_04012024_V1.pdf) |
| bupropion SR | AUVELITY (bupropion/dextromethorphan) |
| bupropion XL | desvenlafaxine ER |
| mirtazapine | DESYREL (trazodone) |
| trazodone | DRIZALMA SPRINKLE (duloxetine DR) |
| TRINTELLIX (vortioxetine) | EFFEXOR XR (venlafaxine) |
| venlafaxine | EMSAM (selegiline) |
| venlafaxine ER capsule | FETZIMA (levomilnacipran) |
| vilazodone | FORFIVO XL (bupropion) |
|  | MARPLAN (isocarboxazid) |
|  | NARDIL (phenelzine) |
|  | nefazodone |
|  | phenelzine |
|  | PRISTIQ (desvenlafaxine) |
|  | REMERON (mirtazapine) |
|  | tranylcypromine |
|  | Trazodone solutionNR |
|  | venlafaxine ER tablet |
|  | VIIBRYD (vilazodone) |
|  | WELLBUTRIN SR (bupropion) |
|  | WELLBUTRIN XL (bupropion) |
|  | ZURZUVAE (zuranolone) |
| **ANTIDEPRESSANTS, SSRIs DUR+** | | |
| citalopram solution, tablet | CELEXA (citalopram) | **Minimum Age Limit**   * **6 years**:ZOLOFT * **7 years**: LEXAPRO, PROZAC * **8 years**:LUVOX * **18 years**: CELEXA, LUVOX CR, PAXIL, PEXEVA, PROZAC 90 mg |
| escitalopram | citalopram capsule |
| fluoxetine capsule | fluoxetine solution, tablet |
| fluvoxamine | fluoxetine DR capsule |
| paroxetine tablet | fluvoxamine ER capsule |
| paroxetine CR | LEXAPRO (escitalopram) |
| paroxetine ER | paroxetine suspension, capsule |
| sertraline tablet, solution | PAXIL (paroxetine) |
|  | PAXIL CR (paroxetine) |
|  | PROZAC (fluoxetine) |
|  | sertraline capsule |
|  | ZOLOFT (sertraline) |
| **ANTIEMETICS DUR+** | | |
| **5HT3 RECEPTOR BLOCKERS** | | **Quantity Limit** (per 31 days) • **6 tablets**: AKYNZEO  • **100 mL**: ZOFRAN solution  See next page for additional PA Criteria/DUR+ Rules |
| ondansetron solution, tablet | ANZIMET (dolasetron) |
| ondansetron ODT 4 mg, 8 mg | granisetron |
|  | ondansetron ODT 16 mg tablet |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** | | |
| **ANTIEMETICS DUR+** *(continued)* | | | | |
|  | SANCUSO (granisetron) |  | See previous page for additional PA Criteria/DUR+ Rules |  |
| **ANTIEMETIC COMBINATIONS** | | **Non-Preferred Agents**  • Have tried 1 preferred agent in the past 6 months    **AKYNZEO** [– **MANUAL PA**](https://medicaid.ms.gov/wp-content/uploads/2019/01/Akynzeo.pdf)    Note: Injectables in this class are closed to point of sale. PA required if not administered in clinic/hospital. |
| DICLEGIS (doxylamine/pyridoxine) | AKYNZEO (netupitant/palonosetron) |
|  | BONJESTA (doxylamine/pyridoxine) |
|  | doxylamine/pyridoxine |
| **CANNABINOIDS** | |
|  | dronabinol |
|  | MARINOL (dronabinol) |
| **NMDA RECEPTOR ANTAGONISTS** | |
| aprepitant | EMEND (aprepitant) |
| **ANTIFUNGALS (ORAL) DUR+** | | | | |
| clotrimazole | ANCOBON (flucytosine) | **Griseofulvin suspension**   * Automatic approval issued for 0-11 years of age     **Griseofulvin tablets**   * Automatic approval issued for 12-17 years of age     **Minimum Age Limit**   * **18 years**: CRESEMBA     **Non-Preferred Criteria**   * Have tried 2 different preferred agents in the past 6 months     **HIV Opportunistic Infection**   * Non-Preferred agent indicated for treatment (^) **AND** * Documented diagnosis of HIV     **CRESEMBA** [– **MANUAL PA**](https://medicaid.ms.gov/wp-content/uploads/2019/01/Cresemba.pdf)    **SPORANOX**   * Requires clinical review | | |
| fluconazole | BREXAFEMME (ibrexafungerp) |
| nystatin | CRESEMBA (isavuconazonium sulfate) |
| terbinafine | DIFLUCAN (fluconazole) |
|  | flucytosine |
|  | griseofulvin |
|  | griseofulvin ultramicrosize |
|  | itraconazole |
|  | ketoconazole |
|  | NOXAFIL (posaconazole) |
|  | ORAVIG (miconazole) |
|  | Posaconazole |
|  | SPORANOX (itraconazole) |
|  | TOLSURA (itraconazole) |
|  | VFEND (voriconazole) |
|  | VIVJOA (oteseconazole) |
|  | voriconazole |
| **ANTIFUNGALS (TOPICAL) DUR+** | | | | |
| **ANTIFUNGALS** | | **Non-Preferred Criteria**  • Have tried 2 different preferred agents in the past 6 months    **MICOTRIN AC, MYCOZYL, and clotrimazole 30 mL solution** • Require clinical review | | |
| ciclopirox cream, gel, solution, suspension | BENSAL HP (salicylic acid) |
| clotrimazole cream, solution Rx & OTC | CILODAN (ciclopirox) |
| econazole | ciclopirox shampoo |
| ketoconazole cream, shampoo | clotrimazole solution (NDC 50228-0502-61) |
| LUZU (luliconazole) | ERTACZO (sertaconazole) |
| miconazole cream, powder, solution OTC | EXTINA (ketoconazole) |
| miconazole/zinc oxide/petrolatum ointment | JUBLIA (efinaconazole) |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **ANTIFUNGALS (TOPICAL) DUR+** *(continued)* | | |
| nystatin cream, ointment, powder | ketoconazole foam | See previous page for additional PA Criteria/DUR+ Rules |
| terbinafine OTC | KETODAN (ketoconazole) |
| tolnaftate cream, solution OTC | LOPROX (ciclopirox) |
|  | luliconazole |
|  | MICOTRIN AC (clotrimazole) |
|  | MYCOZYL AC (clotrimazole) |
|  | MYCOZYL AP (miconazole) |
|  | naftifine |
|  | NAFTIN (naftifine) |
|  | oxiconazole |
|  | OXISTAT (oxiconazole) |
|  | tavaborole |
|  | VOTRIZA-AL (clotrimazole) |
|  | VUSION (miconazole/zinc oxide/petrolatum) |
| **ANTIFUNGAL/STEROID COMBINATIONS** | |
| clotrimazole/betamethasone cream | clotrimazole/betamethasone lotion |
| nystatin/triamcinolone |  |
| **ANTIFUNGALS (VAGINAL)** | | |
| clotrimazole cream OTC | 3-DAY VAGINAL CREAM (clotrimazole) |  |
| clotrimazole-3 cream | GYNAZOLE 1 (butoconazole) |
| miconazole kit OTC | terconazole suppository |
| terconazole cream |  |
|  |  |
| **ANTIHISTAMINES, MINIMALLY SEDATING AND COMBINATIONS DUR+** | | |
| **MINIMALLY SEDATING ANTIHISTAMINES** | | **Non-Preferred Criteria**   * Documented diagnosis of Allergy or Urticaria **AND** * Have tried 2 different preferred agents in the past 12 months |
| cetirizine capsule, solution, tablet OTC | cetirizine chewable tablet OTC |
| loratadine chewable tablet, ODT, solution, tablet OTC | CLARINEX (desloratadine) |
|  | desloratadine |
|  | levocetirizine |
| **MINIMALLY SEDATING ANTIHISTAMINE/DECONGESTANT**  **COMBINATIONS** | |
| cetirizine/pseudoephedrine | CLARINEX-D 12 HOUR  (desloratadine/pseudoephedrine) |
| loratadine/pseudoephedrine | fexofenadine/pseudoephedrine |
| **ANTIMIGRAINE AGENTS, ACUTE TREATMENT** | | |
| **CGRP ORAL AND NASAL** | | **Minimum Age Limit**  See next page for additional PA Criteria/DUR+ Rules |
| NURTEC ODT (rimegepant) | ZAVZPRET (zavegepant) |
| UBRELVY (ubrogepant) |  |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** | | |
| **ANTIMIGRAINE AGENTS, ACUTE TREATMENT DUR+** *(continued)* | | | | |
| **INJECTABLES** | |  | See previous page for additional PA Criteria/DUR+ Rule | s  SYMBRAVO, |
| sumatriptan | IMITREX (sumatriptan) | * **6 years**: MAXALT * **12 years**: almotriptan, sumatriptan/naproxen, ZOMIG nasal spray * **18 years**: FROVA, IMITREX, naratripin, NURTEC ODT, RELPAX, REYVOW, TOSYMRA, UBRELVY, ZEMBRACE, ZOMIG tablets     **Quantity Limit** (per 31 days)   * **ORAL** o **4 tablets**: REYVOW 50 mg o **6 tablets**: almotriptan, RELPAX, ZOMIG o **8 tablets**: NURTEC ODT, REYVOW 100 mg   + **9 tablets**: naratriptan, FROVA, IMITREX, sumatriptan/naproxen, SYMBRAVO o **12 tablets**: MAXALT o **16 tablets**: UBRELVY * **NASAL**    + **1 box**: all agents     **CUMULATIVE Quantity Limit** (per 31 days)   * **INJECTABLES**    + **4 injections**: all agents     **Non-Preferred Criteria**   * **ORAL**   + Have tried 2 preferred oral agents in the past 90 days * **NASAL**    + Have tried 2 preferred oral agents in the past 90 days **AND** o Have tried a preferred nasal agent in the past 90 days     **Almotriptan and sumatriptan/naproxen**   * Automatic approval for 12-17 years of age     **NURTEC ODT and UBRELVY** [**– MANUAL PA**](https://medicaid.ms.gov/wp-content/uploads/2025/02/CGRP-02_28_2025-to-current.V12.pdf)   * Documented diagnosis of Migraine **AND** * Have tried 2 different triptans in the past 6 months **AND** * No concurrent therapy with another CGRP agent or strong CYP3A4 inhibitor     **REYVOW**   * Documented diagnosis of Migraine **AND** * Have tried 2 different triptans in the past 90 days **AND** * Have tried preferred NURTEC ODT in the past 90 days     **SYMBRAVO**   * Requires clinical review     See next page for additional PA Criteria/DUR+ Rules |
|  | ZEMBRACE SYMTOUCH (sumatriptan) |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **ANTIMIGRAINE AGENTS, ACUTE TREATMENT DUR+** *(continued)* | | |
| **NASAL** | | See previous page for additional PA Criteria/DUR+ Rules    **ZAVZPRET** [**– MANUAL PA**](https://medicaid.ms.gov/wp-content/uploads/2025/02/CGRP-02_28_2025-to-current.V12.pdf)   * Documented diagnosis of Migraine **AND** * Have tried 2 different triptans in the past 6 months **AND** * Have tried both NURTEC ODT and UBRELVY in the past 6 months **AND** No concurrent therapy with another CGRP AGENT |
| sumatriptan | IMITREX (sumatriptan) |
|  | TOSYMRA (sumatriptan) |
|  | zolmitriptan |
|  | ZOMIG (zolmitriptan) |
| **TRIPTANS AND RELATED AGENTS (ORAL) DUR+** | |
| naratriptan | almotriptan |
| rizatriptan | eletriptan |
| sumatriptan | FROVA (frovatriptan) |
| zolmitriptan | frovatriptan |
| zolmitriptan ODT | IMITREX (sumatriptan) |
|  | MAXALT (rizatriptan) |
|  | MAXALT MLT (rizatriptan) |
|  | RELPAX (eletriptan) |
|  | REYVOW (lasmiditan) |
|  | sumatriptan/naproxen |
|  | ZOMIG (zolmitriptan) |
|  |  |
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| **ANTIMIGRAINE AGENTS, PROPHYLAXIS** | | |
| **INJECTABLES** | | **Preferred Injectables**   * History of 3 claims with the requested agent in the past 105 days **OR** * New starts require clinical review     **Non-preferred Injectables**   * Require clinical review     **AIMOVIG, AJOVY, and EMGALITY** [– **MANUAL PA**](https://medicaid.ms.gov/wp-content/uploads/2025/02/CGRP-02_28_2025-to-current.V12.pdf)    **VYEPTI** [– **MANUAL PA**](https://medicaid.ms.gov/wp-content/uploads/2021/02/Vyepti.pdf) |
| AIMOVIG Autoinjector (erenumab-aooe) DUR+ | EMGALITY Syringe (galcanezumab-gnlm) 300 mg/mL |
| AJOVY Autoinjector (fremanezumab-vfrm) DUR+ | VYEPTI (eptinezumab-jjmr) |
| AJOVY Syringe (fremanezumab-vfrm) DUR+ |  |
| EMGALITY Pen (galcanezumab-gnlm) DUR+ |  |
| EMGALITY Syringe (galcanezumab-gnlm) 120 mg/mL DUR+ |  |
| **ORAL** | |
|  | QULIPTA (atogepant) |
|  | NURTEC ODT (rimegepant) |
| **\*ANTINEOPLASTICS – SELECTED SYSTEMIC ENZYME INHIBITORS** | | |
| BOSULIF (bosutinib) tablet | AFINITOR (everolimus) | **FARYDAK** [– **MANUAL PA**](https://medicaid.ms.gov/wp-content/uploads/2019/01/Farydak.pdf)    **IBRANCE**   * Documented diagnosis of WD-DDLS for retroperitoneal sarcoma **OR** * All other indications require clinical review     See next page for additional PA Criteria/DUR+ Rules |
| CAPRESLA (vandetanib) | AFINITOR DISPERZ (everolimus) |
| COMETRIQ (cabozantinib) | AKEEGA (niraparib/abiraterone) |
| COTELLIC (cobimetinib) | ALECENSA (alectinib) |
| everolimus | ALUNBRIG (brigatinib) |
| GILOTRIF (afatinib) | AUGTYRO (repotrectinib) |
| ICLUSIG (ponatinib) | AYVAKIT (avapritinib) |
| imatinib | BALVERSA (erdafitinib) |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **\*ANTINEOPLASTICS – SELECTED SYSTEMIC ENZYME INHIBITORS** (*continued*) | | |
| IMBRUVICA (ibrutinib) | BOSULIF (bosutinib) capsule | See previous page for additional PA Criteria/DUR+ Rules    **LENVIMA**  Documented diagnosis of thyroid cancer, hepatocellular carcinoma, or renal cell carcinoma **AND**   * History of 1 claim for everolimus in the past 30 days **AND** * History of 1 anti-angiogenic agent in the past 2 years **OR** * All other indications require clinical review     **LYNPARZA Tablets**   * Documented diagnosis of ovarian cancer, fallopian tube or peritoneal cancer **AND** * History of platinum-based chemotherapy in the past 2 years **OR**   All other indications require clinical review [– **MANUAL PA**](https://medicaid.ms.gov/wp-content/uploads/2020/06/Lynparza-06-03-2020-to-current.V4.pdf) |
| INLYTA (axitinib) | BRAFTOVI (encorafenib) |
| IRESSA (gefitinib) | BRUKINSA (zanubrutinib) |
| JAKAFI (ruxolitinib) | CABOMETYX (cabozantinib) |
| MEKINIST (trametinib) | CALQUENCE (acalabrutinib) |
| NEXAVAR (sorafenib) | COPIKTRA (duvelisib) |
| ROZLYTREK (entrectinib) | DANZITEN (nilotinib) |
| SPRYCEL (dasatinib) | dasatinib |
| STIVARGA (regorafenib) | DATROWAY (datopotomab deruxtecan-dlnk)NR |
| SUTENT (sunitinib) | DAURISMO (glasdegib) |
| TAFINLAR (dabrafenib) | ERIVEDGE (vismodegib) |
| TARCEVA (erlotinib) | ERLEADA (apalutamide) |
| TASIGNA (nilotinib) | erlotinib |
| TURALIO (pexidartinib) | FOTIVDA (tivozanib) |
| TYKERB (lapatinib) | FRUZAQIA (fruquintinib) |
| VOTRIENT (pazopanib) | GAVRETO (pralsetinib) |
| XALKORI (crizotinib) | gefitinib |
| XTANDI (enzalutamide) | GLEEVEC (imatinib) |
| ZELBORAF (vemurafenib) | IBRANCE (palbociclib) |
| ZYDELIG (idelalisib) | IDHIFA (enasidenib) |
| ZYKADIA (ceritinib) | IMKELDI (imatinib) |
|  | INQOVI (decitabine/cedazuridine) |
|  | INREBIC (fedratinib) |
|  | ITOVEBI (inavolisib) |
|  | IWILFIN (eflornithine) |
|  | JAYPIRCA (pirtobrutinib) |
|  | KISQALI (ribociclib) |
|  | KISQALI-FEMARA CO-PACK  (ribociclib/letrozole) |
|  | KOSELUGO (selumetinib/vitamin E) |
|  | KRAZATI (adagrasib) |
|  | lapatinib |
|  | LAZCLUZE (lazertinib) |
|  | LENVIMA (lenvatinib) |
|  | LOBRENA (lorlatinib) |
|  | LUMAKRAS (sotorasib) |
|  | LYNPARZA (olaparib) |
|  | LYTGOBI (futibatinib) |
|  | MEKTOVI (binimetinib) |
|  | NERLYNX (neratinib) |
|  | NUBEQA (darolutamide) |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** | | |
| **\*ANTINEOPLASTICS – SELECTED SYSTEMIC ENZYME INHIBITORS** (*continued*) | | | | |
|  | ODOMZO (sonidegib) |  | See previous page for additional PA Criteria/DUR+ Rules |  |
|  | OGSIVEO (nirogacestat) |  |
|  | OJEMDA (tovorafenib) |
|  | OJJAARA (momelotinib) |
|  | ONUREG (azacitidine) |
|  | ORGOVYX (relugolix) |
|  | pazopanib |
|  | PEMAZYRE (pemigatinib) |
|  | PIQRAY (alpelisib) |
|  | QINLOCK (ripretinib) |
|  | RETEVMO (selpercatinib) |
|  | REVUFORJ (revumenib) |
|  | REZLIDHIA (olutasidenib) |
|  | RUBRACA (rucaparib) |
|  | RYDAPT (midostaurin) |
|  | SCEMBLIX (asciminib) |
|  | sorafenib |
|  | sunitinib |
|  | TABRECTA (capmatinib) |
|  | TAGRISSO (osimertinib) |
|  | TALZENNA (talazoparib) |
|  | TAZVERIK (tazemetostat) |
|  | TECENTRIQ HYBREZA (atezolizumab/hyaluronidase-tqjs) |
|  | TEPMETKO (tepotinib) |
|  | TIBSOVO (ivosidenib) |
|  | TORPENZ (everolimus) |
|  | TRUQAP (capivasertib) |
|  | TUKYSA (tucatinib) |
|  | VANFLYTA (quizartinib) |
|  | VERZENIO (abemaciclib) |
|  | VITRAKVI (larotrectinib) |
|  | VIZIMPRO (dacomitinib) |
|  | VONJO (pacritinib) |
|  | VORANIGO (vorasidenib) |
|  | WELIREG (belzutifan) |
|  | XOSPATA (gilteritinib) |
|  | XPOVIO (selinexor) |
|  | ZEJULA (niraparib) |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** | | |
| **ANTIOBESITY SELECT AGENTS** | | | | |
| SAXENDA (liraglutide) | orlistat | **All agents** [– **MANUAL PA** r](https://medicaid.ms.gov/wp-content/uploads/2025/02/Anti-obesity-Select-Agents-PA-Criteria-02_28_2025-to-Current.V6.pdf)equired    **Wegovy Initial Authorization**   * Age 18 years or older **AND** * Documented diagnosis of Body Mass Index (BMI) >/= 30 **AND** * History of </= 6 claims with Wegovy in the past 9 months **AND** * No history of a claim with Imcivree, Xenical, or any other GLP-1 agonist indicated for treatment of obesity or diabetes in the past 30 days **OR** * **Manual PA required when criteria is not met** * Initial authorization is defined as no more than 6 claims for Wegovy within 9 month period * Reauthorization and maintenance reauthorization require clinical review | | |
| WEGOVY (semaglutide) | XENICAL (orlistat) |
|  |  |
| **ANTIPARASITICS (TOPICAL) DUR+** | | | | |
| **PEDICULICIDES** | | **Minimum Age Limit**   * **2 months**: permethrin 1% (OTC), permethrin 5% * **6 months**: NATROBA, SKLICE * **2 years**:piperonyl/pyrethrins (OTC) * **4 years**: NATROBA * **6 years**: OVIDE * **18 years**: EURAX     **Non-Preferred Criteria**   * **Pediculicides** o Have tried 2 preferred topical lice agents in the past 90 days * **Scabicides** * Have tried permethrin 5% in the past 90 days | | |
| NATROBA (spinosad) | lindane |
| permethrin 1% cream OTC | malathion |
| VANALICE (piperonyl butoxide/pyrethrins) | OVIDE (malathion) |
|  | SKLICE (ivermectin) |
|  | spinosad |
| **SCABICIDES** | |
| ivermectin | CROTAN (crotamiton) |
| permethrin 5% cream | ELIMITE (permethrin) |
|  | EURAX (crotamiton) |
|  | STROMECTOL (ivermectin) |
| **ANTIPARKINSON’S AGENTS (INJECTABLE)** | | | | |
|  | VYALEV (foscarbidopa/foslevodopa) | **VYALEV**  • Requires clinical review | | |
| **ANTIPARKINSON’S AGENTS (ORAL) DUR+** | | | | |
| **ANTICHOLINERGICS** | | * 30 days of therapy with a selegiline agent in the past 45 days       **GOCOVRI**   * Documented diagnosis of Parkinson’s disease **AND** * 30 days of therapy with amantadine IR in the past 105 days **AND** * 30 days of therapy with a carbidopa/levodopa combination agent in the past 45 days | | |
| benztropine |  |
| trihexyphenidyl |  |
| **COMT INHIBITORS** | |
| entacapone | OGENTYS (opicapone) |
|  | TASMAR (tocapone) |
|  | tolcapone |
| ropinirole | pramipexole ER |
|  | ropinirole ER |  | See next page for additional PA Criteria/DUR+ Rules |  |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** | | |
| **ANTIPARKINSON’S AGENTS (ORAL) DUR+** *(continued)* | | | | |
| **MAO-B INHIBITORS** | | •   * 30     **NOURIANZ**  •  •   * 30 | See previous page for additional PA Criteria/DUR+ Rules |  |
| selegiline | AZILECT (rasagiline) | **LODOSYN and INBRIJA**  Documented diagnosis of Parkinson’s disease **AND** days of therapy with a carbidopa/levodopa combination agent in the past 45 days    Documented diagnosis of Parkinson’s Disease **AND**  Have tried 1 preferred carbidopa/levodopa combination agent in the past 30 days **AND** days of therapy with a preferred adjunctive therapy in the past 45 days |
|  | rasagiline |
|  | XADAGO (safinamide) |
|  | ZELAPAR (selegiline) |
| **OTHERS** | |
| amantadine | carbidopa/levodopa ODT |
| bromocriptine | carbidopa/levodopa/entacapone |
| carbidopa | CREXONT (carbidopa/levodopa) |
| carbidopa/levodopa tablet | DHIVY (carbidopa/levodopa) |
| carbidopa/levodopa ER | DUOPA (carbidopa/levodopa) |
|  | GOCOVRI (amantadine) |
|  | INBRIJA (levodopa) |
|  | LODOSYN (carbidopa) |
|  | NOURIANZ (istradefylline) |
|  | OSMOLEX ER (amantadine) |
|  | RYTARY (carbidopa/levodopa) |
|  | SINEMET (carbidopa/levodopa) |
|  | STALEVO (carbidopa/levodopa/entacapone) |
| **ANTIPSORIATICS (TOPICAL)** | | | | |
| calcipotriene cream | calcipotriene foam, ointment, solution |  | | |
| ENSTILAR (calcipotriene/betamethasone) | calcipotriene/betamethasone |
| TACLONEX (calcipotriene/betamethasone) | calcitriol ointment |
|  | DUOBRII (halobetasol/tazarotene) |
|  | SORILUX (calcipotriene) |
|  | tazarotene |
|  | VECTICAL (calcitriol) |
|  | VTAMA (tapinarof) |
|  | ZORYVE (roflumilast) |
| **ANTIPSYCHOTICS DUR+** | | | | |
| **INJECTABLE, ATYPICALS DUR+** | | **Concurrent Therapy Limit for Age < 18 years**   * 90 days with > 2 agents in the last 120 days will require [a **MANUAL PA**](https://medicaid.ms.gov/wp-content/uploads/2024/07/Multiple-Concurrent-Antipsychotics-for-Beneficiaries-Age-less-than-18-7_1_2024.V6.pdf)     **Minimum Age Limit**   * **3 years**: HALDOL     See next page for additional PA Criteria/DUR+ Rules | | |
| ABILIFY ASIMTUFII (aripiprazole) | ERZOFRI (paliperidone palmitate) |
| ABILIFY MAINTENA (aripiprazole) | GEODON (ziprasidone) |
| ARISTADA, ARISTADA INITIO (aripiprazole lauroxil) | olanzapine |
| **INJECTABLE, ATYPICALS DUR+** | |
| INVEGA HAFYERA (paliperidone) | risperidone ER |
| INVEGA SUSTENNA (paliperidone palmitate) | RYKINDO (risperidone) |
| INVEGA TRINZA (paliperidone) | ziprasidone |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** | | |
| **ANTIPSYCHOTICS DUR+** (*continued*) | | | | |
| PERSERIS (risperidone) | ZYPREXA (olanzapine) | * **5 years** * **6 years** * **10 years** * **12 years** * **13 years** * **18 years**   and    **Quantity Limit**   * **3**     **Non-**  •   * 30     •    •    •   * 4 • 1 * 1      * Require     **NUPLAZID**  •  **Quantity Limit**   * **3** | See previous page for additional PA Criteria/DUR+ Rules |  |
| RISPERIDAL CONSTA (risperidone) | ZYPREXA RELPREVV (olanzapine) | : RISPERDAL, thioridazine  : ABILIFY, trifluoperazine  : LATUDA, SAPHRIS, SEROQUEL, SYMBYAX  : INVEGA, molindone, perphenazine, pimozide, thiothixene  : REXULTI,ZYPREXA  : ABILIFY MYCITE, CAPLYTA, CLOZARIL, COBENFY, FANAPT, fluphenazine,  GEODON, loxapine, LYBALVI, NUPLAZID, perphenazine/amitriptyline, SECUADO, VRAYLAR,  all injectable agents    **syringes/year**: ARISTADA INITIO  **Preferred Criteria – Atypical Agents**  Have tried 2 preferred agents in the past 12 months **OR** days of therapy with the requested agent in the past 180 days  **ARISTADO INTIO, ARISTADO ER, INVEGA SUSTENNA, INVEGA TRINZA, PERSERID AND ZYPREXA RELPREEV** Documented diagnosis of schizophrenia or schizoaffective disorder  **ABILIFY MAINTENA, ABILIFY ASIMTUFII, or RISPERDAL CONSTA**  Documented diagnosis of schizophrenia, schizoaffective disorder or bipolar disorder  **INVEGA HAFYERA**  Documented diagnosis of schizophrenia or schizoaffective disorder **AND** claims for INVEGA SUSTENNA in the past year **OR** claim for INVEGA TRINZA in the past year **OR** claim for INVEGA HAFYERA in the past year  **ERZOFRI and risperidone ER** clinical review    Documented diagnosis of Parkinson’s Disease    **syringes/year**: ARISTADA INITIO  See next page for additional PA Criteria/DUR+ Rules |
| UZEDY (risperidone) |  |
| **ORAL** | |
| aripiprazole tablet | ABILIFY (aripiprazole) |
| asenapine | ABILIFY MYCITE (aripiprazole) |
| clozapine tablet | ADASUVE (loxapine) |
| fluphenazine | aripiprazole ODT, solution |
| haloperidol | CAPLYTA (lumateperone) |
| haloperidol lactate | chlorpromazine |
| olanzapine | clozapine ODT |
| perphenazine | CLOZARIL (clozapine) |
| perphenazine/amitriptyline | COBENFY (xanomeline/trospium) |
| quetiapine | FANAPT (iloperidone) |
| quetiapine ER | GEODON (ziprasidone) |
| risperidone | IGALMI (dexmedetomidine) |
| thioridazine | INVEGA (paliperidone) |
| trifluoperazine | LATUDA (lurasidone) |
| VRAYLAR (cariprazine) | lurasidone |
| ziprasidone | LYBALVI (olanzapine/samidorphan) |
|  | NUPLAZID (pimavanserin) |
|  | olanzapine/fluoxetine |
|  | OPIPZA (aripiprazole) |
|  | paliperidone ER |
|  | REXULTI (brexpiprazole) |
|  | RISPERDAL (risperidone) |
|  | SAPHRIS (asenapine) |
|  | SEROQUEL (quetiapine) |
|  | SEROQUEL XR (quetiapine ER) |
|  | SYMBYAX (olanzapine/fluoxetine) |
|  | VERSACLOZ (clozapine) |
|  | ZYPREXA, ZYPREXA ZYDIS (olanzapine) |
| **TRANSDERMAL, ATYPICALS** | |
|  | SECUADO (asenapine) |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** | | |
|  |  | **VRAYLAR**  •  • o o | See previous page for additional PA Criteria/DUR+ Rules |  |
| Documented diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder **OR**  Documented diagnosis major depressive disorder **AND**  30 days of therapy with an antidepressant in the past 45 days **OR**  1 claim for a 90-day supply of an antidepressant in the past 105 days |
| **ANTIRETROVIRALS DUR+** | | | | |
| **CAPSID INHIBITORS** | | **Non-Preferred Criteria**   * 1 claim with the requested agent in the past 105 days     **STRIBILD** [– **MANUAL PA**](https://medicaid.ms.gov/wp-content/uploads/2019/01/Stribild.pdf)    **SUNLENCA**   * Requires clinical review     **TYBOST** [– **MANUAL PA**](https://medicaid.ms.gov/wp-content/uploads/2019/01/Tybost.pdf) | | |
|  | SUNLENCA (lenacapavir) |
| **CD4 DIRECTED ATTACHMENT INHIBITORS** | |
|  | RUKOBIA (fostemsavir) |
| **CD4 DIRECTED HIV-1 INHIBITORS** | |
|  | TROGARZO (ibalizumab-uiyk) |
| **COMBINATION PRODUCTS – NRTIs** | |
| abacavir/lamivudine | COMBIVIR (lamivudine/zidovudine) |
| CABENUVA (cabotegravir/rilpivirine) | EPZICOM (abacavir/lamivudine) |
| DOVATO (dolutegravir/lamivudine) |  |
| lamivudine/zidovudine |  |
| **COMBINATION PRODUCTS – NUCLEOSIDE AND NUCLEOTIDE ANALOG**  **RTIs** | |
| DESCOVY (emtricitabine/tenofovir alafenamide) | TRUVADA (emtricitabine/tenofovir) |
| emtricitabine/tenofovir |  |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **ANTIRETROVIRALS DUR+** (*continued*) | | |
| **COMBINATION PRODUCTS – NUCLEOSIDE AND NUCLEOTIDE ANALOG**  **AND NON-NUCLEOSIDE RTIs** | | See previous page for additional PA Criteria/DUR+ Rules |
| DELSTRIGO (doravirine/lamiviudine/tenofovir) | ATRIPLA (efavirenz/emtricitabine/tenofovir) |
| efavirenz/emtricitabine/tenofovir | CIMDUO (lamivudine/tenofovir) |
| ODEFSEY (emtricitabine/rilpivirine/tenofovir) | COMPLERA (emtricitabine/rilpivirine/tenofovir) |
| **COMBINATION PRODUCTS – PROTEASE INHIBITORS** | |
| lopinavir/ritonavir | KALETRA (lopinavir/ritonavir) |
| **ENTRY INHIBITORS – CCR5 CO-RECEPTOR ANTAGONISTS** | |
|  | maraviroc |
|  | SELZENTRY (maraviroc) |
| **ENTRY INHIBITORS – FUSION INHIBITORS** | |
|  | FUZEON (enfuvirtide) |
| **INTEGRASE STRAND TRANSFER INHIBITORS** | |
| APRETUDE (cabotegravir) | cabotegravir ER |
| ISENTRESS (raltegravir) | ISENTRESS HD (raltegravir) |
| TIVICAY, TIVICAY PD (dolutegravir) | VOCABRIA (cabotegravir) |
| **NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBTORS (NNRTI)** | |
| EDURANT (rilpivirine) | etravirine |
| efavirenz | INTELENCE (etravirine) |
|  | nevirapine, nevirapine ER |
|  | PIFELTRO (doravirine) |
|  |  |
| **NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBTORS (NRTI)** | |
| abacavir | didanosine |
| EMTRIVA (emtricitabine) | emtricitabine |
| lamivudine | EPIVIR (lamivudine) |
| ZIAGEN (abacavir) | RETROVIR (zidovudine) |
| zidovudine | stavudine |
|  | VIREAD (tenofovir disoproxil fumarate) |
| **PHARMACOENHANCER – CYTOCHROME P450 INHIBITORS** | |
|  | TYBOST (cobicistat) |
| **PROTEASE INHIBITORS (NON-PEPTIDIC)** | |
| PREZISTA (darunavir) | APTIVUS (tipranavir) |
|  | darunavir |
|  | PREZCOBIX (darunavir/cobicistat) |
| **PROTEASE INHIBITORS (PEPTIDIC)** | |
| atazanavir | fosamprenavir |
| EVOTAZ (atazanavir/cobicistat) | LEXIVA (fosamprenavir) |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **ANTIRETROVIRALS DUR+** (*continued*) | | |
| ritonavir | NORIVIR (ritonavir) |  |
|  | REYATAZ (atazanavir) |
|  | VIRACEPT (nelfinavir) |
| **SINGLE PRODUCT REGIMENS** | |
| BIKTARVY (bictegravir/emtricitabine/tenofovir) | efavirenz/lamivudine/tenofovir |
| GENVOYA (elvitegravir/cobicistat/emtricitabine/ tenofovir alafenamide) | JULUCA (dolutegravir/rilpivirine) |
| SYMFI (efavirenz/lamivudine/tenofovir) | rilpivirine ER |
| SYMFI LO (efavirenz/lamivudine/tenofovir) | STRIBILD  (elvitegravir/cobicistat/emtricitabine/tenofovir disoproxil fumarate) |
| TRIUMEQ (abacavir/dolutegravir/lamivudine) | SYMTUZA  (darunavir/cobicistat/emtricitabine/tenofovir alafenamide) |
| TRIUMEQ PD  (abacavir/dolutegravir/lamivudine) |  |
| **ANTIVIRALS, ORAL** | | |
| **ANTI-CYTOMEGALOVIRUS AGENTS** | | **Valganciclovir solution**   * Automatic approval issued for 0-12 years of age     **PREVYMIS**   * Requires clinical review |
| valganciclovir tablet | LIVTENCITY (maribavir) |
|  | PREVYMIS (letermovir) |
|  | VALCYTE (valganciclovir) |
|  | valganciclovir solution |
| **ANTI-HERPETIC AGENTS** | |
| acyclovir | SITAVIG (acyclovir) |
| famciclovir | VALTREX (valacyclovir) |
| valacyclovir |  |
| **ANTI-INFLUENZA AGENTS** | |
| oseltamivir | FLUMADINE (rimantadine) |
|  | RAPIVAB (peramivir) |
|  | RELENZA (zanamivir) |
|  | rimantadine |
|  | TAMIFLU (oseltamivir) |
|  | XOFLUZA (baloxavir) |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **ANTIVIRALS, TOPICAL** | | |
| ZOVIRAX (acyclovir) cream | acyclovir |  |
|  | DENAVIR (penciclovir) |
|  | penciclovir |
|  | XERESE (acyclovir/hydrocortisone) |
|  | ZOVIRAX (acyclovir) ointment |
| **AROMATASE INHIBITORS** | | |
| anastrozole | ARIMIDEX (anastrazole) |  |
| exemestane | AROMASIN (exemestane) |
| letrozole | FEMARA (letrozole) |
| **ATOPIC DERMATITIS** | | |
| ADBRY (tralokinumab-ldrm) | CIBINQO (abrocitinib) | **Minimum Age Limit**   * **3 months**: EUCRISA * **2 years**: ELIDEL, tacrolimus 0.03% * **12 years**: OPZELURA * **16 years**: tacrolimus 0.1% |
| ADBRY Autoinjector (tralokinumab-ldrm) | EBGLYSS Pen (lebrikizumab-lbkz) |
| DUPIXENT (dupilumab) DUR+ | NEMLUVIO (nemolizumab-ilto) |
| ELIDEL (pimecrolimus) | OPZELURA (ruxolitinib) |
| EUCRISA (crisaborole) DUR+ | ZORYVE (roflumilast) 0.15% cream |
| pimecrolimus |  |
| tacrolimus |  |
| **ADBRY** [– **MANUAL PA**](https://medicaid.ms.gov/wp-content/uploads/2025/03/Adbry-Atopic-Dermatitis-04_1_2025-to-Current.V2.pdf)  **EBGLYSS**   * Requires clinical review   **CIBINQO**   * Requires clinical review **EUCRISA** * 30 days of therapy with a calcineurin inhibitor or topical steroid in the past 6 months   **DUPIXENT**   * 1 claim with DUPIXENT in the past 60 days **OR** **OPZELURA** * New starts require clinical review (see manual PA links below) • 30 days of therapy with ELIDEL, EUCRISA or tacrolimus in the past 6 months o **Asthma** [– **MANUAL PA**](https://medicaid.ms.gov/wp-content/uploads/2019/05/Dupixent-PA-Asthma.pdf) o **Atopic Dermatitis** [– **MANUAL PA**](https://medicaid.ms.gov/wp-content/uploads/2025/03/Dupixent-Atopic-Dermatitis-04_01_2025-to-Current.V9.pdf) * **COPD** [– **MANUAL PA**](https://medicaid.ms.gov/wp-content/uploads/2025/04/Dupixent-PA-Chronic-Obstructive-Pulmonary-Disease-04_28_2025-to-Current.V1.pdf) * **Eosinophilic Esophagitis** [– **MANUAL PA**](https://medicaid.ms.gov/wp-content/uploads/2024/03/Dupixent-Eosinophilic-Esophagitis-03_01_2024_V3.pdf) o **Nasal Polyposis** [– **MANUAL PA**](https://medicaid.ms.gov/wp-content/uploads/2019/09/Dupixent-PA-_Nasal-Polyposis.pdf) * **Prurigo Nodularis** [– **MANUAL PA**](https://medicaid.ms.gov/wp-content/uploads/2022/11/Dupixent-Prurigo-nodularis-11-7-22-V1.pdf) | | |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **BETA BLOCKERS, ANTIANGINALS & SINUS NODE AGENTS DUR+** | | |
| **ANTIANGINALS** | | **ASPRUZYO SPRINKLE**   * Requires clinical review     **Ranolazine ER**   * Documented diagnosis of angina **AND** * 1 claim for a calcium channel blocker, beta-blocker, nitrate, or combination agent in the past 30 days **OR** 90 days of therapy with the requested agent in the past 105 days     **Non-Preferred Criteria**   * Have tried 2 different preferred agents in the past 6 months **OR** * 90 days of therapy with the requested agent in the past 105 days     **COREG CR**   * Documented diagnosis of hypertension **AND** * Have tried generic carvedilol **AND** 1 preferred agent in the past 6 months **OR** * 90 days of therapy with the requested agent in the past 105 days       **HEMANGEOL**   * Documented diagnosis of infantile hemangioma                           **CORLANOR** [– **MANUAL PA**](https://medicaid.ms.gov/wp-content/uploads/2019/01/Corlanor.pdf) |
|  | ASPRUZYO SPRINKLE (ranolazine) |
|  | ranolazine ER |
| **BETA- AND ALPHA-BLOCKERS** | |
| carvedilol | carvedilol ER |
| labetalol | COREG (carvedilol) |
|  | COREG CR (carvedilol) |
| **BETA-BLOCKER/DIURETIC COMBINATIONS** | |
| atenolol/chlorthalidone | TENORETIC (atenolol/chlorthalidone) |
| bisoprolol/hydrochlorothiazide | ZIAC (bisoprolol/hydrochlorothiazide) |
| metoprolol/hydrochlorothiazide |  |
| propranolol/hydrochlorothiazide |  |
| **BETA-BLOCKERS** | |
| acebutolol | BETAPACE (sotalol) |
| atenolol | BETAPACE AF (sotalol) |
| bisoprolol | betaxolol |
| HEMANGEOL (propranolol) | BYSTOLIC (nebivolol) |
| metoprolol succinate | INDERAL LA (propranolol) |
| metoprolol tartrate | INDERAL XL (propranolol) |
| nadolol | INNOPRAN XL (propranolol) |
| nebivolol | KAPSPARGO SPRINKLE (metoprolol succinate) |
| pindolol | LOPRESSOR (metoprolol tartrate) |
| propranolol | SOTYLIZE (sotalol) |
| propranolol ER | TENORMIN (atenolol) |
| SORINE (sotalol) | TOPROL XL (metoprolol succinate) |
| sotalol |  |
| sotalol AF |  |
| timolol |  |
| **SINUS NODE AGENTS** | |
|  | CORLANOR (ivabradine) |
|  | ivabradine |
| **BILE SALTS** | | |
| ursodiol | BYLVAY (odevixibat) |  |
|  | CHENODAL (chenodiol) |
|  | IQIRVO (elafibranor) |
|  | LIVDELZI (seladelpar) |
|  | LIVMARLI (maralixibat) |
|  | OCALIVA (obeticholic acid) |
|  | RELTONE (ursodiol) |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **BILE SALTS** *(continued)* | | |
|  | URSO FORTE (ursodiol) |  |
| **BLADDER RELAXANT PREPARATIONS DUR+** | | |
| MYRBETRIQ (mirabegron) | darifenacin ER | **Non-Preferred Criteria**  • Have tried 2 different preferred agents in the past 6 months |
| oxybutynin | DETROL (tolterodine) |
| oxybutynin ER | DETROL LA (tolterodine) |
| solifenacin | fesoterodine |
|  | GEMTESA (vibegron) |
|  | mirabegron ER |
|  | tolterodine |
|  | tolterodine ER |
|  | TOVIAZ (fesoterodine) |
|  | trospium |
|  | trospium ER |
|  | VESICARE (solifenacin) |
|  | VESICARE LS (solifenacin) |
| **BONE RESORPTION SUPPRESSION AND RELATED AGENTS DUR+** | | |
| **BISPHOSPHONATES** | | **Non-Preferred Criteria**  • Documented diagnosis of osteoporosis or osteopenia **AND** • Have tried 2 different preferred agents in the past 6 months |
| alendronate tablet | ACTONEL (risedronate) |
| ibandronate tablet | alendronate solution |
| risedronate | ATELVIA (risedronate) |
|  | BINOSTO (alendronate) |
|  | FOSAMAX (alendronate) |
|  | FOSAMAX PLUS D (alendronate/vitamin D3) |
|  | ibandronate syringe/vial |
|  | risedronate DR |
| **OTHERS** | |
| FORTEO (teriparatide) | calcitonin salmon |
| raloxifene | EVENITY (romosozumab-aqqg) |
|  | EVISTA (raloxifene) |
|  | MIACALCIN (calcitonin salmon) |
|  | PROLIA (denosumab) |
|  | teriparatide |
|  | TYMLOS (abaloparatide) |
|  | XGEVA (denosumab) |
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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **BPH AGENTS DUR+** | | |
| **5-ALPHA-REDUCTASE INHIBITORS** | | **CARDURA, FLOMAX, PROSCAR, terazosin, or UROXATRAL** – **Female**   * Documented State-accepted diagnosis     **Non-Preferred Criteria** – **Male**   * Have tried 2 different preferred agents in the past 6 months **OR** * 90 days of therapy with the requested agent in the past 105 days     **ENTADFI**   * Requires clinical review |
| dutasteride | AVODART (dutasteride) |
| finasteride | ENTADFI (finasteride/tadalafil) |
|  | PROSCAR (finasteride) |
| **ALPHA BLOCKERS** | |
| alfuzosin ER | CARDURA (doxazosin) |
| doxazosin | CARDURA XL (doxazosin) |
| tamsulosin | dutasteride/tamsulosin |
| terazosin | FLOMAX (tamsulosin) |
|  | RAPAFLO (silodosin) |
|  | silodosin |
| **PHOSPHODIESTERASE TYPE 5 (PDE5) INHIBITORS** | |
|  | CIALIS (tadalafil) |
|  | tadalafil |
| **BRONCHODILATORS & COPD AGENTS** | | |
| **ANTICHOLINERGIC-BETA AGONIST COMBINATIONS** | | **Minimum Age Limit**   * **6 years**: SPIRIVA RESPIMAT     **SPIRIVA RESPIMAT**   * Automatic approval issued for diagnosis of asthma for > 6 years of age     **BREZTRI AEROSPHERE**   * 3 claims with BREZTRI AEROSPHERE in the past 105 days **OR** * New starts require clinical review **Non-Preferred Criteria** * 1 claim for a preferred agent in the past 6 months **OR** * 3 claims with the requested agent in the past 105 days     **Minimum Age Limit**   * **4 years**: SEREVENT, XOPENEX HFA * **6 years**: XOPENEX Solution * **18 years**: BROVANA, PERFOROMIST, STRIVERDI RESPIMAT     **Quantity Limit** (per 31 days)   * **10.7 units –** Breztri Aerosphere     **XOPENEX HFA and Solution**   * 1 claim for a preferred albuterol (inhaler or vials) in the past 30 days |
| ANORO ELLIPTA (umeclidinium/vilanterol) | BEVESPI AEROSPHERE (glycopyrrolate/formoterol) |
| COMBIVENT RESPIMAT  (ipratropium/albuterol) | DUAKLIR PRESSAIR (aclidinium/formoterol) |
| ipratropium/albuterol |  |
| STIOLTO RESPIMAT (tiotropium/olodaterol) |  |
| **ANTICHOLINERGIC-BATA AGONIST-GLUCOCORTICOIDS**  **COMBINATIONS** | |
|  | BREZTRI AEROSPHERE  (budesonide/glycopyrrolate/formoterol) DUR+ |
|  | TRELEGY ELLIPTA  (fluticasone/umeclidinium/vilanterol) |
| **ANTICHOLINERGICS AND COPD AGENTS** | |
| ATROVENT HFA (ipratropium) | DALIRESP (roflumilast) |
| INCRUSE ELLIPTA (umeclidinium) | OHTUVAYRE (ensifentrine) |
| ipratropium | roflumilast |
| SPIRIVA HANDIHALER (tiotropium) | SPIRIVA RESPIMAT (tiotropium) DUR+ |
|  | tiotropium |
|  | TUDORZA PRESSAIR (aclidinium) |
|  | YUPERI (revefenacin) |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **BRONCHODILATORS & COPD AGENTS** *(continued)* | | |
| **INHALATION SOLUTION DUR+** | | See previous page for additional PA Criteria/DUR+ Rules |
| albuterol | arformoterol |
|  | BROVANA (arformoterol) |
|  | formoterol, formoterol fumarate |
|  | levalbuterol |
|  | PERFOROMIST (formoterol) |
| **INHALERS, LONG ACTING DUR+** | |
| SEREVENT DISKUS (salmeterol) |  |
| STRIVERDI RESPIMAT (olodaterol) |  |
| **INHALERS, SHORT ACTING** | |
| albuterol HFA | levalbuterol HFA |
| VENTOLIN HFA (albuterol) | PROAIR DIGIHALER (albuterol) |
|  | XOPENEX HFA (levalbuterol) |
| **ORAL** | |
| albuterol IR | albuterol ER |
| terbutaline |  |
| **CALCIUM CHANNEL BLOCKERS DUR+** | | |
| **LONG-ACTING** | | **Quantity Limit** (per 21 days)   * **252 capsules**: nimodipine * **2520 mL**: nimodipine     **Non-Preferred Criteria – Long Acting**   * Have tried 2 different preferred Long Acting CCB agents in the past 6 months **OR** * 90 days of therapy with the requested agent in the past 105 days     **Non-Preferred Criteria – Short Acting**   * Have tried 2 different preferred Short Acting CCB agents in the past 6 months **OR** * 90 days of therapy with the requested agent in the past 105 days     **Nimodipine**   * Documented diagnosis of subarachnoid hemorrhage in the past 45 days **AND** * Duration of therapy limited to 21 days |
| amlodipine | CARDIZEM CD (diltiazem) |
| CARTIA XT (diltiazem) | CARDIZEM LA (diltiazem) |
| diltiazem ER 24 HR | diltiazem ER 12 HR |
| diltiazem CD 24 HR | diltiazem LA 24 HR |
| diltiazem XR 24 HR | KATERZIA (amlodipine) |
| DILT-XR 24 HR (diltiazem) | levamlodipine |
| felodipine | MATZIM LA (diltiazem) |
| nifedipine ER | nisoldipine |
| TAZTIA XT (diltiazem) | NORVASC (amlodipine) |
| verapamil ER | PROCARDIA XL (nifedipine) |
| **LONG-ACTING** | |
| verapamil SR | SULAR (nisoldipine) |
|  | TIADYLT ER (diltiazem) |
|  | TIAZAC (diltiazem) |
|  | verapamil PM |
|  | VERELAN PM (verapamil) |
| **SHORT-ACTING** | |
| diltiazem | CARDIZEM (diltiazem) |
| nicardipine | isradipine |
| nifedipine | nimodipine capsule and solution |
| verapamil | NORLIQVA (amlodipine) |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **CALCIUM CHANNEL BLOCKERS DUR+** *(continued)* | | |
|  | NYMALIZE (nimodipine) |  |
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| **CALORIC AGENTS** | | |
| BOOST | **Non-Preferred Agents** [– **MANUAL PA**](https://medicaid.ms.gov/wp-content/uploads/2024/07/Enteral-Nutrition-PACKET-Effective-7_1_2024.V6.pdf)          All non-preferred caloric/nutritional agents  (which are all other products except those specifically listed as preferred) require a manual prior authorization. | |
| BREAKFAST ESSENTIALS |
| BRIGHT BEGINNINGS |
| DUOCAL |
| ENSURE |
| NUTREN |
| OSMOLITE |
| PEDIASURE |
| PROMOD |
| RESOURCE |
| TWOCAL HN |
|  |
| **CEPHALOSPORINS AND RELATED ANTIBIOTICS (ORAL)** | | |
| **BETA LACTAM/BETA-LACTAMASE INHIBITOR COMBINATIONS** | | **Non-Preferred Criteria** – **All Cephalosporin Generations**   * Have tried 2 different preferred agents in the past 6 months     **Maximum Age Limit**   * **18 years**: cefdinir suspension |
| amoxicillin/clavulanate | amoxicillin/clavulanate ER |
|  | AUGMENTIN (amoxicillin/clavulanate) |
| **CEPHALOSPORINS – FIRST GENERATION** | |
| cefadroxil | cephalexin tablet |
| cephalexin capsule, suspension |  |
| **CEPHALOSPORINS – SECOND GENERATION** | |
| cefaclor capsule | cefaclor ER |
| cefprozil | cefaclor suspension |
| cefuroxime |  |
| **CEPHALOSPORINS – THIRD GENERATION** | |
| cefdinir | cefixime suspension |
| cefixime capsule | SUPRAX (cefixime) |
| cefpodoxime |  |
| **COLONY STIMULATING FACTORS** | | |
| FULPHILA (pegfilgrastim-jmdb) | FYLNETRA (pegfilgrastim-pbbk) |  |
| NEUPOGEN (filgrastim) | GRANIX (tbo-filgrastim) |
|  | LEUKINE (sargramostim) |
|  | NEULASTA, NEULASTA ONPRO (pegfilgrastim) |
|  | NIVESTYM (filgrastim-aafi) |
|  | NYVEPRIA (pegfilgrastim-apgf) |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | | | | **PA CRITERIA** |
| **COLONY STIMULATING FACTORS** *(continued)* | | | | | |
|  | RELEUKO (filgrastim-ayow) | | | |  |
|  | ROLVEDON (eflapegrastim-xnst) | | | |
|  | STIMUFEND (pegfilgrastim-fpgk) | | | |
|  | UDENYCA, UDENYCA ONBODY  (pegfilgrastim-cbqv) | | | |
|  | ZARXIO (filgrastim-sndz) | | | |
|  | ZIEXTENZO (pegfilgrastim-bmez) | | | |
| **CYSTIC FIBROSIS AGENTS DUR+** | | | | | |
| PULMOZYME (dornase alfa) |  | ALYFTREK |  | | **Minimum Age Limit**   * **1 month**: KALYDECO granules * **3 months**: PULMOZYME * **1 year**: ORKAMBI * **2 years**: COLY-MYCIN M, TRIKAFTA granules * **6 years**: ALYFTREK, BETHKIS, KALYDECO tablet, KITABIS, SYMDEKO, TOBI, TOBI PODHALER, TRIKAFTA tablet * **7 years**: CAYSTON * **18 years**: BRONCHITOL     **Maximum Age Limit**   * **2 years**: ORKAMBI 75-94 mg granules * **5 years**: KALYDECO, ORKAMBI 100-125 mg granules, ORKAMBI 200-125 mg granules, TRIKAFTA granules * **11 years**: TRIKAFTA 50-25-37.5 mg tablets     **Preferred Agents**   * Documented diagnosis of Cystic Fibrosis **OR** * Require clinical review     **ALYFTREK** [**– MANUAL PA**](https://medicaid.ms.gov/wp-content/uploads/2025/05/Alyftrek-PA-Criteria-05-26-2025-to-Current.V2.pdf)    **KALYDECO** [– **MANUAL PA**](https://medicaid.ms.gov/wp-content/uploads/2023/04/Kalydeco.pdf)    **ORKAMBI** [– **MANUAL PA**](https://medicaid.ms.gov/wp-content/uploads/2019/01/Orkambi.pdf)    **SYMDEKO** [– **MANUAL PA**](https://medicaid.ms.gov/wp-content/uploads/2019/01/Symdeko.pdf)    **TOBI PODHALER** – Require clinical review    **TRIKAFTA** [– **MANUAL PA**](https://medicaid.ms.gov/wp-content/uploads/2024/12/Trikafta-1-1-2025-to-current.V4.pdf) |
| (vanzacaftor/tezacaftor/deutivacaftor) | |  |
| tobramycin (generic TOBI) | BETHKIS (tobramycin) | | | |
|  | BRONCHITOL (mannitol) | | | |
|  | CAYSTON (aztreonam) | | | |
|  | colistimethate | | | |
|  | COLY-MYCIN M (colistin) | | | |
|  | KALYDECO (ivacaftor) | | | |
|  | KITABIS (tobramycin) | | | |
|  | ORKAMBI (lumacaftor/ivacaftor) | | | |
|  | SYMDEKO (tezacaftor/ivacaftor) | | | |
|  | TOBI (tobramycin) | | | |
|  | TOBI PODHALER (tobramycin) | | | |
|  | tobramycin (generic BETHKIS & KITABIS) | | | |
|  | TRIKAFTA (elexacaftor/tezacaftor/ivacaftor) | | | |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | | | | | **PA CRITERIA** |
| **CYTOKINE & CAM ANTAGONISTS DUR+** | | | | | | |
| ACTEMRA (tocilizumab) syringe, vial | ABRILADA (adalimumab-afzb) | | | | | **Preferred Agents** [– **Criteria details found here**](https://medicaid.ms.gov/wp-content/uploads/2024/12/DUR-Preferred-Cytokine-and-CAM-Antagonists-Criteria.pdf)    **Non-Preferred Agents**  • Require clinical review    **IV Administered Agents**  • Require clinical review |
| AVSOLA (infliximab-axxq) | ACTEMRA ACTPEN (tocilizumab) | | | | |
| ENBREL (etanercept) |  | IDACIO (adalimumab-aacf) |  | | |
| HUMIRA (adalimumab) | adalimumab-aaty | | | | |
| KINERET (anakinra) | adalimumab-adaz | | | | |
| methotrexate | adalimumab-adbm | | | | |
| OLUMIANT (baricitinib) | adalimumab-fkjp | | | | |
| OTEZLA (apremilast) | adalimumab-ryvk | | | | |
| RINVOQ (upadacitinib) | AMJEVITA (adalimumab-atto) | | | | |
| RINVOQ LQ (upadacitinib) | ARCALYST (rilonacept) | | | | |
| SIMPONI (golimumab) | BIMZELX (bimekizumab-bkzx) | | | | |
| TALTZ (ixekizumab) | CIMZIA (certolizumab) | | | | |
| TYENNE Syringe, Vial (tocilizumab-aazg) | COSENTYX (secukinumab) | | | | |
| XELJANZ (tofacitinib) tablet | CYLTEZO (adalimumab-adbm) | | | | |
|  | ENTYVIO (vedolizumab) | | | | |
|  | HADLIMA (adalimumab-bwwd) | | | | |
|  | HULIO (adalimumab-fkjp) | | | | |
|  | HYRIMOZ (adalimumab-adaz) | | | | |
|  | IDACIO (adalimumab-aacf) | | | | |
|  | ILARIS (canakinumab) | | | | |
|  | ILUMYA (tildrakizumab-asmn) | | | | |
|  | INFLECTRA (infliximab-dyyb) | | | | |
|  | infliximab | | | | |
|  | JYLAMVO (methotrexate) | | | | |
|  | KEVZARA (sarilumab) | | | | |
|  | LITFULO (ritlecitinib) | | | | |
|  | OMVOH (mirikizumab-mrkz) | | | | |
|  | ORENCIA (abatacept) | | | | |
|  | OTREXUP (methotrexate) | | | | |
|  |  | OTULFI (ustekinumab-aauz) | |  | |
|  |  | PYZCHIVA (ustekinumab-ttwe | | | ) |
|  | RASUVO (methotrexate) | | | | |
|  | REMICADE (infliximab) | | | | |
|  | RENFLEXIS (infliximab-abda) | | | | |
|  | SILIQ (brodalumab) | | | | |
|  | SIMLANDI (adalimumab-ryvk) | | | | |
|  | SIMPONI ARIA (golimumab) | | | | |
|  | SKYRIZI (risankizumab-rzaa) | | | | |
|  | SOTYKTU (deucravacitinib) | | | | |
|  | SPEVIGO (spesolimab-sbzo) | | | | |
|  | STELARA (ustekinumab) | | | | |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | | | **PA CRITERIA** | | |
| **CYTOKINE & CAM ANTAGONISTS DUR+** *(continued)* | | | | | | |
|  | TOFIDENCE (tocilizumab-bavi) | | |  | See previous page for additional PA Criteria/DUR+ Rules |  |
|  | TREMFYA (guselkumab) | | |  |
|  | TREXALL (methotrexate) | | |
|  | TYENNE Autoinjector (tocilizumab-aazg) | | |
|  | XATMEP (methotrexate) | | |
|  | XELJANZ (tofacitinib) solution | | |
|  | XELJANZ XR (tofacitinib) | | |
|  |  | YESINTEK (ustekinumab-kfce) |  |
|  | YUFLYMA (adalimumab-aaty) | | |
|  | YUSIMRY (adalimumab-aqvh) | | |
|  | ZYMFENTRA (infliximab-dyyb) | | |
| **ERYTHROPOIESIS STIMULATING PROTEINS DUR+** | | | | | | |
| EPOGEN (epoetin alfa) | ARANESP (darbepoetin alfa) | | | **Non-Preferred Criteria**   * Documented diagnosis of cancer or chronic renal failure **OR** * Antineoplastic therapy in the past 6 months **AND** * Have tried a preferred RETACRIT or EPOGEN in the past 6 months **OR** * 1 claim for the requested agent in the past 105 days   **JESDUVROQ**   * Requires clinical review     **MIRCERA**   * Documented diagnosis of chronic renal failure in the past 2 years | | |
| MIRCERA (methoxy polyethylene glycol-epoetinbeta) | JESDUVROQ (daprodustat) | | |
| RETACRIT (epoetin alfa-epbx) | PROCRIT (epoetin alfa) | | |
|  | VAFSEO (vadadustat) | | |
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| **FACTOR DEFICIENCY PRODUCTS DUR+** | | | | | | |
| **FACTOR VIII** | | | | **HEMLIBRA**   * 3 claims with HEMLIBRA in the past 105 days **OR** * New starts require clinical review [– **MANUAL PA**](https://medicaid.ms.gov/wp-content/uploads/2019/12/Hemlibra.pdf) | | |
| ADVATE | ADYNOVATE | | |
| AFSTYLA | ELOCTATE | | |
| ALPHANATE | ESPEROCT | | |
| ALTUVIIIO | JIVI | | |
| FEIBA | KCENTRA | | |
| HEMOFIL M | OBIZUR | | |
| HUMATE-P | VONVENDI | | |
| KOATE |  | | |
| KOGENATE FS |  | | |
| **FACTOR VIII** | | | |
| KOVALTRY |  | | |
| NOVOEIGHT |  | | |
| NUWIQ |  | | |
| RECOMBINATE |  | | |
| WILATE |  | | |
| XYNTHA, XYNTHA SOLOFUSE |  | | |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | | | | | **PA CRITERIA** |
| **FACTOR DEFICIENCY PRODUCTS DUR+** *(continued)* | | | | | | |
| **FACTOR IX** | | | | | |  |
| ALPHANINE SD | BEQVEZ | | | | |
| ALPROLIX | REBINYN | | | | |
| BENEFIX |  | | | | |
| IDELVION |  | | | | |
| IXINITY |  | | | | |
| PROFILNINE |  | | | | |
| RIXUBIS |  | | | | |
| **OTHER HEMOPHILIA PRODUCTS** | | | | | |
| COAGADEX (factor X) |  | ALHEMO (concizumab-mtci) | | |  |
| FIBRYGA (fibrinogen) |  | CORIFACT (factor XIII) |  | | |
| HEMLIBRA (emicizumab-kxwh) DUR+ | HYMPAVZI (marstacimab-hncq) | | | | |
| RIASTAP (fibrinogen) | NOVOSEVEN RT (factor VII) | | | | |
|  | SEVENFACT (factor VII) | | | | |
|  | TRETTEN (factor XIII) | | | | |
| **FIBROMYALGIA/NEUROPATHIC PAIN AGENTS** | | | | | | |
| duloxetine (generic CYMBALTA) | CYMBALTA (duloxetine) | | | | |  |
| gabapentin | DIRZALMA SPRINKLE (duloxetine) | | | | |
| pregabalin | duloxetine 40 mg DR capsules (generic IRENKA) | | | | |
| SAVELLA (milnacipran) | gabapentin ER | | | | |
|  |  | GABARONE (gabapentin) | |  | |
|  | GRALISE (gabapentin) | | | | |
|  | HORIZANT (gabapentin enacarbil) | | | | |
|  | LYRICA, LYRICA CR (pregabalin) | | | | |
|  | NEURONTIN (gabapentin) | | | | |
|  | pregabalin ER | | | | |
| **FLUOROQUINOLONES DUR+** | | | | | | |
| ciprofloxacin tablet | BAXDELA (delafloxacin) | | | | | **Non-Preferred Criteria**   * 1 claim for a preferred agent in the past 30 days     **CIPRO Suspension Criteria for Age < 12 Years**   * Anthrax infection or exposure, cystic fibrosis, pneumonic plague, or tularemia **AND** * History of doxycycline in the past 3 months **OR** * 7 days of therapy with a preferred agent from 2 of the classes below in the past 3 months:   + Penicillin   + 2nd or 3rd generation cephalosporin o Macrolide     **LEVAQUIN Solution Criteria for Age < 12 Years**   * Anthrax infection or exposure **AND** * CIPRO suspension in the past 3 months **OR**     See next page for additional PA Criteria/DUR+ Rules |
| levofloxacin tablet | CIPRO (ciprofloxacin) | | | | |
|  | ciprofloxacin suspension | | | | |
|  | levofloxacin solution | | | | |
|  | moxifloxacin | | | | |
|  | ofloxacin | | | | |
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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** | | |
| **FLUOROQUINOLONES DUR+** *(continued)* | | | | |
|  |  |  | See previous page for additional PA Criteria/DUR+ Rules | : |
|  |  | • 7 days of therapy with a preferred agent from 2 of the classes below in the past 3 months o Penicillin  o 2nd or 3rd generation cephalosporin o Macrolide |
|  |  |
| **GAUCHER’S DISEASE** | | | | |
| ELELYSO (taliglucerase alfa) | CERDELGA (eliglustat) |  | | |
| ZAVESCA (miglustat) | CEREZYME (imiglucerase) |
|  | miglustat |
|  | VPRIV (velaglucerase alfa) |
|  | YARGESA (miglustat) |
| **GENITAL WARTS & ACTINIC KERATOSIS AGENTS** | | | | |
| CONDYLOX (podofilox) | CARAC (fluorouracil) | **Minimum Age Limit**   * **12 years**: ALDARA, ZYCLARA * **18 years**: CONDYLOX, PICATO, VEREGEN | | |
| fluorouracil | EFUDEX (fluorouracil) |
| imiquimod | VEREGEN (sinecatechins) |
| podofilox | ZYCLARA (imiquimod) |
| **GI ULCER THERAPIES** | | | | |
| **H2 RECEPTOR ANTAGONISTS** | | **Prilosec suspension**  • Automatic approval issued for 0-2 years of age | | |
| famotidine | cimetidine |
|  | nizatidine |
|  | PEPCID (famotidine) |
| **OTHERS** | |
| CARAFATE (sucralfate) suspension | CARAFATE (sucralfate) tablet |
| misoprostol | CYTOTEC (misoprostol) |
| sucralfate | DARTISLA (glycopyrrolate) |
|  | VOQUEZNA (vonoprazan) |
| **PROTON PUMP INHIBITORS** | |
| esomeprazole capsule | DEXILANT (dexlansoprazole) |
| NEXIUM (esomeprazole) packet | dexlansoprazole |
| omeprazole | esomeprazole packet |
| pantoprazole | KONVOMEP (omeprazole/sodium bicarbonate) |
|  | lansoprazole Rx |
|  | NEXIUM (esomeprazole) capsule |
|  | omeprazole/sodium bicarbonate |
|  | PREVACID (lansoprazole) |
|  | PRILOSEC (omeprazole) packet |
|  | PROTONIX (pantoprazole) |
|  | rabeprazole |
|  | ZEGERID (omeprazole/sodium bicarbonate) |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **GLUCOCORTICOIDS (INHALED)** | | |
| **GLUCOCORTICOIDS** | | **Non-Preferred Criteria**   * **Glucocorticoids** o 2 preferred single-entity agents in the past 6 months **OR** o 90 days of therapy with the requested agent in the past 105 days * **Glucocorticoid/Bronchodilator Combinations** o 2 preferred combination agents in the past 6 months **OR** o 90 days of therapy with the requested agent in the past 105 days * **Note**:   o Institutional-sized products are non-preferred    **AIRDUO DIGIHALER**   * Requires clinical review     **ARMONAIR DIGIHALER**   * Requires clinical review     **PROAIR DIGIHALER** – Require clinical review    **Minimum Age Limit**   * **18 years**: AIRSUPRA     **Quantity Limit** (per 31 days)   * **2 inhalers**: AIRSUPRA -- [**MANUAL P**](https://medicaid.ms.gov/wp-content/uploads/2025/02/Airsupra-PA-Criteria-02-28-2025-to-Current.V1.pdf)**A** |
| ASMANEX (mometasone) | ALVESCO (ciclesonide) |
| budesonide 0.25 mg and 0.5 mg | ARMONAIR DIGIHALER (fluticasone) |
| fluticasone diskus | ARNUITY ELLIPTA (fluticasone) |
| fluticasone HFA | ASMANEX HFA (mometasone) |
| PULMICORT FLEXHALER (budesonide) | budesonide 1 mg |
| QVAR REDIHALER (beclomethasone) | FLOVENT HFA (fluticasone) |
|  | FLOVENT DISKUS (fluticasone) |
|  | PULMICORT (budesonide) nebulizer solution |
| **GLUCOCORTICOID/BRONCHODILATOR COMBINATIONS** | |
| ADVAIR DISKUS (fluticasone/salmeterol) | AIRDUO DIGIHALER (fluticasone/salmeterol) |
| ADVAIR HFA (fluticasone/salmeterol) | AIRSUPRA (albuterol/budesonide) |
| DULERA (mometasone/formoterol) | BREO ELLIPTA (fluticasone/vilanterol) |
| fluticasone/salmeterol diskus | BREYNA (budesonide/formoterol) |
| fluticasone/salmeterol HFA | budesonide/formoterol |
| SYMBICORT (budesonide/formoterol) | fluticasone/vilanterol |
|  | WIXELA INHUB (fluticasone/salmeterol) |
| **GROWTH HORMONES DUR+** | | |
| GENOTROPIN (somatropin) | HUMATROPE (somatropin) | **All Agents**   * **Age > 18 years** o Documented diagnosis of craniopharyngioma, panhypopituitarism, Prader-Willi Syndrome,   Turner Syndrome or an approvable adult diagnosis **OR** o Documented procedure of cranial irradiation     * **Age < 18 years** o Documented diagnosis of idiopathic short stature **AND** o Documented approvable pediatric diagnosis **OR** o Documented approvable pediatric diagnosis     **Minimum Age Limit**   * **3 years**: NGENLA     **Maximum Age Limit**   * **18 years**: NGENLA and SKYTROFA     See next page for additional PA Criteria/DUR+ Rules |
| NORDITROPIN FLEXPRO (somatropin) | NGENLA (somatrogon-ghla) |
| SKYTROFA (lonapegsomatropin-tcgd) | OMNITROPE (somatropin) |
|  | SEROSTIM (somatropin) |
|  | SOGROYA (somapacitan-beco) |
|  | VOXZOGO (vosoritide) |
|  | ZOMACTON (somatropin) |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** | | |
|  |  |  | See previous page for additional PA Criteria/DUR+ Rules |  |
| **Non-Preferred Criteria**   * Documented approvable diagnosis for age as above **AND** * Have tried 1 preferred agent in the past 6 months **OR** * 84 days of therapy with the requested agent in the past 105 days   **SKYTROFA**   * < 18 years **AND** * No history of diagnosis of Prader-Willi Syndrome **AND**   28 days of therapy with a preferred short-acting growth hormone in the past 105 days |
|  | **H. PYLORI COMBINATION TREATMENTS** | | | |
| PYLERA (bismuth subcitrate potassium/metronidazole/ tetracycline) | bismuth subcitrate  potassium/metronidazole/tetracycline | **Quantity Limit**  • **1 treatment course/year**: all agents | | |
| lansoprazole/amoxicillin/clarithromycin |
|  | OMECLAMOX  (omeprazole/clarithromycin/amoxicillin) |
|  | TALICIA (omeprazole/amoxicillin/rifabutin) |
|  | VOQUEZNA DUAL PAK  (vonoprazan/amoxicillin) |
|  | VOQUEZNA TRIPLE PAK  (vonoprazan/amoxicillin/clarithromycin) |
|  |
|  | **HEPATITIS B TREATMENTS** | | | |
| entecavir | adefovir dipivoxil |  | | |
| lamivudine HBV | BARACLUDE (entecavir) |
| tenofovir disoproxil fumarate | VEMLIDY (tenofovir alafenamide) |
|  | VIREAD (tenofovir disoproxil fumarate) |
|  | **HEPATITIS C TREATMENTS** | | | |
| MAVYRET (glecaprevir/pibrentasvir) ∞ | EPCLUSA (sofosbuvir/velpatasvir) ∞ | **∞ EPCLUSA, HARVONI, MAVYRET, SOVALDI, VOSEVI, ZEPATIER**   * Requir[e **MANUAL PA**](https://medicaid.ms.gov/wp-content/uploads/2024/07/Hep-C-PACKET-Effective-7_1_2024.V15.pdf)     Note:   * **EPCLUSA, HARVONI, MAVYRET and SOVALDI have FDA-approved pediatric indications** | | |
| PEGASYS (peginterferon alfa-2a) | HARVONI (ledipasvir/sofosbuvir) ∞ |
| ribavirin tablet | ledipasvir/sofosbuvir ∞ |
| sofosbuvir/velpatasvir | ribavirin capsule |
|  | SOVALDI (sofosbuvir) ∞ |
|  | VIEKIRA PAK (ombitasvir/paritaprevir/ritonavir) |
|  | VOSEVI (sofosbuvir/velpatasvir/voxilaprevir) ∞ |
|  | ZEPATIER (elbasvir/grazoprevir) ∞ |
|  | **HEREDITARY ANGIOEDEMA** | | | |
| BERINERT (C1 esterase inhibitor) | CINRYZE (C1 esterase inhibitor) |  | | |
| icatibant | FIRAZYR (icatibant) |
|  | KALBITOR (ecallantide) |
|  | ORLADEYO (berotralstat) |
|  | RUCONEST (C1 esterase inhibitor) |
|  | SAJAZIR (icatibant) |
|  | TAKHZYRO (lanadelumab-flyo) |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
|  | **HYPERURICEMIA & GOUT DUR+** | |
| allopurinol | ALOPRIM (allopurinol) | **Non-Preferred Criteria**  • Have tried 2 different preferred agents in the past 6 months |
| colchicine tablet | colchicine capsule |
| probenecid | COLCRYS (colchicine) |
| probenecid/colchicine | febuxostat |
|  | GLOPERBA (colchicine) |
|  | MITIGARE (colchicine) |
|  | ULORIC (febuxostat) |
|  | ZYLOPRIM (allopurinol) |
|  | **HYPOGLYCEMIA TREATMENT** | |
| BAQSIMI (glucagon) | GVOKE (glucagon) Step Edit | **Minimum Age Limit**   * **1 year**: BAQSIMI * **2 years**: GVOKE * **6 years**: ZEGALOGUE     **Quantity Limit** (per 31 days)   * **2 packs (or kits)**: BAQSIMI, glucagon, GVOKE, ZEGALOGUE     **Non-Preferred Criteria** – **GVOKE**   * 1 claim with preferred BAQSIMI or ZEGALOGUE in the past 30 days |
| GLUCAGEN (glucagon) |  |
| glucagon emergency kit |  |
| glucagon vial |  |
| ZEGALOGUE (dasiglucagon) |  |
|  | **HYPOGLYCEMICS, BIGUANIDES** | |
| metformin | GLUMETZA (metformin) | **Non-Preferred Criteria**   * Have tried 2 different preferred DPP4 agents in the past 6 months **OR** * 90 days of therapy with the requested agent in the past 105 days Note:   Concomitant use of a GLP-1 agent and a DPP-4 agent requires clinical review |
| metformin ER (generic GLUCOPHAGE XR) | metformin ER (generic FORTAMET) |
|  | metformin ER (generic GLUMETZA) |
|  | metformin solution |
|  | RIOMET (metformin) |
| JANUMET (sitagliptin/metformin) | alogliptin |
| JANUMET XR (sitagliptin/metformin) | alogliptin/metformin |
| JANUVIA (sitagliptin) | JENTADUETO XR (linagliptin/metformin) |
| JENTADUETO (linagliptin/metformin) | KAZANO (alogliptin/metformin) |
| TRADJENTA (linagliptin) | KOMBIGLYZE XR (saxagliptin/metformin) |
|  | NESINA (alogliptin) |
|  | ONGLYZA (saxagliptin) |
|  | OSENI (alogliptin/pioglitazone) |
|  | saxagliptin |
|  | saxagliptin/metformin ER |
|  | sitagliptin |
|  | sitagliptin/metformin |
|  | ZITUVIMET (sitagliptin/metformin) |
|  | ZITUVIMET XR (sitagliptin/metformin) |
|  | ZITUVIO (sitagliptin) |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS DUR+** | | |
| BYETTA (exenatide) | BYDUREON (exenatide) | **Minimum Age Limit**   * **10 years**: BYDUREON BCISE, TRULICITY, VICTOZA * **18 years**: BYETTA, MOUNJARO, OZEMPIC, RYBELSUS     **Preferred Criteria**  Documented diagnosis of Type 2 Diabetes **and** no history of SAXENDA or WEGOVY in the past 30 days **OR** No documented diagnosis for Type 2 Diabetes **and** 84 days of therapy with the requested agent in the past 105 days    **Non-Preferred Criteria**   * Documented diagnosis of Type 2 Diabetes **AND** * No history of SAXENDA or WEGOVY in the past 30 days **AND** * 84 days of therapy with TRULICITY in the past 6 months **AND** * 84 days of therapy with either preferred BYETTA or VICTOZA in the past 6 months * **OR** * Documented diagnosis of Type 2 Diabetes **AND** * 84 days of therapy with the request agent in the past 105 days Note: * Concomitant use of a GLP-1 agonist and a DPP-4 agent requires clinical review. • Please see the PDL category Anti-obesity Select Agents for a list of covered agents.     **RYBELSUS 1.5 mg and 3 mg**  Require clinical review |
| TRULICITY (dulaglutide) | exenatide |
| VICTOZA (liraglutide) | liraglutide |
|  | MOUNJARO (tirzepatide) |
|  | OZEMPIC (semaglutide) |
|  | RYBELSUS (semaglutide) |
|  | SOLIQUA (insulin glargine/lixisenatide) |
|  | SYMLINPEN (pramlintide) |
|  | XULTOPHY (insulin degludec/liraglutide) |
|  |  |
| **HYPOGLYCEMICS, INSULINS & RELATED AGENTS DUR+** | | |
| HUMALOG MIX 75/25 vial (insulin lispro/lispro protamine) | ADMELOG (insulin lispro) | **Non-Preferred Criteria**   * Documented diagnosis of Diabetes Mellitus **AND** * Have tried 1 preferred agent in the past 6 months **OR** * 1 claim with the requested agent in the past 105 days     **Quantity Limit**   * [**Insulin quantity limits can be found here**](https://medicaid.ms.gov/wp-content/uploads/2024/07/Insulin-and-Diabetic-Pen-QL-FINAL-7_2024.V9.pdf)     **Note**:   * Insulin pen formulations are not covered for Long Term Care (LTC) beneficiaries. |
| HUMULIN 70/30 vial (insulin NPH/regular) | AFREZZA (insulin regular) |
| HUMULIN N (insulin NPH) | APIDRA (insulin glulisine) |
| HUMULIN R (insulin regular) | BASAGLAR (insulin glargine) |
| HUMULIN R U-500 (insulin regular) | FIASP (insulin aspart/niacinamide) |
| insulin aspart | HUMALOG; HUMALOG JUNIOR, KWIKPEN, TEMPO PEN (insulin lispro) |
| insulin aspart protamine mix 70/30 vial |
| insulin lispro | HUMALOG MIX KWIKPEN 50/50, 75/25 (insulin lispro/lispro protamine) |
| insulin lispro protamine mix 75/25 vial | HUMULIN 70/30 KWIKPEN (insulin N/regular) |
| LANTUS (insulin glargine) | HUMULIN N KWIKPEN (insulin N) |
| TOUJEO (insulin glargine) | insulin degludec |
| TOUJEO MAX (insulin glargine) | insulin glargine |
|  | insulin glargine-yfgn |
|  | LEVEMIR (insulin detemir) |
|  | LYUMJEV (insulin lispro-aabc) |
|  | NOVOLIN 70/30 (insulin NPH/regular) |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** | | |
| **HYPOGLYCEMICS, INSULINS & RELATED AGENTS DUR+** *(continued)* | | | | |
|  | NOVOLIN N (insulin NPH) |  | See previous page for additional PA Criteria/DUR+ Rules |  |
|  | NOVOLIN R (insulin regular) |  |
|  | NOVOLOG (insulin aspart) |
|  | NOVOLOG MIX 70/30 (insulin aspart protamine/aspart) |
|  | REZVOGLAR (insulin glargine-aglr) |
|  | SEMGLEE (insulin glargine-yfgn) |
|  | TRESIBA (insulin degludec) |
| **HYPOGLYCEMICS, MEGLITINIDES DUR+** | | | | |
| nateglinide |  |  | | |
| repaglinide |  |
| **HYPOGLYCEMICS, SODIUM GLUCOSE COTRANSPORTER-2 (SGLT-2) INHIBITORS DUR+** | | | | |
| **SGLT-2 INHIBITORS** | | **Non-Preferred Criteria**   * Have tried 2 different preferred SGLT-2 inhibitors in the past 6 months **OR** * 90 days of therapy with the requested agent in the past 105 days | | |
| FARXIGA (dapagliflozin) | dapagliflozin |
| JARDIANCE (empagliflozin) | INPEFA (sotagliflozin) |
|  | INVOKANA (canagliflozin) |
|  | STEGLATRO (ertugliflozin) |
| **SGLT-2 INHIBITOR COMBINATIONS** | |
| GLYXAMBI (empagliflozin/linagliptin) | dapagliflozin/metformin ER |
| SYNJARDY (empagliflozin/metformin) | INVOKAMET (canagliflozin/metformin) |
| SYNJARDY XR (empagliflozin/metformin) | INVOKAMET XR (canagliflozin/metformin) |
| TRIJARDY XR (empagliflozin/linagliptin/metformin) | QTERN (dapagliflozin/saxagliptin) |
|  | SEGLUROMET (ertugliflozin/metformin) |
|  | STEGLUJAN (ertugliflozin/sitagliptin) |
|  | XIGDUO XR (dapagliflozin/metformin) |
| **HYPOGLYCEMICS, THIAZOLIDINEDIONES (TZDs) and TZD Combinations** | | | | |
| pioglitazone | ACTOPLUS MET (pioglitazone/metformin) |  | | |
| pioglitazone/metformin | ACTOS (pioglitazone) |
|  | DUETACT (pioglitazone/metformin) |
| **IDIOPATHIC PULMONARY FIBROSIS DUR+** | | | | |
| OFEV (nintedanib) | ESBRIET (pirfenidone) | **All Agents**   * Documented diagnosis of Idiopathic Pulmonary Fibrosis     **OFEV**   * Documented diagnosis of Idiopathic Pulmonary Fibrosis **OR** * 90 days of therapy with Ofev in the past 105 days **ESBRIET or pirfenidone** * Requires clinical review | | |
|  | pirfenidone |
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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** | | |
| **IMMUNE GLOBULINS** | | | | |
| BIVIGAM | ALYGLO |  | | |
| FLEBOGAMMA | ASCENIV |
| GAMASTAN | CABLIVI |
| GAMMAGARD | CUTAQUIG |
| GAMMAGARD S-D | CUVITRU |
| GAMUNEX-C | GAMMAKED |
| HIZENTRA | GAMMAPLEX |
| HYQVIA | OCTAGAM |
| PANZYGA |  |
| PRIVIGEN |  |
| XEMBIFY |  |
| **IMMUNOLOGIC THERAPIES FOR ASTHMA** | | | | |
| DUPIXENT (dupilumab) DUR+ | CINQAIR (reslizumab) | **CINQAIR**  • Requires clinical review | | |
| FASENRA (benralizumab) | NUCALA (mepolizumab) |
| XOLAIR (omalizumab) | TEZSPIRE (tezepelumab-ekko) |  | See below for additional PA Criteria/DUR+ Rules |  |
| **DUPIXENT FASENRA**   * 1 claim with DUPIXENT in the past 60 days **OR** • Requires clinical review [– **MANUAL PA**](https://medicaid.ms.gov/wp-content/uploads/2023/01/Fasenra.pdf) * New starts require clinical review (see manual PA links below)    + **Asthma** [– **MANUAL PA**](https://medicaid.ms.gov/wp-content/uploads/2019/05/Dupixent-PA-Asthma.pdf)  **NUCALA**   + **Atopic Dermatitis** [– **MANUAL PA**](https://medicaid.ms.gov/wp-content/uploads/2024/12/Dupixent-Atopic-Dermatitis-12_18_2024-to-current.V8.pdf) • Requires clinical review   + **COPD** [– **MANUAL PA**](https://medicaid.ms.gov/wp-content/uploads/2025/04/Dupixent-PA-Chronic-Obstructive-Pulmonary-Disease-04_28_2025-to-Current.V1.pdf)   + **Eosinophilic Esophagitis** [– **MANUAL PA**](https://medicaid.ms.gov/wp-content/uploads/2024/03/Dupixent-Eosinophilic-Esophagitis-03_01_2024_V3.pdf)  **TEZSPIRE** o **Nasal Polyposis** [– **MANUAL PA**](https://medicaid.ms.gov/wp-content/uploads/2019/09/Dupixent-PA-_Nasal-Polyposis.pdf) • Requires clinical review o **Prurigo Nodularis** [– **MANUAL PA**](https://medicaid.ms.gov/wp-content/uploads/2022/11/Dupixent-Prurigo-nodularis-11-7-22-V1.pdf)   **XOLAIR**   * 1 claim with XOLAIR in the past 45 days **OR** * New starts require clinical review [– **MANUAL PA**](https://medicaid.ms.gov/wp-content/uploads/2023/01/Xolair-Asthma-1.pdf) | | | | |
| **IMMUNOSUPPRESSIVE AGENTS, ORAL** | | | | |
| AZASAN (azathioprine) | ASTAGRAF XL (tacrolimus) | **Minimum Age Limit**   * **13 years**: RAPAMUNE * **18 years**: ZORTRESS     **Maximum Age Limit**   * **12 years**: PROGRAF Granules       See next page for additional PA Criteria/DUR+ Rules | | |
| azathioprine | ENVARSUS XR (tacrolimus) |
| CELLCEPT (mycophenolate) | MYFORTIC (mycophenolate) |
| cyclosporine | PROGRAF (tacrolimus) |
| everolimus | REZUROCK (belumosudil) |
| mycophenolate | ZORTRESS (everolimus) |
| mycophenolic acid |  |
| NEORAL (cyclosporine) |  |
| RAPAMUNE (sirolimus) |  |
| SANDIMMUNE (cyclosporine) |  |
| sirolimus |  |
| tacrolimus |  |
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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** |  | **PA CRITERIA** |
| See previous page for additional PA Criteria/DUR+ Rules    **Preferred Criteria**   * **AZASAN**    + Documented diagnosis of kidney transplant, RA, or a State-accepted diagnosis * **CELLCEPT**    + Documented diagnosis of heart, kidney, or liver transplant or a State-accepted diagnosis * **GENGRAF, NEORAL, SANDIMMUNE**    + Documented diagnosis of heart transplant, kidney transplant, liver transplant, psoriasis, RA, or a State-accepted diagnosis * **Everolimus** o Documented diagnosis of kidney or liver transplant * **RAPAMUNE**    + Documented diagnosis of kidney transplant * **Tacrolimus** o Documented diagnosis of heart, kidney, liver, or lung transplant or a State-accepted diagnosis     **Non-Preferred Criteria**   * **MYHIBBIN Suspension**    + Documented diagnosis of heart, kidney, or liver transplant or a State-accepted diagnosis **AND** o 30 days of therapy with mycophenolate suspension in the past 105 days **OR** o 90 days of therapy with MYHIBBIN Suspension in the past 105 days * **ASTAGRAF XR or ENVARSUS XR**    + Documented diagnosis of heart, kidney, liver, or lung transplant or a State-accepted diagnosis **AND** o 30 days of therapy with tacrolimus IR in the past 105 days **OR** o 90 days of therapy with the requested agent in the past 105 days * **PROGRAF Granules** o Age < 11 years **AND**   + Documented diagnosis of heart, kidney, liver, or lung transplant or a State-accepted diagnosis * **MYFORTIC**    + Documented diagnosis of kidney transplant or psoriasis * **ZORTRESS**    + Documented diagnosis of kidney or liver transplant | | |  |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | | | **PA CRITERIA** |
| **INTRANASAL RHINITIS AGENTS** | | | | |
| **ANTICHOLINERGICS** | | | | **Non-Preferred Criteria** – **Corticosteroids**   * Documented diagnosis of allergic rhinitis **AND** * Have tried 1 different preferred agent in the past 6 months |
| ipratropium |  | | |
| **ANTIHISTAMINE/CORTICOSTEROID COMBINATIONS** | | | |
|  | azelastine/fluticasone | | |
|  | DYMISTA (azelastine/fluticasone) | | |
|  | RYALTRIS (olopatadine/mometasone) | | |
| **ANTIHISTAMINES** | | | |
| azelastine | olopatadine | | |
|  | PATANASE (olopatadine) | | |
| **CORTICOSTEROIDS** | | | |
| fluticasone | BECONASE AQ (beclomethasone) | | |
|  | flunisolide | | |
|  | mometasone | | |
|  | NASONEX (mometasone) | | |
|  | OMNARIS (ciclesonide) | | |
|  | QNASL (beclomethasone) | | |
|  | XHANCE (fluticasone) | | |
|  | ZETONNA (ciclesonide) | | |
| **IRON CHELATING AGENTS** | | | | |
| deferasirox (all manufacturers except those listed as non-preferred) | deferasirox (manufacturers starting with 45963, 62332) | | | **JADENU** [– **MANUAL PA**](https://medicaid.ms.gov/wp-content/uploads/2019/01/JADENU.pdf) |
| deferiprone 1,000 mg tablet | | |
| deferiprone 500 mg tablet | EXJADE (deferasirox) | | |
| FERRIPROX (deferiprone) | JADENU, JADENU SPRINKLE (deferasirox) | | |
| **IRRITABLE BOWEL SYNDROME/SHORT BOWEL SYNDROME AGENTS/SELECTED AGENTS DUR+** | | | | |
| **IRRITABLE BOWEL SYNDROME CONSTIPATION DUR+** | | | | **Minimum Age Limit**   * **1 year**: GATTEX * **6 years**: LINZESS 72 mcg * **18 years**: AMITIZA**,** IBSRELA, LINZESS 145 mcg & 290 mcg, MOTEGRITY, MOVANTIK, MYTESI, RELISTOR, SYMPROIC, TRULANCE, VIBERZI     **Gender Limit**   * **Female** – AMITIZA 8 mcg       See next page for additional PA Criteria/DUR+ Rules |
| LINZESS (linaclotide) | AMITIZA (lubiprostone) | | |
| lubiprostone | IBSRELA (tenapanor) | | |
| TRULANCE (plecanatide) | MOTEGRITY (prucalopride) | | |
|  | MOVANTIK (naloxegol) | | |
|  |  | prucalopride |  |
|  | RELISTOR (methylnaltrexone) | | |
|  | SYMPROIC (naldemedine) | | |
| **IRRITABLE BOWEL SYNDROME DIARRHEA** | | | |
| dicyclomine | alosetron | | |
| ED-SPAZ (hyoscyamine) | LOTRONEX (alosetron) DUR+ | | |
| hyoscyamine, hyoscyamine ER | VIBERZI (eluxadoline) DUR+ | | |
| HYOSYNE (hyoscyamine) |  | | |
| LEVSIN, LEVSIN-SL (hyoscyamine) |  | | |
| NULEV (hyoscyamine) |  | | |
| OSCIMIN, OSCIMIN SL (hyoscyamine) |  | | |
| **SHORT BOWEL SYNDROME AND SELECTED GI AGENTS DUR+** | | | |
|  | GATTEX (teduglutide) | | |
|  | MYTESI (crofelemer) | | |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | | **PA CRITERIA** |
| **IRRITABLE BOWEL SYNDROME – CONSTIPATION DUR+** | | | |
| **Chronic Idiopathic Constipation (CIC):**  Amitiza 24 mcg, LINZESS 72 mcg, LINZESS  145 mcg, MOTEGRITY, TRULANCE  • **Preferred CIC Agents** o Documented diagnosis of CIC in the past year **AND**  o No history of GI or bowel obstruction  • **LINZESS 72 mcg** o Age 6-17 years **AND**   * Documented diagnosis of CIC or pediatric functional constipation in the past year   **AND**   * No history of GI or bowel obstruction   • **Non-Preferred CIC Agents** o Documented diagnosis of CIC **AND** o No history of GI or bowel obstruction **AND**  o Have tried 2 preferred CIC agents in the past 6 months **OR**  o 1 claim with the requested agent in the past 105 days | **Irritable Bowel Syndrome – Constipation**  **Dominant (IBS-C):** AMITIZA 8 mcg, IBSRELA,  LINZESS 290 mcg, TRULANCE  • **Preferred IBS-C Agents** o Documented diagnosis of IBS-C in the past year **AND**  o No history of GI or bowel obstruction  • **Non-Preferred IBS-C Agents** o Documented diagnosis of IBS-C in the past year **AND**   * No history of GI or bowel obstruction **AND** o Have tried 2 preferred IBS-C agents in the past 6 months **OR** * 1 claim with the requested agent in the past 105 days | | **Opioid Induced Constipation (OIC):** AMITIZA 24 mcg, MOVANTIK, RELISTOR, SYMPROIC   * **Preferred OIC Agents** o Documented diagnosis of OIC **and** chronic pain in the past year **AND** o No history of GI or bowel obstruction **AND** o 1 claim for an opioid in the past 30 days * **Non-Preferred OIC Agents** o All preferred criteria met **AND**   o Have tried 1 preferred OIC agents in the past 6 months **OR** o 1 claim with the requested agent in the past 105 days      • **Relistor Injection** o Above OIC criteria **OR**  o Documented diagnosis of OIC **and** active cancer in the past year **AND** o No history of GI or bowel obstruction **AND** o 1 claim for an opioid in the past 30 days |
| **IRRITABLE BOWEL SYNDROME – DIARRHEA** | | | |
| * **VIBERZI** [New starts require clinical review]   Documented diagnosis of IBS – D in the past year **and** 1 claim for Viberzi in the past 105 days  o   * **LOTRONEX**   o 1 claim for LOTRONEX in the past 105 days **OR** o New starts require clinical review [– **MANUAL PA**](https://medicaid.ms.gov/wp-content/uploads/2019/01/Lotronex.pdf)  • **XIFAXAN** – (see Antibiotics, GI) | | | |
| **SHORT BOWEL SYNDROME AND SELECTED GI AGENTS DUR+** | | | |
| **HIV/AIDS Non-infectious Diarrhea**  • **MYTESI** o Documented diagnosis of HIV/AIDS **and** non-infectious diarrhea in the past year **AND**  o 1 claim for an antiretroviral in the past 30 days | | **Short Bowel Syndrome (SBS)**  • **GATTEX**  o 1 claim for GATTEX in the past 105 days **OR** o New starts require clinical review | |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **LEUKOTRIENE MODIFIERS DUR+** | | |
| montelukast | ACCOLATE (zafirlukast) | **Minimum Age Limit**   * **12 years**: ZYFLO & ZYFLO CR     **Non-Preferred Criteria**   * Have tried 2 different preferred agents in the past 6 months |
| zafirlukast | SINGULAIR (montelukast) |
|  | zileuton |
|  | ZYFLO (zileuton) |
|  |  |
| **LIPOTROPICS, OTHER (NON-STATINS)** | | |
| **ACL INHIBITORS AND COMBINATIONS** | | **Non-Preferred Criteria** – **Fibric Acid Derivatives** o Have tried 2 different preferred Fibric Acid Derivative agents in the past 6 months    **JUXTAPID** [– **MANUAL PA**](https://medicaid.ms.gov/wp-content/uploads/2019/01/Juxtapid.pdf)    **KYNAMRO**   * Requires clinical review     **LEQVIO**   * Requires clinical review     **NEXLETOL and NEXLIZET**   * Require clinical review     **PRALUENT** [– **MANUAL PA**](https://medicaid.ms.gov/wp-content/uploads/2023/09/Praluent-04-25-23.V3.pdf) |
|  | NEXLETOL (bempedoic acid) |
|  | NEXLIZET (bempedoic acid/ezetimibe) |
| **ANGIOPOIETIN-LIKE 3 INHIBITORS** | |
|  | EVKEEZA (evinacumab-dgnb) |
| **BILE ACID SEQUESTRANTS** | |
| cholestyramine | colesevelam |
| cholestyramine light | COLESTID (colestipol) |
| **LIPOTROPICS, OTHER (NON-STATINS)** | | |
| colestipol tablet | colestipol packet | **REPATHA** [– **MANUAL PA**](https://medicaid.ms.gov/wp-content/uploads/2023/09/Repatha-10-16-2019-to-current.V1.pdf)    **WELCHOL**   * Documented diagnosis of Type 2 Diabetes **AND** * 30 days of therapy with an antidiabetic agent in the past 6 months **OR**   90 days of therapy with WELCHOL in the past 105 days |
|  | PREVALITE (cholestyramine) |
|  | QUESTRAN (cholestyramine) |
|  | QUESTRAN LIGHT (cholestyramine) |
|  | WELCHOL (colesevelam) |
| **CHOLESTEROL ABSORPTION INHIBITORS** | |
| ezetimibe | ZETIA (ezetimibe) |
| **FIBRIC ACID DERIVATIVES** | |
| fenofibrate | fenofibric acid |
| gemfibrozil | FENOGLIDE (fenofibrate) |
|  | FIBRICOR (fenofibric acid) |
|  | LIPOFEN (fenofibrate) |
|  | LOPID (gemfibrozil) |
|  | TRICOR (fenofibrate) |
|  | TRILIPIX (fenofibric acid) |
| **MTP INHIBITOR** | |
|  | JUXTAPID (lomitapide) |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | | | **PA CRITERIA** | | |
| **LIPOTROPICS, OTHER (NON-STATINS)** *(continued)* | | | | | | |
| **NIACIN** | | | |  | See previous page for additional PA Criteria/DUR+ Rules |  |
| niacin ER |  | | |  |
| **OMEGA-3 FATTY ACIDS** | | | |
| omega-3 acid ethyl esters | icosapent ethyl | | |
|  | LOVAZA (omega-3 acid ethyl esters) | | |
| **PCSK-9 INHIBITORS** | | | |
| REPATHA (evolocumab) | LEQVIO (inclisiran) | | |
|  | PRALUENT (alirocumab) | | |
|  |  | | |
| **LIPOTROPICS, STATINS DUR+** | | | | | | |
| **STATINS** | | | | **Minimum Age Limit**   * **10 years**:ATORVALIQ Suspension   **Non-Preferred Criteria**   * Have tried 2 different preferred statin or statin combination agents in the past 6 months **OR** * 90 days of therapy with the requested agent in the past 105 days     **Simvastatin**  Daily doses > 80 mg require clinical review | | |
| atorvastatin | ALTOPREV (lovastatin) | | |
| lovastatin | ATORVALIQ (atorvastatin) | | |
| pravastatin | CRESTOR (rosuvastatin) | | |
| rosuvastatin | EZALLOR SPRINKLE (rosuvastatin) | | |
| simvastatin | FLOLIPID (simvastatin) | | |
|  | fluvastatin | | |
|  | fluvastatin ER | | |
|  | LESCOL XL (fluvastatin) | | |
|  | LIPITOR (atorvastatin) | | |
|  | LIVALO (pitavastatin) | | |
|  | pitavastatin | | |
|  | ZOCOR (simvastatin) | | |
|  | ZYPITAMAG (pitavastatin) | | |
| **STATIN COMBINATIONS** | | | |
| ezetimibe/simvastatin | amlodipine/atorvastatin | | |
|  | CADUET (amlodipine/atorvastatin) | | |
|  | VYTORIN (ezetimibe/simvastatin) | | |
| **MISCELLANEOUS BRAND/GENERIC** | | | | | | |
| **ALLERGEN EXTRACT IMMUNOTHERAPY** | | | | **CUMULATIV**[**E quantity limit** (](http://www.medicaid.ms.gov/Documents/Pharmacy/QuantityLimitsUpdate7-1-10.pdf)per 31 days)   * **31 tablets**: alprazolam ER     **Quantity Limit** (per 31 days)   * **2 kits**: epinephrine     **EVRYSDI** [– **MANUAL PA**](https://medicaid.ms.gov/wp-content/uploads/2024/01/Evrysdi-01-10-2024-to-current.V3.pdf) | | |
|  | GRASTEK | | |
|  | ORALAIR | | |
|  | RAGWITEK | | |
| **EPINEPHRINE** | | | |
| epinephrine (Mylan) | AUVI-Q (epinephrine) | | |
|  | epinephrine (all other manufacturers) | | |
|  | EPIPEN (epinephrine) | | |
|  | EPIPEN JR (epinephrine) | | |
|  |  | NEFFY (epinephrine) |  |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | | | | **PA CRITERIA** | | |
| **MISCELLANEOUS BRAND/GENERIC** *(continued)* | | | | | | | |
| **MISCELLANEOUS** | | | | |  | See previous page for additional PA Criteria/DUR+ Rules |  |
| alprazolam | alprazolam ER | | | |  |
| hydroxyzine HCL | CAMZYOS (mavacamten) | | | |
| hydroxyzine pamoate |  | CRENESSITY (crinecerfont) | |  |
| megestrol | EVRYSDI (risdiplam) | | | |
| REVLIMID (lenalidomide) | KORLYM (mifepristone) | | | |
|  | lenalidomide | | | |
|  |  | TRYNGOLZA (olezarsen) |  | |
|  | VERQUVO (vericiguat) | | | |
|  | VISTARIL (hydroxyzine pamoate) | | | |
|  | XANAX, XANAX XR (alprazolam) | | | |
| **SUBLINGUAL NITROGLYCERIN** | | | | |
| nitroglycerin |  | | | |
| NITROLINGUAL (nitroglycerin) |  | | | |
| NITROSTAT (nitroglycerin) |  | | | |
| **MOVEMENT DISORDER AGENTS DUR+** | | | | | | | |
| AUSTEDO (deutetrabenazine) | INGREZZA INITIATION PACK (valbenazine) | | | | **AUSTEDO and AUSTEDO XR**   * Documented diagnosis of Huntington’s chorea **OR** * Documented diagnosis of tardive dyskinesia **AND** * 90 days of therapy with either agent in the past 105 days **OR** * New starts require clinical review [– **MANUAL PA**](https://medicaid.ms.gov/wp-content/uploads/2024/01/Austedo-01-10-2024-to-current.V7.pdf)       **INGREZZA**   * Documented diagnosis of Huntington’s chorea **OR** * Documented diagnosis of tardive dyskinesia **AND** * 90 days of therapy with this agent in the past 105 days **OR** ew starts require clinical review [– **MANUAL PA**](https://medicaid.ms.gov/wp-content/uploads/2024/01/Ingrezza-01-10-2024-to-current.V7.pdf) | | |
| AUSTEOD XR (deutetrabenazine) | XENAZINE (tetrabenazine) | | | |
| INGREZZA (valbenazine) |  | | | |
| INGREZZA SPRINKLE (valbenazine) |  | | | |
| tetrabenazine |  | | | |
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| **MULTIPLE SCLEROSIS AGENTS DUR+** | | | | | | | |
| BETASERON (interferon beta-1b) | AMPYRA (dalfampridine) | | | | **Preferred Agents**   * Documented diagnosis of multiple sclerosis     **Non-Preferred Criteria**   * Documented diagnosis of multiple sclerosis **AND** * Have tried 2 different preferred agents in the past 6 months **OR** * 3 claims with the requested agent in the last 105 days     **KESIMPTA, PONVORY, TASCENSO ODT, and ZEPOSIA**   * Require clinical review     See next page for additional PA Criteria/DUR+ Rules | | |
| COPAXONE (glatiramer) 20 mg | AUBAGIO (teriflunomide) | | | |
| dalfampridine ER | AVONEX (interferon beta-1a) | | | |
| dimethyl fumarate | BAFIERTAM (monomethyl fumarate) | | | |
| fingolimod | BRIUMVI (ublituximab-xiiy) | | | |
| REBIF (interferon beta-1b) | COPAXONE (glatiramer) 40 mg | | | |
| REBIF REBIDOSE (interferon beta-1b) | GILENYA (fingolimod) | | | |
| teriflunomide | glatiramer | | | |
| TYSABRI (natalizumab) | GLATOPA (glatiramer) | | | |
|  | KESIMPTA PEN (ofatumumab) | | | |
|  | MAVENCLAD (cladribine) | | | |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **MULTIPLE SCLEROSIS AGENTS DUR+** *(continued)* | | |
|  | MAYZENT (siponimod) | See previous page for additional PA Criteria/DUR+ Rules      **MAVENCLAD** [– **MANUAL PA**](https://medicaid.ms.gov/wp-content/uploads/2023/04/Mavenclad.pdf)    **MAYZENT** [– **MANUAL PA**](https://medicaid.ms.gov/wp-content/uploads/2019/09/Mayzent.pdf)    **OCREVUS and OCREVUS ZUNOVO** [– **MANUAL PA**](https://medicaid.ms.gov/wp-content/uploads/2024/10/Ocrevus-or-Ocrevus-Zunovo-02-03-2020-to-current.V5-Draft.pdf) |
|  | OCREVUS (ocrelizumab) |
|  | OCREVUS ZUNOVO  (ocrelizumab/hyaluronidase-ocsq) |
|  | PLEGRIDY (peginterferon beta-1a) |
|  | PONVORY (ponesimod) |
|  | TASCENSO ODT (fingolimod) |
|  | TECFIDERA (dimethyl fumarate) |
|  | VUMERITY (diroximel fumarate) |
|  | ZEPOSIA (ozanimod) |
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| **MUSCULAR DYSTROPHY AGENTS** | | |
| EMFLAZA (deflazacort) | AGAMREE (vamorolone) | **AGAMREE** [– **MANUAL PA**](https://medicaid.ms.gov/wp-content/uploads/2025/03/Agamree-PA-Criteria-04-01-2025-to-Current.V1-1.pdf)    **ELEVIDYS** [– **MANUAL PA**](https://medicaid.ms.gov/wp-content/uploads/2025/01/Elevidys_criteria-01-27-2025-to-Current.-V3.pdf)    **EMFLAZA** [– **MANUAL P**](https://medicaid.ms.gov/wp-content/uploads/2019/01/Emflaza.pdf)**A**    **EXONDYS** [– **MANUAL PA**](https://medicaid.ms.gov/wp-content/uploads/2019/04/Exondys.pdf)    **VILTEPSO** [– **MANUAL PA**](https://medicaid.ms.gov/wp-content/uploads/2021/01/Viltepso.pdf)    **VYONDYS** [– **MANUAL PA**](https://medicaid.ms.gov/wp-content/uploads/2021/01/Vyondys-53.pdf) |
|  | AMONDYS-45 (casimersen) |
|  | deflazacort |
|  | DUVYZAT (givinostat) |
|  | ELEVIDYS (delandistrogene moxeparvovecrokl) |
|  | EXONDYS-51 (eteplirsen) |
|  | VILTEPSO (viltolarsen) |
|  | VYONDYS-53 (golodirsen) |
| **NSAIDS** | | |
| **COX II SELECTIVE** | | **Quantity Limit** (per 31 days)   * **20 tablets**: ketorolac tablets     **ELYXYB**   * Requires clinical review     **Non-Preferred Criteria – COX II Selective**   * No history of a contraindicated GI disorder or coagulation disorder **AND** * Documented diagnosis of Osteoarthritis, Rheumatoid Arthritis, Familial Adenomatous Polyposis, or Ankylosing Spondylitis **AND** * Have tried 1 preferred COX-II selective agent **OR** * 90 days of therapy with the requested agent in the past 105 days   See next page for additional PA Criteria/DUR+ Rules |
| meloxicam | CELEBREX (celecoxib) |
|  | celecoxib |
|  | ELYXYB (celecoxib) |
| **NON-SELECTIVE** | |
| diclofenac sodium | DAYPRO (oxaprozin) |
| diclofenac sodium ER | diclofenac potassium |
| EC-naproxen DR 500 mg tablet | DOLOBID (diflunisal) |
| etodolac tablet | etodolac capsule, etodolac ER |
| flurbiprofen | FELDENE (piroxicam) |
| ibuprofen | fenoprofen |
| indomethacin capsule | indomethacin ER, indomethacin suppository |
| ketoprofen | ketoprofen |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** | | |
| **NSAIDS** *(continued)* | | | | |
| ketorolac | kiprofen |  | See previous page for additional PA Criteria/DUR+ Rules |  |
| nabumetone | LOFENA (diclofenac potassium) | **Non-Preferred Criteria – Non-Selective & Combinations**   * No history of a contraindicated GI disorder or coagulation disorder **AND** * Have tried 2 different preferred non-selective agents in the past 6 months |
| naproxen 250 mg, 500 mg | meclofenamate |
| piroxicam | mefenamic acid |
| sulindac | NALFON (fenoprofen) |
|  | NAPRELAN (naproxen) |
|  | NAPROSYN 375 mg (naproxen) |
|  | naproxen 375 mg, naproxen CR 375 mg, naproxen ER 500 mg |
|  | oxaprozin |
|  | RELAFEN DS (nabumetone) |
|  | TOLECTIN 600 mg (tolmetin) |
|  | tolmetin |
| **NSAID/GI PROTECTANT COMBINATIONS** | |
|  | ARTHROTEC 50 mg, 75 mg  (diclofenac/misoprostol) |
|  | diclofenac/misoprostol |
|  | ibuprofen/famotidine |
|  | naproxen/esomeprazole |
|  | VIMOVO (naproxen/esomeprazole) |
| **OPHTHALMIC AGENTS** | | | | |
| **ANTIBIOTICS** | | **Minimum Age Limit**   * **16 years**: RESTASIS * **17 years**: XIIDRA * **18 years**: CEQUA, MIEBO**,** VEVYE     **Quantity Limit** (per 31 days)   * **2 mL**: VEVYE * **3 mL**: MIEBO * **5.5 mL**: RESTASIS Multidose * **60 units**: CEQUA, RESTASIS Droperette, XIIDRA     **Non-Preferred Criteria**   * **Anti-Inflammatory Agents** o Have tried 2 different preferred agents in the past 6 months * **Dry Eye Agents / CEQUA** o 4 claims for RESTASIS Droperette and XIIDRA in the past 6 months **EYSUVIS**   Requires clinical review    See next page for additional PA Criteria/DUR+ Rules | | |
| bacitracin/polymyxin | AZASITE (azithromycin) |
| ciprofloxacin | bacitracin |
| erythromycin | BESIVANCE (besifloxacin) |
| gentamicin | CILOXAN (ciprofloxacin) |
| moxifloxacin | gatifloxacin |
| ofloxacin | NATACYN (natamycin0 |
| polymyxin B/trimethoprim | neomycin/bacitracin/polymyxin |
| tobramycin | OCUFLOX (ofloxacin) |
|  | sulfacetamide |
|  | TOBREX (tobramycin) |
|  | VIGAMOX (moxifloxacin) |
| **ANTIBIOTIC-STEROID COMBINATIONS** | |
| BLEPHAMIDE S.O.P.  (sulfacetamide/prednisolone) | MAXITROL (neomycin/polymyxin/dexamethasone) |
| neomycin/bacitracin/polymyxin/hydrocortisone | neomycin/polymyxin/gramicidin |
| neomycin/polymyxin/dexamethasone | TOBRADEX ST (tobramycin/dexamethasone) |
| PRED-G (gentamicin/prednisolone) |  |
| sulfacetamide/prednisolone |  |
| TOBRADEX (tobramycin/dexamethasone) |  |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** | | |
| **OPHTHALMIC AGENTS** *(continued)* | | | | |
| tobramycin/dexamethasone |  |  | See previous page for additional PA Criteria/DUR+ Rules |  |
| ZYLET (tobramycin/loteprednol) |  |
| **MIEBO**   * Requires clinical review     **RESTASIS Multidose**   * Require clinical review     **TYRVAYA**   * Requires clinical review     **VEVYE**  Requires clinical review |
| **ANTI-INFLAMMATORY AGENTS** | |
| dexamethasone | ACULAR, ACULAR LS (ketorolac) |
| diclofenac sodium | ACUVAIL (ketorolac) |
| difluprednate | bromfenac |
| FLAREX (fluorometholone) | BROMSITE (bromfenac) |
| fluorometholone | DUREZOL (difluprednate) |
| flurbiprofen | FML (fluorometholone) |
| FML FORTE (fluorometholone) | ILEVRO (nepafenac) |
| ketorolac | INVELTYS (loteprednol) |
| MAXIDEX (dexamethasone) | LOTEMAX, LOTEMAX SM (loteprednol) |
| PRED MILD (prednisolone) | loteprednol |
| prednisolone acetate | NEVANAC (nepafenac) |
| prednisolone sodium phosphate | PRED FORTE (prednisolone) |
|  | PROLENSA (bromfenac) |
|  |  |
| **DRY EYE AGENTS** | |
| RESTASIS Droperette (cyclosporine) | CEQUA (cyclosporine) |
| XIIDRA (lifitegrast) | cyclosporine |
|  | EYSUVIS (loteprednol) |
|  | MIEBO (perfluorohexyloactane) |
|  | RESTASIS Multidose (cyclosporine) |
|  | TYRVAYA (varenicline) |
|  | VEVYE (cyclosporine) |
| **OPHTHALMIC, GLAUCOMA AGENTS** | | | | |
| **BETA BLOCKERS** | | **Minimum Age Limit**   * **18 years**: IYUZEH     **Non-Preferred Criteria**   * Have tried 2 different preferred agents in the past 6 months **OR** * 90 days of therapy with the requested agent in the past 105 days | | |
| BETIMOL (timolol) | betaxolol |
| carteolol | BETOPTIC S (betaxolol) |
| ISTALOL (timolol) | timolol droperette, daily drop, gel |
| levobunolol | TIMOPTIC; TIMOPTIC OCUDOSE, XE (timolol) |
| timolol drops 0.25%, 0.5% |  |
| **CARBONIC ANHYDRASE INHIBITORS** | |
| dorzolamide | AZOPT (brinzolamide) |
|  | brinzolamide |
| **COMBINATION AGENTS** | |
| COMBIGAN (brimonidine/timolol) | brimonidine/timolol |
| dorzolamide/timolol | COSOPT (dorzolamide/timolol) |
| SIMBRINZA (brinzolamide/brimonidine) | dorzolamide/timolol PF |
| **PARASYMPATHOMIMETICS** | |
| pilocarpine | PHOSPHOLINE IODIDE (echothiophate iodide) |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** | | |
| **OPHTHALMIC, GLAUCOMA AGENTS** *(continued)* | | | | |
| **PROSTAGLANDIN ANALOGS** | |  | See previous page for additional PA Criteria/DUR+ Rules |  |
| latanoprost | bimatoprost |  |
|  | IYUZEH (latanoprost) |
|  | LUMIGAN (bimatoprost) |
|  | tafluprost |
|  | TRAVATAN Z (travoprost) |
|  | travoprost |
|  | VYZULTA (latanoprost) |
|  | XALATAN (latanoprost) |
|  | XELPROS (latanoprost) |
|  | ZIOPTAN (tafluprost) |
| **RHO KINASE INHIBITORS/COMBINATIONS** | |
| RHOPRESSA (netarsudil) |  |
| ROCKLATAN (netarsudil/latanoprost) |  |
| **SYMPATHOMIMETICS** | |
| ALPHAGAN P (brimonidine) | brimonidine 0.1%, 0.15% |
| brimonidine 0.2% |  |
| **OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS** | | | | |
| ALREX (loteprednol) | ALOCRIL (nedocromil) | **Non-Preferred Criteria**   * Have tried 2 different preferred agents in the past 6 months     **VERKAZIA**   * Requires clinical review | | |
| azelastine | ALOMIDE (lodoxamide) |
| cromolyn | bepotastine |
| ketotifen OTC | BEPREVE (bepotastine) |
| olopatadine | epinastine |
| ZADITOR (ketotifen) | LASTACAFT (alcaftadine) |
|  | VERKAZIA (cyclosporine) |
|  | ZERVIATE (cetirizine) |
| **OPIATE DEPENDENCE TREATMENTS** | | | | |
| **DEPENDENCE** | | Buprenorphine/naloxone provider summary foun[d **here**](https://medicaid.ms.gov/wp-content/uploads/2014/04/BuprenorphineNaloxoneBuprenorphineSummaryProviders-v2023-01-23.pdf)      **SUBLOCADE** [– **MANUAL PA**](https://medicaid.ms.gov/wp-content/uploads/2019/01/Sublocade.pdf)    **VIVITROL** [– **MANUAL PA**](https://medicaid.ms.gov/wp-content/uploads/2019/01/Vivitrol.pdf) | | |
| buprenorphine/naloxone SL tablet DUR+ | BRIXADI (buprenorphine) |
| naltrexone | buprenorphine DUR+ |
| SUBOXONE (buprenorphine/naloxone) DUR+ | buprenorphine/naloxone film DUR+ |
|  | lofexidine |
|  | LUCEMYRA (lofexidine) |
|  | SUBLOCADE (buprenorphine) |
|  | VIVITROL (naltrexone) |
|  | ZUBSOLV (buprenorphine/naloxone) |
| **TREATMENT** | |
| KLOXXADO (naloxone) | LIFEMS NALOXONE (naloxone convenience kit) |
| naloxone |  |
| NARCAN (naloxone) |  |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** | | |
|  | **OPIATE DEPENDENCE TREATMENTS** *(continued)* | | | |
| OPVEE (nalmefene) |  |  | See previous page for additional PA Criteria/DUR+ Rules |  |
| REXTOVY (naloxone) |  |  |
| ZIMHI (naloxone) |  |
|  | **OTIC ANTIBIOTICS** | | | |
| CIPRO HC (ciprofloxacin/hydrocortisone) | ciprofloxacin | **Maximum Age Limit**   * **9 years**: CIPRO HC     **Ciprofloxacin/Dexamethasone Suspension Criteria**   * Age > 6 months **AND** * Experiencing otorrhea secondary to recent, post-tympanostomy tube placement **AND** * Continued otorrhea after 10 days of otic treatment with ciprofloxacin ophthalmic solution **and** dexamethasone ophthalmic suspension | | |
| CORTISPORIN-TC  (neomycin/colistin/hydrocortisone) | ciprofloxacin/fluocinolone |
| fluocinolone | ciprofloxacin/dexamethasone |
| neomycin/polymyxin/hydrocortisone | DERMOTIC (fluocinolone) |
|  | FLAC OTIC OIL (fluocinolone) |
|  | hydrocortisone/acetic acid |
|  | OTOVEL (ciprofloxacin/fluocinolone) |
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|  | **PANCREATIC ENZYMES** | | | |
| CREON (lipase/protease/amylase) | PERTZYE (lipase/protease/amylase) | **Non-Preferred Criteria**  • Have tried 2 different preferred agents in the past 6 months | | |
| ZENPEP (lipase/protease/amylase) | VIOKACE (lipase/protease/amylase) |
|  | **PARATHYROID AGENTS** | | | |
| calcitriol | doxercalciferol |  | | |
| cinacalcet | RAYALDEE (calcifediol) |
| ergocalciferol | ROCALTROL (calcitriol) |
| paricalcitol | SENSIPAR (cinacalcet) |
| ZEMPLAR (paricalcitol) | YORVIPATH (palopegteriparatide) |
|  | **PHOSPHATE BINDERS** | | | |
| calcium acetate | AURYXIA (ferric citrate) |  | | |
| CALPHRON (calcium acetate) | FOSRENOL (lanthanum) |
| sevelamer carbonate tablet | lanthanum |
|  | MAGNEBIND (calcium carbonate/magnesium) |
|  | RENVELA (sevelamer) |
|  | sevelamer carbonate packet, sevelamer HCl |
|  | VELPHORO (sucroferric oxyhydroxide) |
|  | XPHOZAH (tenapanor) |
|  | **PLATELET AGGREGATION INHIBITORS** | | | |
| aspirin/dipyridamole | EFFIENT (prasugrel) | **Non-Preferred Criteria**   * Documented diagnosis **AND** * Have tried 2 different preferred agents in the past 6 months **OR** * 90 days of therapy with the requested agent in the past 105 days     **ZONTIVITY** [– **MANUAL PA**](https://medicaid.ms.gov/wp-content/uploads/2019/01/Zontivity.pdf) | | |
| BRILINTA (ticagrelor) | PLAVIX (clopidogrel) |
| cilostazol |  |
| clopidogrel |  |
| dipyridamole |  |
| pentoxifylline |  |
| prasugrel |  |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **PLATELET STIMULATING AGENTS** | | |
| NPLATE (romiplostim) | ALVAIZ (eltrombopag) |  |
| PROMACTA (eltrombopag) tablet | DOPTELET (avatrombopag) |
|  | MULPLETA (lusutrombopag) |
|  | PROMACTA (eltrombopag) packet |
|  | TAVALISSE (fostamatinib) |
| **POTASSIUM REMOVING AGENTS** | | |
| LOKELMA (sodium zirconium cyclosilicate) | KIONEX (sodium polystyrene sulfonate) |  |
| SPS (sodium polystyrene sulfonate) suspension | sodium polystyrene sulfonate |
|  | SPS (sodium polystyrene sulfonate) enema |
|  | VELTASSA (patiromer calcium sorbitex) |
| **PRENATAL VITAMINS** | | |
| CLASSIC PRENATAL | All prenatal vitamins are non-preferred except for those specifically indicated as preferred. | List of Preferred NDC’s for Prenatal Vitamins can be foun[d **here**](https://medicaid.ms.gov/wp-content/uploads/2024/08/Mississippi-Division-of-Medicaid-Prenatal-NDC-List_v3-8_1_2024.pdf) |
| COMPLETE NATAL DHA |
| COMPLETENATE |
| M-NATAL PLUS |
| NIVA-PLUS |
| PRENATAL PLUS VITAMIN-MINERAL |
| **PRENATAL VITAMINS** *(continued)* | | |
| PNV 72, 95, 124, and 137 / IRON / FOLIC ACID | All prenatal vitamins are non-preferred except for those specifically indicated as preferred. | List of Preferred NDC’s for Prenatal Vitamins can be foun[d **here**](https://medicaid.ms.gov/wp-content/uploads/2024/08/Mississippi-Division-of-Medicaid-Prenatal-NDC-List_v3-8_1_2024.pdf) |
| SE-NATAL-19 |
| STUART ONE |
| THRIVITE RX |
| TRICARE |
| TRINATAL RX 1 |
| WESNATAL DHA COMPLETE |
| WESTAB PLUS |
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| **PSEUDOBULBAR AFFECT AGENTS** | | |
|  | NUEDEXTA (dextromethorphan/quinidine) | **Non-Preferred Criteria**   * Documented diagnosis of pseudobulbar affect disorder **OR** * 90 days of therapy with NUEDEXTA in the past 105 days |
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| **PULMONARY ANTIHYPERTENSIVE AGENTS** | | |
| **ACTIVIN SIGNALING INHIBITORS** | | **Minimum Age Limit**   * **18 years**: ADEMPAS, OPSYNVI, TADLIQ     **Maximum Age Limit**   * **12 years**: REVATIO suspension     **Preferred Criteria** • **PAH Agents**  See next page for additional PA Criteria/DUR+ Rules |
|  | WINREVAIR (sotatercept-csrk) |
| **COMBINATION AGENTS** | |
| OPSYNVI (macitentan/tadalafil) | |
| **ENDOTHELIN RECEPTOR ANTAGONISTS** | |
| ambrisentan | OPSUMIT (macitentan) |
| bosentan | TRACLEER (bosentan) |
| LETAIRIS (ambrisentan) | TRYVIO (aprocitentan) |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** | | |
| **PULMONARY ANTIHYPERTENSIVE AGENTS** (*continued*) | | | | |
| **PDE5 INHIBITORS** | | o    • o  o o  •   * <   •   * 90     **Non**  •  •   * 90     • | See previous page for additional PA Criteria/DUR+ Rules |  |
| sildenafil (generic REVATIO) tablet, suspension | ADCIRCA (tadalafil) | Documented diagnosis of pulmonary hypertension  **Sildenafil tablets**  < 1 year of age **and** documented diagnosis of pulmonary hypertension, patent ductus arteriosus, or persistent fetal circulation **OR**  > 1 year of age **and** documented diagnosis of pulmonary hypertension **OR**  90 days of therapy with the requested agent in the past 105 days  **Sildenafil suspension** 12 years of age **AND**  Documented diagnosis of pulmonary hypertension, patent ductus arteriosus, or persistent fetal circulation, or a history of a heart transplant **OR** days stable therapy with sildenafil suspension in the past 105 days  **-Preferred Criteria**  Documented diagnosis of pulmonary hypertension **AND**  Have tried 1 preferred PAH agent in the past 6 months **OR** days of therapy with the requested agent in the past 105 days  **LIQREV, OPSUMIT, OPSYNVI, ORENITRAM ER, TYVASO, and VENTAVIS**  Require clinical review |
| tadalafil | ALYQ (tadalafil) |
|  | LIQREV (sildenafil) |
|  | REVATIO (sildenafil) |
|  | TADLIQ (tadalafil) |
| **PROSTACYCLINS** | |
|  | ORENITRAM ER (treprostinil) |
|  | ORENITRAM TITRATION PAK (treprostinil) |
|  | TYVASO (treprostinil) |
|  | VENTAVIS (iloprost) |
| **SELECTIVE PROSTACYCLINE RECEPTOR AGONISTS** | |
|  | UPTRAVI (selexipag) |
| **SOLUABLE GUANYLATE CYCLASE STIMULATORS** | |
|  | ADEMPAS (riociguat) |
| **ADEMPAS TADLIQ**   * Documented diagnosis of persistent/recurrent chronic thromboembolic pulmonary • Documented diagnosis of pulmonary hypertension **AND** hypertension (WHO Group 4) orpulmonary arterial hypertension (WHO Group 1) **AND** • Have tried preferred sildenafil suspension in the past 6 months **OR** * Have tried 1 preferred PAH agent in the past 6 months **OR** • 90 days of therapy with TADLIQ in the past 105 days * 90 days of therapy with ADEMPAS in the past 105 days   **UPTRAVI**   * Documented diagnosis of pulmonary hypertension **AND** * Have tried 1 preferred endothelin receptor antagonist in the past 6 months **AND** * Have tried 1 preferred PDE5 inhibitor in the past 6 months **OR** * 90 days of therapy with UPTRAVI in the past 105 days | | | | |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **ROSACEA TREATMENTS** | | |
| metronidazole | AVAR (sulfacetamide sodium/sulfur) | Note:   * Topical Sulfonamides used for Rosacea will require a manual PA for age > 21 years. * Other labeled indications are limited to < 21 years. |
|  | AVAR LS (sulfacetamide sodium/sulfur) |
|  | AVAR-E (sulfacetamide sodium/sulfur) |
|  | BP 10-1 (sulfacetamide sodium/sulfur) |
|  | brimonidine |
|  | EPSOLAY (benzoyl peroxide) |
|  | FINACEA (azelaic acid) |
|  | METROCREAM (metronidazole) |
|  | METROGEL (metronidazole) |
|  | MIRVASO (brimonidine) |
|  | NORITATE (metronidazole) |
|  | OVACE (sulfacetamide sodium) |
|  | OVACE PLUS (sulfacetamide sodium) |
|  | RHOFADE (oxymetazoline) |
|  | ROSADAN (metronidazole) |
|  | ROSULA (sulfacetamide sodium/sulfur) |
|  | sodium sulfacetamide |
|  | sodium sulfacetamide/sulfur |
|  | SOOLANTRA (ivermectin) |
|  | SUMADAN (sulfacetamide sodium/sulfur) |
|  | SUMADAN XLT (sulfacetamide sodium/sulfur/avob |
|  | SUMAXIN (sulfacetamide sodium/sulfur) |
|  | SUMAXIN CP (sulfacetamide sodium/sulfur) |
|  | SUMAXIN TS (sulfacetamide sodium/sulfur) |
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| **SEDATIVE HYPNOTIC AGENTS** | | |
| **BENZODIAZEPINES DUR+** | | **MS DOM Opioid Initiative** [– **Criteria details found here**](https://medicaid.ms.gov/wp-content/uploads/2025/04/OPIOID-PACKET-Effective-4-28-2025-to-Current.V10.pdf)   * Concomitant use of Opioids and Benzodiazepines     **Maximum Age Limit**   * **64 years**: zolpidem 7.5 mg, 10 mg, and 12.5 mg     **Gender and Dose Limit**   * **Female**: AMBIEN 5 mg, AMBIEN CR 6.25 mg, INTERMEZZO 1.75 mg * **Male**: all strengths of zolpidem     **Non-Preferred Criteria**   * Have tried 2 different preferred agents in the past 6 months   See next page for additional PA Criteria/DUR+ Rules |
| estazolam | flurazepam |
| temazepam 15 mg, 30 mg capsule | HALCION (triazolam) |
|  | quazepam |
|  | RESTORIL (temazepam) |
|  | temazepam 7.5 mg, 22.5 mg capsule |
|  | triazolam |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** | | |
| **SEDATIVE HYPNOTIC AGENTS** *(continued)* | | | | |
| **OTHERS DUR+** | | •  •  OR  •  •    •  •    Note  • | See previous page for additional PA Criteria/DUR+ Rules |  |
| eszopiclone | AMBIEN (zolpidem) | **HETLIOZ capsules**  Age 18 years or older **AND**  Documented diagnosis of circadian rhythm sleep disorder    Age 16 years and older **AND**  Documented diagnosis of Smith-Magenis syndrome  **HETLIOZ liquid**  Age 3-15 years **AND**  Documented diagnosis of Smith-Magenis syndrome  :  Single-source benzodiazepines and barbiturates are NOT covered. o PA’s will NOT be issued for these drugs.  See below for additional PA Criteria/DUR+ Rules |
| ramelteon | AMBIEN CR (zolpidem) |
| zaleplon | BELSOMRA (suvorexant) |
| zolpidem tablet | DAYVIGO (lemborexant) |
|  | doxepin |
|  | EDULAR (zolpidem) |
|  | HETLIOZ LQ (tasimelteon) |
|  | LUNESTA (eszopiclone) |
|  | QUVIVIQ (daridorexant) |
|  | ROZEREM (ramelteon) |
|  | tasimelteon |
|  | zolpidem capsule |
|  | zolpidem sublingual tablet |
|  | zolpidem ER |
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| **CUMULATIVE Quantity Limit** – **Benzodiazepines**   * **31 units/31 days**: Quantity limit per rolling days for all strengths. DUR+ will allow an early refill override for one dose or therapy change per year.     **CUMULATIVE Quantity Limit** – **Triazolam**   * **10 units/31 days**: Quantity limit per rolling days for all strengths. * **60 units/365 days**: Quantity limit per rolling days for all strengths.     **CUMULATIVE Quantity Limit** – **Non-Benzodiazepines**   * **31 units/31 days**: Quantity limit per rolling days for all strengths. DUR+ will allow an early refill override for one dose or therapy change per year.     **CUMULATIVE Quantity Limit** – **HETLIOZ LQ**   * **1 bottle (48 mL or 158 mL)**: Quantity limit per rolling days for all strengths. DUR+ will allow an early refill override for one dose or therapy change per year.     **CUMULATIVE Quantity Limit** – **ZOLPIMIST**   * **1 canister/31 days**: male; Quantity limit per rolling days for all strengths. DUR+ will allow an early refill override for one dose or therapy change per year. * **1 canister/62 days:** female; Quantity limit per rolling days for all strengths. DUR+ will allow an early refill override for one dose or therapy change per year. | | | | |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **SELECT CONTRACEPTIVE PRODUCTS** | | |
| **INJECTABLE CONTRACEPTIVES** | | **Non-Preferred Criteria**  • 1 claim with the requested agent in the past 105 days |
| medroxyprogesterone | DEPO-PROVERA (medroxyprogesterone) |
| **INTRAVAGINAL CONTRACEPTIVES** | |
| ENILLORING (etonogestrel/ethinyl estradiol) | PHEXXI (lactic acid/citric acid/potassium bitartrate) |
| **ORAL CONTRACEPTIVES DUR+** | |
| All oral contraceptives are preferred except for those specifically indicated as non-preferred. | AMETHIA (levonorgestrel/ethinyl estradiol) |
| AMETHYST (levonorgestrel/ethinyl estradiol) |
| BALCOLTRA (levonorgestrel/ethinyl estradiol) |
| BEYAZ (drospirenone/ethinyl estradiol/levomefolate) |
| CAMRESE (levonorgestrel/ethinyl estradiol) |
| CAMRESE LO (levonorgestrel/ethinyl estradiol) |
| JOLESSA (levonorgestrel/ethinyl estradiol) |
| LO LOESTRIN FE (norethindrone/ethinyl estradiol/iron) |
| LOESTRIN (norethindrone/ethinyl estradiol) |
| LOESTRIN FE (norethindrone/ethinyl estradiol/iron) |
| MINZOYA (levonorgestrel/ethinyl estradiol/iron) |
| NATAZIA (estradiol valerate/dienogest) |
| NEXTSTELLIS (drospirenone/estetrol) |
| OCELLA (ethinyl estradiol/drospirenone) |
| SAFYRAL (drospirenone/ethinyl estradiol/levomefolate) |
| SIMPESSE (levonorgestrel/ethinyl estradiol) |
| TAYTULLA (norethindrone/ethinyl estradiol/iron) |
| TYDEMY (drospirenone/ethinyl estradiol/levomefolate) |
| YASMIN (ethinyl estradiol/drospirenone) |
| YAZ (ethinyl estradiol/drospirenone) |
| **TRANSDERMAL CONTRACEPTIVES** | |
| XULANE (norelgestromin/ethinyl estradiol) | norelgestromin/ethinyl estradiol |
|  | TWIRLA (levonorgestrel/ethinyl estradiol) |
|  | ZAFEMY (norelgestromin/ethinyl estradiol) |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **SICKLE CELL AGENTS** | | |
| DROXIA (hydroxyurea) | ADAKVEO (crizanlizumab-tmca) | **ENDARI** [– **MANUAL PA**](https://medicaid.ms.gov/wp-content/uploads/2019/01/Endari.pdf) |
| hydroxyurea | CASGEVY (exagamglogene autotemcel) |
|  | ENDARI (glutamine) |
|  | HYDREA (hydroxyurea) |
|  | l-glutamine |
|  | LYFGENIA (lovotibeglogene autotemcel) |
|  | SIKLOS (hydroxyurea) |
|  |  |
| **SKELETAL MUSCLE RELAXANTS DUR+** | | |
| baclofen 5 mg, 10 mg, 20 mg tablet | AMRIX (cyclobenzaprine) | **Quantity Limit**   * **84 tablets/180 days**: carisoprodol     **Non-Preferred Criteria**   * Documented diagnosis of an approvable indication **AND** * Have tried 2 different preferred agents in the past 6 months     **Baclofen granules, solution, and suspension**   * Require clinical review.     **Carisoprodol**   * Documented diagnosis of acute musculoskeletal condition **AND** * No history with meprobamate in the past 105 days **AND** * History of 1 claim for cyclobenzaprine in the past 21     **Carisoprodol with codeine**   * Requires clinical review.       **Metaxalone 640 mg and TANLOR**   * Requires clinical review |
| chlorzoxazone | baclofen 15 mg tablet |
| cyclobenzaprine 5 mg, 10 mg tablet | baclofen suspension |
| methocarbamol | carisoprodol |
| tizanidine tablet | carisoprodol/aspirin |
|  | cyclobenzaprine 7.5 mg tablet |
|  | cyclobenzaprine ER |
|  | DANTRIUM (dantrolene) |
|  | dantrolene |
|  | FEXMID (cyclobenzaprine) |
|  | FLEQSUVY (baclofen) |
|  | LORZONE (chlorzoxazone) |
|  | LYVISPAH (baclofen) |
|  | metaxalone |
|  | NORGESIC (orphenadrine/aspirin/caffeine) |
|  | NORGESIC FORTE (orphenadrine/aspirin/caffeine) |
|  | orphenadrine |
|  | orphenadrine/aspirin/caffeine |
|  | ORPHENGESIC FORTE  (orphenadrine/aspirin/caffeine) |
|  | SOMA (carisoprodol) |
|  | TANLOR (methocarbamol) |
|  | tizanidine capsule |
|  | ZANAFLEX (tizanidine) |
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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **SMOKING DETERRENTS** | | |
| **NICOTINE TYPE** | | **Minimum Age Limit**   * **18 years**: CHANTIX     **Quantity Limit**   * **336 tablets/year**: CHANTIX 0.5 mg tabs, 1 mg tabs, and continuing pack * **2 treatment courses/year**: CHANTIX Starter Pack |
| nicotine gum OTC | NICOTROL INHALER CARTRIDGE |
| nicotine lozenge OTC | NICOTROL NASAL SPRAY |
| nicotine patch OTC |  |
| **NON-NICOTINE TYPE** | |
| bupropion SR |  |
| CHANTIX (varenicline) |  |
| varenicline |  |
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| **STEROIDS (TOPICAL)** | | |
| **LOW POTENCY** | | **Non-Preferred Criteria**   * **Low Potency** o Have tried 2 different preferred low potency agents in the past 6 months * **Medium Potency** o Have tried 2 different preferred medium potency agents in the past 6 months * **High Potency** o Have tried 2 different preferred high potency agents in the past 6 months * **Very High Potency** o Have tried 2 different preferred very high potency agents in the past 6 months     **Clobetasol 0.025%**   * Requires clinical review |
| alclometasone | fluocinolone |
| DERMA-SMOOTH-FS (fluocinolone) | hydrocortisone lotion |
| desonide | HYDROXYM (hydrocortisone) |
| hydrocortisone cream, ointment, solution | PROCTOCORT (hydrocortisone) |
| **MEDIUM POTENCY** | |
| fluticasone | BESER (fluticasone) |
| mometasone | CAPEX (fluocinolone) |
| PANDEL (hydrocortisone probutate) | clocortolone |
| prednicarbate cream | CLODERM (clocortolone) |
|  | flurandrenolide |
|  | fluticasone lotion |
|  | LOCOID (hydrocortisone butyrate) |
|  | prednicarbate ointment |
|  | SYNALAR (fluocinolone) |
| **HIGH POTENCY** | |
| betamethasone dipropionate cream, lotion | amcinonide |
| betamethasone dipropionate augmented | betamethasone dipropionate ointment |
| betamethasone valerate | desoximetasone |
| fluocinolone | diflorasone |
| fluocinonide | Halcinonide |
| fluocinonide-E | HALOG (halcinonide) |
| triamcinolone cream, ointment, lotion | KENALOG (triamcinolone) |
|  | TOPICORT (desoximetasone) |
|  | triamcinolone spray |
|  | VANOS (fluocinonide) |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** | | |
| **STEROIDS (TOPICAL)** *(continued)* | | | | |
| **VERY HIGH POTENCY** | |  | See previous page for additional PA Criteria/DUR+ Rules |  |
| clobetasol cream, foam, gel, ointment, shampoo, solution | APEXICON E (diflorasone) |  |
| clobetasol-E | BRYHALI (halobetasol) |
| halobetasol | clobetasol emulsion |
|  | clobetasol 0.025% cream |
|  | CLOBEX (clobetasol) |
|  | CLODAN (clobetasol) |
|  | DIPROLENE (betamethasone) |
|  | halobetasol |
|  | IMPEKLO (clobetasol) |
|  | IMPOYZ (clobetasol) 0.025% cream |
|  | LEXETTE (halobetasol) |
|  | OLUX (clobetasol) |
|  | TEMOVATE (clobetasol) |
|  | TOVET (clobetasol) |
|  | ULTRAVATE (halobetasol) |
| **STIMULANTS AND RELATED AGENTS DUR+** | | | | |
| **SHORT-ACTING** | | **Minimum Age Limit**   * **3 years**: ADDERALL, EVEKEO, PROCENTRA, ZENZEDI * **6 years**: ADDERALL XR, ADHANSIA XR, ADZENYS ER SUSPENSION, ADZENYS XR ODT, APTENSIO XR, atomoxetine, AZSTARYS, clonidine ER, CONCERTA ER, COTEMPLA XR   ODT, DAYTRANA, DESOXYN, DEXEDRINE, DYANAVEL XR, EVEKEO ODT, FOCALIN,  FOCALIN XR, JORNAY PM, METADATE CD, METHYLIN, ONYDA XR, QELBREE,  QUILLICHEW, QUILLIVANT XR, RELEXXII ER, RITALIN LA, VYVANSE, XELSTRYM   * **7 years**: XYREM * **13 years**: MYDAYIS * **16 years**: modafinil * **18 years**: armodafinil, SUNOSI, WAKIX     **Maximum Age Limit**   * **18 years**: clonidine ER, COTEMPLA XR ODT, DAYTRANA, EVEKEO ODT, guanfacine ER     **Quantity Limit** – **Stimulants** (per 31 days)   * **31 tablets**: ADDERALL XR, ADHANSIA XR, ADZENYS XR ODT, APTENSIO XR, AZSTARYS, CONCERTA ER 18, 27, & 54 mg, COTEMPLA XR-ODT 8.6 mg, DAYTRANA, DEXEDRINE   See next page for additional PA Criteria/DUR+ Rules | | |
| dexmethylphenidate | ADDERALL  (dextroamphetamine/amphetamine) |
| dextroamphetamine | amphetamine |
| dextroamphetamine/amphetamine | EVEKEO (amphetamine) |
| Methylphenidate tablet | EVEKEO ODT (amphetamine) |
| PROCENTRA (dextroamphetamine) | FOCALIN (dexmethylphenidate) |
|  | methamphetamine |
|  | METHYLN (methylphenidate) |
|  | Methylphenidate chewable tablet |
|  | RITALIN (methylphenidate) |
|  | ZENZEDI (dextroamphetamine) |
| **LONG-ACTING** | |
| ADDERALL XR  (dextroamphetamine/amphetamine) | ADZENYS XR ODT (amphetamine) |
| CONCERTA (methylphenidate) | APTENSIO XR (methylphenidate) |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** | | |
| **STIMULANTS AND RELATED AGENTS DUR+** *(continued)* | | | | |
| dexmethylphenidate ER | AZSTARYS  (serdexmethylphenidate/dexmethylphenidate) |  | See previous page for additional PA Criteria/DUR+ Rules |  |
| Spansule, DYANAVEL XR Tablet, FOCALIN XR, JORNAY PM, METADATE CD, METHYLIN ER, MYDAYIS 37.5 mg & 50 mg, QUILLICHEW, RELEXXII ER, RITALIN LA & SR, VYVANSE, XELSTRYM   * **62 tablets**: ADDERALL, CONCERTA ER 36 mg, COTEMPLA XR-ODT 17.3 & 25.9 mg, DESOXYN, EVEKEO, FOCALIN, METHYLIN, ZENZEDI * **248 mL**: DYANAVEL XR Suspension * **310 mL**: METHYLIN, PROCENTRA * **372 mL**: QUILLIVANT XR     **Quantity Limit** – **Narcolepsy** (per 31 days)   * **31 tablets**: armodafinil 150, 200 & 250 mg, modafinil 200 mg, SUNOSI * **46.5 tablets**: modafinil 100 mg   **62 tablets**: armodafinil 50 mg, WAKIX    **Quantity Limit** – **Non-Stimulants** (per 31 days)   * **31 tablets**: atomoxetine, guanfacine ER,QELBREE 100 mg * **62 tablets**: QELBREE 150 mg and 200 mg * **124 tablets**: clonidine ER * **1 bottle (30 mL or 60 mL)**: ONYDA XR Suspension         **VYVANSE**   * Documented diagnosis of binge eating disorder or ADD/ADHD OR * 90 days of therapy with Vyvanse in the past 90 days                                       See next page for additional PA Criteria/DUR+ Rules |
| dextroamphetamine ER | COTEMPLA XR ODT (methylphenidate) |
| dextroamphetamine/amphetamine ER (generic ADDERALL XR) | DAYTRANA (methylphenidate) |
| DYANAVEL XR (amphetamine) suspension | DEXEDRINE (dextroamphetamine) |
| lisdexamfetamine | dextroamphetamine/amphetamine ER (generic MYDAYIS ER) |
| methylphenidate CD | DYANAVEL XR (amphetamine) tablets |
| methylphenidate ER tablet | FOCALIN XR (dexmethylphenidate) |
| methylphenidate LA | JORNAY PM (methylphenidate) |
| QUILLICHEW ER (methylphenidate) | methylphenidate patch |
| QUILLIVANT XR (methylphenidate) | methylphenidate ER capsule |
| VYVANSE (lisdexamfetamine) capsules | MYDAYIS (dextroamphetamine/amphetamine) |
|  | RELEXXII (methylphenidate) |
|  | RITALIN LA (methylphenidate) |
|  | VYVANSE (lisdexamfetamine) chewable tablets |
|  | XELSTRYM (dextroamphetamine) |
| **NARCOLEPSY** | |
| armodafinil | NUVIGIL (armodafinil) |
| modafinil | PROVIGIL (modafinil) |
| SUNOSI (solriamfetol) | sodium oxybate |
| XYREM (sodium oxybate) | WAKIX (pitolisant) |
|  | XYWAV (calcium/magnesium/potassium/sodium oxybate) |
| **NON-STIMULANTS** | |
| atomoxetine | INTUNIV (guanfacine) |
| clonidine ER | NEXICLON XR (clonidine) |
| guanfacine ER | ONYDA XR (clonidine) |
| QELBREE (viloxazine) | STRATTERA (atomoxetine) |
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| **PREFERRED AGENTS** | | **NON-PREFERRED AGENTS** | | | | **PA CRITERIA** | |
| **STIMULANTS AND RELATED AGENTS DUR+** (*continued*) | | | | | | | |
|  | | | See previous page for additional PA Criteria/DUR+ Rules | | | |  |
| **Non-Preferred Short Acting Criteria**    **ADD/ADHD**   * Documented diagnosis of ADD/ADHD **AND** * Have tried 2 different preferred Short Acting agents in the past 6 months **OR** • 1 claim for a 30-day supply with the requested agent in the past 105 days     **Narcolepsy**:ADDERALL, EVEKEO, METHYLIN, PROCENTRA, RITALIN,  ZENZEDI   * Documented diagnosis of narcolepsy **AND** * 30 days of therapy with preferred modafinil or armodafinil in the past 6 months **AND** * 1 preferred agent indicated for narcolepsy in the past 6 months **OR** * Have tried 1 claim for a 30-day supply with the requested agent in the past 105 days | | | | | **Non-Preferred Long Acting Criteria**    **ADD/ADHD**   * Documented diagnosis of ADD/ADHD **AND** * Have tried 2 different preferred Long-Acting agents in the past 6 months **OR** * 1 claim for a 30-day supply with the requested agent in the past 105 days     **Narcolepsy**: ADDERALL XR, APTENSIO XR, CONCERTA ER, DEXEDRINE, METADATE CD,  METHYLIN ER, MYDAYIS, NUVIGIL, PROVIGIL, QUILLICHEW, QUILLIVANT XR, RITALIN LA   * Documented diagnosis of narcolepsy **AND** * 30 days of therapy with preferred modafinil or armodafinil in the past 6 months **AND** * 1 different preferred agent indicated for narcolepsy in the past 6 months **OR** * 1 claim for a 30-day supply with the requested agent in the past 105 days | | |
| **Armodafinil** **ONYDA XR**   * Documented diagnosis of narcolepsy, obstructive sleep apnea, shift work sleep • Requires clinical review disorder, or bipolar depression   **QELBREE**  **Atomoxetine** • Documented diagnosis of ADD/ADHD **AND**   * Age > 21 years **AND** • 30 days of therapy with a preferred ADHD agent in the past 105 days **OR** * Documented diagnosis of ADD/ADHD• 30 days of therapy with QELBREE in the past 105 days     **Clonidine ER** **SUNOSI**   * Documented diagnosis of ADD/ADHD• Documented diagnosis of narcolepsy or obstructive sleep apnea **AND** * 30 days of therapy with preferred modafinil or armodafinil in the past 6 months   **Guanfacine ER**   * Documented diagnosis of ADD/ADHD **VYVANSE** * Documented diagnosis of binge eating disorder or ADD/ADHD   **JORNAY PM**   * Documented diagnosis of ADD/ADHD **AND**  **WAKIX** * 84 days of therapy with 2 different preferred LA methylphenidate agents in the • Requires clinical review past 12 months **AND** * 84 days of therapy with 1 preferred non-methylphenidate LA stimulant agent **XYREM**   in the past 12 months **OR** Documented diagnosis of narcolepsy or excessive daytime sleepiness OR 30 days of therapy with this   * Documented diagnosis of ADD/ADHD **AND** agent in the past 105 days * 84 days of therapy with JORNAY PM in the past 105 days   **XYWAV**   * Requires clinical review | | | | | | | |
|  | See next page for additional PA Criteria/DUR+ Rules | | |  | | | |

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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | | **PA CRITERIA** | | |
| **STIMULANTS AND RELATED AGENTS DUR+** (*continued*) | | | | | |
| **Modafinil**    • Documented diagnosis of narcolepsy, disorder, depression, sleep deprivation or Steiner | | See previous page for additional PA Criteria/DUR+ Rules | |  | |
| obstructive sleep apnea, shift work sleep  t Myotonic Dystrophy Syndrome | |
| **TETRACYCLINES DUR+** | | | | | |
| doxycycline hyclate | demeclocycline | | **Non-Preferred Agents**   * Have tried 2 different preferred agents in the past 6 months     **Demeclocycline**   * Documented diagnosis of Syndrome of Inappropriate Antidiuretic Hormone Secretion (SIADH) will allow for automatic approval     **ORACEA**   * Requires clinical review | | |
| doxycycline monohydrate capsule | DORYX (doxycycline hyclate) | |
| minocycline capsule | DORYX MPC (doxycycline hyclate) | |
| tetracycline capsule | doxycycline hyclate DR | |
|  | doxycycline IR/DR | |
|  | doxycycline monohydrate suspension, tablet | |
|  | LYMEPAK (doxycycline hyclate) | |
|  | MINOCIN (minocycline) | |
|  | minocycline tablet | |
|  | minocycline ER | |
|  | MINOLIRA ER (minocycline) | |
|  | MORGIDOX (doxycycline hyclate) | |
|  | NUZYRA (omadacycline) | |
|  | ORACEA (doxycycline monohydrate) | |
|  | SOLODYN (minocycline) | |
|  | tetracycline tablet | |
| **ULCERATIVE COLITIS & CROHN’S AGENTS DUR+ \*See Cytokine & CAM Antagonists Class for Additional Agents\*** | | | | | |
| **ORAL** | | | **Non-Preferred Criteria**   * Documented diagnosis of Ulcerative Colitis **AND** * Have tried 2 different preferred agents in the past 6 months **OR** * 90 days of therapy with the requested agent in the past 105 days     **VELSIPITY**   * Requires clinical review | | |
| APRISO (mesalamine) | AZULFIDINE (sulfasalazine) | |
| balsalazide | COLAZAL (balsalazide) | |
| budesonide | DELZICOL (mesalamine) | |
| PENTASA (mesalamine) | DIPENTUM (olsalazine) | |
| sulfasalazine | LIALDA (mesalamine) | |
| sulfasalazine DR | mesalamine | |
| UCERIS (budesonide) | mesalamine DR, mesalamine ER | |
|  | VELSIPITY (etrasimod) | |
| **RECTAL** | | |
| mesalamine suppository | budesonide | |
|  | CANASA (mesalamine) | |
|  | mesalamine enema | |
|  | ROWASA (mesalamine) | |
|  | SFROWASA (mesalamine) | |
|  | UCERIS (budesonide) | |
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| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | |  | | **PA CRITERIA** |
|  | **UREA CYCLE DISORDER AGENTS** | | | |  |
| CARBAGLU (carglumic acid) | BUPHENYL (sodium phenylbutyrate) | |  | |  |
|  | carglumic acid | |
|  | OLPRUVA (sodium phenylbutyrate) | |
|  | PHEBURANE (sodium phenylbutyrate) | |
|  | RAVICTI (glycerol phenylbutyrate) | |