

Nevada Medicaid and Nevada Check Up

Preferred Drug List (PDL)

Effective October 10, 2024

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

* Nevada Medicaid’s PDL only includes select drug classes
* PDL Preferred Products do not require Prior Authorization (PA) unless subject to additional clinical criteria (indicated by PA next to drug name)
* Non-Preferred Products require PA for approval
* Drugs not on the PDL are subject to Nevada’s mandatory generic substitution requirements PA requests may be submitted by electronic PA (ePA), fax, or phone:
* ePA: [Prime Therapeutics Prior Authorization Forms | CoverMyMeds](https://www.covermymeds.health/prior-authorization-forms/prime)
* Fax: 844-347-3202
* PA fax forms: [nv.primetherapeutics.com](https://nv.primetherapeutics.com/)
* Phone: 800-695-5526

Key:

|  |  |  |
| --- | --- | --- |
| cap = capsule  ER = extended release inj = injection  IR = immediate release  nebs = nebulizer | ODT = oral disintegrating tablet oint = ointment  PA = Prior Authorization QL = Quantity Limit | soln = solution supp = suppository susp = suspension tab = tablet |

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| **Preferred Products** | **Non-Preferred Products** | **Prior Authorization Criteria** |
| 21B **Miscellaneous Analgesics** | | |
| 89B ***Neuropathic Pain/Fibromyalgia Agents*** | | |
| duloxetine  gabapentin | Cymbalta®  Gralise® | \* No PA if ICD-10 – M79.1; M60.0–  M60.9, M61.1 (fibromyalgia) |
| lidocaine 5% patch (generic for Lidoderm®) PA QL | Horizant®  Lyrica® CR |  |
| Lyrica® IR | pregabalin IR |  |
| Neurontin*®* | pregabalin CR |  |
| Savella® PA\* | Qutenza® |  |
| 90B ***Mixed Acting Opioid Analgesics*** | | |
| Nucynta® | ConZip® |  |
| Nucynta® ER | Seglentis® |
| tramadol IR | tramadol ER |
| tramadol/APAP | Ultracet® |
| 22B**Opiate Agonists** | | |
| Butrans® | buprenorphine patch |  |
| fentanyl patch QL PA | hydrocodone bitartrate ER cap |
| morphine sulfate SA tab (all generic extended release) QL | methadone  Methadose® |
|  | MS Contin® QL |
|  | oxycodone SR QL |
|  | oxymorphone SR |
| 23B**Opiate Agonists – Abuse Deterrents** | | |
| Xtampza® ER | hydrocodone bitartrate ER tab Hysingla® ER  Oxycontin® QL |  |
| 24B **Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) – Oral** | | |
| celecoxib cap QL | Cambia® powder |  |
| diclofenac sodium DR tab | diclofenac potassium |
| ibuprofen susp | diclofenac sodium tab ER |
| ibuprofen tab | diclofenac w/ misoprostol tab |
| indomethacin IR cap | Duexis® tab |
| ketorolac tab QL PA | etodolac IR cap |
| meloxicam tab | etodolac IR tab |
| nabumetone tab | etodolac ER tab |

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| **Preferred Products** | **Non-Preferred Products** | **Prior Authorization Criteria** |
| naproxen susp naproxen tab naproxen DR tab piroxicam cap sulindac tab | indomethacin ER cap ketoprofen cap mefenamic cap meloxicam susp Naprelan® CR tab naproxen CR tab naproxen ER tab oxaprozin tab  Sprix® spray Vimovo® tab Zipsor® cap  Zorvolex® cap |  |
| 1B**Antihistamines** | | |
| **Preferred Products** | **Non-Preferred Products** | **Prior Authorization Criteria** |
| 25B **H1 Blockers – Non-Sedating** | | |
| cetirizine tab, chewable OTC cetirizine soln 1 mg/1 mL levocetirizine tab, soln  loratadine D OTC | Allegra® cetirizine D OTC  cetirizine cap OTC  cetirizine soln 5 mg/5 mL OTC | A two-week trial of one preferred drug is required before a non- preferred drug will be authorized. |
| loratadine tab, ODT, chewable, soln OTC | Clarinex® Clarinex-D® Claritin® desloratadine fexofenadine  fexofenadine D OTC  Xyzal® |
| 2B**Anti-Infective Agents** | | |
| **Preferred Products** | **Non-Preferred Products** | **Prior Authorization Criteria** |
| 26B **Aminoglycosides** | | |
| 91B***Inhaled Aminoglycosides*** | | |
| Bethkis® Kitabis® Pak  tobramycin 300 mg/5 mL nebulizer | Tobi Podhaler®  tobramycin 300 mg/4 mL nebulizer |  |

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| **Preferred Products** | **Non-Preferred Products** | **Prior Authorization Criteria** |
| 27B **Antivirals** | | |
| 92B ***Alpha Interferons*** | | |
| Pegasys®  Pegasys® convenient pack Peg-Intron® and Redipen |  |  |
| 93B ***Anti-hepatitis Agents – Polymerase Inhibitors/Combination Products*** | | |
| Mavyret® PA sofosbuvir/velpatasvir (generic for Epclusa®) PA | Epclusa® Harvoni® QL  ledipasvir/sofosbuvir QL  Sovaldi® QL Viekira® Pak QL Vosevi®  Zepatier® |  |
| 94B ***Anti-hepatitis Agents – Ribavirin*** | | |
| ribavirin |  |  |
| 95B ***Anti-herpetic Agents*** | | |
| acyclovir famciclovir  valacyclovir |  |  |
| 96B***Influenza Agents*** | | |
| amantadine oseltamivir cap/susp rimantadine  Relenza® | Rapivab® Tamiflu® Xofluza® |  |
| 28B **Cephalosporins** | | |
| 97B***Second-Generation Cephalosporins*** | | |
| cefaclor cap cefuroxime tab cefprozil tab and susp | Ceclor® Ceclor® CD cefaclor susp cefaclor ER tab Ceftin®  Cefzil® |  |
| 98B***Third-Generation Cephalosporins*** | | |
| cefdinir cap and susp PA  cefpodoxime tab and susp PA | cefixime cap and susp PA  Suprax® PA |  |

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| **Preferred Products** | **Non-Preferred Products** | | **Prior Authorization Criteria** |
| 29B **Macrolides** | | | |
| azithromycin tab/susp | Dificid® |  |  |
| clarithromycin tab/susp clarithromycin XL erythromycin base erythromycin ethylsuccinate  Erythrocin® | Zithromax® |  |
| 30B**Quinolones** | | | |
| 99B***Quinolones – 2nd Generation*** | | | |
| ciprofloxacin tabs PA  Cipro® susp PA | ofloxacin PA | |  |
| 100B***Quinolones – 3rd Generation*** | | | |
| levofloxacin PA  moxifloxacin PA | Avelox® PA | |  |
| 31B**Topical Anti-Infectives, Vaginal** | | | |
| Cleocin® cream | clindamycin |  |  |
| Cleocin® ovule | Clindesse® |  |
| metronidazole (generic for | Vandazole® |  |
| Vandazole®)  Nuvessa® | Xaciato® |  |
| 3B**Autonomic Agents** | | | |
| **Preferred Products** | **Non-Preferred Products** | | **Prior Authorization Criteria** |
| 32B**Sympathomimetics** | | | |
| 101B***Self-Injectable Epinephrine*** | | | |
| epinephrine auto inj | Adrenaclick® | QL |  |
| Epipen® | Auvi-Q® |  |
| Epipen Jr® | Symjepi® |  |

4B**Biologic Response Modifiers**

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| **Preferred Products** | **Non-Preferred Products** | **Prior Authorization Criteria** |
| 33B**Immunomodulators** | | |
| 102B***Immunomodulators: Atopic Dermatitis*** | | |
| Dupixent® PA  Elidel® topical QL PA  Eucrisa® topical PA | Adbry® inj  Cibinqo® tab Opzelura® topical |  |

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| **Preferred Products** | **Non-Preferred Products** | **Prior Authorization Criteria** |
| tacrolimus topical (generic for Protopic®) QL PA | pimecrolimus topical |  |
| 103B***Targeted Immunomodulator*** | | |
| Actemra® PA Avsola® PA Cimzia® PA Cosentyx® PA Enbrel® PA Humira® PA Inflectra® PA Infliximab PA Kevzara® PA Kineret® PA Olumiant® PA Orencia® PA Otezla® PA Renflexis® PA Simponi® PA Stelara® PA Xeljanz® IR PA | adalimumab-aacf adalimumab-aaty adalimumab-adbm adalimumab-adaz adalimumab-fkjp adalimumab-ryvk Abrilada® Amjevita® Bimzelx® Cyltezo® Enspryng® Entyvio® Hadlima®  Hulio® Hyrimoz® Idacio® Ilaris® Ilumya® Omvoh® Remicade® Rinvoq® Siliq® Simlandi® Sotyktu® Spevigo® Skyrizi® Taltz® Tremfya® Uplizna® Velsipity® Yuflyma® Yusimry®  Xeljanz® ER |  |

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| **Preferred Products** | **Non-Preferred Products** | **Prior Authorization Criteria** |
|  | Zeposia® |  |
| 104B***Colony Stimulating Factors*** | | |
| Neupogen® syringe and vial PA  Nyvepria® PA | Nivestym® syringe and vial Releuko® syringe and vial Leukine®  Zarxio®  Granix® syringe and vial Fulphila®  Ziextenzo® Udenyca®  Neulasta® |  |
| 105B***Immune Globulins*** | | |
| Gamunex-C® Gammagard Liquid® Hizentra®  Privigen® | Asceniv® Bivigam® Cutaquig® Cuvitru® Cytogam® Flebogamma® Gamastan® Gamastan S-D® Gammagard S-D® Gammaked® Gammaplex® Hepagam B® Hyperhep B S-D® Hyperrab® Hyqvia®  Kedrab® Octagam® Panzyga® Varizig®  Xembify® |  |

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| **Preferred Products** | | | **Non-Preferred Products** | **Prior Authorization Criteria** |
| 34B **Multiple Sclerosis Agents** | | | | |
| 106B***Injectable*** | | | | |
| Avonex® PA |  |  | Briumvi® | Trial of only one agent is required |
| Avonex® Admin Pack PA | | | Extavia® | before moving to a non-preferred |
| Betaseron® PA | |  | glatiramer | agent. |
| Copaxone® QL PA | |  | Glatopa® |  |
| Tysabri® PA |  |  | Kesimpta® Lemtrada® Ocrevus® Plegridy®  Rebif® QL |  |
| 107B***Oral*** | | | | |
| teriflunomide (generic for | | | Aubagio® |  |
| Aubagio®) PA |  |  | Bafiertam® |
| dimethyl fumarate | | (generic for | Gilenya® |
| Tecfidera®) PA | |  | Mavenclad® |
| fingolimod (generic for Gilenya®) | | | Mayzent® |
| PA |  |  | Ponvory® |
|  |  |  | Tecfidera® |
|  |  |  | Vumerity® |
|  |  |  | Zeposia® |
| 108B***Specific Symptomatic Treatment*** | | | | |
| dalfampridine | QL PA |  | Ampyra® QL |  |

5B**Cardiovascular Agents**

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| **Preferred Products** | **Non-Preferred Products** | **Prior Authorization Criteria** |
| 35B **Antihypertensive Agents** | | |
| 109B***Angiotensin II Receptor Antagonists*** | | |
| losartan losartan HCTZ olmesartan  olmesartan HCTZ valsartan valsartan HCTZ | Atacand® Avapro® Benicar® candesartan Cozaar® Diovan® Diovan HCTZ®  Edarbi® |  |

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| **Preferred Products** | **Non-Preferred Products** | **Prior Authorization Criteria** |
|  | Edarbyclor® eprosartan Hyzaar® irbesartan Micardis®  telmisartan |  |
| 110B***Angiotensin-Converting Enzyme Inhibitors (ACE Inhibitors)*** | | |
| benazepril benazepril HCTZ captopril captopril HCTZ enalapril tab enalapril HCTZ enalapril soln PA\* lisinopril  lisinopril HCTZ  ramipril | Accuretic® Epaned® soln fosinopril Mavik® moexipril perindopril Qbrelis® soln quinapril Quinaretic®  trandolapril | \*PA not required if age 10 and younger |
| 111B***Beta-Blockers*** | | |
| acebutolol atenolol  atenolol/chlorthalidone bisoprolol bisoprolol/HCTZ carvedilol IR  Coreg CR® labetalol metoprolol tartrate  metoprolol succinate  nadolol (generic for Corgard®) nebivolol (generic for Bystolic®) metoprolol/HCTZ  propranolol propranolol ER propranolol soln sotalol  sotalol AF | betaxolol  carvedilol ER (generic for Coreg CR®)  Corgard® Kapspargo® pindolol propranolol/HCTZ Sotylize®  timolol |  |

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| **Preferred Products** | | **Non-Preferred Products** | **Prior Authorization Criteria** |
| 112B***Calcium-Channel Blockers*** | | | |
| amlodipine amlodipine/benazepril amlodipine/olmesartan amlodipine/valsartan Cartia XT®  Diltia XT® diltiazem ER diltiazem IR felodipine ER nicardipine nifedipine ER Taztia XT® verapamil IR  verapamil ER | | amlodipine/valsartan/HCT Exforge®  Exforge HCT® isradipine Katerzia® Lotrel® nisoldipine ER Norvasc®  Nymalize® solution |  |
| 113B***Vasodilators – Inhaled*** | | | |
| Ventavis® PA  Tyvaso® PA | | Tyvaso DPI® |  |
| 114B***Vasodilators – Oral*** | | | |
| Orenitram® ER PA | | Adcirca® |  |
| sildenafil tab PA | | Adempas® |
| sildenafil susp PA | | Alyq® |
| tadalafil PA |  | ambrisentan |
| Tracleer® | tab PA | bosentan Letairis®  Liqrev® suspension Opsumit® Opsynvi®  Revatio® tab Revatio® susp Tadliq® suspension Tracleer® tab for susp  Uptravi® |
| 36B **Antilipemics** | | | |
| 115B***Bile Acid Sequestrants*** | | | |
| colestipol | | colesevelam |  |

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| **Preferred Products** | **Non-Preferred Products** | | **Prior Authorization Criteria** |
| cholestyramine | Questran® | |  |
| Welchol® |
| 116B***Cholesterol Absorption Inhibitors*** | | | |
| ezetimibe | Zetia® | |  |
| 117B***Fibric Acid Derivatives*** | | | |
| fenofibrate (generic for Antara®, Lofibra®, and Tricor®)  fenofibric acid (generic for Trilipix®)  gemfibrozil Lipofen® | Antara®  fenofibrate (generic for Fenoglide® and Lipofen®)  fenofibric acid (generic for Fibricor®)  Fenoglide® Fibricor® Tricor® Triglide®  Trilipix® | |  |
| 118B***HMG-CoA Reductase Inhibitors (Statins)*** | | | |
| atorvastatin | Altoprev® | |  |
| ezetimibe/simvastatin | amlodipine/atorvastatin | |
| lovastatin | Caduet® |  |
| pravastatin | Crestor® | QL |
| rosuvastatin | Ezallor® |  |
| simvastatin | fluvastatin IR | |
|  | fluvastatin XL | |
|  | Lescol® |  |
|  | Lescol XL® | |
|  | Lipitor® |  |
|  | Livalo® |  |
|  | Pravachol® | |
|  | Zocor® |  |
|  | Zypitamag® | |
|  | Vytorin® |  |
| 119B***Niacin Agents*** | | | |
| Niacin ER (all generics)  Niaspan® | Niacor® | |  |
| 120B***Omega-3 Fatty Acids*** | | | |
| omega-3-acid | Lovaza® | |  |

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| **Preferred Products** | **Non-Preferred Products** | **Prior Authorization Criteria** |
| Vascepa® | icosapent |  |
| 121B***PCSK9 Inhibitors*** | | |
| Praluent® PA  Repatha® PA |  |  |
| 37B **Miscellaneous Heart Failure Agents** | | |
| Entresto® tab PA QL  ivabradine PA QL | Corlanor® tab and soln QL  Entresto® sprinkle cap QL  Verquvo® |  |

6B**Dermatological Agents**

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| **Preferred Products** | **Non-Preferred Products** | **Prior Authorization Criteria** |
| 38B **Antipsoriatic Agents** | | |
| calcipotriene cream (generic for Dovonex®)  calcipotriene foam (generic for Sorilux®)  calcipotriene oint, soln Dovonex® cream Taclonex® susp | calcipotriene/betamethasone oint, susp  Duobrii® lotion Enstilar® Sorilux® foam Taclonex® oint Vtama®  Zoryve® |  |
| 39B**Topical Analgesics** | | |
| capsaicin diclofenac 1% gel  diclofenac 3% gel Flector® lidocaine lidocaine HC lidocaine viscous  lidocaine/prilocaine  lidocaine 5% patch (generic for Lidoderm®) PA QL | diclofenac solution Emla® LenzaPro® Licart® Pennsaid® ZTLido® |  |
| 40B**Topical Anti-infectives** | | |
| 122B***Acne Agents: Topical, Benzoyl Peroxide, Antibiotics, and Combination Products*** | | |
| Acanya® PA\*  Azelex® 20% cream PA\* | Aczone® gel  Amzeeq® foam | \*PA not required if under 21 years old |

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| **Preferred Products** | **Non-Preferred Products** | **Prior Authorization Criteria** |
| benzoyl peroxide (2.5%, 5%, and  10% only) PA\* clindamycin PA\*  erythromycin/benzoyl peroxide sodium PA\* | benzoyl per aerosol clindamycin aerosol  clindamycin/benzoyl peroxide gel dapsone gel  Duac CS® erythromycin Onexton® gel  sodium sulfacetamide/sulfur sulfacetamide  Winlevi® |  |
| 123B***Impetigo Agents: Topical*** | | |
| mupirocin oint | Altabax® Centany®  mupirocin cream |  |
| 124B***Topical Antivirals*** | | |
| acyclovir oint (generic for Zovirax® oint)  Denavir®  docosanol OTC (generic for Abreva®)  Xerese® cream Zovirax® cream | acyclovir cream  penciclovir (generic for Denavir®) Zovirax® oint |  |
| 125B***Topical Scabicides*** | | |
| lindane | Eurax® |  |
| Natroba® | ivermectin |
| Nix® | malathion |
| permethrin | Ovide® |
| Rid® | Sklice® |
| Ulesfia® | spinosad  Vanalice® gel |
| 41B**Topical Antineoplastics** | | |
| 126B***Topical Retinoids*** | | |
| adapalene gel (generic for Differin® gel) PA\*  Retin-A PA\* | Arazlo® adapalene cream  adapalene/benzoyl peroxide | \*PA not required if under 21 years of age |

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

7B**Electrolytic and Renal Agents**

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| **Preferred Products** | **Non-Preferred Products** | **Prior Authorization Criteria** |
| 42B**Phosphate Binding Agents** | | |
| calcium acetate cap calcium acetate tab Phoslyra®  sevelamer carbonate tab sevelamer carbonate powder pack | Auryxia® Fosrenol®  lanthanum carbonate PhosLo® gel cap Renvela® tab Renvela® powder pack sevelamer Hcl Velphoro®  Xphozah® |  |
| 43B**Potassium-Removing Agents** | | |
| Lokelma®  sodium polystyrene sulfonate SPS® | Veltassa® |  |

8B**Gastrointestinal Agents**

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| **Preferred Products** | **Non-Preferred Products** | **Prior Authorization Criteria** |
| 44B **Antiemetics** | | |
| 127B***Pregnancy-induced Nausea and Vomiting Treatment*** | | |
| Bonjesta®  OTC doxylamine 25 mg/pyridoxine 10 mg | Diclegis®  doxylamine-pyridoxine tab 10-10 |  |
| 128B***Serotonin-receptor Antagonists/Combo*** | | |
| granisetron QL PA  ondansetron QL PA | Akynzeo® Anzemet® QL Barhemsys® Sancuso®  Zofran® QL |  |

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| **Preferred Products** | **Non-Preferred Products** | **Prior Authorization Criteria** |
|  | Zuplenz® QL |  |
| 45B **Antiulcer Agents** | | |
| 129B***H2 Blockers*** | | |
| Famotidine tab and susp ranitidine tab  ranitidine syrup PA\* |  | \* PA not required for < 12 years of age |
| 130B***Proton Pump Inhibitors (PPIs)*** | | |
| omeprazole pantoprazole tab Protonix® susp | Aciphex® Dexilant® dexlansoprazole esomeprazole lansoprazole Nexium® cap  Nexium® powder for susp pantoprazole susp Prevacid®  Prilosec®  Protonix® tab rabeprazole sodium |  |
| 46B**Functional Gastrointestinal Disorder Drugs** | | |
| Linzess® PA  lubiprostone (generic for Amitiza®)  PA  Movantik® PA  Relistor® syringe PA | Amitiza® Ibsrela® Motegrity® Relistor® tab Symproic® Trulance®  Zelnorm® |  |
| 47B**Gastrointestinal Anti-inflammatory Agents** | | |
| Apriso® Canasa® supp Colazal® Delzicol® Pentasa®  sulfasalazine DR | balsalazide Lialda®  mesalamine (generic for Apriso) mesalamine (generic for Asacol HD)  mesalamine (generic for Delzicol) |  |

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| **Preferred Products** | **Non-Preferred Products** | **Prior Authorization Criteria** |
| sulfasalazine IR | mesalamine (generic Lialda) mesalamine enema susp  mesalamine supp |  |
| 48B**Gastrointestinal Enzymes** | | |
| Creon® | Pertzye® |  |
| Pancreaze® | Viokace® |
| Zenpep® |  |
| 9B**Genitourinary Agents** | | |
| **Preferred Products** | **Non-Preferred Products** | **Prior Authorization Criteria** |
| 49B **Benign Prostatic Hyperplasia (BPH) Agents** | | |
| 131B***5-Alpha Reductase Inhibitors*** | | |
| dutasteride | Avodart® |  |
| finasteride | dutasteride/tamsulosin |
|  | Jalyn® |
|  | Proscar® |
| 132B***Alpha-Blockers*** | | |
| alfuzosin | Cardura® |  |
| doxazosin | Flomax® |
| tamsulosin | Minipress® |
| terazosin | prazosin |
|  | Rapaflo® |
|  | silodosin |
|  | Uroxatral® |
| 50B **Bladder Antispasmodics** | | |
| bethanechol Detrol® Detrol LA®  oxybutynin IR and ER tab/syrup solifenacin  Toviaz® | darifenacin ER Ditropan XL® flavoxate Gelnique® gel Gemtesa Myrbetriq® Oxytrol® Sanctura® tolterodine trospium  Vesicare® |  |

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

10B**Hematological Agents**

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| **Preferred Products** | **Non-Preferred Products** | **Prior Authorization Criteria** |
| 51B **Anticoagulants** | | |
| 133B***Oral*** | | |
| Coumadin® Eliquis® PA\* Jantoven®  Pradaxa® cap QL PA\* | Savaysa®  dabigatran cap (generic for Pradaxa® cap)  Pradaxa® oral pellets | \* No PA required if approved diagnosis code transmitted on claim. |
| Warfarin Xarelto® tab PA\* Xarelto® susp PA\*\* | \*\*Approval only in individuals unable to have oral tablets appropriately administered. |
| 134B***Injectable*** | | |
| enoxaparin | Arixtra® |  |
| fondaparinux | Lovenox® |
| Fragmin® |  |
| 52B**Erythropoiesis-Stimulating Agents** | | |
| Aranesp® PA QL  Retacrit® PA | Epogen® QL Mircera® QL Procrit® QL Reblozyl®  Vafseo® QL |  |
| 53B**Platelet Inhibitors** | | |
| Aggrenox® aspirin Brilinta® QL PA cilostazol clopidogrel dipyridamole  prasugrel QL PA | anagrelide aspirin/dipyridamole Durlaza®  Effient® QL Plavix® Yosprala®  Zontivity® |  |

11B**Hormones and Hormone Modifiers**

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| **Preferred Products** | **Non-Preferred Products** | **Prior Authorization Criteria** |
| 54B **Androgens** | | |
| Androderm® PA | AndroGel® gel packet |  |

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| **Preferred Products** | **Non-Preferred Products** | **Prior Authorization Criteria** |
| AndroGel® gel pump PA testosterone gel pump (generic for Androgel®) PA | Fortesta® Natesto® Testim®  testosterone gel packet testosterone solution  Vogelxo® |  |
| 55B **Antidiabetic Agents** | | |
| 135B***Alpha-Glucosidase Inhibitors/Amylin Analogs/Miscellaneous*** | | |
| acarbose Glyset® Symlin® PA \* | Cycloset® Precose® | \* No PA required if diagnosis of Type 2 diabetes transmitted on claim.  Trial of only one agent is required before moving to a non-preferred agent. |
| 136B***Biguanides*** | | |
| metformin (generic for Glucophage®) metformin ER (generic for  Glucophage XR®)  metformin ER (generic for Glumetza®)  metformin soln (generic for Riomet®)\*  Riomet® ER suspension\* | Glumetza®  metformin ER (generic for Fortamet®)  metformin 625 mg tab | Trial of only one agent is required before moving to a non-preferred agent.  \* Approval only in individuals unable to have oral tablets appropriately administered. |
| 137B***Dipeptidyl Peptidase-4 Inhibitors and Combinations with Metformin*** | | |
| Janumet® Janumet XR® Januvia® Jentadueto® Jentadueto XR®  Tradjenta® | alogliptin alogliptin/metformin alogliptin/pioglitazone saxagliptin saxagliptin/metformin ER | Trial of only one agent is required before moving to a non-preferred agent. |
| 138B***Incretin Mimetics and Combinations*** | | |
| Byetta® PA, QL Ozempic® PA, QL Rybelsus® PA, QL  Trulicity® PA, QL | Bydureon BCise® QL liraglutide QL Mounjaro® QL  Soliqua® QL | Trial of only one agent is required before moving to a non-preferred agent. |

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| **Preferred Products** | **Non-Preferred Products** | **Prior Authorization Criteria** |
| Victoza® PA, QL | Xultophy® QL |  |
| 139B***Meglitinides*** | | |
| repaglinide | nateglinide | Trial of only one agent is required before moving to a non-preferred agent. |
| 140B***Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitors and Combinations*** | | |
| Farxiga® Glyxambi® Invokamet® Invokana® Jardiance® Synjardy® Synjardy XR® Xigduo XR® | dapagliflozin (generic for Farxiga®) dapagliflozin/metformin ER (generic for Xigduo XR®)  Inpefa® Invokamet XR® Qtern® Segluromet® Steglatro® Steglujan®  Trijardy XR® | For Antidiabetic indication, trial of only one agent is required before moving to a non-preferred agent. |
| 141B***Sulfonylureas*** | | |
| glimepiride (generic for Amaryl®) glipizide (generic for Glucotrol®)  glipizide ER (generic for Glucotrol XL®)  glyburide (generic for DiaBeta®, Micronase®)  glyburide micronized (generic for Glynase®) | Amaryl® Glynase® Glucotrol XL®  glyburide/metformin (generic for Glucovance®) glipizide/metformin (generic for  Metaglip®) | Trial of only one agent is required before moving to a non-preferred agent. |
| 142B***Thiazolidinediones and Combinations*** | | |
| pioglitazone | Actos® Actoplus Met® Duetact®  pioglitazone/metformin  pioglitazone/glimepiride | Trial of only one agent is required before moving to a non-preferred agent. |
| 56B **Anti-Hypoglycemic Agents** | | |
| Baqsimi® GlucaGen HypoKit® Gvoke® pen  Zegalogue® | glucagon emergency kit Gvoke® syringe |  |

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| **Preferred Products** | **Non-Preferred Products** | **Prior Authorization Criteria** |
| 57B**Insulins** | | |
| 143B***Rapid-Acting Insulins*** | | |
| Apidra®  Apidra Solostar® Humalog®  Humalog KwikPen® U-100 Humalog Junior KwikPen®  insulin aspart (generic for Novolog®)  insulin lispro (generic for Humalog®)  Novolog® | Admelog® Admelog Solostar® Afrezza®  Fiasp®  Fiasp FlexTouch® Humalog KwikPen® U-200 Lyumjev®  Lyumjev KwikPen® | Trial of only one agent is required before moving to a non-preferred agent. |
| 144B***Short-Intermediate Acting Insulins*** | | |
| Humulin R® U-500  Novolin N® Novolin R® | Humulin N®  Humulin N KwikPen® Humulin R® U-100 | Trial of only one agent is required before moving to a non-preferred agent. |
| 145B***Long-Acting Insulins*** | | |
| Lantus®  Lantus SoloStar® Levemir®  Toujeo Max SoloStar® Toujeo SoloStar® Tresiba®  Tresiba FlexTouch® | Basaglar KwikPen® insulin glargine-YFGN Rezvoglar® Semglee® | Trial of only one agent is required before moving to a non-preferred agent. |
| 146B***Pre-Mixed Insulin Combinations*** | | |
| Humulin 70/30® Humalog 75/25® Humalog 50/50®  Novolog 70/30® | Novolin 70/30® | Trial of only one agent is required before moving to a non-preferred agent. |
| 58B**Pituitary Hormones** | | |
| 147B***Growth Hormone Modifiers*** | | |
| Genotropin® PA Norditropin® PA Nutropin AQ® PA | Humatrope® Ngenla® Nutropin® Omnitrope®  Saizen® |  |

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| **Preferred Products** | **Non-Preferred Products** | **Prior Authorization Criteria** |
|  | Serostim® Sogroya® Skytrofa® Somavert® Tev-Tropin® Zomacton®  Zorbtive® |  |
| 59B**Progestins for Cachexia** | | |
| megestrol acetate susp (generic for Megace®) | Megace ES® |  |
|  |  |  |
| 60B **Uterine Disorder Treatment** | | |
| Myfembree® PA  Oriahnn® PA  Orilissa® PA |  | Prior Auth required for class |

12B**Monoclonal Antibodies for the Treatment of Respiratory Conditions**

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| **Preferred Products** | **Non-Preferred Products** | | **Prior Authorization Criteria** |
| Dupixent® PA | Cinqair® | |  |
| Fasenra® PA | Tezspire® | |
| Nucala® PA | Xolair® vial | |
| Xolair® syringe PA |  | |
| 13B**Musculoskeletal Agents** | | | |
| **Preferred Products** | **Non-Preferred Products** | | **Prior Authorization Criteria** |
|  | 61B **Antigout** | **Agents** |  |
| allopurinol (100 mg, 300 mg) | allopurinol 200 mg | |  |
| colchicine tab (generic for  Colcrys®) PA, QL | colchicine cap QL  Colcrys® QL | |
| febuxostat | Mitigare® QL | |
| probenecid | Uloric® | |
| probenecid/colchicine | Zyloprim® | |
| 62B **Bone Resorption Inhibitors** | | | |
| 148B***Bisphosphonates*** | | | |
| alendronate tab ibandronate tab  risedronate (generic for Actonel®) | Actonel®  alendronate soln Atelvia® | |  |

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| **Preferred Products** | **Non-Preferred Products** | **Prior Authorization Criteria** |
|  | Binosto® Fosamax Plus D®  risedronate (generic for Atelvia®) |  |
| 149B***Nasal Calcitonins*** | | |
| calcitonin-salmon nasal spray | Miacalcin® |  |
| 63B **Restless Leg Syndrome Agents** | | |
| pramipexole IR ropinirole IR  ropinirole ER |  |  |
| 64B**Skeletal Muscle Relaxants** | | |
| baclofen | carisoprodol 250 mg tab |  |
| carisoprodol 350 mg tab  chlorzoxazone 500 mg tab | chlorzoxazone 250 mg, 375 mg, and 750 mg tab |
| cyclobenzaprine IR |  |
| cyclobenzaprine ER |  |
| dantrolene |  |
| methocarbamol |  |
| orphenadrine |  |
| tizanidine |  |

14B**Neurological Agents**

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| **Preferred Products** | **Non-Preferred Products** | **Prior Authorization Criteria** |
| 65B **Alzheimer’s Agents** | | |
| 150B***Cholinesterase Inhibitors*** | | |
| donepezil tab, ODT Exelon® patch | Adlarity® patch Aricept® galantamine galantamine ER Razadyne® ER  rivastigmine |  |
| 151B***NMDA Receptor Antagonist*** | | |
| memantine IR tab | memantine soln memantine ER (generic for Namenda XR®)  Namenda®  Namenda XR® |  |

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| **Preferred Products** | **Non-Preferred Products** | **Prior Authorization Criteria** |
|  | Namzaric® |  |
| 66B **Anticonvulsants** | | |
| carbamazepine  carbamazepine ER cap (generic for Carbatrol®)  carbamazepine ER tab (generic for Tegretol XR®)  Carbatrol® Celontin® Depakene® Depakote® Depakote Sprinkle® divalproex sodium  divalproex sodium ER Epidiolex® PA  Epitol® ethosuximide felbamate Felbatol® Fycompa® gabapentin Gabitril® lacosamide tab lacosamide soln Lamictal®  Lamictal® dose pack Lamictal ODT® lamotrigine lamotrigine ER levetiracetam levetiracetam ER levetiracetam soln Lyrica®  Neurontin® oxcarbazepine Qudexy XR®  Tegretol® | Aptiom® Banzel® Briviact® Depakote ER® Diacomit® Eprontia® Fintepla® Keppra® Keppra XR® Keppra® soln Lamictal XR®  lamotrigine dose pack Oxtellar XR®  Sabril® Spritam® Topamax® topiramate ER Trileptal® Trokendi XR® vigabatrin Vimpat® tab Vimpat® soln Xcopri® | PA required for members under 18 years old.  Trial of only one agent is required before moving to a non-preferred agent. |

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| **Preferred Products** | **Non-Preferred Products** | **Prior Authorization Criteria** |
| Tegretol XR® topiramate IR valproic acid valproic acid soln Zarontin® zonisamide  Ztalmy® |  |  |
| 152B***Barbiturates*** | | |
| Mysoline®  phenobarbital primidone |  | PA required for members under 18 years old. |
| 67B **Anticonvulsants** | | |
| 153B***Benzodiazepines*** | | |
| clobazam clonazepam clorazepate Diastat®  diazepam (generic for Valium®) diazepam rectal (generic for Diastat®)  Nayzilam® spray PA Tranxene T-Tab® Valium®  Valtoco® spray PA | Klonopin® Onfi® Sympazan® | PA required for members under 18 years of age.  Trial of only one agent is required before moving to a non-preferred agent. |
| 154B***Hydantoins*** | | |
| Cerebyx® Dilantin® fosphenytoin  phenytoin products | Phenytek® | Trial of only one agent is required before moving to a non-preferred agent. |
| 68B **Anti-Migraine Agents** | | |
| 155B***Calcitonin Gene-Related Peptide (CGRP) Receptor Antagonists*** | | |
| Aimovig® PA  Ajovy® PA  Emgality® 120 mg PA Nurtec® ODT PA, QL Qulipta® PA, QL | Emgality® 100 mg Vyepti® |  |

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| **Preferred Products** | **Non-Preferred Products** | **Prior Authorization Criteria** |
| Ubrelvy® PA, QL |  |  |
| 156B***Serotonin-Receptor Agonists (Triptans)*** | | |
| Frova® QL  Relpax® QL  rizatriptan tab (generic for Maxalt®)  QL  rizatriptan ODT (generic for Maxalt MLT®) QL  sumatriptan nasal spray QL  sumatriptan tab QL | almotriptan QL Amerge® QL eletriptan QL frovatriptan QL Imitrex® tab and inj QL Maxalt® QL  Maxalt MLT® QL naratriptan QL Onzetra® Reyvow® sumatriptan inj QL  sumatriptan/naproxen QL  Tosymra® Treximet®  Zembrace SymTouch® QL zolmitriptan tab QL zolmitriptan nasal spray QL  zolmitriptan ODT (generic for Zomig ZMT®) QL  Zomig® nasal spray QL  Zomig® tab QL  Zomig ZMT® |  |
| 69B **Antiparkinsonian Agents** | | |
| 157B***Dopamine Precursors*** | | |
| carbidopa/levodopa carbidopa/levodopa ER carbidopa/levodopa ODT carbidopa/levodopa/entacapone | Duopa® Inbrija® Lodosyn® Rytary®  Stalevo® | Trial of only one preferred agent is required before moving to a non- preferred agent. |
| 158B***Non-Ergot Dopamine Agonists*** | | |
| pramipexole IR ropinirole IR ropinirole ER | Apokyn® Azilect® Mirapex®  Mirapex® ER |  |

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| **Preferred Products** | **Non-Preferred Products** | **Prior Authorization Criteria** |
|  | Neupro® pramipexole ER Requip® Requip XL®  rasagiline |  |
| 70B **Movement Disorders** | | |
| Austedo® PA  Austedo XR® PA  Austedo XR® titration pack PA  Ingrezza® cap PA Ingrezza® sprinkle cap PA tetrabenazine | Xenazine® |  |
| 15B**Ophthalmic Agents** | | |
| **Preferred Products** | **Non-Preferred Products** | **Prior Authorization Criteria** |
| 71B **Antiglaucoma Agents** | | |
| Alphagan P® Azopt® betaxolol Betoptic S® carteolol Combigan® dorzolamide  dorzolamide/timolol latanoprost levobunolol Lumigan® Rhopressa® Rocklatan® Simbrinza®  timolol drops, gel soln (generic for Timoptic®, Timoptic-XE®) Travatan Z® | Betagan® Betoptic® bimatoprost brimonidine brimonidine/timolol brinzolamide Cosopt®  Cosopt PF® dorzolamide/timolol PF Iyuzeh™  Ocupress® Phospholine Iodide®  tafluprost (generic for Zioptan®) Timoptic®  Timoptic-XE® travoprost Trusopt® Vyzulta® Xalatan®  Xelpros® |  |

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| **Preferred Products** | **Non-Preferred Products** | **Prior Authorization Criteria** |
|  | Zioptan® |  |
| 72B**Ophthalmic Antihistamines** | | |
| azelastine Bepreve®  ketotifen (generic for Alaway®, Zaditor®)  Lastacaft®  olopatadine (generic for Pataday®) Zaditor® OTC | Alaway® OTC Alocril® Alomide® bepotastine Elestat® Optivar® Pataday®  Zerviate® |  |
| 73B**Ophthalmic Anti-infectives** | | |
| 159B***Ophthalmic Macrolides*** | | |
| erythromycin oint | Azasite® |  |
| 160B***Ophthalmic Quinolones*** | | |
| Besivance® ciprofloxacin  moxifloxacin (generic for Vigamox®)  ofloxacin Zymaxid® | Ciloxan® gatifloxacin  moxifloxacin (generic for Moxeza®)  Ocuflox® Vigamox® |  |
| 74B**Ophthalmic Anti-infective/Anti-inflammatory Combinations** | | |
| neomycin/polymyxin/dexamethaso ne oint, susp  Pred-G® sulfacetamide/prednisolone soln TobraDex®  tobramycin/dexamethasone susp (generic for TobraDex®) | Blephamide® Maxitrol®  neomycin/bacitracin/polymyxin/hyd rocortisone oint  neomycin/polymyxin/hydrocortison e susp  TobraDex ST®  Zylet® |  |
| 75B**Ophthalmic Anti-inflammatory Agents** | | |
| 161B***Ophthalmic Corticosteroids*** | | |
| Alrex®  difluprednate (generic for Durezol®)  Flarex® FML®  FML Forte® | dexamethasone Durezol® fluorometholone Inveltys® Lotemax®  loteprednol |  |

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| **Preferred Products** | **Non-Preferred Products** | **Prior Authorization Criteria** |
| Maxidex® Pred Forte® | Omnipred®  Pred Mild® prednisolone |  |
| 162B***Ophthalmic Nonsteroidal Anti-inflammatory Drugs (NSAIDs)*** | | |
| diclofenac soln flurbiprofen soln Ilevro® ketorolac soln  Nevanac® | Acular® Acular LS® Acuvail® bromfenac  Prolensa® |  |
| 76B**Ophthalmics for Dry Eye Disease** | | |
| artificial tears Restasis® Xiidra® | Cequa®  Eysuvis®  Restasis Multidose®  Tyrvaya® |  |

16B**Otic Agents**

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| **Preferred Products** | **Non-Preferred Products** | **Prior Authorization Criteria** |
| 77B**Otic Anti-infectives** | | |
| 163B***Otic Quinolones*** | | |
| Ciprodex® ciprofloxacin/dexamethasone (generic for Ciprodex®)  Cipro HC®  ofloxacin | Cetraxal® ciprofloxacin 0.2% soln Otiprio®  Otovel® |  |

17B**Psychotropic Agents**

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| **Preferred Products** | **Non-Preferred Products** | **Prior Authorization Criteria** |
| 78B **ADHD Agents** | | |
| Adderall XR® PA, QL amphetamine salts combo IR (generic for Adderall®) PA  amphetamine salts combo ER (generic for Adderall XR®) PA, QL atomoxetine PA, QL  clonidine ER PA, QL  Concerta® PA, QL | Adderall® Adhansia XR® Adzenys XR ODT®  amphetamine ER susp (generic for Adzenys XR ODT®)  Aptensio XR® QL  Azstarys® Cotempla XR-ODT® | PA required for entire class. |

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| **Preferred Products** | **Non-Preferred Products** | **Prior Authorization Criteria** |
| Daytrana® PA, QL dexmethylphenidate PA dexmethylphenidate ER PA, QL  dextroamphetamine (generic for Dexedrine®, Dextrostat®) PA  dextroamphetamine SR (generic for Dexedrine Spansule®) PA guanfacine ER PA  Jornay PM® PA Metadate CD® PA Methylin® soln PA  methylphenidate (generic for Ritalin®, Methylin®) PA  methylphenidate CD (generic for Metadate CD®) PA, QL methylphenidate ER (generic for  Concerta®, Aptensio XR®) PA, QL  methylphenidate LA (generic for Ritalin LA®) PA, QL methylphenidate solution PA  Qelbree® PA, QL Ritalin LA® PA, QL Vyvanse® PA, QL | Desoxyn® Dexedrine® QL  dextroamphetamine soln (generic for ProCentra®)  Dyanavel XR® QL  Evekeo® Evekeo ODT® Focalin® Focalin XR® QL Intuniv® QL  lisdexamfetamine (generic for Vyvanse®) QL  Metadate ER® QL methamphetamine methylphenidate chew  methylphenidate ER (generic for Relexxii®) QL  methylphenidate patch (generic for Daytrana®) QL  Mydayis® ProCentra® QuilliChew ER® QL Quillivant XR® QL Relexxii®  Ritalin® Strattera® QL Xelstrym®  Zenzedi® |  |
| 79B **Antidepressants** | | |
| 164B***Other*** | | |
| bupropion IR bupropion SR bupropion XL  desvenlafaxine succinate ER (generic for Pristiq®) duloxetine  Forfivo XL® | Aplenzin® Auvelity®  bupropion XL (generic for Forfivo XL®)  Cymbalta®  desvenlafaxine ER Effexor XR® | PA required for members under 18 years old. |

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| **Preferred Products** | **Non-Preferred Products** | **Prior Authorization Criteria** |
| mirtazapine mirtazapine ODT Pristiq® trazodone venlafaxine  venlafaxine hydrochloride ER | Fetzima® Trintellix® Viibryd®  venlafaxine besylate ER  Wellbutrin SR® Wellbutrin XL® |  |
| 165B***Selective Serotonin Reuptake Inhibitors (SSRIs)*** | | |
| citalopram escitalopram fluoxetine paroxetine IR Pexeva® sertraline | Celexa® fluvoxamine Lexapro® Luvox® paroxetine ER Paxil® Prozac®  Zoloft® | PA required for members under 18 years old. |
| 80B **Antipsychotics** | | |
| 166B***Atypical Antipsychotics – Oral/Topical*** | | |
| aripiprazole clozapine clozapine ODT Fanapt®  lurasidine (generic for Latuda®)  Nuplazid® PA\* olanzapine olanzapine ODT  paliperidone ER (generic for Invega®)  quetiapine IR quetiapine ER Rexulti® risperidone risperidone ODT Saphris® Vraylar®  ziprasidone | Abilify®  Abilify MyCite® asenapine Caplyta® Clozaril® Fazaclo® Geodon® Invega® Latuda® Lybalvi® Risperdal®  Risperdal M-Tab® Secuado® Seroquel® Seroquel XR® Zyprexa® Zyprexa Zydis® | PA required for members under 18 years old.  \* No PA required if Parkinson’s related psychosis ICD code on claim  Trial of only one agent is required before moving to a non-preferred agent. |

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| **Preferred Products** | **Non-Preferred Products** | **Prior Authorization Criteria** |
| 167B***Atypical Antipsychotics – Long Acting Injectable*** | | |
| Abilify Asimtufii® (aripiprazole) Abilify Maintena® (aripiprazole) Aristada® (aripiprazole lauroxil)  Aristada Initio® (aripiprazole lauroxil)  Invega Hafyera® (paliperidone palmitate)  Invega Sustenna® (paliperidone palmitate)  Invega Trinza® (paliperidone palmitate)  Perseris® (risperidone) Risperdal Consta® (risperidone) Uzedy® (risperidone)  Zyprexa Relprevv® (olanzapine pamoate) | Rykindo® (risperidone) | PA required for members under 18 years old.  Treatment-naïve patients must demonstrate tolerability per FDA- label prior to initiating the long- acting injectable. |
| 81B **Anxiolytics, Sedatives, and Hypnotics** | | |
| estazolam QL flurazepam QL Rozerem® QL temazepam QL triazolam QL zaleplon QL zolpidem IR QL zolpidem SL QL | Ambien® QL Ambien CR® QL Belsomra® QL Doral® QL Edluar® QL eszopiclone Hetlioz® Hetlioz LQ® Lunesta® Silenor® QL Sonata® zolpidem CR QL  Zolpimist® | No PA required if approved diagnosis code transmitted on claim (all agents in this class).  PA required for members under 18 years old. |
| 82B**Psychostimulants** | | |
| 168B***Narcolepsy Agents*** | | |
| Nuvigil® PA, QL \* Provigil® PA, QL \*  Wakix® PA | armodafinil QL \* modafinil QL \*  Sunosi | \* No PA required for ICD-10 code G47.4 |

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| **Preferred Products** | **Non-Preferred Products** | **Prior Authorization Criteria** |
|  | Xyrem® QL  Xywav® |  |

18B**Respiratory Agents**

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| **Preferred Products** | **Non-Preferred Products** | | **Prior Authorization Criteria** |
| 83B **Nasal Antihistamines** | | | |
| azelastine | Patanase® | |  |
| Dymista® |
| olopatadine |
| 84B **Respiratory Anti-inflammatory Agents** | | | |
| 169B***Leukotriene Receptor Antagonists*** | | | |
| montelukast | Accolate® |  |  |
| zafirlukast | Singulair® zileuton ER  Zyflo® |  |
|  | 85B **Nasal** | **Corticosteroids** |  |
| fluticasone (generic for Flonase®) | Beconase AQ® | |  |
| triamcinolone acetonide | Flonase® | |
|  | flunisolide | |
|  | Nasonex® | |
|  | Omnaris® | |
|  | Qnasl® | |
|  | Xhance® | |
|  | Zetonna® | |
| 170B***Phosphodiesterase Type 4 Inhibitors or Combination*** | | | |
| roflumilast PA, QL  Ohtuvayre™ PA, QL | Daliresp® QL | |  |
| 86B**Long-Acting Maintenance Therapy** | | | |
| 171B***Inhaled Glucocorticoids*** | | | |
| Arnuity Ellipta® | Alvesco® | |  |
| budesonide nebs (generic for Pulmicort®) | ArmonAir Digihaler®  Asmanex HFA® | |
| fluticasone propionate HFA  (generic for Flovent HFA®) QL | QVAR RediHaler® | |
| fluticasone propionate Diskus (generic for Flovent Diskus®) QL |  | |

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| **Preferred Products** | **Non-Preferred Products** | **Prior Authorization Criteria** |
| Flovent Diskus® QL  Flovent HFA® QL  Pulmicort Flexhaler® |  |  |
| 172B***Glucocorticoids/Long-Acting Beta-2 Adrenergic (LABA) Combination Products*** | | |
| Advair® Diskus | AirDuo Digihaler® |  |
| Advair HFA® | AirDuo RespiClick® |
| Breo Ellipta®  Dulera® | budesonide/formoterol (generic for  Symbicort®) |
| Symbicort® | fluticasone propionate/salmeterol pow (generic for AirDuo®, Advair  Diskus®) |
|  | vilanterol/fluticasone (generic for  Breo Ellipta®) |
|  | Wixela Inhub® |
| 173B***Long-Acting Beta Adrenergics (LABAs)*** | | |
| Serevent Diskus® QL | Brovana® |  |
| Striverdi Respimat® | Perforomist® |
| 174B***Anticholinergics and Combination Products*** | | |
| Anoro Ellipta® | Bevespi Aerosphere® |  |
| Incruse Ellipta® | Breztri Aerosphere® |
| Spiriva® | Duaklir Pressair® |
| Spiriva Respimat® | Lonhala Magnair® |
| Stiolto Respimat® | Trelegy Ellipta® |
| Tudorza Pressair® | Yupelri® |
| **Short-Acting/Rescue Therapy** | | |
| 175B***Short-Acting Beta Adrenergics (SABAs)*** | | |
| albuterol sulfate (generic for Proventil®, Ventolin®) QL albuterol soln (generic for  AccuNeb®) QL | albuterol HFA (generic for ProAir HFA®, Proventil HFA®, Ventolin HFA®) QL  ProAir Digihaler® QL |  |
| levalbuterol PA, QL | ProAir RespiClick® QL |
| levalbuterol HFA PA, QL | Xopenex® QL |
| Proair HFA® QL | Xopenex HFA® QL |
| Proventil HFA® QL |  |
| Ventolin HFA® QL |  |

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| **Preferred Products** | **Non-Preferred Products** | **Prior Authorization Criteria** |
| 176B***Ipratropium and Combinations*** | | |
| Atrovent HFA® Combivent Respimat® ipratropium nebs  ipratropium/albuterol nebs QL |  |  |

19B**Toxicology Agents**

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| **Preferred Products** | **Non-Preferred Products** | **Prior Authorization Criteria** |
| 87B **Antidotes** | | |
| 177B***Opiate Antagonists*** | | |
| Kloxxado® naloxone  Narcan® | Zimhi® |  |
| 88B**Substance Abuse Agents** | | |
| Brixadi®  buprenorphine SL tab QL buprenorphine/naloxone SL tab QL naltrexone tab  Sublocade® Suboxone® QL  Vivitrol® PA | buprenorphine/naloxone film QL  Lucemyra® Zubsolv® QL |  |

Droxia® Siklos® Endari®

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

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

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