**Ohio Medicaid**

Pharmacy Benefit Management Program



Unified Preferred Drug List

**Medicaid Fee-for-Service and Managed Care Plans**

Effective April 1, 2025

**Helpful Links**

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| **Prior Authorization (PA)**  [Prior Authorization (PA) Information | medicaid.ohio.gov](https://medicaid.ohio.gov/stakeholders-and-partners/phm/prior-authorization-information/prior-authorization-information)   * **General Prior Authorization Requirements** * **PA and Step Therapy Frequently Asked Questions (FAQ)** | **Unified Preferred Drug List (UPDL)**  [Ohio Unified Preferred Drug List | medicaid.ohio.gov](https://medicaid.ohio.gov/stakeholders-and-partners/phm/unified-pdl)   * **Unified Preferred Drug List (UPDL)** |

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| **General Information** |
| * The Statewide UPDL is not an all-inclusive list of drugs covered by the Ohio Department of Medicaid (ODM). Non UPDL drugs receive PA in accordance with the Gainwell SPBM medical necessity policy as posted on the Gainwell SPBM website. * Medications that are new to the market will be non-preferred, PA required, until reviewed by the ODM Pharmacy and Therapeutics (P&T) Committee. * The UPDL document is organized by therapeutic class. Brand name drugs are listed in CAPITAL letters; generic drug names are listed in lower case letters. In most cases, when a generic of a brand-name drug is available, the generic drug will be preferred and appear on the UPDL while the brand name will be non‐preferred but not appear on the UPDL. The [Drug Search tool](https://spbm.medicaid.ohio.gov/PreferredDrugSearch/NDCSearch) is a handy reference to check the status of a drug. Some generic drugs may require a specific labeler, or the brand to be dispensed. * ODM will only cover drugs that are part of the Medicaid Drug Rebate Program, with limited exceptions. This document may not reflect the most current rebate status of a drug (i.e., a drug may be listed on the document but is non-rebateable and therefore non-payable). * Some therapeutic categories are deemed ‘legacy’ categories. These categories are denoted with an “\*” and LEGACY CATEGORY listed next to their title on the table on contents and their place within the criteria document. Legacy is defined as: Patients who have a claim for a non-preferred drug in the previous 120 days will be automatically approved to continue the drug. Patients who have taken the drug previously, but do not have claims history (e.g., new to Medicaid), will need to submit a prior authorization to continue coverage.   - ALL authorizations must be prescribed in accordance with FDA approved labeling or listed on a CMS-supported compendia. |

* For ALL authorizations, there must be a trial and failure of preferred strengths prior to authorization of non-preferred strengths (if available).
* For ALL non-preferred authorizations, there must be documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug form (i.e., allergies, drug-drug interactions, contraindications, or intolerances). Must have had an inadequate clinical response of preferred individual components for any combination non-preferred product.
* For any nonsolid oral dosage formulation, there must be documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation (if available).
* For non-preferred extended-release formulations, there must be documentation of an inadequate clinical response with its immediate release formulation (if available).
* For non-preferred brand names that have preferred generics, there must be documentation of an inadequate clinical response or allergy to two or more generic labelers (if available).
* For ALL subsequent authorizations, there must be documentation of patient’s clinical response to treatment and ongoing safety monitoring unless

otherwise stated.

* [Some therapeutic categories may have quantity limits on specific drugs. For a list of the quantity limits on specific drugs, please reference the Quantity](https://spbm.medicaid.ohio.gov/SPContent/DocumentLibrary/UPDL) [Limit Document found here: Quantity Limits Document | spbm.medicaid.ohio.gov](https://spbm.medicaid.ohio.gov/SPContent/DocumentLibrary/UPDL)

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| **Terminology/Abbreviations:** |
| **AR** (Age Restriction) – An edit allowing claims for members within a defined age range to be covered without PA  **BvG** (Brand Preferred Over the Generic) – The brand name drug is preferred over the generic equivalent  **PA** (Clinical Prior Authorization) – PA is required before the drug will be covered  **ST** (Step Therapy) – Drug requires a trial with one or more preferred drugs before being covered |

**UPDL Format**

- With a few exceptions, the clinical criteria have a cumulative top-to-bottom format.

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| **Example Category** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| Example Drug | Example Drug | **LENGTH OF AUTHORIZATIONS:** X days or Initial: X days; Subsequent: X days (if |
| different)  **LEGACY\*:**  Patients who have a claim for a non-preferred drug in the previous 120 days will be automatically approved to continue the drug. Patients who have taken the drug previously, but do not have claims history (e.g. new to Medicaid), will need to submit a prior authorization in order to continue coverage.  **CLINICAL PA CRITERIA *(if applicable):***  **“DRUG” CRITERIA *(if applicable)*:**  **STEP THERAPY CRITERIA:**   * Must have had an inadequate clinical response of at least X days with at least X preferred drugs   **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least X days with X preferred drugs   **ADDITIONAL “DRUG” CRITERIA *(if applicable)*:**  **ADDITIONAL INFORMATION *(if applicable)*:**  **SUBSEQUENT AUTHORIZATION CRITERIA:**   * Must provide documentation of patient’s response to treatment from   baseline and/or attestation of clinical stabilization  **AR** – a PA is required for patients X years and older OR younger than X years |

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| **Interpretation of UPDL Format** | |
| - The UPDL criteria is designed to have a cumulative approach from top-to-bottom. The following scenarios will aid in illustrating this point: | |
| **Scenario 1: Clinical PA drug**   * All Authorizations * Clinical PA Criteria   **Scenario 2: Clinical PA drug with drug-specific criteria**   * All Authorizations * Drug-Specific Criteria   **Scenario 3: Step-therapy drug**   * All Authorizations * Clinical PA Criteria (if applicable) * Step Therapy Criteria | **Scenario 4: Non-preferred drug**   * All Authorizations * Clinical PA Criteria (if applicable) * Step Therapy Criteria (if applicable) * Non-Preferred Criteria   **Scenario 5: Non-preferred drug with drug-specific criteria**   * All Authorizations * Clinical PA Criteria (if applicable) * Step Therapy Criteria (if applicable) * Non-Preferred Criteria * Additional Drug-Specific Criteria |

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| **Analgesic Agents: Gout** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| allopurinol 100, 300mg | allopurinol 200mg | **LENGTH OF AUTHORIZATIONS:** 365 days  **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 30 days with at least one preferred drug in this UPDL category   **ADDITIONAL COLCHICINE CAPSULE (MITIGARE) CRITERIA:**   * + Must have had an inadequate clinical response of 30 days with colchicine tablets |
| colchicine tab | febuxostat |
| probenecid | MITIGARE BvG |
| probenecid/colchicine |  |

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| **Analgesic Agents: NSAIDS** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| celecoxib | diclofenac/misoprostol | **LENGTH OF AUTHORIZATIONS:** 365 days  **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs in this UPDL category, if indicated for diagnosis   **AR** – naproxen susp: a PA is required for patients 12 years old and older |
| diclofenac sodium DR, ER, gel 1% | diclofenac patch 1.3%; soln 1.5%, 2% |
| etodolac IR, ER | diclofenac potassium |
| flurbiprofen | ELYXYB |
| ibuprofen | fenoprofen |
| indomethacin IR, ER cap | ibuprofen/famotidine |
| ketorolac | indomethacin supp, susp |
| mefenamic acid | ketoprofen IR, ER |
| meloxicam tab | meclofenamate |
| nabumetone | meloxicam cap |
| naproxen IR | naproxen EC, ER |
| naproxen susp AR | naproxen/esomeprazole |
| oxaprozin | RELAFEN DS |
| piroxicam |  |
| sulindac |  |

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| **Analgesic Agents: Opioids** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **SHORT-ACTING** | | *\*\*Ohio law requires prescribers to request and review an OARRS report before initially prescribing or personally furnishing any controlled substance, such as an opioid analgesic or a benzodiazepine, and gabapentin\*\**  **LENGTH OF AUTHORIZATIONS:** Initial short-acting and long-acting requests may only be authorized for up to 90 days. For reauthorization, up to 180 days.  **BUPRENORPHINE TOPICAL (BUTRANS) CRITERIA:**   * For doses greater than 5 mcg/hour must provide documentation of an inadequate clinical response with at least one opioid formulation taken for at least 30 of the last 60 days   **MORPHINE SULFATE ER (MS CONTIN) CRITERIA:**   * Unless receiving for cancer pain, palliative care, or end-of- life/hospice care, must provide documentation of an inadequate clinical response with at least one opioid formulation taken for at least 30 of the last 60 days * Must also meet LONG-ACTING OPIOID CRITERIA   **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 7 days of at least two unrelated preferred drugs of the same duration of action (SHORT-ACTING or LONG-ACTING) * Must also meet applicable SHORT-ACTING or LONG-ACTING OPIOID CRITERIA   **ADDITIONAL SHORT-ACTING OPIOIDS CRITERIA:**   * The system defines an “initial request” as having no opioid claims in the previous 90 days * **Initial short-acting requests** can be authorized up to 90 days   + Length of authorization is dependent on indication, |
| APAP/codeine | APAP/caffeine/ dihydrocodeine |
| but/APAP/caff/cod 50/325/40/30mg | but/APAP/caff/cod 50/300/40/30mg |
| but/ASA/caff/cod | DSUVIA |
| butorphanol | hydrocodone/APAP 5, 7.5, 10-300mg |
| codeine | hydrocodone/ibuprofen |
| hydrocodone/APAP | levorphanol |
| hydromorphone IR | meperidine |
| morphine IR | oxymorphone IR |
| oxycodone IR cap, soln, tab | pentazocine/naloxone |
| oxycodone/APAP | PROLATE |
| tramadol IR 50mg | ROXYBOND |
| tramadol/APAP | SEGLENTIS |
|  | tramadol IR soln, 25, 100mg tab |
| **LONG-ACTING** | |
| BUTRANS BvG PA | BELBUCA |
| morphine ER tab PA | buprenorphine TD patch weekly |
|  | fentanyl |
|  | hydrocodone bitartrate ER 12HR cap |
|  | hydrocodone bitartrate ER 24HR tab |
|  | hydromorphone ER |
|  | methadone |
|  | morphine ER 24HR cap |
|  | oxycodone ER |
|  | oxymorphone ER |
|  | tramadol ER |

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|  |  | previous patient utilization, and requested length of therapy (could be more restrictive)   * To exceed acute opioid limits, documentation of the following must be provided:   + Diagnosis code which must be for somatic type pain   + Prescriber attestation that the benefits and risks   of opioid therapy have been discussed with patient   * Exemptions to the additional criteria:   + Patients receiving short-acting opioids for active cancer treatment, palliative care, and end-of- life/hospice care, sickle cell, severe burn, traumatic crushing of tissue, amputation, major orthopedic surgery   + Prescriber attestation that patient is opioid tolerant (i.e., new to Medicaid or was on higher dose in hospital) * **Subsequent short-acting requests** can be authorized up to 180 days   + Documentation of the following must be provided:     - Current treatment plan     - Demonstrated adherence to treatment plan through progress notes, including pain and function scores, random urine screening results reviewed, concerns addressed, and no serious adverse outcomes observed   + Exemptions to the additional criteria:     - Patients receiving short-acting opioids for cancer pain, palliative care, or end-of-life/hospice care     - Patients residing in LTC facilities are exempted from urine drug screening requirements * **Dose escalation requests** can be authorized up to 180 days   + Documentation of the following must be provided:     - Prescriber attestation that dose escalation is |

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|  |  | likely to result in improved function or pain control   * Requests for a cumulative daily dose > 80 MED must be prescribed by or in consultation with a pain specialist, specialist in the area of the body affected by pain, or anesthesiologist   *Patients with initial prescriptions for opioid therapy, defined as no rx claims for opioids in the last 90 days, will be limited to 30 MED per day and a maximum of 7 days per prescription. Prior authorization will be required to exceed these limits.*  **ADDITIONAL LONG-ACTING OPIOIDS CRITERIA:**   * The system defines an “initial long-acting request” as having no opioid claims in the previous 90 days * **Initial long-acting requests** can be authorized up to 90 days   + Documentation of the following must be provided:     - Request is a daily dose equivalent of ≤ 80 MED     - Inadequate clinical response to both non- opioid pharmacologic and non- pharmacologic treatments     - Current use of opioids for ≥ 30 of the last 60 days     - Treatment plan including risk assessment, substance abuse history, concurrent therapies, and requirements for random urine screenings (baseline urine drug tests must be submitted)     - Pain and function scores at each visit     - Opioid contract required to be in place and submitted with PA form   + Exemptions to the additional criteria:     - Patients receiving long-acting opioids for cancer pain, palliative care, or end-of-life/hospice care     - Patients residing in LTC facilities are exempted from urine drug screening and opioid contract   requirements |

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|  |  | * **Subsequent long-acting req**   days   * + Documentation of th     - Current trea     - Demonstrate through pro function sco reviewed, co adverse out   + Exemptions to the a     - Patients rec pain, palliati     - Patients resi from urine requirement * **Dose escalation requests** ca   + Documentation of th     - Prescriber a likely to resu control     - Requests fo must be pres pain special affected by   **ADDITIONAL TRANSMUCOSAL FENTAN**   * Must be prescribed by an on hospice/palliative prescriber * Must be concurrently taking therapeutic dose of any of th days without adequate pain   ≥ 60 mg oral morphine/day | **uests** can be authorized up to 180  e following must be provided: tment plan  d adherence to treatment plan  gress notes, including pain and  res, random urine screening results ncerns addressed, and no serious comes observed  dditional criteria:  eiving long-acting opioids for cancer ve care, or end-of-life/hospice care ding in LTC facilities are exempted drug screening and opioid contract s  n be authorized up to 180 days e following must be provided:  ttestation that dose escalation is lt in improved function or pain  r a cumulative daily dose > 80 MED cribed by or in consultation with a ist, specialist in the area of the body pain, or anesthesiologist  **YL CRITERIA:**  cologist, pain specialist, or  a long-acting opioid at a e following for at least 7 relief:  ≥ 8 mg oral hydromorphone/day |
| ≥ 25 mcg/hr transdermal fentanyl | ≥ 25 mg oral oxymorphone/day |
| ≥ 30 mg oral oxycodone/day | Equianalgesic dose of another opioid |

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|  |  | **BUPRENORPHINE BUCCAL FILM (BELBUCA) CRITERIA:**   * Must meet ADDITIONAL LONG-ACTING OPIOID Criteria |

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| **Blood Formation, Coagulation, and Thrombosis Agents: Colony Stimulating Factors** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| FULPHILA PA | FYLNETRA | **LENGTH OF AUTHORIZATIONS**: 30 days or duration of chemotherapy regimen  **CLINICAL PA CRITERIA:**   * Must provide documentation of diagnosis, patient’s weight (for weight-based dosed medications only), and duration of treatment   **NON-PREFERRED CRITERIA:**   * + Must have had an inadequate clinical response of at least 14 days with at least one preferred drug in this UPDL category |
| NEUPOGEN PA | GRANIX |
| NIVESTYM PA | LEUKINE |
| NYVEPRIA PA | NEULASTA |
|  | RELEUKO |
|  | ROLVEDON |
|  | STIMUFEND |
|  | UDENYCA |
|  | ZARXIO |
|  | ZIEXTENZO |

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| **Blood Formation, Coagulation, and Thrombosis Agents: Hematopoietic Agents** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| EPOGEN PA | ARANESP | **LENGTH OF AUTHORIZATIONS**: 180 days; except 365 days for patients with chronic renal failure  **CLINICAL PA CRITERIA:**   * Must provide documentation of baseline hemoglobin level   **NON-PREFERRED CRITERIA:**   * + Must have had an inadequate clinical response of at least 14 days with at least one preferred drug in this UPDL category   **SUBSEQUENT AUTHORIZATION CRITERIA:**   * + Provide current hemoglobin lab result |
| RETACRIT PA | MIRCERA |
|  | PROCRIT |

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| **Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia A, von Willebrand Disease, and Factor XIII Deficiency\* LEGACY CATEGORY** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| ADVATE PA | NUWIQ INJ | **LENGTH OF AUTHORIZATIONS**: 365 Days  **CLINICAL PA CRITERIA:**   * Must provide documentation of patient’s body weight (for weight-based dosed medications only)   **NON-PREFERRED CRITERIA:**   * + Must have had an inadequate clinical response of at least 14 days with at least one preferred drug in this UPDL category   **ADDITIONAL EXTENDED HALF-LIFE FACTOR CRITERIA**   * + Must provide attestation that the patient is not a suitable candidate for treatment with a shorter-acting half-life drug |
| ADYNOVATE PA | OBIZUR |
| AFSTYLA PA | SEVENFACT |
| ALPHANATE PA | VONVENDI |
| ALTUVIIIO PA |  |
| CORIFACT PA |  |
| ELOCTATE PA |  |
| ESPEROCT PA |  |
| FEIBA PA |  |
| HEMLIBRA PA |  |
| HEMOFIL M PA |  |
| HUMATE-P PA |  |
| JIVI PA |  |
| KOATE PA |  |
| KOGENATE FS PA |  |
| KOVALTRY PA |  |
| NOVOEIGHT PA |  |
| NOVOSEVEN RT PA |  |
| NUWIQ KIT PA |  |
| RECOMBINATE PA |  |
| WILATE PA |  |
| XYNTHA PA |  |

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| **Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia B\* LEGACY CATEGORY** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| ALPHANINE SD PA | SEVENFACT | **LENGTH OF AUTHORIZATIONS**: 365 Days  **CLINICAL PA CRITERIA:**   * Must provide documentation of patient’s body weight (for weight-based dosed medications only)   **NON-PREFERRED CRITERIA:**   * + Must have had an inadequate clinical response of at least 14 days with at least one preferred drug in this UPDL category   **ADDITIONAL EXTENDED HALF-LIFE FACTOR CRITERIA**   * + Must provide attestation that the patient is not a suitable candidate for treatment with a shorter-acting half-life drug |
| ALPROLIX PA |
| BENEFIX PA |
| FEIBA PA |
| IDELVION PA |
| IXINITY PA |
| NOVOSEVEN RT PA |
| PROFILNINE PA |
| REBINYN PA |
| RIXUBIS PA |

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| **Blood Formation, Coagulation, and Thrombosis Agents: Heparin-Related Preparations** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| enoxaparin | fondaparinux | **LENGTH OF AUTHORIZATIONS**: 35 days; except 365 days for patients with cancer, pregnancy, or unable to be converted to an oral anticoagulant  **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 14 days with at least one preferred drug in this UPDL category |
| FRAGMIN |

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| **Blood Formation, Coagulation, and Thrombosis Agents: Oral Anticoagulants** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| ELIQUIS | dabigatran cap | **LENGTH OF AUTHORIZATION:** 365 days  **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs in this UPDL category   **AR** – PRADAXA PELLET PAK, XARELTO SUSP: a PA is required for patients 12 years and older |
| PRADAXA CAP BvG, PELLET PAK AR | SAVAYSA |
| warfarin |  |
| XARELTO SUSP AR, TAB |  |

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| **Blood Formation, Coagulation, and Thrombosis Agents: Oral Antiplatelet** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| aspirin IR, ER |  | All products are covered without a PA |
| aspirin/dipyridamole ER |
| BRILINTA |
| clopidogrel |
| prasugrel |

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| **Cardiovascular Agents: Angina, Hypertension and Heart Failure** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **ACE INHIBITORS/DIURETICS/COMBINATIONS** | | **LENGTH OF AUTHORIZATIONS:** 365 days except nimodipine: 21 days  **PROPRANOLOL ORAL SOLN (HEMANGEOL) CRITERIA:**   * Must provide documentation of the patient’s weight   **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 30 days of at least two preferred drugs with the same mechanism of action, if available and indicated for the same diagnosis in this UPDL category   **ADDITIONAL APROCITENTAN (TRYVIO) CRITERIA:**   * Must have had an inadequate clinical response of at least 30 days of at least four different classes of antihypertensive medications concurrently without adequate blood pressure control   **ADDITIONAL FINERENONE (KERENDIA) CRITERIA:**   * Must be on a maximally tolerated dose of an angiotensin-converting enzyme inhibitor or angiotensin receptor blocker **AND** * Must provide documentation of an inadequate clinical response to a SGLT2 Inhibitor **OR** provide documentation of medical necessity beyond convenience for why the patient cannot try a SGLT2 inhibitor (i.e., chronic kidney disease diagnosis)   **ADDITIONAL MAVACAMTEN (CAMZYOS) CRITERIA:**   * Must be prescribed by or in consultation with a cardiologist * Must provide documentation of NYHA Class II-III symptoms and left   ventricular ejection fraction ≥55%  **ADDITIONAL SOTAGLIFLOZIN (INPEFA) CRITERIA:**   * Must provide documentation of an inadequate clinical response to at least two SGLT2 Inhibitors (refer to Endocrine Agents: Diabetes – Non-Insulin class for complete list) |
| amlodipine/benazepril | QBRELIS |
| benazepril |
| benazepril/HCTZ |
| captopril |
| captopril/HCTZ |
| enalapril soln, tab |
| enalapril/HCTZ |
| fosinopril |
| fosinopril/HCTZ |
| lisinopril |
| lisinopril/HCTZ |
| moexipril |
| quinapril |
| quinapril/HCTZ |
| ramipril |
| trandolapril |
| trandolapril/verapamil |
| **ARBs/DIURETICS/COMBINATIONS** | |
| amlodipine/olmesartan | EDARBI |
| amlodipine/valsartan | EDARBYCLOR |
| amlodipine/valsartan/HCTZ | valsartan soln |
| candesartan |  |
| candesartan/HCTZ |  |
| irbesartan |  |
| irbesartan/HCTZ |  |
| losartan |  |
| losartan/HCTZ |  |
| olmesartan |  |
| olmesartan/amlodipine/HCTZ |  |
| olmesartan/HCTZ |  |
| telmisartan |  |
| telmisartan/amlodipine |  |

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| telmisartan/HCTZ valsartan tab  valsartan/HCTZ | | **ADDITIONAL VERICIGUAT (VERQUVO) CRITERIA:**   * Must provide documentation of ejection fraction * Must have been hospitalized for the treatment of heart failure in the previous 180 days or needs treatment with an outpatient intravenous diuretic in the previous 90 days * Must be treated with an agent from **ALL** the following unless contraindicated:   + Angiotensin-converting enzyme inhibitor, angiotensin II receptor blocker, **OR** an angiotensin receptor neprilysin inhibitor   + Beta-blocker   + Aldosterone antagonist and/or SGLT2 inhibitor as appropriate for renal function   **AR** – SOTYLIZE SOLN: a PA is required for patients 6 years and older |
| **BETA BLOCKERS/COMBINATIONS** | |
| acebutolol atenolol  atenolol/chlorthalidone betaxolol  bisoprolol bisoprolol/HCTZ carvedilol IR HEMANGEOL PA  labetalol metoprolol succ metoprolol tart metoprolol/HCTZ nadolol  nebivolol propranolol IR, ER sotalol  timolol | carvedilol ER INNOPRAN XL KAPSPARGO SOTYLIZE AR |
| **CALCIUM CHANNEL BLOCKERS** | |
| amlodipine cartia XT diltiazem IR  diltiazem 12HR ER cap diltiazem 24HR ER cap felodipine ER levamlodipine nicardipine  nifedipine IR, ER  verapamil IR, ER, SR | diltiazem 24HR ER tabs isradipine  KATERZIA  nimodipine nisoldipine NORLIQVA NYMALIZE  verapamil ER (gen of VERELAN PM) |
| **OTHER** | |
| amiloride amiloride/HCTZ  clonidine IR, patch | aliskiren  ASPRUZYO SPRINKLE CAMZYOS |

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| doxazosin | clonidine ER (gen of NEXICLON XR) |
| ENTRESTO TAB BvG | CORLANOR |
| eplerenone | ENTRESTO SPRINKLE CAP |
| guanfacine IR, ER | INPEFA |
| hydralazine | KERENDIA |
| methyldopa | spironolactone susp |
| minoxidil | TRYVIO |
| ranolazine | VERQUVO |
| spironolactone |  |
| spironolactone/HCTZ |  |
| terazosin |  |

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| **Cardiovascular Agents: Antiarrhythmics** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| amiodarone | MULTAQ | **LENGTH OF AUTHORIZATIONS:** 365 Days  **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 30 days with at least one preferred drug in this UPDL category |
| disopyramide |
| dofetilide |
| flecainide |
| mexiletine |
| NORPACE CR |
| propafenone IR, ER |
| quinidine IR, ER |

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| **Cardiovascular Agents: Lipotropics** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **BILE ACID SEQUESTRANTS** | | **LENGTH OF AUTHORIZATIONS:** See below  **CLINICAL PA CRITERIA:**   * Must provide baseline labs **AND** have adherence to 90 days of preferred lipid lowering medications * Must have had an inadequate clinical response of at least 90 days **AND** unable to reach goal LDL-C (see below) despite treatment with maximally tolerated or high-potency statin (or a clinical reason that these drugs cannot be utilized) * Must have had an inadequate clinical response of at least 90 days AND unable to reach goal LDL-C (see below) despite treatment with ezetimibe OR documentation that LDL is >25% above goal despite current statin therapy   **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 30 days (or 90 days for fibrates) with at least one preferred drug in the same drug class   **ADDITIONAL LOVASTATIN ER (ALTOPREV), PITAVASTATIN (LIVALO), FLUVASTATIN (LESCOL) CRITERIA:**   * Must have had an inadequate clinical response of at least 30 days with two preferred drugs in the same drug class   **ADDITIONAL COLESEVELAM (WELCHOL) CRITERIA:**   * Must provide documentation of a Type 2 Diabetes diagnosis   **ADDITIONAL ICOSAPENT ETHYL CRITERIA:**   * Must provide documentation of baseline labs indicating triglyceride levels ≥500mg/dL after an inadequate clinical response to fibrates, niacin, and diet/exercise |
| cholestyramine light, regular | colesevelam packet |
| colesevelam tab | colestipol granules |
| colestipol tab |  |
| prevalite |  |
| **FIBRIC ACID DERIVATIVES** | |
| fenofibrate 48, 54, 145, 160mg tab | fenofibrate IR, DR cap |
| gemfibrozil | fenofibrate 40, 120mg tab |
|  | fenofibric acid |
| **PCSK9 INHIBITORS** | |
| PRALUENT PA |  |
| REPATHA PA |
| **STATINS/COMBINATIONS** | |
| atorvastatin | ALTOPREV |
| ezetimibe/simvastatin | amlodipine/atorvastatin |
| lovastatin | ATORVALIQ |
| pravastatin | EZALLOR |
| rosuvastatin | fluvastatin IR, ER |
| simvastatin | pitavastatin |
|  | ZYPITAMAG |
| **OTHER** | |
| ezetimibe | icosapent ethyl cap |
| niacin IR, ER OTC | JUXTAPID |
| omega-3-acid ethyl esters | NEXLETOL |
|  | NEXLIZET |
|  | niacin ER tab |

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| JUXTAPID (Initial) | 180 days |
| icosapent ethyl cap, LOVAZA, ACL inhibitors (Initial) | 84 days |
| All others (Initial and Subsequent) | 365 days |

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|  |  | **ADDITIONAL LOMITAPIDE (JUXTAPID) & ATP CITRATE LYASE (ACL) INHIBITOR CRITERIA:**   * Must provide documentation of baseline labs **AND** have documented adherence to 90 days of prescribed lipid lowering medications * Must have had inadequate clinical response of at least 90 days **AND** unable to reach goal LDL-C with high-potency statin, ezetimibe and PCSK9 inhibitor (or a clinical reason that these drugs cannot be utilized)   **ADDITIONAL INFORMATION:**   * High potency statins: atorvastatin (LIPITOR) 40-80mg & rosuvastatin (CRESTOR) 20-40mg * LDL goals for Familial Hypercholesterolemia (includes Heterozygous & Homozygous FH): LDL ≤ 100mg/dL for adults or LDL ≤ 110mg/dL for those   < 18 years of age   * LDL goals for Clinical Atherosclerotic Cardiovascular Disease (ASCVD) not at very high risk: LDL ≤ 70mg/dL * LDL goals for Clinical Atherosclerotic Cardiovascular Disease (ASCVD) at   very high risk: LDL ≤ 55mg/dL   * Must provide documentation of multiple major ASCVD events or 1 major ASCVD event and multiple high-risk conditions if citing goal LDL ≤ 55mg/dL |

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| **Cardiovascular Agents: Pulmonary Arterial Hypertension\* LEGACY CATEGORY** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **ENDOTHELIN RECEPTOR ANTAGONISTS** | | **LENGTH OF AUTHORIZATIONS:** 365 Days  **CLINICAL PA CRITERIA:**   * Must provide documentation of NYHA Functional Class symptoms for Pulmonary Hypertension experienced by patient   **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs in this UPDL category, one of which must be a phosphodiesterase-5 inhibitor   **ADDITIONAL INFORMATION:**   * Patients who have class III or IV symptoms defined by the NYHA Functional Class for Pulmonary Hypertension may be authorized for inhalation or intravenous agents   **AR** – sildenafil susp: a PA is required for patients 18 years and older  **AR** – TADLIQ: a PA is required for patients younger than 18 years |
| ambrisentan PA | OPSUMIT |
| bosentan PA | TRACLEER SUSP |
| **PDE5 INHIBITORS** | |
| sildenafil PA | LIQREV |
| sildenafil susp AR PA |
| tadalafil PA |
| TADLIQ AR PA |
| **PROSTAGLANDINS** | |
| epoprostenol | ORENITRAM |
| treprostinil |
| TYVASO |
| VENTAVIS |
| **OTHER** | |
|  | ADEMPAS |
| OPSYNVI |
| UPTRAVI |
| WINREVAIR |

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| **Central Nervous System (CNS) Agents: Alzheimer’s Agents\* LEGACY CATEGORY** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| donepezil AR | ADLARITY AR | **LENGTH OF AUTHORIZATIONS**: 365 Days  **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs in this UPDL category   **AR** – All drugs: a PA is required for patients younger than 40 years |
| galantamine IR tab, ER cap AR | galantamine soln AR |
| memantine ER, IR tab AR | memantine soln AR |
| rivastigmine cap AR | NAMZARIC AR |
| rivastigmine patch AR |  |

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| **Central Nervous System (CNS) Agents: Anti-Migraine Agents, Acute** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **CGRP INHIBITORS** | | **LENGTH OF AUTHORIZATIONS**: 180 Days  **STEP THERAPY CRITERIA:**   * Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs in this UPDL category **OR** documentation why patient is unable to take product not requiring step therapy   **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 14 days with at least one preferred drug and one step therapy drug in this UPDL category, one of which has the same mechanism of action if available   **ADDITIONAL INFORMATION:**   * NURTEC has a maximum quantity of **8** tablets per month for acute migraines |
| NURTEC ODT ST | ZAVZPRET |
| UBRELVY ST |
| **TRIPTANS/COMBINATIONS** | |
| IMITREX NASAL SPRAY | almotriptan |
| naratriptan | eletriptan |
| rizatriptan | frovatriptan |
| sumatriptan inj, nasal spray, tab | sumatriptan/naproxen |
|  | TOSYMRA |
|  | zolmitriptan |
| **OTHER** | |
|  | dihydroergotamine |
| MIGERGOT |
| REYVOW |

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| **Central Nervous System (CNS) Agents: Anti-Migraine Agents, Cluster Headache** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| verapamil IR, ER | EMGALITY 100mg/ml | **LENGTH OF AUTHORIZATIONS:** 180 days  **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 60 days to at least one preferred drug in this UPDL category   **ADDITIONAL INFORMATION:**   * An inadequate clinical response to verapamil is defined as a titration to at least 480mg daily or maximally tolerated dose based on blood   pressure or heart rate and maintained for at least 60 days |

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| **Central Nervous System (CNS) Agents: Anti-Migraine Agents, Prophylaxis** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| AIMOVIG ST | NURTEC ODT | **LENGTH OF AUTHORIZATIONS:** Initial: 180 days; Subsequent: 365 days  **STEP THERAPY CRITERIA:**   * Must have had an inadequate clinical response of at least 30 days with at least two preferred controller migraine drugs.   + For patients already established on a serotonergic medication, only one preferred controller migraine drugs will be required * Must include objective documentation of severity, frequency, type of migraine, and number of headache days per month * Controller migraine drug classes include beta-blockers, anticonvulsants, serotonin-norepinephrine reuptake inhibitors, or tricyclic antidepressants   **ERENUMAB (AIMOVIG) CRITERIA:**   * Must have had an inadequate clinical response of at least 60 days with the 70mg dose to request a dose increase   **FREMANEZUMAB (AJOVY) CRITERIA:**   * Must have demonstrated efficacy for at least 90 days before quarterly administration will be authorized   **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 30 days with at least three preferred controller migraine drugs **AND** one step therapy drug in this UPDL category   **ADDITIONAL INFORMATION:**   * NURTEC has a maximum quantity of **16** tablets per month for migraine prophylaxis   **SUBSEQUENT AUTHORIZATION CRITERIA:**   * Must provide documentation of patient’s clinical response to treatment (Objective documentation of severity, frequency, and number of headache days per month). |
| AJOVY ST | QULIPTA |
| EMGALITY 120mg/ml ST |  |
| Cardiovascular Agents: Beta-  Blockers |  |
| CNS Agents: Anticonvulsants |  |
| CNS Agents: Serotonin-  Norepinephrine Reuptake Inhibitors |  |
| CNS Agents: Tricyclic  Antidepressants |  |

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| **Central Nervous System (CNS) Agents: Anticonvulsants\* LEGACY CATEGORY** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| BANZEL TAB BvG | APTIOM | **LENGTH OF AUTHORIZATIONS:** 365 days except EPIDIOLEX and DIACOMIT –  Initial: 180 days  **STEP THERAPY CRITERIA:**   * Must have had an inadequate clinical response of at least 30 days with at least one preferred drug in this UPDL category   **CANNABIDIOL (EPIDIOLEX) CRITERIA**   * Must have had an inadequate clinical response of at least 30 days with any two of the following anticonvulsants: clobazam, levetiracetam, valproic acid, lamotrigine, topiramate, rufinamide, or felbamate within the past 365 days (members who meet this criterion will not require a PA)   **STIRIPENTOL (DIACOMIT) CRITERIA**   * Exempt from Legacy rules * Must be prescribed by or in consultation with a neurologist * Must be concomitantly taking clobazam (ONFI) * Must provide documentation of addressed comorbidities and baseline hematologic testing (CBC)   + Patients with phenylketonuria (PKU) must provide evidence of total daily amount of phenylalanine   + Prescribers must include management plans for patients with neutrophil counts <1,500 cells/mm3 or platelet count   <150,000/µL   * Must provide documentation of patient’s weight   + Maximum daily dose does not exceed: 50 mg/kg/day or 3,000mg/day   **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 30 days with at |
| BRIVIACT SOLN AR, TAB | CELONTIN BvG |
| carbamazepine IR, ER | clonazepam ODT |
| clobazam | ELEPSIA XR |
| clonazepam | felbamate |
| DIACOMIT PA | FINTEPLA |
| divalproex DR, ER | lamotrigine ER |
| EPIDIOLEX PA | levetiracetam ER tab |
| EPRONTIA AR | MOTPOLY XR |
| ethosuximide | oxcarbazepine susp |
| FYCOMPA ST | OXTELLAR XR BvG |
| gabapentin | QUDEXY XR BvG |
| lacosamide | rufinamide tab, soln |
| lamotrigine chew, IR, ODT | SPRITAM BvG |
| levetiracetam IR tab, soln | SYMPAZAN |
| oxcarbazepine IR tab | tiagabine |
| phenobarbital | topiramate sprinkle cap |
| phenytoin IR, ER | TROKENDI XR BvG |
| pregabalin IR | vigabatrin |
| primidone | vigabatrin powder AR |
| topiramate IR | XCOPRI |
| TRILEPTAL SUSP BvG | ZONISADE SUSP |
| valproic acid | ZTALMY |
| VIGAFYDE AR |  |
| zonisamide cap |  |

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|  |  | least two preferred drugs in this UPDL category   * For prescribers who are credentialed as a neurology specialty with Ohio Medicaid, there must have been an inadequate clinical response of at least 30 days with one preferred anticonvulsant drug in the standard tablet/capsule dosage form.   **AR** – BRIVIACT SOLN: a PA is required for patients 12 years and older **AR** – EPRONTIA SOLN: a PA is required for patients 12 years and older **AR** – vigabatrin powder: a PA is required for patients 2 years and older  **AR** – VIGAFYDE SOLN: a PA is required for patients 2 years and older |

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| **Central Nervous System (CNS) Agents: Anticonvulsants Rescue** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| diazepam gel |  | All products are covered without a PA  **AR** – LIBERVANT: a PA is required for patients 5 years and older  **AR** – NAYZILAM: a PA is required for patients younger than 12 years old  **AR** – VALTOCO: a PA is required for patients younger than 6 years old |
| LIBERVANT AR |
| NAYZILAM AR |
| VALTOCO AR |

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| **Central Nervous System (CNS) Agents: Antidepressants\* LEGACY CATEGORY** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **NDRIs** | | **LENGTH OF AUTHORIZATIONS:** 365 Days except 14 days with no renewal for ZURZUVAE  **PSYCHIATRIST EXEMPTION:**   * Prescribers (as identified below) are exempt from prior authorization of any non-preferred antidepressant, or step therapy of any preferred drug, in the standard tablet/capsule dosage forms. Other dosage forms may still require prior authorization. The exemption will be processed by the claims system when the pharmacy has submitted the prescriber on the claim using the individual national provider identifier (NPI) for the prescriber. **Prescribers are defined as:** Physicians with a specialty in psychiatry, nurse practitioners certified in psychiatric mental health, or clinical nurse specialists certified in psychiatric mental health, who are credentialed with the Ohio Department of Medicaid.   **CLINICAL PA CRITERIA:**   * + Must have a diagnosis of moderate to severe Post-Partum Depression (PPD) no earlier than the 3rd trimester OR within 12 months of pregnancy delivery   **STEP THERAPY CRITERIA:**   * + Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs in this UPDL category   **NON-PREFERRED CRITERIA:**   * + Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs in this UPDL category   **ADDITIONAL DEXTROMETHORPHAN/BUPROPION (AUVELITY) CRITERIA:**   * + Must have an inadequate clinical response of at least 30 days with **ALL**   of the following:   * + - ONE norepinephrine/dopamine reuptake inhibitor (NDRI)     - ONE serotonin and norepinephrine reuptake inhibitor (SNRI) |
| bupropion | APLENZIN |
| bupropion SR (gen of WELLBUTRIN SR) | bupropion XL (gen of FORFIVO XL) |
| bupropion XL (gen of WELLBUTRIN XL) |  |
| **SNRIs** | |
| desvenlafaxine succ ER (gen of PRISTIQ) | desvenlafaxine ER (gen of KHEDEZLA) |
| duloxetine 20, 30, 60mg | DRIZALMA SPRINKLE |
| venlafaxine IR tab, ER cap | duloxetine 40mg |
|  | FETZIMA |
|  | venlafaxine ER tab |
| **SSRIs** | |
| citalopram tab, soln | citalopram cap |
| escitalopram | fluoxetine IR 60mg, DR |
| fluoxetine IR 10, 20, 40mg | fluvoxamine ER |
| fluoxetine soln | paroxetine ER tab |
| fluvoxamine IR | sertraline cap |
| paroxetine IR tab, soln |  |
| sertraline tab |  |
| **OTHER** | |
| mirtazapine | AUVELITY |
| nefazodone | CAPLYTA |
| tranylcypromine | clomipramine |
| trazodone 50, 100, 150mg | EMSAM |
| vilazodone | MARPLAN |
| VRAYLAR ST | phenelzine |
| ZURZUVAE PA | REXULTI |
|  | trazodone 300mg |
|  | TRINTELLIX |

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|  |  | * TWO selective serotonin reuptake inhibitors (SSRIs) (ONE of which must be either vilazodone (VIIBRYD) OR vortioxetine   (TRINTELLIX)) |

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| **Central Nervous System (CNS) Agents: Attention Deficit Hyperactivity Disorder Agents** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **NON-STIMULANTS** | | **LENGTH OF AUTHORIZATIONS:** 365 days  **STEP THERAPY CRITERIA:**   * Must have had an inadequate clinical response of at least 30 days with atomoxetine **OR** at least one preferred ADHD agent.   **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs in this UPDL category   **ADDITIONAL INFORMATION:**   * Requests for non-preferred immediate-release formulations must have all required trials with preferred immediate-release drugs, and requests for non-preferred extended-release formulations must have all required trials with preferred extended-release drugs * For patients established on drugs that change from preferred to non-preferred on January 1, a prior authorization is **NOT** required until **after** June 30th of that year.   **AR** –amphetamine/dextroamphetamine, dextroamphetamine IR: a PA is required for patients younger than 3 years  **AR** –amphetamine/dextroamphetamine XR, atomoxetine, dextroamphetamine ER, dexmethylphenidate & XELSTRYM: a PA is required for patients younger than 6 years  **AR** – dextroamphetamine soln: a PA is required for patients 12 years and older  **AR** – methylphenidate soln/susp/chewable tab: a PA is required for patients 12 years and older  **AR** – ONYDA XR SUSP: a PA is required for patients 12 years and older |
| atomoxetine cap AR |  |
| clonidine ER |
| guanfacine ER |
| ONYDA XR SUSP AR |
| QELBREE ST |
| **STIMULANTS** | |
| amphetamine/dextroamphetamine  IR, ER AR | ADZENYS XR ODT  amphetamine tab |
| CONCERTA | AZSTARYS AR |
| dexmethylphenidate tab AR | COTEMPLA XR ODT |
| dexmethylphenidate ER (generic of  FOCALIN XR) AR | DAYTRANA BvG  dextroamphetamine soln AR |
| dextroamphetamine IR tab, ER cap AR | EVEKEO ODT |
| DYANAVEL XR | JORNAY PM |
| FOCALIN XR AR | lisdexamfetamine cap |
| methylphenidate ER cap (generic of METADATE CD, RITALIN LA) | methamphetamine  methylphenidate chewable tab AR |
| methylphenidate ER tab (generic of  CONCERTA, METHYLIN ER, RITALIN SR) | methylphenidate ER cap, tab (generic of  APTENSIO XR, RELEXXII) |
| methylphenidate soln AR | MYDAYIS BvG |
| methylphenidate tab | VYVANSE CHEWABLE TAB BvG |
| PROCENTRA BvG AR | XELSTRYM AR |
| QUILLICHEW ER AR |  |
| QUILLIVANT XR AR |  |
| RITALIN LA |  |
| VYVANSE CAP BvG |  |

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| **Central Nervous System (CNS) Agents: Atypical Antipsychotics\* LEGACY CATEGORY** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| ABILIFY ASIMTUFII, MAINTENA | ABILIFY MYCITE | **LENGTH OF AUTHORIZATIONS:** 365 Days  **PSYCHIATRIST EXEMPTION:**   * Prescribers (as identified below) are exempt from prior authorization of any non-preferred antidepressant, or step therapy of any preferred drug, in the standard tablet/capsule dosage forms. Other dosage forms may still require prior authorization. The exemption will be processed by the claims system when the pharmacy has submitted the prescriber on the claim using the individual national provider identifier (NPI) for the prescriber. **Prescribers are defined as:** Physicians with a specialty in psychiatry, nurse practitioners certified in psychiatric mental health, or clinical nurse specialists certified in psychiatric mental health, who are credentialed with the Ohio Department of Medicaid.   **PALIPERIDONE PALMITATE (INVEGA HAFYERA) CRITERIA:**   * + Must have had 4 months of treatment with INVEGA SUSTENNA or 3 months with INVEGA TRINZA   **STEP THERAPY CRITERIA:**   * + Must have had an inadequate clinical response of at least 30 days with at least one preferred drug in this UPDL category   **NON-PREFERRED CRITERIA:**   * + Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs in this UPDL category   **ADDITIONAL ARIPIPRAZOLE (ABILIFY MYCITE) CRITERIA:**   * + Must be prescribed by or in consultation with a psychiatrist following an aripiprazole serum blood level draw indicating need for further investigation of adherence   **ADDITIONAL OLANZAPINE/SAMIDORPHAN (LYBALVI) CRITERIA:** |
| aripiprazole | aripiprazole ODT, soln |
| ARISTADA | CAPLYTA |
| ARISTADA INITIO | clozapine ODT |
| asenapine ST | COBENFY |
| clozapine | fluoxetine/olanzapine |
| FANAPT ST | LYBALVI |
| GEODON | NUPLAZID |
| INVEGA HAFYERA ER PA | REXULTI |
| INVEGA SUSTENNA | risperidone microspheres |
| INVEGA TRINZA | SECUADO |
| lurasidone | VERSACLOZ |
| olanzapine | ZYPREXA RELPREVV |
| paliperidone tab |  |
| PERSERIS |  |
| quetiapine IR, ER |  |
| RISPERDAL CONSTA BvG |  |
| risperidone |  |
| RYKINDO |  |
| UZEDY |  |
| VRAYLAR ST |  |
| ziprasidone |  |

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|  |  | * Must provide documentation that patient is not using opioids or undergoing acute opioid withdrawal   **ADDITIONAL PIMAVANSERIN (NUPLAZID) CRITERIA:**   * For Parkinson-related Hallucinations & Delusions **ALL** of the following must be met:   + Psychotic symptoms are severe and frequent enough to warrant treatment with an antipsychotic **AND** are not related to dementia or delirium   + The patient’s other Parkinson’s Disease drugs have been reduced or adjusted and psychotic symptoms persist **OR** patient is unable to tolerate adjustment of these other drugs   + Must have been inadequate clinical response or contraindication to at least 30 days of either quetiapine or clozapine * An exemption to the criteria will be authorized for prescribers with a neurology specialty to a patient with a history of the related condition   **ADDITIONAL INFORMATION:**   * Long-acting injectable antipsychotics may be billed by the pharmacy if they are not dispensed directly to the patient. If not administered by the pharmacist, the drug must be released only to the administering provider or administering provider’s staff, following all regulations for a   Prescription Pick-Up Station as described by the Ohio Board of Pharmacy |

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| **Central Nervous System (CNS) Agents: Fibromyalgia Agents** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| pregabalin IR | SAVELLA | **LENGTH OF AUTHORIZATIONS**: 365 Days  **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs in different classes (see Additional Information section below)   **ADDITIONAL INFORMATION**   * Drugs and drug classes include gabapentin, pregabalin, short- and/or long-acting opioids, skeletal muscle relaxants, SNRIs, SSRIs, trazodone, and tricyclic antidepressants |

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| **Central Nervous System (CNS) Agents: Medication Assisted Treatment of Opioid Addiction** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| BRIXADI | buprenorphine | **LENGTH OF AUTHORIZATIONS**: 180 days except 14 days for LUCEMYRA  **ADDITIONAL LOFEXIDINE (LUCEMYRA) CRITERIA**   * May be authorized if **ALL** of the following criteria are met:   + Must provide medical justification supporting why an opioid taper (such as with buprenorphine or methadone) cannot be used   + Must have had an inadequate clinical response or contraindication to clonidine * Must provide documentation that the drug was initiated in an inpatient setting to be exempt from the above criteria   **BUPRENORPHINE SAFETY EDITS AND DRUG UTILIZATION REVIEW CRITERIA:**   * Prescribing for buprenorphine products must follow the requirements of Ohio Administrative Code rule 4731-33-03 *Office based treatment for opioid addiction*. * In favor of eliminating prior authorization for all forms of oral short acting buprenorphine- containing products, ODM and the Managed Care Plans will implement safety edits and a retrospective drug utilization review process for all brand and generic forms of oral short acting buprenorphine-containing products. Safety edits are in place for dosages over 24mg of buprenorphine equivalents/day. * buprenorphine sublingual tablets (generic SUBUTEX) will be restricted to pregnancy, breastfeeding, or allergy/contraindication to preferred products * buprenorphine injection (SUBLOCADE) dosing schedule will be limited to 300mg/30 days   **ADDITIONAL INFORMATION**   * VIVITROL, SUBLOCADE, and BRIXADI may be billed by the pharmacy if it is not dispensed directly to the patient. If not administered by the pharmacist, the drug must be released only to the administering provider or administering provider's staff, following all regulations for a   Prescription Pick-Up Station as described by the Ohio Board of Pharmacy. |
| buprenorphine/naloxone | LUCEMYRA BvG |
| clonidine IR, ER |  |
| SUBLOCADE |  |
| SUBOXONE |  |
| VIVITROL |  |
| ZUBSOLV |  |

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| **Central Nervous System (CNS) Agents: Movement Disorders** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| AUSTEDO IR, XR PA ST |  | **LENGTH OF AUTHORIZATIONS:** 365 Days  **CLINICAL PA CRITERIA:**   * Must be prescribed by or in consultation with a neurologist or psychiatrist   **STEP THERAPY CRITERIA:**   * Must have an inadequate clinical response of at least 90 days to a maximally tolerated dose of tetrabenazine for Huntington’s Disease only |
| INGREZZA PA ST |
| tetrabenazine |

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| **Central Nervous System (CNS) Agents: Multiple Sclerosis\* LEGACY CATEGORY** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| AVONEX | BAFIERTAM | **LENGTH OF AUTHORIZATIONS**: 365 Days  **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 30 days with at least one preferred drug in this UPDL category   **ADDITIONAL OCRELIZUMAB (OCREVUS) CRITERIA:**   * Must provide documentation of diagnosis of primary progressive multiple sclerosis **OR** must have had an inadequate clinical response of at least 30 days with at least one preferred drug in this UPDL category   **ADDITIONAL SIPONIMOD (MAYZENT) CRITERIA:**   * Must provide documentation of CYP2C9 genotype |
| BETASERON | glatiramer |
| COPAXONE BvG | glatopa |
| dalfampridine | MAVENCLAD |
| dimethyl fumarate | MAYZENT |
| fingolimod | OCREVUS |
| GILENYA | PLEGRIDY |
| KESIMPTA | PONVORY |
| REBIF | TASCENSO ODT |
| teriflunomide | VUMERITY |
|  | ZEPOSIA |

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| **Central Nervous System (CNS) Agents: Narcolepsy** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| amphetamine/  dextroamphetamine IR/ER AR | SUNOSI  WAKIX | **LENGTH OF AUTHORIZATIONS:** 365 days  **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response with at least two preferred drugs - either at least 30 days of armodafinil or modafinil; **OR** at least 7 days of a preferred amphetamine or methylphenidate drug in this UPDL category   **ADDITIONAL OXYBATE SALTS (XYWAV) CRITERIA:**   * + Must have documented adherence to sodium restricted diet   **AR** –amphetamine/dextroamphetamine: a PA is required for patients younger than 3 years  **AR** –amphetamine/dextroamphetamine XR, dextroamphetamine ER: a PA is required for patients younger than 6 years |
| armodafinil | XYREM BvG |
| dextroamphetamine ER AR | XYWAV |
| methylphenidate ER |  |
| methylphenidate tab |  |
| modafinil |  |

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| **Central Nervous System (CNS) Agents: Neuropathic Pain** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **DIBENZAZEPINES** | | **LENGTH OF AUTHORIZATIONS**: 365 Days  **STEP THERAPY CRITERIA:**   * Must have had an inadequate clinical response of at least 30 days with generic lidocaine patch   **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs in different drug classes in this UPDL category   **ADDITIONAL GABAPENTIN (GRALISE) AND GABAPENTIN ENCARBIL (HORIZANT) CRITERIA**   * Must have had an inadequate clinical response to a preferred gabapentin product |
| carbamazepine IR, ER | oxcarbazepine susp |
| oxcarbazepine tab |
| TRILEPTAL SUSP BvG |
| **GAPAPENTINOIDS** | |
| gabapentin IR | GRALISE BvG |
| HORIZANT |
| **TRICYCLIC ANTIDEPRESSANTS** | |
| amitriptyline |  |
| desipramine |
| doxepin 10, 25, 50, 75, 100, 150mg |
| doxepin soln |
| imipramine |
| nortriptyline |
| **OTHER** | |
| duloxetine 20, 30, 60mg | duloxetine 40mg |
| lidocaine patch | pregabalin ER |
| pregabalin IR |  |
| ZTLIDO ST |  |

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| **Central Nervous System (CNS) Agents: Parkinson's Agents** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **COMT INHIBITORS** | | **LENGTH OF AUTHORIZATIONS**: 365 Days  **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 30 days with at least one preferred drug in this UPDL category   **ADDITIONAL APOMORPHINE (APOKYN/KYNMOBI), LEVODOPA INHALATION (INBRIJA), & ISTRADEFYLLINE (NOURIANZ) CRITERIA:**   * Must have had inadequate clinical response to at least 30 days with one other drug for the treatment of “off episodes” (COMT inhibitor, dopamine agonist, or MAO-B inhibitor) |
| entacapone | ONGENTYS |
| tolcapone |
| **DOPAMINE AGONISTS** | |
| pramipexole IR | apomorphine |
| ropinirole IR, ER | KYNMOBI |
|  | NEUPRO |
|  | pramipexole ER |
| **MAO-B INHIBITORS** | |
| selegiline | rasagiline |
| XADAGO |
| ZELAPAR |
| **OTHER** | |
| amantadine cap, tab | amantadine soln |
| carbidopa | carbidopa/levodopa dispersible |
| carbidopa/levodopa IR, ER | carbidopa/levodopa/entacapone |
|  | CREXONT |
|  | GOCOVRI |
|  | INBRIJA |
|  | NOURIANZ |
|  | OSMOLEX ER |
|  | RYTARY |

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| **Central Nervous System (CNS) Agents: Restless Legs Syndrome** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| pramipexole IR | HORIZANT | **LENGTH OF AUTHORIZATIONS:** 365 Days  **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 30 days with at least one preferred drug in this UPDL category |
| ropinirole IR, ER | NEUPRO |

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| **Central Nervous System (CNS) Agents: Sedative-Hypnotics, Non-Barbiturate** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| BELSOMRA | DAYVIGO | **LENGTH OF AUTHORIZATIONS**: 180 Days  **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 7 days with at least two preferred drugs in this UPDL category   **ADDITIONAL INFORMATION**   * Non-controlled medications may be authorized if the prescriber indicates the patient has a history of addiction |
| estazolam | doxepin 3, 6mg |
| eszopiclone | EDLUAR |
| ramelteon | flurazepam |
| temazepam | quazepam |
| triazolam | QUVIVIQ |
| zaleplon | zolpidem cap, SL |
| zolpidem tab ER, IR | ZOLPIMIST |

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| **Central Nervous System (CNS) Agents: Skeletal Muscle Relaxants, Non-Benzodiazepine** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| baclofen susp AR, tab | baclofen soln | **LENGTH OF AUTHORIZATIONS**: 365 Days  **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs in this UPDL category   **ADDITIONAL CARISOPRODOL (SOMA) CRITERIA:**   * Must provide medical justification that no other muscle relaxant or agent to treat fibromyalgia, or any musculoskeletal condition would serve the clinical needs of the patient   **AR** – FLEQSUVY (baclofen susp): a PA is required for patients 12 years and older |
| chlorzoxazone 500mg | carisoprodol |
| cyclobenzaprine IR | chlorzoxazone 250, 375, 750mg |
| dantrolene | cyclobenzaprine ER |
| metaxalone 800mg | FLEQSUVY AR |
| methocarbamol | LYVISPAH |
| orphenadrine | metaxalone 400mg |
| tizanidine | orphenadrine/ASA/caffeine |
|  | TANLOR |

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| **Central Nervous System (CNS) Agents: Smoking Deterrents** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| bupropion SR |  | All products are covered without a PA |
| CHANTIX |
| nicotine |
| varenicline |

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| **Dermatologic Agents: Oral Acne Products** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| amnesteem PA | ABSORICA | **LENGTH OF AUTHORIZATIONS:** 150 days  **CLINICAL PA CRITERIA:**   * Must have had an inadequate clinical response of at least 90 days with at least one preferred topical **AND** one preferred oral antibiotic for acne   **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 90 days with at least two preferred drugs in this UPDL category   **ADDITIONAL INFORMATION**   * Authorization length will be for no more than 150 days at a time then must take 56 days off |
| claravis PA | ABSORICA LD |
| isotretinoin PA |  |
| zenatane PA |  |

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| **Dermatologic Agents: Topical Acne Products** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **NON-RETINOIDS** | | **LENGTH OF AUTHORIZATIONS**: 365 Days  **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response with at least two preferred drugs in this UPDL category. Trials must be 30 days for preferred non-retinoids and 90 days for preferred retinoids.   **ADDITIONAL CLINDAMYCIN/ADAPALENE/BENZOYL PEROXIDE (CABTREO) CRITERIA**   * Must provide documentation for patient’s inability to use the   individual drugs in this UPDL category  **ADDITIONAL INFORMATION**   * All retinoids - May be authorized with a diagnosis of skin cancer * tazarotene (TAZORAC) - May be authorized with a diagnosis of psoriasis   **AR** - All topical retinoids: a PA is required for patients 24 years and older |
| azelaic acid gel | CLINDACIN KIT |
| benzoyl peroxide | clindamycin foam |
| clindamycin gel, lot, soln, swabs | clindamycin/benz perox 1.2-3.75% |
| clind/benz perox 1-5%, 1.2-2.5%, 1.2-5% | dapsone gel |
| erythromycin | FINACEA FOAM |
| erythromycin/benzoyl peroxide | NEUAC |
| ONEXTON GEL BvG | sodium sulfacetamide/sulfur |
| sodium sulfacetamide gel, liq | sodium sulfacetamide pads |
|  | WINLEVI |
|  | ZMA CLEAR SUSP |
| **RETINOIDS/COMBINATIONS** | |
| adapalene gel AR 0.1%, 0.3% | adapalene cream AR |
| adapalene/benzoyl peroxide AR | ARAZLO AR |
| ALTRENO AR | CABTREO GEL AR |
| RETIN-A MICRO AR BvG 0.04%, 0.1% | clindamycin/tretinoin AR |
| tretinoin AR cream, gel | RETIN-A MICRO AR 0.06%, 0.08% BvG |
|  | tazarotene AR cream, foam, gel 0.1% |
|  | tretinoin micro AR 0.04%, 0.1% |

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| **Endocrine Agents: Androgens** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| depo-testosterone AR PA | AVEED AR | **LENGTH OF AUTHORIZATIONS:** 365 Days  **CLINICAL PA CRITERIA:**   * Must provide documentation of baseline lab work to support the need for testosterone supplementation. If baseline testosterone level is within normal limits, provide clinical justification for why replacement therapy is required.   **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 90 days with   **ALL** preferred drugs in this UPDL category  **ADDITIONAL TESTOSTERONE ENANTHATE (XYOSTED) CRITERIA:**   * Must have a trial and failure of a preferred testosterone cypionate injectable product **OR** * Must provide a clinical rationale why testosterone cypionate injectable product is not appropriate   **SUBSEQUENT AUTHORIZATION CRITERIA:**   * Must provide documentation of patient’s clinical response to treatment and ongoing safety monitoring (i.e., testosterone and hematocrit)   **AR**: All drugs: a PA is required for patients younger than 18 years |
| testosterone cypionate AR PA | JATENZO AR |
| testosterone gel 1% packet AR PA | methyltestosterone AR |
| testosterone gel 1.62% pump AR PA | NATESTO AR |
|  | TESTOPEL AR |
|  | testosterone gel 1% pump AR |
|  | testosterone gel 1.62% packet AR |
|  | testosterone gel 2% AR |
|  | testosterone soln 30mg/ACT AR |
|  | TLANDO AR |
|  | XYOSTED AR |

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| **Endocrine Agents: Diabetes – Hypoglycemia Treatments** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| BAQSIMI | glucagon emerg kit [labeler 63323] | **LENGTH OF AUTHORIZATIONS**: 365 Days  **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least one preferred drug in this UPDL category **OR** the inability of the member and/or caregiver to administer a preferred glucagon product in a timely fashion   **SUBSEQUENT AUTHORIZATION CRITERIA:**   * Renewal will be allowed for expired/unused products **WITHOUT**   documentation of patient’s clinical response to treatment |
| GLUCAGEN HYPOKIT |
| glucagon emerg kit [labeler 00548] |
| GVOKE |
| ZEGALOGUE |

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| **Endocrine Agents: Diabetes – Insulin** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **RAPID-ACTING** | | **LENGTH OF AUTHORIZATIONS**: 365 Days  **STEP THERAPY CRITERIA:**   * Must have had an inadequate clinical response (defined as the inability to reach target A1C) after at least 120 days with at least one preferred drug having a similar duration of action in this UPDL category   **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response (defined as the inability to reach target A1C) after at least 120 days with at least two preferred drugs having a similar duration of action in this UPDL category   **ADDITIONAL TEMPO PEN CRITERIA**   * Must have had an inadequate clinical response or documentation of medical necessity beyond convenience for why the patient cannot use the corresponding FlexPens or Kwikpens   **ADDITIONAL INHALED INSULIN (AFREZZA) CRITERIA:**   * Must provide documentation of spirometry testing prior to initiation with a predicted FEV1 ≥70% - Will not be authorized for patients with asthma or COPD * Must provide documentation of being nicotine-free for at least 180 days   **ADDITIONAL INFORMATION**   * An inadequate clinical response is defined as the inability to reach A1C goal after at least 120 days of current regimen with documented adherence and appropriate dose escalation.   + Must include a patient specific A1C goal if less than 7%   + Must include current A1C (within last 6 months) * Requests may be authorized for patients with a condition that is difficult to control (i.e., prone to ketoacidosis, hypoglycemia) |
| APIDRA | ADMELOG |
| HUMALOG U-100 KWIKPEN, VIAL | AFREZZA |
| insulin aspart | FIASP |
| insulin lispro | HUMALOG U-100 TEMPO PEN |
|  | HUMALOG U-200 |
|  | LYUMJEV |
|  | NOVOLOG U-100 |
| **SHORT-ACTING** | |
| HUMULIN R U-500 | HUMULIN R U-100 |
| NOVOLIN R U-100 |
| **INTERMEDIATE-ACTING** | |
|  | HUMULIN N U-100 |
| NOVOLIN N U-100 |
| **LONG-ACTING** | |
| LANTUS BvG | BASAGLAR |
| LEVEMIR | insulin degludec |
| TOUJEO BvG | insulin glargine |
| TRESIBA BvG ST | REZVOGLAR |
|  | SEMGLEE BvG |
| **MIXED INSULIN** | |
| HUMALOG 50-50 | NOVOLIN 70-30 |
| HUMALOG 75-25 | NOVOLOG 70-30 |
| HUMULIN 70-30 |  |
| insulin aspart pro/insulin aspart |  |

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|  |  | **SUBSEQUENT AUTHORIZATION CRITERIA:**   * Must provide documentation of patient’s clinical response to treatment and ongoing safety monitoring   + Must include a patient specific A1C goal if less than 7%   + Must include current A1C (within last 6 months) |

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| **Endocrine Agents: Diabetes – Non-Insulin** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **DPP4 INHIBITORS/COMBINATIONS** | | **LENGTH OF AUTHORIZATIONS:** 365 Days  **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 120 days with at least three preferred drugs in this UPDL category, if available.   **ADDITIONAL SITAGLIPTIN (ZITUVIO) CRITERIA**   * Must have had a trial of at least 120 days with JANUVIA **OR** must provide documentation of medical necessity for patient’s inability to use JANUVIA   **ADDITIONAL INFORMATION**   * An inadequate clinical response is defined as the inability to reach A1C goal after at least 120 days of current regimen, with use of two or more drugs concomitantly per ADA guidelines, documented adherence, and appropriate dose escalation (must achieve   maximum recommended dose or document that maximum  recommended dose is not tolerated or is clinically inappropriate).   * + Must include a patient specific A1C goal if less than 7%   + Must include current A1C (within last 6 months) * For non-preferred drugs that have preferred drugs in the same drug class: must provide documentation that there was at least one inadequate clinical response with a drug in same drug class   **SUBSEQUENT AUTHORIZATION CRITERIA:**   * Must provide documentation of patient’s clinical response to treatment and ongoing safety monitoring   + Must include a patient specific A1C goal if less than 7%   + Must include current A1C (within last 6 months) * Must meet all initial clinical criteria for subsequent authorizations. |
| JANUMET | alogliptin |
| JANUMET XR | alogliptin/metformin |
| JANUVIA | alogliptin/pioglitazone |
| JENTADUETO | JENTADUETO XR |
| KOMBIGLYZE XR BvG | saxagliptin |
| ONGLYZA BvG | saxagliptin/metformin |
| TRADJENTA | sitagliptin/metformin (gen of ZITUVIMET) |
|  | ZITUVIO BvG |
| **GLP-1 RECEPTOR AGONISTS/COMBINATIONS** | |
| BYETTA | BYDUREON BCISE |
| TRULICITY | liraglutide |
| VICTOZA BvG | MOUNJARO |
|  | OZEMPIC |
|  | RYBELSUS |
|  | SOLIQUA |
|  | XULTOPHY |
| **METFORMIN** | |
| metformin ER (gen of GLUCOPHAGE XR) | metformin ER (gen of FORTAMET, GLUMETZA) |
| metformin IR 500, 850, 1000mg | metformin IR 625mg |
|  | metformin soln |
| **SGLT2 INHIBITORS/COMBINATIONS** | |
| FARXIGA BvG | dapagliflozin |
| JARDIANCE | dapagliflozin/metformin ER |
| SYNJARDY | GLYXAMBI |
| XIGDUO XR BvG | INVOKAMET |
|  | INVOKANA |
|  | QTERN |
|  | SEGLUROMET |
|  | STEGLATRO |
|  | STEGLUJAN |
|  | SYNJARDY XR |
|  | TRIJARDY XR |

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| **SULFONYLUREAS/COMBINATIONS** | |  |
| glimepiride | glimepiride/pioglitazone |
| glipizide IR, ER |
| glipizide/metformin |
| glyburide |
| glyburide/metformin |
| **OTHER** | |
| acarbose | SYMLINPEN |
| miglitol |
| nateglinide |
| pioglitazone |
| pioglitazone/metformin |
| repaglinide |

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| **Endocrine Agents: Endometriosis** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| danazol ST | SYNAREL | **LENGTH OF AUTHORIZATIONS**: 365 Days  **STEP THERAPY CRITERIA:**   * Must have had an inadequate clinical response of at least 84 days with at least one preferred NSAID and one oral contraceptive   **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 84 days with at least one preferred step-therapy drug in this UPDL category.   **ADDITIONAL INFORMATION:**   * A total lifetime duration of therapy of 730 days between ORILISSA and MYFEMBREE or 365 days for LUPRON DEPOT will be authorized |
| DEPO-SUBQ PROVERA 104 ST |
| LUPRON DEPOT ST 3.75, 11.25mg |
| MYFEMBREE ST |
| ORILISSA ST |

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| **Endocrine Agents: Estrogenic Agents** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **ORAL** | | **LENGTH OF AUTHORIZATIONS**: 365 Days  **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs in this UPDL category. |
| ANGELIQ | DUAVEE |
| estradiol tab | estradiol/norethindrone |
| ethinyl estradiol/norethindrone | MENEST |
| PREMARIN TAB |  |
| PREMPHASE |  |
| PREMPRO |  |
| **TOPICAL** | |
| DIVIGEL BvG | estradiol gel 0.06% (generic of ESTROGEL) |
| ELESTRIN |
| estradiol cream |
| **TRANSDERMAL** | |
| CLIMARA | EVAMIST |
| COMBIPATCH | MENOSTAR |
| dotti |  |
| estradiol patch |  |
| lyllana |  |
| MINIVELLE |  |
| VIVELLE -DOT |  |
| **VAGINAL** | |
| ESTRING | estradiol 10mcg vag tab |
| PREMARIN CREAM | FEMRING |

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| **Endocrine Agents: Growth Hormone** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **DAILY-DOSING** | | **LENGTH OF AUTHORIZATIONS**: Initial: 180 days; Subsequent: 365 days  **CLINICAL PA CRITERIA:**  **Pediatric Approvals (under 18 years of age):**   * Must be treated and followed by a pediatric endocrinologist, nephrologist, clinical geneticist, endocrinologist, or gastroenterologist (or as appropriate for diagnosis) * Must provide documentation to justify criteria being met, including height, weight, bone age (children), date and results of most current x-ray, stimulus test results, IGF-1 levels, and a growth chart (children) * Must not be used in combination with another somatropin agent   **Adult Approvals (18 years of age or older):**   * Must be treated and followed by an endocrinologist * Must provide documentation of growth hormone deficiency by means of a negative response to an appropriate stimulation test (clonidine test is not acceptable for adults)   **STEP THERAPY CRITERIA:**   * Must have had an inadequate clinical response of at least 90 days with at least one preferred daily-dosed growth hormone formulation   **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 90 days with at least one preferred drug of similar duration of action in this UPDL category   **SUBSEQUENT AUTHORIZATION CRITERIA:**   * Must provide documentation of patient’s clinical response to treatment and ongoing safety monitoring (i.e., height, weight gain, improved body composition) * For adults: must provide documentation by endocrinologist that   discontinuing agent would have a detrimental effect on body composition or other metabolic parameters |
| GENOTROPIN PA | HUMATROPE |
| NORDITROPIN PA | NUTROPIN |
|  | OMNITROPE |
|  | SEROSTIM |
|  | ZOMACTON |
| **WEEKLY-DOSING** | |
| SKYTROFA PA ST | NGENLA |
| SOGROYA |

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| **Endocrine Agents: Osteoporosis – Bone Ossification Enhancers** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **BISPHOSPHONATES** | | **LENGTH OF AUTHORIZATIONS**: 365 Days  **CLINICAL PA CRITERIA:**   * Must have had an inadequate clinical response of at least 365 days with one bisphosphonate * A total lifetime duration of therapy of 730 days will be authorized between any parathyroid analog   **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 365 days with at least one preferred drug with the same mechanism of action if available   **ADDITIONAL “OTHER BONE RESORPTION SUPPRESSION AND RELATED AGENTS” CRITERIA:**   * Must have had an inadequate clinical response of at least 365 days with one bisphosphonate * A total lifetime duration of therapy of 730 days will be authorized between any parathyroid analog * A total lifetime duration of therapy of 365 days will be authorized for EVENITY   **ADDITIONAL INFORMATION**   * Patients should only be on ONE of the therapeutic classes (bisphosphonates, calcitonin-salmon) |
| alendronate tab | alendronate soln |
| ibandronate | BINOSTO |
|  | FOSAMAX PLUS D |
|  | risedronate |
|  | zoledronic acid |
| **OTHER BONE RESORPTION SUPPRESSION AND RELATED AGENTS** | |
| calcitonin-salmon | EVENITY |
| FORTEO BvG PA | PROLIA |
| raloxifene | teriparatide |
|  | TYMLOS |

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| **Endocrine Agents: Progestin Agents** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| medroxyprogesterone acetate tab |  | All products are covered without a PA |
| megestrol |
| norethindrone acetate |
| progesterone |
| progesterone in oil |

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| **Endocrine Agents: Uterine Fibroids** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| LUPRON DEPOT PA 3.75, 11.25mg |  | **LENGTH OF AUTHORIZATIONS**: Up to 180 Days  **CLINICAL PA CRITERIA:**   * Must have had an inadequate clinical response of at least 90 days with at least one oral contraceptive   **ADDITIONAL INFORMATION:**   * A total lifetime duration of therapy of 730 days between MYFEMBREE and ORIAHNN or 365 days for LUPRON DEPOT will be authorized |
| MYFEMBREE PA |
| ORIAHNN PA |

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| **Gastrointestinal Agents: Anti-Emetics** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **5-HT3 ANTAGONISTS** | | **LENGTH OF AUTHORIZATIONS**: 365 Days  **CLINICAL PA CRITERIA:**   * dronabinol is only covered for nausea and vomiting associated with chemotherapy in adult patients who failed at least 3 days with at least one preferred drug in this UPDL category.   **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 3 days with at least one preferred drug in this UPDL category |
| granisetron tab | ondansetron 16mg |
| ondansetron 4, 8mg | SANCUSO |
| **ANTICHOLINERGICS** | |
| scopolamine |  |
| **ANTIHISTAMINES and ANTIHISTAMINE COMBINATIONS** | |
| dimenhydrinate | BONJESTA |
| diphenhydramine |
| doxylamine/pyridoxine |
| meclizine |
| trimethobenzamide |
| **PHENOTHIAZINES** | |
| prochlorperazine  promethazine |  |
| **SUBSTANCE P/NEUROKININ 1 (NK-1) ANTAGONISTS** | |
| aprepitant 40mg, tripac  EMEND 125mg SUSP | aprepitant 80, 125mg |
| **OTHER** | |
| dronabinol PA | metoclopramide ODT |
| metoclopramide |

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| **Gastrointestinal Agents: Bowel Preparations** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| CLENPIQ | MOVIPREP | **LENGTH OF AUTHORIZATIONS:** 365 Days  **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response with at least one preferred drug in this UPDL category. |
| GAVILYTE -C | PLENVU |
| GAVILYTE -G | SUFLAVE |
| GAVILYTE -N | SUTAB |
| GOLYTELY |  |
| sod sulf-potass sulf-mag sulf soln |  |

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| **Gastrointestinal Agents: Crohn’s Disease** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| azathioprine 50mg | azathioprine 75, 100mg | **LENGTH OF AUTHORIZATIONS**: 365 days  **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs in this UPDL category. |
| budesonide ER |
| mercaptopurine |
| methotrexate |
| sulfasalazine IR, DR |

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| **Gastrointestinal Agents: Hepatic Encephalopathy** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| lactulose XIFAXAN ST |  | **LENGTH OF AUTHORIZATIONS**: 365 Days  **STEP THERAPY CRITERIA:**   * Must have had an inadequate clinical response of at least 14 days with at least one preferred drug in this UPDL category |

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| **Gastrointestinal Agents: Irritable Bowel Syndrome (IBS) with Diarrhea** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| diphenoxylate/atropine | alosetron | **LENGTH OF AUTHORIZATIONS**: 365 Days  **STEP THERAPY CRITERIA:**   * Must have had an inadequate clinical response of at least 14 days with at least one preferred drug in this UPDL category   **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 14 days with at least one preferred drug and one step therapy drug in this UPDL   category. |
| loperamide | VIBERZI |
| XIFAXAN ST |  |

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| **Gastrointestinal Agents: Pancreatic Enzymes** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| CREON | VIOKACE | **LENGTH OF AUTHORIZATIONS**: 365 Days  **STEP THERAPY CRITERIA:**   * For a diagnosis of Cystic Fibrosis, no trials required * For all other diagnoses, must have had an inadequate clinical response of at least 14 days with at least one preferred drug in this UPDL category   **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs in this UPDL category. |
| PERTZYE ST |
| ZENPEP |

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| **Gastrointestinal Agents: Proton Pump Inhibitors** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| esomeprazole | DEXILANT BvG | **LENGTH OF AUTHORIZATIONS**: 180 days, except as listed under additional criteria  **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs in this UPDL category.   **ADDITIONAL CRITERIA FOR PPI DOSES GREATER THAN ONCE DAILY**   * Must have had an inadequate clinical response of at least 30 days of once daily dosing with the requested drug **OR** * For H. Pylori diagnosis: Must provide documentation of diagnosis   + Authorization length: 30 days * For any of the following diagnoses: carcinoma of GI tract, COPD, Crest Syndrome, dyspepsia, esophageal varices, gastritis, gastroparesis, scleroderma, symptomatic uncomplicated Barret’s Esophagus, systemic mastocytosis, or Zollinger Ellison Syndrome: Must provide documentation of diagnosis **AND** must have failed once-daily dosing of the requested drug   + Authorization length: 365 days   **ADDITIONAL INFORMATION**   * Request may be authorized If the drug was initiated in the hospital for the treatment of a condition such as a GI bleed or the presence of a gastrostomy and/or jejunostomy (G, GJ, J-tube)   **AR** – PROTONIX PAK/pantoprazole packet: a PA is required for patients 6 years and older |
| lansoprazole cap | esomeprazole granules |
| NEXIUM GRANULES BvG | KONVOMEP |
| omeprazole | lansoprazole ODT |
| pantoprazole tab | omeprazole/sodium bicarbonate |
| PROTONIX PAK AR BvG | pantoprazole packet AR |
| rabeprazole | PRILOSEC SUSP |

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| **Gastrointestinal Agents: Ulcerative Colitis** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **ORAL** | | **LENGTH OF AUTHORIZATIONS**: 365 Days; except UCERIS FOAM – 90 days  **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs in this UPDL category   **ADDITIONAL BUDESONIDE (UCERIS) CRITERIA:**   * Must have had a documented side effect, allergy, or treatment failure of at least 30 days with mesalamine enema or suppository   **ADDITIONAL OZANIMOD (ZEPOSIA) AND ETRASIMOD (VELSIPITY) CRITERIA:**   * Must have had a documented side effect, allergy, or treatment failure of at least 90 days with at least one preferred Systemic Immunomodulator indicated for Ulcerative Colitis (refer to Immunomodulator Agents: Systemic Inflammatory Disease class for complete list) |
| balsalazide disodium | DIPENTUM |
| budesonide ER tab | mesalamine DR tab 800mg |
| mesalamine DR cap, tab 1.2gm | mesalamine ER cap 500mg |
| mesalamine ER cap 0.375gm | VELSIPITY |
| PENTASA BvG | ZEPOSIA |
| sulfasalazine IR, DR |  |
| **RECTAL** | |
| mesalamine enema, supp | mesalamine enema kit |
| SF ROWASA |
| UCERIS FOAM BvG |

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| **Gastrointestinal Agents: Unspecified GI** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| bisacodyl | AEMCOLO | **LENGTH OF AUTHORIZATIONS**: 365 days except 3 days for AEMCOLO  **STEP THERAPY CRITERIA:**   * Must have had an inadequate clinical response to at least 14 days with at least two preferred drugs in this UPDL category, if indicated for diagnosis   **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 14 days with one step therapy drug in this UPDL category, if indicated for diagnosis   **ADDITIONAL METHYLNALTREXONE (RELISTOR) AND NALDEMEDINE (SYMPROIC) CRITERIA:**   * Must have a history of chronic pain requiring continuous opioid therapy for ≥84 days   **ADDITIONAL RIFAMYCIN DELAYED-RELEASE (AEMCOLO) CRITERIA:**   * Must have the inability to take, or failure of **ALL** of the following: azithromycin, ciprofloxacin, levofloxacin, ofloxacin, or rifaximin   **SUBSEQUENT AUTHORIZATION CRITERIA:**   * Must provide documentation of patient’s clinical response to treatment and ongoing safety monitoring (i.e., decreased frequency of specialized nutrition support or improvement in symptoms) |
| dicyclomine | AMITIZA |
| diphenoxylate/atropine | GATTEX |
| lactulose | IBSRELA |
| LINZESS | MOTEGRITY |
| loperamide | MYTESI |
| lubiprostone ST | RELISTOR |
| MOVANTIK ST | SYMPROIC |
| polyethylene glycol |  |
| senna |  |
| TRULANCE ST |  |
| XIFAXAN ST |  |

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| **Genitourinary Agents: Benign Prostatic Hyperplasia** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **ALPHA BLOCKERS** | | **LENGTH OF AUTHORIZATIONS**: 365 Days  **TADALAFIL (CIALIS) CRITERIA:**   * Must have had an inadequate clinical response of at least 30 days with at least one alpha-1 adrenergic blocker. If prostate volume of > 30cc on imaging, a prostate specific antigen (PSA) > 1.5ng/dL, or palpable prostate enlargement on digital rectal exam (DRE), then a trial of at least 90 days of finasteride is required.   **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 60 days with at least two preferred drugs, with at least one preferred with the same mechanism of action, if available |
| alfuzosin | CARDURA XL |
| doxazosin |
| prazosin |
| silodosin |
| tamsulosin |
| terazosin |
| **5-ALPHA-REDUCTASE (5AR) INHIBITORS** | |
| dutasteride |  |
| finasteride 5mg |
| **ALPHA BLOCKER/5AR/PDE5 INHIBITOR COMBINATIONS** | |
|  | dutasteride/tamsulosin |
| **PHOSPHODIESTERASE 5 (PDE5) INHIBITORS** | |
| tadalafil PA 2.5, 5mg |  |

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| **Genitourinary Agents: Electrolyte Depleter Agents** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **CALCIUM BASED** | | **LENGTH OF AUTHORIZATIONS**: 365 Days  **STEP THERAPY CRITERIA:**   * Must have had an inadequate clinical response of at least 7 days with at least one preferred drug in this UPDL category   **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs in this UPDL category, one of which must have the same mechanism of action as the requested non-preferred drug, if available |
| calcium acetate, carbonate |  |
| PHOSLYRA SOLN |
| **IRON BASED** | |
| VELPHORO ST | AURYXIA |
| **OTHER** | |
| sevelamer | FOSRENOL POWDER |
| lanthanum carbonate |
| XPHOZAH |

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| **Genitourinary Agents: Urinary Antispasmodics** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **ANTIMUSCARINICS** | | **LENGTH OF AUTHORIZATIONS**: 365 Days  **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs in this UPDL category with different active ingredients   **AR** – MYRBETRIQ GRANULES: a PA is required for patients younger than 3 years old AND 5 years and older  **AR** – VESICARE LS: a PA is required for patients younger than 2 years old AND 5  years and older |
| fesoterodine | darifenacin |
| oxybutynin IR, ER | tolterodine IR, ER |
| OXYTROL | VESICARE LS AR |
| solifenacin |  |
| trospium IR, ER |  |
| **BETA-3 AGONISTS** | |
| MYRBETRIQ TAB BvG | GEMTESA |
| mirabegron tab |
| MYRBETRIQ GRANULES AR |

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| **Hyperkalemia Agents: Potassium Binders** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| LOKELMA | kionex susp | **LENGTH OF AUTHORIZATIONS:** 365 Days  **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 30 days with at least one preferred drug in this UPDL category. |
| sodium polystyrene sulfonate |
| VELTASSA |

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| **Immunomodulator Agents: Systemic Inflammatory Disease** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **INTERLEUKIN ANTAGONISTS** | | **LENGTH OF AUTHORIZATIONS**: Initial: 90 days; Subsequent: 365 days  **CLINICAL PA CRITERIA:**   * Authorization of dosing regimens (loading/maintenance) will be based upon diagnosis. Document the requested loading and maintenance dosing on PA form, if applicable * Must not have a current, active infection * Must provide evidence of negative TB test prior to initiation of biologic therapy, if required by labeling   **STEP THERAPY CRITERIA:**   * Must had had an inadequate clinical response of at least 90 days with at least one preferred TNF inhibitor indicated for diagnosis in this UPDL category   **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 90 days with at least two preferred drugs in this UPDL category that are not biosimilars of the same reference product, if indicated for diagnosis   + For non-preferred biosimilars: must provide documentation of inadequate clinical response to its preferred reference product   **ADDITIONAL ALOPECIA AREATA CRITERIA:**   * Must be prescribed by or in consultation with a specialist (i.e., dermatologist, rheumatologist) * Must provide documentation of an inadequate clinical response of at least 90 days with a topical steroid   **ADDITIONAL ATOPIC DERMATITIS CRITERIA:**   * Must have at least 10% body surface area (BSA) involvement with an inadequate clinical response of at least 90 days with two of the |
| ADBRY PA | ACTEMRA |
| DUPIXENT PA | BIMZELX |
| EBGLYSS PA | COSENTYX |
| KINERET PA | ILUMYA |
| SKYRIZI INJ PA | KEVZARA |
| TALTZ PA ST | OMVOH |
| TREMFYA PA | SILIQ |
| TYENNE PA (Bio of ACTEMRA) | SKYRIZI IV SOLN |
|  | STELARA |
| **JAK INHIBITORS** | |
| RINVOQ PA | CIBINQO |
| XELJANZ IR PA | LITFULO |
|  | OLUMIANT |
|  | XELJANZ SOLN, XR |
| **TNF INHIBITORS** | |
| adalimumab-adaz PA (gen of HYRIMOZ) | ABRILADA (Bio of HUMIRA) |
| adalimumab-fkjp PA (gen of HULIO) | adalimumab-aacf (gen of IDACIO) |
| AMJEVITA PA 10/0.1ml (Bio of HUMIRA) | adalimumab-aaty (gen of YUFLYMA) |
| ENBREL PA | adalimumab-adbm (gen of CYLTEZO) |
| HUMIRA PA | adalimumab-ryvk (gen of SIMLANDI) |
| INFLECTRA PA (Bio of REMICADE) | AMJEVITA 10/0.2ml (Bio of HUMIRA) |
| SIMLANDI BvG PA (Bio of HUMIRA) | AVSOLA (Bio of REMICADE) |
|  | CIMZIA |
|  | HADLIMA (Bio of HUMIRA) |
|  | HYRIMOZ (Bio of HUMIRA) |
|  | infliximab (gen of REMICADE) |
|  | RENFLEXIS (Bio of REMICADE) |
|  | SIMPONI |
|  | YUSIMRY (Bio of HUMIRA) |
|  | ZYMFENTRA |

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| **OTHER** | | following: topical corticosteroids or topical calcineurin inhibitors [e.g., ELIDEL] unless atopic dermatitis is severe and involves >25% BSA |
| OTEZLA PA | ENTYVIO |
| ORENCIA |
| SOTYKTU |

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| **Infectious Disease Agents: Antibiotics – Cephalosporins** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| cefaclor IR, ER | cefixime cap | **LENGTH OF AUTHORIZATIONS**: Based on indication  **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 3 days with at least one preferred antibiotic in this UPDL category.   **ADDITIONAL INFORMATION**   * Requests may be authorized if the patient is completing a course of therapy that was started in the hospital or other similar location or was started before Medicaid eligibility, only the remaining course will be authorized   **SUBSEQUENT AUTHORIZATION CRITERIA:**   * Must provide documentation of patient’s clinical response to treatment,   ongoing safety monitoring, **AND** medical necessity for continued use  **AR** – cefaclor susp: a PA is required for patients 12 years and older **AR** – cefixime susp: a PA is required for patients 12 years and older **AR** – cefprozil susp: a PA is required for patients 12 years and older  **AR** – cephalexin susp: a PA is required for patients 12 years and older |
| cefaclor susp AR | cefixime susp AR |
| cefadroxil | cefpodoxime |
| cefdinir | cephalexin cap 750mg, tab |
| cefprozil |  |
| cefprozil susp AR |  |
| cefuroxime |  |
| cephalexin cap 250, 500mg |  |
| cephalexin susp AR |  |

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| **Infectious Disease Agents: Antibiotics – Inhaled** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| tobramycin 300mg/5ml neb soln PA | ARIKAYCE | **LENGTH OF AUTHORIZATIONS:** Initial: 180 days; Subsequent: 365 days  **CLINICAL PA CRITERIA:**   * Must provide documentation of cultures demonstrating drug is prescribed in alignment with approved indication   **NON-PREFERRED CRITERIA:**   * + Must have had an inadequate clinical response of at least 28 days with at least one preferred drug in this UPDL category   **SUBSEQUENT AUTHORIZATION CRITERIA:**   * + Must provide documentation of patient’s clinical response to treatment and ongoing safety monitoring (i.e., culture conversion, symptom improvement) |
| tobramycin inj | CAYSTON |
|  | TOBI PODHALER |
|  | tobramycin 300mg/4ml neb soln |

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| **Infectious Disease Agents: Antibiotics – Macrolides** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| azithromycin | clarithromycin ER | **LENGTH OF AUTHORIZATIONS**: Based on indication  **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 3 days with at least one preferred drug in this UPDL category   **ADDITIONAL INFORMATION**   * Requests may be authorized if the patient is completing a course of therapy that was started in the hospital or other similar location or was started before Medicaid eligibility, only the remaining course will be authorized   **SUBSEQUENT AUTHORIZATION CRITERIA:**   * Must provide documentation of patient’s clinical response to treatment,   ongoing safety monitoring, **AND** medical necessity for continued use  **AR** – clarithromycin susp: a PA is required for patients 12 years and older |
| clarithromycin IR, susp AR | erythromycin IR, ER |

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| **Infectious Disease Agents: Antibiotics – Quinolones** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| CIPRO ORAL SUSP AR | BAXDELA | **LENGTH OF AUTHORIZATIONS**: Based on indication  **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 3 days with at least one preferred drug in this UPDL category   **ADDITIONAL INFORMATION**   * Requests may be authorized if the patient is completing a course of therapy that was started in the hospital or other similar location or was started before Medicaid eligibility, only the remaining course will be authorized   **SUBSEQUENT AUTHORIZATION CRITERIA:**   * Must provide documentation of patient’s clinical response to treatment,   ongoing safety monitoring, **AND** medical necessity for continued use  **AR** – ciprofloxacin susp: a PA is required for patients 12 years and older  **AR** – CIPRO ORAL SUSP: a PA is required for patients 12 years and older  **AR** – levofloxacin oral soln: a PA is required for patients 12 years and older |
| ciprofloxacin | ofloxacin |
| ciprofloxacin susp AR |  |
| levofloxacin soln AR, tab |  |
| moxifloxacin |  |

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| **Infectious Disease Agents: Antibiotics – Tetracyclines** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| doxycycline 20, 50, 100mg | demeclocycline | **LENGTH OF AUTHORIZATIONS**: Based on indication for acute infections or 365 days for acne  **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 3 days with at least one preferred drug for acute infections **OR** at least 90 days with at least one preferred oral drug for acne in this UPDL category   **ADDITIONAL INFORMATION**   * Requests may be authorized if the patient is completing a course of therapy that was started in the hospital or other similar location or was started before Medicaid eligibility, only the remaining course will be authorized   **SUBSEQUENT AUTHORIZATION CRITERIA:**   * Must provide documentation of patient’s clinical response to treatment,   ongoing safety monitoring, **AND** medical necessity for continued use  **AR** – doxycycline susp: a PA is required for patients 12 years and older |
| doxycycline susp AR | doxycycline 75, 150mg |
| minocycline IR | doxycycline DR |
| tetracycline | minocycline ER |
|  | MINOLIRA |
|  | NUZYRA |

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| **Infectious Disease Agents: Antifungals** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| clotrimazole | BREXAFEMME | **LENGTH OF AUTHORIZATIONS**: Based on indication  **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 3 days with at least two preferred drugs, if indicated for the diagnosis in this UPDL category   **ADDITIONAL OTESECONAZOLE (VIVJOA) CRITERIA:**   * Must provide documentation of at least three symptomatic episodes of vulvovaginal candidiasis in the past 12 months * Must provide documentation of non-reproductive potential (i.e., post- menopausal) * Must have had an inadequate clinical response of at least 180-day maintenance course with oral fluconazole shown by documentation of more than one breakthrough infection   **ADDITIONAL INFORMATION:**   * posaconazole can be approved for aspergillosis treatment and prophylaxis without trials of preferred agents * Requests may be authorized if the patient is completing a course of therapy that was started in the hospital or other similar location or was started before Medicaid eligibility, only the remaining course will be authorized   **SUBSEQUENT AUTHORIZATION CRITERIA:**   * Must provide documentation of patient’s clinical response to treatment,   ongoing safety monitoring, **AND** medical necessity for continued use  **AR** – voriconazole susp: a PA is required for patients 12 years and older |
| fluconazole | CRESEMBA |
| griseofulvin | flucytosine |
| itraconazole cap | itraconazole soln |
| ketoconazole | NOXAFIL PAK |
| nystatin | ORAVIG |
| terbinafine | posaconazole |
| voriconazole susp AR, tab | TOLSURA |
|  | VIVJOA |

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| **Infectious Disease Agents: Antivirals – Hepatitis C Agents** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| MAVYRET PA | HARVONI | **LENGTH OF AUTHORIZATIONS:** Dependent upon authorized course  **CLINICAL PA CRITERIA:**   * Only regimens recommended by the American Association for the Study of Liver Diseases (AASLD) will be authorized * Please see the [Hepatitis C Direct Acting Antiviral Prior Authorization](https://spbm.medicaid.ohio.gov/SPDocumentLibrary/DocumentLibrary/Forms/Hepatitis%20C%20PA%20Fillable%20Form.pdf) [Form](https://spbm.medicaid.ohio.gov/SPDocumentLibrary/DocumentLibrary/Forms/Hepatitis%20C%20PA%20Fillable%20Form.pdf) for criteria   **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response defined as not achieving sustained virologic response (SVR) with guideline-recommended preferred drugs in this UPDL category |
| PEGASYS PA | ledipasvir/sofosbuvir |
| ribavirin PA | SOVALDI |
| sofosbuvir/velpatasvir PA | VOSEVI |
|  | ZEPATIER |

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| **Infectious Disease Agents: Antivirals – Herpes** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| acyclovir | famciclovir | **LENGTH OF AUTHORIZATIONS**: For the duration of the prescription (up to 180 days)  **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 3 days with at least one preferred drug in this UPDL category |
| valacyclovir | SITAVIG |

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| **Infectious Disease Agents: Antivirals – HIV\* LEGACY CATEGORY** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **INTEGRASE STRAND TRANSFER INHIBITORS** | | **LENGTH OF AUTHORIZATIONS:** 365 Days  **ABACAVIR/DOLUTEGRAVIR/LAMIVUDINE (TRIUMEQ PD) CRITERIA:**   * Must provide documentation of patient’s weight (only authorized for those 6 – 25 kg)   **FOSTEMSAVIR (RUKOBIA) CRITERIA:**   * Must provide documentation of a multidrug-resistant HIV-1 infection   **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 30 days with at least one preferred drug in this UPDL category. If applicable, the request must address the inability to use the individual components.   **AR** – ISENTRESS CHEWABLE TABLET: a PA is required for patients 12 years and older  **AR** – lamivudine soln: a PA is required for patients 3 years and older  **AR** – nevirapine soln: a PA is required for patients 3 years and older |
| APRETUDE | VOCABRIA |
| ISENTRESS |
| ISENTRESS CHEW TAB AR |
| TIVICAY |
| TIVICAY PD |
| **NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS** | |
| abacavir | abacavir soln |
| emtricitabine | lamivudine tab |
| entecavir |  |
| lamivudine soln AR |  |
| tenofovir dis fum 300mg |  |
| VIREAD TAB, POWDER |  |
| zidovudine |  |
| **NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS** | |
| efavirenz | EDURANT |
| nevirapine soln AR | etravirine |
| PIFELTRO | nevirapine IR, ER tab |
| **PROTEASE INHIBITORS** | |
| atazanavir | APTIVUS |
| darunavir 600, 800mg tab | fosamprenavir |
| EVOTAZ | NORVIR POWDER |
| PREZCOBIX | PREZISTA SUSP, 75, 150mg TAB |
| REYATAZ POWDER | VIRACEPT |
| ritonavir tab |  |
| **OTHER SINGLE INGREDIENT PRODUCTS** | |
| RUKOBIA PA | FUZEON |
| SELZENTRY BvG |
| SUNLENCA |
| TYBOST |
| **COMBINATION PRODUCTS** | |

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| abacavir/lamivudine | CIMDUO |
| BIKTARVY | lamivudine/zidovudine |
| CABENUVA | STRIBILD |
| COMPLERA | SYMFI BvG |
| DELSTRIGO | SYMFI LO BvG |
| DESCOVY |  |
| DOVATO |  |
| efavirenz/emtricitabine/tenofovir | |
| emtricitabine/tenofovir dis fum | |
| GENVOYA |  |
| JULUCA |  |
| lopinavir/ritonavir |  |
| ODEFSEY |  |
| SYMTUZA |  |
| TRIUMEQ |  |
| TRIUMEQ PD PA |  |

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| **Ophthalmic Agents: Antibiotic and Antibiotic-Steroid Combination Drops and Ointments** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| bacitracin-polymyxin | AZASITE | **LENGTH OF AUTHORIZATIONS**: 30 days  **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 3 days with at least two preferred drugs in this UPDL category.   **ADDITIONAL INFORMATION**   * Requests may be authorized if the patient is completing a course of therapy that was started in the hospital or other similar location or was started before Medicaid eligibility, only the remaining course will be authorized |
| CILOXAN | bacitracin |
| ciprofloxacin | BESIVANCE |
| erythromycin | gatifloxacin |
| gentamicin | moxifloxacin (generic of MOXEZA) |
| moxifloxacin | neo/poly/hydrocortisone |
| neo/poly/bacitracin | sulfacetamide sodium oint 10% |
| neo/poly/bacitracin/hydrocortisone | TOBRADEX ST |
| neo/poly/dexamethasone | ZYLET |
| neo/poly/gramicidin |  |
| ofloxacin |  |
| polymyxin/trimethoprim |  |
| sulfacetamide sodium soln 10% |  |
| sulfacetamide/prednisolone |  |
| TOBRADEX OINT |  |
| tobramycin |  |
| tobramycin/dexameth 0.3/0.1% |  |
| TOBREX OINT |  |

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| **Ophthalmic Agents: Antihistamines & Mast Cell Stabilizers** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| azelastine | alomide | **LENGTH OF AUTHORIZATIONS**: 365 Days  **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 7 days with at least two preferred drugs in this UPDL category. |
| BEPREVE BvG | bepotastine |
| cromolyn | epinastine |
| ketotifen | ZERVIATE |
| olopatadine |  |

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| **Ophthalmic Agents: Dry Eye Treatments** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| RESTASIS TRAYS BvG | CEQUA | **LENGTH OF AUTHORIZATIONS**: 14 days for EYSUVIS; 365 days for all other drugs  **STEP THERAPY CRITERIA:**   * Must have had an inadequate clinical response of at least 14 days with at least one preferred drug in this category in the previous 120 days   **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs in this UPDL category. |
| XIIDRA ST | cyclosporine |
|  | EYSUVIS |
|  | MIEBO |
|  | RESTASIS MULTI-DOSE |
|  | TYRVAYA |
|  | VEVYE |

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| **Ophthalmic Agents: Glaucoma Agents** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **ALPHA-2 AGONISTS** | | **LENGTH OF AUTHORIZATIONS**: 365 Days  **STEP THERAPY CRITERIA:**   * Must have had an inadequate clinical response of at least 30 days with at least one preferred drug in the same class, if available   **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs in the same class, if available |
| ALPHAGAN P 0.1% BvG | apraclonidine |
| ALPHAGAN P 0.15% BvG | brimonidine 0.1%, 0.15% |
| brimonidine 0.2% | IOPIDINE |
| **BETA BLOCKERS** | |
| betaxolol | BETIMOL |
| carteolol | BETOPTIC S |
| levobunolol | timolol maleate once daily, PF |
| timolol gel, soln |  |
| **CARBONIC ANHYDRASE INHIBITORS** | |
| AZOPT BvG ST | brinzolamide |
| dorzolamide |
| **PROSTAGLANDINS** | |
| latanoprost | bimatoprost |
| TRAVATAN Z BvG ST | IYUZEH |
|  | LUMIGAN |
|  | tafluprost |
|  | travoprost |
|  | VYZULTA |
|  | XELPROS |
| **OTHER** | |
| COMBIGAN BvG ST | brimonidine/timolol |
| dorzolamide/timolol |
| RHOPRESSA |
| ROCKLATAN |
| SIMBRINZA |

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| **Ophthalmic Agents: NSAIDs** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| diclofenac | ACUVAIL | **LENGTH OF AUTHORIZATIONS**: 30 days  **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 3 days with at least two preferred drugs in this UPDL category. |
| flurbiprofen | bromfenac |
| ketorolac | ILEVRO |
| NEVANAC |  |

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| **Ophthalmic Agents: Ophthalmic Steroids** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| ALREX BvG | INVELTYS | **LENGTH OF AUTHORIZATIONS**: 30 days  **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 7 days with at least two preferred drugs in this UPDL category. |
| dexamethasone sodium phosphate | LOTEMAX SM |
| difluprednate | loteprednol |
| DUREZOL |  |
| FLAREX |  |
| fluorometholone |  |
| FML FORTE |  |
| LOTEMAX BvG |  |
| MAXIDEX |  |
| PRED FORTE |  |
| PRED MILD |  |
| prednisolone acetate |  |
| prednisolone sodium phosphate |  |

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| **Otic Agents: Antibacterial and Antibacterial/Steroid Combinations** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| CIPRO HC | ciprofloxacin ciprofloxacin/fluocinolone | **LENGTH OF AUTHORIZATIONS**: 30 days  **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 3 days with at least two preferred drugs in this UPDL category. |
| ciprofloxacin/dexamethasone |
| CORTISPORIN-TC |
| neomycin/poly B/hydrocortisone |
| ofloxacin |

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| **Respiratory Agents: Antihistamines – Second Generation** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| cetirizine cap, syr, tab | cetirizine chewable AR | **LENGTH OF AUTHORIZATIONS**: 365 Days  **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 7 days with at least two different preferred drugs in this UPDL category.   **AR** – cetirizine chewable, loratadine chewable: a PA is required for patients 6 years and older |
| cetirizine/pseudoephedrine | CLARINEX-D |
| desloratadine | loratadine chewable AR |
| fexofenadine | fexofenadine/pseudoephedrine |
| levocetirizine |  |
| loratadine rapid dissolve |  |
| loratadine syr, tab |  |
| loratadine/pseudoephedrine |  |

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| **Respiratory Agents: Cystic Fibrosis** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| KALYDECO PA | BRONCHITOL | **LENGTH OF AUTHORIZATIONS:** Initial: 90 days; Subsequent: 365 days  **CLINICAL PA CRITERIA:**   * Must be prescribed by or in consultation with a pulmonologist or infectious disease specialist * Must provide documentation of the specific Cystic Fibrosis Transmembrane Conductance Regular (CFTR) genetic mutation   **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 30 days with at least one preferred drug in this UPDL category.   **ADDITIONAL BRONCHITOL CRITERIA:**   * Must be used as an add-on maintenance therapy * Must provide documentation of a completed BRONCHITOL Tolerance Test   **AR** – TRIKAFTA PAK: a PA is required for patients 6 years and older |
| ORKAMBI PA |
| PULMOZYME PA |
| SYMDEKO PA |
| TRIKAFTA PA PAK AR, TAB |

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| **Respiratory Agents: Epinephrine Auto-Injectors** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| epinephrine (labeler 49502) | AUVI-Q | **LENGTH OF AUTHORIZATIONS:** 365 Days  **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response to at least one preferred drug in this UPDL category.   **SUBSEQUENT AUTHORIZATION CRITERIA:**   * Subsequent reauthorizations for expired epinephrine auto-injectors are allowable |
| EPIPEN |
| EPIPEN JR |

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| **Respiratory Agents: Hereditary Angioedema** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **ACUTE** | | **LENGTH OF AUTHORIZATIONS**: Acute: 30 days; Prophylaxis: 180 Days  **CLINICAL PA CRITERIA:**   * Acute Treatment   + Must provide documentation that diagnosis is verified by a C4 level below the lower limit of normal as defined by laboratory testing AND one of the following:     - C1 inhibitor (C1-INH) antigenic level below the lower limit of normal as defined by laboratory testing; OR     - C1-INH functional level below the lower limit of normal as defined by laboratory testing * Prophylactic Treatment   + Must provide documentation that diagnosis is verified by a C4 level below the lower limit of normal as defined by laboratory testing AND one of the following:     - C1 inhibitor (C1-INH) antigenic level below the lower limit of normal as defined by laboratory testing; OR     - C1-INH functional level below the lower limit of normal as defined by laboratory testing; OR     - Presence of a known HAE-causing C1-INH mutation * All indications   + History of moderate or severe attacks such as airway swelling, severe abdominal pain, facial swelling, nausea and vomiting, or painful facial distortion   **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 3 days with at least one preferred acute drug in this UPDL category to request a non-preferred acute drug. * Must have had an inadequate clinical response of at least 14 days with at least one preferred prophylaxis drug to request a non-preferred   prophylaxis drug. |
| BERINERT PA | KALBITOR |
| icatibant acetate PA | RUCONEST |
| **PROPHYLAXIS** | |
| TAKHZYRO PA | CINRYZE |
| HAEGARDA |
| ORLADEYO |

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| **Respiratory Agents: Inhaled Agents** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **ANTICHOLINERGIC BRONCHODILATORS/COMBINATIONS** | | **LENGTH OF AUTHORIZATIONS**: 365 Days  **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs in this UPDL category.   **ADDITIONAL STEROID-CONTAINING INHALER CRITERIA:**   * Must have had an inadequate clinical response of at least 14 days with at least one preferred steroid-containing drug   **ADDITIONAL BUDESONIDE/ALBUTEROL (AIRSUPRA) CRITERIA:**   * Must have had an inadequate clinical response of at least 14 days with either DULERA or SYMBICORT   **AR** – albuterol nebulizer soln 0.021% (0.63mg/3mL), 0.042% (1.25mg/3mL): a PA is required for patients 13 years and older  **AR** – budesonide nebulizer soln: a PA is required for patients 13 years and older |
| ANORO ELLIPTA | BEVESPI AEROSPHERE |
| ATROVENT HFA | DUAKLIR PRESSAIR |
| COMBIVENT RESPIMAT | tiotropium inhaled caps |
| INCRUSE ELLIPTA | TUDORZA |
| ipratropium | YUPELRI |
| ipratropium/albuterol neb soln |  |
| SPIRIVA BvG |  |
| STIOLTO |  |
| **ADRENERGIC BRONCHODILATORS** | |
| albuterol HFA | arformoterol neb |
| albuterol neb 0.021% (0.63mg/3mL), | formoterol fumarate |
| 0.042% (1.25mg/3mL) AR | levalbuterol |
| albuterol neb 0.083% (2.5mg/3mL) | PROAIR DIGIHALER, RESPICLICK |
| albuterol neb 0.5% (5mg/mL) conc |  |
| BROVANA BvG |  |
| SEREVENT DISKUS |  |
| STRIVERDI RESPIMAT |  |
| VENTOLIN HFA |  |
| XOPENEX HFA BvG |  |
| **BRONCHODILATOR/GLUCOCORTICOID COMBINATIONS** | |
| ADVAIR DISKUS BvG | AIRDUO DIGIHALER |
| ADVAIR HFA BvG | AIRSUPRA |
| DULERA | BREO ELLIPTA BvG |
| SYMBICORT BvG | BREYNA |
|  | BREZTRI AEROSPHERE |
|  | budesonide/formoterol |
|  | fluticasone/salmeterol |
|  | TRELEGY ELLIPTA |
|  | WIXELA INHUB |
| **GLUCOCORTICOIDS** | |

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| ARNUITY ELLIPTA ALVESCO  ASMANEX TWISTHALER ARMONAIR DIGIHALER  budesonide neb susp AR ASMANEX HFA FLOVENT  fluticasone propionate PULMICORT FLEXHALER  QVAR | |  |
| **OTHER** | |
| cromolyn neb soln |  |

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| **Respiratory Agents: Leukotriene Receptor Modifiers & Inhibitors** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| montelukast | zileuton ER | **LENGTH OF AUTHORIZATIONS**: 365 Days  **STEP THERAPY CRITERIA:**   * Must have had an inadequate clinical response of at least 30 days with at least one preferred drug in this UPDL category.   **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 30 days with at least two preferred drugs in this UPDL category. |
| zafirlukast ST | ZYFLO |

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| **Respiratory Agents: Monoclonal Antibodies-Anti-IL/Anti-IgE** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| DUPIXENT PA | CINQAIR | **LENGTH OF AUTHORIZATIONS:** Initial: 180 days; Subsequent: 365 days  **CLINICAL PA CRITERIA:**   * Must be prescribed by or in consultation with an applicable specialist (i.e., allergist/ immunologist, pulmonologist, or otolaryngologist) * For **Asthma** – Must have had uncontrolled asthma symptoms and/or exacerbations despite at least 30 days with:   + Medium dose preferred ICS/LABA inhaler for 6 years and older **OR** medium dose preferred ICS/LABA inhaler with tiotropium or high dose ICS/LABA inhaler if 12 years and older * For **Chronic Rhinosinusitis with Nasal Polyposis** – Must have had an inadequate clinical response of at least 30 days to at least one oral corticosteroid AND one nasal corticosteroid spray * For **Chronic Urticaria** – Must have had an inadequate clinical response to at least 14 days with at least two different second-generation antihistamines at 4 times standard dose   **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 90 days with at least one preferred drug in this UPDL category.   **SUBSEQUENT AUTHORIZATION CRITERIA:**   * Must provide documentation of patient’s clinical response to treatment and   ongoing safety monitoring (i.e., PFT improvement, reduced affected BSA) |
| FASENRA PA | NUCALA |
| XOLAIR PA | TEZSPIRE |

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| **Respiratory Agents: Nasal Preparations** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **GLUCOCORTICOIDS/COMBINATIONS** | | **LENGTH OF AUTHORIZATIONS**: 365 days  **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs in this UPDL category, if available |
| flunisolide | azelastine/fluticasone spray |
| fluticasone (generic of FLONASE) | BECONASE AQ |
|  | mometasone |
|  | OMNARIS |
|  | QNASL |
|  | RYALTRIS |
|  | XHANCE |
|  | ZETONNA |
| **OTHER** | |
| azelastine |  |
| ipratropium |
| olopatadine |

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| **Respiratory Agents: Pulmonary Fibrosis** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| OFEV PA | pirfenidone | **LENGTH OF AUTHORIZATIONS:** 365 Days  **CLINICAL PA CRITERIA:**   * Must be prescribed by or in consultation with a pulmonologist   **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 30 days with at least one preferred drug in this UPDL category. |

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| **Topical Agents: Antifungals** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| ALEVAZOL | ciclopirox kit | **LENGTH OF AUTHORIZATIONS**: 365 days  **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs in this UPDL category, if indicated for diagnosis   **ADDITIONAL EFINACONAZOLE (JUBLIA) CRITERIA:**   * Must have had an inadequate clinical response of at least 48 weeks of ciclopirox AND 6 weeks of oral terbinafine (if fingernail) **OR** 12 weeks of oral terbinafine (if toenail) |
| butenafine | ERTACZO |
| ciclopirox | JUBLIA |
| clotrimazole | ketoconazole foam |
| clotrimazole/betamethasone | luliconazole |
| econazole | miconazole/zinc/white petrolatum oint |
| ketoconazole | naftifine |
| miconazole | oxiconazole |
| nystatin | OXISTAT |
| nystatin/triamcinolone | tavaborole |
| terbinafine |  |
| tolnaftate |  |

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| **Topical Agents: Antiparasitics** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| NATROBA BvG | CROTAN | **LENGTH OF AUTHORIZATIONS**: 14 Days  **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 14 days with at least one preferred drug in this UPDL category. |
| permethrin | ivermectin lot |
| piperonyl butoxide/pyrethrins | malathion |
| VANALICE | spinosad |

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| **Topical Agents: Corticosteroids** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| **LOW POTENCY** | | **LENGTH OF AUTHORIZATIONS**: 365 days  **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 14 days with at least two preferred drugs of similar potency in this UPDL category. |
| desonide cream, oint | alclometasone |
| fluocinolone acetonide 0.01% cream, soln | desonide lotion |
| hydrocortisone | TEXACORT |
| **MEDIUM POTENCY** | |
| betamethasone valerate | betamethasone val aerosol foam |
| fluocinolone acetonide 0.01% oil | clocortolone pivalate |
| flurandrenolide | fluocinolone acetonide 0.025% |
| fluticasone propionate cream, oint | hydrocortisone butyrate, valerate |
| prednicarbate | PANDEL |
| triamcinolone cream, lotion, oint | triamcinolone spray |
| **HIGH POTENCY** | |
| betamethasone dip/calcipotriene oint | betamethasone dip |
| fluocinonide 0.05% | betamethasone dip/calcipotriene susp |
| mometasone furoate | desoximetasone |
|  | diflorasone diacetate |
|  | ENSTILAR |
|  | fluticasone propionate lotion |
|  | fluocinonide 0.1% |
|  | halcinonide |
|  | HALOG |
| **ULTRA HIGH POTENCY** | |
| clobetasol propionate | APEXICON E |
| BRYHALI |
| halobetasol propionate |
| ULTRAVATE |

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| **Topical Agents: Immunomodulators** | | |
| **PREFERRED AGENTS** | **NON-PREFERRED AGENTS** | **PA CRITERIA** |
| ELIDEL AR BvG | EUCRISA | **LENGTH OF AUTHORIZATIONS**: 365 Days  **NON-PREFERRED CRITERIA:**   * Must have had an inadequate clinical response of at least 30 days with at least one preferred drug in this UPDL category.   **ADDITIONAL ROFLUMILAST (ZORYVE) CRITERIA:**   * **0.15% CREAM:** Must have had an inadequate clinical response of at least 30 days with at least one preferred topical corticosteroid OR topical calcineurin inhibitor * **0.3% CREAM:** Must have had an inadequate clinical response of at least 30 days with at least one preferred topical corticosteroid OR topical calcipotriene * **FOAM:** Must have had an inadequate clinical response of at least 30 days with at least one preferred agent indicated for Seborrheic Dermatitis (such as a topical antifungal, topical calcineurin inhibitor, or topical corticosteroid)   **AR** – ELIDEL, pimecrolimus, and tacrolimus: a PA is required for patients younger than 2 years old |
| tacrolimus AR | HYFTOR |
|  | OPZELURA |
|  | pimecrolimus AR |
|  | VTAMA |
|  | ZORYVE CREAM, FOAM |