



COLORADO
Department of Health Care
Policy & Financing



Colorado Department of Health Care Policy and Financing Preferred Drug List (PDL) Effective April 1, 2022

PA Forms: Available online at <https://www.colorado.gov/hcpf/pharmacy-resources>

PA Requests: Colorado Pharmacy Call Center Phone Number: 800-424-5725 | Colorado Pharmacy Call Center Fax Number: 800-424-5881

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

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

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

Please see the [Brand Favored Product List](#) for a list of medications where the brand name drug is more cost effective than the generic drug.

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

Preferred Agents	Non-preferred Agents	Prior Authorization Criteria (All Non-preferred products will be approved for one year unless otherwise stated.)
I. Analgesics		
Therapeutic Drug Class: NON-OPIOID ANALGESIA AGENTS - Oral - Effective 4/1/2022		
No PA Required	PA Required	
Duloxetine 20 mg, 30 mg, 60 mg capsule	CYMBALTA (duloxetine) capsule	Non-preferred oral non-opioid analgesic agents may be approved if member meets all of the following criteria: <ul style="list-style-type: none"> Member has trialed and failed duloxetine (20mg, 30mg, or 60mg) AND has trialed and failed gabapentin OR pregabalin capsule (Failure is defined as lack of efficacy with 8-week trial, allergy, intolerable side effects, or significant drug-drug interaction) Prior authorization will be required for Lyrica (pregabalin) capsule dosages > 600mg per day (maximum of 3 capsules daily) and gabapentin dosages > 3600mg per day.
Gabapentin capsule, tablet, solution	DRIZALMA (duloxetine DR) sprinkle capsules	
Pregabalin capsule	Duloxetine 40 mg capsule	
	GRALISE (gabapentin ER) tablet	
	HORIZANT (gabapentin ER) tablet	

SAVELLA (milnacipran) tablet, titration pack	LYRICA (pregabalin) capsule, solution, CR tablet NEURONTIN (gabapentin) capsule, tablet, solution Pregabalin solution, ER tablet	
Therapeutic Drug Class: NON-OPIOID ANALGESIA AGENTS - Topical - Effective 4/1/2022		
No PA Required LIDODERM ^{BNR} (lidocaine) patch	PA Required Lidocaine patch ZTLIDO (lidocaine) topical system	Non-preferred topical products require a trial/failure with an adequate 8-week trial of gabapentin AND pregabalin AND duloxetine AND lidocaine patch. Failure is defined as lack of efficacy with an 8-week trial, allergy, intolerable side effects, or significant drug-drug interaction. Prior authorization will be required for lidocaine patch quantities exceeding 90 patches per 30 days (maximum of 3 patches daily).
Therapeutic Drug Class: NON-STEROIDAL ANTI-INFLAMMATORIES (NSAIDS) - Oral - Effective 4/1/2022		
No PA Required CAMBIA (diclofenac) powder packet Celecoxib capsule Diclofenac potassium tablet Diclofenac sodium EC/DR tablet Ibuprofen suspension, tablet (RX) Indomethacin capsule, ER capsule Ketorolac tablet** Meloxicam tablet Nabumetone tablet Naproxen DR/ER, tablet (RX) Naproxen EC* tablet (RX) *(all manufacturers except Woodward)	PA Required ARTHROTEC (diclofenac sodium/ misoprostol) tablet CELEBREX (celecoxib) capsule DAYPRO (oxaprozin) caplet Diclofenac sodium ER tablet Diclofenac sodium/misoprostol tablet Diflunisal tablet DUEXIS (ibuprofen/famotidine) tablet ELYXYB (celecoxib) solution Etodolac capsule; IR, ER tablet FELDENE (piroxicam) capsule Fenoprofen capsule, tablet Flurbiprofen tablet Ibuprofen/famotidine tablet	DUEXIS (ibuprofen/famotidine) or VIMOVO (naproxen/esomeprazole) may be approved if the member meets the following criteria: <ul style="list-style-type: none"> • Trial and failure[‡] of all preferred NSAIDs at maximally tolerated doses AND • Trial and failure[‡] of three preferred proton pump inhibitors in combination with NSAID within the last 6 months AND • Has a documented history of gastrointestinal bleeding <p>All other non-preferred oral agents may be approved following trial and failure[‡] of four preferred agents. [‡]Failure is defined as lack of efficacy, contraindication to therapy, allergy, intolerable side effects, or significant drug-drug interactions.</p> <p>**Ketorolac tablets quantity limits: 5-day supply per 30 days and 20 tablets per 30 days</p>

<p>Naproxen suspension*</p> <p>*(all manufacturers except <i>Acella</i>)</p> <p>Sulindac tablet</p>	<p>INDOCIN (indomethacin) suspension</p> <p>Ketoprofen IR, ER capsule</p> <p>Meclofenamate capsule</p> <p>Mefenamic acid capsule</p> <p>Meloxicam suspension</p> <p>Meloxicam (submicronized) capsule</p> <p>NALFON (fenoprofen) capsule, tablet</p> <p>NAPRELAN (naproxen CR) tablet</p> <p>NAPROSYN (naproxen) suspension</p> <p>Naproxen EC tablet (<i>Woodward only</i>)</p> <p>Naproxen suspension (<i>Acella only</i>)</p> <p>Naproxen sodium CR, ER, IR tablet</p> <p>Naproxen/esomeprazole DR tablet</p> <p>Oxaprozin tablet</p> <p>Piroxicam capsule</p> <p>RELAFEN DS (nabumetone) tablet</p> <p>Tolmetin tablet, capsule</p> <p>VIMOVO (naproxen/esomeprazole) DR tablet</p> <p>VIVLODEX (meloxicam, submicronized) capsule</p> <p>ZIPSOR (diclofenac potassium) capsule</p> <p>ZORVOLEX (diclofenac, submicronized) capsule</p>	
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Therapeutic Drug Class: NON-STEROIDAL ANTI-INFLAMMATORIES (NSAIDS) - Non-Oral - Effective 4/1/2022

No PA Required	PA Required	
<p>Diclofenac 1.5% topical solution</p> <p>Diclofenac sodium 1% gel (OTC/Rx)</p>	<p>Diclofenac 1.3% topical patch</p> <p>FLECTOR (diclofenac) 1.3% topical patch</p> <p>Ketorolac nasal spray</p> <p>LICART (diclofenac) 1.3% topical patch</p> <p>PENNSAID (diclofenac solution) 2% solution packet</p> <p>SPRIX (ketorolac) nasal spray</p>	<p>SPRIX (ketorolac) may be approved if meeting the following criteria:</p> <ul style="list-style-type: none"> Member is unable to tolerate, swallow or absorb oral NSAID formulations OR Member has trialed and failed three preferred oral or topical NSAID agents (failure is defined as lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions) Quantity limit: 5-single day nasal spray bottles per 30 days <p>All other non-preferred topical agents may be approved for members who have trialed and failed one preferred agent. Failure is defined as lack of efficacy with 14-day trial, allergy, intolerable side effects, or significant drug-drug interaction.</p> <p>FLECTOR (diclofenac) quantity limit: 2 patches per day</p> <p>Diclofenac 3% gel (generic Solaraze) prior authorization criteria can be found in the Antineoplastic agents, topical, section of the PDL.</p>

Opioid Utilization Policy (long-acting and short-acting opioids):

It is highly encouraged that the healthcare team utilize the Prescription Drug Monitoring Program (PDMP) to aid in ensuring safe and efficacious therapy for members using controlled substances.

Total Morphine Milligram Equivalent Policy Effective 10/1/17:

- The maximum allowable morphine milligram equivalent (MME) is 200 MME. Prescriptions for short-acting (SA) and long-acting (LA) opioids are cumulatively included in this calculation. The prescription that exceeds the cumulative MME limit of 200 MME for a member will require prior authorization and may require a provider-to-provider telephone consultation with the pain management physician (free of charge and provided by Health First Colorado).
- Prior authorization will be granted to allow for tapering
- Prior authorization for 1 year will be granted for diagnosis of sickle cell anemia
- Prior authorization for 1 year will be granted for admission to or diagnosis of hospice or end of life care
- Prior authorization for 1 year will be granted for pain associated with cancer

MME calculation is conducted using conversion factors from the following website: <http://agencymeddirectors.wa.gov/Calculator/DoseCalculator.htm>

Only one long-acting opioid agent (including different strengths) and one short-acting opioid agent (including different strengths) will be considered for a prior authorization.

Medicaid provides guidance on the treatment of pain, including tapering, on our webpage under the heading Pain Management Resources and Opioid Use at: <https://www.colorado.gov/pacific/hcpf/pain-management-resources-and-opioid-use>

Opioid Naïve Policy Effective 8/1/17 (Update effective 11/27/19 in Italics):

Members who have not filled a prescription for an opioid within the past 180 days will be identified as “opioid treatment naïve” and have the following limitations placed on the initial prescription(s):

- The prescription is limited to short-acting opioid agents *or Butrans (buprenorphine) 5mcg patch*. Use of other long-acting opioid agents will require prior authorization approval for members identified as opioid treatment naïve.
- The days’ supply of the first, second, and third prescription for an opioid will be limited to 7 days, the quantity will be limited to 8 dosage forms per day (tablets, capsules), maximum #56 tablets/capsules for a 7-day supply

- The fourth prescription for an opioid will require prior authorization, filling further opioid prescriptions may require a clinical pharmacist review or provider to provider telephone consultation with a pain management physician (free of charge and provided by Health First Colorado).
- If a member has had an opioid prescription filled within the past 180 days, then this policy would not apply to that member and other opioid policies would apply as applicable.

Dental Prescriptions Opioid Policy Effective 11/15/18 (implemented in the claims system 01/07/19):

Members who receive an opioid prescribed by a dental provider will be subject to day supply limits and quantity per day limits for short acting opioids.

- The prescription is limited to short-acting opioid agents only. Use of long-acting opioid agents and short acting fentanyl agents will require prior authorization approval for members' prescriptions written by a dental provider.
- The days' supply of the first, second, and third prescription for an opioid will be limited to 4 days, the quantity will be limited to 6 dosage forms per day (tablets, capsules), maximum #24 tablets/capsules for a 4-day supply
- The fourth prescription for an opioid will require prior authorization. A prior authorization for the fourth fill may be approved for up to a 7-day supply and the quantity will be limited to 8 dosage forms per day (#56 tablets/capsules) for members with any of the following diagnoses/undergoing any of the following procedures:
 - Traumatic oro-facial tissue injury with major mandibular/maxillary surgical procedures
 - Severe cellulitis of facial planes
 - Severely impacted teeth with facial space infection necessitating surgical management
- Other potential exemptions that exceed the first 3 fill limits (day supply and quantity) may be evaluated with a provider-to-provider telephone consult with a pain management specialist (free of charge and provided by Health First Colorado)

If a member has had an opioid prescription prescribed by a non-dental provider, then this policy would not apply to that member and other opioid policies would apply as applicable. Dental prescriptions do not impact the opioid treatment naïve policy, but the prescriptions will be counted towards the Morphine Milligram Equivalent (MME) daily dose.

Opioid and Benzodiazepine Combination Effective 9/15/19:

Prior authorization will be required for members receiving long-term therapy with an opioid medication who are newly started on a benzodiazepine medication **OR** for members receiving long-term therapy with a benzodiazepine medication who are newly started on an opioid medication. Prior authorization may be approved if meeting the following:

- The member discontinued or is no longer taking either the opioid or benzodiazepine medication and will not be using these in combination **OR**
- The member will not be taking the prescribed opioid and benzodiazepine medications at the same time based on prescribed dosing interval (such as prn administration) for the regimen **AND** the prescriber attests that the member has received appropriate counseling* regarding the risks associated with combining opioid and benzodiazepine medications including increased risk for sedation, respiratory depression, overdose, and overdose-related death and counseling regarding the FDA Boxed Warning for combining these medications **OR**
- The prescriber has evaluated the regimen and attests that it is appropriate for the member to continue use of the concomitant opioid and benzodiazepine medication regimen as prescribed **AND** the prescriber attests that the member has received appropriate counseling* regarding the risks associated with combining opioid and benzodiazepine medications including increased risk for sedation, respiratory depression, overdose, and overdose-related death and counseling regarding the FDA Boxed Warning for combining these medications **OR**
- Prior authorization may be approved for members receiving palliative or hospice care **OR**
- For benzodiazepine prior authorizations, approval may be granted if the benzodiazepine is being prescribed for seizure disorder or convulsions.

**If counseling has not been provided, the prescriber attests that a reasonable effort will be made to contact the member or the member's pharmacy to ensure that counseling is provided.*

Opioid and Quetiapine Combination Effective 9/15/19:

Pharmacy claims for members receiving opioid and quetiapine medications in combination will require entry of point-of-sale DUR service codes (Reason for Service, Professional Service, Result of Service) for override of drug-drug interaction (DD) related to risk of increased sedation from concomitant use of this drug combination.

Opioid and Buprenorphine-Containing substance use disorder (SUD) Product Combination Effective 06/01/21:

Opioid claims submitted for members currently receiving buprenorphine-containing SUD medications will require entry of point-of-sale DUR service codes (Reason for Service, Professional Service, Result of Service) for override of drug-drug interaction (DD) with use of this drug combination.

Therapeutic Drug Class: OPIOIDS, Short Acting - Effective 4/1/2022

No PA Required* (if criteria and quantity limit is met)	PA Required	<p>*Preferred codeine and tramadol products do not require prior authorization for adult members (18 years of age or greater) if meeting all other opioid policy criteria.</p> <p>Preferred codeine or tramadol products prescribed for members < 18 years of age must meet the following criteria:</p> <ul style="list-style-type: none"> Preferred tramadol and tramadol-containing products may be approved for members < 18 years of age if meeting the following: <ul style="list-style-type: none"> Member is 12 years to 17 years of age AND Tramadol is NOT being prescribed for post-surgical pain following tonsil or adenoid procedure AND Member's BMI-for-age is not > 95th percentile per CDC guidelines AND Member does not have obstructive sleep apnea or severe lung disease OR For members < 12 years of age with complex conditions or life-limiting illness who are receiving care under a pediatric specialist, tramadol and tramadol-containing products may be approved on a case-by-case basis Preferred Codeine and codeine-containing products will receive prior authorization approval for members meeting the following criteria may be approved for members < 18 years of age if meeting the following: <ul style="list-style-type: none"> Member is 12 years to 17 years of age AND Codeine is NOT being prescribed for post-surgical pain following tonsil or adenoid procedure AND Member's BMI-for-age is not > 95th percentile per CDC guidelines AND Member does not have obstructive sleep apnea or severe lung disease AND Member is not pregnant or breastfeeding AND Renal function is not impaired (GFR > 50 ml/min) AND Member is not receiving strong inhibitors of CYP3A4 (such as erythromycin, clarithromycin, telithromycin, itraconazole, ketoconazole, posaconazole, fluconazole [≥200mg daily], voriconazole, delavirdine, and milk thistle) AND Member meets <u>one</u> of the following: <ul style="list-style-type: none"> Member has trialed codeine or codeine-containing products in the past with no history of allergy or adverse drug reaction to codeine Member has not trialed codeine or codeine-containing products in the past and the prescriber acknowledges reading the following statement: "Approximately 1-2% of the population metabolizes codeine in a manner that exposes them to a much higher potential for toxicity. Another notable proportion of the population may not clinically respond to codeine. We ask that you please have close follow-up with members newly starting codeine and codeine-containing products to monitor for safety and efficacy."
Acetaminophen/codeine tablets*	Acetaminophen / codeine elixir	
Hydrocodone/acetaminophen solution, tablet	APADAZ (benzhydrocodone/ acetaminophen) tablet	
Hydromorphone tablet	ASCOMP WITH CODEINE (codeine/ butalbital/aspirin/caffeine)	
Morphine IR solution, tablet	Benzhydrocodone/acetaminophen tablet	
NUCYNTA (tapentadol) tablet**	Butalbital/caffeine/acetaminophen/codeine* capsule	
Oxycodone solution, tablet	Butalbital/caffeine/aspirin/codeine capsule	
Oxycodone/acetaminophen tablet	Butalbital compound/codeine	
Tramadol 50mg*	Butorphanol tartrate (nasal) spray	
Tramadol/acetaminophen tablet*	Carisoprodol/aspirin/codeine	
	Codeine tablet	
	Dihydrocodeine/acetaminophen/caffeine tablet	
	DILAUDID (hydromorphone) solution, tablet	
	FIORICET/CODEINE (codeine/ butalbital/acetaminophen/caffeine) capsule	
	FIORINAL/CODEINE (codeine/ butalbital/aspirin/caffeine) capsule	
	Hydrocodone/ibuprofen tablet	
	Hydromorphone solution	
	Levorphanol tablet	

	<p>LORTAB (hydrocodone/acetaminophen) elixir</p> <p>Meperidine solution, tablet</p> <p>Morphine concentrated solution, oral syringe</p> <p>OXAYDO (oxycodone) tablet</p> <p>Oxycodone capsule, syringe, concentrated solution</p> <p>Oxymorphone tablet</p> <p>Pentazocine/naloxone tablet</p> <p>PERCOCET (oxycodone/ acetaminophen) tablet</p> <p>ROXICODONE (oxycodone) tablet</p> <p>Tramadol 100mg tablet</p> <p>ULTRACET (tramadol/ acetaminophen) tablet</p> <p>ULTRAM (tramadol) tablet</p>	<p>Non-preferred tramadol products may be approved following trial and failure of generic tramadol 50mg tablet AND generic tramadol/acetaminophen tablet.</p> <p>All other non-preferred short-acting opioid products may be approved following trial and failure of three preferred products. Failure is defined as allergy‡, lack of efficacy, intolerable side effects, or significant drug-drug interaction.</p> <p>‡Allergy: hives, maculopapular rash, erythema multiforme, pustular rash, severe hypotension, bronchospasm, and angioedema</p> <p><u>Quantity Limits:</u> Short-acting opioids will be limited to a total of 120 tablets per 30 days (4/day) per member for members who are not included in the opioid treatment naive policy.</p> <ul style="list-style-type: none"> • **Nucynta IR will have a maximum daily quantity of 6 tablets (180 tabs per 30 days). • Exceptions will be made for members with a diagnosis of a terminal illness (hospice or palliative care) or sickle cell anemia. • For members who are receiving more than 120 tablets currently and who do not have a qualifying exemption diagnosis, a 6-month prior authorization can be granted via the prior authorization process for providers to taper members. • Please note that if more than one agent is used, the combined total utilization may not exceed 120 units in 30 days. There may be allowed certain exceptions to this limit for acute situations (for example: post-operative surgery, fractures, shingles, car accident). <p><u>Maximum Doses:</u> Tramadol: 400mg/day Codeine: 360mg/day Butorphanol intranasal: 10ml per 30 days (four 2.5ml 10mg/ml package units per 30 days)</p>
Therapeutic Drug Class: FENTANYL PREPARATIONS (buccal, transmucosal, sublingual) - Effective 4/1/2022		
	<p>PA Required</p> <p>ABSTRAL (fentanyl citrate) SL tablet</p> <p>ACTIQ (fentanyl citrate) lozenge</p> <p>Fentanyl citrate lozenge, buccal tablet</p> <p>FENTORA (fentanyl citrate) buccal tablet</p>	<p>Fentanyl buccal, intranasal, transmucosal, and sublingual products:</p> <p>Prior authorization approval may be granted for members experiencing breakthrough cancer pain and those that have already received and are tolerant to opioid drugs for the cancer pain AND are currently being treated with a long-acting opioid drug. The prior authorization may be granted for up to 4 doses per day. For patients in hospice or palliative care, prior authorization will be automatically granted regardless of the number of doses prescribed.</p>
Therapeutic Drug Class: OPIOIDS, Long Acting - Effective 4/1/2022		
No PA Required (*if dose met)	<p>PA Required</p> <p>*OXYCONTIN (oxycodone ER) tablet</p>	<p>*Oxycontin may be approved for members who have trialed and failed‡ treatment with TWO preferred agents.</p>

<p>BUTRANS^{BNR} (buprenorphine) transdermal patch</p> <p>*Fentanyl 12mcg, 25mcg, 50mcg, 75mcg, 100mcg transdermal patch</p> <p>Morphine ER (generic MS Contin) tablet</p> <p>*NUCYNTA ER (tapentadol ER)</p> <p>Tramadol ER (generic Ultram ER) tablet</p>	<p>BELBUCA (buprenorphine) buccal film</p> <p>Buprenorphine buccal film, transdermal patch</p> <p>CONZIP (tramadol ER) capsule</p> <p>Fentanyl 37mcg, 62mcg, 87mcg transdermal patch</p> <p>Hydrocodone ER capsule, tablet</p> <p>Hydromorphone ER tablet</p> <p>*HYSINGLA (hydrocodone ER) tablet</p> <p>KADIAN (morphine ER) capsule</p> <p>Methadone (all forms)</p> <p>MORPHABOND (morphine ER) tablet</p> <p>Morphine ER capsules</p> <p>MS CONTIN (morphine ER) tablet</p> <p>Oxycodone ER tablet</p> <p>Oxymorphone ER tablet</p> <p>Tramadol ER (generic Ryzolt/Conzip)</p> <p>XTAMPZA ER (oxycodone) capsule</p> <p>*ZOHYDRO ER (hydrocodone) capsule</p>	<p>All other non-preferred products may be approved for members who have trialed and failed‡ three preferred products.</p> <p>‡Failure is defined as lack of efficacy with 14-day trial due to allergy (hives, maculopapular rash, erythema multiforme, pustular rash, severe hypotension, bronchospasm, and angioedema), intolerable side effects, or significant drug-drug interaction.</p> <p><u>Methadone:</u> Members may receive 30-day approval when prescribed for neonatal abstinence syndrome without requiring trial and failure of preferred agents or opioid prescriber consultation.</p> <p><u>Methadone Continuation:</u> Members who have been receiving methadone for pain indications do not have to meet non-preferred criteria. All new starts for methadone will require prior authorization under the non-preferred criteria listed above.</p> <p><i>If a prescriber would like to discuss strategies for tapering off methadone or transitioning to other pain management therapies for a Health First Colorado member, consultation with the Health First Colorado pain management physician is available free of charge by contacting the pharmacy call center helpdesk and requesting an opioid prescriber consult.</i></p> <p><u>Reauthorization:</u> Reauthorization for a non-preferred agent may be approved if the following criteria are met:</p> <ul style="list-style-type: none"> • Provider attests to continued benefit outweighing risk of opioid medication use AND • Member met original prior authorization criteria for this drug class at time of original authorization <p><u>Quantity/Dosing Limits:</u></p> <ul style="list-style-type: none"> • Oxycontin, Nucynta ER, and Zohydro ER will only be approved for twice daily dosing. • Hysingla will only be approved for once daily dosing. • Fentanyl patches will require a PA for doses of more than 15 patches/30 days (if using one strength) or 30 patches for 30 days (if using two strengths). For fentanyl patch strengths of 37mcg/hr, 62mcg/hr, and 87mcg/hr, member must trial and fail two preferred strengths of separate patches that will provide the desired dose (such as 12mcg/hr + 50mcg/hr = 62mcg/hr).
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II. Anti-Infectives

Therapeutic Drug Class: **ANTIBIOTICS, INHALED** -Effective 1/1/2022

No PA Required (*Must meet eligibility criteria)	PA Required	*CAYSTON (aztreonam) inhalation solution may be approved if the following criteria are met:																			
Tobramycin inhalation solution (generic TOBI) *CAYSTON (aztreonam) inhalation solution	ARIKAYCE (amikacin liposomal) inhalation vial	<ul style="list-style-type: none">Member has a history of trial and failure of preferred tobramycin solution for inhalation (failure is defined as lack of efficacy with a 4-week trial, intolerable side effects, or significant drug-drug interactions) OR provider attests that member cannot use preferred tobramycin solution for inhalation due to documented allergy or contraindication to therapy ANDThe member has known colonization of <i>Pseudomonas aeruginosa</i> in the lungs ANDThe member has been prescribed an inhaled beta agonist to use prior to nebulization of Cayston (aztreonam). ARIKAYCE (amikacin) may be approved if the following criteria are met: <ul style="list-style-type: none">Member has refractory mycobacterium avium complex (MAC) lung disease with limited or no alternative treatment options available ANDMember has trialed and failed 6 months of therapy with a 3-drug regimen that includes a macrolide (failure is defined as lack of efficacy, contraindication to therapy, allergy, intolerable side effects, or significant drug-drug interactions). All other non-preferred inhaled antibiotic agents may be approved if the following criteria are met: <ul style="list-style-type: none">The member has a diagnosis of cystic fibrosis with known colonization of <i>Pseudomonas aeruginosa</i> in the lungs ANDMember has history of trial and failure of preferred tobramycin solution for inhalation (failure is defined as lack of efficacy with a 4-week trial, contraindication to therapy, allergy, intolerable side effects or significant drug-drug interactions).	<table><tr><th colspan="4">Table 1: Minimum Age, Maximum Dose, and Quantity Limitations</th></tr><tr><th></th><th>Minimum Age</th><th>Maximum Dose</th><th>Quantity Limit (based on day supply limitation for pack size dispensed)</th></tr><tr><td>ARIKAYCE (amikacin)</td><td>≥ 18 years</td><td>590 mg daily</td><td>Not applicable</td></tr><tr><td>BETHKIS (tobramycin)</td><td>Age ≥ 6 years</td><td>300 mg twice daily</td><td>28-day supply per 56-day period</td></tr></table>			Table 1: Minimum Age, Maximum Dose, and Quantity Limitations					Minimum Age	Maximum Dose	Quantity Limit (based on day supply limitation for pack size dispensed)	ARIKAYCE (amikacin)	≥ 18 years	590 mg daily	Not applicable	BETHKIS (tobramycin)	Age ≥ 6 years	300 mg twice daily	28-day supply per 56-day period
	Table 1: Minimum Age, Maximum Dose, and Quantity Limitations																				
						Minimum Age	Maximum Dose	Quantity Limit (based on day supply limitation for pack size dispensed)													
	ARIKAYCE (amikacin)					≥ 18 years	590 mg daily	Not applicable													
	BETHKIS (tobramycin)					Age ≥ 6 years	300 mg twice daily	28-day supply per 56-day period													
	BETHKIS (tobramycin) inhalation ampule																				
	KITABIS (tobramycin) nebulizer pak																				
TOBI (tobramycin) inhalation solution																					
TOBI PODHALER (tobramycin) inhalation capsule																					
Tobramycin inhalation ampule (generic Bethkis)																					
Tobramycin nebulizer pak (generic Kitabis)																					

		<table><tr><td>CAYSTON (aztreonam)</td><td>≥ 7 years</td><td>225 mg daily</td><td>28-day supply per 56-day period</td></tr><tr><td>KITABIS PAK (tobramycin)</td><td>Age ≥ 6 years</td><td>300 mg twice daily</td><td>28-day supply per 56-day period</td></tr><tr><td>TOBI [†] (tobramycin)</td><td>Age ≥ 6 years</td><td>300 mg twice daily</td><td>28-day supply per 56-day period</td></tr><tr><td>TOBI PODHALER (tobramycin)</td><td>Age ≥ 6 years</td><td>112 mg twice daily</td><td>28-day supply per 56-day period</td></tr></table> <p>[†] Limitations apply to brand product formulation only</p> <p>Members currently stabilized on any inhaled antibiotic agent in this class may receive approval to continue on that agent.</p>	CAYSTON (aztreonam)	≥ 7 years	225 mg daily	28-day supply per 56-day period	KITABIS PAK (tobramycin)	Age ≥ 6 years	300 mg twice daily	28-day supply per 56-day period	TOBI [†] (tobramycin)	Age ≥ 6 years	300 mg twice daily	28-day supply per 56-day period	TOBI PODHALER (tobramycin)	Age ≥ 6 years	112 mg twice daily	28-day supply per 56-day period
CAYSTON (aztreonam)	≥ 7 years	225 mg daily	28-day supply per 56-day period															
KITABIS PAK (tobramycin)	Age ≥ 6 years	300 mg twice daily	28-day supply per 56-day period															
TOBI [†] (tobramycin)	Age ≥ 6 years	300 mg twice daily	28-day supply per 56-day period															
TOBI PODHALER (tobramycin)	Age ≥ 6 years	112 mg twice daily	28-day supply per 56-day period															
Therapeutic Drug Class: ANTI-HERPETIC AGENTS - Oral -Effective 1/1/2022																		
No PA Required Acyclovir tablet, capsule Acyclovir suspension (<i>members under 5 years or with a feeding tube</i>) Famciclovir tablet Valacyclovir tablet	PA Required Acyclovir suspension (<i>members over 5</i>) SITAVIG (acyclovir) buccal tablet VALTREX (valacyclovir) tablet ZOVIRAX (acyclovir) suspension	<p>Non-preferred products may be approved for members who have failed an adequate trial with two preferred products with different active ingredients. Failure is defined as lack of efficacy with 14-day trial, allergy, intolerable side effects, or significant drug-drug interaction.</p> <p>Sitavig (acyclovir) buccal tablet may be approved for diagnosis of recurrent herpes labialis (cold sores) if member meets non-preferred criteria listed above AND has failed trial with oral acyclovir suspension. Failure is defined as lack of efficacy with 14-day trial, allergy, intolerable side effects, or significant drug-drug interaction.</p> <p>For members with a diagnosis of Bell’s palsy, valacyclovir 1000 mg three times daily may be approved for 7 days if member presents with severe facial palsy.</p> <p>Acyclovir suspension may be approved for:</p> <ul style="list-style-type: none">• Members under 5 years of age OR• Members with a feeding tube OR• Members meeting non-preferred criteria listed above. <table><tr><th colspan="3">Maximum Dose Table</th></tr><tr><th></th><th>Adult</th><th>Pediatric</th></tr><tr><td>Acyclovir</td><td>4000 mg daily</td><td>3200 mg daily</td></tr><tr><td>Valacyclovir</td><td>4000 mg daily</td><td>Age 2-11 years: 3000mg daily Age ≥ 12 years: 4000mg daily</td></tr></table>		Maximum Dose Table				Adult	Pediatric	Acyclovir	4000 mg daily	3200 mg daily	Valacyclovir	4000 mg daily	Age 2-11 years: 3000mg daily Age ≥ 12 years: 4000mg daily			
Maximum Dose Table																		
	Adult	Pediatric																
Acyclovir	4000 mg daily	3200 mg daily																
Valacyclovir	4000 mg daily	Age 2-11 years: 3000mg daily Age ≥ 12 years: 4000mg daily																

Therapeutic Drug Class: ANTI-HERPETIC AGENTS- Topical - Effective 1/1/2022		
No PA Required	PA Required	Non-Preferred Zovirax and acyclovir ointment/cream formulations may be approved for members who have failed an adequate trial with the preferred topical acyclovir ointment/cream product (diagnosis, dose and duration) as deemed by approved compendium. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) Xerese (acyclovir/hydrocortisone) prior authorization may be approved for members that meet the following criteria: <ul style="list-style-type: none">• Documented diagnosis of recurrent herpes labialis AND• Member is immunocompetent AND• Member has failed treatment of at least 10 days with acyclovir (Failure is defined as significant drug-drug interaction, lack of efficacy, contraindication to or intolerable side effects) AND• Member has failed treatment of at least one day with famciclovir 1500 mg OR valacyclovir 2 grams twice daily (Failure is defined as significant drug-drug interaction, lack of efficacy, contraindication to or intolerable side effects)
Acyclovir ointment	Acyclovir cream	
DENAVIR (penciclovir) cream	XERESE (acyclovir/ hydrocortisone) cream	
ZOVIRAX ^{BNR} (acyclovir) cream	ZOVIRAX (acyclovir) ointment	
Therapeutic Drug Class: FLUOROQUINOLONES – Oral -Effective 1/1/2022		
No PA Required (*if meeting eligibility criteria)	PA Required	*CIPRO (ciprofloxacin) suspension may be approved for members < 5 years of age without prior authorization. For members ≥ 5 years of age, CIPRO (ciprofloxacin) suspension may be approved for members who cannot swallow a whole or crushed tablet. Non-preferred products may be approved for members who have failed an adequate trial (7 days) with at least one preferred product. (Failure is defined as: lack of efficacy, contraindication to therapy, allergy, intolerable side effects, or significant drug-drug interaction). Levofloxacin solution may be approved for members < 5 years of age with prescriber attestation that member is unable to take Cipro (ciprofloxacin) crushed tablet or suspension OR for members < 5 years of age for treatment of pneumonia. For members ≥ 5 years of age, levofloxacin solution may be approved for members who require administration via feeding tube OR who have failed an adequate trial (7 days) of ciprofloxacin suspension. Failure is defined as lack of efficacy, allergy, intolerable side effects, significant drug-drug interaction, or contraindication to therapy.
*CIPRO (ciprofloxacin) oral suspension	BAXDELA (delafloxacin) tablet	
*Ciprofloxacin oral suspension	CIPRO (ciprofloxacin) tablet	
Ciprofloxacin tablet	Ciprofloxacin ER tablet	
Levofloxacin tablet	Levofloxacin oral solution	
	Moxifloxacin tablet	
	Ofloxacin tablet	
Therapeutic Drug Class: HEPATITIS C VIRUS TREATMENTS - Effective 1/1/2022		
Direct Acting Antivirals (DAAs)		
PA Required for all agents in this class Prior authorization requests must be submitted via the Hepatitis C Prior Authorization Request Form link on the Pharmacy Resources page		Preferred Hepatitis C Virus Treatment Regimens

EPCLUSA (sofosbuvir/velpatasvir) 200 mg -50 mg, 150 mg-37.5 mg tablet, pellet pack	EPCLUSA 400 mg-100 mg (sofosbuvir/velpatasvir) tablet
HARVONI (ledipasvir/sofosbuvir) 45mg-200mg tablet, pellet pack	HARVONI 90 mg-400 mg (ledipasvir/sofosbuvir) tablet
Ledipasvir/Sofosbuvir 90 mg-400 mg tablet (<i>Asequa only</i>)	SOVALDI (sofosbuvir) tablet, pellet packet
MAVYRET (glecaprevir/pibrentasvir) tablet, pellet pack	VIEKIRA PAK (ombitasvir/paritaprevir/ ritonavir/dasabuvir) tablet
Sofosbuvir/Velpatasvir 400mg- 100mg (<i>Asequa only</i>)	ZEPATIER (elbasvir/grazoprevir) tablet
VOSEVI ^{2nd Line} tablet (sofosbuvir/velpatasvir/voxilapre vir)	

Harvoni tablet/pellet (ledipasvir/sofosbuvir)	May be approved for members 3 years and older for GT 1, 4-6 who are NC, have CC; or GT 1 in combination with ribavirin in DC; or GT 1,4 in combination with ribavirin for liver transplant recipients who are NC, have CC; AND meet the below applicable criteria. Harvoni pellet may be approved for members 3 years of age or older weighing less than 17 kg or members 3 years of age or older that are unable to take/swallow ledipasvir/sofosbuvir oral tablets; AND meet the below applicable criteria.
Mavyret tablet (glecaprevir/pibrentasvir)	May be approved for members 3 years and older for GT 1-6 who are NC or have CC (Child-Pugh A), OR for members 3 years and older with GT 1 who previously have been treated with a regimen containing an HCV NS5A inhibitor or an NS3/4A protease inhibitor, but not both; AND meet the applicable criteria below regarding initial treatment or re-treatment.
Epclusa tablet/pellet (sofosbuvir/velpatasvir)	May be approved for members 3 years and older or weighing at least 17 kg for GT 1-6 who are NC, have CC (Child-Pugh A); or in combination with ribavirin in DC; AND meet the applicable criteria below regarding initial treatment or retreatment. Epclusa pellet may be approved for members ≥ 3 years of age weighing less than 17 kg or members 3 years of age or older that are unable to take/swallow ledipasvir/sofosbuvir oral tablets; AND meet the applicable criteria below regarding initial treatment or retreatment.
Vosevi tablet ^{2nd Line} (sofosbuvir/velpatasvir/ voxilaprevir)	May be approved for members 18 years or older with chronic HCV infection who are NC, have CC (Child-Pugh A) AND meet one of the following: <ul style="list-style-type: none">GT 1-6 and has previously failed treatment with a regimen containing an NS5A inhibitor (such as ledipasvir, daclatasvir, or ombitasvir) ORGT 1a or 3 and has previously failed treatment with a regimen containing sofosbuvir without an NS5A inhibitor AND meet the applicable criteria below for re-treatment.

(GT-Genotype, NC-Non-Cirrhotic, CC-Compensated Cirrhosis, DC-Decompensated Cirrhosis)

Initial Treatment (all agents):
Preferred agents may be approved for initial treatment if the following criteria are met:

- HCV treatment is being prescribed either through consultation with an expert in hepatitis C treatment OR the primary care provider attests to having received sufficient education to safely prescribe the listed hepatitis C medications **AND**
- Prescriber attests that the member has been counseled about the importance of adherence to initial therapy to treat hepatitis C **AND**

		<ul style="list-style-type: none"> Physician attests to meeting <u>one</u> of the following: <ul style="list-style-type: none"> Member has a diagnosis of chronic HCV infection (presence of HCV RNA viral load for ≥ 6 months) OR Member has a diagnosis of acute HCV infection in the setting of solid organ transplant OR Prescriber wishes to treat a member with acute HCV infection upon initial diagnosis and acknowledges that the rate of spontaneous resolution of acute infection has been considered as part of assessing the need to initiate antiviral therapy (acute HCV infection may spontaneously clear in 20-50% of patients) <p>All other non-preferred agents may be approved if the criteria for initial treatment above are satisfied AND documentation is provided indicating an acceptable rationale for not prescribing a preferred treatment regimen (acceptable rationale may include patient-specific medical contraindications to a preferred treatment or cases where a member has initiated treatment on a non-preferred drug and needs to complete therapy).</p> <p>Re-treatment: All requests for HCV re-treatment for members who have failed therapy with a DAA will be reviewed on a case-by-case basis. Additional information will be requested for retreatment requests including (but not limited to):</p> <ul style="list-style-type: none"> Previous regimen medications and dates treated Genotype of previous HCV infection Any information regarding adherence to previously trialed regimen(s) and current chronic medications Adverse effects experienced from previous treatment regimen Concomitant therapies during previous treatment regimen Vosevi regimens will require verification that member has been tested for evidence of active hepatitis B virus (HBV) infection and for evidence of prior HBV infection prior to initiating treatment. <p>Members currently receiving treatment with a non-preferred agent will receive approval to finish their treatment regimen, provided required documentation is sent via normal PAR process.</p>
Ribavirin Products		
<p>No PA Required</p> <p>Ribavirin capsule</p> <p>Ribavirin tablet</p>	<p>PA Required</p> <p>RIBASPHERE (ribavirin) tablet, dosepack</p>	<p>Non-preferred ribavirin products require prior authorizations which will be evaluated on a case-by-case basis.</p>

Therapeutic Drug Class: **HUMAN IMMUNODEFICIENCY VIRUS (HIV) TREATMENTS, ORAL** - *Effective 1/1/2022*

Effective 01/14/22, oral products indicated for HIV pre-exposure prophylaxis (PrEP) or post-exposure prophylaxis (PEP) are eligible for coverage with a written prescription by an enrolled pharmacist. Additional information regarding pharmacist enrollment can be found at <https://hcpf.colorado.gov/pharm-serv>.

Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTIs)

No PA Required	PA Required	All products are preferred and do not require prior authorization.
EDURANT (rilpivirine) tablet		
Efavirenz capsule, tablet		
Etravirine tablet		
INTELENCE (etravirine) tablet		
Nevirapine suspension, IR tablet, ER tablet		
PIFELTRO (doravirine) tablet		
SUSTIVA (efavirenz) capsule, tablet		
VIRAMUNE (nevirapine) suspension		
VIRAMUNE XR (nevirapine ER) tablet		

Nucleoside/Nucleotide Reverse Transcriptase Inhibitors (NRTIs)

No PA Required	PA Required	All products are preferred and do not require prior authorization.
Abacavir solution, tablet		
Didanosine DR capsule		
Emtricitabine capsule		
EMTRIVA (emtricitabine) capsule, solution		
EPIVIR (lamivudine) solution, tablet		
Lamivudine solution, tablet		
RETROVIR (zidovudine) capsule, syrup		
Stavudine capsule, solution		
Tenofovir disoproxil fumarate (TDF) tablet		
VIREAD (TDF) oral powder, tablet		

ZIAGEN (abacavir) solution, tablet		
Zidovudine capsule, syrup, tablet		
TDF – Tenofovir disoproxil fumarate		
Protease Inhibitors (PIs)		
No PA Required	PA Required	All products are preferred and do not require prior authorization.
APTIVUS (tipranavir) capsule		
Atazanavir capsule		
CRIXIVAN (indinavir) capsule		
Fosamprenavir tablet		
INVIRASE (saquinavir) tablet		
LEXIVA (fosamprenavir) suspension, tablet		
NORVIR (ritonavir) powder packet, solution, tablet		
PREZISTA (darunavir) suspension, tablet		
REYATAZ (atazanavir) capsule, powder pack		
Ritonavir tablet		
VIRACEPT (nelfinavir) tablet		
Other Agents		
No PA Required	PA Required	All products are preferred and do not require prior authorization.
ISENTRESS (raltegravir) chewable, powder pack, tablet		
ISENTRESS HD (raltegravir) tablet		
RUKOBIA (fostemsavir tromethamine ER) tablet		
SELZENTRY (maraviroc) solution, tablet		
TIVICAY (dolutegravir) tablet		
TIVICAY PD (dolutegravir) tablet for suspension		

TYBOST (cobicistat) tablet		
VOCABRIA (cabotegravir) tablet		
Combination Agents		
<p>No PA Required*</p> <p>*Dispense as written (DAW) should be indicated on the prescription</p> <p>Abacavir/Lamivudine tablet</p> <p>Abacavir/Lamivudine/Zidovudine tablet</p> <p>ATRIPLA* (efavirenz/emtricitabine/TDF) tablet</p> <p>BIKTARVY (bictegravir/emtricitabine/TAF) tablet</p> <p>CIMDUO (lamivudine/TDF) tablet</p> <p>COMBIVIR (lamivudine/zidovudine) tablet</p> <p>COMPLERA (emtricitabine/rilpivirine/TDF) tablet</p> <p>DELSTRIGO (doravirine/lamivudine/TDF) tablet</p> <p>DESCOVY (emtricitabine/TAF) tablet</p> <p>DOVATO (dolutegravir/lamivudine) tablet</p> <p>Efavirenz/Emtricitabine/TDF tablet</p> <p>Efavirenz/Lamivudine/TDF tablet</p> <p>Emtricitabine/TDF tablet</p> <p>EPZICOM (abacavir/lamivudine) tablet</p> <p>EVOTAZ (atazanavir/cobicistat) tablet</p> <p>GENVOYA (elvitegravir/cobicistat/emtricitabine/TAF) tablet</p> <p>JULUCA (dolutegravir/rilpivirine) tablet</p> <p>KALETRA (lopinavir/ritonavir) solution, tablet</p>	PA Required	All products are preferred and do not require prior authorization.

Lamivudine/Zidovudine tablet Lopinavir/Ritonavir solution, tablet ODEFSEY (emtricitabine/rilpivirine/TAF) tablet PREZCOBIX (darunavir/cobicistat) tablet STRIBILD (elvitegravir/cobicistat/emtricitabine/TDF) tablet SYMFI/SYMFI LO (efavirenz/lamivudine/TDF) tablet SYMTUZA (darunavir/cobicistat/emtricitabine/TAF) tablet TEMIXYS (lamivudine/TDF) tablet TRIUMEQ (abacavir/dolutegravir/lamivudine) tablet TRIZIVIR (abacavir/lamivudine/zidovudine) tablet TRUVADA* (emtricitabine/TDF) tablet TAF – Tenofovir alafenamide TDF – Tenofovir disoproxil fumarate			
Therapeutic Drug Class: TETRACYCLINES - <i>Effective 7/1/2021</i>			
No PA Required	PA Required		<p>Prior authorization for non-preferred tetracycline agents may be approved if member has trialed/failed a preferred doxycycline product AND preferred minocycline. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.</p> <p>Prior authorization for liquid oral tetracycline formulations may be approved if member has difficulty swallowing and cannot take solid oral dosage forms.</p> <p>Nuzyra (omadacycline) prior authorization may be approved if member meets all of the following criteria: the above “non-preferred” prior authorization criteria and the following:</p> <ul style="list-style-type: none"> • Member has trialed and failed[†] therapy with a preferred doxycycline product and preferred minocycline OR clinical rationale is provided describing why these medications cannot be trialed (including resistance and sensitivity) AND • Member has diagnosis of either Community Acquired Bacterial Pneumonia (CABP) or Acute Bacterial Skin and Skin Structure Infection (ABSSSI) or
Doxycycline hyclate capsules	Demeclocycline tablet		
Doxycycline hyclate tablets	DORYX (doxycycline DR) tablet		
Doxycycline monohydrate 50mg, 100mg capsule	Doxycycline hyclate DR tablet		
Doxycycline monohydrate tablets	Doxycycline monohydrate 40mg, 75mg, 150mg capsule		
Minocycline capsules	Doxycycline monohydrate suspension		
	Minocycline IR, ER tablet		
	MINOLIRA (minocycline)		
	MORGIDOX (doxycycline/skin cleanser)		

	<p>NUZYRA (omadacycline)*</p> <p>SOLODYN ER (minocycline)</p> <p>Tetracycline capsule</p> <p>VIBRAMYCIN (doxycycline) capsule, suspension, syrup</p> <p>XIMINO ER (minocycline)</p>	<p>clinical rationale and supporting literature describing/supporting intended use AND one of the following:</p> <ul style="list-style-type: none"> ○ If member diagnosis is ABSSSI, member must have trial and failure[†] of sulfamethoxazole/trimethoprim product in addition to preferred tetracyclines OR ○ If member diagnosis is CABP, member must have trial and failure[†] of either a beta-lactam antibiotic (amoxicillin/clavulanic acid) or a macrolide (azithromycin) <p>AND</p> <ul style="list-style-type: none"> • Maximum duration of use is 14 days <p>[†]Failure is defined as lack of efficacy with 7-day trial, allergy, intolerable side effects, or significant drug-drug interaction.)</p>
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III. Cardiovascular

Therapeutic Drug Class: **ALPHA-BLOCKERS** - *Effective 4/1/2022*

No PA Required	PA Required	
Prazosin capsule	MINIPRESS (prazosin) capsule	Non-preferred products may be approved following trial and failure of one preferred product (failure is defined as lack of efficacy with 4-week trial, allergy or intolerable side effects).

Therapeutic Drug Class: **BETA-BLOCKERS** - *Effective 4/1/2022*

Beta-Blockers, Single Agent

No PA Required	PA Required	<p>Non-preferred products may be approved following trial and failure with two preferred products (failure is defined as lack of efficacy with 4-week trial, allergy, intolerable side effects or significant drug-drug interactions).</p> <p>HEMANGEOL (propranolol) oral solution may be approved for members between 5 weeks and 1 year of age with proliferating infantile hemangioma requiring systemic therapy.</p> <p>Maximum dose: 1.7 mg/kg twice daily</p> <p>KASPARGO SPRINKLE (metoprolol succinate) extended-release capsule may be approved for members ≥ 6 years of age that have difficulty swallowing or require medication administration via a feeding tube.</p> <p>Maximum dose: 200mg/day (adult); 50mg/day (pediatric)</p> <p>Members currently stabilized on timolol oral tablet non-preferred products may receive approval to continue on that product.</p> <table><tr><th colspan="5">Table 1: Receptor Selectivity and Other Properties of Preferred Beta Blockers</th></tr><tr><td></td><td>β₁</td><td>β₂</td><td>Alpha-1 receptor antagonist</td><td>Intrinsic sympathomimetic activity (ISA)</td></tr><tr><td></td><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td><td></td></tr></table>	Table 1: Receptor Selectivity and Other Properties of Preferred Beta Blockers						β ₁	β ₂	Alpha-1 receptor antagonist	Intrinsic sympathomimetic activity (ISA)																																																		
Table 1: Receptor Selectivity and Other Properties of Preferred Beta Blockers																																																														
	β ₁		β ₂	Alpha-1 receptor antagonist	Intrinsic sympathomimetic activity (ISA)																																																									
Acebutolol capsule	Betaxolol tablet																																																													
Atenolol tablet	CORGARD (nadolol) tablet																																																													
Bisoprolol tablet	COREG (carvedilol) tablet																																																													
BYSTOLIC ^{BNR} (nebivolol) tablet	COREG CR (carvedilol ER) capsule																																																													
Carvedilol IR tablet	HEMANGEOL (propranolol) solution																																																													
Carvedilol ER capsule	INDERAL LA/XL (propranolol ER) capsule																																																													
Labetalol tablet	INNOPRAN XL (propranolol ER) capsule																																																													
Metoprolol tartrate tablet	KASPARGO (metoprolol succinate) sprinkle capsule																																																													
Metoprolol succinate ER tablet	LOPRESSOR (metoprolol tartrate) tablet																																																													
Nadolol tablet	Nebivolol tablet																																																													
Pindolol tablet																																																														

Propranolol IR tablet, solution Propranolol ER capsule	TENORMIN (atenolol) tablet		Acebutolol	X			X
	Timolol tablet TOPROL XL (metoprolol succinate) tablet		Atenolol	X			
			Betaxolol	X			
			Bisoprolol	X			
			Carvedilol	X	X	X	
			Labetalol	X	X	X	
			Metoprolol succinate	X			
			Metoprolol tartrate	X			
			Nadolol	X	X		
			Nebivolol	X			
			Pindolol	X	X		X
			Propranolol	X	X		
Beta-Blockers, Anti-Arrhythmics							
No PA Required	PA Required	SOTYLIZE (sotalol) oral solution may be approved for members 3 days to < 5 years of age. For members ≥ 5 years of age, SOTYLIZE (sotalol) oral solution may be approved for members who-cannot swallow a sotalol tablet OR members that have trialed and failed therapy with one preferred product. (Failure is defined as allergy or intolerable side effects.) Maximum dose: 320 mg/day					
Sotalol tablet	BETAPACE (sotalol) tablet SOTYLIZE (sotalol) solution						
Beta-Blockers, Combinations							
No PA Required	PA Required	Non-preferred products may be approved following trial and failure with two preferred products (failure is defined as lack of efficacy with 4-week trial, allergy, intolerable side effects or significant drug-drug interactions).					
Atenolol/Chlorthalidone tablet	Nadolol/Bendroflumethiazide tablet						
Bisoprolol/HCTZ tablet	Propranolol/HCTZ tablet						
Metoprolol/HCTZ tablet	TENORETIC (atenolol/chlorthalidone) tablet ZIAC (bisoprolol/HCTZ) tablet						
Therapeutic Drug Class: CALCIUM CHANNEL-BLOCKERS - <i>Effective 4/1/2022</i>							
Dihydropyridines (DHPs)							
No PA Required	PA Required	Non-preferred products may be approved following trial and failure of two preferred agents. Failure is defined as lack of efficacy, contraindication to therapy, allergy, intolerable side effects, or significant drug-drug interactions.					
Amlodipine tablet	ADALAT CC (nifedipine ER) tablet						
Felodipine ER tablet	KATERZIA (amlodipine) suspension						

Nifedipine IR capsule Nifedipine ER tablet	Isradipine capsule Nicardipine capsule Nimodipine capsule Nisoldipine ER tablet NORVASC (amlodipine) tablet NYMALIZE (nimodipine) solution, oral syringe PROCARDIA (nifedipine) capsule PROCARDIA XL (nifedipine ER) tablet SULAR (nisoldipine ER) tablet	NYMALIZE (nimodipine) oral syringe may be approved for adult members (≥ 18 years of age) with subarachnoid hemorrhage who also have a feeding tube or have difficulty swallowing solid dosage forms. Maximum dose: 360 mg/day for 21 days (6 syringes/day or 126 syringes/21 days) KATERZIA (amlodipine) suspension may be approved if meeting the following: <ul style="list-style-type: none"> The member has a feeding tube or confirmed difficulty swallowing solid oral dosage forms AND For members < 6 years of age, the prescriber confirms that the member has already been receiving the medication following initiation in a hospital or other clinical setting
Non-Dihydropyridines (Non-DHPs)		
No PA Required Diltiazem IR tablet Diltiazem ER capsule Verapamil IR, ER tablet Verapamil ER 120 mg, 180 mg, 240 mg capsule	PA Required CALAN SR (verapamil ER) tablet CARDIZEM (diltiazem) tablet CARDIZEM CD/LA (diltiazem CD/ER) capsule, tablet TIAZAC ER (diltiazem ER) capsule Verapamil ER 360 mg capsule Verapamil PM ER 100 mg, 200 mg, 300 mg capsule VERELAN/PM (verapamil ER) pellet capsule	Non-preferred products may be approved following trial and failure of three preferred agents. Failure is defined as lack of efficacy, contraindication to therapy, allergy, intolerable side effects, or significant drug-drug interactions.
Therapeutic Drug Class: ANGIOTENSIN MODIFIERS - Effective 7/1/2021		
Angiotensin-converting enzyme inhibitors (ACE Inh)		
No PA Required Benazepril tablet Enalapril tablet Fosinopril tablet	PA Required ACCUPRIL (quinapril) tablet ALTACE (ramipril) capsule Captopril	Non-preferred ACE inhibitors, ACE inhibitor combinations, ARBs, ARB combinations, renin inhibitors, and renin inhibitor combination products may be approved for members who have trialed and failed treatment with three preferred products (failure is defined as lack of efficacy with a 4-week trial, allergy, intolerable side effects, or significant drug-drug interaction).

Lisinopril tablet	EPANED powder/solution* (enalapril)	*Epaned (enalapril) solution may be approved without trial and failure of three preferred agents for members under the age of 5 years who cannot swallow a whole or crushed tablet. *Qbrelis (lisinopril) solution may be approved for members 6 years of age or older who cannot swallow a whole or crushed tablet and have trialed and failed Epaned (enalapril) solution. Failure is defined as lack of efficacy with a 4-week trial, allergy, intolerable side effects, or significant drug-drug interaction.
Quinapril tablet	LOTENSIN (benazepril) tablet	
Ramipril tablet	Moexipril tablet	
	Perindopril tablet	
	PRINIVIL (lisinopril) tablet	
	QBRELIS (lisinopril) solution*	
	Trandolapril tablet	
	VASOTEC (enalapril) tablet	
	ZESTRIL (lisinopril) tablet	
ACE Inhibitor Combinations		
No PA Required	PA Required	Non-preferred ACE inhibitors, ACE inhibitor combinations, ARBs, ARB combinations, renin inhibitors, and renin inhibitor combination products may be approved for members who have trialed and failed treatment with three preferred products (failure is defined as lack of efficacy with a 4-week trial, allergy, intolerable side effects, or significant drug-drug interaction).
Amlodipine/Benazepril	ACCURETIC (quinapril HCTZ)	
Enalapril HCTZ	Benazepril HCTZ	
Lisinopril HCTZ	Captopril HCTZ	
	Fosinopril HCTZ	
	LOTENSIN HCT (benazepril HCTZ)	
	LOTREL (amlodipine/benazepril)	
	Quinapril HCTZ	
	Trandolapril/Verapamil	
	VASERETIC (enalapril HCTZ)	
	ZESTORETIC (lisinopril HCTZ)	
Angiotensin II receptor blockers (ARBs)		
No PA Required	PA Required	Non-preferred ACE inhibitors, ACE inhibitor combinations, ARBs, ARB combinations, renin inhibitors, and renin inhibitor combination products may be approved for members who have trialed and failed treatment with three preferred
Irbesartan	ATACAND (candesartan)	
Losartan	AVAPRO (irbesartan)	

<p>Olmesartan</p> <p>Telmisartan</p> <p>Valsartan</p>	<p>BENICAR (olmesartan)</p> <p>Candesartan</p> <p>COZAAR (losartan)</p> <p>DIOVAN (valsartan)</p> <p>EDARBI (azilsartan)</p> <p>Eprosartan</p> <p>MICARDIS (telmisartan)</p>	<p>products (failure is defined as lack of efficacy with a 4-week trial, allergy, intolerable side effects, or significant drug-drug interaction).</p>
ARB Combinations		
<p>No PA Required (unless indicated*)</p> <p>Amlodipine/olmesartan</p> <p>Amlodipine/valsartan</p> <p>Irbesartan HCTZ</p> <p>Losartan HCTZ</p> <p>Olmesartan HCTZ</p> <p>Valsartan HCTZ</p> <p>ENTRESTO (sacubitril/valsartan)*</p>	<p>PA Required</p> <p>Amlodipine/valsartan/HCTZ</p> <p>ATACAND HCT (candesartan HCTZ)</p> <p>AVALIDE (irbesartan HCTZ)</p> <p>AZOR (amlodipine/olmesartan)</p> <p>BENICAR HCT (olmesartan HCTZ)</p> <p>Candesartan HCTZ</p> <p>DIOVAN HCT (valsartan HCTZ)</p> <p>EDARBYCLOR (azilsartan/chlorthalidone)</p> <p>EXFORGE (amlodipine/valsartan)</p> <p>EXFORGE HCT (amlodipine/valsartan/ HCTZ)</p> <p>HYZAAR (losartan HCTZ)</p> <p>MICARDIS HCT (telmisartan HCTZ)</p> <p>Olmesartan/amlodipine/HCTZ</p> <p>Telmisartan/amlodipine</p>	<p>Non-preferred ACE inhibitors, ACE inhibitor combinations, ARBs, ARB combinations, renin inhibitors, and renin inhibitor combination products may be approved for members who have trialed and failed treatment with three preferred products (failure is defined as lack of efficacy with a 4-week trial, allergy, intolerable side effects, or significant drug-drug interaction).</p> <p>*ENTRESTO (sacubitril/valsartan) may be approved for members if the following criteria are met:</p> <ul style="list-style-type: none"> • Member is ≥ 1 year of age and has a diagnosis of symptomatic heart failure with systemic left ventricular systolic dysfunction (LVSD) and/or has chronic heart failure with a below-normal left ventricular ejection fraction (LVEF) • Diagnosis will be verified through automated verification (AutoPA) of the appropriate corresponding ICD-10 diagnosis codes related to the indicated use of the medication.

	Telmisartan HCTZ TRIBENZOR (amlodipine/olmesartan/ HCTZ)	
Renin Inhibitors & Renin Inhibitor Combinations		
	PA Required Aliskiren TEKTURNA (aliskiren) TEKTURNA HCT (aliskiren HCTZ)	Non-preferred renin inhibitors and renin inhibitor combination products may be approved for members who have failed treatment with three preferred products from the angiotensin modifier class (failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction). Renin inhibitors and combinations will not be approved in patients with diabetes. Renin inhibitors are contraindicated when used in combination with an ACE-inhibitor, ACE-inhibitor combination, ARB, or ARB-combination.
Therapeutic Drug Class: PULMONARY ARTERIAL HYPERTENSION THERAPIES - <i>Effective 1/1/2022</i>		
Phosphodiesterase Inhibitors		
*Must meet eligibility criteria *REVATIO ^{BNR} (sildenafil) oral suspension *Sildenafil (generic Revatio) 20 mg tablet *Tadalafil 20mg tablet	PA Required ADCIRCA (tadalafil) tablet ALYQ (tadalafil) 20mg tablet REVATIO (sildenafil) 20mg tablet Sildenafil (generic Revatio) oral suspension	*Eligibility criteria for preferred products: Preferred sildenafil and tadalafil tablet formulations may be approved for a diagnosis of pulmonary hypertension or right-sided heart failure. REVATIO (sildenafil) suspension may be approved for a diagnosis of pulmonary hypertension for members < 5 years of age or members ≥ 5 years of age who are unable to take/swallow tablets. Non-preferred products may be approved if meeting the following: <ul style="list-style-type: none"> • Member has a diagnosis of pulmonary hypertension AND • Member has trialed and failed treatment with preferred sildenafil tablet AND preferred tadalafil tablet. Failure is defined as lack of efficacy with 4-week trial, allergy, intolerable side effects, or significant drug-drug interaction. Members who have been previously stabilized on a non-preferred product may receive approval to continue on the medication.
Endothelin Antagonists		
*Must meet eligibility criteria *Ambrisentan tablet *TRACLEER ^{BNR} 62.5mg, 125mg (bosentan) tablet	PA Required Bosentan (generic Tracleer) 62.5mg, 125mg tablet LETAIRIS (ambrisentan) tablet OPSUMIT (macitentan) tablet TRACLEER (bosentan) 32mg tablet for suspension	*Eligibility Criteria for all agents in the class Approval may be granted for a diagnosis of pulmonary hypertension. Member and prescriber should be enrolled in applicable REMS program for prescribed medication. Non-preferred agents may be approved for members who have trialed and failed two preferred agents. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction. Members who have been previously stabilized on a non-preferred product may receive approval to continue on the medication.

Prostanoids

*Must meet eligibility criteria	PA Required	*Eligibility Criteria for all agents in the class
*Epoprostenol (generic Flolan) vial	REMODULIN (treprostinil) vial	Approval will be granted for a diagnosis of pulmonary hypertension.
*FLOLAN (epoprostenol) vial	Treprostinil (generic Remodulin) vial	Non-preferred products may be approved for members who have failed treatment with a Preferred Product. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, contraindication to IV therapy or significant drug-drug interaction).
*ORENITRAM (treprostinil) ER tablet	TYVASO (treprostinil) inhalation solution	Members who have been previously stabilized on a non-preferred product may receive approval to continue on the medication.
*VENTAVIS (iloprost) inhalation solution	UPTRAVI (selexipag) tablet, dose pack, vial	
	VELETRI (epoprostenol) vial	

Guanylate Cyclase (sGC) Stimulator

	PA Required	
	ADEMPAS (riociguat) tablet	<p>ADEMPAS (riociguat) may be approved for members who meet the following criteria:</p> <ul style="list-style-type: none"> For members of childbearing potential: <ul style="list-style-type: none"> Member is not pregnant and is able to receive monthly pregnancy tests while taking ADEMPAS and one month after stopping therapy AND Member and their partners are utilizing one of the following contraceptive methods during treatment and for one month after stopping treatment (IUD, contraceptive implants, tubal sterilization, a hormone method with a barrier method, two barrier methods, vasectomy with a hormone method, or vasectomy with a barrier method) <p>AND</p> <ul style="list-style-type: none"> Member has a CrCl ≥ 15 mL/min) and is not on dialysis AND Member does not have severe liver impairment (Child Pugh C) AND Prescriber attests to compliance with the ADEMPAS REMS Program AND Member has a diagnosis of persistent/recurrent chronic thromboembolic pulmonary hypertension (CTEPH) (WHO Group 4) after surgical treatment or has inoperable CTEPH OR Member has a diagnosis of pulmonary hypertension and has failed treatment with a preferred product for pulmonary hypertension. (Failure is defined as a lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction).

Therapeutic Drug Class: **LIPOTROPICS** - Effective 4/1/2022

Bile Acid Sequestrants

No PA Required	PA Required	
Colesevelam tablet	Colesevelam packet	Non-preferred bile acid sequestrants may be approved if the member has failed treatment with 2 preferred products in the last 12 months (failure is defined as lack of efficacy with 4-week trial, allergy, intolerable side effects or significant drug-drug interactions).
Colestipol tablet	COLESTID (colestipol) tablet, granules	
Cholestyramine packet, light packet, powder	Colestipol granules	Non-preferred lipotropic agents with a preferred product with same strength, dosage form, and active ingredient will be approved with adequate trial and/or failure of the preferred product with the same ingredient (such as preferred ezetimibe and Zetia) and

	<p>QUESTRAN (cholestyramine/sugar) packet, powder</p> <p>QUESTRAN LIGHT (cholestyramine/ aspartame) packet, powder</p> <p>WELCHOL (colesevelam) tablet, packet</p>	2 additional agents. (Failure is defined as: lack of efficacy with 4-week trial, allergy, intolerable side effects or significant drug-drug interactions).
Fibrates		
<p>No PA Required</p> <p>Fenofibrate capsule, tablet (generic Lofibra/Tricor)</p> <p>Gemfibrozil tablet</p>	<p>PA Required</p> <p>ANTARA (fenofibrate) capsule</p> <p>Fenofibric acid DR capsule</p> <p>Fenofibric acid tablet</p> <p>Fenofibrate capsule (generic Antara/Fenoglide/ Lipofen)</p> <p>FENOGLIDE (fenofibrate) tablet</p> <p>LIPOFEN (fenofibrate) capsule</p> <p>LOPID (gemfibrozil) tablet</p> <p>TRICOR (fenofibrate nano) tablet</p> <p>TRILIPIX (fenofibric acid) capsule</p>	<p>Non-preferred fibrates may be approved if the member has failed treatment with generic gemfibrozil or generic fenofibrate and niacin ER in the last 12 months (failure is defined as lack of efficacy with 4-week trial of each drug, allergy, intolerable side effects or significant drug-drug interactions).</p> <p>Non-preferred lipotropic agents with a preferred product with same strength, dosage form, and active ingredient will be approved with adequate trial and/or failure of the preferred product with the same ingredient (such as preferred ezetimibe and Zetia) and 2 additional agents. (Failure is defined as: lack of efficacy with 4-week trial, allergy, intolerable side effects or significant drug-drug interactions).</p>
Other Lipotropics		
<p>No PA Required</p> <p>Ezetimibe tablet</p> <p>Niacin ER tablet</p> <p>*Omega-3 ethyl esters capsule (generic Lovaza)</p>	<p>PA Required</p> <p>Icosapent ethyl capsule</p> <p>LOVAZA (omega-3 ethyl esters) capsule</p> <p>NEXLETOL (bempedoic acid) tablet</p> <p>NEXLIZET (bempedoic acid/ezetimibe) tablet</p> <p>NIASPAN ER (niacin ER) tablet</p> <p>VASCEPA (icosapent ethyl) capsule</p> <p>ZETIA (ezetimibe) tablet</p>	<p>Non-preferred lipotropic agents with a preferred product with same strength, dosage form, and active ingredient will be approved with adequate trial and/or failure of the preferred product with the same ingredient (such as preferred ezetimibe and Zetia) and 2 additional agents. (Failure is defined as: lack of efficacy with 4-week trial, allergy, intolerable side effects or significant drug-drug interactions).</p> <p>*Omega-3 ethyl esters (generic Lovaza) may be approved for members who have a baseline triglyceride level ≥ 500 mg/dL</p> <p>Lovaza (brand name) may be approved if meeting the following:</p> <ul style="list-style-type: none"> • Member has a baseline triglyceride level ≥ 500 mg/dl AND • Member has failed an adequate trial of omega-3 Ethyl Esters AND an adequate trial of gemfibrozil or fenofibrate (failure is defined as lack of efficacy with 4-week trial, allergy, intolerable side effects or significant drug-drug interactions)

		<p>Vascepa (icosapent ethyl) may be approved if meeting the following:</p> <ul style="list-style-type: none"> • Member has a baseline triglyceride level > 500 mg/dl AND • Member has failed an adequate trial of generic omega-3 ethyl esters AND an adequate trial of gemfibrozil or fenofibrate (failure is defined as lack of efficacy with 4-week trial, allergy, intolerable side effects or significant drug-drug interactions) <p>OR</p> <ul style="list-style-type: none"> • Medication is being prescribed to reduce CV risk for members on maximally tolerated statin therapy with triglyceride levels ≥ 150mg/dL and LDL-C levels between 41-100 mg/dL AND member meets <u>one</u> of the following: <ul style="list-style-type: none"> ○ Member is ≥ 45 years of age and has established atherosclerotic CV disease (e.g., coronary artery disease, cerebrovascular/carotid disease, peripheral arterial disease) OR ○ Member is ≥ 50 years of age with diabetes mellitus and has <u>one or more</u> of the following additional risk factors for CV disease: <ul style="list-style-type: none"> ▪ Male ≥ 55 years of age or female ≥ 65 years of age ▪ Cigarette smoker ▪ Hypertension ▪ HDL-C ≤ 40 mg/dL for men or ≤ 50 mg/dL for women ▪ hsCRP >3.00 mg/L (0.3 mg/dL) ▪ CrCl 30 to 59 mL/min ▪ Retinopathy ▪ Micro- or macroalbuminuria ▪ ABI <0.9 without symptoms of intermittent claudication • Maximum Dose: 4g daily
Therapeutic Drug Class: STATINS -Effective 4/1/2022		
No PA Required	PA Required	
Atorvastatin tablet	ALTOPREV (lovastatin ER) tablet	<p>Non-preferred Statins may be approved following trial and failure of treatment with two preferred products (failure is defined as lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions).</p> <p>Age Limitations: Altoprev will not be approved for members < 18 years of age. Fluvastatin and lovastatin will not be approved for members < 10 years of age. Livalo will not be approved for members < 8 years of age.</p>
Lovastatin tablet	CRESTOR (rosuvastatin) tablet	
Pravastatin tablet	EZALLOR (rosuvastatin) sprinkle capsule	
Rosuvastatin tablet	Fluvastatin capsule, ER tablet	
Simvastatin tablet	LESCOL XL (fluvastatin ER) tablet	
	LIPITOR (atorvastatin) tablet	
	LIVALO (pitavastatin) tablet	
	ZOCOR (simvastatin) tablet	

	ZYPITAMAG (pitavastatin) tablet	
Therapeutic Drug Class: STATIN COMBINATIONS -Effective 4/1/2022		
	PA Required Amlodipine/atorvastatin tablet CADUET (amlodipine/atorvastatin) tablet Ezetimibe/simvastatin tablet VYTORIN (ezetimibe/simvastatin) tablet	Non-preferred Statin combinations may be approved following trial and failure of treatment with two preferred products (failure is defined as lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions). Age Limitations: Vytorin (ezetimibe/simvastatin) will not be approved for members < 18 years of age. Caduet (amlodipine/atorvastatin) will not be approved for members < 10 years of age.
IV. Central Nervous System		
Therapeutic Drug Class: ANTICONVULSANTS -Oral-Effective 4/1/2022		
No PA Required	PA Required <i>Non-preferred brand name medications do not require a prior authorization when the equivalent generic is preferred and “dispense as written” is indicated on the prescription.</i>	Members currently stabilized (in outpatient or acute care settings) on any non-preferred medication in this class may receive prior authorization approval to continue on that medication. Non-preferred brand name medications do not require a prior authorization when the equivalent generic is preferred and “dispense as written” is indicated on the prescription.
Barbiturates		<u>Non-Preferred Products Newly Started for Treating Seizure Disorder or Convulsions:</u> Non-preferred medications newly started for members with a diagnosis of seizure disorder/convulsions may be approved if prescribed by a neurologist, or in consultation with a neurologist, and the following criteria are met: <ul style="list-style-type: none">• If being prescribed in consultation with a neurologist, then the prescription meets minimum age and maximum dose limits listed in Table 1 AND• For medications indicated for use as adjunctive therapy, the medication is being used in conjunction with another anticonvulsant medication AND• The prescription meets additional criteria listed for any of the following: APTIOM (eslicarbazepine): <ul style="list-style-type: none">• Member has history of trial and failure‡ of any carbamazepine-containing product BRIVIACT (brivaracetam): <ul style="list-style-type: none">• Member has history of trial and failure‡ of any levetiracetam-containing product DIACOMIT (stiripentol): <ul style="list-style-type: none">• Member is concomitantly taking clobazam AND• Member has diagnosis of seizures associated with Dravet syndrome
Phenobarbital elixir, solution, tablet Primidone tablet	MYSOLINE (primidone)	
Hydantoins		
DILANTIN (phenytoin) 30 mg capsules DILANTIN suspension PHENYTEK (phenytoin ER) Phenytoin suspension, chewable, ER capsule	DILANTIN (phenytoin ER) Infatab, 100 mg capsules	
Succinamides		
Ethosuximide capsule, solution	CELONTIN (methsuximide) Kapseal ZARONTIN (ethosuximide) capsule, solution	

		<p>ELEPSIA XR (levetiracetam ER) tablet</p> <ul style="list-style-type: none">Member has history of trial and failure‡ of levetiracetam ER (KEPPRA XR) <p>EPIDIOLEX (cannabidiol):</p> <ul style="list-style-type: none">Member has diagnosis of seizures associated with Lennox-Gastaut syndrome (LGS) or Dravet Syndrome ORMember has a diagnosis of seizures associated with tuberous sclerosis complex (TSC). <p>FINTEPLA (fenfluramine):</p> <ul style="list-style-type: none">Member has a diagnosis of seizures associated with Dravet syndrome <p>ONFI (clobazam) oral suspension:</p> <ul style="list-style-type: none">Member has diagnosis of seizures associated with Lennox-Gastaut syndrome (LGS) ANDMember has documented swallowing difficulty due to young age and/or a medical condition, and is unable to use preferred tablet and capsule formulations ANDMember is not taking a concomitant opioid (or concomitant opioid therapy has been determined to be clinically appropriate due to inadequacy of alternative treatment options) <p>OXTELLAR XR (oxcarbazepine ER):</p> <ul style="list-style-type: none">Member is being treated for partial-onset seizures ANDMember has history of trial and failure‡ of any carbamazepine or oxcarbazepine-containing product <p>SPRITAM (levetiracetam) tablet for suspension</p> <ul style="list-style-type: none">Member has history of trial and failure‡ of levetiracetam solution <p>SYMPAZAN (clobazam) film:</p> <ul style="list-style-type: none">Member has history of trial and failure‡ of clobazam tablet or solution ORProvider attests that member cannot take clobazam tablet or solution <p><u>Non-Preferred Products Newly Started for Non-Seizure Disorder Diagnoses:</u> Non-preferred medications newly started for non-seizure disorder diagnoses may be approved if meeting the following criteria:</p> <ul style="list-style-type: none">Member has history of trial and failure‡ of two preferred agents ANDThe prescription meets minimum age and maximum dose limits listed in Table 1. <p>‡Failure is defined as lack of efficacy, allergy, intolerable side effects, significant drug-drug interaction, documented contraindication to therapy, or inability to take preferred formulation. Members identified as HLA-B*15:02 positive, carbamazepine and oxcarbazepine should be avoided per Clinical Pharmacogenetics Implementation</p>
Benzodiazepines		
Clobazam tablet	Clobazam suspension	
Clonazepam tablet, ODT	KLONOPIN (clonazepam) tablet	
	ONFI (clobazam) suspension, tablet	
	SYMPAZAN (clobazam) SL film	
Valproic Acid and Derivatives		
DEPAKOTE (divalproex DR) sprinkle capsule, tablet	DEPAKOTE ER (divalproex ER) tablet	
Divalproex sprinkle capsule, DR tablet, ER tablet		
Valproic acid capsule, solution		
Carbamazepine Derivatives		
Carbamazepine IR tablet, ER tablet, chewable, ER capsule, suspension	APTiom (eslicarbazepine) tablet	
	EQUETRO (carbamazepine) capsule	
CARBATROL ER (carbamazepine) capsule	OXTELLAR XR (oxcarbazepine) tablet	
Oxcarbazepine tablet, suspension	TRILEPTAL (oxcarbazepine) tablet	
TEGRETOL (carbamazepine) suspension, tablet		
TEGRETOL XR (carbamazepine ER) tablet		
TRILEPTAL (oxcarbazepine) suspension		
Lamotrigines		
	LAMICTAL (lamotrigine) tablet kit, ODT kit	

LAMICTAL (lamotrigine) chewable/dispertab, tablet	LAMICTAL XR (lamotrigine ER) titration kit	Consortium Guideline. This may be considered a trial for prior authorization approvals of a non-preferred agent.																																																																																																															
LAMICTAL ODT ^{BNR} (lamotrigine)	Lamotrigine ODT, ER tablet, ER/IR/ODT titration kit																																																																																																																
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	EPIDIOLEX (cannabidiol) solution																																																																																																																
		<table> <tr> <th colspan="3">Table 1: Non-preferred Product Minimum Age and Maximum Dose</th></tr> <tr> <th></th><th>Minimum Age**</th><th>Maximum Dose**</th></tr> <tr> <td>Barbiturates</td><td></td><td></td></tr> <tr> <td>primidone (MYSOLINE)</td><td></td><td>2,000 mg per day</td></tr> <tr> <td>Benzodiazepines</td><td></td><td></td></tr> <tr> <td>clobazam (ONFI)</td><td>2 years</td><td>40 mg per day</td></tr> <tr> <td>clobazam film (SYMPAZAN)</td><td>2 years</td><td>40 mg per day</td></tr> <tr> <td>clobazam suspension</td><td>2 years</td><td>40 mg per day</td></tr> <tr> <td>clonazepam (KLONOPIN)</td><td></td><td>20 mg per day</td></tr> <tr> <td>Brivaracetam/Levetiracetam</td><td></td><td></td></tr> <tr> <td>brivaracetam (BRIVIACT)</td><td>1 month</td><td>200 mg per day</td></tr> <tr> <td>levetiracetam (KEPPRA)</td><td>1 month</td><td>3,000 mg per day</td></tr> <tr> <td>levetiracetam (SPRITAM)</td><td>4 years</td><td>3,000 mg per day</td></tr> <tr> <td>levetiracetam ER (ELEPSIA XR)</td><td>12 years</td><td>3,000 mg per day</td></tr> <tr> <td>levetiracetam ER (KEPPRA XR)</td><td>12 years</td><td>3,000 mg per day</td></tr> <tr> <td>Carbamazepine Derivatives</td><td></td><td></td></tr> <tr> <td>carbamazepine (EPITOL)</td><td></td><td>1,600 mg per day</td></tr> <tr> <td>carbamazepine ER (EQUETRO)</td><td></td><td>1,600 mg per day</td></tr> <tr> <td>eslicarbazepine (APTIOM)</td><td>4 years</td><td>1,600 mg per day</td></tr> <tr> <td>oxcarbazepine ER (OXTELLAR XR)</td><td>6 years</td><td>2,400 mg per day</td></tr> <tr> <td>Hydantoins</td><td></td><td></td></tr> <tr> <td>ethotoin (PEGANONE)</td><td></td><td>3,000 mg per day</td></tr> <tr> <td>phenytoin ER (DILANTIN) 100mg capsules, suspension, Infatab</td><td></td><td>1,000 mg loading dose 600 mg/day maintenance dose</td></tr> <tr> <td>Lamotrigines</td><td></td><td></td></tr> <tr> <td>lamotrigine IR (LAMICTAL)</td><td>2 years</td><td>500 mg per day</td></tr> <tr> <td>lamotrigine (LAMICTAL ODT)</td><td>2 years</td><td>500 mg per day</td></tr> <tr> <td>lamotrigine ER (LAMICTAL XR)</td><td>13 years</td><td>600 mg per day</td></tr> <tr> <td>Succinamides</td><td></td><td></td></tr> <tr> <td>ethosuximide (ZARONTIN)</td><td></td><td>20 mg/kg/day</td></tr> <tr> <td>methsuximide (CELONTIN)</td><td></td><td>Not listed</td></tr> <tr> <td>Valproic Acid and Derivatives</td><td></td><td></td></tr> <tr> <td>divalproex ER (DEPAKOTE ER)</td><td>10 years</td><td>60 mg/kg/day</td></tr> <tr> <td>Topiramates</td><td></td><td></td></tr> <tr> <td>topiramate (TOPAMAX)</td><td>2 years</td><td>400 mg per day</td></tr> <tr> <td>topiramate ER (QUDEXY XR)</td><td>2 years</td><td>400 mg per day</td></tr> <tr> <td>topiramate ER (TROKENDI XR)</td><td>6 years</td><td>400 mg per day</td></tr> <tr> <td>Other</td><td></td><td></td></tr> </table>	Table 1: Non-preferred Product Minimum Age and Maximum Dose				Minimum Age**	Maximum Dose**	Barbiturates			primidone (MYSOLINE)		2,000 mg per day	Benzodiazepines			clobazam (ONFI)	2 years	40 mg per day	clobazam film (SYMPAZAN)	2 years	40 mg per day	clobazam suspension	2 years	40 mg per day	clonazepam (KLONOPIN)		20 mg per day	Brivaracetam/Levetiracetam			brivaracetam (BRIVIACT)	1 month	200 mg per day	levetiracetam (KEPPRA)	1 month	3,000 mg per day	levetiracetam (SPRITAM)	4 years	3,000 mg per day	levetiracetam ER (ELEPSIA XR)	12 years	3,000 mg per day	levetiracetam ER (KEPPRA XR)	12 years	3,000 mg per day	Carbamazepine Derivatives			carbamazepine (EPITOL)		1,600 mg per day	carbamazepine ER (EQUETRO)		1,600 mg per day	eslicarbazepine (APTIOM)	4 years	1,600 mg per day	oxcarbazepine ER (OXTELLAR XR)	6 years	2,400 mg per day	Hydantoins			ethotoin (PEGANONE)		3,000 mg per day	phenytoin ER (DILANTIN) 100mg capsules, suspension, Infatab		1,000 mg loading dose 600 mg/day maintenance dose	Lamotrigines			lamotrigine IR (LAMICTAL)	2 years	500 mg per day	lamotrigine (LAMICTAL ODT)	2 years	500 mg per day	lamotrigine ER (LAMICTAL XR)	13 years	600 mg per day	Succinamides			ethosuximide (ZARONTIN)		20 mg/kg/day	methsuximide (CELONTIN)		Not listed	Valproic Acid and Derivatives			divalproex ER (DEPAKOTE ER)	10 years	60 mg/kg/day	Topiramates			topiramate (TOPAMAX)	2 years	400 mg per day	topiramate ER (QUDEXY XR)	2 years	400 mg per day	topiramate ER (TROKENDI XR)	6 years	400 mg per day	Other		
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Benzodiazepines																																																																																																																	
clobazam (ONFI)	2 years	40 mg per day																																																																																																															
clobazam film (SYMPAZAN)	2 years	40 mg per day																																																																																																															
clobazam suspension	2 years	40 mg per day																																																																																																															
clonazepam (KLONOPIN)		20 mg per day																																																																																																															
Brivaracetam/Levetiracetam																																																																																																																	
brivaracetam (BRIVIACT)	1 month	200 mg per day																																																																																																															
levetiracetam (KEPPRA)	1 month	3,000 mg per day																																																																																																															
levetiracetam (SPRITAM)	4 years	3,000 mg per day																																																																																																															
levetiracetam ER (ELEPSIA XR)	12 years	3,000 mg per day																																																																																																															
levetiracetam ER (KEPPRA XR)	12 years	3,000 mg per day																																																																																																															
Carbamazepine Derivatives																																																																																																																	
carbamazepine (EPITOL)		1,600 mg per day																																																																																																															
carbamazepine ER (EQUETRO)		1,600 mg per day																																																																																																															
eslicarbazepine (APTIOM)	4 years	1,600 mg per day																																																																																																															
oxcarbazepine ER (OXTELLAR XR)	6 years	2,400 mg per day																																																																																																															
Hydantoins																																																																																																																	
ethotoin (PEGANONE)		3,000 mg per day																																																																																																															
phenytoin ER (DILANTIN) 100mg capsules, suspension, Infatab		1,000 mg loading dose 600 mg/day maintenance dose																																																																																																															
Lamotrigines																																																																																																																	
lamotrigine IR (LAMICTAL)	2 years	500 mg per day																																																																																																															
lamotrigine (LAMICTAL ODT)	2 years	500 mg per day																																																																																																															
lamotrigine ER (LAMICTAL XR)	13 years	600 mg per day																																																																																																															
Succinamides																																																																																																																	
ethosuximide (ZARONTIN)		20 mg/kg/day																																																																																																															
methsuximide (CELONTIN)		Not listed																																																																																																															
Valproic Acid and Derivatives																																																																																																																	
divalproex ER (DEPAKOTE ER)	10 years	60 mg/kg/day																																																																																																															
Topiramates																																																																																																																	
topiramate (TOPAMAX)	2 years	400 mg per day																																																																																																															
topiramate ER (QUDEXY XR)	2 years	400 mg per day																																																																																																															
topiramate ER (TROKENDI XR)	6 years	400 mg per day																																																																																																															
Other																																																																																																																	

Felbamate tablet, suspension FINTEPLA (fenfluramine) solution FYCOMPA (perampanel) suspension, tablet GABITRIL (tiagabine) tablet Rufinamide suspension, tablet SABRIL (vigabatrin) powder packet, tablet Tiagabine tablet Vigabatrin tablet, powder packet VIMPAT (lacosamide) solution, kit, tablet XCOPRI (cenobamate) tablet, pack	cannabidiol (EPIDIOLEX) cenobamate (XCOPRI) felbamate tablet, suspension fenfluramine (FINTEPLA) lacosamide (VIMPAT) perampanel (FYCOMPA) rufinamide (BANZEL) tablet and suspension stiripentol (DIACOMIT) tiagabine tiagabine (GABITRIL) vigabatrin vigabatrin (SABRIL) vigabatrin (VIGADRONE) powder packet zonisamide (ZONEGRAN)	1 year 18 years 2 years 2 years 1 month 4 years 1 year 2 years 12 years 12 years 1 month 1 month 1 month 16 years	20 mg/kg/day 400 mg per day 26 mg per day 400 mg per day 12 mg per day 3,200 mg per day 3,000 mg per day 64 mg per day 64 mg per day 3,000 mg per day 3,000 mg per day 3,000 mg per day 600 mg per day
	**Limits based on data from FDA package insert. Approval for age/dosing that falls outside of the indicated range may be evaluated on a case-by-case basis.		

Therapeutic Drug Class: NEWER GENERATION ANTI-DEPRESSANTS -Effective 4/1/2022

No PA Required	PA Required	
Bupropion IR, SR, XL tablet	<i>Non-preferred brand name medications do not require a prior authorization when the equivalent generic is preferred and “dispense as written” is indicated on the prescription.</i> APLENZIN (bupropion ER) tablet Bupropion XL (generic Forfivo XL) tablet CELEXA (citalopram) tablet CYMBALTA (duloxetine) capsule Desvenlafaxine fumarate ER tablet DRIZALMA (duloxetine) sprinkle capsule EFFEXOR XR (venlafaxine ER) capsule Escitalopram solution FETZIMA (levomilnacipran ER) capsule, titration pak	Prior authorization for Fetzima, Trintellix, or Viibryd may be approved for members who have failed an adequate trial with four preferred newer generation anti-depressant products (failure is defined as lack of efficacy with 6-week trial, allergy, intolerable side effects, or significant drug-drug interaction). All non-preferred products not listed above may be approved for members who have failed adequate trial with three preferred newer generation anti-depressant products. If three preferred newer generation anti-depressant products are not available for indication being treated, approval of prior authorization for non-preferred products will require adequate trial of all preferred products FDA approved for that indication (failure is defined as lack of efficacy with 6-week trial, allergy, intolerable side effects, or significant drug-drug interaction). Citalopram doses higher than 40mg/day for ≤60 years of age and 20mg/day for >60 years of age will require prior authorization. Please see the FDA guidance at: https://www.fda.gov/drugs/drugsafety/ucm297391.htm for important safety information. Members currently stabilized on a non-preferred newer generation antidepressant may receive approval to continue on that agent for one year if medically necessary. Verification may be provided from the prescriber or the pharmacy.
Citalopram tablet, solution		
Desvenlafaxine succinate ER tablet		
Duloxetine (generic Cymbalta) capsule		
Escitalopram tablet		
Fluoxetine capsules, solution		
Fluvoxamine tablet		
Mirtazapine tablet, ODT		
Paroxetine IR tablet		
Sertraline tablet, solution		
Trazodone tablet		

<p>Venlafaxine IR tablet</p> <p>Venlafaxine ER capsules</p>	<p>Fluoxetine IR tablet, fluoxetine DR capsule</p> <p>Fluvoxamine ER capsule</p> <p>FORFIVO XL (bupropion ER) tablet</p> <p>LEXAPRO (escitalopram) tablet</p> <p>Nefazodone tablet</p> <p>Paroxetine ER tablet</p> <p>PAXIL (paroxetine) tablet, suspension</p> <p>PAXIL CR (paroxetine ER) tablet</p> <p>PEXEVA (paroxetine mesylate) tablet</p> <p>PRISTIQ (desvenlafaxine succinate ER) tablet</p> <p>PROZAC (fluoxetine) Pulvule</p> <p>REMERON (mirtazapine) tablet, Soltab (ODT)</p> <p>TRINTELLIX (vortioxetine) tablet</p> <p>Venlafaxine ER tablets</p> <p>VIIBRYD (vilazodone) tablet</p> <p>WELLBUTRIN SR, XL (bupropion) tablet</p> <p>ZOLOFT (sertraline) tablet, oral concentrate</p>	
Therapeutic Drug Class: MONOAMINE OXIDASE INHIBITORS (MAOIs) -Effective 4/1/2022		
	<p>PA Required</p> <p>EMSAM (selegiline) patch</p> <p>MARPLAN (isocarboxazid) tablet</p> <p>NARDIL (phenelzine) tablet</p> <p>Phenelzine tablet</p>	<p>Non-preferred products may be approved for members who have failed adequate trial (8 weeks) with three preferred anti-depressant products. If three preferred anti-depressant products are not available for indication being treated, approval of prior authorization for non-preferred products will require adequate trial of all preferred anti-depressant products FDA approved for that indication. (Failure is defined as: lack of efficacy after 8-week trial, allergy, intolerable side effects, or significant drug-drug interaction)</p>

	Tranlycypromine tablet	Members currently stabilized on a Non-preferred MAOI antidepressant may receive approval to continue on that agent for one year if medically necessary. Verification may be provided from the prescriber or the pharmacy.
Therapeutic Drug Class: TRICYCLIC ANTI-DEPRESSANTS (TCAs) -Effective 4/1/2022		
No PA Required Amitriptyline tablet Desipramine tablet Doxepin 10mg, 25mg, 50mg, 75mg, 100mg, 150mg capsule Doxepin oral concentrate Imipramine HCl tablet Nortriptyline capsule, solution	PA Required <i>Non-preferred brand name medications do not require a prior authorization when the equivalent generic is preferred and “dispense as written” is indicated on the prescription.</i> Amoxapine tablet ANAFRANIL (clomipramine) capsule Clomipramine capsule Imipramine pamoate capsule Maprotiline tablet NORPRAMIN (desipramine) tablet PAMELOR (nortriptyline) capsule Protriptyline tablet Trimipramine capsule	Non-preferred products may be approved for members who have failed adequate trial (8 weeks) with three preferred tricyclic products. If three preferred products are not available for indication being treated, approval of prior authorization for non-preferred products will require adequate trial of all tricyclic preferred products FDA approved for that indication. (Failure is defined as: lack of efficacy after 8-week trial, allergy, intolerable side effects, or significant drug-drug interaction) Members currently stabilized on a non-preferred tricyclic antidepressant may receive approval to continue on that agent for one year if medically necessary. Verification may be provided from the prescriber or the pharmacy. Silenor (doxepin 3mg, 6mg) approval criteria can be found on the Appendix P
Therapeutic Drug Class: ANTI-PARKINSON’S AGENTS -Effective 4/1/2022		
Dopa decarboxylase inhibitors, dopamine precursors and combinations		
No PA Required Carbidopa/Levodopa IR, ER tablet Carbidopa/Levodopa/Entacapone tablet	PA Required Carbidopa tablet Carbidopa/Levodopa ODT DHIVY (carbidopa/levodopa) tablet DUOPA (carbidopa/levodopa) suspension INBRIJA (levodopa) capsule for inhalation LODOSYN (carbidopa) tablet	Non-preferred agents may be approved with adequate trial and failure of carbidopa-levodopa IR and ER formulations (failure is defined as lack of efficacy with a 4-week trial, allergy, intolerable side effects or significant drug-drug interactions). Carbidopa or levodopa single agent products may be approved for members with diagnosis of Parkinson’s Disease as add-on therapy to carbidopa-levodopa. Non-preferred medications that <u>are not</u> prescribed for Parkinson’s Disease (or an indication related to Parkinson’s Disease) may receive approval without meeting trial and failure step therapy criteria.

	RYTARY ER (carbidopa/levodopa) capsule SINEMET (carbidopa/levodopa) IR tablet STALEVO (carbidopa/levodopa/ entacapone) tablet	<p>Members with history of trial and failure of a non-preferred Parkinson's Disease agent that is the brand/generic equivalent of a preferred product (same strength, dosage form and active ingredient) may be considered as having met a trial and failure of the equivalent preferred.</p> <p>Members currently stabilized on a non-preferred product may receive approval to continue therapy with that product.</p>
MAO-B inhibitors		
No PA Required Selegiline capsule Selegiline tablet	PA Required AZILECT (rasagiline) tablet Rasagiline tablet XADAGO (safinamide) tablet ZELAPAR (selegiline) ODT	<p>Non-preferred agents may be approved with adequate trial and failure of selegiline capsule or tablet (failure is defined as lack of efficacy with a 4-week trial, allergy, intolerable side effects or significant drug-drug interactions).</p> <p>Non-preferred medications that <u>are not</u> prescribed for Parkinson's Disease (or an indication related to Parkinson's Disease) may receive approval without meeting trial and failure step therapy criteria.</p> <p>Members with history of trial and failure of a non-preferred Parkinson's Disease agent that is the brand/generic equivalent of a preferred product (same strength, dosage form and active ingredient) may be considered as having met a trial and failure of the equivalent preferred.</p> <p>Members currently stabilized on a non-preferred product may receive approval to continue therapy with that product.</p>
Dopamine Agonists		
No PA Required Pramipexole IR tablet Ropinirole IR tablet	PA Required APOKYN (apomorphine) SC cartridge Bromocriptine capsule, tablet KYNMOBI (apomorphine) SL film MIRAPEX (pramipexole) IR, ER tablet NEUPRO (rotigotine) patch PARLODEL (bromocriptine) capsule, tablet Pramipexole ER tablet Ropinirole ER tablet	<p>Non-preferred agents may be approved with adequate trial and failure of ropinirole IR AND pramipexole IR (failure is defined as lack of efficacy with 4-week trial, documented contraindication to therapy, allergy, intolerable side effects or significant drug-drug interactions).</p> <p>APOKYN (apomorphine subcutaneous cartridge) may be approved if meeting the following:</p> <ul style="list-style-type: none"> • APOKYN (apomorphine) is being used as an adjunct to other medications for acute, intermittent treatment of hypomobility, "off" episodes ("end-of-dose wearing off" and unpredictable "on/off" episodes) in patients with advanced Parkinson's disease AND • Due to the risk of profound hypotension and loss of consciousness, member is not concomitantly using a 5HT3 antagonist such as ondansetron, granisetron, dolasetron, palonosetron or alosetron. <p>Maximum dose: 6mg (0.6mL) three times per day</p> <p>KYNMOBI (apomorphine sublingual film) may be approved if meeting the following:</p>

		<ul style="list-style-type: none"> KYNMOBI (apomorphine) is being used for the acute, intermittent treatment of “off” episodes in patients with Parkinson's disease AND Due to the risk of profound hypotension and loss of consciousness, member must not be concomitantly using a 5HT3 antagonist such as ondansetron, granisetron, dolasetron, palonosetron or alosetron. <p>Maximum dose: 30mg five times per day</p> <p>Non-preferred medications that <u>are not</u> prescribed for Parkinson’s Disease (or an indication related to Parkinson’s Disease) may receive approval without meeting trial and failure step therapy criteria.</p> <p>Members with history of trial and failure of a non-preferred Parkinson’s Disease agent that is the brand/generic equivalent of a preferred product (same strength, dosage form and active ingredient) may be considered as having met a trial and failure of the equivalent preferred.</p> <p>Members currently stabilized on a non-preferred product may receive approval to continue therapy with that product.</p>
Other Parkinson’s agents		
<p>No PA Required</p> <p>Amantadine capsule, tablet, solution/syrup</p> <p>Benztropine tablet</p> <p>Trihexyphenidyl tablet, elixir</p>	<p>PA Required</p> <p>COMTAN (entacapone) tablet</p> <p>Entacapone tablet</p> <p>GOCOVRI ER (amantadine ER) capsule</p> <p>NOURIANZ (istradefylline) tablet</p> <p>ONGENTYS (opicapone) capsule</p> <p>OSMOLEX ER (amantadine) tablet</p> <p>TASMAR (tolcapone) tablet</p> <p>Tolcapone tablet</p>	<p>Non-preferred agents may be approved with adequate trial and failure of two preferred agents (failure is defined as lack of efficacy with 4-week trial, documented contraindication to therapy, allergy, intolerable side effects or significant drug-drug interactions).</p> <p>Non-preferred medications that <u>are not</u> prescribed for Parkinson’s Disease (or an indication related to Parkinson’s Disease) may receive approval without meeting trial and failure step therapy criteria.</p> <p>Members with history of trial and failure of a non-preferred Parkinson’s Disease agent that is the brand/generic equivalent of a preferred product (same strength, dosage form and active ingredient) may be considered as having met a trial and failure of the equivalent preferred.</p> <p>Members currently stabilized on a non-preferred product may receive approval to continue therapy with that product.</p>
Therapeutic Drug Class: BENZODIAZEPINES (NON-SEDATIVE HYPNOTIC) Effective 4/1/2022		
<p>No PA Required (*may be subject to age limitations)</p> <p>Alprazolam IR, ER tablet*</p> <p>Chlordiazepoxide capsule*</p>	<p>PA Required</p> <p>Alprazolam ODT, oral concentrate</p> <p>ATIVAN (lorazepam) tablet, Intensol concentrate</p> <p>Diazepam Intensol</p>	<p>Non-preferred products may be approved following trial and failure of three preferred agents. Failure is defined as lack of efficacy, contraindication to therapy, allergy, intolerable side effects, or significant drug-drug interactions.</p> <p><u>Children:</u> Prior authorization will be required for all agents when prescribed for children <18 years of age (with the exception of oral solution products) and may be approved with prescriber verification of necessity of use for member age.</p>

Clorazepate tablet*	LOREEV (lorazepam ER) capsule	<p>Diazepam Intensol may be approved following trial and failure of the preferred 5 mg/5 mL oral solution. Failure is defined as intolerable side effects, drug-drug interaction, or lack of efficacy.</p> <p>All benzodiazepine anxiolytics will require prior authorization for members ≥ 65 years of age when exceeding 90 days of therapy.</p> <p>Continuation of Therapy:</p> <ul style="list-style-type: none">Members < 65 years of age who are currently stabilized on a non-preferred benzodiazepine medication may receive approval to continue that medication.Members < 18 years of age who are currently stabilized on a non-preferred oral solution product may receive authorization to continue that medication. <p>Prior authorization will be required for prescribed doses that exceed the maximum (Table 1).</p> <table><tr><th colspan="3">Table 1 Maximum Doses</th></tr><tr><th>Product</th><th>Maximum Daily Dose</th><th>Maximum Monthly Dose</th></tr><tr><td>Alprazolam tablet</td><td rowspan="5"><u>Adults ≥ 18 years:</u> 10 mg/day</td><td rowspan="5">Total of 300 mg from all dosage forms per 30 days</td></tr><tr><td>Alprazolam ER tablet</td></tr><tr><td>Alprazolam ODT</td></tr><tr><td>XANAX (alprazolam) tablet</td></tr><tr><td>XANAX XR (alprazolam ER) tablet</td></tr><tr><td>Alprazolam Intensol oral concentrate 1 mg/mL</td><td></td><td></td></tr><tr><td>Clorazepate tablet</td><td rowspan="2"><u>>12 years:</u> 90 mg/day <u>Children 9-12 years:</u> up to 60 mg/day</td><td rowspan="2">Total of 2,700 mg (adults) and 1,800 mg (children) from all tablet strengths per 30 days</td></tr><tr><td>TRANXENE (clorazepate) T-Tab</td></tr><tr><td>Chlordiazepoxide capsule</td><td><u>Adults ≥ 18 years:</u> 300 mg/day <u>Children 6-17 years:</u> up to 40 mg/day (pre-operative apprehension and anxiety)</td><td>Total of 9,000 mg (adults) and 120 mg (children, pre-op therapy) from all tablet strengths per 30 days</td></tr><tr><td>Diazepam Intensol oral concentrate 5 mg/mL</td><td rowspan="2"><u>Adults ≥ 18 years:</u> 40 mg/day <u>Children:</u> N/A</td><td rowspan="2">Total of 1200 mg from all dosage forms per 30 days</td></tr><tr><td>Diazepam solution 5 mg/5 mL</td></tr></table>	Table 1 Maximum Doses			Product	Maximum Daily Dose	Maximum Monthly Dose	Alprazolam tablet	<u>Adults ≥ 18 years:</u> 10 mg/day	Total of 300 mg from all dosage forms per 30 days	Alprazolam ER tablet	Alprazolam ODT	XANAX (alprazolam) tablet	XANAX XR (alprazolam ER) tablet	Alprazolam Intensol oral concentrate 1 mg/mL			Clorazepate tablet	<u>>12 years:</u> 90 mg/day <u>Children 9-12 years:</u> up to 60 mg/day	Total of 2,700 mg (adults) and 1,800 mg (children) from all tablet strengths per 30 days	TRANXENE (clorazepate) T-Tab	Chlordiazepoxide capsule	<u>Adults ≥ 18 years:</u> 300 mg/day <u>Children 6-17 years:</u> up to 40 mg/day (pre-operative apprehension and anxiety)	Total of 9,000 mg (adults) and 120 mg (children, pre-op therapy) from all tablet strengths per 30 days	Diazepam Intensol oral concentrate 5 mg/mL	<u>Adults ≥ 18 years:</u> 40 mg/day <u>Children:</u> N/A	Total of 1200 mg from all dosage forms per 30 days	Diazepam solution 5 mg/5 mL
Table 1 Maximum Doses																													
Product	Maximum Daily Dose		Maximum Monthly Dose																										
Alprazolam tablet	<u>Adults ≥ 18 years:</u> 10 mg/day		Total of 300 mg from all dosage forms per 30 days																										
Alprazolam ER tablet																													
Alprazolam ODT																													
XANAX (alprazolam) tablet																													
XANAX XR (alprazolam ER) tablet																													
Alprazolam Intensol oral concentrate 1 mg/mL																													
Clorazepate tablet	<u>>12 years:</u> 90 mg/day <u>Children 9-12 years:</u> up to 60 mg/day	Total of 2,700 mg (adults) and 1,800 mg (children) from all tablet strengths per 30 days																											
TRANXENE (clorazepate) T-Tab																													
Chlordiazepoxide capsule	<u>Adults ≥ 18 years:</u> 300 mg/day <u>Children 6-17 years:</u> up to 40 mg/day (pre-operative apprehension and anxiety)	Total of 9,000 mg (adults) and 120 mg (children, pre-op therapy) from all tablet strengths per 30 days																											
Diazepam Intensol oral concentrate 5 mg/mL	<u>Adults ≥ 18 years:</u> 40 mg/day <u>Children:</u> N/A	Total of 1200 mg from all dosage forms per 30 days																											
Diazepam solution 5 mg/5 mL																													
Diazepam tablet*, solution	TRANXENE T-TAB (clorazepate) tablet																												
Lorazepam tablet*, oral concentrate	XANAX (alprazolam) tablet																												
Oxazepam capsule*	XANAX XR (alprazolam ER) tablet																												

		Diazepam tablet	<u>Adults ≥ 18 years:</u> 40 mg/day <u>Children 6 months to 18 years:</u> up to 10 mg/day	Total of 1200 mg (adults) and 300 mg (pediatrics) from all dosage forms per 30 days
		ATIVAN (lorazepam) Intensol concentrate 2 mg/mL	<u>Adults ≥ 18 years:</u> 10 mg/day <u>Children:</u> N/A	Total of 300 mg from all dosage forms per 30 days
		ATIVAN (lorazepam) tablet		
		Lorazepam oral concentrated soln 2 mg/mL		
		Lorazepam tablet		
		Oxazepam capsule	<u>Adults ≥ 18 years:</u> 120 mg/day <u>Children 6-18 years:</u> absolute dosage not established	Total of 3600 mg from all dosage forms per 30 days
Therapeutic Drug Class: ANXIOLYTIC, NON- BENZODIAZEPINES - <i>Effective 4/1/2022</i>				
No PA Required Buspirone tablet	PA Required	Non-preferred products may be approved following trial and failure of buspirone. Failure is defined as lack of efficacy, contraindication to therapy, allergy, intolerable side effects, or significant drug-drug interactions.		
Therapeutic Drug Class: ATYPICAL ANTI-PSYCHOTICS - Oral and Topical- <i>Effective 4/1/2022</i> The following injectable products are not self-administered and are dispensed according to FDA label without being subject to PDL criteria: Aristada (aripiprazole lauroxil) IM, Aristada Initio (aripiprazole lauroxil) IM, Abilify Maintena (aripiprazole) IM, Invega Sustenna (paliperidone palmitate) IM, Invega Trinza (paliperidone palmitate) IM, Invega Hafyera (paliperidone palmitate) IM, Zyprexa Relprevv (olanzapine pamoate) IM, Risperdal Consta (risperidone) IM, Perseris (risperidone) SC, Geodon (ziprasidone) IM. See appendix P for more information.				
No PA Required* Aripiprazole tablet Clozapine tablet LATUDA (lurasidone) 2nd line** Olanzapine tablet, ODT Quetiapine IR tablet*** Quetiapine ER tablet	PA Required <i>Non-preferred brand name medications do not require a prior authorization when the equivalent generic is preferred and “dispense as written” is indicated on the prescription.</i> ABILIFY (aripiprazole) tablet, MyCite Aripiprazole oral solution****, ODT Asenapine SL tablet CAPLYTA (lumateperone) capsule	Non-preferred products may be approved for members meeting all of the following: <ul style="list-style-type: none">• Medication is being prescribed for an FDA-Approved indication AND• Prescription meets dose and age limitations (Table 1) AND• Member has history of trial and failure of three preferred products with FDA approval for use for the prescribed indication (failure defined as lack of efficacy with 6-week trial, allergy, intolerable side effects, significant drug-drug interactions, or known interacting genetic polymorphism that prevents safe preferred product dosing) *Age Limits: All products including preferred products will require a PA for members younger than the FDA approved age for the agent (Table 1). Members younger than the FDA approved age for the agent who are currently stabilized on an atypical antipsychotic will be eligible for grandfathering. Atypical Antipsychotic prescriptions for members under 5 years of age may require a provider-provider		

<p>Risperidone tablet, ODT, oral solution</p> <p>Ziprasidone</p>	<p>Clozapine ODT</p> <p>CLOZARIL (clozapine) tablet, ODT</p> <p>FANAPT (iloperidone) tablet, pack</p> <p>GEODON (ziprasidone) capsule</p> <p>INVEGA ER (paliperidone) tablet</p> <p>LYBALVI (olanzapine/samidorphan) tablet</p> <p>NUPLAZID (pimavanserin) capsule, tablet</p> <p>Olanzapine/Fluoxetine capsule</p> <p>Paliperidone ER tablet</p> <p>REXULTI (brexpiprazole) tablet</p> <p>RISPERDAL (risperidone) tablet, oral solution</p> <p>SAPHRIS (asenapine) SL tablet</p> <p>SECUADO (asenapine) patch</p> <p>SEROQUEL IR (quetiapine IR)*** tablet</p> <p>SEROQUEL XR (quetiapine ER)*** tablet</p> <p>SYMBYAX (olanzapine/fluoxetine) capsule</p> <p>VERSACLOZ (clozapine) suspension</p> <p>VRAYLAR (cariprazine) capsule</p> <p>ZYPREXA (olanzapine) tablet</p> <p>ZYPREXA ZYDIS (olanzapine) ODT</p>	<p>telephone consult with a child and adolescent psychiatrist (provided at no cost to provider or member).</p> <p>**Latuda (lurasidone) may be approved for the treatment of schizophrenia or bipolar depression if the member has tried and failed treatment with one preferred product (qualifying diagnosis verified by AutoPA).</p> <p>***Quetiapine IR when given at subtherapeutic doses may be restricted for therapy. Low-dose quetiapine (<150mg/day) is only FDA approved as part of a drug titration schedule to aid patients in getting to the target quetiapine dose. PA will be required for quetiapine < 150mg per day except for utilization (when appropriate) in members 65 years or older. PA will be approved for members 10-17 years of age with approved diagnosis (Table 1) stabilized on <150mg quetiapine IR per day.</p> <p>****Aripiprazole solution: Aripiprazole <u>tablet</u> quantity limit is 2 tablets/day for pediatric members to allow for incremental dose titration and use of the preferred tablet formulation should be considered for dose titrations when possible and clinically appropriate. If incremental dose cannot be achieved with titration of the aripiprazole tablet for members < 18 years of age OR for members unable to swallow solid tablet dosage form, aripiprazole solution may be approved. For all other cases, aripiprazole solution is subject to meeting non-preferred product approval criteria listed above.</p> <p>Nuplazid (pimavanserin tartrate) may be approved for the treatment of hallucinations and delusions associated with Parkinson's Disease psychosis AND following trial and failure of therapy with quetiapine or clozapine (failure will be defined as intolerable side effects, drug-drug interaction, or lack of efficacy).</p> <p>Abilify MyCite may be approved if meeting all of the following:</p> <ul style="list-style-type: none"> • Member has history of adequate trial and failure of 5 preferred agents (one trial must include aripiprazole tablet). Failure is defined as lack of efficacy with 6-week trial on maximally tolerated dose, allergy, intolerable side effects, significant drug-drug interactions AND • Information is provided regarding adherence measures being recommended by provider and followed by member (such as medication organizer or digital medication reminders) AND • Member has history of adequate trial and failure of 3 long-acting injectable formulations of atypical antipsychotics, one of which must contain aripiprazole (failure is defined as lack of efficacy with 8-week trial, allergy, intolerable side effects, significant drug-drug interactions) AND • Abilify MyCite is being used with a MyCite patch and member is using a compatible mobile application. AND • Medication adherence information is being shared with their provider via a web portal or dashboard.
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Table 1 Atypical Antipsychotics – FDA Approved Indication, Age Range, Quantity and Maximum Dose					
Brand	Generic	Approved Indications	Age Range	Maximum Daily Dose by Age/Indication	Quantity and Maximum Dose Limitations
ABILIFY	aripiprazole	Schizophrenia Bipolar I Disorder Bipolar I Disorder Irritability w/autistic disorder Tourette's disorder	≥ 13 years ≥ 18 years 10-17 years 6-17 years 6-18 years	30 mg 30 mg 15 mg 15 mg 20 mg	Maximum one tablet per day (maximum of two tablets per day allowable for members < 18 years of age to accommodate for incremental dose changes)
CLOZARIL	clozapine	Treatment-resistant schizophrenia Recurrent suicidal behavior in schizophrenia or schizoaffective disorder	≥ 18 years	900 mg	Maximum dosage of 900mg per day
CAPLYTA	lumateperone	Schizophrenia Bipolar I Disorder Bipolar II Disorder	≥ 18 years	42 mg	Maximum dosage of 42mg per day
	clozapine	Treatment-resistant schizophrenia Recurrent suicidal behavior in schizophrenia or schizoaffective disorder	≥ 18 years	900 mg	Maximum dosage of 900mg per day
FANAPT	iloperidone	Schizophrenia	≥ 18 years	24 mg	Maximum two tablets per day
GEODON	ziprasidone	Schizophrenia Bipolar I Disorder	≥ 18 years ≥ 18 years	200 mg 160 mg	Maximum two capsules per day
INVEGA	paliperidone	Schizophrenia & schizoaffective disorder	≥ 12 years and weight ≥ 51 kg ≥ 12 years and weight < 51 kg	12 mg 6 mg	Maximum one capsule per day
LATUDA	lurasidone	Schizophrenia Schizophrenia Bipolar I disorder Bipolar I disorder	≥ 18 years 13-17 years ≥ 18 years 10–17 years	160 mg 80 mg 120 mg 80 mg	Maximum one tablet per day (If dosing 160mg for schizophrenia, then max of two tablets per day)
NUPLAZID	pimavanserin	Parkinson's disease psychosis	≥ 18 years	34 mg	Maximum dosage of 34mg per day
RISPERDAL	risperidone	Schizophrenia Schizophrenia Bipolar mania Irritability w/autistic disorder	≥ 18 years 13-17 years ≥ 10 years 5–17 years	12mg 6 mg 6 mg 3 mg	Maximum dosage of 12mg/day

REXULTI	brexpiprazole	Schizophrenia Adjunctive treatment of MDD	≥ 13 years ≥ 18 years	4 mg 3 mg	Maximum of 3mg/day for MDD adjunctive therapy, Maximum of 4mg/day for schizophrenia
SAPHRIS	asenapine	Schizophrenia Bipolar mania or mixed episodes	≥ 18 years ≥ 10 years	20 mg 20 mg	Maximum two tablets per day
SECUADO	asenapine patch	Schizophrenia	≥ 18 years	7.6 mg/ 24 hours	Maximum 1 patch per day
SEROQUEL	quetiapine	Schizophrenia Schizophrenia Bipolar I mania or mixed Bipolar I mania or mixed Bipolar I depression Bipolar I Disorder Maintenance	≥ 18 years 13-17 years ≥ 18 years 10-17 years ≥ 18 years ≥ 18 years	750 mg 800 mg 800 mg 600 mg 300 mg 800 mg	Maximum three tablets per day
SEROQUEL XR	quetiapine ER	Schizophrenia Bipolar I mania Bipolar I mania Bipolar I depression Adjunctive treatment of MDD	≥ 13 years ≥ 18 years 10-17 years ≥ 18 years ≥ 18 years	800 mg 800 mg 600 mg 300 mg 300 mg	Maximum one tablet per day (for 300mg & 400mg tablets max 2 tablets per day)
SYMBYAX	olanzapine/ fluoxetine	Acute depression in Bipolar I Disorder Treatment resistant depression (MDD)	≥ 10 years	12 mg olanzapine/ 50 mg fluoxetine	Maximum three capsules per day (18mg olanzapine/75mg fluoxetine)
VRAYLAR	cariprazine	Schizophrenia Acute manic or mixed episodes with Bipolar I disorder Depressive episodes with Bipolar I disorder	≥ 18 years ≥ 18 years ≥ 18 years	6 mg 6 mg 3 mg	Maximum dosage of 6mg/day
ZYPREXA ZYPREXA ZYDIS	olanzapine	Schizophrenia Acute manic or mixed episodes with Bipolar I disorder	≥ 13 years	20 mg	Maximum one tablet per day

Therapeutic Drug Class: CALCITONIN GENE – RELATED PEPTIDE INHIBITORS (CGRPis) -Effective 4/1/2022

PA Required for all agents		*Preferred agents (Aimovig, Ajovy, Nurtec may be approved if meeting the following criteria:
*AIMOVIG (erenumab-aooe) auto-injector	EMGALITY (galcanezumab-gnlm) pen, syringe	<u>Preferred Medications for Migraine Prevention (must meet all of the following):</u> <ul style="list-style-type: none"> The requested medication is being used as preventive therapy for episodic or chronic migraine AND Member has diagnosis of migraine with or without aura AND Member has tried and failed 2 oral preventive pharmacological agents listed as Level A per the most current American Headache Society/American Academy of Neurology guidelines (such as divalproex, topiramate, metoprolol, propranolol). Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction OR If the prescribed medication is Nurtec, the member has tried and failed two preferred injectable product formulations (Aimovig and Ajovy). Failure is defined as lack of efficacy, contraindication to therapy, allergy, intolerable side effects, or significant drug-drug interaction.
*AJOVY (fremanezumab-vfrm) auto-injector, syringe	QULIPTA (atogepant) tablet	
*NURTEC (rimegepant) ODT	UBRELVY (ubrogepant) tablet	
		<u>Preferred Medications for Acute Migraine Treatment (must meet all of the following):</u>

- The requested medication is being used as acute treatment for migraine headache AND
- Member has history of trial and failure of two triptans (failure is defined as lack of efficacy with 4-week trial, contraindication to therapy, allergy, intolerable side effects, or significant drug-drug interaction).

Non-Preferred Medications for Migraine Prevention (must meet all of the following):

- The requested medication is being used as preventive therapy for episodic or chronic migraine AND
- Member has diagnosis of migraine with or without aura AND
- Member has tried and failed two oral preventive pharmacological agents listed as Level A per the most current American Headache Society/American Academy of Neurology guidelines (such as divalproex, topiramate, metoprolol, propranolol). Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction AND
- The requested medication is not being used in combination with another CGRP medication AND
- The member has history of adequate trial and failure of all preferred products indicated for preventive therapy (failure is defined as lack of efficacy with 4-week trial, contraindication to therapy, allergy, intolerable side effects, or significant drug-drug interaction).

Non-Preferred Medications for Acute Migraine Treatment (must meet all of the following):

- Member is 18 years of age or older AND
- Medication is being prescribed to treat migraine headache with moderate to severe pain AND
- The requested medication is not being used in combination with another CGRP medication AND
- Member has history of trial and failure with all of the following (failure is defined as lack of efficacy with 4-week trial, allergy, contraindication, intolerable side effects, or significant drug-drug interaction):
 - Two triptans AND
 - One NSAID agent AND
 - One preferred agent indicated for acute migraine treatment

Non-Preferred Medications for Treatment of Episodic Cluster Headache (must meet all of the following):

- Member is 19-65 years of age AND
- Member meets diagnostic criteria for episodic cluster headache (has had no more than 8 attacks per day, a minimum of one attack every other day, and at least 4 attacks during the week prior to this medication being prescribed) AND
- Member is not taking other preventive medications to reduce the frequency of cluster headache attacks AND

		<ul style="list-style-type: none"> Member has history of trial and failure of all of the following (failure is defined as lack of efficacy with 4-week trial, contraindication to therapy, allergy, intolerable side effects, or significant drug-drug interaction): <ul style="list-style-type: none"> Oxygen therapy AND Sumatriptan subcutaneous or intranasal AND Zolmitriptan intranasal AND Initial authorization will be limited to 8 weeks. Continuation (12-month authorization) will require documentation of clinically relevant improvement with no less than 30% reduction in headache frequency in a 4-week period. <p><u>Age Limitations:</u> Emgality 100mg: 19-65 years All other products: ≥ 18 years</p> <p><u>Maximum Dosing:</u> Aimovig (erenumab): 140mg per 30 days Emgality 120mg (galcanezumab): 240mg once as first loading dose then 120mg monthly Emgality 100mg (galcanezumab): 300mg per 30 days Ajovy (fremanezumab): 225mg monthly or 675mg every three months Nurtec (rimegepant): Prevention: 16 tablets/30 days; Acute Treatment: 8 tablets/30 days Qulipta (atogepant): 30 tablets/30 days Ubrelvy 50 mg (ubrogepant): 16 tablets/30 days (800 mg per 30 days) Ubrelvy 100 mg (ubrogepant): 16 tablets/30 days (1,600 mg per 30 days)</p> <p>Members with current prior authorization approval on file for Emgality (galcanezumab) 120mg may receive one-year approval for an alternative preferred injectable product formulation (Aimovig or Ajovy) without needing to meet criteria listed above.</p> <p>Members with current prior authorization approval on file for a preferred agent may receive approval for continuation of therapy with the preferred agent.</p>
Therapeutic Drug Class: LITHIUM AGENTS -Effective 4/1/2022		
No PA Required Lithium carbonate capsule, tablet Lithium ER tablet	PA Required <i>Non-preferred brand name medications do not require a prior authorization when the equivalent generic is preferred and “dispense as written” is indicated on the prescription.</i> LITHOBID ER (lithium ER) tablet	Non-preferred products may be approved with trial and failure of one preferred agent (failure is defined as lack of efficacy with 6-week trial, allergy, intolerable side effects, significant drug-drug interactions, intolerance to dosage form). Members currently stabilized on a non-preferred product may receive approval to continue therapy with that product.
Therapeutic Drug Class: NEUROCOGNITIVE DISORDER AGENTS -Effective 4/1/2022		
*Must meet eligibility criteria	PA Required	

*Donepezil 5mg, 10mg tablet	ARICEPT (donepezil) tablet	<p>*Eligibility criteria for Preferred Agents – Preferred products may be approved for a diagnosis of neurocognitive disorder (eligible for AutoPA automated approval).</p> <p>Non-preferred products may be approved if the member has failed treatment with one of the preferred products in the last 12 months. (Failure is defined as lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions)</p> <p>Members currently stabilized on a non-preferred product may receive approval to continue on that agent for one year if medically necessary and if there is a diagnosis of neurocognitive disorder.</p>
*Donepezil ODT	Donepezil 23mg tablet	
*Galantamine IR tablet	EXELON (rivastigmine) patch	
*Memantine IR tablets	Galantamine solution, ER capsule	
*Rivastigmine capsule, patch	Memantine ER capsule, IR solution	
	MESTINON (pyridostigmine) IR/ER tablet, syrup	
	NAMENDA (memantine) tablet	
	NAMENDA XR (memantine ER) capsule	
	NAMZARIC (memantine/donepezil ER) capsule	
	Pyridostigmine syrup, IR/ER tablet	
	RAZADYNE ER (galantamine) capsule	

Therapeutic Drug Class: SEDATIVE HYPNOTICS -Effective 4/1/2022

Non-Benzodiazepines

No PA Required* (unless age, dose, or duplication criteria apply)	PA Required	
	AMBIEN (zolpidem) tablet	<p>Non-preferred non-benzodiazepine sedative hypnotics may be approved for members who have failed treatment with two preferred non-benzodiazepine agents (failure is defined as lack of efficacy with a 2-week trial, allergy, intolerable side effects, or significant drug-drug interaction).</p> <p><u>Children:</u> Prior authorization will be required for all agents for children < 18 years of age.</p> <p><u>Duplications:</u> Only one agent in the sedative hypnotic drug class will be approved at a time (concomitant use of agents in the same sedative hypnotic class or differing classes will not be approved).</p> <p>All sedative hypnotics will require prior authorization for members ≥ 65 years of age when exceeding 90 days of therapy.</p> <p>Belsomra (suvorexant) may be approved for adult members that meet the following:</p> <ul style="list-style-type: none"> Members has trialed and failed therapy with two preferred agents (failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) AND Member is not receiving strong inhibitors (such as erythromycin, clarithromycin, telithromycin, itraconazole, ketoconazole, posaconazole, fluconazole, voriconazole, delavirdine, and milk thistle) or inducers (such as
Eszopiclone tablet	AMBIEN CR (zolpidem ER) tablet	
Zaleplon capsule	BELSOMRA (suvorexant) tablet	
Zolpidem IR tablet	DAYVIGO (lemoborexant) tablet	
Zolpidem ER tablet	EDLUAR (zolpidem) SL tablet	
	LUNESTA (eszopiclone) tablet	
	QUVIVIQ (daridorexant)	
	Ramelteon tablet	
	ROZEREM (ramelteon) tablet	
	Zolpidem SL tablet	

		<p>carbamazepine, oxcarbazepine, phenobarbital, phenytoin, rifampin, rifabutin, rifapentine, dexamethasone, efavirenz, etravirine, nevirapine, darunavir/ritonavir, ritonavir, and St John's Wort) of CYP3A4 AND</p> <ul style="list-style-type: none"> Member does not have a diagnosis of narcolepsy <p>Dayvigo (lemborexant) may be approved for adult member that meet the following:</p> <ul style="list-style-type: none"> Member has trialed and failed therapy with two preferred agents AND Belsonra (suvorexant). Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction AND Member is not receiving strong inhibitors (such as erythromycin, clarithromycin, telithromycin, itraconazole, ketoconazole, posaconazole, fluconazole, voriconazole, delavirdine, and milk thistle) or inducers (such as carbamazepine, oxcarbazepine, phenobarbital, phenytoin, rifampin, rifabutin, rifapentine, dexamethasone, efavirenz, etravirine, nevirapine, darunavir/ritonavir, ritonavir, and St John's Wort) of CYP3A4 AND Member does not have a diagnosis of narcolepsy <p>Rozerem (ramelteon) may be approved for adult members with a history/concern of substance abuse or for documented concern of diversion within the household without failed treatment on a preferred agent</p> <p>Prior authorization will be required for prescribed doses exceeding maximum (Table 1).</p>
Benzodiazepines		
<p>No PA Required* (unless age, dose, or duplication criteria apply)</p> <p>Temazepam 15mg, 30mg capsule</p> <p>Triazolam tablet</p>	<p>PA Required</p> <p>Estazolam tablet</p> <p>Flurazepam capsule</p> <p>HALCION (triazolam) tablet</p> <p>RESTORIL (temazepam) capsule</p> <p>Temazepam 7.5mg, 22.5mg capsule</p>	<p>Non-preferred benzodiazepine sedative hypnotics may be approved for members who have trialed and failed therapy with two preferred benzodiazepine agents (failure is defined as lack of efficacy with a 2-week trial, allergy, intolerable side effects, or significant drug-drug interaction).</p> <p>Temazepam 7.5mg and 22.5 mg may be approved if the member has trialed and failed temazepam 15mg or 30mg AND one other preferred product (failure is defined as lack of efficacy with a 2-week trial, allergy, intolerable side effects, or significant drug-drug interaction).</p> <p><u>Children:</u> Prior authorization will be required for all sedative hypnotic agents when prescribed for children < 18 years of age.</p> <p><u>Duplications:</u> Only one agent in the sedative hypnotic drug class will be approved at a time (concomitant use of agents in the same sedative hypnotic class or differing classes will not be approved).</p> <p>All sedative hypnotics will require prior authorization for member's ≥ 65 years of age when exceeding 90 days of therapy.</p>

		<p>Members currently stabilized on a non-preferred benzodiazepine medication may receive authorization to continue that medication.</p> <p>Prior authorization will be required for prescribed doses exceeding maximum (Table 1).</p>
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Table 1: Sedative Hypnotic Maximum Dosing		
Brand	Generic	Maximum Dose
Non-Benzodiazepine		
Ambien CR	Zolpidem CR	12.5 mg/day
Ambien IR	Zolpidem IR	10 mg/day
Belsomra	Suvorexant	20 mg/day
Dayvigo	Lemborexant	10mg/day
Edluar	Zolpidem sublingual	10 mg/day
Intermezzo	Zolpidem sublingual	Men: 3.5mg/day Women: 1.75 mg/day
Lunesta	Eszopiclone	3 mg/day
Quviviq	Daridorexant	50 mg/day
Sonata	Zaleplon	20 mg/day
Rozerem	Ramelteon	8 mg/day
Benzodiazepine		
Halcion	Triazolam	0.5 mg/day
Restoril	Temazepam	30 mg/day
-	Estazolam	2 mg/day
-	Flurazepam	30 mg/day
Doral	Quazepam	15 mg/day

Therapeutic Drug Class: SKELETAL MUSCLE RELAXANTS -Effective 4/1/2022		
<p>No PA Required (if under 65 years of age)*</p> <p>Baclofen tablet</p> <p>Cyclobenzaprine 5mg and 10mg tablet</p> <p>Methocarbamol tablet</p> <p>Tizanidine tablet</p>	<p>PA Required</p> <p>AMRIX ER (cyclobenzaprine ER) capsule</p> <p>Carisoprodol tablet</p> <p>Carisoprodol/Aspirin tablet</p> <p>Chlorzoxazone tablet</p> <p>Cyclobenzaprine 7.5mg tablet, ER capsule</p> <p>DANTRIUM (dantrolene) capsule</p>	<p>All agents in this class will require a PA for members 65 years of age and older. The maximum allowable approval will be for a 7-day supply.</p> <p>Authorization for any CARISOPRODOL product will be given for a maximum 3-week one-time authorization for members with acute, painful musculoskeletal conditions who have failed treatment with three preferred products within the last 6 months.</p> <p>*Dantrolene may be approved for members 5-17 years of age who have trialed and failed‡ one preferred agent and meet the following criteria:</p> <ul style="list-style-type: none"> • Documentation of age-appropriate liver function tests AND • One of following diagnoses: Multiple Sclerosis, Cerebral Palsy, stroke, upper motor neuron disorder, or spinal cord injury

	<p>*Dantrolene capsule</p> <p>FEXMID (cyclobenzaprine) tablet</p> <p>LORZONE (chlorzoxazone) tablet</p> <p>Metaxalone tablet</p> <p>NORGESIC FORTE (orphenadrine/aspirin/caffeine) tablet</p> <p>Orphenadrine ER tablet</p> <p>SKELAXIN (metaxalone) tablet</p> <p>SOMA (carisoprodol) tablet</p> <p>Tizanidine capsule</p> <p>ZANAFLEX (tizanidine) capsule, tablet</p>	<ul style="list-style-type: none"> Dantrolene will be approved for the period of one year If a member is stabilized on dantrolene at <18 years of age, they may continue to receive approval after turning 18 years of age <p>All other non-preferred skeletal muscle relaxants may be approved for members who have trialed and failed‡ three preferred agents. ‡Failure is defined as: lack of efficacy with 14 day trial, allergy, intolerable side effects, contraindication to, or significant drug-drug interactions.</p>
Therapeutic Drug Class: STIMULANTS AND RELATED AGENTS -Effective 4/1/2022		
<p>*No PA Required (if age, max daily dose, and diagnosis met)</p> <p>ADDERALL XR^{BNR} (mixed amphetamine salts ER) capsule</p> <p>Amphetamine salts, mixed (generic Adderall) tablet</p> <p>Armodafinil tablet</p> <p>Atomoxetine capsule</p> <p>CONCERTA^{BNR} (methylphenidate ER) tablet</p> <p>Dexmethylphenidate IR tablet</p> <p>Dexmethylphenidate ER capsule</p> <p>Guanfacine ER tablet</p>	<p>PA Required</p> <p>ADDERALL (amphetamine salts, mixed) tablet</p> <p>ADHANSIA XR (methylphenidate ER) capsule</p> <p>ADZENYS ER (amphetamine) suspension</p> <p>ADZENYS XR-ODT (amphetamine)</p> <p>Amphetamine salts, mixed ER (generic Adderall XR) capsule,</p> <p>Amphetamine tablet (generic Evekeo), ER suspension (generic Adzenys)</p> <p>APTENSIO XR (methylphenidate ER) capsule</p> <p>ASTARYS (serdexmethylphenidate/dexmethylphenidate) capsule</p> <p>Clonidine ER tablet</p>	<p>*Preferred medications may be approved through AutoPA for indications listed in Table 1 (preferred medications may also receive approval for off-label use for fatigue associated with multiple sclerosis).</p> <p>Non-preferred medications may be approved for members meeting the following criteria (for Sunosi (solriamfetol) and Wakix (pitolisant), refer to specific criteria listed below):</p> <ul style="list-style-type: none"> Prescription meets indication/age limitation criteria (Table 1) AND If member is ≥ 6 years of age: <ul style="list-style-type: none"> Has documented trial and failure‡ with three preferred products in the last 24 months AND For members unable to swallow solid oral dosage forms, two of the trials must include preferred products that may be administered without swallowing whole (methylphenidate solution, dexmethylphenidate ER, Vyvanse, or Adderall XR) OR If member is 3 –5 years of age: <ul style="list-style-type: none"> Has documented trial and failure‡ with one preferred product in the last 24 months AND For members unable to swallow solid oral dosage forms, the trial medication must include a preferred product that may be

Methylphenidate (generic Methylin/Ritalin) solution, tablet Methylphenidate ER 36mg tablet (generic Concerta) (<i>Patriot only</i>) Modafinil tablet VYVANSE (lisdexamfetamine) capsule	COTEMPLA XR-ODT (methylphenidate ER) DAYTRANA (methylphenidate) patch DESOXYN (methamphetamine) tablet DEXEDRINE (dextroamphetamine) Spansule Dextroamphetamine ER capsule, solution, tablet DYANAVEL XR (amphetamine) suspension EVEKEO (amphetamine) ODT, tablet FOCALIN (dexmethylphenidate) tablet FOCALIN XR (dexmethylphenidate) capsule INTUNIV (guanfacine ER) tablet JORNAY PM (methylphenidate) capsule Methamphetamine tablet METHYLIN (methylphenidate) solution Methylphenidate CD/ER/LA capsule, tablet, chewable tablet, ER, tablet (generic Relexxi/Ritalin) Methylphenidate ER 18mg, 27mg, 54mg tablet (generic Concerta) Methylphenidate ER 36mg tablet (generic Concerta) (all manufacturers except <i>Patriot</i>) Methylphenidate ER 72 mg tablet MYDAYIS ER (dextroamphetamine/ amphetamine) capsule NUVIGIL (armodafinil) tablet PROCENTRA (dextroamphetamine) solution PROVIGIL (modafinil) tablet	administered without swallowing whole (methylphenidate solution, dexmethylphenidate ER, Vyvanse, or Adderall XR). SUNOSI (solriamfetol) prior authorization may be approved if member meets the following criteria: <ul style="list-style-type: none"> • Member is 18 years of age or older AND • Member has diagnosis of either narcolepsy or obstructive sleep apnea (OSA) and is experiencing excessive daytime sleepiness AND • Member does not have end stage renal disease AND • If Sunosi is being prescribed for OSA, member has 1 month trial of CPAP AND • Member has trial and failure[‡] of modafinil AND armodafinil AND one other agent in stimulant PDL class. WAKIX (pitolisant) prior authorization may be approved if member meets the following criteria: <ul style="list-style-type: none"> • Member is 18 years of age or older AND • Member has diagnosis of narcolepsy and is experiencing excessive daytime sleepiness AND • Member does not have end stage renal disease (eGFR <15 mL/minute) AND • Member does not have severe hepatic impairment AND • Member does not have a history of QT interval prolongation AND • Member has trial and failure[‡] of modafinil AND armodafinil AND one other agent in the stimulant PDL class AND • Member has been counseled that Wakix may reduce the efficacy of hormonal contraceptives and regarding use an alternative non-hormonal method of contraception during Wakix therapy and for at least 21 days after discontinuing treatment. Maximum Dose (all products): See Table 2 Exceeding Max Dose: Prior authorization may be approved for doses that are higher than the listed maximum dose (Table 2) for members meeting the following criteria: <ul style="list-style-type: none"> • Member is taking medication for indicated use listed in Table 1 AND • Member has 30-day trial and failure[‡] of three different preferred or non- preferred agents at maximum doses listed in Table 2 AND • Documentation of member's symptom response to maximum doses of three other agents is provided AND • Member is not taking a sedative hypnotic medication (such as temazepam, triazolam, or zolpidem from the Sedative Hypnotic PDL class).
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	<p>QELBREE (viloxazine ER) capsule</p> <p>QUILLICHEW ER (methylphenidate) chewable tablet</p> <p>QUILLIVANT XR (methylphenidate) suspension</p> <p>RELEXXII (methylphenidate ER) tablet</p> <p>RITALIN (methylphenidate) IR/ER tablet</p> <p>RITALIN LA (methylphenidate ER) capsule</p> <p>STRATTERA (atomoxetine) capsule</p> <p>SUNOSI (solriamfetol) tablet</p> <p>VYVANSE (lisdexamfetamine) chewable tablet</p> <p>WAKIX (pitolisant) tablet</p> <p>ZENZEDI (dextroamphetamine) tablet</p>	<p>‡Failure is defined as: lack of efficacy with 4-week trial, allergy, intolerable side effects, or significant drug-drug interaction.</p>
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Table 1: Diagnosis and Age Limitations

- Approval for medically accepted indications not listed in Table 1 may be given with prior authorization review and may require submission of peer-reviewed literature or medical compendia showing safety and efficacy of the medication used for the prescribed indication.
- Preferred medications may also receive approval for off-label use for fatigue associated with multiple sclerosis if meeting all other criteria for approval.
- **Bolded drug names are preferred** (subject to preferential coverage changes for brand/generic equivalents)

Drug	Diagnosis and Age Limitations
Stimulants–Immediate Release	
Amphetamine sulfate (EVEKEO)	ADHD (Age ≥ 3 years), Narcolepsy (Age ≥ 6 years)
Dexmethylphenidate IR (FOCALIN)	ADHD (Age ≥ 6 years)
Dextroamphetamine IR (ZENZEDI)	ADHD (Age 3 to ≤ 16 years), Narcolepsy (Age ≥ 6 years)
Dextroamphetamine solution (PROCENTRA)	ADHD (Age 3 to ≤ 16 years), Narcolepsy (Age ≥ 6 years)
Methamphetamine (DESOXYN)	ADHD (Age ≥ 6 years)
methylphenidate IR (generic METHYLIN, RITALIN)	<p>ADHD (Age ≥ 6 years[†]), Narcolepsy (Age ≥ 6 years), OSA.</p> <p>[†]Prior Authorization for members 3-6 years of age with a diagnosis of ADHD may be approved with prescriber attestation to the following:</p> <ul style="list-style-type: none"> • Member’s symptoms have not significantly improved despite adequate behavior interventions AND • Member experiences moderate-to-severe continued disturbance in functioning AND

	<ul style="list-style-type: none"> Prescriber has determined that the potential benefits of starting methylphenidate before the age of 6 years outweigh the potential harm of delaying treatment.
Mixed amphetamine salts IR (generic ADDERALL)	ADHD (Age ≥ 3 years), Narcolepsy (Age ≥ 6 years)
Stimulants –Extended-Release	
Amphetamine ER (ADZENYS XR-ODT and ADZENYS ER suspension)	ADHD (Age ≥ 6 years)
Amphetamine ER (DYANAVEL XR)	ADHD (Age ≥ 6 years)
Mixed-amphetamine salts ER (ADDERALL XR)	ADHD (Age ≥ 6 years)
Dexmethylphenidate ER (generic Focalin XR)	ADHD (Age ≥ 6 years)
Dextroamphetamine ER (DEXEDRINE)	ADHD (Age 6 to ≤ 16 years), Narcolepsy (Age ≥ 6 years)
Dextroamphetamine ER/amphetamine ER (MYDAYIS ER)	ADHD (Age ≥ 13 years)
Dextroamphetamine IR and ER (DEXTROSTAT)	ADHD and Narcolepsy (IR ≥ 3 years, ER ≥ 6 years)
Lisdexamfetamine dimesylate (VYVANSE capsule , Vyvanse chewable)	ADHD (Age ≥ 6 years), Moderate to severe binge eating disorder in adults (Age ≥ 18 years)
Methylphenidate ER OROS (CONCERTA)	ADHD (Age ≥ 6 years), Narcolepsy (Age ≥ 6 years), OSA
Methylphenidate patch (DAYTRANA)	ADHD (Age ≥ 6 years)
Methylphenidate SR (METADATE ER)	ADHD (Age ≥ 6 years), Narcolepsy (Age ≥ 6 years)
Methylphenidate ER (METADATE CD)	ADHD (Age ≥ 6 years)
Methylphenidate ER (QUILLICHEW ER)	ADHD (Age 6 years to ≤ 65 years), Narcolepsy (Age ≥ 6 years)
Methylphenidate ER (QUILLIVANT XR)	ADHD (Age ≥ 6 years), Narcolepsy (Age ≥ 6 years)
Methylphenidate ER (RITALIN LA)	ADHD (Age ≥ 6 years)
Methylphenidate ER (ADHANSIA XR)	ADHD (Age ≥ 6 years)
Non-Stimulants	
Atomoxetine (generic STRATTERA)	ADHD (Age ≥ 6 years)
Clonidine ER (KAPVAY)	ADHD (Age ≥ 6 years), Treatment of ADHD as adjunct to stimulants
Guanfacine ER (generic INTUNIV)	ADHD (Age ≥ 6 years), Treatment of ADHD as adjunct to stimulants
Viloxazine ER (QELBREE)	ADHD (Age 6 years to ≤ 17 years)
Wakefulness-promoting Agents	
Armodafinil (generic NUVIGIL)	Excessive sleepiness associated with narcolepsy, OSA, and SWD (Age ≥ 18 years)
Modafinil (PROVIGIL)	Excessive sleepiness associated with narcolepsy, OSA, SWD, and adjunct therapy to treat fatigue and sleepiness in patients with major depressive disorder (MDD) (Age ≥ 18 years)
Pitolisant (WAKIX)	Excessive sleepiness associated with narcolepsy (Age ≥ 18 years)
Solriamfetol (SUNOSI)	Excessive sleepiness associated with narcolepsy, OSA (Age ≥ 18 years)
KEY: ADHD —attention-deficit/hyperactivity disorder, OSA —obstructive sleep apnea, SWD —shift work disorder	

Table 2: Maximum Dose

Drug	Maximum Daily Dose
ADDERALL	60 mg
ADDERALL XR	60 mg
ADHANSIA XR	85 mg
ADZENYS XR ODT	18.8 mg (age 6-12)
ADZENYS ER SUSPENSION	12.5 mg (age ≥ 13)
AMPHETAMINE SALTS	40 mg
APTENSIO XR	60 mg
CONCERTA	54 mg (age 6-12) or 72 mg (≥ age 13)
COTEMPLA XR-ODT	51.8 mg
DEXTROAMPHETAMINE ER	60 mg
DAYTRANA	30 mg
DESOXYN	25 mg
DEXEDRINE	60 mg
DEXTROSTAT	60 mg
DYANAVEL XR	20 mg
EVEKEO	60 mg
FOCALIN	20 mg
FOCALIN XR	40 mg
INTUNIV ER	4 mg (age 6-12) or 7 mg (age ≥ 13)
JORNAY PM	100 mg
KAPVAY ER	0.4 mg
METADATE CD	60 mg
METADATE ER	60 mg
METHYLIN	60 mg
METHYLIN ER	60 mg
METHYLIN SUSPENSION	60 mg
METHYLPHENIDATE	60 mg
METHYLPHENIDATE ER	60 mg
MYDAYIS ER	25 mg (age 13-17) or 50 mg (age ≥ 18)
NUVIGIL	250 mg
PROCENTRA	60 mg
PROVIGIL	400 mg
QELBREE	400 mg
QUILLICHEW ER	60 mg
QUILLIVANT XR	60 mg
RITALIN IR	60 mg
RITALIN SR	60 mg
RITALIN LA	60 mg
STRATTERA	100 mg
SUNOSI	150 mg
VYVANSE CAPSULES AND CHEWABLE TABLETS	70 mg

WAKIX		35.6 mg											
ZENZEDI		60 mg											
Therapeutic Drug Class: TRIPTANS, DITANS AND OTHER MIGRAINE TREATMENTS - Oral -Effective 4/1/2022													
No PA Required (quantity limits may apply) Eletriptan tablet (generic Relpax) Naratriptan tablet (generic Amerge) Rizatriptan tablet, ODT (generic Maxalt) Sumatriptan tablet (generic Imitrex)	PA Required Almotriptan tablet AMERGE (naratriptan) tablet FROVA (frovatriptan) tablet Frovatriptan tablet IMITREX (sumatriptan) tablet MAXALT/MAXALT MLT (rizatriptan) tablet, ODT RELPA (eletriptan) tablet REYVOW (lasmiditan) tablet Sumatriptan/Naproxen tablet TREXIMET (sumatriptan/naproxen) tablet Zolmitriptan tablet, ODT ZOMIG/ZOMIG ZMT (zolmitriptan) tablet, ODT	Non-preferred oral products may be approved for members who have trialed and failed three preferred oral products. Failure is defined as lack of efficacy with 4-week trial, allergy, documented contraindication to therapy, intolerable side effects, or significant drug-drug interaction. <u>Note:</u> The safety, tolerability, and efficacy of coadministering lasmiditan with a triptan or a gepant has not been assessed. Quantity Limits: <table><tr><td>Amerge (naratriptan), Frova (frovatriptan), Imitrex (sumatriptan), Zomig (zolmitriptan)</td><td>Max 9 tabs/30 days</td></tr><tr><td>Treximet (sumatriptan/naproxen)</td><td>Max 9 tabs/30 days</td></tr><tr><td>Axert (almotriptan) and Relpax (eletriptan)</td><td>Max 6 tabs/30 days</td></tr><tr><td>Maxalt (rizatriptan)</td><td>Max 12 tabs/30 days</td></tr><tr><td>Reyvow (lasmiditan)</td><td>Max 8 tabs/30 days</td></tr></table>		Amerge (naratriptan), Frova (frovatriptan), Imitrex (sumatriptan), Zomig (zolmitriptan)	Max 9 tabs/30 days	Treximet (sumatriptan/naproxen)	Max 9 tabs/30 days	Axert (almotriptan) and Relpax (eletriptan)	Max 6 tabs/30 days	Maxalt (rizatriptan)	Max 12 tabs/30 days	Reyvow (lasmiditan)	Max 8 tabs/30 days
Amerge (naratriptan), Frova (frovatriptan), Imitrex (sumatriptan), Zomig (zolmitriptan)	Max 9 tabs/30 days												
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Axert (almotriptan) and Relpax (eletriptan)	Max 6 tabs/30 days												
Maxalt (rizatriptan)	Max 12 tabs/30 days												
Reyvow (lasmiditan)	Max 8 tabs/30 days												
Therapeutic Drug Class: TRIPTANS, DITANS, AND OTHER MIGRAINE TREATMENTS - Non-Oral -Effective 4/1/2022													
No PA Required (quantity limits may apply) IMITREX ^{BNR} (sumatriptan) nasal spray Sumatriptan vial Zolmitriptan nasal spray (<i>Amneal only</i>)	PA Required IMITREX (sumatriptan) cartridge, pen injector ONZETRA XSAIL (sumatriptan) nasal powder Sumatriptan cartridge, nasal spray, pen injector TOSYMRA (sumatriptan) nasal spray ZEMBRACE SYMTOUCH (sumatriptan) auto-injector Zolmitriptan nasal spray (all other manufacturers)	Zembrace Symtouch injection, Tosymra nasal spray, or Onzetra Xsail nasal powder may be approved for members who have trialed and failed one preferred non-oral triptan products AND two oral triptan agents with different active ingredients. Failure is defined as lack of efficacy with 4-week trial, allergy, intolerable side effects, significant drug-drug interaction, or documented inability to take alternative dosage form. All other non-preferred products may be approved for members who have trailed and failed one preferred non-oral triptan product AND one preferred oral triptan product. Failure is defined as lack of efficacy with 4-week trial, allergy, intolerable side effects or significant drug-drug interactions, documented inability to tolerate dosage form. Quantity Limits:											

	ZOMIG (zolmitriptan) nasal spray	Imitrex (sumatriptan) injection	Max 4 injectors / 30 days
		Imitrex (sumatriptan) nasal spray	Max 6 inhalers / 30 days
		Onzetra Xsail (sumatriptan) nasal powder	Max 16 nosepieces / 30 days
		Tosymra (sumatriptan) nasal spray	Max 12 nasal spray devices / 30 days
		Zembrace Symtouch (sumatriptan) injection	Max 36mg / 30 days
		Zomig (zolmitriptan) nasal spray	Max 6 inhalers / 30 days

V. Dermatological

Therapeutic Drug Class: ACNE AGENTS– Topical -Effective 7/1/2021

No PA Required (if age and diagnosis criteria are met*)	PA Required	
<p><i>Brand/generic changes effective 8/10/21</i></p> <p>*ACZONE (dapson) gel</p> <p>*Adapalene gel</p> <p>*Adapalene/benzoyl peroxide (generic Epiduo)</p> <p>*Clindamycin phosphate solution, medicated swab</p> <p>*Clindamycin/benzoyl peroxide gel jar (generic Benzacilin)</p> <p>*Clindamycin/benzoyl peroxide (generic Duac)</p> <p>*Dapsone gel</p> <p>*DIFFERIN^{BNR} (adapalene) gel pump</p> <p>*Erythromycin solution</p> <p>*Erythromycin / Benzoyl peroxide</p> <p>*Sulfacetamide sodium suspension</p> <p>*RETIN-A^{BNR} (tretinoin) cream, gel</p>	<p>ACANYA (clindamycin/benzoyl peroxide) gel, pump</p> <p>ACZONE (dapson) pump</p> <p>Adapalene cream, gel pump, solution</p> <p>AKLIEF (trifarotene) cream</p> <p>AKTIPAK (erythromycin/benzoyl peroxide)</p> <p>ALTRENO (tretinoin) lotion</p> <p>AMZEEQ (minocycline) foam</p> <p>ARAZLO (tazarotene) lotion</p> <p>ATRALIN (tretinoin) gel</p> <p>AVITA (tretinoin)</p> <p>AZELEX (azelaic acid) cream</p> <p>BENZACLIN (clindamycin/benzoyl peroxide) (all products)</p> <p>BENZAMYCIN (erythromycin) gel</p> <p>CLEOCIN (clindamycin) gel, lotion, pledgets, solution</p> <p>CLINDACIN (clindamycin phosphate)</p> <p>CLINAGEL (clindamycin phosphate) gel</p>	<p>Authorization for all acne agents prescribed solely for cosmetic purposes will not be approved.</p> <p>Preferred topical clindamycin and erythromycin products may be approved by AutoPA verification of ICD-10 diagnosis code for acne vulgaris, psoriasis, cystic acne, comedonal acne, disorders of keratinization, neoplasms, folliculitis, hidradenitis suppurativa, or perioral dermatitis (erythromycin only). Approval of preferred topical clindamycin and erythromycin products for other medically accepted indications may be considered following clinical prior authorization review by a call center pharmacist.</p> <p>All other preferred topical acne agents may be approved if meeting the following criteria:</p> <ul style="list-style-type: none"> For members > 25 years of age, may be approved following prescriber verification that the medication is not being utilized for cosmetic purposes AND prescriber verification that the indicated use is for acne vulgaris, psoriasis, cystic acne, disorders of keratinization, neoplasms, or comedonal acne. These medications are only eligible for prior authorization approval for the aforementioned diagnoses. For members ≤ 25 years of age, may be approved for a diagnosis of acne vulgaris, psoriasis, cystic acne, disorders of keratinization, neoplasms, or comedonal acne. Diagnosis will be verified through automated verification (AutoPA) of the appropriate corresponding ICD-10 diagnosis code related to the indicated use of the medication. <p>Non-preferred topical products may be approved for members meeting all of the following criteria:</p> <ul style="list-style-type: none"> Member has trialed/failed three preferred topical products with different mechanisms (such as tretinoin, antibiotic). Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction AND Prescriber verification that the medication is being prescribed for one of the following diagnoses: acne vulgaris, psoriasis, cystic acne, disorders of keratinization, neoplasms, or comedonal acne.

	<p>Clindamycin phosphate gel, lotion, foam</p> <p>Clindamycin/tretinoin</p> <p>Dapsone pump</p> <p>DIFFERIN (adapalene) cream, lotion</p> <p>EPIDUO FORTE (adapalene/benzoyl peroxide)</p> <p>ERY/ERYGEL (erythromycin/ethanol)</p> <p>Erythromycin gel, med swab</p> <p>EVOCLIN (clindamycin) foam</p> <p>FABIOR (tazarotene) foam</p> <p>KLARON (sulfacetamide) suspension</p> <p>NEUAC (clindamycin/benzoyl peroxide) gel</p> <p>ONEXTON (clindamycin/benzoyl peroxide)</p> <p>RETIN-A MICRO (tretinoin) (all products)</p> <p>ROSULA (sulfacetamide sodium/ sulfur) cloths, wash</p> <p>Sulfacetamide sodium cleansing gel, lotion, shampoo, wash</p> <p>Sulfacetamide sodium/ sulfur cleanser, cream, pad, suspension, wash</p> <p>SUMADAN (sulfacetamide sodium/sulfur) kit, wash</p> <p>SUMAXIN (sulfacetamide sodium/sulfur kit, pads, suspension, wash</p> <p>Tazarotene cream</p> <p>TAZORAC (tazarotene) cream, gel</p>	
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	Tretinoin (all products) Tretinoin microspheres (all products) ZIANA (clindamycin/tretinoin) gel	
Therapeutic Drug Class: ACNE AGENTS– ORAL ISOTRETINOIN -Effective 7/1/2021		
PA Required for all agents		<i>Preferred product criteria update (effective 1/1/22):</i> Preferred products may be approved for adults and children ≥ 12 years of age for treating severe acne vulgaris or for treating moderate acne vulgaris in members unresponsive to conventional therapy. Non-preferred products may be approved for members meeting the following: <ul style="list-style-type: none"> Member has trialed/failed two preferred agents (failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) AND Member is an adult or child ≥ 12 years of age with severe, recalcitrant nodulocystic acne and has been unresponsive to conventional therapy.
AMNESTEEM capsule CLARAVIS capsule	ABSORICA capsule ABSORICA LD capsule Isotretinoin capsule MYORISAN capsule ZENATANE capsule	
Therapeutic Drug Class: ANTI-PSORIATICS - Oral -Effective 1/1/2022		
No PA Required	PA Required	
Acitretin capsule	Methoxsalen capsule OXSORALEN-ULTRA (methoxsalen) capsule SORIATANE (acitretin) capsule	Prior authorization for non-preferred oral agents may be approved with failure of two preferred anti-psoriatic agents, one of which must be a preferred oral agent. Failure is defined as lack of efficacy of a 4-week trial, allergy, intolerable side effects or significant drug-drug interaction.
Therapeutic Drug Class: ANTI-PSORIATICS -Topical -Effective 1/1/2022		
No PA Required	PA Required	
Calcipotriene solution DOVONEX ^{BNR} (calcipotriene) cream TACLONEX SCALP ^{BNR} (calcipotriene/betamethasone) suspension TACLONEX ^{BNR} (calcipotriene/betamethasone) ointment	Calcipotriene cream, foam, ointment Calcipotriene/betamethasone dipropionate ointment, suspension (generic Taclonex) Calcitriol ointment DUOBRII (halobetasol/tazarotene) lotion ENSTILAR (calcipotriene/betamethasone) foam SORILUX (calcipotriene) foam VECTICAL (calcitriol) ointment	Prior authorization for non-preferred topical agents may be approved with failure of two preferred topical agents. If non-preferred topical agent being requesting is a combination product, trial of two preferred agents must include a preferred combination agent. Failure is defined as lack of efficacy of a 4-week trial, allergy, intolerable side effects or significant drug-drug interaction. Preferred and non-preferred products that contain a corticosteroid ingredient (such as betamethasone) will be limited to 4 weeks of therapy. Continued use will require one week of steroid-free time in between treatment periods. Members with >30% of their body surface area affected may not use Enstilar (calcipotriene/betamethasone DP) foam or Taclonex (calcipotriene/betamethasone DP) ointment products as safety and efficacy have not been established.
Therapeutic Drug Class: IMMUNOMODULATORS, TOPICAL – Effective 1/1/2022		

<p><i>Brand/generic changes effective 5/12/22</i></p> <p>No PA Required</p> <p>ELIDEL^{BNR} (pimecrolimus) cream</p> <p>PROTOPIC (tacrolimus) ointment</p> <p>Tacrolimus ointment</p>	<p>PA Required</p> <p>OPZELURA (ruxolitinib)</p> <p>Pimecrolimus cream</p>	<p>Non-preferred topical immunomodulator products may be approved for atopic dermatitis following adequate trial and failure‡ of one prescription topical corticosteroid AND two preferred agents. ‡Failure is defined as a lack of efficacy with one month trial, allergy, intolerable side effects, contraindication to, or significant drug-drug interactions.</p> <p>For members under 18 years of age, must be prescribed by or in consultation with a dermatologist or allergist/immunologist.</p>
Therapeutic Drug Class: ANTINEOPLASTIC AGENTS, TOPICAL – <i>Effective 7/1/2021</i>		
<p>No PA Required (unless indicated*)</p> <p>*Diclofenac 3% gel (generic Solaraze)</p> <p>Fluorouracil 5% cream (generic Efudex)</p> <p>Fluorouracil 2%, 5% solution</p>	<p>PA Required</p> <p>CARAC (fluorouracil)</p> <p>EFUDEX (fluorouracil)</p> <p>Fluorouracil 0.5% cream (generic Carac)</p> <p>PANRETIN (alitretinoin)</p> <p>PICATO (ingenol mebutate)</p> <p>TARGRETIN (bexarotene)</p> <p>TOLAK (fluorouracil)</p> <p>VALCHLOR (mechlorethamine)</p>	<p>*Diclofenac 3% gel (generic Solaraze) may be approved if the member has a diagnosis of actinic keratosis (AK).</p> <p>TARGRETIN (bexarotene) gel or VALCHLOR (mechlorethamine) gel may be approved for members who meet the following criteria:</p> <ul style="list-style-type: none"> • Member is ≥ 18 years of age AND • Member has been diagnosed with Stage IA or IB cutaneous T-cell lymphoma (CTCL) AND • Member has refractory or persistent CTCL disease after other therapies OR has not tolerated other therapies • Member and partners have been counseled on appropriate use of contraception <p>Non-preferred agents may be approved for members who have failed an adequate trial of all preferred products FDA-approved for that indication. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.</p>
Therapeutic Drug Class: ROSACEA AGENTS - <i>Effective 7/1/2021</i>		
<p>No PA Required</p> <p>FINACEA^{BNR} (azelaic acid) gel</p> <p>METROGEL^{BNR} (metronidazole)</p> <p>Metronidazole cream, lotion</p> <p>Metronidazole 0.75% gel</p>	<p>PA Required</p> <p>Azelaic acid gel</p> <p>*Doxycycline monohydrate DR capsule (generic Oracea)</p> <p>FINACEA (azelaic acid) foam</p> <p>METROCREAM (metronidazole)</p> <p>Metronidazole 1% gel, pump</p> <p>MIRVASO (brimonidine)</p>	<p>Prior authorization for non-preferred products in this class may be approved if member meets the following criteria:</p> <ul style="list-style-type: none"> • Member has a diagnosis of persistent (non-transient) facial erythema with inflammatory papules and pustules due to rosacea AND • Prescriber attests that medication is not being used solely for cosmetic purposes AND • Member has tried and failed two preferred agents of different mechanisms of action (Failure is defined as lack of efficacy with 4-week trial, allergy, intolerable side effects) <p>*Oracea (doxycycline monohydrate DR) may be approved if the following criteria are met:</p>

	<p>NORITATE (metronidazole)</p> <p>*ORACEA (doxycycline monohydrate DR) capsule</p> <p>RHOFADE (oxymetazoline)</p> <p>ROSADAN (metronidazole)</p> <p>SOOLANTRA (ivermectin)</p> <p>ZILXI (minocycline)</p>	<ul style="list-style-type: none"> Member has taken generic doxycycline for a minimum of three months and failed therapy in the last 6 months. Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions AND Member has history of an adequate trial/failure (8 weeks) of 2 other preferred agents (oral or topical). Failure is defined as lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions AND Member is ≥ 18 years of age and has been diagnosed with rosacea with inflammatory lesions (papules and pustules)
Therapeutic Drug Class: TOPICAL STEROIDS – Effective 1/1/2022		
Low potency		
<p>No PA Required</p> <p>Hydrocortisone (Rx) cream, ointment, lotion</p> <p>DERMA-SMOOTHIE-FS ^{BNR} (fluocinolone) 0.01% oil</p> <p>Desonide 0.05% cream, ointment</p> <p>Fluocinolone 0.01% cream</p>	<p>PA Required</p> <p>Alclometasone 0.05% cream, ointment</p> <p>CAPEX (fluocinolone) 0.01% shampoo</p> <p>DESONATE (desonide) 0.05% gel</p> <p>Desonide 0.05% lotion</p> <p>Fluocinolone 0.01% body oil, 0.01% scalp oil, 0.01% solution</p> <p>SYNALAR (fluocinolone) 0.01% solution</p> <p>SYNALAR TS (fluocinolone/skin cleanser) Kit</p> <p>TEXACORT (hydrocortisone) 2.5% solution</p>	<p>Non-preferred Low Potency topical corticosteroids may be approved following adequate trial and failure of two preferred agents in the Low Potency class (failure is defined as lack of efficacy with 4-week trial, allergy, intolerable side effects or significant drug-drug interactions).</p>
Medium potency		
<p>No PA Required</p> <p>Betamethasone dipropionate 0.05% lotion</p> <p>Betamethasone valerate 0.1% cream, ointment</p> <p>Fluocinolone 0.025% cream</p>	<p>PA Required</p> <p>BESER (fluticasone) lotion, emollient kit</p> <p>Betamethasone dipropionate 0.05% cream</p> <p>Betamethasone valerate 0.1% lotion, 0.12% foam</p> <p>Clocortolone 0.1% cream, cream pump</p>	<p>Non-preferred Medium Potency topical corticosteroids may be approved following adequate trial and failure of two preferred agents in the Medium Potency class (failure is defined as: lack of efficacy with 4-week trial, allergy, intolerable side effects or significant drug-drug interactions).</p>

<p>Fluticasone 0.05% cream, 0.005% ointment</p> <p>Mometasone 0.1% cream, 0.1% ointment, 0.1% solution</p> <p>Triamcinolone acetonide 0.025% cream, 0.1% cream, 0.025% ointment, 0.05% ointment, 0.1% ointment, 0.025% lotion, 0.1% lotion</p>	<p>CLODERM (clocortolone) 0.1% cream, cream pump</p> <p>CUTIVATE (fluticasone) 0.05% cream, lotion</p> <p>DERMATOP (prednicarbate) 0.1% ointment</p> <p>Diflorasone 0.05% cream</p> <p>Fluocinolone 0.025% ointment</p> <p>Fluocinonide-E 0.05% cream</p> <p>Flurandrenolide 0.05% cream, lotion, ointment</p> <p>Fluticasone 0.05% lotion</p> <p>Hydrocortisone butyrate 0.1% cream, lotion, solution, ointment, lipid/lipocream</p> <p>Hydrocortisone valerate 0.2% cream, ointment</p> <p>KENALOG (triamcinolone) spray</p> <p>LOCOID (hydrocortisone butyrate) 0.1% lotion</p> <p>LOCOID LIPOCREAM (hydrocortisone butyrate-emollient) 0.1% cream</p> <p>LUXIQ (betamethasone valerate) 0.12% foam</p> <p>PANDEL (hydrocortisone probutate) 0.1% cream</p> <p>Prednicarbate 0.1% cream, ointment</p> <p>PSORCON (diflorasone) 0.05% cream</p> <p>SYNALAR (fluocinolone) 0.025% cream/kit, ointment/kit</p> <p>Triamcinolone 0.147 mg/gm spray</p>	
High potency		
<p>No PA Required (*unless exceeds duration of therapy)</p>	<p>PA Required</p> <p>Amcinonide 0.1% cream, lotion</p> <p>APEXICON-E (diflorasone/emollient) 0.05% cream</p>	<p>Non-preferred High Potency topical corticosteroids may be approved following adequate trial and failure of two preferred agents in the High Potency class (failure is defined as lack of efficacy with 4-week trial, allergy, intolerable side effects or significant drug-drug interactions).</p>

<p>*Betamethasone dipropionate/propylene glycol (augmented) 0.05% cream</p> <p>*Fluocinonide 0.05% cream, 0.05% gel, 0.05% solution, 0.05% ointment</p> <p>*Triamcinolone acetonide 0.5% cream, 0.5% ointment</p>	<p>Betamethasone dipropionate 0.05% ointment</p> <p>Desoximetasone 0.05%, 0.25% cream, 0.05% gel, 0.05%, 0.25% ointment</p> <p>Diflorasone 0.05% ointment</p> <p>Halcinonide 0.1% cream</p> <p>HALOG (halcinonide) 0.1% cream, ointment, solution</p> <p>TOPICORT (desoximetasone) 0.05%, 0.25% cream, 0.05% gel, 0.05%, 0.25% ointment</p>	<p>*All High Potency topical corticosteroids will require prior authorization beyond 4 weeks of therapy. The provider will be encouraged to transition to a medium or low potency topical steroid after this time has elapsed.</p>
Very high potency		
<p>No PA Required (unless exceeds duration of therapy*)</p> <p>*Betamethasone dipropionate/propylene glycol (augmented) 0.05% ointment</p> <p>*Clobetasol 0.05% cream, 0.05% gel, 0.05% ointment, 0.05% solution</p> <p>*Fluocinonide 0.1% cream</p>	<p>PA Required</p> <p>Betamethasone dipropionate/propylene glycol (augmented) 0.05% gel, 0.05% lotion</p> <p>BRYHALI (halobetasol) 0.01% lotion</p> <p>Clobetasol emollient/emulsion 0.05% cream, foam</p> <p>Clobetasol 0.05% lotion, foam, spray, shampoo</p> <p>CLOBEX (clobetasol) 0.05% spray, 0.05% shampoo</p> <p>CLODAN (clobetasol) 0.05% shampoo</p> <p>Desoximetasone 0.25% spray</p> <p>DIPROLENE (betamethasone dipropionate/propylene glycol, augmented) 0.05% ointment</p> <p>Halobetasol 0.05% cream, foam, ointment</p> <p>IMPEKLO (clobetasol) 0.05% lotion</p> <p>LEXETTE (halobetasol) 0.05% foam</p> <p>OLUX (clobetasol) 0.05% foam</p> <p>OLUX-E (clobetasol) 0.05% foam</p> <p>TEMOVATE (clobetasol) 0.05% cream, ointment</p>	<p>Non-preferred Very High Potency topical corticosteroids may be approved following adequate trial and failure of clobetasol propionate in the same formulation as the product being requested (if the formulation of the requested non-preferred product is not available in preferred clobetasol product options, then trial and failure of any preferred clobetasol product formulation will be required). Failure is defined as lack of efficacy with 2-week trial, allergy, intolerable side effects or significant drug-drug interactions.</p> <p>*All Very High Potency topical corticosteroids will require prior authorization beyond 2 weeks of therapy. If clobetasol propionate shampoo is being used to treat plaque psoriasis, then prior authorization will be required beyond 4 weeks of therapy. The provider will be encouraged to transition to a medium or low potency topical steroid after this time has elapsed.</p>

	<p>TOPICORT (desoximetasone) 0.25% spray</p> <p>TOVET EMOLLIENT (clobetasol) 0.05% foam</p> <p>ULTRAVATE (halobetasol) 0.05% lotion</p> <p>VANOS (fluocinonide) 0.1% cream</p>	
<h2 style="text-align: center;">VI. Endocrine</h2>		
<p style="text-align: center;">Therapeutic Drug Class: ANDROGENIC AGENTS, Topical, Injectable, Oral -Effective 7/1/2021</p>		
<p style="text-align: center;">PA Required for all agents in this class</p>		
<p>ANDRODERM (testosterone) patch</p> <p>ANDROGEL (testosterone) gel 1.62% pump^{BNR}</p> <p>ANDROGEL (testosterone) gel packet^{BNR}</p> <p>Testosterone cypionate IM injection</p> <p><i>Injectable testosterone cypionate is a pharmacy benefit when self-administered. Administration in an office setting is a medical benefit.</i></p>	<p>ANDROID (methyltestosterone) capsule</p> <p>DEPO-TESTOSTERONE (testosterone cypionate) IM injection</p> <p>FORTESTA (testosterone) gel</p> <p>JATENZO (testosterone undecanoate) capsules</p> <p>METHITEST (methyltestosterone) tablet</p> <p>Methyltestosterone capsule</p> <p>NATESTO (testosterone) nasal spray</p> <p>TESTIM (testosterone) gel</p> <p>TESTRED (methyltestosterone) capsule</p> <p>Testosterone gel, packet, pump</p> <p>Testosterone enanthate IM injection</p> <p>VOGELXO (testosterone)</p> <p>XYOSTED (testosterone enanthate) SC injection</p>	<p><u>Hypogonadotropic or Primary Hypogonadism (may be secondary to Klinefelter Syndrome):</u></p> <p>Preferred products may be approved for members meeting the following:</p> <ul style="list-style-type: none"> Member is a male patient ≥ 16 years of age with a documented diagnosis of hypogonadotropic or primary hypogonadism OR ≥ 12 years of age with a diagnosis of hypogonadotropic or primary hypogonadism secondary to Klinefelter Syndrome (all other diagnoses will require manual review) AND Member has two documented low serum testosterone levels below the lower limit of normal range for testing laboratory prior to initiation of therapy AND Member does not have a diagnosis of breast or prostate cancer AND If the member is > 40 years of age, has prostate-specific antigen (PSA) < 4 ng/mL or has no palpable prostate nodule AND Member has baseline hematocrit $< 50\%$ <p>Reauthorization Criteria (requests for renewal of a currently expiring prior authorization for a preferred product may be approved for members meeting the following criteria):</p> <ul style="list-style-type: none"> Member is a male patient ≥ 16 years of age with a documented diagnosis of hypogonadotropic or primary hypogonadism OR ≥ 12 years of age with a diagnosis of hypogonadotropic or primary hypogonadism secondary to Klinefelter Syndrome AND Serum testosterone is being regularly monitored (at least annually) to achieve total testosterone level in the middle tertile of the normal reference range AND Member does not have a diagnosis of breast or prostate cancer AND Member has a hematocrit $< 54\%$ <p><u>Gender Transition/Affirming Hormone Therapy:</u></p> <p>Preferred androgenic drugs may be approved for members meeting the following:</p> <ol style="list-style-type: none"> Female sex assigned at birth > 16 years of age AND

		<ol style="list-style-type: none"> Is undergoing female to male transition AND Has a negative pregnancy test prior to initiation AND Has baseline hematocrit < 50% or hematocrit < 54% for continuation of therapy. <p>Non-Preferred Products:</p> <p>Non-preferred topical androgenic agents may be approved for patients meeting the above criteria with trial and failed‡ therapy with two preferred topical androgen formulations.</p> <p>Non-preferred injectable androgenic agents may be approved for patients meeting the above criteria with trial and failed‡ therapy with a preferred injectable androgenic drug.</p> <p>Prior authorization for oral androgen agents (tablet, capsule, buccal) may be approved if member has trialed and failed‡ therapy with a preferred topical agent AND testosterone cypionate injection.</p> <p>‡Failure is defined as lack of efficacy with 8 week trial, allergy, intolerable side effects, contraindication to, or significant drug-drug interaction.</p> <p>For all agents and diagnoses, members < 16 years of age will require a manual prior authorization review by a pharmacist (with exception of members ≥ 12 years of age with a diagnosis of hypogonadotropic or primary hypogonadism secondary to Klinefelter Syndrome).</p>
Therapeutic Drug Class: BONE RESORPTION SUPPRESSION AND RELATED AGENTS -Effective 10/1/2021		
Bisphosphonates		
<p>No PA Required</p> <p>Alendronate tablet, solution</p> <p>Ibandronate tablet</p>	<p>PA Required</p> <p>ACTONEL (risedronate) tablet</p> <p>ATELVIA (risedronate) tablet</p> <p>BONIVA (ibandronate) tablet</p> <p>FOSAMAX (alendronate) tablet</p> <p>FOSAMAX plus D (alendronate/vit D) tablet</p> <p>Risedronate tablet</p>	<p>Non-preferred bisphosphonates may be approved for members who have failed treatment with one preferred product at treatment dose. Failure is defined as lack of efficacy with a 12-month trial, allergy, intolerable side effects, or significant drug-drug interaction.</p> <p>For members who have a low risk of fracture, discontinuation of bisphosphonate therapy and drug holiday should be considered following 5 years of treatment. Low risk is defined as having a bone mineral density, based on the most recent T-score, of greater than (better than) -2.5 AND no history of low trauma or fragility fracture.</p>
Non-Bisphosphonates		
	<p>PA Required</p> <p>Calcitonin salmon nasal spray</p>	<p>CALCITONIN SALMON (nasal) may be approved if the member meets the following criteria:</p>

	<p>FORTEO (teriparatide) SC pen</p> <p>Raloxifene tablet</p> <p>Teriparatide SC pen</p> <p>TYMLOS (abaloparatide) SC pen</p>	<ul style="list-style-type: none"> Member has a diagnosis of post-menopausal osteoporosis (BMD T-scores of -2.5 or less) AND Has trial and failure of preferred bisphosphonate for 12 months (failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) OR Member cannot swallow solid oral dosage forms or has a feeding tube. <p>Quantity limit: One spray daily</p> <p>RALOXIFENE may be approved if the member meets the following criteria:</p> <ul style="list-style-type: none"> Diagnosis of postmenopausal osteoporosis (BMD T-scores of -2.5 or less) AND Has trial and failure of preferred bisphosphonate for one year (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) <p>Maximum dose: 60mg daily</p> <p>FORTEO (teriparatide) or generic teriparatide may be approved if the member meets the following criteria:</p> <ul style="list-style-type: none"> Member has one of the following diagnoses: <ul style="list-style-type: none"> Osteoporosis, (BMD T-scores of -2.5 or less) primary or hypogonadal in men Osteoporosis due to corticosteroid use Postmenopausal osteoporosis <p>AND</p> <ul style="list-style-type: none"> Member is post-menopausal with very high risk for fracture* OR member has history of trial and failure of a preferred bisphosphonate for one year. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction AND For brand FORTEO, member has trialed and failed generic teriparatide. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction AND Prior authorization will be given for one year and total exposure of parathyroid hormone analogs (Forteo and Tymlos) shall not exceed two years <p>Maximum dose: 20mcg daily</p> <p>TYMLOS (abaloparatide) may be approved if the member meets the following criteria:</p> <ul style="list-style-type: none"> Member has a diagnosis of postmenopausal osteoporosis (BMD T-scores of -2.5 or less) AND Member is post-menopausal with very high risk for fracture* OR member has history of trial and failure of a preferred bisphosphonate for one year (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) AND Prior authorization will be given for one year and total exposure of parathyroid hormone analogs (Forteo and Tymlos) shall not exceed two years. <p>Maximum dose: 80 mcg daily</p> <p>All other non-preferred non-bisphosphonates may be approved for members who have failed treatment with one preferred bisphosphonate product at treatment dose. Failure is defined as lack of efficacy with a 12-month trial, allergy, unable to use oral therapy, intolerable side effects, or significant drug-drug interaction.</p>
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*Members at very high risk for fracture: Members will be considered at very high risk for fracture if they meet one of the following:

- A history of fracture within the past 12 months **OR**
- Fractures experienced while receiving guideline-supported osteoporosis therapy **OR**
- A history of multiple fractures **OR**
- A history of fractures experienced while receiving medications that cause skeletal harm (such as long-term glucocorticoids) **OR**
- A very low T-score (less than -3.0) **OR**
- A high risk for falls or a history of injurious falls **OR**
- A very high fracture probability by FRAX (> 30% for a major osteoporosis fracture or > 4.5% for hip fracture)

Note: Prior authorization criteria for Prolia (denosumab) and other injectable bone resorption and related agents are listed on Appendix P.

Therapeutic Drug Class: CONTRACEPTIVES - Oral Effective 10/1/2021

Effective 01/14/22, oral contraceptive products are eligible for coverage with a written prescription by an enrolled pharmacist. Additional information regarding pharmacist enrollment can be found at <https://hcpf.colorado.gov/pharm-serv>.

No PA Required		PA Required	Non-preferred oral contraceptive products may be approved if member fails one-month trial with four preferred agents OR if preferred products with medically necessary ingredients and/or doses are unavailable. Failure is defined as: allergy, intolerable side effects, or significant drug-drug interaction.
No PA Required <u>Monophasic 28:</u>	No PA Required <u>Biphasic:</u>	All other rebateable oral contraceptive products are non-preferred	
Altavera 28 0.15-30 Apri 28 0.15-30 Aubra 28 0.1-20 Aubra EQ-28 0.1-20 Aviane 28 0.1-20 Balziva 28 0.4-35 Cryselle 28 0.3-30 Cyclofem 28 1-35 Dasetta 28 1-35 Drospirenone-EE 28 0.3-30 Drospirenone-EE-Levomefolate 28 3-20 Drospirenone-EE-Levomefolate 28 3-30 Elinest 28 0.3-30 Enskyce 28 0.15-30 Estarylla 28 0.25-35 Ethynodiol-EE 28 1-50 Falmina 28 0.1-20 Femynor 28 0.25-35 Isibloom 28 0.15-30	Azurette 28 Bekyree 28 Cyred 28 Desogestrel-EE 28 Emoquette 28 Kariva 28 Lo Loestrin FE 28 1-10 Mircette 28 Violele 28 <u>Triphasic:</u> Alyacen 7-7-7 28 Caziant 7-7-7 28 Cyclofem 7-7-7 28 Dasetta 7-7-7 28 Enpresse 28 Levonest 28 Levonorgestrel-EE Triphasic 28 Norgestimate-EE 0.18-0.215-0.25/0.025 Norgestimate-EE 0.18-0.215-0.25/0.035 Nortrel Triphasic 28 Pirmella 7-7-7		<u>Prescription Contraceptive Products 12-Month Supply:</u> Initial fills of oral contraceptive products may be dispensed for up to a three-month supply to establish tolerance (lack of adverse events). If the prescribed medication is tolerated for at least three months of therapy, subsequent fills of that medication will be eligible to be filled for up to a twelve-month supply.

<p> Juleber 28 0.15-30 Kelnor 28 1-35 Kurvelo 28 0.15-30 Larissia 28 0.1-20 Lessina 28 0.1-20 Levonorgestrel-EE 28 0.1-20 Levonorgestrel-EE 28 0.15-30 Levora 28 0.15-30 Lillow 28 0.15-30 Low-Ogestrel 28 0.3-30 Lutera 28 0.1-20 Marlissa 28 0.15-30 Mili 28 0.25-35 Mono-Linyah 28 0.25-35 Necon 28 0.5-35 Norgestimate-EE 28 0.25-35 Nortrel 28 0.5-35 Nortrel 28 1-35 Ocella 28 3-30 Orsythia 28 1-20 Philith 28 0.4-35 Pirmella 28 1-35 Portia 28 0.15-30 No PA Required Previfem 28 0.25-35 Sprintec 28 0.25-35 Sronyx 28 0.1-20 Syeda 28 3-30 Vienva 28 0.1-20 Vyfemla 28 0.4-35 Wera 28 0.5-35 <u>Monophasic 21:</u> Hailey 21 1.5-30 Junel 21 1-20 Junel 21 1.5-30 Larin 21 1-20 Larin 21 1.5-30 Norethindrone-EE 21 1-20 Nortrel 21 1-35 <u>Norethindrone Only:</u> Camila 28 0.35 Deblitane 28 0.35 Errin 28 0.35 Heather 28 0.35 Jencycla 28 0.35 </p>	<p> Tri-Estarylla 28 Tri Femynor 28 Tri-Linyah 28 Tri-Lo-Estarylla 28 Tri-Lo-Marzia 28 Tri-Lo-Mini 28 Tri-Lo-Sprintec 28 Tri-Sprintec 28 Tri-Vylibra Lo 28 Velivet 7-7-7 28 <u>Extended Cycle:</u> Amethia 91 0.03 – 0.15 – 0.01 Ashlyna 91 0.15-10-30 Iclevia 91 0.15-30 Introvale 91 0.15-30 Jolessa 91 0.15-30 Levonorgestrel-EE 91 0.1-10-20 Levonorgestrel-EE 91 0.15-0.03 Levonorgestrel-EE 91 0.15-0.03-0.01 Setlakin 91 0.15-30 <u>Continuous Cycle:</u> No PA Required Aurovela FE 1-20 Aurovela FE 1.5-30 Blisovi FE 1-20 Blisovi FE 1.5-30 Camrese Lo 1-20 Gianvi 3-20 Hailey FE 1.5-30 Hailey FE 1-20 Jasmiel 3-20 Junel FE 1-20 Junel FE 1.5-30 Junel FE 24 1-20 Larin FE 1-20 Larin FE 24 1-20 Larin FE 1.5-30 LoJaimiess 1-20 Loryna 3-20 Microgestin FE 1-20 Nikki 3-20 Norethindrone-EE-FE 24 1-20 Norethindrone-EE-FE 1-20 Tarina FE 24 1-20 </p>		
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Jolivet 28 0.35 Lyza 28 0.35 Norethindrone 28 0.35 Norlyda 28 0.35 Sharobel 28 0.35 *EE – Ethinyl Estradiol	Tarina FE 1-20 Tarina FE 1-20 EQ *EE – Ethinyl Estradiol		
Therapeutic Drug Class: CONTRACEPTIVES - Topical <i>Effective 10/1/2021</i>			
Effective 01/14/22, topical contraceptive patch products are eligible for coverage with a written prescription by an enrolled pharmacist. Additional information regarding pharmacist enrollment can be found at https://hcpf.colorado.gov/pharm-serv .			
No PA Required ANNOVERA (segesterone acetate/EE) vaginal ring NUVARING ^{BNR} (etonorgestrel/EE) vaginal ring XULANE (norgestromin/EE) TD patch *EE – Ethinyl Estradiol	PA Required Etonorgestrel/EE vaginal ring PHEXXI (lactic acid/citric/potassium) vaginal gel TWIRLA (levonorgestrel/EE) TD patch ZAFEMY (norgestromin/EE) TD patch	Non-preferred topical contraceptive products may be approved following a trial and failure of one preferred topical contraceptive product. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction. PHEXXI (lactic acid/citric acid/potassium) vaginal gel may be approved for members who meet the following criteria: <ul style="list-style-type: none">Medication is being prescribed for the prevention of pregnancy ANDMember is unable to use any of the following methods of contraception due to failure, contraindication, intolerance, or preference:<ul style="list-style-type: none">Injection (such as medroxyprogesterone acetate)Oral ContraceptiveTransdermal PatchVaginal Contraceptive RingDiaphragmCervical Cap AND <ul style="list-style-type: none">PHEXXI (lactic acid/citric acid/potassium) is not being prescribed concomitantly with a vaginal ring product, ANDProvider attests that member has been counseled regarding a higher rate of pregnancy prevention with the use of other methods of contraception (such as injection, oral contraception, transdermal patch, vaginal ring) as compared to PHEXXI. <u>Prescription Contraceptive Products 12-Month Supply:</u> Initial fills of patch and vaginal ring contraceptive products may be dispensed for up to a three-month supply to establish tolerance (lack of adverse events). If the prescribed medication is tolerated for at least three months of therapy, subsequent fills of that medication will be eligible to be filled for up to a twelve-month supply. <i>Note: Depot and IUD formulations are billed through the medical benefit.</i>	
Therapeutic Drug Class: DIABETES MANAGEMENT CLASSES, INSULINS- <i>Effective 10/1/2021</i>			
Rapid-Acting			
No PA Required	PA Required		

<p><i>Brand/generic changes effective 5/12/22</i></p> <p>HUMALOG (insulin lispro) 100 U/mL cartridge, vial, KwikPen, pen</p> <p>HUMALOG Jr. (insulin lispro) KwikPen</p> <p>Insulin aspart cartridge, pen, vial</p> <p>Insulin lispro pen, vial</p> <p>Insulin lispro, Jr. Kwikpen</p> <p>NOVOLOG (insulin aspart) cartridge, vial, FlexTouch pen</p>	<p>ADMELOG (insulin lispro) Solostar pen, vial</p> <p>AFREZZA (regular insulin) cartridge, unit</p> <p>APIDRA (insulin glulisine) Solostar pen, vial</p> <p>FIASP (insulin aspart) FlexTouch pen, PenFill, vial</p> <p>HUMALOG (insulin lispro) 200 U/mL pen</p> <p>LYUMJEV (insulin lispro-aabc) Kwikpen, vial</p>	<p>Non-preferred products may be approved following trial and failure of treatment with two preferred products (failure is defined as allergy [hives, maculopapular rash, erythema multiforme, pustular rash, severe hypotension, bronchospasm, and angioedema] or intolerable side effects).</p> <p>Afrezza (human insulin) may be approved if meeting the following criteria:</p> <ul style="list-style-type: none"> • Member is 18 years or older AND • Member has trialed and failed treatment with two preferred products (failure is defined as allergy [hives, maculopapular rash, erythema multiforme, pustular rash, severe hypotension, bronchospasm, or angioedema] or intolerable side effects) AND • Member must not have chronic lung disease such as COPD or asthma AND • If member has type 1 diabetes, must use in conjunction with long-acting insulin AND • Member must not be a smoker
Short-Acting		
<p>No PA Required</p> <p>HUMULIN R U-100 (insulin regular) vial (OTC)</p> <p>HUMULIN R U-500 (insulin regular) concentrated vial, Kwikpen</p> <p>NOVOLIN R U-100 (insulin regular) FlexPen (OTC)</p>	<p>PA Required</p> <p>HUMULIN R U-100 (insulin regular) KwikPen (OTC)</p> <p>NOVOLIN R U-100 (insulin regular) vial (OTC)</p>	<p>Non-preferred products may be approved following trial and failure of treatment with one preferred product (failure is defined as allergy or intolerable side effects).</p>
Intermediate-Acting		
<p>No PA Required</p> <p>HUMULIN N U-100 (insulin NPH) vial (OTC)</p> <p>NOVOLIN N U-100 (insulin NPH) FlexPen (OTC)</p>	<p>PA Required</p> <p>HUMULIN N U-100 (insulin NPH) KwikPen (OTC)</p> <p>NOVOLIN N U-100 (insulin NPH) vial (OTC)</p>	<p>Non-preferred products may be approved following trial and failure of treatment with one preferred product (failure is defined as allergy or intolerable side effects).</p>
Long-Acting		
<p>No PA Required</p> <p>LANTUS (insulin glargine) vial, Solostar</p>	<p>PA Required</p>	<p>Non-preferred products may be approved if the member has failed treatment with Levemir AND Lantus (failure is defined as allergy or intolerable side effects).</p>

LEVEMIR (insulin detemir) vial, FlexTouch	BASAGLAR (insulin glargine) KwikPen SEMGLEE (insulin glargine) pen, vial TOUJEO (insulin glargine) Solostar TOUJEO MAX (insulin glargine) Solostar TRESIBA (insulin degludec) FlexTouch, vial	
Mixtures		
No PA Required <i>Brand/generic changes effective 5/12/22</i> HUMALOG MIX 50/50 Kwikpen, vial HUMALOG MIX 75/25 Kwikpen, vial HUMULIN 70/30 (OTC) Kwikpen, vial Insulin aspart protamine/insulin aspart 70/30 FlexPen, vial (generic Novolog Mix) Insulin lispro protamine/insulin lispro 75/25 Kwikpen (generic Humalog Mix) NOVOLOG MIX 70/30 FlexPen	PA Required NOVOLOG MIX 70/30 vial NOVOLIN 70/30 FlexPen, vial (OTC)	Non-preferred products may be approved if the member has failed treatment with two of the preferred products (failure is defined as: allergy or intolerable side effects).
Therapeutic Drug Class: DIABETES MANAGEMENT CLASSES, NON- INSULINS- 10/1/2021		
Amylin		
	PA Required SYMLIN (pramlintide) pen	SYMLIN (pramlintide) may be approved following trial and failure of metformin AND trial and failure of a DPP4-inhibitor or GLP-1 analogue. Failure is defined as lack of efficacy (such as not meeting hemoglobin A1C goal despite adherence to regimen) following 3-month trial, allergy, intolerable side effects, or a significant drug-drug interaction. Prior authorization may be approved for Symlin (pramlintide) products for members with a diagnosis of Type 1 diabetes without requiring trial and failure of other products.

		Maximum Dose: Prior authorization will be required for doses exceeding FDA-approved dosing listed in product package labeling.										
Biguanides												
No PA Required Metformin 500mg, 850mg, 1000mg tablets Metformin ER 500mg, 750mg tablets (generic Glucophage XR)	PA Required FORTAMET (metformin) GLUCOPHAGE (metformin) GLUCOPHAGE XR (metformin XR) GLUMETZA ER (metformin) Metformin ER (generic Fortamet, Glumetza) RIOMET (metformin) solution RIOMET ER (metformin) suspension	Non-preferred products may be approved for members who have failed treatment with two preferred products. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction. Liquid metformin may be approved for members who meet one of the following: <ul style="list-style-type: none">Member is under the age of 12 with a feeding tube ORPrescriber confirms that member has difficulty swallowing										
Dipeptidyl Peptidase-4 Enzyme inhibitors (DPP-4is)												
*Must meet eligibility criteria *JANUVIA (sitagliptin) tablet *TRADJENTA (linagliptin) tablet	PA Required Alogliptin tablet NESINA (alogliptin) tablet ONGLYZA (saxagliptin) tablet	*Approval for preferred products require a 3-month trial of (or documented contraindication to) metformin prior to initiation of therapy. Non-preferred DPP-4 inhibitors may be approved after a member has failed a 3-month trial of metformin AND a 3-month trial of two preferred products. Failure is defined as lack of efficacy (such as not meeting hemoglobin A1C goal despite adherence to regimen), allergy, intolerable side effects, or a significant drug-drug interaction. <u>Maximum Dose:</u> Prior authorization will be required for doses exceeding the FDA-approved maximum dosing listed in the following table: <table><tr><th>DPP4</th><th>FDA-Approved Max Dose</th></tr><tr><td>Alogliptin (generic Nesina)</td><td>25 mg/day</td></tr><tr><td>Januvia (sitagliptin)</td><td>100 mg/day</td></tr><tr><td>Nesina (alogliptin)</td><td>25 mg/day</td></tr><tr><td>Onglyza (saxagliptin)</td><td>5 mg/day</td></tr></table>	DPP4	FDA-Approved Max Dose	Alogliptin (generic Nesina)	25 mg/day	Januvia (sitagliptin)	100 mg/day	Nesina (alogliptin)	25 mg/day	Onglyza (saxagliptin)	5 mg/day
DPP4	FDA-Approved Max Dose											
Alogliptin (generic Nesina)	25 mg/day											
Januvia (sitagliptin)	100 mg/day											
Nesina (alogliptin)	25 mg/day											
Onglyza (saxagliptin)	5 mg/day											

		Tradjenta (linagliptin)	5 mg/day																	
DPP-4 Inhibitors – Combination with Metformin																				
*Must meet eligibility criteria	PA Required																			
*JANUMET (sitagliptin/metformin)	Alogliptin/metformin	*Approval for preferred combination agent products require a 3-month trial of (or documented contraindication to) metformin prior to initiation of therapy.																		
*JANUMET XR (sitagliptin/metformin)	JENTADUETO (linagliptin/metformin)	Non-preferred combination products may be approved for members who have been stable on the two individual ingredients of the requested combination for three months AND have had adequate three-month trial and failure of a preferred combination agent. Failure is defined as lack of efficacy (such as not meeting hemoglobin A1C goal despite adherence to regimen), allergy, intolerable side effects, or a significant drug-drug interaction.																		
	JENTADUETO XR (linagliptin/metformin)																			
	KAZANO (alogliptin/metformin)																			
	KOMBIGLYZE (saxagliptin/metformin)																			
Glucagon-like Peptide-1 Receptor Agonists (GLP-1 Analogues)																				
*Must meet eligibility criteria	PA Required																			
*BYETTA (exenatide)	ADLYXIN (lixisenatide)	* Preferred products may be approved for members with a diagnosis of type 2 diabetes following a 3-month trial of (or documented contraindication to) metformin prior to initiation of therapy.																		
*TRULICITY (dulaglutide)	BYDUREON BCISE (exenatide ER)	Non-preferred products may be approved for members with a diagnosis of type 2 diabetes following trial and failure of a 3-month trial of metformin AND a 3-month trial of two preferred products. Failure is defined as lack of efficacy (such as not meeting hemoglobin A1C goal despite adherence to regimen), allergy, intolerable side effects, limited dexterity resulting in the inability to administer doses of a preferred product, or a significant drug-drug interaction.																		
*VICTOZA (liraglutide)	OZEMPIC (semaglutide)																			
	RYBELSUS (semaglutide)																			
		<u>Maximum Dose:</u> Prior authorization is required for all products exceeding maximum dose listed in product package labeling.																		
		<table><tr><th colspan="2">Table 1: GLP-1 Analogue Maximum Dose</th></tr><tr><td>Adlyxin (lixisenatide)</td><td>20mcg per day</td></tr><tr><td>Bydureon BCISE (exenatide)</td><td>2mg weekly</td></tr><tr><td>Byetta (exenatide)</td><td>20mcg per day</td></tr><tr><td>Ozempic (semaglutide)</td><td>1mg weekly</td></tr><tr><td>RYBELSUS (semaglutide)</td><td>14 mg daily</td></tr><tr><td>Trulicity (dulaglutide)</td><td>4.5mg weekly</td></tr><tr><td>Victoza (liraglutide)</td><td>1.8mg per day</td></tr></table>			Table 1: GLP-1 Analogue Maximum Dose		Adlyxin (lixisenatide)	20mcg per day	Bydureon BCISE (exenatide)	2mg weekly	Byetta (exenatide)	20mcg per day	Ozempic (semaglutide)	1mg weekly	RYBELSUS (semaglutide)	14 mg daily	Trulicity (dulaglutide)	4.5mg weekly	Victoza (liraglutide)	1.8mg per day
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Trulicity (dulaglutide)	4.5mg weekly																			
Victoza (liraglutide)	1.8mg per day																			
		Note: Authorization for GLP-1 analogues prescribed solely for weight loss will not be approved.																		

Other Hypoglycemic Combinations		
	<p>PA Required</p> <p>Alogliptin/pioglitazone tablet</p> <p>AVANDARYL (rosiglitazone/glimepiride)</p> <p>DUETACT (pioglitazone/glimepiride)</p> <p>Glipizide/metformin tablet</p> <p>GLUCOVANCE (glyburide/metformin)</p> <p>Glyburide/metformin tablet</p> <p>GLYXAMBI (empagliflozin/linagliptin)</p> <p>METAGLIP (glipizide/metformin)</p> <p>OSENI (alogliptin/pioglitazone)</p> <p>Pioglitazone/glimepiride</p> <p>QTERN (dapagliflozin/saxagliptin)</p> <p>SOLIQUA (insulin glargine/lixisenatide) pen</p> <p>STEGLUJAN (ertugliflozin/sitagliptin)</p> <p>TRIJARDY XR (empagliflozin/linagliptin/metformin)</p> <p>XULTOPHY (insulin degludec/liraglutide) pen</p>	<p>Non-preferred products may be approved for members who have been stable on each of the individual ingredients in the requested combination for 3 months (including cases where the ingredients are taken as two separate 3-month trials or when taken in combination for at least 3 months).</p>
Meglitinides		
	<p>PA Required</p> <p>Nateglinide</p> <p>PRANDIN (repaglinide)</p> <p>Repaglinide</p> <p>STARLIX (nateglinide)</p>	<p>Non-preferred products may be approved for members who have failed treatment with one sulfonylurea. Failure is defined as: lack of efficacy (such as not meeting hemoglobin A1C goal despite adherence to regimen), allergy, intolerable side effects, or significant drug-drug interaction.</p>
Meglitinides Combination with Metformin		

	PA Required Repaglinide/metformin	Non-preferred products may be approved for members who have been stable on the two individual ingredients of the requested combination for 3 months.
Sodium-Glucose Cotransporter 2 inhibitors (SGLT-2is)		
No PA Required FARXIGA (dapagliflozin) INVOKANA (canagliflozin) JARDIANCE (empagliflozin)	PA Required STEGLATRO (ertugliflozin)	<p>Non-preferred products may receive approval following trial and failure with two preferred products. Failure is defined as lack of efficacy with 3-month trial (such as not meeting hemoglobin A1C goal despite adherence to regimen), allergy, intolerable side effects, or a significant drug-drug interaction.</p> <p>FARXIGA (dapagliflozin), INVOKANA (canagliflozin) and JARDIANCE (empagliflozin) are contraindicated in members on dialysis. STEGLATRO (ertugliflozin) therapy is not recommended when eGFR is persistently 30 to less than 60 mL/min/1.73 m² and it is contraindicated in patients with an eGFR less than 30 mL/min/1.73 m² or on dialysis.</p> <p><u>Maximum Dose:</u> Prior authorization is required for all products exceeding maximum dose listed in product package labeling.</p>
SGLT-2 Inhibitors Combination with Metformin		
No PA Required INVOKAMET (canagliflozin/metformin) INVOKAMET XR (canagliflozin/metformin) XIGDUO XR (dapagliflozin/metformin)	PA Required SEGLUROMET (ertugliflozin/metformin) SYNJARDY (empagliflozin/metformin) SYNJARDY XR (empagliflozin/metformin)	<p>Non-preferred products may be approved for members who have been stable on the two individual ingredients of the requested combination for 3 months.</p> <p>INVOKAMET, INVOKAMET XR, SYNJARDY, SYNJARDY XR and XIGDUO XR are contraindicated in patients with an eGFR less than 30 mL/min/1.73 m² or on dialysis. SEGLUROMET therapy is not recommended when eGFR is persistently 30 to less than 60 mL/min/1.73 m² and it is contraindicated in patients with an eGFR less than 30 mL/min/1.73 m² or on dialysis.</p>
Thiazolidinediones (TZDs)		
No PA Required Pioglitazone	PA Required ACTOS (pioglitazone) AVANDIA (rosiglitazone)	Non-preferred agents may be approved following trial and failure of metformin AND trial and failure of one preferred product. Failure is defined as lack of efficacy (such as not meeting hemoglobin A1C goal despite adherence to regimen) with a 3-month trial, allergy, intolerable side effects, or a significant drug-drug interaction.
Thiazolidinediones Combination with Metformin		
	PA Required ACTOPLUS MET (pioglitazone/metformin) ACTOPLUS MET XR (pioglitazone/metformin)	Non-preferred products may be approved for members who have been stable on the two individual ingredients of the requested combination for 3 months.

	Pioglitazone/metformin																					
Therapeutic Drug Class: ESTROGEN AGENTS -Effective 10/1/2021																						
No PA Required	PA Required	<p>Non-preferred parenteral estrogen agents may be approved with trial and failure of one preferred parenteral agent. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.</p> <p>Non-preferred oral estrogen agents may be approved with trial and failure of one preferred oral agent. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.</p> <p>Non-preferred transdermal estrogen agents may be approved with trial and failure of two preferred transdermal agents. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.</p> <table><tr><th colspan="2">Table 1: Transdermal Estrogen FDA-Labeled Dosing</th></tr><tr><td>ALORA (estradiol) patch</td><td>2/week</td></tr><tr><td>CLIMARA (estradiol) patch</td><td>1/week</td></tr><tr><td>DOTTI (estradiol) patch</td><td>2/week</td></tr><tr><td>Estradiol patch (once weekly)</td><td>1/week</td></tr><tr><td>Estradiol patch (twice weekly)</td><td>2/week</td></tr><tr><td>LYLLANA (estradiol) patch</td><td>2/week</td></tr><tr><td>MENOSTAR (estradiol) patch</td><td>1/week</td></tr><tr><td>MINIVELLE (estradiol) patch</td><td>2/week</td></tr><tr><td>VIVELLE-DOT (estradiol) patch</td><td>2/week</td></tr></table> <p>Note: Estrogen agents are a covered benefit for gender transition/affirming hormone therapy.</p>	Table 1: Transdermal Estrogen FDA-Labeled Dosing		ALORA (estradiol) patch	2/week	CLIMARA (estradiol) patch	1/week	DOTTI (estradiol) patch	2/week	Estradiol patch (once weekly)	1/week	Estradiol patch (twice weekly)	2/week	LYLLANA (estradiol) patch	2/week	MENOSTAR (estradiol) patch	1/week	MINIVELLE (estradiol) patch	2/week	VIVELLE-DOT (estradiol) patch	2/week
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MENOSTAR (estradiol) patch	1/week																					
MINIVELLE (estradiol) patch	2/week																					
VIVELLE-DOT (estradiol) patch	2/week																					
Parenteral																						
DELESTROGEN ^{BNR} (estradiol valerate) vial	Estradiol valerate vial																					
DEPO-ESTRODIOL (estradiol cypionate) vial																						
Oral/Transdermal																						
CLIMARA ^{BNR} (estradiol) patch	ALORA (estradiol) patch																					
Estradiol oral tablet	DOTTI (estradiol) patch																					
MINIVELLE ^{BNR} (estradiol) patch	ESTRACE (estradiol) oral tablet																					
VIVELLE-DOT ^{BNR} (estradiol) patch	Estradiol daily patch																					
	Estradiol bi-weekly patch																					
	LYLLANA (estradiol) patch																					
	MENOSTAR (estradiol) patch																					
Therapeutic Drug Class: GLUCAGON, SELF-ADMINISTERED -Effective 10/1/2021																						
No PA Required (*Must meet eligibility criteria)	PA Required	<p>*Gvoke (glucagon) may be approved following trial and failure of GlucaGen (glucagon) OR a preferred glucagon emergency kit (failure is defined as allergy to ingredients in product, intolerable side effects, or inability to administer dosage form).</p> <p>Non-preferred products may be approved if the member has failed treatment with Gvoke (glucagon) AND one other preferred product (failure is defined as allergy to ingredients in product, intolerable side effects, or contraindication to dosing form).</p> <p>Quantity limit for second-line preferred (Gvoke) and non-preferred products: 2 doses per year unless used / damaged / lost</p>																				
GLUCAGEN HYPOKIT (glucagon)	BAQSIMI (glucagon) nasal spray																					
Glucagon Emergency Kit	Glucagon Emergency Kit (Fresenius only)																					
GVOKE (glucagon)* Hypopen, Syringe	ZEGLAOGUE (dasiglucagon) autoinjector, syringe																					

Therapeutic Drug Class: GROWTH HORMONES -Effective 4/1/2022								
<p>No PA Required (if diagnosis and dose met)</p> <p>GENOTROPIN (somatropin) cartridge, Miniquick pen</p> <p>NORDITROPIN (somatropin) Flexpro pen</p>	<p>PA Required</p> <p>HUMATROPE (somatropin) cartridge</p> <p>NUTROPIN AQ (somatropin) Nuspin injector</p> <p>OMNITROPE (somatropin) cartridge, vial</p> <p>SAIZEN (somatropin) cartridge, vial</p> <p>SEROSTIM (somatropin) vial</p> <p>SKYTROFA (lonapegsomatropin-tcgd) cartridge</p> <p>ZOMACTON (somatropin) vial</p> <p>ZORBTIVE (somatropin) vial</p>	<p>All preferred products may be approved if the member has one of the qualifying diagnoses listed below (diagnosis may be verified through AutoPA) AND if prescription does not exceed limitations for maximum dosing (Table 1).</p> <p>Non-preferred Growth Hormone products may be approved if the following criteria are met:</p> <ul style="list-style-type: none"> Member failed treatment with one preferred growth hormone product (failure is defined as lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions). Member has a qualifying diagnosis: <ul style="list-style-type: none"> Prader-Willi Syndrome (PWS) Chronic renal insufficiency/failure requiring transplantation (defined as Creatinine Clearance < 30mL/min) Turner's Syndrome Hypopituitarism: as a result of pituitary disease, hypothalamic disease, surgery, radiation therapy or trauma verified by one of the following: <ul style="list-style-type: none"> Has failed at least one GH stimulation test (peak GH level < 10 ng/mL) Has at least one documented low IGF-1 level (below normal range for patient's age – refer to range on submitted lab document) Has deficiencies in ≥ 3 pituitary axes (i.e. TSH, LH, FSH, ACTH, ADH) Cachexia associated with AIDS Noonan Syndrome Short bowel syndrome Neonatal symptomatic growth hormone deficiency (limited to 3-month PA approval) Prescription does not exceed limitations for FDA-labeled maximum dosing for prescribed indication based on prescriber submission/verification of patient weight from most recent clinical documentation <table border="1"> <caption>Table 1: Growth Hormone Product Maximum Dosing*</caption> <tr> <th>Medication</th><th>Pediatric Max Dosing (age < 18 years)</th><th>Adult Max Dosing (age ≥ 18 years)</th></tr> <tr> <td>Genotropin</td><td>0.33 mg/kg/week</td><td>0.08 mg/kg/week</td></tr> </table>	Medication	Pediatric Max Dosing (age < 18 years)	Adult Max Dosing (age ≥ 18 years)	Genotropin	0.33 mg/kg/week	0.08 mg/kg/week
Medication	Pediatric Max Dosing (age < 18 years)	Adult Max Dosing (age ≥ 18 years)						
Genotropin	0.33 mg/kg/week	0.08 mg/kg/week						

		Humatrope	0.375 mg/kg/week	0.0875 mg/kg/week
		Norditropin Flexpro	0.47 mg/kg/week	0.112 mg/kg/week
		Nutropin AQ Nuspin	0.357 mg/kg/week	0.175 mg/kg/week for ≤35 years of age 0.0875 mg/kg/week for >35 years of age
		Omnitrope	0.33 mg/kg/week	0.08 mg/kg/week
		Saizen	0.18 mg/kg/week	0.07 mg/kg/week
		Serostim	Not Indicated	42 mg/week for cachexia with HIV only (in combination with antiretroviral therapy)
		Zomacton	0.375 mg/kg/week	0.0875 mg/kg/week
		Zorbtive	Not Indicated	8 mg/28 days for short bowel syndrome only
		*Based on FDA labeled indications and dosing		

VII. Gastrointestinal

Therapeutic Drug Class: **BILE SALTS** -Effective 4/1/2022

No PA Required	PA Required	
Ursodiol capsule	BYLVAY (odevixibat) capsule, pellet	<p>Chenodal (chenodiol) and Actigall (ursodiol) may be approved for members who meet the following criteria:</p> <ul style="list-style-type: none"> Member is ≥ 18 years of age AND Member has tried and failed therapy with a 12-month trial of a preferred ursodiol product (failure is defined as lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions). <p>Cholbam (cholic acid) may be approved for members who meet the following criteria:</p> <ul style="list-style-type: none"> Bile acid synthesis disorders: <ul style="list-style-type: none"> Member age must be greater than 3 weeks old AND Member has a diagnosis for bile acid synthesis disorder due to single enzyme defect (Single Enzyme-Defect Disorders: Defective sterol nucleus synthesis, 3β-hydroxy-Δ-c27-steroid oxidoreductase deficiency, AKR1D1 deficiency, CYP7A1 deficiency, Defective side-chain synthesis, CYP27A1 deficiency (cerebrotendinous xanthomatosis), 2-methylacyl-CoA racemase deficiency (AMACR), 25-hydroxylation pathway (Smith–Lemli–Opitz). Peroxisomal disorder including Zellweger spectrum disorders: <ul style="list-style-type: none"> Member age must be greater than 3 weeks old AND Member has diagnosis of peroxisomal disorders (PDs) including Zellweger spectrum disorders AND Member has manifestations of liver disease, steatorrhea or complications from decreased fat-soluble vitamin absorption.
Ursodiol tablet	CHENODAL (chenodiol) tablet	
	CHOLBAM (cholic acid) capsule	
	LIVMARLI (maralixibat) solution	
	OCALIVA (obeticholic acid) tablet	
	RELTONE (ursodiol) capsule	
	URSO (ursodiol) tablet	
	URSO FORTE (ursodiol) tablet	

		<p>Ocaliva (obeticholic acid), Urso (ursodiol), and Urso Forte (ursodiol) may be approved for members meeting the following criteria:</p> <ul style="list-style-type: none"> • Member is ≥ 18 years of age AND • Medication is prescribed by or in consultation with a gastroenterologist, hepatologist, or liver transplant provider AND • Member has the diagnosis of Primary Biliary Cholangitis as evidenced by two of the following at the time of diagnosis: <ul style="list-style-type: none"> ○ Evidence of cholestasis with an alkaline phosphatase elevation of at least 1.5 times the upper limit of normal ○ Presence of antimitochondrial antibody with titer of 1:40 or higher ○ Histologic evidence of nonsuppurative destruction cholangitis and destruction of interlobular bile ducts AND • Due to risk of serious liver injury, member does not have Primary Biliary Cholangitis with advanced cirrhosis, AND • Member has failed treatment with a preferred ursodiol product for at least 1 year with an inadequate response OR • Member has had intolerable side effects, drug-drug interaction, or allergy to preferred ursodiol formulations. <p>All other non-preferred products may receive approval for use for FDA-labeled indications as outlined in product package labeling.</p>
Therapeutic Drug Class: ANTI-EMETICS, Oral -Effective 1/1/2022		
<p>No PA Required</p> <p>DICLEGIS DR^{BNR} tablet (doxylamine/pyridoxine)</p> <p>Meclizine (Rx) tablet</p> <p>Metoclopramide solution, tablet</p> <p>Ondansetron ODT, tablet</p> <p>Ondansetron oral suspension/ solution* (<5 years)</p> <p>Prochlorperazine tablet</p> <p>Promethazine syrup, tablet</p> <p>Trimethobenzamide capsule</p>	<p>PA Required</p> <p>AKYNZEO (netupitant/palonosetron) capsule</p> <p>ANTIVERT (meclizine) tablet</p> <p>Aprepitant capsule, tripack</p> <p>BONJESTA ER (doxylamine/pyridoxine) tablet</p> <p>Doxylamine 25mg (OTC) tablet</p> <p>Doxylamine/pyridoxine tablet (generic Diclegis)</p> <p>Dronabinol capsule</p> <p>EMEND (aprepitant) capsule, powder for suspension, dose/tri pack</p> <p>Granisetron tablet</p> <p>MARINOL (dronabinol) capsule</p>	<p>Ondansetron solution may be approved for members < 5 years and those members ≥ 5 years of age with a feeding tube.</p> <p>Emend (aprepitant) TriPack or Emend (aprepitant) powder kit may be approved following trial and failure of two preferred products AND Emend (aprepitant) <u>capsule</u>. Failure is defined as lack of efficacy with 14-day trial, allergy, intolerable side effects, or significant drug-drug interaction.</p> <p>Doxylamine/pyridoxine tablet (generic) or Bonjesta (doxylamine/pyridoxine) may be approved for 9 months if meeting the following criteria:</p> <ul style="list-style-type: none"> • Member has nausea and vomiting associated with pregnancy AND • Member has trialed and failed DICLEGIS DR tablet AND one of the following (failure is defined as lack of efficacy with a 7-day trial, allergy, intolerable side effects, or significant drug-drug interaction): <ul style="list-style-type: none"> ○ Antihistamine (such as diphenhydramine, dimenhydrinate, meclizine) OR <ul style="list-style-type: none"> ○ Dopamine antagonist (such as metoclopramide, prochlorperazine, promethazine) OR ○ Serotonin antagonist (ondansetron, granisetron)

	Metoclopramide ODT Pyridoxine 50mg or 100mg (OTC) tablet REGLAN (metoclopramide) tablet TIGAN (trimethobenzamide) capsule VARUBI (rolapitant) tablet ZOFRAN (ondansetron) tablet ZUPLENZ (ondansetron) film	All other non-preferred products may be approved for members who have trialed and failed treatment with two preferred products. Failure is defined as lack of efficacy with 14-day trial, allergy, intolerable side effects, or significant drug-drug interaction. Dronabinol prior authorization may be approved for members meeting above non-preferred criteria OR via AutoPA for members with documented HIV diagnosis.
Therapeutic Drug Class: ANTI-EMETICS, Non-Oral -Effective 1/1/2022		
No PA Required Prochlorperazine suppository Promethazine 12.5 mg, 25 mg suppository Scopolamine patch	PA Required COMPRO (prochlorperazine) suppository PROMETHEGAN 50 mg (Promethazine) suppository SANCUSO (granisetron) patch TRANSDERM-SCOP patch (scopolamine)	Non-preferred products may be approved for members who have trialed and failed treatment with two preferred products. Failure is defined as lack of efficacy with 14-day trial, allergy, intolerable side effects, or significant drug-drug interaction.
Therapeutic Drug Class: GI MOTILITY, CHRONIC -Effective 10/1/2021		
PA Required for all agents in this class		All agents will only be approved for FDA labeled indications and up to FDA approved maximum doses listed below.
AMITIZA ^{BNR} (lubiprostone) capsule LINZESS (linaclotide) capsule MOVANTIK (naloxegol) tablet	Alosetron tablet LOTRONEX (alosetron) tablet Lubiprostone capsule MOTEGRITY (prucalopride) tablet RELISTOR (methylnaltrexone) tablet, syringe SYMPROIC (naldemedine) tablet TRULANCE (plecanatide) tablet VIBERZI (eluxadoline) tablet	Preferred agents may be approved if the member meets the following criteria: <ul style="list-style-type: none"> Has diagnosis of Irritable Bowel Syndrome – Constipation (IBS-C), Chronic Idiopathic Constipation (CIC), or Opioid Induced Constipation (OIC) in patients with opioids prescribed for noncancer pain AND Member does not have a diagnosis of GI obstruction AND For indication of OIC, member opioid use must exceed 4 weeks of treatment For indications of CIC, OIC, IBS-C; member must have documentation of adequate trial of two or more over-the-counter motility agents (polyethylene glycol, docusate or bisocodyl, for example). OR If the member cannot take oral medications, then the member must fail a 7-day trial with a nonphosphate enema (docusate or bisocodyl enema). Failure is defined as a lack of efficacy for a 7 day trial, allergy, intolerable side effects, contraindication to, or significant drug-drug interaction AND For indication of IBS-D, must have documentation of adequate trial and

		<p>failure with loperamide and trial and failure with dicyclomine or hyoscyamine. Failure is defined as a lack of efficacy for a 7-day trial, allergy, intolerable side effects, contraindication to, or significant drug-drug interaction.</p> <p>Non-preferred agents may be approved if the member meets the following criteria:</p> <ul style="list-style-type: none"> • Member meets all listed criteria for preferred agents AND • Member has trialed and failed two preferred agents OR if the indication is OIC caused by methadone, then a non-preferred agent may be approved after an adequate trial of MOVANTIK (naloxegol). Failure is defined as a lack of efficacy for a 7-day trial, allergy, intolerable side effects, contraindication to, or significant drug-drug interaction AND • If prescribed Viberzi (eluxadoline) or Lotronex (alosetron), member meets the additional criteria for those agents listed below. <p>VIBERZI (eluxadoline) may be approved for members who meet the following additional criteria:</p> <ul style="list-style-type: none"> • Diagnosis of Irritable Bowel Syndrome – Diarrhea (IBS-D) AND • Member has a gallbladder AND • Member does not have severe hepatic impairment (Child-Pugh C), history of severe constipation, known mechanical gastrointestinal obstruction, biliary duct obstruction, history of pancreatitis or structural disease of the pancreas AND • Member does not drink more than 3 alcoholic drinks per day <p>LOTROXEX (alosetron) and generic alosetron may be approved for members who meet the following additional criteria:</p> <ul style="list-style-type: none"> • Member is a female with Irritable Bowel Syndrome – Diarrhea (IBS-D) with symptoms lasting 6 months or longer AND • Member does not have severe hepatic impairment (Child-Pugh C), history of severe constipation or ischemic colitis, hypercoagulable state, Crohn’s disease or ulcerative colitis, or known mechanical gastrointestinal obstruction.
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Medication	FDA approved indication	FDA Max Dose
Amitiza (lubiprostone)	IBS-C (females only), CIC, OIC (not caused by methadone)	48mcg/day
Linzess (linaclotide)	IBS-C, CIC	290mcg/day
Movantik (naloxegol)	OIC	25mg/day
Viberzi (eluxadoline)	IBS-D	200mg/day
Relistor syringe (methylnaltrexone)	OIC	12mg SQ/day
Relistor oral (methylnaltrexone)	OIC	450mg/day

	Lotronex (alosetron)	IBS-D (females only)	2mg/day (females only)
	Symproic (Naldemedine)	OIC	0.2mg/day
	Trulance (plecanatide)	CIC, IBS-C	3mg/day
	Motegrity (prucalopride)	CIC	2mg/day

CIC – chronic idiopathic constipation, OIC – opioid induced constipation, IBS – irritable bowel syndrome, D – diarrhea predominant, C – constipation predominant

Therapeutic Drug Class: H. PYLORI TREATMENTS -Effective 1/1/2022

No PA Required	PA Required	
PYLERA tablet (bismuth subcitrate/metronidazole tetracycline)	Amoxicillin/ lansoprazole/clarithromycin OMECLAMOX-PAK (amoxicillin/ omeprazole/clarithromycin) TALICIA tablet (omeprazole/amoxicillin/ rifabutin)	Non-preferred <i>H. pylori</i> treatments should be used as individual product ingredients unless one of the individual products is not commercially available, then a PA for the combination product may be given.

Therapeutic Drug Class: HEMORRHOIDAL, ANORECTAL, AND RELATED TOPICAL ANESTHETIC AGENTS - Effective 4/1/2022

Hydrocortisone single agent		
No PA Required	PA Required	
ANUSOL-HC (hydrocortisone) 2.5% cream with applicator CORTIFOAM (hydrocortisone) 10% aerosol Hydrocortisone 1% cream with applicator Hydrocortisone 2.5% cream with applicator Hydrocortisone enema PROCTO-MED HC (hydrocortisone) 2.5% cream PROCTO-PAK (hydrocortisone) 1% cream PROCTOSOL-HC 2.5% (hydrocortisone) cream	COLOCORT (hydrocortisone) enema CORTENEMA (hydrocortisone) enema MICORT-HC (hydrocortisone) cream	Non-preferred products may be approved following trial and failure of therapy with 3 preferred products (failure is defined as lack of efficacy with 4-week trial, allergy, intolerable side effects or significant drug-drug interactions).

PROCTOZONE-HC 2.5% (hydrocortisone) cream		
Lidocaine single agent		
No PA Required Lidocaine 5% ointment	PA Required Lidocaine 3% cream	
Other and Combinations		
No PA Required Lidocaine-Hydrocortisone 3-0.5% cream with applicator Lidocaine-Prilocaine Cream PROCTOFOAM-HC (hydrocortisone-pramoxine) 1%-1% foam	PA Required Hydrocortisone-Pramoxine 1%-1% cream Lidocaine-Hydrocortisone in Coleus 2%-2% cream kit Lidocaine-Hydrocortisone 2.8%-0.55% gel Lidocaine-Hydrocortisone 3%-0.5% cream w/o applicator, cream kit Lidocaine-Hydrocortisone 3%-1% cream kit Lidocaine-Hydrocortisone 3%-2.5% gel kit PLIAGIS (lidocaine-tetracaine) 7%-7% cream RECTIV (nitroglycerin) 0.4% ointment SYNERA (lidocaine-tetracaine) patch	
Therapeutic Drug Class: PANCREATIC ENZYMES -Effective 1/1/2022		
No PA Required CREON (pancrelipase) capsule PANCREAZE (pancrelipase) capsule ZENPEP (pancrelipase) capsule	PA Required PERTZYE (pancrelipase) capsule VIOKACE (pancrelipase) tablet	Non-preferred products may be approved for members who have failed an adequate trial (4 weeks) with at least two preferred products. (Failure is defined as lack of efficacy, allergy, intolerable side effects or significant drug-drug interaction.) Members currently stabilized on a Non-preferred pancreatic enzyme may receive approval to continue on that agent for one year if medically necessary.
Therapeutic Drug Class: PROTON PUMP INHIBITORS -Effective 1/1/2022		
No PA Required Esomeprazole DR capsule (RX) Lansoprazole DR capsules (RX)	PA Required ACIPHEX (rabeprazole) tablet, sprinkle capsule DEXILANT (dexlansoprazole) capsule	For members treating GERD symptoms that are controlled on PPI therapy, it is recommended that the dose of the PPI be re-evaluated or step-down with an H2 blocker (such as famotidine or ranitidine) be trialed in order to reduce long-term PPI use.

<p>NEXIUM^{BNR} (esomeprazole) oral suspension packet</p> <p>Omeprazole DR capsule (RX)</p> <p>Pantoprazole tablet</p> <p>Lansoprazole ODT (lansoprazole) <i>(for members under 2 years)</i></p>	<p>Esomeprazole DR 49.3 capsule (RX), (OTC) capsule, packet for oral suspension</p> <p>Lansoprazole DR capsule OTC</p> <p>NEXIUM (esomeprazole) capsule (RX), 24HR (OTC)</p> <p>Omeprazole/Na Bicarbonate capsule, packet for oral suspension</p> <p>Omeprazole DR tablet (OTC), ODT (OTC)</p> <p>Pantoprazole packet for oral suspension</p> <p>PREVACID (lansoprazole) capsule, Solutab, suspension</p> <p>PRILOSEC (omeprazole) suspension</p> <p>PROTONIX (pantoprazole DR) tablet, packet for oral suspension</p> <p>Rabeprazole tablet</p> <p>ZEGERID (omeprazole/Na bicarbonate) capsule, packet for oral suspension</p>	<p>Prior authorization for non-preferred proton pump inhibitors may be approved if all of the following criteria are met:</p> <ul style="list-style-type: none"> ● Member has a qualifying diagnosis (below) AND ● Member has trailed and failed therapy with three preferred agents within the last 24 months. (Failure is defined as: lack of efficacy following 4-week trial, allergy, intolerable side effects, or significant drug-drug interaction) AND ● Member has been diagnosed using one of the following diagnostic methods: <ul style="list-style-type: none"> ○ Diagnosis made by GI specialist ○ Endoscopy ○ X-ray ○ Biopsy ○ Blood test ○ Breath Test <p>Qualifying Diagnoses: Barrett's esophagus, duodenal ulcer, erosive esophagitis, gastric ulcer, GERD, GI Bleed, H. pylori infection, hypersecretory conditions (Zollinger-Ellison), NSAID-induced ulcer, pediatric esophagitis, requiring mechanical ventilation, requiring a feeding tube</p> <p>Quantity Limits: All agents will be limited to once daily dosing except when used for the following diagnoses: Barrett's esophagus, GI Bleed, H. pylori, hypersecretory conditions (Zollinger-Ellison), or members who have spinal cord injury with associated acid reflux.</p> <p>Adult members with GERD on once daily, high-dose PPI therapy who continue to experience symptoms may receive initial prior authorization approval for a 4-week trial of twice daily, high-dose PPI therapy. Continuation of the twice daily dosing regimen for GERD beyond 4 weeks will require additional prior authorization approval verifying adequate member response to the dosing regimen and approval may be placed for one year. If a member with symptomatic GERD does not respond to twice daily, high-dose PPI therapy, this should be considered a treatment failure.</p> <p>Pediatric members (< 18 years of age) on once daily dosing of a PPI who continue to experience symptoms may receive one-year prior authorization approval for twice daily PPI therapy.</p> <p>Age Limits: Nexium 24H and Zegerid will not be approved for members less than 18 years of age.</p> <p>Prevacid Solutab may be approved for members < 2 years of age OR for members ≥ 2 years of age with a feeding tube.</p>
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Therapeutic Drug Class: NON-BIOLOGIC ULCERATIVE COLITIS AGENTS- Oral -Effective 1/1/2022		
No PA Required APRISO ^{BNR} (mesalamine ER) capsule LIALDA ^{BNR} (mesalamine DR) tablet PENTASA (mesalamine) capsule Sulfasalazine IR and DR tablet	PA Required ASACOL HD (mesalamine DR) tablet AZULFIDINE (sulfasalazine) Entab, tablet Balsalazide capsule Budesonide DR tablet COLAZAL (balsalazide) capsule DELZICOL (mesalamine DR) capsule DIPENTUM (olsalazine) capsule Mesalamine DR tablet (generic Asacol HD, Lialda) Mesalamine DR/ER capsule (generic Apriso, Delzicol) UCERIS (budesonide) tablet	<p>Prior authorization for non-preferred oral formulations will require trial and failure of two preferred oral products with different active ingredients AND one preferred rectal product. If inflammation is not within reach of topical therapy, trial of preferred rectal product is not required. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.</p> <p>Uceris (budesonide) tablet: Prior authorization may be approved following trial and failure of one preferred oral product AND one preferred rectal product. If inflammation is not within reach of topical therapy, trial of preferred rectal product is not required. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction. Approval will be placed for 8 weeks. Further prior authorization may be approved if 7 days of steroid-free time has elapsed and member continues to meet the above criteria.</p>
Therapeutic Drug Class: NON-BIOLOGIC ULCERATIVE COLITIS AGENTS- Rectal -Effective 1/1/2022		
No PA Required Mesalamine suppository Mesalamine 4gm/60 ml enema (generic SF ROWASA)	PA Required CANASA (mesalamine) suppository Mesalamine enema, kit ROWASA/SF ROWASA enema, kit (mesalamine) UCERIS (budesonide) foam	<p>Prior authorization for non-preferred rectal formulations will require trial and failure of one preferred rectal formulation and one preferred oral formulation (Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction).</p> <p>Uceris (budesonide) foam: If the above criteria are met, Uceris (budesonide) foam prior authorization may be approved for 6 weeks. Further prior authorization may be approved if 7 days of steroid-free time has elapsed and member continues to meet the above criteria.</p>
VIII. Hematological		
Therapeutic Drug Class: ANTICOAGULANTS- Oral -Effective 10/1/2021		
No PA Required ELIQUIS (apixaban) tablet PRADAXA (dabigatran) capsule	PA Required BEVYXXA (betrixaban) tablet SAVAYSA (edoxaban) tablet	<p>BEVYXXA (betrixaban) may be approved if all the following criteria have been met:</p> <ul style="list-style-type: none"> • The member has trialed and failed therapy with two preferred agents. (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) AND • Member is not on dialysis AND

<p>Warfarin tablet</p> <p>XARELTO (rivaroxaban) 10 mg, 15 mg, 20 mg tablet, dose pack</p>	<p>XARELTO (rivaroxaban) 2.5 mg tablet</p>	<ul style="list-style-type: none"> • The member is need of prophylaxis for DVT following hospitalization for an acute medical illness who are at risk for thromboembolic events due to limited mobility AND • The member does not have a mechanical prosthetic heart valve <p>SAVAYSA (edoxaban) may be approved if all the following criteria have been met:</p> <ul style="list-style-type: none"> • The member has failed therapy with two preferred agents. (Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction) AND • Member is not on dialysis AND • Member does not have CrCl > 95 mL/min AND • The member has a diagnosis of deep vein thrombosis (DVT), pulmonary embolism (PE) OR • The member has a diagnosis of non-valvular atrial fibrillation AND • The member does not have a mechanical prosthetic heart valve <p>XARELTO 2.5mg (rivaroxaban) may be approved for members meeting all of the following criteria:</p> <ul style="list-style-type: none"> • Xarelto 2.5mg is being prescribed to reduce major CV events in members diagnosis of chronic coronary artery disease (CAD) or peripheral artery disease AND • Xarelto 2.5mg is being taken twice daily and in combination with aspirin 75-100mg daily AND • Member must not be receiving dual antiplatelet therapy, other non-aspirin antiplatelet therapy, or other oral anticoagulant AND • Member must not have had an ischemic, non-lacunar stroke within the past month AND • Member must not have had a hemorrhagic or lacunar stroke at any time <p>All other non-preferred oral agents require trial and failure of two preferred oral agents. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.</p> <p>Continuation of Care: Members with current prior authorization approval on file for a non-preferred <u>oral</u> anticoagulant medication may continue to receive approval for that medication</p>
Therapeutic Drug Class: ANTICOAGULANTS- Parenteral -Effective 10/1/2021		
<p>No PA Required</p> <p>Enoxaparin syringe</p> <p>Enoxaparin vial</p>	<p>PA Required</p> <p>ARIXTRA (fondaparinux) syringe</p> <p>Fondaparinux (generic Arixtra)</p> <p>FRAGMIN (dalteparin) vial, syringe</p>	<p>Non-preferred parenteral anticoagulants may be approved if member has trial and failure of one preferred parenteral agent. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction</p> <p>ARIXTRA (fondaparinux) may be approved if the following criteria have been met:</p> <ul style="list-style-type: none"> • Member is 18 years of age or older AND • Member has a CrCl > 30 ml/min AND

	LOVENOX (enoxaparin) syringe, vial	<ul style="list-style-type: none"> Member weighs > 50 kg AND Member has a documented history of heparin induced-thrombocytopenia OR Member has a contraindication to enoxaparin <p>Members currently stabilized on fondaparinux (Arixtra) or dalteparin (Fragmin) may receive prior authorization approval to continue receiving that medication.</p>
Therapeutic Drug Class: ANTI-PLATELETS -Effective 10/1/2021		
No PA Required AGGRENOX (ASA/dipyridamole) capsule ASA/dipyridamole ER capsule BRILINTA (ticagrelor) tablet Cilostazol tablet Clopidogrel tablet Dipyridamole tablet Pentoxifylline ER tablet Prasugrel tablet	PA Required EFFIENT (prasugrel) tablet PLAVIX (clopidogrel) tablet ZONTIVITY (vorapaxar) tablet	<p>Patients taking Brilinta (ticagrelor) must also be taking a maintenance dose of aspirin not exceeding 100 mg/day.</p> <p>Zontivity (vorapaxar) may be approved for patients with a diagnosis of myocardial infarction or peripheral artery disease without a history of stroke, transient ischemic attack, intracranial bleeding, or active pathological bleeding. Patients must also be taking aspirin and/or clopidogrel concomitantly.</p> <p>Non-preferred products without criteria will be reviewed on a case-by-case basis.</p>
Therapeutic Drug Class: COLONY STIMULATING FACTORS -Effective 10/1/2021		
PA Required for all agents in this class*		<p>*Prior authorization for preferred agents may be approved if meeting the following criteria:</p> <ul style="list-style-type: none"> Medication is being used for one of the following indications: <ul style="list-style-type: none"> Cancer patient receiving myelosuppressive chemotherapy –to reduce incidence of infection (febrile neutropenia) (Either the post nadir ANC is less than 10,000 cells/mm3 or the risk of neutropenia for the member is calculated to be greater than 20%) Acute Myeloid Leukemia (AML) patients receiving chemotherapy Bone Marrow Transplant (BMT) Peripheral Blood Progenitor Cell Collection and Therapy Hematopoietic Syndrome of Acute Radiation Syndrome Severe Chronic Neutropenia (Evidence of neutropenia infection exists or ANC is below 750 cells/mm3) <p>AND</p>
NEUPOGEN (filgrastim) vial, syringe UDENYCA (pegfilgrastim-cbqv) ZIEXTENZO (pegfilgrastim-bmez)	FULPHILA (pegfilgrastim-jmdb) GRANIX (tbo-filgrastim) LEUKINE (sargramostim) NEULASTA (pegfilgrastim) syringe NIVESYM (filgrastim-aafi) ZARXIO (filgrastim-sndz)	

		<ul style="list-style-type: none"> For Udenyca (pegfilgrastim-cbqv) or Ziextenzo (pegfilgrastim-bmez), the member meets the following criteria: <ul style="list-style-type: none"> Member has trial and failure of Neupogen. Failure is defined as lack of efficacy, intolerable side effects, drug-drug interaction, or contraindication to Neupogen therapy. Trial and failure of Neupogen will not be required if meeting one of the following: <ul style="list-style-type: none"> Member has limited access to caregiver or support system for assistance with medication administration OR Member has inadequate access to healthcare facility or home care interventions. <p>Prior authorization for non-preferred agents may be approved if meeting the following criteria:</p> <ul style="list-style-type: none"> Medication is being used for one of the following indications: <ul style="list-style-type: none"> Cancer patient receiving myelosuppressive chemotherapy –to reduce incidence of infection (febrile neutropenia) (Either the post nadir ANC is less than 10,000 cells/mm3 or the risk of neutropenia for the member is calculated to be greater than 20%) Acute Myeloid Leukemia (AML) patients receiving chemotherapy Bone Marrow Transplant (BMT) Peripheral Blood Progenitor Cell Collection and Therapy Hematopoietic Syndrome of Acute Radiation Syndrome Severe Chronic Neutropenia (Evidence of neutropenia infection exists or ANC is below 750 cells/mm3) <p>AND</p> <ul style="list-style-type: none"> Member has history of trial and failure of Neupogen AND one other preferred agent. Failure is defined as a lack of efficacy with a 3-month trial, allergy, intolerable side effects, significant drug-drug interactions, or contraindication to therapy. Trial and failure of Neupogen will not be required if meeting one of the following: <ul style="list-style-type: none"> Member has limited access to caregiver or support system for assistance with medication administration OR Member has inadequate access to healthcare facility or home care interventions.
Therapeutic Drug Class: ERYTHROPOIESIS STIMULATING AGENTS <i>Effective 10/1/2021</i>		
PA Required for all agents in this class*		<p>*Prior Authorization is required for all products and may be approved if meeting the following:</p> <ul style="list-style-type: none"> Medication is being administered in the member's home or in a long-term care facility AND Member meets <u>one</u> of the following: <ul style="list-style-type: none"> A diagnosis of cancer, currently receiving chemotherapy, with chemotherapy-induced anemia, and hemoglobin[†] of 10g/dL or lower OR
<p><i>Preferred changes effective 5/1/2022</i></p> <p>RETACRIT (epoetin alfa-epbx) (Pfizer only)</p>	<p>ARANESP (darbepoetin alfa)</p> <p>EPOGEN (epoetin alfa)</p> <p>MIRCERA (methoxy peg-epoetin beta)</p>	

PROCRIT (epoetin alfa)		<ul style="list-style-type: none"> ○ A diagnosis of chronic renal failure, and hemoglobin[†] below 10g/dL OR ○ A diagnosis of hepatitis C, currently taking ribavirin and failed response to a reduction of ribavirin dose, and hemoglobin[†] less than 10g/dL (or less than 11g/dL if symptomatic) OR ○ A diagnosis of HIV, currently taking zidovudine, hemoglobin[†] less than 10g/dL, and serum erythropoietin level of 500 (mU/mL) or less OR ○ Member is undergoing elective, noncardiac, nonvascular surgery and medication is given to reduce receipt of allogenic red blood cell transfusions, hemoglobin[†] is greater than 10g/dL, but less than or equal to 13g/dL and high risk for perioperative blood loss. Member is not willing or unable to donate autologous blood pre-operatively <p>AND</p> <ul style="list-style-type: none"> ● For any non-preferred product, member has trialed and failed treatment with one preferred product. Failure is defined as lack of efficacy with a 6-week trial, allergy, intolerable side effects, or significant drug-drug interaction. <p>[†]Hemoglobin results must be from the last 30 days.</p>
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IX. Immunological

Therapeutic Drug Class: **IMMUNE GLOBULINS** -Effective 1/1/2022

PA Required for all agents in this class*		
<p>CUVITRU 20% SQ liquid</p> <p>GAMMAGARD 10% IV/SQ liquid</p> <p>GAMMAKED 10% IV/SQ liquid</p> <p>GAMMAPLEX 5%, 10% IV liquid</p> <p>GAMUNEX-C 10% IV/SQ liquid</p> <p>HIZENTRA 20% SQ liquid</p> <p>PRIVIGEN 10% IV liquid</p> <p><i>If immune globulin is being administered in a long-term care facility or in a member's home by</i></p>	<p>BIVIGAM 10% IV liquid</p> <p>CUTAQUIG 16.5% SQ liquid</p> <p>FLEBOGAMMA DIF 5%, 10% IV liquid</p> <p>GAMMAGARD S/D vial</p> <p>HYQVIA 10% SQ liquid</p> <p>OCTAGAM 5%, 10% IV liquid</p> <p>PANZYGA 10% IV liquid</p> <p>XEMBIFY 20% IV liquid</p>	<p>Preferred agents may be approved for members meeting at least one of the approved conditions listed below for prescribed doses not exceeding maximum (Table 1).</p> <p>Non-preferred agents may be approved for members meeting the following:</p> <ul style="list-style-type: none"> ● Member meets at least one of the approved conditions listed below AND ● Member has history of trial and failure of two preferred agents (failure is defined as lack of efficacy with 4-week trial, allergy, intolerable side effects or significant drug-drug interactions) AND ● Prescribed dose does not exceed listed maximum (Table 1) <p>Approved Conditions for Immune Globulin Use:</p> <ul style="list-style-type: none"> ● Primary Humoral Immunodeficiency disorders including: <ul style="list-style-type: none"> ○ Common Variable Immunodeficiency (CVID) ○ Severe Combined Immunodeficiency (SCID) ○ X-Linked Agammaglobulinemia ○ X-Linked with Hyperimmunoglobulin M (IgM) Immunodeficiency ○ Wiskott-Aldrich Syndrome ○ Members < 13 years of age with pediatric Human Immunodeficiency Virus (HIV) and CD-4 count > 200/mm3 ● Neurological disorders including: <ul style="list-style-type: none"> ○ Guillain-Barré Syndrome ○ Relapsing-Remitting Multiple Sclerosis

<i>a home healthcare provider, it should be billed as a pharmacy claim. All other claims must be submitted through the medical benefit.</i>		<ul style="list-style-type: none">○ Chronic Inflammatory Demyelinating Polyneuropathy○ Myasthenia Gravis○ Polymyositis and Dermatomyositis○ Multifocal Motor Neuropathy● Kawasaki Syndrome● Chronic Lymphocytic Leukemia (CLL)● Autoimmune Neutropenia (AN) with absolute neutrophil count < 800 mm and history of recurrent bacterial infections● Autoimmune Hemolytic Anemia (AHA)● Liver or Intestinal Transplant● Immune Thrombocytopenia Purpura (ITP) including:<ul style="list-style-type: none">○ Requiring preoperative therapy for undergoing elective splenectomy with platelet count < 20,000○ Members with active bleeding & platelet count <30,000○ Pregnant members with platelet counts <10,000 in the third trimester○ Pregnant members with platelet count 10,000 to 30,000 who are bleeding● Multisystem Inflammatory Syndrome in Children (MIS-C) <table><tr><th colspan="2">Table 1: FDA-Approved Maximum Immune Globulin Dosing</th></tr><tr><td>Asceniv – IV admin</td><td>800 mg/kg every 3 to 4 weeks</td></tr><tr><td>Bivigam – IV admin</td><td>800 mg/kg every 3 to 4 weeks</td></tr><tr><td>Cuvitru – SQ admin</td><td>12.6 grams every 2 weeks</td></tr><tr><td>Flebogamma DIF – IV admin</td><td>600 mg/kg every 3 weeks</td></tr><tr><td>Gammaplex 5% – IV Infusion</td><td>800mg/kg every 3 weeks</td></tr><tr><td>Gammagard liquid – SQ or IV admin</td><td>2.4 grams/kg/month</td></tr><tr><td>Gammaked – SQ or IV admin</td><td>600 mg/kg every 3 weeks</td></tr><tr><td>Gamunex-C – SQ or IV admin</td><td>600 mg/kg every 3 weeks</td></tr><tr><td>Hizentra – SQ admin</td><td>0.4g/kg per week</td></tr><tr><td>Octagam – IV admin</td><td>600 mg/kg every 3 to 4 weeks</td></tr><tr><td>Panzyga – IV admin</td><td>2 g/kg every 3 weeks</td></tr><tr><td>Privigen – IV admin</td><td>2 g/kg</td></tr></table> <p>Members currently receiving a preferred or non-preferred immunoglobulin product may receive approval to continue therapy with that product at prescribed doses not exceeding maximum (Table 1).</p>	Table 1: FDA-Approved Maximum Immune Globulin Dosing		Asceniv – IV admin	800 mg/kg every 3 to 4 weeks	Bivigam – IV admin	800 mg/kg every 3 to 4 weeks	Cuvitru – SQ admin	12.6 grams every 2 weeks	Flebogamma DIF – IV admin	600 mg/kg every 3 weeks	Gammaplex 5% – IV Infusion	800mg/kg every 3 weeks	Gammagard liquid – SQ or IV admin	2.4 grams/kg/month	Gammaked – SQ or IV admin	600 mg/kg every 3 weeks	Gamunex-C – SQ or IV admin	600 mg/kg every 3 weeks	Hizentra – SQ admin	0.4g/kg per week	Octagam – IV admin	600 mg/kg every 3 to 4 weeks	Panzyga – IV admin	2 g/kg every 3 weeks	Privigen – IV admin	2 g/kg
Table 1: FDA-Approved Maximum Immune Globulin Dosing																												
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Privigen – IV admin	2 g/kg																											
Therapeutic Drug Class: NEWER GENERATION ANTIHISTAMINES -Effective 1/1/2022																												
No PA Required Cetirizine (OTC) tablet, syrup/solution (OTC/RX) Desloratadine tablet (RX)	PA Required Cetirizine (OTC) chewable tablet, softgel CLARINEX (desloratadine) tablet Desloratadine ODT (RX)	 Non-preferred single agent antihistamine products may be approved for members who have failed treatment with two preferred products in the last 6 months. For members with respiratory allergies, an additional trial of an intranasal corticosteroid will be required in the last 6 months.																										

Levocetirizine tablet (RX/OTC) Loratadine tablet (OTC), syrup/solution (OTC)	Fexofenadine tablet (OTC), suspension (OTC) Levocetirizine solution (RX) Loratadine chewable (OTC), ODT (OTC)	Failure is defined as lack of efficacy with a 14 day trial, allergy, intolerable side effects, or significant drug-drug interaction.
Therapeutic Drug Class: ANTIHISTAMINE/DECONGESTANT COMBINATIONS - <i>Effective 1/1/2022</i>		
No PA Required Loratadine-D (OTC) tablet	PA Required Cetirizine-PSE (OTC) CLARINEX-D (desloratadine-D) Fexofenadine/PSE (OTC)	Non-preferred antihistamine/decongestant combinations may be approved for members who have failed treatment with two preferred products in the last 6 months. For members with respiratory allergies, an additional trial of an intranasal corticosteroid will be required in the last 6 months. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.
Therapeutic Drug Class: INTRANASAL RHINITIS AGENTS - <i>Effective 1/1/2022</i>		
No PA Required Azelastine 0.15%, 137 mcg Budesonide (OTC) Fluticasone (RX) Ipratropium Triamcinolone acetonide (OTC)	PA Required Azelastine/Fluticasone BECONASE AQ (beclomethasone dipropionate) DYMISTA (azelastine/ fluticasone) Flunisolide 0.025% Fluticasone (OTC) Mometasone NASONEX (mometasone) Olopatadine OMNARIS (ciclesonide) PATANASE (olopatadine) QNASL (beclomethasone) XHANCE (fluticasone)	Non-preferred products may be approved following trial and failure of treatment with three preferred products (failure is defined as lack of efficacy with a 2-week trial, allergy, intolerable side effects or significant drug-drug interactions). Non-preferred combination agents may be approved following trial of individual products with same active ingredients AND trial and failure of one additional preferred agent (failure is defined as lack of efficacy with 2-week trial, allergy, intolerable side effects or significant drug-drug interactions).

	ZETONNA (ciclesonide)	
Therapeutic Drug Class: LEUKOTRIENE MODIFIERS -Effective 1/1/2022		
No PA Required Montelukast tablet, chewable	PA Required ACCOLATE (zafirlukast) tablet Montelukast granules SINGULAIR (montelukast) tablet, chewable, granules Zafirlukast tablet Zileuton ER tablet ZYFLO (zileuton) tablet	<p>Non-preferred products may be approved if meeting the following criteria:</p> <ul style="list-style-type: none"> Member has trialed and failed treatment with one preferred product (failure is defined as lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions) AND Member has a diagnosis of asthma. <p>Montelukast granules may be approved if a member has tried and failed montelukast chewable tablets AND has difficulty swallowing.</p>
Therapeutic Drug Class: METHOTREXATE PRODUCTS -Effective 1/1/2022		
No PA Required Methotrexate oral tablet, vial	PA Required OTREXUP (methotrexate) auto-injector RASUVO (methotrexate) auto-injector REDITREX (methotrexate) syringe TREXALL (methotrexate) oral tablet XATMEP (methotrexate) oral solution	<p>OTREXUP, REDITREX or RASUVO may be approved if meeting the following criteria:</p> <ul style="list-style-type: none"> Member has diagnosis of severe, active rheumatoid arthritis OR active polyarticular juvenile idiopathic arthritis (pJIA) OR inflammatory bowel disease (IBD) AND Member has trialed and failed preferred methotrexate tablet formulation (failure is defined as lack of efficacy, allergy, intolerable side effects, or inability to take oral product formulation) AND Member is unable to administer preferred methotrexate vial formulation due to limited functional ability (such as vision impairment, limited manual dexterity and/or limited hand strength). <p>TREXALL may be approved if meeting the following criteria:</p> <ul style="list-style-type: none"> Member has trialed and failed preferred methotrexate tablet formulation. Failure is defined as allergy or intolerable side effects. <p>XATMEP may be approved for members who meet the following criteria:</p> <ul style="list-style-type: none"> Member is < 18 years of age Member has a diagnosis of acute lymphoblastic leukemia OR Member has a diagnosis of active polyarticular juvenile idiopathic arthritis (pJIA) and has had an insufficient therapeutic response to, or is intolerant to, an adequate trial of first-line therapy including full dose non-steroidal anti-inflammatory agents (NSAIDs) AND

		<ul style="list-style-type: none"> Member has a documented swallowing difficulty due to young age and/or a medical condition and is unable to use the preferred methotrexate tablet formulation <p><i>Methotrexate can cause serious embryo-fetal harm when administered during pregnancy and it is contraindicated for use during pregnancy for the treatment of non-malignant diseases. Advise members of reproductive potential to use effective contraception during and after treatment with methotrexate, according to FDA product labeling.</i></p> <p>Members currently stabilized on a non-preferred methotrexate product may receive approval to continue on that agent.</p>
Therapeutic Drug Class: MULTIPLE SCLEROSIS AGENTS -Effective 4/1/2022		
Disease Modifying Therapies		
<p>No PA Required (unless indicated*)</p> <p>AVONEX (interferon beta 1a) injection</p> <p>BETASERON (interferon beta 1b) injection</p> <p>COPAXONE^{BNR} (glatiramer) 20MG injection</p> <p>Dimethyl fumarate tablet</p> <p>*AUBAGIO (teriflunomide) tablet**2nd Line**</p> <p>*GILENYA (fingolimod) 0.5 mg tablet**2nd Line**</p> <p>*KESIMPTA (ofatumumab) pen**2nd Line**</p>	<p>PA Required</p> <p>BAFIERTAM (monomethyl fumarate DR) capsule</p> <p>COPAXONE (glatiramer) 40MG injection</p> <p>EXTAVIA (interferon beta 1b) vial</p> <p>GLATOPA (glatiramer) injection</p> <p>Glatiramer 20mg, 40mg injection</p> <p>MAVENCLAD (cladribine) tablet</p> <p>MAYZENT (siponimod) tablet, pack</p> <p>PLEGRIDY (peg-interferon beta 1a) syringe, pen</p> <p>PONVORY (ponesimod) tablet</p> <p>REBIF (interferon beta 1a) syringe</p> <p>TECFIDERA (dimethyl fumarate) tablet</p> <p>VUMERITY (diroximel DR) capsule</p> <p>ZEPOSIA (ozanimod) capsule</p>	<p>*Second-line preferred agents (Gilenya, Aubagio, Kesimpta) may be approved if meeting the following:</p> <ul style="list-style-type: none"> Member has a diagnosis of a relapsing form of multiple sclerosis confirmed on MRI by presence of new spinal lesions, cerebellar lesions, brain stem lesions, or change in brain atrophy AND Medication is being prescribed by a neurologist or in consultation with a neurologist AND Prescriber attests to shared decision making with respect to risks versus benefits of medical treatment AND Additional safety criteria for prescribed agent are met (Table 1) AND Member meets one of the following: <ul style="list-style-type: none"> Member has trialed and failed treatment with Avonex (interferon beta-1a) OR Betaseron (interferon beta-1b) OR Copaxone (glatiramer) OR dimethyl fumarate. Failure is defined as intolerable side effects, contraindication to therapy, drug-drug interaction, or lack of efficacy OR Member has documented diagnosis of multiple sclerosis made by neurologist in the last 3 years OR member has history of diagnosis made by a neurologist > 3 years ago but is naïve to all medications indicated for the treatment of relapsing forms of multiple sclerosis <p><u>Non-Preferred Products:</u> Non-preferred products may be approved if meeting the following:</p> <ul style="list-style-type: none"> The requested medication is being prescribed by a neurologist or in consultation with a neurologist AND Member has a diagnosis of a relapsing form of multiple sclerosis AND Member has previous trial and failure with three preferred agents. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction AND If the prescribed agent is Mayzent (simponimod), Mavenclad (cladribine), Vumerity (diroxemmel fumarate), or Bafiertam (monomethyl fumarate DR), then

		<ul style="list-style-type: none"> ○ The safety criteria for prescribed agent are met (Table 1) AND ○ Additional criteria listed below for the respective prescribed agent are met. <p>Copaxone (glatiramer) 40mg may be approved for members who have severe intolerable injection site reactions to brand Copaxone 20mg (such as pain requiring local anesthetic, oozing, lipoatrophy, swelling, or ulceration).</p> <p>Mayzent (simponimod):</p> <ul style="list-style-type: none"> ● Member does not have diagnosis of macular degeneration AND ● Member has no evidence of relapse in the 3 months preceding initiation of therapy AND ● Member has previous trial and failure of three preferred agents, one of which must be Gilenya (fingolimod). Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction. <p>Mavenclad (cladribine):</p> <ul style="list-style-type: none"> ● Member has history of ≥ 1 relapse in the 12 months preceding initiation of therapy AND ● Member has previous trial and failure of three other therapies for relapsing forms of multiple sclerosis (failure is defined as lack of efficacy with 3-month trial, allergy, intolerable side effects, or significant drug-drug interactions) <p>Vumerity (diroximel fumarate) or Bafiertam (monomethyl fumarate DR):</p> <ul style="list-style-type: none"> ● Member has previous trial and failure of three preferred agents, one of which must be Tecfidera (dimethyl fumarate). Failure is defined as lack of efficacy, allergy, significant drug-drug interactions, intolerable side effects (if GI adverse events, must meet additional criteria below) AND ● If the requested medication is being prescribed due to GI adverse events with Tecfidera (dimethyl fumarate) therapy (and no other reason for failure of Tecfidera is given), then the following additional criteria must be met: <ul style="list-style-type: none"> ○ Member has trialed a temporary dose reduction of Tecfidera (with maintenance dose being resumed within 4 weeks) AND ○ Member has trialed taking Tecfidera (dimethyl fumarate) with food AND ○ GI adverse events remain significant despite maximized use of gastrointestinal symptomatic therapies (such as calcium carbonate, bismuth subsalicylate, PPIs, H2 blockers, anti-bloating/anti-constipation agents, anti-diarrheal, and centrally acting anti-emetics) AND ○ Initial authorization will be limited to 3 months. Continuation (12-month authorization) will require documentation of clinically significant reduction in GI adverse events. <p>Members currently stabilized on a preferred second-line or non-preferred product (with the exception of brand Tecfidera) may receive approval to continue therapy with that agent. Members currently stabilized on brand Tecfidera may use the preferred generic equivalent formulation.</p>
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Table 1: Safety Criteria for Initiating Multiple Sclerosis Disease Modifying Therapy								
Brand	AUBAGIO	BAFIERTA M	GILENYA	KESIMP TA	MAYZENT	MAVENCL AD	TECFIDER A	VUMERIT Y
Generic	teriflunomide	monomethyl fumarate DR	fingolimod	ofatumumab	siponimod	cladribine	dimethyl fumarate	diroximel fumarate
No active infections ^a	X	X	X	X	X	X	X	X
Baseline CBC w/diff	X	X			X	X ^{c,g}	X	X
Baseline ALT, AST, bilirubin ≤ 2x ULN ^b	X	X	X		X	X	X	X
Negative baseline pregnancy test	X	X			X	X	X	
Using highly effective contraception (if childbearing potential)	X	X	X	X	X	X	X	X
Other	<ul style="list-style-type: none"> Documented baseline blood pressure Skin or blood screening test for <i>M. tuberculosis</i> 		<ul style="list-style-type: none"> No significant CV history^f QTc interval < 500 ms No Class 1a or Class III antiarrhythmic use Baseline ocular coherence eye exam 	<ul style="list-style-type: none"> Regular monitoring of immunoglobulin levels required Avoid live-attenuated and live vaccines Use is contraindicated with active hepatitis B virus (HBV) infection Member counseled regarding risk of PML^e 	<ul style="list-style-type: none"> No CYP2C9*3/*3 genotype No significant CV history^f QTc interval < 500 ms Baseline eye evaluation that includes macula exam 	<ul style="list-style-type: none"> No current evidence of malignancy No current immunosuppressive or myelosuppressive therapy 	<ul style="list-style-type: none"> Member counseled regarding risks of anaphylaxis, angioedema and PML^e 	
Maximum dose	14 mg per day	190 mg twice a day ^a	Age and weight based ^d	20 mg at weeks 0, 1 and 2, then 20 mg	60 mg per 30 days	Not exceeding 3.5 mg/kg during full	240 mg twice a day	924 mg per day

		<table><tr><td></td><td></td><td></td><td></td><td>once monthly starting at Week 4</td><td></td><td>treatment course</td><td></td><td></td></tr></table> <p>a – including herpes zoster or other active serious infections (or chronic: such as hepatitis, tuberculosis, and HIV) b – ULN - upper limit of normal c – plus at 2 and 6 months post-initiation and periodically thereafter d – GILENYA maximum dose: <u>≥ 10 years of age and > 40 kg body weight</u>: 0.5 mg once daily; <u>≥ 10 years of age and ≤ 40 kg body weight</u>: 0.25 mg once daily e – PML - progressive multifocal leukoencephalopathy f – No h/o MI, CVA, TIA, unstable angina, NYHA Class III-IV HF AND no Mobitz type II second-degree, third-degree AV block, or sick sinus syndrome, unless patient has a functioning pacemaker g – Lymphocytes must be within normal limits before initiating the first treatment course and ≥ 800 cells per microliter before initiating the second treatment course</p>					once monthly starting at Week 4		treatment course		
				once monthly starting at Week 4		treatment course					
Symptom Management Therapies											
	<p>PA Required</p> <p>AMPYRA ER (dalfampridine) tablet</p> <p>Dalfampridine ER tablet</p>	<p>Ampyra (dalfampridine) prior authorization may be approved if all of the following criteria are met:</p> <ul style="list-style-type: none">• Member has a diagnosis of MS; Member is ambulatory and has established a baseline which is defined as ambulating between 8-45 seconds Timed 25-foot Walk (T25FW) assessment OR has established a baseline activities of daily living (ADL) AND• Member has no history of seizure disorder AND• Member has no history of moderate to severe renal dysfunction (CrCl > 50 ml/min) AND• Prescriber is a neurologist or is prescribed in consultation with a neurologist AND• The prescribed dose does not exceed 10 mg twice daily. <p>Reauthorization of Ampyra (dalfampridine) may be approved if medical record documentation indicates that member’s symptoms are stable or there is improvement in ambulation (measured by T25FW assessment) or improvement in ADLs.</p>									
Therapeutic Drug Class: TARGETED IMMUNE MODULATORS -Effective 1/1/2022 <i>Preferred agents:</i> ENBREL (etanercept); HUMIRA (adalimumab); OTEZLA (apremilast) tablet; KEVZARA (sarilumab); TALTZ (ixekizumab); XELJANZ IR (tofacitinib) tablet											
Rheumatoid Arthritis, Polyarticular Course Juvenile Idiopathic Arthritis, and Ankylosing Spondylitis											
<p>No PA Required (if diagnosis met) (*Must meet eligibility criteria)</p> <p>ENBREL (etanercept)</p>	<p>PA Required</p> <p>ACTEMRA (tocilizumab) syringe, Actpen</p> <p>CIMZIA (certolizumab) kit</p> <p>COSENTYX (secukinumab) syringe, pen-injector</p>	<p>First line preferred agents (HUMIRA, ENBREL, and XELJANZ IR) may receive approval for use for FDA-labeled indications.</p> <p>Quantity Limit: XELJANZ IR is limited to 2 tablets per day or 60 tablets for a 30-day supply</p>									

<p>HUMIRA (adalimumab)</p> <p>*KEVZARA (sarilumab) pen, syringe</p> <p>*TALTZ (ixekizumab)</p> <p>XELJANZ IR (tofacitinib) tablet</p>	<p>ILARIS (canakinumab) vial</p> <p>KINERET (anakinra) syringe</p> <p>OLUMIANT (baricitinib) tablet</p> <p>ORENCIA (abatacept) syringe, clickject</p> <p>RINVOQ (upadacitinib) tablet</p> <p>SIMPONI (golimumab) pen, syringe</p> <p>XELJANZ (tofacitinib) solution</p> <p>XELJANZ XR (tofacitinib ER) tablet</p> <p>*for information on IV infused Targeted Immune Modulators please see Appendix P</p>	<p>*TALTZ (ixekizumab) may receive approval for use for FDA-labeled indications following trial and failure[‡] of HUMIRA or ENBREL.</p> <p>*KEVZARA (sarilumab) may receive approval for use for FDA-labeled indications following trial and failure[‡] of HUMIRA or ENBREL AND XELJANZ IR.</p> <p>KINERET (anakinra) may receive approval for:</p> <ul style="list-style-type: none"> FDA-labeled indications following trial and failure[‡] of HUMIRA or ENBREL AND XELJANZ IR OR Treatment of systemic juvenile idiopathic arthritis (sJIA) or Adult Onset Still's Disease (AOSD) <p>ILARIS (canakinumab) may receive approval if meeting the following:</p> <ul style="list-style-type: none"> Medication is being prescribed for systemic juvenile idiopathic arthritis (sJIA) or Adult Onset Still's Disease (AOSD), AND Member has trialed and failed[‡] KINERET (anakinra) AND ACTEMRA (tocilizumab) <p>XELJANZ (tofacitinib) XR approval will require verification of the clinically relevant reason for use of the XELJANZ XR formulation versus the XELJANZ IR formulation, in addition to meeting non-preferred criteria listed below.</p> <p>All other non-preferred agents may receive approval for FDA-labeled indications following trial and failure[‡] of all indicated preferred agents.</p> <p>[‡]Failure is defined as lack of efficacy with a three-month trial, contraindication to therapy, allergy, intolerable side effects, or significant drug-drug interaction.</p> <p>Members currently taking COSENTYX may receive approval to continue on that agent.</p> <p><i>The Department would like to remind providers that many products are associated with patient-centered programs that are available to assist with drug administration, education, and emotional support related to our members' various disease states.</i></p>
Psoriatic Arthritis		
<p>No PA Required (if diagnosis met) (*Must meet eligibility criteria)</p> <p>ENBREL (etanercept)</p> <p>HUMIRA (adalimumab)</p> <p>*OTEZLA (apremilast) tablet</p>	<p>PA Required</p> <p>CIMZIA (certolizumab) kit</p> <p>COSENTYX (secukinumab) syringe, pen-injector</p> <p>ORENCIA (abatacept) syringe, clickject</p> <p>RINVOQ (upadacitinib) tablet</p>	<p>First line preferred agents (HUMIRA, ENBREL, XELJANZ IR) may receive approval for psoriatic arthritis indication.</p> <p>Quantity Limit: XELJANZ IR is limited to 2 tablets per day or 60 tablets for a 30-day supply</p> <p>*OTEZLA (apremilast) may receive approval for psoriatic arthritis indication following trial and failure[‡] of HUMIRA or ENBREL AND XELJANZ IR or TALTZ.</p>

<p>*TALTZ (ixekizumab)</p> <p>XELJANZ IR (tofacitinib) tablet</p>	<p>SIMPONI (golimumab) pen, syringe</p> <p>STELARA (ustekinumab) syringe</p> <p>TREMFYA (guselkumab) injector, syringe</p> <p>XELJANZ XR (tofacitinib ER) tablet</p> <p>*for information on IV infused Targeted Immune Modulators please see Appendix P</p>	<p>*TALTZ (ixekizumab) may receive approval for psoriatic arthritis indication following trial and failure[‡] of HUMIRA or ENBREL AND XELJANZ IR or OTEZLA.</p> <p>STELARA (ustekinumab) syringe for subcutaneous use may receive approval if meeting the following:</p> <ul style="list-style-type: none"> Member has trial and failure[‡] of HUMIRA or ENBREL AND XELJANZ IR AND TALTZ or OTEZLA AND Prescriber acknowledges that loading dose administration prior to approval of STELARA for maintenance therapy using the above criteria should be avoided and will not result in an automatic approval of STELARA for maintenance therapy AND Prior authorization approval may be given for an initial 16 week supply and authorization approval for continuation may be provided based on clinical response. <p>XELJANZ (tofacitinib) XR approval will require verification of the clinically relevant reason for use of the XELJANZ XR formulation versus the XELJANZ IR formulation, in addition to meeting non-preferred criteria listed below.</p> <p>All other non-preferred agents may receive approval for psoriatic arthritis following trial and failure[‡] of HUMIRA or ENBREL AND XELJANZ IR AND TALTZ or OTEZLA.</p> <p>[‡]Failure is defined as lack of efficacy with a three-month trial, contraindication to therapy, allergy, intolerable side effects, or significant drug-drug interaction.</p> <p>Members currently taking COSENTYX may receive approval to continue on that agent.</p> <p><i>The Department would like to remind providers that many products are associated with patient-centered programs that are available to assist with drug administration, education, and emotional support related to our members' various disease states.</i></p>
Plaque Psoriasis		
<p>No PA Required (if diagnosis met) (*Must meet eligibility criteria)</p> <p>ENBREL (etanercept)</p> <p>HUMIRA (adalimumab)</p> <p>*OTEZLA (apremilast) tablet</p>	<p>PA Required</p> <p>CIMZIA (certolizumab) kit</p> <p>COSENTYX (secukinumab) syringe, pen-injector</p> <p>SILIQ (brodalumab) syringe</p> <p>SKYRIZI (risankizumab-rzaa) syringe, kit</p>	<p>First line preferred agents (HUMIRA, ENBREL) may receive approval for plaque psoriasis indication.</p> <p>*Second line preferred agents (TALTZ, OTEZLA) may receive approval for plaque psoriasis indication following trial and failure[‡] of HUMIRA OR ENBREL.</p> <p>STELARA (ustekinumab) syringe for subcutaneous use may receive approval if meeting the following:</p> <ul style="list-style-type: none"> Member has trial and failure[‡] of one indicated first line agent (HUMIRA, ENBREL) AND two indicated second line agents (TALTZ, OTEZLA), AND

*TALTZ (ixekizumab)	STELARA (ustekinumab) syringe TREMFYA (guselkumab) injector, syringe *for information on IV infused Targeted Immune Modulators please see Appendix P	<ul style="list-style-type: none"> Prescriber acknowledges that loading dose administration prior to approval of STELARA for maintenance therapy using the above criteria should be avoided and will not result in an automatic approval of STELARA for maintenance therapy AND Prior authorization approval may be given for an initial 16 week supply and authorization approval for continuation may be provided based on clinical response. <p>All other non-preferred agents may receive approval for plaque psoriasis indication following trial and failure[‡] of one indicated first line agent (HUMIRA, ENBREL) AND two second line agents (TALTZ, OTEZLA).</p> <p>[‡]Failure is defined as lack of efficacy with a three-month trial, contraindication to therapy, allergy, intolerable side effects, or significant drug-drug interaction.</p> <p>Members currently taking COSENTYX may receive approval to continue on that agent.</p> <p><i>The Department would like to remind providers that many products are associated with patient-centered programs that are available to assist with drug administration, education, and emotional support related to our members' various disease states.</i></p>
Crohn's Disease and Ulcerative Colitis		
No PA Required (if diagnosis met) (*Must meet eligibility criteria) HUMIRA (adalimumab) *XELJANZ IR (tofacitinib) tablet	PA Required CIMZIA (certolizumab) kit SIMPONI (golimumab) pen, syringe STELARA (ustekinumab) syringe XELJANZ XR (tofacitinib ER) tablet *for information on IV infused Targeted Immune Modulators please see Appendix P	<p>First line preferred agents (HUMIRA) may receive approval for Crohn's disease and ulcerative colitis indications.</p> <p>*XELJANZ IR may receive approval for ulcerative colitis indication following trial and failure[‡] of HUMIRA.</p> <p>Quantity Limit: XELJANZ IR is limited to 2 tablets per day or 60 tablets for a 30-day supply</p> <p>STELARA (ustekinumab) syringe for subcutaneous use may receive approval if meeting the following:</p> <ul style="list-style-type: none"> For treatment of moderately-to-severely active Crohn's disease, member has trial and failure[†] of all indicated preferred agents (HUMIRA) OR for treatment of moderately-to-severely active ulcerative colitis, member has trial and failure[†] of all indicated preferred agents (HUMIRA and XELJANZ IR) AND Prescriber acknowledges that loading dose administration prior to approval of STELARA for maintenance therapy using the above criteria should be avoided and will not result in an automatic approval of STELARA for maintenance therapy AND Prior authorization approval may be given for an initial 16 week supply and authorization approval for continuation may be provided based on clinical

		<p>response.</p> <p>XELJANZ (tofacitinib) XR approval will require verification of the clinically relevant reason for use of the XELJANZ XR formulation versus the XELJANZ IR formulation, in addition to meeting non-preferred criteria listed below.</p> <p>All other non-preferred agents may receive approval for FDA-labeled indications following trial and failure[†] of all indicated preferred agents.</p> <p>Members currently taking COSENTYX may receive approval to continue on that agent.</p> <p>[†]Failure is defined as lack of efficacy with a three-month trial, contraindication to therapy, allergy, intolerable side effects, or significant drug-drug interaction. Note that trial and failure of Xeljanz IR will not be required when prescribed for ulcerative colitis for members ≥ 50 years of age that have an additional CV risk factor.</p> <p><i>The Department would like to remind providers that many products are associated with patient-centered programs that are available to assist with drug administration, education, and emotional support related to our members' various disease states.</i></p>
Other indications		
<p>Must meet eligibility criteria*</p> <p>ENBREL (etanercept)</p> <p>HUMIRA (adalimumab)</p> <p>*OTEZLA (apremilast) tablet</p> <p>*TALTZ (ixekizumab)</p> <p>XELJANZ IR (tofacitinib) tablet</p>	<p>PA Required</p> <p>ACTEMRA (tocilizumab) syringe, Actpen</p> <p>ARCALYST (rilonacept) injection</p> <p>CIMZIA (certolizumab) kit</p> <p>COSENTYX (secukinumab) syringe, pen-injector</p> <p>ILARIS (canakinumab) vial</p> <p>KINERET (anakinra) syringe</p> <p>*for information on IV infused Targeted Immune Modulators please see Appendix P</p>	<p>First line preferred agents (HUMIRA, ENBREL, and XELJANZ IR) may receive approval for use for FDA-labeled indications.</p> <p>Quantity Limit: XELJANZ IR is limited to 2 tablets per day or 60 tablets for a 30-day supply</p> <p>*Second-line preferred agents may receive approval for FDA-labeled indications following trial and failure[‡] of all indicated first-line preferred agents (ENBREL, HUMIRA, XELJANZ IR).</p> <p>ARCALYST (rilonacept) may receive approval if meeting the following:</p> <ul style="list-style-type: none"> Medication is being prescribed for one of the following autoinflammatory periodic fever syndromes (approval for all other indications is subject to meeting non-preferred criteria listed below): <ul style="list-style-type: none"> Cryopyrin-associated Autoinflammatory Syndrome (CAPS), including: <ul style="list-style-type: none"> Familial Cold Autoinflammatory Syndrome (FCAS) Muckle-Wells Syndrome (MWS) Maintenance of remission of Deficiency of Interleukin-1 Receptor Antagonist (DIRA) in adults and pediatric patients weighing at least 10 kg Treatment of recurrent pericarditis and reduction in risk of recurrence in adults and children ≥ 12 years of age <p>AND</p>

		<ul style="list-style-type: none"> • Member has trialed and failed[‡] colchicine AND • Initial approval will be given for 12 weeks and authorization approval for continuation will be provided based on clinical response. <p>ILARIS (canakinumab) may receive approval if meeting the following:</p> <ul style="list-style-type: none"> • Medication is being prescribed for one of the following autoinflammatory periodic fever syndromes (approval for all other indications is subject to meeting non-preferred criteria listed below): <ul style="list-style-type: none"> ○ Familial Mediterranean Fever (FMF) ○ Hyperimmunoglobulinemia D syndrome (HIDS) ○ Mevalonate Kinase Deficiency (MKD) ○ Neonatal onset multisystem inflammatory disease (NOMID) ○ TNF Receptor Associated Periodic Syndrome (TRAPS) ○ Cryopyrin-associated Autoinflammatory Syndrome (including Familial Cold Autoinflammatory Syndrome and Muckle-Wells Syndrome) <p>AND</p> <ul style="list-style-type: none"> • Member has trialed and failed[‡] colchicine. <p>KINERET (anakinra) may receive approval if meeting the following:</p> <ul style="list-style-type: none"> • Medication is being prescribed for one of the following indications (approval for all other indications is subject to meeting non-preferred criteria below): <ul style="list-style-type: none"> ○ Neonatal onset multisystem inflammatory disease (NOMID). ○ Familial Mediterranean Fever (FMF) <p>AND</p> <ul style="list-style-type: none"> • Member has trialed and failed[‡] colchicine. <p>All other non-preferred agents may receive approval for FDA-labeled indications following trial and failure[‡] of all indicated preferred agents (ENBREL, HUMIRA, XELJANZ IR, TALTZ, OTEZLA).</p> <p>[‡]Failure is defined as lack of efficacy with a three-month trial, contraindication to therapy, allergy, intolerable side effects, or significant drug-drug interaction.</p> <p>Members currently taking COSENTYX (secukinumab) may receive approval to continue on that agent.</p> <p><i>The Department would like to remind providers that many products are associated with patient-centered programs that are available to assist with drug administration, education, and emotional support related to our members' various disease states.</i></p>
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X. Miscellaneous

Therapeutic Drug Class: **EPINEPHRINE PRODUCTS** -Effective 1/1/2022

No PA Required	PA Required	<p>Non-preferred products may be approved if the member has failed treatment with one of the preferred products. Failure is defined as allergy to ingredients in product or intolerable side effects.</p> <p>Quantity limit: 4 auto injectors per year unless used / damaged / lost</p>
<p>EPIPEN^{BNR} 0.3 mg/0.3 ml (epinephrine) auto-injector</p> <p>EPIPEN JR^{BNR} 0.15 mg/0.15 ml, (epinephrine) auto-injector</p>	<p>Epinephrine 0.15mg/0.15ml, 0.3mg/0.3ml auto-injector (generic Adrenaclick, EpiPen)</p> <p>SYMJEPI 0.15mg/0.3ml, 0.3mg/0.3ml (epinephrine) syringe</p>	
Therapeutic Drug Class: NEWER HEREDITARY ANGIOEDEMA PRODUCTS -Effective 1/1/2022		
PA Required for all agents in this class		<u>Medications Indicated for Routine Prophylaxis:</u>
<p><u>Prophylaxis:</u></p> <p>HAEGARDA (C1 esterase inhibitor) vial</p> <p><u>Treatment:</u></p> <p>BERINERT (C1 esterase inhibitor) kit</p> <p>Icatibant syringe (generic FIRAZYR)</p>	<p><u>Prophylaxis:</u></p> <p>CINRYZE (C1 esterase inhibitor) kit</p> <p>ORLADEYO (berotralstat) oral capsule</p> <p>TAKHZYRO (lanadelumab-flyo) vial</p> <p><u>Treatment:</u></p> <p>FIRAZYR (icatibant acetate) syringe</p> <p>RUCONEST (C1 esterase inhibitor, recomb) vial</p>	<p>Members are restricted to coverage of one medication for <u>routine prophylaxis</u> at one time. Prior authorization approval will be for one year.</p> <p>HAEGARDA (C1 esterase inhibitor (human)) may be approved for members meeting the following criteria:</p> <ul style="list-style-type: none"> Member has a diagnosis of HAE confirmed by laboratory tests obtained on two separate instances at least one month apart (C4 level, C1-INH level) AND Member has a documented history of at least one symptom of a moderate to severe HAE attack (moderate to severe abdominal pain, facial swelling, airway swelling) in the absence of hives or a medication known to cause angioedema AND Member meets at least one of the following: <ul style="list-style-type: none"> Haegarda is being used for short-term prophylaxis to undergo a surgical procedure or major dental work OR Haegarda is being used for long-term prophylaxis and member meets one of the following: <ul style="list-style-type: none"> History of ≥ 1 attack per month resulting in documented ED admission or hospitalization OR History of laryngeal attacks OR History of ≥ 2 attacks per month involving the face, throat, or abdomen AND Member is not taking medications that may exacerbate HAE including ACE inhibitors and estrogen-containing medications AND Member has received hepatitis A and hepatitis B vaccination AND Provider attests to performing annual testing or screening (as appropriate) for HBV, HCV, and HIV <p>Maximum Dose: 60 IU/kg Minimum Age: 10 years</p> <p>CINRYZE (C1 esterase inhibitor (human)) may be approved for members meeting the following criteria:</p>

		<ul style="list-style-type: none"> ○ Member has history of trial and failure of Haegarda. Failure is defined as lack of efficacy allergy, intolerable side effects, or a significant drug-drug interaction AND ○ Member has a diagnosis of HAE confirmed by laboratory tests obtained on two separate instances at least one month apart (C4 level, C1-INH level) AND ○ Member has a documented history of at least one symptom of a moderate to severe HAE attack (moderate to severe abdominal pain, facial swelling, airway swelling) in the absence of hives or a medication known to cause angioedema AND ○ Member meets at least one of the following: <ul style="list-style-type: none"> ▪ Cinryze is being used for <u>short-term prophylaxis</u> to undergo a surgical procedure or major dental work OR ▪ Cinryze is being used for <u>long-term prophylaxis</u> and member meets one of the following: <ul style="list-style-type: none"> ○ History of ≥ 1 attack per month resulting in documented ED admission or hospitalization OR ○ History of laryngeal attacks OR ○ History of ≥ 2 attacks per month involving the face, throat, or abdomen AND ○ Member is not taking medications that may exacerbate HAE including ACE inhibitors and estrogen-containing medications AND ○ Member has received hepatitis A and hepatitis B vaccination AND ○ Provider attests to performing annual testing or screening (as appropriate) for HBV, HCV, and HIV. <p>Minimum age: 6 years Maximum dose: 100 Units/kg</p> <p>ORLADEYO (berotralstat) may be approved for members meeting the following criteria:</p> <ul style="list-style-type: none"> ○ Member has history of trial and failure of HAEGARDA. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction AND ○ Member has a diagnosis of HAE confirmed by laboratory tests obtained on two separate instances at least one month apart (C4 level, C1-INH level) AND ○ Member has a documented history of at least one symptom of a moderate to severe HAE attack (moderate to severe abdominal pain, facial swelling, airway swelling) in the absence of hives or a medication known to cause angioedema AND ○ ORLADEYO is prescribed by or in consultation with an allergist or immunologist AND ○ Appropriate drug interaction interventions will be made for members using concomitant medications that may require dose adjustments (such as
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		<p>cyclosporine, fentanyl, pimozide, digoxin) AND</p> <ul style="list-style-type: none"> Member meets at least one of the following: <ul style="list-style-type: none"> ORLADEYO is being used for short-term prophylaxis to undergo a surgical procedure or major dental work ORLADEYO is being used for long-term prophylaxis and member meets one of the following: <ul style="list-style-type: none"> History of ≥ 1 attack per month resulting in documented ED admission or hospitalization OR History of laryngeal attacks OR History of ≥ 2 attacks per month involving the face, throat, or abdomen AND Member is not taking medications that may exacerbate HAE, including ACE inhibitors and estrogen-containing medications <p>Minimum age: 12 years Maximum dose: 150 mg once daily</p> <p>TAKHZYRO (lanadelumab-flyo) may be approved for members meeting the following criteria:</p> <ul style="list-style-type: none"> Member has history of trial and failure of Haegarda. Failure is defined as: lack of efficacy, allergy, intolerable side effects, or a significant drug-drug interaction AND Member has a diagnosis of HAE confirmed by laboratory tests obtained on two separate instances at least one month apart (C4 level, C1-INH level) AND Member has a documented history of at least one symptom of a moderate to severe HAE attack (moderate to severe abdominal pain, facial swelling, airway swelling) in the absence of hives or a medication known to cause angioedema AND Member is not taking medications that may exacerbate HAE including ACE inhibitors and estrogen-containing medications AND Member has received hepatitis A and hepatitis B vaccination. <p>Minimum age: 12 years Maximum dose: The recommended starting dose is 300mg every 2 weeks. A dosing interval of 300 mg every 4 weeks is also effective and may be considered if the patient is well-controlled (attack free) for more than 6 months</p> <p><u>Medications Indicated for Treatment of Acute Attacks:</u></p> <p>Members are restricted to coverage of one medication for <u>treatment of acute attacks</u> at one time. Prior authorization approval will be for one year.</p> <p>FIRAZYR (icatibant acetate) may be approved for members meeting the following criteria:</p>
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		<ul style="list-style-type: none"> ○ Member has a diagnosis of HAE confirmed by laboratory tests obtained on two separate instances at least one month apart (C4 level, C1-INH level) AND ○ Member has a documented history of at least one symptom of a moderate to severe HAE attack (moderate to severe abdominal pain, facial swelling, airway swelling) in the absence of hives or a medication known to cause angioedema AND ○ Member is not taking medications that may exacerbate HAE including ACE inhibitors and estrogen-containing medications <p>Minimum age: 18 years Maximum dose: 30mg</p> <p>BERINERT (C1 esterase inhibitor (human)) may be approved for members meeting the following criteria:</p> <ul style="list-style-type: none"> ○ Member has a diagnosis of HAE confirmed by laboratory tests obtained on two separate instances at least one month apart (C4 level, C1-INH level) AND ○ Member has a documented history of at least one symptom of a moderate to severe HAE attack (moderate to severe abdominal pain, facial swelling, airway swelling) in the absence of hives or a medication known to cause angioedema AND ○ Member is not taking medications that may exacerbate HAE including ACE inhibitors and estrogen-containing medications AND ○ Member has received hepatitis A and hepatitis B vaccination AND ○ Provider attests to performing annual testing or screening (as appropriate) for HBV, HCV, and HIV <p>Minimum age: 6 years Max dose: 20 IU/kg</p> <p>RUCONEST (C1 esterase inhibitor (recombinant)) may be approved for members meeting the following criteria:</p> <ul style="list-style-type: none"> ○ Member has a history of trial and failure of Firazyr OR Berinert. Failure is defined as lack of efficacy, allergy, intolerable side effects, or a significant drug-drug interaction AND ○ Member has a diagnosis of HAE confirmed by laboratory tests obtained on two separate instances at least one month apart (C4 level, C1-INH level) AND ○ Member has a documented history of at least one symptom of a moderate to severe HAE attack (moderate to severe abdominal pain, facial swelling, airway swelling) in the absence of hives or a medication known to cause angioedema AND ○ Member is not taking medications that may exacerbate HAE including ACE inhibitors and estrogen-containing medications AND ○ Member has received hepatitis A and hepatitis B vaccination AND
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		<ul style="list-style-type: none"> ○ Provider attests to performing annual testing or screening (as appropriate) for HBV, HCV, and HIV. <p>Minimum age: 13 years Maximum dose: 4200 Units/dose</p> <p>All other non-preferred agents may be approved if the member has trialed and failed at least two preferred agents with the same indicated role in therapy as the prescribed medication (prophylaxis or treatment). Failure is defined as lack of efficacy, allergy, intolerable side effects, or a significant drug-drug interaction.</p>
Therapeutic Drug Class: PHOSPHATE BINDERS -Effective 7/1/2021		
<p>No PA Required</p> <p><i>Brand/generic changes effective 07/15/21</i></p> <p>Calcium acetate capsule</p> <p>PHOSLYRA (calcium acetate)</p> <p>RENAGEL^{BNR} (sevelamer HCl 800mg tablet)</p> <p>RENVELA^{BNR} (sevelamer carbonate) tablet</p> <p>RENVELA^{BNR} (sevelamer carbonate) powder pack</p> <p>Sevelamer HCl 800mg tablet</p>	<p>PA Required</p> <p>AURYXIA (ferric citrate)</p> <p>Calcium acetate tablet</p> <p>CALPHRON (calcium acetate)</p> <p>FOSRENOL (lanthanum carbonate) chewable tablet, powder pack</p> <p>Lanthanum carbonate chewable tablet, powder pack</p> <p>Sevelamer carbonate tablet, powder pack</p> <p>Sevelamer HCl 400mg tablet</p> <p>VELPHORO (sucroferric oxide)</p>	<p>Prior authorization for non-preferred products in this class may be approved if member meets all the following criteria:</p> <ul style="list-style-type: none"> ● Member has diagnosis of end stage renal disease AND ● Member has elevated serum phosphorus [> 4.5 mg/dL or > 1.46 mmol/L] AND ● Provider attests to member avoidance of high phosphate containing foods from diet AND ● Member has trialed and failed‡ one preferred agent (lanthanum products require trial and failure‡ of a preferred sevelamer product). <p>Auryxia (ferric citrate) may be approved if the member meets all the following criteria:</p> <ul style="list-style-type: none"> ● Member is diagnosed with end-stage renal disease, receiving dialysis, and has elevated serum phosphate (> 4.5 mg/dL or > 1.46 mmol/L). AND ● Provider attests to counseling member regarding avoiding high phosphate containing foods from diet AND ● Member has trialed and failed‡ three preferred agents with different mechanisms of action prescribed for hyperphosphatemia in end stage renal disease <p>OR</p> <ul style="list-style-type: none"> ● Member is diagnosed with chronic kidney disease with iron deficiency anemia and is not receiving dialysis AND ● Member has tried and failed‡ at least two different iron supplement product formulations (OTC or RX) <p>Velphoro (sucroferric oxyhydroxide tablet, chewable) may be approved if the member meets all of the following criteria:</p> <ul style="list-style-type: none"> ● Member is diagnosed with chronic kidney disease and receiving dialysis and has elevated serum phosphate (> 4.5 mg/dL or > 1.46 mmol/L). AND ● Provider attests to counseling member regarding avoiding high phosphate containing foods from diet AND ● Member has trialed and failed‡ two preferred agents, one of which must be a preferred sevelamer product <p>Maximum Dose: Velphoro 3000mg daily</p>

		<p>Members currently stabilized on a non-preferred lanthanum product may receive approval to continue therapy with that product.</p> <p>‡Failure is defined as lack of efficacy with 6 week trial, allergy, intolerable side effects, or significant drug-drug interaction.</p> <p><i>Note: Medications administered in a dialysis unit or clinic are billed through the Health First Colorado medical benefit or Medicare with members with dual eligibility.</i></p>
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Therapeutic Drug Class: PRENATAL VITAMINS / MINERALS -Effective 10/1/2021

*Must meet eligibility criteria	PA Required	
<p>COMPLETE NATAL DHA tablet</p> <p>M-NATAL PLUS tablet</p> <p>NESTABS tablets</p> <p>PNV 29-1 tablet</p> <p>PREPLUS CA-FE 27 mg – FA 1 mg tablet</p> <p>SE-NATAL 19 chewable tablet</p> <p>THRIVITE RX tablet</p> <p>TRINATAL RX 1 tablet</p> <p>VITAFOL gummies</p> <p>VP-PNV-DHA softgel</p> <p>WESTAB PLUS tablet</p>	<p>All other rebateable prescription products are non-preferred</p>	<p>*Preferred and non-preferred prenatal vitamin products are a benefit for members from 11-60 years of age who are pregnant, lactating, or trying to become pregnant.</p> <p>Prior authorization for non-preferred agents may be approved if member fails 7-day trial with four preferred agents. Failure is defined as: allergy, intolerable side effects, or significant drug-drug interaction.</p>

XI. Ophthalmic

Therapeutic Drug Class: OPHTHALMIC, ALLERGY -Effective 4/1/2022

No PA Required	PA Required	
<p>ALREX (loteprednol) 2%</p> <p>Cromolyn 4%</p>	<p>ALAWAY (ketotifen) 0.025% (OTC)</p> <p>ALOCRIIL (nedocromil) 2%</p>	<p>Non-preferred products may be approved following trial and failure of therapy with two preferred products (failure is defined as lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions).</p>

Ketotifen 0.025% (OTC) LASTACFT (alcaftadine) 0.25% Olopatadine 0.2% (OTC) (generic Pataday Once Daily) Olopatadine 0.1% (RX) Olopatadine 0.2% (RX) (all manufacturers except <i>Sandoz</i>) PAZEO (olopatadine) 0.7% (RX)	ALOMIDE (lodoxamide) 0.1% Azelastine 0.05% BEPREVE (bepotastine) 1.5% Bepotastine 1.5% Epinastine 0.05% Olopatadine 0.1% (OTC) Olopatadine 0.2% (RX) (<i>Sandoz only</i>) PATADAY ONCE DAILY (olopatadine) 0.2% (OTC) PATADAY TWICE DAILY (olopatadine) 0.1% (OTC) PATADAY XS ONCE DAILY (olopatadine) 0.7% (OTC) ZADITOR (ketotifen) 0.025% (OTC) ZERViate (cetirizine) 0.24%	
Therapeutic Drug Class: OPHTHALMIC, IMMUNOMODULATORS -Effective 4/1/2022		
No PA Required RESTASIS ^{BNR} (cyclosporine 0.05%)	PA Required CEQUA (cyclosporine) 0.09% solution Cyclosporine 0.05% vials RESTASIS MULTIDOSE (cyclosporine) 0.05% XIIDRA (lifitegrast) 5% solution	Non-preferred products may be approved for members meeting all of the following criteria: <ul style="list-style-type: none"> Member is 18 years and older AND Member has a diagnosis of chronic dry eye AND Member has failed a 3-month trial of one preferred product. Failure is defined as a lack of efficacy, allergy, intolerable side effects, contraindication to, or significant drug-drug interactions AND Prescriber is an ophthalmologist, optometrist or rheumatologist <u>Maximum Dose/Quantity:</u> 60 single use containers for 30 days 5.5 mL/20 days for Restasis Multi-Dose
Therapeutic Drug Class: OPHTHALMIC, ANTI-INFLAMMATORIES -Effective 4/1/2022		
NSAIDs		

<p>No PA Required</p> <p>Diclofenac 0.1%</p> <p>Flurbiprofen 0.03%</p> <p>ILEVRO (nepafenac) 0.03%</p> <p>Ketorolac 0.5%, Ketorolac LS 0.4%</p>	<p>PA Required</p> <p>ACULAR (ketorolac) 0.5%, LS 0.4%</p> <p>ACUVAIL (ketorolac/PF) 0.45%</p> <p>Bromfenac 0.09%</p> <p>BROMSITE (bromfenac) 0.075%</p> <p>NEVANAC (nepafenac) 0.1%</p> <p>PROLENSA (bromfenac) 0.07%</p>	<p>Durezol (difluprednate) may be approved if meeting the following criteria:</p> <ul style="list-style-type: none"> Member has a diagnosis of severe intermediate uveitis, severe panuveitis, or severe uveitis with the complication of uveitic macular edema AND has trialed and failed prednisolone acetate 1% (failure is defined as lack of efficacy, allergy, contraindication to therapy, intolerable side effects, or significant drug-drug interaction) OR Members with a diagnosis other than those listed above require trial and failure of three preferred agents (failure is defined as lack of efficacy, contraindication to therapy, allergy, intolerable side effects, or significant drug-drug interaction). <p>Lotemax SM (loteprednol etabonate) or Inveltys (loteprednol etabonate) may be approved if meeting all of the following:</p> <ul style="list-style-type: none"> Member is ≥ 18 years of age AND Lotemax SM or Inveltys (loteprednol etabonate) is being used for the treatment of post-operative inflammation and pain following ocular surgery AND Member has trialed and failed therapy with two preferred loteprednol formulations (failure is defined as lack of efficacy with 2-week trial, allergy, contraindication to therapy, intolerable side effects, or significant drug-drug interaction) AND Member has trialed and failed therapy with two preferred agents that do not contain loteprednol (failure is defined as lack of efficacy with 2-week trial, contraindication to therapy, allergy, intolerable side effects, or significant drug-drug interaction) AND Member does not have any of the following conditions: <ul style="list-style-type: none"> Viral diseases of the cornea and conjunctiva including epithelial herpes simplex keratitis (dendritic keratitis), vaccinia, and varicella OR Mycobacterial infection of the eye and fungal diseases of ocular structures
Corticosteroids		
<p>No PA Required</p> <p>FLAREX (fluorometholone) 0.1%</p> <p>Fluorometholone 0.1% drops</p> <p>FML FORTE (fluorometholone) 0.25% drops</p> <p>LOTEMAX^{BNR} (loteprednol) 0.5% drops</p> <p>LOTEMAX (loteprednol) 0.5% ointment</p> <p>MAXIDEX (dexamethasone) 0.1%</p> <p>PRED MILD (prednisolone) 0.12%</p> <p>Prednisolone acetate 1%</p>	<p>PA Required</p> <p>Dexamethasone 0.1%</p> <p>Difluprednate 0.05%</p> <p>DUREZOL (difluprednate) 0.05%</p> <p>EYSUVIS (loteprednol) 0.25%</p> <p>FML LIQUIFILM (fluorometholone) 0.1% drop</p> <p>FML S.O.P (fluorometholone) 0.1% ointment</p> <p>INVELTYS (loteprednol) 1%</p> <p>LOTEMAX (loteprednol) 0.5% gel</p> <p>LOTEMAX SM (loteprednol) 0.38% gel</p> <p>Loteprednol 0.5% drops, 0.5% gel</p> <p>PRED FORTE (prednisolone) 1%</p> <p>Prednisolone sodium phosphate 1%</p>	<p>Eysuvis (loteprednol etabonate) may be approved if meeting all of the following:</p> <ul style="list-style-type: none"> Member is ≥ 18 years of age AND Eysuvis (loteprednol etabonate) is being used for short-term treatment (up to two weeks) of the signs and symptoms of dry eye disease AND Member has failed treatment with one preferred product in the Ophthalmic Immunomodulator therapeutic class. Failure is defined as lack of efficacy with a 3-month trial, contraindication to therapy, allergy, intolerable side effects, or significant drug-drug interaction) AND Member does not have any of the following conditions:

		<ul style="list-style-type: none"> • Viral diseases of the cornea and conjunctiva including epithelial herpes simplex keratitis (dendritic keratitis), vaccinia, and varicella OR • Mycobacterial infection of the eye and fungal diseases of ocular structures • <u>Quantity limit</u>: one bottle/15 days <p>All other non-preferred products may be approved with trial and failure of three preferred agents (failure is defined as lack of efficacy with 2-week trial, allergy, contraindication, intolerable side effects, or significant drug-drug interaction).</p>
Therapeutic Drug Class: OPHTHALMIC, GLAUCOMA -Effective 4/1/2022		
Beta-blockers		<p>Non-preferred products may be approved following trial and failure of therapy with three preferred products, including one trial with a preferred product having the same general mechanism (such as prostaglandin analogue, alpha2-adrenergic agonist, beta-blocking agent, or carbonic anhydrase inhibitor). Failure is defined as lack of efficacy with 4-week trial, allergy, intolerable side effects or significant drug-drug interactions.</p> <p>Non-preferred combination products may be approved following trial and failure of therapy with one preferred combination product AND trial and failure of individual products with the same active ingredients as the combination product being requested (if available) to establish tolerance. Failure is defined as lack of efficacy with 4-week trial, allergy, intolerable side effects or significant drug-drug interactions.</p> <p>Preservative free products may be approved with provider documentation of adverse effect to preservative-containing product.</p>
No PA Required	PA Required	
Levobunolol 0.5%	Betaxolol 0.5%	
Timolol (generic Timoptic) 0.25%, 0.5%	BETOPIC-S (betaxolol) 0.25%	
	Carteolol 1%	
	ISTALOL (timolol) 0.5%	
	Timolol (generic Istalol) 0.5% drops	
	Timolol GFS 0.25%, 0.5%	
	TIMOPTIC, TIMOPTIC OCUDOSE (timolol) 0.25%, 0.5%	
	TIMOPTIC-XE (timolol GFS) 0.25%, 0.5%	
Carbonic anhydrase inhibitors		
No PA Required	PA Required	
AZOPT ^{BNR} (brinzolamide) 1%	Brinzolamide 1%	
Dorzolamide 2%	TRUSOPT (dorzolamide) 2%	
Prostaglandin analogue		
No PA Required	PA Required	
Latanoprost 0.005%	Bimatoprost 0.03%	
LUMIGAN (bimatoprost) 0.01%	Travoprost 0.004%	

TRAVATAN Z ^{BNR} (travoprost) 0.004%	VYZULTA (latanoprostene) 0.024% XALATAN (latanoprost) 0.005% XELPROS (latanoprost) 0.005% ZIOPTAN (tafluprost PF) 0.0015%	
Alpha-2 adrenergic agonists		
No PA Required	PA Required	
ALPHAGAN P 0.1% (brimonidine)	Apraclonidine 0.5%	
ALPHAGAN P ^{BNR} 0.15% (brimonidine)	Brimonidine 0.15%	
Brimonidine 0.2%	IOPIDINE (apraclonidine) 0.5%, 1%	
Other ophthalmic, glaucoma and combinations		
No PA Required	PA Required	
COMBIGAN ^{BNR} 0.2%-0.5% (brimonidine/timolol)	Brimonidine/Timolol 0.2%-0.5%	
Dorzolamide/Timolol 2%-0.5%	COSOPT/COSOPT PF (dorzolamide/timolol) 2%-0.5%	
Dorzolamide/Timolol PF 2%-0.5%	ISOPTO CARPINE (pilocarpine) 1%, 2%, 4%	
	PHOSPHOLINE IODIDE (echothiophate) 0.125%	
	Pilocarpine 1%, 2%, 4%	
	RHOPRESSA (netarsudil) 0.02%	
	ROCKLATAN (netarsudil/latanoprost) 0.02%-0.005%	
	SIMBRINZA (brinzolamide/brimonidine) 1%-0.2%	
XII. Renal/Genitourinary		

Therapeutic Drug Class: BENIGN PROSTATIC HYPERPLASIA (BPH) AGENTS -Effective 7/1/2021		
No PA Required	PA Required	<p>Prior authorization for non-preferred products in this class may be approved if member meets all of the following criteria:</p> <ul style="list-style-type: none"> Member has tried and failed‡ three preferred agents AND For combinations agents, member has tried and failed‡ each of the individual agents within the combination agent and one other preferred agent. <p>‡Failure is defined as lack of efficacy with 8-week trial, allergy, intolerable side effects, contraindication to, or significant drug-drug interaction.</p> <p>*CIALIS (tadalafil) may be approved for members with a documented diagnosis of BPH who have failed a trial of finasteride (at least 3 months in duration) AND either a trial of a nonselective alpha blocker (therapeutic dose for at least two months) OR a trial of tamsulosin (therapeutic dose for at least one month). Documentation of BPH diagnosis will require BOTH of the following:</p> <ul style="list-style-type: none"> AUA Prostate Symptom Score ≥ 8 AND Results of a digital rectal exam. <p>Cialis (tadalafil) will not be approved for any patient continuing alpha-blocker therapy as this combination is contraindicated in this population.</p> <p>Doses exceeding 5mg per day of Cialis (tadalafil) will not be approved.</p>
Alfuzosin ER tablet	AVODART (dutasteride)	
Doxazosin tablet	CARDURA (doxazosin)	
Dutasteride capsule	CARDURA XL (doxazosin ER)	
Finasteride tablet	*CIALIS (tadalafil) 2.5 mg, 5 mg	
Tamsulosin capsule	Dutasteride/tamsulosin	
Terazosin capsule	FLOMAX (tamsulosin)	
	JALYN (dutasteride/tamsulosin)	
	PROSCAR (finasteride)	
	RAPAFLO (silodosin)	
	Silodosin capsule	
	*Tadalafil 2.5 mg, 5 mg	
Therapeutic Drug Class: ANTI-HYPERURICEMICS -Effective 1/1/2022		
No PA Required	PA Required	<p>Non-preferred xanthine oxidase inhibitor products (allopurinol or febuxostat formulations) may be approved following trial and failure of preferred allopurinol. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction. If member has tested positive for the HLA-B*58:01 allele, it is not recommended that they trial allopurinol. A positive result on this genetic test will count as a failure of allopurinol.</p> <p>Prior authorization for all other non-preferred agents (non-xanthine oxidase inhibitors) may be approved after trial and failure of two preferred products. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.</p> <p>GLOPERBA (colchicine) oral solution may be approved for members who require individual doses <0.6 mg OR for members who have documented swallowing difficulty due to young age and/or a medical condition (preventing use of solid oral dosage form).</p> <p>Colchicine tablet quantity limits:</p> <ul style="list-style-type: none"> Chronic hyperuricemia/gout prophylaxis: 60 tablets per 30 days Familial Mediterranean Fever: 120 tablets per 30 days
<i>Brand/generic changes effective 1/27/2022</i>	Colchicine capsule	
Allopurinol tablet	COLCRYS (colchicine) tablet	
Colchicine tablet	Febuxostat tablet	
Probenecid tablet	GLOPERBA (colchicine) oral solution	
Probenecid/Colchicine tablet	MITIGARE (colchicine) capsule	
	ULORIC (febuxostat) tablet	
	ZYLOPRIM (allopurinol) tablet	

Therapeutic Drug Class: OVERACTIVE BLADDER AGENTS -Effective 10/1/2021		
No PA Required GELNIQUE (oxybutynin) gel MYRBETRIQ (mirabegron) tablet Oxybutynin IR, ER tablets, syrup Oxybutynin ER tablets Solifenacin tablet TOVIAZ (fesoterodine ER)	PA Required Darifenacin ER tablet DETROL (tolterodine) DETROL LA (tolterodine ER) DITROPAN (brand) DITROPAN XL (brand) ENABLEX (darifenacin) Flavoxate GELNIQUE (oxybutynin) gel pump MYRBETRIQ (mirabegron) suspension OXYTROL (oxybutynin patch) SANCTURA (trospium) SANCTURA XL (trospium ER) Tolterodine Trospium ER capsule, tablet VESICARE (solifenacin)	Non-preferred products may be approved for members who have failed treatment with two preferred products. Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction. Members with hepatic failure can receive approval for trospium (Sanctura) or trospium extended release (Sanctura XR) products without a trial on a Preferred product.
XIII. RESPIRATORY		
Therapeutic Drug Class: RESPIRATORY AGENTS -Effective 1/1/2022		
Inhaled Anticholinergics		
No PA Required (unless indicated*) <u>Solutions</u> Ipratropium solution <u>Short-Acting Inhalation Devices</u>	PA Required <u>Solutions</u> LONHALA MAGNAIR (glycopyrrolate) solution YUPELRI (revefenacin) solution	*SPIRIVA RESPIMAT (tiotropium) 1.25 mcg may be approved for members ≥ 6 years of age with a diagnosis of asthma (qualifying diagnosis verified by AutoPA). SPIRIVA RESPIMAT is intended to be used by members whose asthma is not controlled with regular use of a combination medium-dose inhaled corticosteroid and long-acting beta agonist (LABA).

<p>ATROVENT HFA (ipratropium)</p> <p><u>Long-Acting Inhalation Devices</u></p> <p>SPIRIVA Handihaler (tiotropium)</p> <p>*SPIRIVA RESPIMAT (tiotropium)</p>	<p><u>Short-Acting Inhalation Devices</u></p> <p><u>Long-Acting Inhalation Devices</u></p> <p>INCRUSE ELLIPTA (umeclidinium)</p> <p>SEEBRI NEOHALER (glycopyrrolate)</p> <p>TUDORZA PRESSAIR (aclidinium)</p>	<p>*SPIRIVA RESPIMAT (tiotropium) 2.5 mcg may be approved for members with a diagnosis of COPD who have trialed and failed SPIRIVA HANDIHALER. Failure is defined as intolerable side effects or inability to use dry powder inhaler (DPI) formulation.</p> <p>LONHALA MAGNAIR (glycopyrrolate) may be approved for members ≥ 18 years of age with a diagnosis of COPD including chronic bronchitis and emphysema who have trialed and failed\ddagger treatment with two preferred anticholinergic agents.</p> <p>Non-preferred single agent anticholinergic agents may be approved for members with a diagnosis of COPD including chronic bronchitis and/or emphysema who have trialed and failed\ddagger treatment with two preferred agents, one of which must be SPIRIVA HANDIHALER.</p> <p>\ddaggerFailure is defined as lack of efficacy with 6-week trial, allergy, intolerable side effects, or significant drug-drug interaction.</p>
Inhaled Anticholinergic Combinations		
<p>No PA Required</p> <p><u>Solutions</u></p> <p>Albuterol/ipratropium solution</p> <p><u>Short-Acting Inhalation Devices</u></p> <p>COMBIVENT RESPIMAT (albuterol/ipratropium)</p> <p><u>Long-Acting Inhalation Devices</u></p> <p>ANORO ELLIPTA (umeclidinium/vilanterol)</p>	<p>PA Required</p> <p><u>Solutions</u></p> <p><u>Short-Acting Inhalation Devices</u></p> <p><u>Long-Acting Inhalation Devices</u></p> <p>BEVESPI AEROSPHERE (glycopyrrolate/formoterol fumarate)</p> <p>BREZTRI AEROSPHERE (budesonide/glycopyrrolate/ formoterol)</p> <p>DUAKLIR PRESSAIR (aclidinium/formoterol)</p> <p>STIOLTO RESPIMAT (tiotropium/olodaterol)</p> <p>UTIBRON NEOHALER (glycopyrrolate/indacaterol)</p>	<p>BREZTRI AEROSPHERE (budesonide/glycopyrrolate/formoterol) may be approved for members ≥ 18 years of age with a diagnosis of COPD who have trialed and failed\ddagger treatment with two preferred anticholinergic-containing agents.</p> <p>DUAKLIR PRESSAIR (aclidinium/formoterol) may be approved for members ≥ 18 years of age with a diagnosis of COPD who have trialed and failed\ddagger treatment with two preferred anticholinergic-containing agents.</p> <p>All other non-preferred inhaled anticholinergic combination agents may be approved for members with a diagnosis of COPD including chronic bronchitis and/or emphysema who have trialed and failed\ddagger treatment with two preferred inhaled anticholinergic combination agents OR three preferred inhaled anticholinergic-containing agents (single ingredient or combination).</p> <p>Members who are currently stabilized on Bevespi Aerosphere may receive approval to continue therapy with that product.</p> <p>\ddaggerFailure is defined as lack of efficacy with 6-week trial, allergy, intolerable side effects, or significant drug-drug interaction.</p>
Inhaled Beta2 Agonists (short acting)		
<p>No PA Required</p> <p><u>Solutions</u></p> <p>Albuterol solution, for nebulizer</p> <p><u>Inhalers</u></p>	<p>PA Required</p> <p><u>Solutions</u></p> <p>Levalbuterol solution</p> <p>XOPENEX (levalbuterol) solution</p>	<p>Non-preferred, short acting beta2 agonists may be approved for members who have failed treatment with one preferred agent. Failure is defined as lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction.</p>

PROAIR ^{BNR} HFA (albuterol) VENTOLIN ^{BNR} HFA (albuterol)	<u>Inhalers</u> Albuterol HFA Levalbuterol HFA PROAIR DIGIHALER, RESPICLICK (albuterol) PROVENTIL (albuterol) HFA inhaler XOPENEX (levalbuterol) Inhaler	MDI formulation quantity limits: 2 inhalers / 30 days
Inhaled Beta2 Agonists (long acting)		
*Must meet eligibility criteria <u>Solutions</u> <u>Inhalers</u> *SEREVENT DISKUS (salmeterol) inhaler	PA Required <u>Solutions</u> BROVANA (arformoterol) solution PERFOROMIST (formoterol) solution <u>Inhalers</u> STRIVERDI RESPIMAT (olodaterol)	* SEREVENT (salmeterol) may be approved for members with moderate to very severe COPD. Serevent will not be approved for treatment of asthma in members needing add-on therapy due to safety risks associated with monotherapy. Non-preferred agents may be approved for members with moderate to severe COPD, AND members must have failed a trial of Serevent. Failure is defined as lack of efficacy with a 6-week trial, allergy, intolerable side effects, or significant drug-drug interaction. For treatment of members with diagnosis of asthma needing add-on therapy, please refer to preferred agents in combination Long-Acting Beta Agonist/Inhaled Corticosteroid therapeutic class.
Inhaled Corticosteroids		
No PA Required <u>Solutions</u> Budesonide nebulers <u>Inhalers</u> ASMANEX Twisthaler (mometasone) FLOVENT DISKUS (fluticasone) FLOVENT HFA (fluticasone) PULMICORT FLEXHALER (budesonide)	PA Required <u>Solutions</u> PULMICORT (budesonide) nebulers <u>Inhalers</u> ALVESCO (ciclesonide) inhaler ARMONAIR DIGIHALER (fluticasone propionate) ARNUITY ELLIPTA (fluticasone furoate) ASMANEX HFA (mometasone furoate) inhaler QVAR REDIHALER (beclomethasone)	Non-preferred inhaled corticosteroids may be approved in members with asthma who have failed an adequate trial of two preferred agents. An adequate trial is defined as at least 6 weeks. (Failure is defined as: lack of efficacy with a 6-week trial, allergy, contraindication to, intolerable side effects, or significant drug-drug interactions.) <u>Maximum Dose:</u> Pulmicort (budesonide) nebulizer suspension: 2mg/day
Inhaled Corticosteroid Combinations		

No PA Required	PA Required	
<p>ADVAIR DISKUS^{BNR} (fluticasone/salmeterol)</p> <p>ADVAIR HFA (fluticasone/salmeterol)</p> <p>DULERA (mometasone/ formoterol)</p> <p>SYMBICORT^{BNR} (budesonide/formoterol) inhaler</p>	<p>AIRDUO DIGIHALER, RESPICLICK (fluticasone/salmeterol)</p> <p>BREO Ellipta (vilanterol/fluticasone furoate)</p> <p>Budesonide/formoterol (generic Symbicort)</p> <p>Fluticasone/salmeterol (generic Airduo)</p> <p>Fluticasone/salmeterol (generic Advair)</p> <p>TRELEGY ELLIPTA (fluticasone furoate/ umeclidinium/vilanterol)</p> <p>WIXELA INHUB (fluticasone/salmeterol)</p>	<p>Non-preferred inhaled corticosteroid combinations may be approved for members meeting both of the following criteria:</p> <ul style="list-style-type: none"> • Member has a qualifying diagnosis of asthma or severe COPD; AND • Member has failed two preferred agents (Failure is defined as lack of efficacy with a 6-week trial, allergy, intolerable side effects, significant drug-drug interactions, or dexterity/coordination limitations (per provider notes) that significantly impact appropriate use of a specific dosage form.) <p>TRELEGY ELLIPTA (fluticasone furoate/umeclidinium/vilanterol) may be approved if the member has trialed/failed three preferred inhaled corticosteroid combination products AND Spiriva. Failure is defined as lack of efficacy with a 6-week trial, allergy, intolerable side effects, significant drug-drug interactions, or dexterity/coordination limitations (per provider notes) that significantly impact appropriate use of a specific dosage form.</p>
Phosphodiesterase Inhibitors (PDEIs)		
No PA Required	PA Required	
	<p>DALIRESP (roflumilast)</p>	<p>DALIRESP (roflumilast) may be approved for members when the following criteria are met:</p> <ul style="list-style-type: none"> • Member has severe COPD associated with chronic bronchitis and a history of COPD exacerbations (2 or more per year) AND • Member must be ≥ 18 years of age AND • Member must have failed a trial of TWO of the following (Failure is defined as lack of efficacy, allergy, intolerable side effects or significant drug-drug interaction): <ul style="list-style-type: none"> ○ A long-acting beta2 agonist ○ A preferred inhaled anticholinergic or anticholinergic combination product • AND • Member does not have moderate to severe liver disease (Child Pugh B or C)